23 Chapter

GENDER ISSUES

23.1 INTRODUCTION

Major component of Health & Family Welfare Programme is related to Health problems of women and children, as they are more vulnerable to ill health and diseases. Since women constitute about half of population, it is essential to know the health status of women so that the causes of ill health are identified, discussed and misconceptions removed. Ill health of women is mainly due to poor nutrition, gender discrimination, low age at marriage, risk factors during pregnancy, unsafe, unplanned and multiple deliveries, limited access to family planning methods and unsafe abortion services.

The Government seeks to provide services in a life cycle approach. Under the RCH Programme, the need for improving women health in general and bringing down maternal mortality rate has been strongly stressed in the National Population Policy 2000. This policy recommends a holistic strategy for bringing about total inter-sectoral coordination at the grassroot levels and involving the NGOs, Civil Societies, Panchayati Raj Institutions and Women's Group in bringing down Maternal Mortality Rate and Infant Mortality Rate.

The major interventions include provisioning of additional ANMs and Public Health/Staff Nurses in certain sub-centres, PHCs/CHCs, Laboratory Technicians, Referral Transport, 24-Hours Delivery Services at PHCs/CHCs, Safe Motherhood Consultants, Safe Abortion Services, Essential Obsetetric Care, Emergency Obstetric Care, Skilled Manpower on contractual and hiring basis, Training of Dais, Training of MBBS doctors in Anesthetic Skills for Emergency Obstetric Care at FRUs, operationalisation of FRUs through supply of drugs in the form of emergency obstetric drug kits, Blood Storage Centers (BSC) at FRUs and prevention and management of RTI/STI. Details of these interventions are given in the Maternal Health Chapter of this Report. However, some points on these Programmes are given in this chapter.

23.2 JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission (NHM). It is being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among poor pregnant women. Launched on 12 April, 2005, the scheme is under implementation in all States and Union Territories (UTs), with a special focus on Low Performing States (LPS).

The number of JSY beneficiaries has risen from 7.39 lakhs in 2005-06 to more than 104.38 lakhs in 2014-15, with the expenditure on this scheme increasing from Rs. 38.29 crores to Rs. 1668 crores in 2014-15. Institutional deliveries in India have risen sharply from 47% in 2008 to over 78.7% in 2013-14.

23.2.1 Accrediting private health institutions

In order to increase the choice of delivery care institutions, States are encouraged to accredit at least two willing private institutions per block to provide delivery services. The State and District authorities should draw up a list of criteria/ protocols for such accreditation.

23.2.2 Direct Benefits Transfer under JSY

Direct Benefit Transfer (DBT) mode of payments was initially rolled out in 43 districts w.e.f. 1.1.2013 and in 78 districts from 1.7.2013. Now the initiative has been expanded across the country in all the districts. Under this initiative, eligible pregnant women are entitled to get JSY benefit directly into their bank accounts through Aadhaar number. Payments made through DBT mechanism in FY 2015-16 till 30.09.2015 are as under:

Payment Made (from 01.04.2015 to 30.09.2015)	**Number of Beneficiaries**	**Amount** (in Rs.)
Aadhaar based payments	13851	20953019
Payments through Core Banking Solution (CBS)	1702004	2120030645
Total	**1715855**	**2140983664**

23.2.3 Progress and achievement

JSY has been a phenomenal success both in terms of number of mothers covered and expenditure incurred on the scheme. From a modest figure of 7.39 lakhs beneficiaries in 2005-06, the scheme currently provides benefit to more than one crore beneficiaries every year.

In terms of achievement, the JSY is considered to be one of the important factors in increased utilization of public health facilities by the pregnant women for delivery care services which are reflected in the following:

- Increase in institutional deliveries which gone up from 47% (District Level Household Survey-III, 2007-08) to 78.7% (RSOC:2013-14);
- Maternal Mortality Rate (MMR) which declined from 254 maternal deaths per 1,00,000 live births in 2004-06 to 167 maternal deaths per 1,00,000 live births during 2011-13;
- Infant Mortality Rate (IMR) has declined from 58 per 1000 live births in 2005 to 40 per 1000 live births in 2013 and
- The Neo-Natal Mortality Rate (NMR) has declined from 37 per 1000 live births in 2006 to 28 per 1000 live births in 2013.

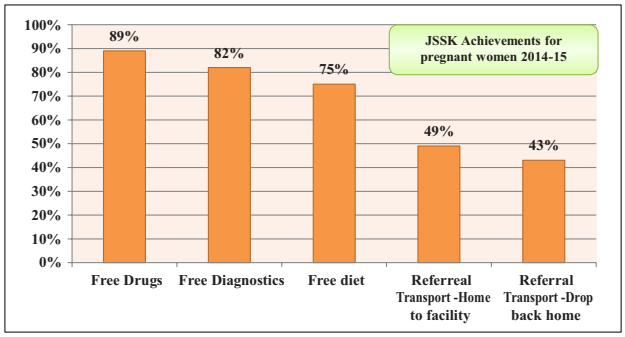
23.3 JANANI SHISHU SURAKSHA KARYAKRAM (JSSK)

- Building on the phenomenal progress of the JSY scheme, Government of India has launched **Janani Shishu Suraksha Karyakram (JSSK)** on 1st June, 2011. The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. The entitlements include free drugs and consumables, free diet during stay at normal delivery and C-section, free diagnostics and free blood wherever required. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements were put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. In 2013, the scheme was expanded to cover complications during ante-natal and post-natal period and also sick infants upto 1 year of age.
- Prior to launch of NHM, Call Centre based

ambulance network was virtually non-existent. Now, most States have the facility where people can dial 108 or 102 or 104 telephone number for calling an ambulance. A total of over 21,000 ambulances/patient transport vehicles are now operational across States.

- Utilization of public health infrastructure by pregnant women has increased dramatically as a result of JSY & JSSK. As many as 1.30 crore women delivered in Government health facilities last year (2014-15).

- All States and Union Territories are implementing this scheme. As per the latest reports received from the States/UTs, 89% pregnant women availed free drugs, 82% free diagnostics, 75% free diet, 49% free home to facility transport and 56.03% free drop back home. For sick infants, 73% sick infants availed free drugs, 40% free diagnostics, 10% sick infants free home to facility transport and 28% free drop back home.



23.3.1 Launch of India Newborn Action Plan (INAP): In September 2014, INAP was launched for accelerating the reduction of preventable newborn deaths and stillbirths in the country with the goal of attaining 'Single Digit Neo-natal Mortality Rate (NMR) by 2030' and 'Single Digit Still Birth Rate (SBR) by 2030'. The neo-natal deaths are expected to reduce to below 2.28 lakh annually by 2030, once the goal is achieved.

23.3.2 Facility Based Newborn Care: A continuum of newborn care has been established with the launch of home based and facility based newborn care components ensuring that every newborn receives essential care right from the time of birth and first 48 hours at the health facility and then at home during the first 42 days of life. Newborn Care Corners (NBCCs) are established at delivery points to provide essential newborn care at birth, while Special Newborn Care Units (SNCUs) at District Hospital/Medical College and Newborn Stabilization Units (NBSUs) at FRUs provide care for sick newborns. As on June 2015, a total of 14,441 NBCCs, 2,020 NBSUs and 575 SNCUs have been made operational across the country.

23.4 NATIONAL AMBULANCE SERVICES (NAS)

At the time of launch of NRHM, such ambulances networks were non-existent. As on date, 31 States/ UTs have the facility where people can dial 108 or 102 telephone number for calling an ambulance. Dial 108 is predominantly an emergency response system, primarily designed to attend to patients of critical care, trauma and accident victims etc. Dial 102 services essentially consist of basic patient transport aimed to cater the needs of pregnant women and children though other categories are also taking benefit and are not excluded. JSSK entitlements e.g. free transport from home to facility, inter facility transfer in case of referral and drop back for mother and children are the key focus of 102 service. This service can be accessed through a toll free call to a Call Centre.

Presently, 7358 Dial-108, 400 Dial-104 and 7836 Dial-102 Emergency Response Service Vehicles are operational under NRHM, besides 6290 empanelled vehicles for transportation of patients, particularly pregnant women and sick infants from home to public health facilities and back.

23.5 MOTHER AND CHILD TRACKING SYSTEM (MCTS)

It is a name based tracking system, launched by the Government of India as an innovative application of information technology, directed towards improving the healthcare service delivery system and strengthening the monitoring mechanism. MCTS is designed to capture information and track all pregnant women and children (0-5 Years) so that they receive 'full' maternal and child health services and it thereby contributes to the reduction in maternal, infant and child morbidity and mortality, which is one of the goals of National Health Mission (NHM).

A total of 1,18,68505 pregnant women were registered in MCTS during 2015-16 (till Oct.), which indicates a registration of 67.57 % as against estimated number of pregnant women in 2015-16 (till Oct.). Similarly, a total of 82,38,820 children were registered in MCTS during 2015-16 (till Oct.) which indicates a registration of 52% as against estimated number of infants in 2015-16 (till Oct.).

23.6 RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

RBSK has been launched to provide child health screening and early interventions services by expanding the reach of mobile health teams at block level. These teams will also carry out screening of all the children in the age group 0–6 years enrolled at Anganwadi Centres at least twice a year. RBSK covers 30 common health conditions. States/UTs may incorporate a few more conditions based on high prevalence/endemicity. An estimated 27 crore children in the age group of zero to eighteen (0-18) years are expected to be covered in a phased manner.

23.7 SEX - RATIO

Adverse Child Sex-Ratio in India

The Child Sex Ratio (CSR) for the age group of 0-6 years as per the 2011 Census has dipped further to 918 girls as against 927 per thousand boys as recorded in the 2001 Census. This negative trend reaffirms the fact that the girl child is at higher risk than ever before. Except for the States/ UTs viz. Puducherry (967), Tamil Nadu (943), Karnataka (948), Delhi (871), Goa (942), Kerala (964), Mizoram (970), Gujarat (890), Arunachal Pradesh (972), Andaman & Nicobar Islands (968), Himachal Pradesh (909), Haryana (834), Chandigarh (880) and Punjab (846), the Child Sex Ratio has shown a declining trend in 18 States and 3 UTs. The steepest fall of 79 points is in Jammu & Kashmir and the largest improvement of Child Sex Ratio of 48 points is in Punjab.

Jammu & Kashmir, Maharashtra and Haryana have had the worst decline in the past 30 years in Child Sex Ratio. Among the larger States, Chhattisgarh has the highest Child Sex Ratio (CSR) of 969 followed by Kerala with 964. Haryana (834) is at the bottom followed by Punjab (846). The Census 2011 saw a declining trend even in North Eastern States except in Arunachal Pradesh and Mizoram. Half of the districts in the country showed decline in the Child Sex Ratio greater than the national average. The number of districts with Child Sex Ratio of 950 and above has reduced from 259 to 182.

Reasons for adverse Sex Ratio

Some of the reasons commonly put forward to explain the consistently low levels of Sex Ratio are son preference, neglect of the girl child resulting in higher mortality at younger age, female infanticide, female foeticide, higher Maternal Mortality and male bias. Easy availability of the sex determination tests and abortion services may also be proving to be catalyst in the process, which may be further stimulated by pre-conception sex selection facilities. Sex determination techniques have been in use in India since 1975, primarily

for the determination of genetic abnormalities. However, these techniques were widely misused to determine the sex of the foetus and subsequent elimination, if the foetus was found to be a female.

Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994

In order to check female foeticide, the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, was brought into operation from 1st January, 1996. The Act has since been amended to make it more comprehensive. The amended Act came into force with effect from 14.2.2003 and it has been renamed as "Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994" (PC&PNDT Act).

The technique of pre-conception sex selection has been brought within the ambit of this Act so as to pre-empt the use of such technologies, which significantly contribute to the declining Sex Ratio. The use of ultrasound machines has also been brought within the purview of this Act more explicitly so as to curb their misuse for detection and disclosure of sex of the foetus, lest it should lead to female foeticide. The Central Supervisory Board (CSB) constituted under the Chairmanship of Minister for Health & Family Welfare has been further empowered for monitoring the implementation of the Act. State level Supervisory Boards in the line with the CSB constituted at the Centre, have been introduced for monitoring and reviewing the implementation of the Act in States/ UTs. The State/UT level Appropriate Authority has been made a multi-member body for better implementation and monitoring of the Act in the States. More stringent punishments are prescribed under the Act, so as to serve as a deterrent against violations of the Act. The Appropriate Authorities are empowered with the powers of Civil Court for search, seizure and sealing the machines, equipments and records of the violators of law including sealing of premises and commissioning of witnesses. It has been made mandatory to maintain proper records in respect of the use of ultrasound machines and other equipments capable of detection of sex of foetus and also in respect of tests and procedures that may lead to pre-conception selection of sex. The sale of ultrasound machines has been regulated through laying down the condition of sale only to the bodies registered under the Act.

Punishment under the Act: The PC&PNDT Act, 1994 protects the pregnant woman but provides for the following penalties:

➢ **For doctors/owner of clinics:**

- Up to 3 years of imprisonment with fine up to Rs. 10,000 for the first offence;
- Up to 5 years of imprisonment with fine up to Rs. 50, 000 for subsequent offence and
- Suspension of registration with the Medical Council if charges are framed by the court and till the case is disposed of, removal of the name for 5 years from the medical register in the case of first offence and permanent removal in case of subsequent offence.

➢ **For husband/family member or any other person abetting sex selection:**

- Up to 3 years of imprisonment with a fine up to Rs. 50,000 for the first offence.
- Up to 5 years of imprisonment with fine up to Rs. 1 lakh for subsequent offence.

➢ **For any advertisement regarding sex selection:**

- Up to 3 years of imprisonment and up to Rs. 10,000 fine.

Implementation of PC&PNDT Act in States/ UTs

As per Quarterly Progress Reports (QPRs) submitted by States/UTs, 51795 bodies have been registered under the PC&PNDT Act. So far, a total of 1435 machines have been sealed and seized for violations of the law. A total of 2140 ongoing court cases and 304 convictions have been secured under the PC&PNDT Act and following conviction the medical licenses of 100 doctors have been suspended/ cancelled.

As a result of intensification of the drive against illegal sex determination, 474 cases have been filed in 2013-2014, 288 in 2012-13, 279 in 2011-12 as compared to 157 in 2010-11.

PROGRESS CARD

Sl. No.	Indicators	Up to March 2014	Up to Sept. 2015	Progress made
1	Total registered facilities	49544	51795	2251
2	Ongoing court cases under PC & PNDT Act	1798	2140	342
3	No. of cases disposed off	590	759	169
4	No. of convictions secured	192	304	112
5	No. of medical licenses cancelled	81	100	19

Steps taken by the Government of India:-

New Amendment to the 'Pre-conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Rules, 1996: Government of India has recently notified several important amendments in the rules under the Act, as mentioned below:

- Rule 11(2) has been amended to provide for confiscation of unregistered machines and punishment against unregistered clinics/ facilities. Earlier, the guilty could escape by paying penalty equal to five times of the registration fee.
- Rule 3B has been inserted with regard to the regulation of portable ultrasound machines and regulation of services to be offered by Mobile Genetic Clinic.
- Rule 3(3) (3) has been inserted restricting the registration of medical practitioners qualified under the Act to conduct ultrasonography in a maximum of two ultrasound facilities within a district. Number of hours during which the Registered Medical Practitioner would be present in each clinic would be specified clearly.
- Rule 5(1) has been amended to enhance the Registration fee for bodies under Rule 5 of the PNDT Rules, 1996 from the existing Rs. 3000/ to Rs. 25000/- for Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic or Imaging Centre and from Rs. 4000/- to Rs. 35000/- for an institute, hospital, nursing home or any place providing jointly the service of a Genetic Counselling Centre, Genetic Laboratory and Genetic Clinic, Ultrasound Clinic or Imaging Centre.
- Rule 13 has been amended mandating every Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic and Imaging Centre, to intimate every change of employee, place, address and equipment installed, to the Appropriate Authority 30 days in advance of the expected date of such change and seek issuance of

a new certificate with the changes duly incorporated.

- Rules for six months training in ultrasound for the MBBS Doctors have been notified vide GSR.14 (E) dated 10 January, 2014. The rules include the training curriculum, criteria for accreditation of institutions and procedure for competency based evaluation test.
- Revised form F has been notified Vide G.S.R. 77 (E)-dated 31st January, 2014. The revised format is more simplified as the invasive and non-invasive portions have been separated.
- Rules for Code of conduct for Appropriate Authorities have been notified vide G.S.R. 119(E)-Dated 24th February, 2014. Legal, monitoring, administrative and financial procedures have been explicitly laid down to facilitate appropriate authorities in the course of effective implementation of the PC&PNDT Act.

Monitoring and review of the implementation scaled up

- Central Supervisory Board (CSB) under the PNDT Act has been reconstituted. The 18th, 19th, 20th and 21st meetings of CSB have been held at an interval of six months on 14th January, 2012, 20th July, 2012, 16th January, 2013 and 23rd July, 2013. The 23rd meeting of the CSB was held on 24 June, 2015 where important policy decisions were taken for effective implementation of the Act.
- 14 States with the most skewed Child Sex Ratio have been identified for concerted attention.
- Directions given vide Order dated 04.03.2013 by the Hon'ble Supreme Court in the matter of WP(C) 349/2006 were communicated to the States/UTs at the level of Health Minister to Chief Ministers and Chief Secretaries to ensure immediate compliance.
- National Inspection and Monitoring Committee (NIMC) pool has been expanded. A pool of 140 people from different disciplines has been created. The targets for Results-Framework Document (RFD) have been increased from 5 inspections in 2012-13 to 20 in 2015-16. In the current year, out of the proposed 20 visits, 12 NIMC inspections have been conducted till November, 2015 in the 12 States of Punjab, Pudducherry, Tripura, Sikkim, Uttar Pradesh, Odisha, Bihar, Mizoram, Andhra Pradesh, Haryana, Rajasthan and Maharashtra. As a result of these NIMC visits, 4 show cause notices were issued, 8 Ultrasound machines were recommended for sealing, 2 clinics were sealed, 2 registrations were cancelled and 1 registration was suspended besides sealing of two 2 Mobile Medical Units (MMUs). The four NIMC visits in the States of Gujarat, Chhattisgarh, Telengana and Jharkhand have been conducted in December, 2015, reports of these visits are awaited.
- The intensification of the drive against sex determination through effective implementation of the Act is being reviewed regularly in State level meetings. Five regional review workshops are proposed to be conducted in the current year for reviewing the implementation of PC&PNDT Act in the country. The first one in the series was conducted for the North Eastern States in Imphal on 6th November, 2015 and the second workshop for the Northern States was conducted on 4th December, 2015 at Chandigarh.
- A National review under the chairmanship of Additional Secretary and Mission Director, Ministry of Health & Family Welfare was

held on 21 September, 2015 through video conference. It was attended by 18 States and 5 UTs.

- A meeting under the Chairmanship of Director (PNDT) was held on 14 September with FICCI Medical Electronic Forum to discuss the prevailing issues related to the manufactures and sellers of ultrasound machine.
- An Expert Committee has been constituted under the chairmanship of Joint Secretary on the recommendation of Central Supervisory Board to look into the amendments to the PC&PNDT Act. The first meeting of the expert committee was held on 24th November, 2015.

Capacity building programme for all stakeholders

- State level capacity building programmes on enforcement of the Act are organized for all district PNDT Officers in the States of Bihar, Chhattisgarh, Goa, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Maharashtra, Odisha, Rajasthan, Sikkim, Uttarakhand, Uttar Pradesh, West Bengal, Chandigarh and Puducherry.
- Sensitisation programmes for Judicial Officers and public prosecutors are also being conducted in the States of Andhra Pradesh, Gujarat, Jharkhand, Karnataka, Maharashtra, Rajasthan, Uttarakhand, Uttar Pradesh, West Bengal and Chandigarh.
- The national capacity building workshop for State Appropriate Authorities and State Nodal Officers of PNDT is being planned by Ministry of Health & Family Welfare in collaboration with UNFPA.

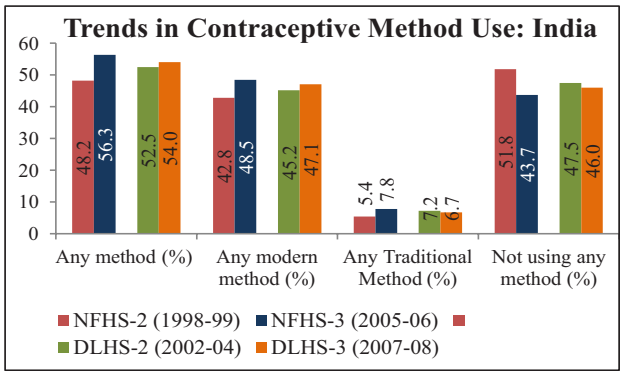
Other initiatives taken by Ministry of Health & Family Welfare

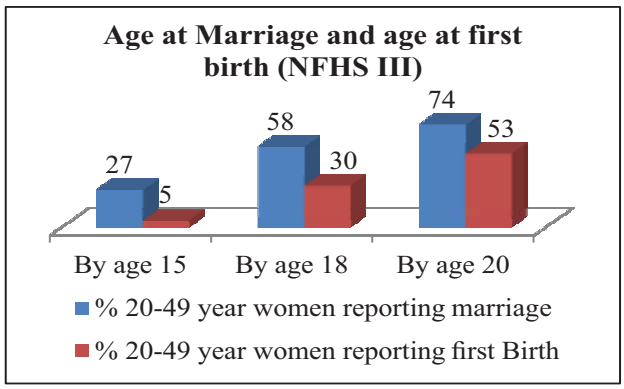
- National campaign ***"Beti Bachao, Beti Padhao"*** has been launched in 100 gender critical districts in partnership with Ministry of WCD and HRD. As a part of pre-launch activities under the Scheme, 6 regional consultations with the State/UT Governments, District Collectors/Deputy Commissioners and District Chief Medical Officers were organized to discuss the District Action Plan under the *"Beti Bachao Beti Padhao"* Scheme.
- Medical Council of India has accepted the proposal to include a chapter on the issue of declining of Child Sex Ratio in the MBBS curriculum for the sensitizations of MBBS doctors.
- Medical Council of India has been directed to cancel registration of doctors convicted under the Act.
- The Central Government is rendering financial support to strengthen implementation structures under NHM for including setting up dedicated PNDT Cells, capacity building, monitoring, advocacy campaign etc. Rs. 2935.79 lakh, Rs.1731.56 lakh, Rs 2311.19 lakh and Rs. 3470.53 lakh have been allocated under NHM during 2012-13, 2013-14, 2014-15 and 2015-16 respectively, besides the financial assistance for IEC campaigns.
- Ministry for Health & Family Welfare has a dedicated Toll Free Telephone **(1800 110 500)** to facilitate the public to lodge complaint anonymously, if so desired, against any violation of the provisions of the Act by any authority or individual and to seek PNDT related general information.

23.8 FAMILY PLANNING

Nation-wide, the small family norm is widely accepted (the wanted fertility rate for India

as a whole is 1.9 and the general awareness of contraception is almost universal (98% among women and 98.6% among men). Contraceptive use is generally rising. The proximate determinants of fertility like, age at marriage and age at first childbirth (which are societal preferences) are also showing good improvement at the national level.





Family planning has undergone a paradigm shift and emerged as one of the interventions to reduce maternal and infant mortalities and morbidities. It is well-established that the States with high contraceptive prevalence rate have lower maternal and infant mortalities.

Greater investments in family planning can thus help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induced abortion and eliminate most of these deaths. Studies show that if the current unmet need for family planning could be fulfilled over the next 5 years, we can avert 35,000 maternal deaths, 1.2 million infant death, which could save more than Rs. 4450 crores and Rs. 6500 crores, if safe abortion services are coupled with increased family planning services. This strategic direction is the guiding principle in implementation of family planning programme in future.

All the family planning services are available in the public health facilities without a difference of caste, creed or sex. The Family Planning programme provides information, services and supplies free of cost to all beneficiaries.

The Schemes under the Family Planning programme are oriented to empower the women to make informed decisions and choices regarding the size and composition of her family. The expansion of the current basket of choices is under consideration, thereby improving access to a wider spectrum of contraceptives.

The ongoing ASHA schemes (Home Delivery of Contraceptives/Ensuring Spacing at Birth/ Pregnancy Testing Kits) have increased the community outreach of FP programme. The introduction of RMNCH+A counsellors, besides IEC/BCC, has been a tool in generating awareness and demand for FP services.

23.9 LAUNCH OF MISSION INDRADHANUSH(MI)

Mission Indradhanush was launched in December, 2014 to reach 90 lakh unimmunized/partially immunized children by 2020. It has been implemented in 201 districts in 1st Phase. 297 additional districts are to be covered in 2nd Phase. About 20 lakh children received full immunization during the Phase-1 of Mission Indradhanush.

Approval of four new vaccines namely Rotavirus, Inactivated Polio Vaccine (IPV), Measles-Rubella Vaccine and Japanese Encephalitis Vaccine extended to adults. This will significantly reduce

vaccine preventable morbidity, disability and mortality.

23.10 KILKARI & MOBILE ACADEMY

To create proper awareness among pregnant women, parents of children and field workers about the importance of Anti Natal Care (ANC), Institutional Delivery, Post-Natal Care (PNC) and Immunization, it was decided to implement the Kilkari and Mobile Academy services in pan India in phased manner. In the first phase Kilkari would be launched in 6 States viz. Uttarakhand, Jharkhand, Uttar Pradesh, Odisha, Rajasthan (HPDs) and Madhya Pradesh (HPDs). The Mobile Academy would be launched in 4 States viz. Uttarakhand, Jharkhand, Rajasthan and Madhya Pradesh.

Mobile Academy is an anytime, anywhere audio training course on inter-personal communication skills that the ASHA can access from her mobile phone. It gives ASHAs tips on how to convince families to adopt priority RMNCH behaviours, while refreshing her existing knowledge. The course is 240 minutes long and consists of 11 chapters with 4 lessons each. At the end of each chapter, there is a quiz for them and all ANM/ ASHAs passing the course will be provided with a certificate.

These services will be hosted centrally by Ministry of Health & Family Welfare and a single source of information for these services will be Mother and Child Tracking System (MCTS). Also these services will be free of cost to States/UTs and the beneficiaries.

23.11 DEVELOPMENT OF NURSING SERVICES

Nursing Personnel are the largest workforces in a hospital. They play an important role in the healthcare delivery system. Nursing personnel are better equipped through this programme to provide quality patient care in the hospitals and in other settings also. As per the available statistics, 95% of the beneficiaries are women only and, therefore, the programme will have significant impact on women empowerment.