19 Chapter

# GENDER ISSUES

## 19.1 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 folk 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.

In order to overcome these problems, the women need to be educated, motivate/persuaded to accept the Family Welfare Programme to increase demand for services. Accordingly, 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 intersectoral 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.

Several new initiatives have been taken to make the maternal health programme broad based and client friendly to reduce maternal mortality. 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 below:

## 19.2 JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission (NHM). It is one of the largest conditional schemes in the world and is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among pregnant women. Launched on 12 April 2005, JSY is being implemented in all States and Union Territories (UTs), with a special focus on Low Performing States (LPS). JSY is a centrally sponsored scheme, which integrates cash assistance with delivery and post-delivery care using Accredited Social Health Activist (ASHA) as an effective link between the government and pregnant women.

**Important Features of JSY**

The scheme focuses on pregnant woman with a special dispensation for States that have low institutional delivery rates, namely, the States of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha and Jammu and Kashmir. While these States have been named Low Performing States (LPS), the remaining States have been named High Performing States (HPS).

**Eligibility for Cash Assistance**

The eligibility for cash assistance under the JSY is as shown below:

| | |
|---|---|
| **Low Performing States (LPS)** | All pregnant women delivering in government health centres, such as Sub Centers (SCs)/Primary Health Centers (PHCs)/Community Health Centers (CHCs)/First Referral Units (FRUs)/general wards of district or State hospitals or accredited private institutions |
| **High Performing States (HPS)** | All BPL/Scheduled Caste/Scheduled Tribe (SC/ST) women delivering in a government health centre, such as SC/PHC/CHC/FRU/general wards of district or state hospital or accredited private institutions. |

**Cash Assistance for Institutional Delivery (in Rs.)**

The cash entitlement for different categories of mothers is as follows:

| Category | Rural area | | Total | Urban area | | Total |
|---|---|---|---|---|---|---|
| | Mother's Package | ASHA's package* | (Amount in Rs.) | Mother's package | ASHA's package** | (Amount In Rs.) |
| LPS | 1400 | 600 | 2000 | 1000 | 400 | 1400 |
| HPS | 700 | 600 | 1300 | 600 | 400 | 1000 |

**ASHA package of Rs. 600 in rural areas include Rs. 300 for ANC component and Rs. 300 for facilitating institutional delivery.*
***ASHA package of Rs. 400 in urban areas include Rs. 200 for ANC component and Rs. 200 for facilitating institutional delivery.*

**Physical & Financial progress**

The number of beneficiaries under the scheme has increased manifold i.e. from 7.38 lakhs in 2005-06 to 106.48 lakhs in 2013-14. Similarly, expenditure has increased from Rs. 38.29 crores in 2005-06 to Rs. 1762.82 crores in 2013-14.

**Subsidizing cost of Caesarean Section**

The Yojana subsidizes the cost of Caesarean Section or for the management of Obstetric complications, up to Rs. 1500/- per delivery to the Government Institutions, where Government specialists are not in position.

**Cash assistance for Home Delivery**

In addition to institutional delivery benefit, BPL pregnant women who prefer to deliver at home are entitled to a cash assistance of Rs. 500 per delivery under the JSY. The conditionalities of age of pregnant women i.e. 19 years or above and only up to two children have been removed w.e.f. 8.5.2013.

## 19.3 JANANI SHISHU SURAKSHA KARYAKARAM (JSSK)

**Free Service Guarantees at Public Health Facilities Janani Shishu Suraksha Karyakram (JSSK):**

- Building on the phenomenal progress of the JSY scheme, Janani Shishu Suraksha

Karyakram (JSSK), launched in 2011 provides service guarantee in the form of entitlements to pregnant women, sick newborns and infants for free delivery including caesarean section and free treatment in public health institutions. This includes free to and for transport between home and institution, diet, diagnostics, drugs, other consumables and blood transfusion if required.

- The child health programme under the National Health Mission (NHM) comprehensively integrates interventions that improve child survival and addresses factors contributing to infant and under-five mortality. Since neonatal deaths are the biggest contributor to child deaths which is approximately 57% of the under five deaths, improving child survival hinges on improving newborn health. It is now well recognised that child survival cannot be addressed in isolation as it is intricately linked to the health of the mother, which is further determined by her health and development as an adolescent. Therefore, the concept of Continuum of Care, which emphasises care during critical life stages, in order to improve child survival, is being followed under the national programme. Another dimension of this approach is to ensure that essential services are made available at home, through community outreach and through health facilities at various levels (primary, first referral units and tertiary healthcare facilities). The newborn and child health are key pillars of the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategic approach, 2013.

- On 18th Sept 2014, *India Newborn Action Plan (INAP)* was launched in response to Global Newborn Action Plan. INAP lays out a vision and a plan for India to end preventable newborn deaths, accelerate progress and scale up high-impact yet cost-effective interventions. INAP has a clear vision supported by goals, strategic intervention packages, priority actions and a monitoring framework. For the first time, INAP also articulates the Government of India's specific attention on preventing still births. With clearly marked timelines for implementation, monitoring and evaluation and scaling-up of proposed interventions, it is expected that all stakeholders working towards improving newborn health in India will stridently work towards attainment of the goals of "*Single Digit Neo-natal Mortality Rate (NMR) by 2030"* and *"Single Digit Still Birth Rate (SBR) by 2030*". The efforts have been accelerated in identified 184 high priority districts in the country.

- In order to address newborn health in high priority districts, Newborn Care Corners (NBCCs) are being established at delivery points to provide essential newborn care at birth, while Special Newborn Care Units (SNCUs) and Newborn Stabilization Units (NBSUs) provide care for sick newborns in these poorest priority districts with respect to health indicators. Complete elimination of out of pocket expenses with provision of free transport, drugs, diagnostics and diet to all sick newborns and infants is being ensured in the country through Janani Shishu Suraksha Karyakram (JSSK). All public and private health facilities are now guided to ensure single dose of Injection Vitamin K prophylaxis at birth even at the sub center by ANM.

- More than Rs. 2000 crore have been allocated to the States for the year 2013-14 for providing the free entitlements under JSSK while Rs. 2107 crore was allocated during 2012-13 under RCH & NRHM Flexipool.

## 19.4 MOTHER AND CHILD TRACKING SYSTEM (MCTS)

MCTS has been implemented across the country in all the States. MCTS was started in December 2009. It has registered more than 7.6 crore Pregnant Women/Mother and more than 6.45 crore of Children and their Health Care Services record. More than 2.2 lakh ANMs and 9.2 lakh ASHAs have been registered on MCTS Portal. Out of above, 1.99 crore Pregnant Women and 1.78 crore children have been registered in 2014-15.

MCTS was strengthened for Mother and Children Fact Sheets, Reporting and Seeding of Aadhaar Numbers for direct cash transfer to JSY beneficiaries and its monitoring. Potential JSY beneficiary's data was integrated with Public Financial Management System (PFMS) for making the direct payments. SMSes were sent to potential JSY beneficiaries for getting the Aadhaar Numbers and opening of Bank Accounts. Technical support was provided for MCT Helpdesk. USSD based technology has been implemented for data updation by ANM.

## 19.5 RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

This initiative was launched in February 2013 and provides for Child Health Screening and Early Intervention Services through early detection and management of 4 Ds i.e. Defects at birth, Diseases, Deficiencies, Development delays including disability. In 2014-15, 12922 RBSK Mobile Health Teams and 266 Districts Early Intervention Centre have been approved. In the first quarter of 2014-15 (March to June 2014), about 1.33 crore children have been screened, 8.44 lakhs children have been referred to health facilities for the treatment. About 4.36 lakhs children have received secondary tertiary care.

## 19.6 RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

This initiative was launched in January 2014 to reach out to 253 million adolescents in the country in their own spaces and introduces peer-led interventions at the community level, supported by augmentation of facility based services. This initiative broadens the focus of the adolescent health programme beyond reproductive and sexual health and brings in focus on life skills, nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse.

## 19.7 PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES (PNDT) (PROHIBITION OF SEX SELECTION ACT, 1994)

**Adverse Child Sex Ratio (CBR) in India**

The Child Sex Ratio (CBR) 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 recorded in 2001 Census. This negative trend reaffirms the fact that the girl child is more at risk than ever before. Except for the States/UTs viz. Puducherry (967), TamilNadu (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 CSR has shown a declining trend in 18 States and 3 UTs. The steepest fall of 79 points is in J&K and the largest increase of 48 points is in Punjab. **(Appendix-I)**

Jammu and Kashmir, Maharashtra and Haryana have had the worst 30 years decline in Child Sex

Ratios. 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). This census saw a declining trend even in North Eastern States expect Mizoram and Arunachal Pradesh. Half of the districts in the country showed decline in the CSR greater than national average. The number of districts with Child Sex Ratio of 950 and above has been 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 in enumeration of population. 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 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".

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. 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 of Health & Family Welfare has been further empowered for monitoring the implementation of the Act. State level Supervisory Boards in the line of the CSB constituted at the Centre, has 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. 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 equipmentscapable 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**

- Imprisonment up to 3 years and fine up to Rs. 10,000;
- For any subsequent offences, he/she may be imprisoned up to 5 years and fine up to Rs. 50,000/1,00,000 and
- The name of the Registered Medical Practitioner is reported by the Appropriate Authority to the State Medical Council concerned for taking necessary action

including suspension of the registration if the charges are framed by the court and till the case is disposed of and on conviction, for removal of his name for a period of 5 years for the first offence and permanently for the subsequent offence.

**Implementation of PC & PNDT Act in States/UTs**

As per the reports received from States/UTs up to June 2014, 50311 bodies have been registered under the Act, and a total number of 1933 on going cases for various violations of the law are in the Courts. 206 cases of conviction have been secured in various States/UTs and 1686 ultrasound machines have been sealed and seized for various violations of the provisions of the Act. The rate of convictions in Haryana, Punjab, Rajasthan and Maharashtra is the highest in the country. 98 medical licenses of the convicted doctors have been suspended. **(Appendix-II)**

**Six monthly Progress Card on the implementation of the Act**

| | Cases | Convictions | Sealing | License cancellation/ suspensions |
|---|---|---|---|---|
| May 2011 | 869 | 55 | 409 | - |
| Jan. 2012 | 1040 | 85 | 869 | 16 |
| June 2012 | 1212 | 111 | 866 | 33 |
| Jan. 2013 | 1327 | 111 | 989 | 33 |
| July 2013 | 1521 | 116 | 1180 | 53 |
| Sept. 2013 | 1833 | 143 | 1242 | 65 |
| April 2014 | 1919 | 191 | 1685 | 83 |

*Recent steps taken by the Government of India*

*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 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 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 and
- Rule 13 has been amended mandating every Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic and Imaging Centre intimation 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.

**Recently, following amendments has been notified**

| S. No. | Amendments in PC & PNDT Rules | Notification dates |
|---|---|---|
| 1. | Six month training curriculum for sonologists | 10th Jan. 2014 |
| 2. | Revised version of Form-F | 4th Feb. 2014 |
| 3. | Code of Conduct for Appropriate Authorities | 26th Feb. 2014 |

**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. 22nd meeting of CSB was held on 13th Oct. 2014. Important amendments to the PNDT Rules have been approved and notified.
- 14 States with the most skewed child sex ratio have been identified for concerted attention.
- Inspections by the National Inspection and Monitoring Committee (NIMC) have been scaled up. Inspections have been carried out in 64 districts of 29 States. A total of 114 clinics were inspected and 83 clinics were sealed from August 2011- Sept. 2014. 28 cases have already been filed in court.
- The intensification of the drive against sex determination through effective implementation of the Act is being reviewed regularly in State meetings. 5 Regional review workshops were organized in Financial Year 2013-14. In Financial Year 2014-15, regional reviews for northern and western States/UTs were organized on 30th Oct. and 24th Nov. 2014 respectively.

**Capacity building programme for all stakeholders**

- State level capacity building programme on enforcement of the Act has also been organized for district PNDT officers in the States of Rajasthan, Gujarat, West Bengal, Haryana, Kerala, Maharashtra, Uttar Pradesh and Bihar.
- Capacity building programmes for Judicial Officers and public prosecutors have been conducted in Chandigarh, Maharashtra, Uttar Pradesh, West Bengal, Andhra Pradesh, Gujarat and Rajasthan.

**Other initiatives taken by Ministry of Health & Family Welfare**

- Ministry of Women and Child Development has been working in close coordination with the Ministry of Health & Family Welfare on "Beti Bachao-Beti Padhaao (BBBP)" campaign in 100 gender critical districts in the country.
- Instruction has been given to States/UTs for institutional strengthening at State and District level for strict and effective implementation of PC & PNDT Act.
- In addition to the Ministry's website (www.mohfw.nic.in), an independent website, 'pndt.gov.in' for PNDT Division has been launched by the Minister of Health & Family Welfare. This website contains all the relevant information relating to the Act and the Rules.
- Minister of Health & Family Welfare launched the 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.

**Appendix-I**

## Trend of child sex ratio in last three Censuses

| S. No. | State/UT | 1991 | 2001 | Absolute Difference (1991-2001) | 2001 | 2011 | Absolute Difference (2001-2011) |
|---|---|---|---|---|---|---|---|
| | | Total | Total | Total | Total | Total | Total |
| 1 | Jammu & Kashmir | NA | 941 | **NA** | 941 | 862 | **-79** |
| 2 | Dadra & Nagar Haveli | 1013 | 979 | **-34** | 979 | 926 | **-53** |
| 3 | Lakshadweep | 941 | 959 | **18** | 959 | 911 | **-48** |
| 4 | Daman & Diu | 958 | 926 | **-32** | 926 | 904 | **-22** |
| 5 | Andhra Pradesh | 975 | 961 | **-14** | 961 | 939 | **-22** |
| 6 | Rajasthan | 916 | 909 | **-7** | 909 | 888 | **-21** |
| 7 | Nagaland | 993 | 964 | **-29** | 964 | 943 | **-21** |
| 8 | Manipur | 974 | 957 | **-17** | 957 | 936 | **-21** |
| 9 | Maharashtra | 946 | 913 | **-33** | 913 | 894 | **-19** |
| 10 | Uttaranchal | 948 | 908 | **-40** | 908 | 890 | **-18** |
| 11 | Jharkhand | 979 | 965 | **-14** | 965 | 948 | **-17** |
| 12 | Uttar Pradesh | 927 | 916 | **-11** | 916 | 902 | **-14** |
| 13 | Madhya Pradesh | 941 | 932 | **-9** | 932 | 918 | **-14** |
| 14 | Odisha | 967 | 953 | **-14** | 953 | 941 | **-12** |
| 15 | Tripura | 967 | 966 | **-1** | 966 | 957 | **-9** |
| 16 | Bihar | 953 | 942 | **-11** | 942 | 935 | **-7** |
| 17 | Sikkim | 965 | 963 | **-2** | 963 | 957 | **-6** |
| 18 | Chhattisgarh | 974 | 975 | **1** | 975 | 969 | **-6** |
| 19 | West Bengal | 967 | 960 | **-7** | 960 | 956 | **-4** |
| 20 | Meghalaya | 986 | 973 | **-13** | 973 | 970 | **-3** |
| 21 | Assam | 975 | 965 | **-10** | 965 | 962 | **-3** |
| 22 | Puducherry | 963 | 967 | **4** | 967 | 967 | **0** |
| 23 | Tamil Nadu | 948 | 942 | **-6** | 942 | 943 | **1** |
| 24 | Karnataka | 960 | 946 | **-14** | 946 | 948 | **2** |
| 25 | Delhi | 915 | 868 | **-47** | 868 | 871 | **3** |
| 26 | Goa | 964 | 938 | **-26** | 938 | 942 | **4** |
| 27 | Kerala | 958 | 960 | **2** | 960 | 964 | **4** |
| 28 | Mizoram | 969 | 964 | **-5** | 964 | 970 | **6** |
| 29 | Gujarat | 928 | 883 | **-45** | 883 | 890 | **7** |
| 30 | Arunachal Pradesh | 982 | 964 | **-18** | 964 | 972 | **8** |
| 31 | Andaman & Nicobar Islands | 973 | 957 | **-16** | 957 | 968 | **11** |
| 32 | Himachal Pradesh | 951 | 896 | **-55** | 896 | 909 | **13** |
| 33 | Haryana | 879 | 819 | **-60** | 819 | 834 | **15** |
| 34 | Chandigarh | 899 | 845 | **-54** | 845 | 880 | **35** |
| 35 | Punjab | 875 | 798 | **-77** | 798 | 846 | **48** |
| | **INDIA** | **945** | **927** | **-18** | **927** | **918** | **-9** |

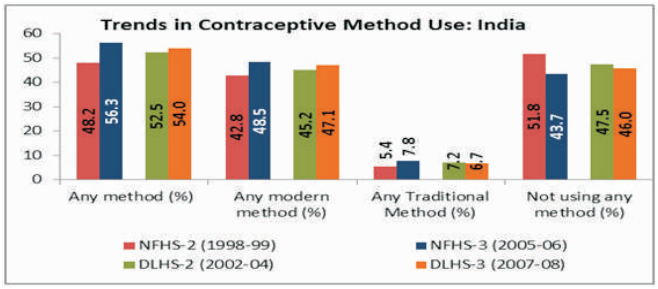
**Appendix-II**

**Status of Registration, Cases and Convictions under PC & PNDT Act *(upto June, 2014)***

| S. No. | State/UT | No. of bodies registered | No. of on-going Court/Police Cases | No. of convictions | No. of suspension/ cancellation of medical license | No. of Machines Seized/Sealed |
|---|---|---|---|---|---|---|
| 1 | Andhra Pradesh | 5003 | 52 | 0 | 0 | 132 |
| 2 | Arunachal Pradesh | 35 | 0 | 0 | 0 | 0 |
| 3 | Assam | 705 | 5 | 0 | 0 | 0 |
| 4 | Bihar | 1418 | 6 | 11 | 0 | 6 |
| 5 | Chhattisgarh | 656 | 7 | 0 | 0 | 0 |
| 6 | Goa | 152 | 1 | 0 | 0 | 1 |
| 7 | Gujarat | 4400 | 126 | 6 | 1 | 3 |
| 8 | Haryana | 1594 | 100 | 54 | 9 | 241 |
| 9 | Himachal Pradesh | 258 | 0 | 1 | 0 | 0 |
| 10 | Jammu & Kashmir | 315 | 6 | 1 | 0 | 72 |
| 11 | Jharkhand | 695 | 19 | 0 | 0 | 0 |
| 12 | Karnataka | 2878 | 45 | 0 | 0 | 0 |
| 13 | Kerala | 1548 | 0 | 0 | 0 | 0 |
| 14 | Madhya Pradesh | 1404 | 18 | 2 | 2 | 2 |
| 15 | Maharashtra | 9020 | 483 | 61 | 59 | 709 |
| 16 | Manipur | 87 | 0 | 0 | 0 | 0 |
| 17 | Meghalaya | 36 | 0 | 0 | 0 | 0 |
| 18 | Mizoram | 47 | 0 | 0 | 0 | 0 |
| 19 | Nagaland | 45 | 0 | 0 | 0 | 0 |
| 20 | Odisha | 685 | 24 | 3 | 0 | 6 |
| 21 | Punjab | 1396 | 127 | 28 | 4 | 0 |
| 22 | Rajasthan | 2232 | 585 | 37 | 21 | 387 |
| 23 | Sikkim | 24 | 0 | 0 | 0 | 0 |
| 24 | Tamil Nadu | 5494 | 77 | 0 | 0 | 72 |
| 25 | Tripura | 66 | 0 | 0 | 0 | 0 |
| 26 | Uttarakhand | 538 | 24 | 0 | 0 | 5 |
| 27 | Uttar Pradesh | 5300 | 137 | 1 | 0 | 34 |
| 28 | West Bengal | 2238 | 13 | 0 | 0 | 14 |
| 29 | A & N. Island | 10 | 0 | 0 | 0 | 0 |
| 30 | Chandigarh | 112 | 2 | 0 | 0 | 2 |
| 31 | D. & N. Haveli | 13 | 0 | 0 | 0 | 0 |
| 32 | Daman & Diu | 12 | 0 | 0 | 0 | 0 |
| 33 | Delhi | 1794 | 62 | 1 | 2 | 0 |
| 34 | Lakshadweep | 18 | 0 | 0 | 0 | 0 |
| 35 | Puducherry | 83 | 0 | 0 | 0 | 0 |
| | **TOTAL** | **50311** | **1933** | **206** | **98** | **1686** |

## 19.8 FAMILY PLANNING

The last survey figures available are from NFHS-3 (2005-06) and DLHS-3 (2007-08), which are being used for describing current family planning situation in India. Nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.9 (NFHS-3) and the general awareness of contraception is almost universal (98% among women and 98.6% among men: NFHS-3). Both NFHS and DLHS surveys showed that contraceptive use is generally rising (see adjoining figure). Contraceptive use among married women (aged 15-49 years) was 56.3% in NFHS-3 (an increase of 8.1 percentage points from NFHS-2) while corresponding increase between DLHS-2 & 3 is relatively lesser (from 52.5% to 54.0%). 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. The adjoining figure indicates the current position of social determinants of fertility in the country.




AHS survey has been conducted in 9 States (8 EAG States + Assam) which indicates that:

- Contraceptive use has been static in almost all AHS States except Bihar which has shown a decrease in use of modern contraceptives.

### Current Family Planning Efforts

Family planning have 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, save more than Rs. 4450 crore and save Rs. 6500 crore, 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.

### Contraceptive services under the National Family Welfare Programme

The methods available currently in India may be broadly divided into two categories, spacing methods and permanent methods. There is another method (Emergency Contraceptive Pill) to be used in cases of emergency.

**Spacing Methods-** These are the reversible methods of contraception to be used by the couples who wish to have children in future. These include:

#### A. Oral Contraceptive Pills (OCP)

- These are hormonal pills which have to be taken by a woman, preferably at a fixed time, daily. The strip also contains additional placebo/iron pills to be consumed during the hormonal pill free days. The method may be used by majority of women after screening by a trained provider.
- At present, there is a scheme for delivery of OCPs at the doorstep of beneficiaries by ASHA with a minimal charge. The brand "MALA-N" is available free of cost at all public healthcare facilities.

**B. Condoms**

- These are the barrier methods of contraception which offer the dual protection of preventing unwanted pregnancies as well as transmission of RTI/STI including HIV. The brand "Nirodh" is available free of cost at government health facilities and supplied at doorstep by ASHAs for minimal cost.

**C. Intrauterine Contraceptive Devices (IUCD)**

- Copper containing IUCDs are a highly effective method for long term birth spacing.
- Should not be used by women with uterine anomalies or women with active PID or those who are at increased risk of STI/RTI (women with multiple partners).
- The acceptor needs to return for follow up visit after 1, 3 and 6 months of IUCD insertion as the expulsion rate is highest in this duration.
- Two types:

o Cu IUCD 380A (10 yrs)
o Cu IUCD 375 (5 yrs)

- New approach of method delivery- postpartum IUCD insertion by specially trained providers to tap the opportunities offered by institutional deliveries.

**Permanent Methods-** These methods may be adopted by any member of the couple and are generally considered irreversible.

**A. Female Sterilisation-**

- **Two techniques:**

o **Minilap-** Minilaparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked. Can be performed by a trained MBBS doctor.

o **Laparoscopic-** Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen. Can be done only by trained and certified gynaecologist/surgeon.

**B. Male Sterilisation-**

- Through a puncture or small incision in the scrotum, the provider locates each of the 2 tubes that carries sperm to the penis (vas deferens) and cuts or blocks it by cutting and tying it closed or by applying heat or electricity (cautery). The procedure is performed by MBBS doctors trained in these. However, the couple needs to use an alternative method of contraception for first three months after sterilization till no sperms are detected in semen.
- Two techniques being used in India:

o Conventional

o Non- Scalpel Vasectomy – no incision, only puncture and hence no stiches.

**Emergency Contraceptive Pill (ECP)**

- To be consumed in cases of emergency arising out of unplanned/unprotected intercourse.
- The pill should be consumed within 72 hours of the sexual act and should never be considered a replacement for a regular contraceptive.

**Other Commodities - Pregnancy Testing Kits (PTKs)**

- Helps to detect pregnancy as early as one week after the missed period, thus proving an early opportunity for medical termination of pregnancy, thus saving lives lost to unsafe abortions.

- These are available at the subcentre level and also carried by ASHA.

**Service Delivery Points**

- All the spacing methods, viz. IUCDs, OCPs and Condoms are available at the public health facilities beginning from the sub-centre level. Additionally, OCPs, condoms and emergency contraceptive pills (since are not skill based services) are available at the village level also through trained ASHAs.
- Permanent methods are generally available at primary health centre level or above. They are provided by MBBS doctors who have been trained to provide these services. Laparoscopic sterilization is being offered at CHCs and above level by a specialist gynaecologist/surgeon only.

These services are provided to around 20 crores eligible couples; Details of services provided at different level are as under:

| Family Planning Method | Service Provider | Service Location |
|---|---|---|
| **Spacing Methods** | | |
| IUD 380 A/IUCD 375 | Trained & certified ANMs, LHVs, SNs and Doctors | Sub-centre & higher levels |
| Oral Contraceptive Pills (OCPs) | Trained ASHAs, ANMs, LHVs, SNs and Doctors | Village level<br>Sub-centre & higher levels |
| Condoms | Trained ASHAs, ANMs, LHVs, SNs and Doctors | Village level<br>Sub-centre & higher levels |
| **Limiting Methods** | | |
| Minilap | Trained & certified MBBS Doctors & Specialist Doctors | PHC & higher levels |
| Laparoscopic Sterilization | Trained & certified Specialist Doctors (OBG & General Surgeons) | Usually CHC & higher levels |
| NSV: No Scalpel Vasectomy | Trained & certified MBBS Doctors & Specialist Doctors | PHC & higher levels |
| **Emergency Contraception** | | |
| Emergency Contraceptive Pills (ECPs) | Trained ASHAs, ANMs, LHVs, SNs and Doctors | Village level, Sub-centre & higher levels |

*Note: Contraceptives like OCPs, Condoms are also provided through Social Marketing Organizations*

The Salient Features of the Family Planning Programme

**A. On-going interventions**

- More emphasis on Spacing methods like IUCD.
- Availability of Fixed Day Static Services at all facilities.
- Emphasis on minilaptubectomy services because of its logistical simplicity and requirement of only MBBS doctors and not post graduate gynaecologists/surgeons.
- A rational human resource development plan is in place for provision of IUCD, minilap and NSV to empower the facilities (DH, CHC, PHC, SHC) with at least one provider for each of the services and Sub Centres with ANMs trained in IUD insertion.
- Ensuring quality care in Family Planning services by establishing Quality Assurance Committees at state and district levels.

- Accreditation of more private/NGO facilities to increase the provider base for family planning services under PPP.
- Increasing male participation and promoting Non-Scalpel Vasectomy.
- Compensation scheme for sterilization acceptors - under the scheme of Ministry of Health & Family Welfare (MoHFW) provides compensation for loss of wages to the beneficiary and also to the service provider (& team) for conducting sterilisations. The compensation scheme has been enhanced in 11 High Focus States from the year 2014.
- *'National Family Planning Indemnity Scheme'* under which clients are indemnified in the eventualities of deaths, complications and failures sterilization. The providers/accredited institutions are indemnified against litigations in those eventualities.
- PPIUCD Incentive for service providers and ASHAs.
- Improving contraceptives supply management up to peripheral facilities.
- Demand generation activities in the form of display of posters, billboards and other audio and video materials in the various facilities.
- Strong political will and advocacy at the highest level, especially in states with high fertility rates.

**B. New interventions to improve access to contraception:**

**Home Delivery of Contraceptives (HDC)**

- A new scheme has been launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries. The scheme was launched in 233 pilot districts of 17 States on 11 July 2011 and is now expanded to the entire country from 17th Dec. 2012.
- ASHA is charging a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep i.e. Rs. 1 for a pack of 3 condoms, Rs. 1 for a cycle of OCPs and Rs. 2 for a pack of one tablet of ECP.

**C. Ensuring Spacing at Birth (ESB)**

- Under a new scheme launched by the Govt. of India (GoI), services of ASHAs to be utilised for counselling newly married couples to ensure spacing of 2 years after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child. The scheme is operational in 18 States (EAG, North Eastern and Gujarat and Haryana). ASHA would be paid following incentives under the scheme:

o Rs. 500/- to ASHA for delaying first child birth by 2 years after marriage.

o Rs. 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child.

o Rs. 1000/- in case the couple opts for a permanent limiting method up to 2 children only.

- Ministry of Health and Family Welfare (MoHFW) has introduced short term IUCD (5 years effectivity), Cu IUCD 375 under the National Family Planning programme. Training of state level trainers has already been completed and process is underway to train service providers up to the sub-center level.
- A new method of IUCD insertion (post-partum IUCD insertion) has been introduced by the Government.
- Promoting Post-partum Family Planning services at district hospitals by providing for placement of dedicated Family Planning Counsellors and training of personnel.

**D. Pregnancy Testing Kits (PTKs)**

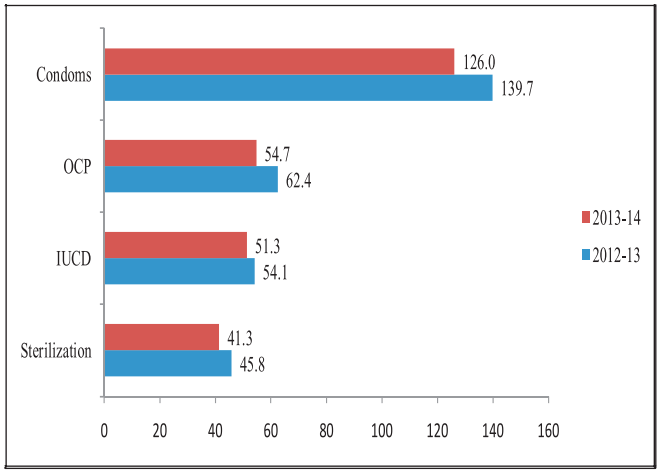
- Nishchay- Home based Pregnancy Test Kits (PTKs) was launched under NRHM in 2008

across the country and was anchored with the Family Planning Division.

- The PTKs are being made available at sub-centers and to the ASHAs.
- The PTKs facilitate the early detection and decision making for the outcomes of pregnancy.

**Progress made under Family Planning Programme**

**Service Delivery 2013-14-:** The performance of Family Planning services (in lakhs) during 2013-14 is provided below (source: HMIS):




- Number of IUCDs and sterilisations has remained static in spite of declining CBR and TFR. There is a need to sustain momentum to reach the replacement level fertility.
- Considering the current efforts to focus on spacing, it is expected that IUCD performance would increase in near future.
- State wise sterilisation and IUCD achievements is provided at ***Appendix-2***

**Promotion of IUCDs as a short & long term spacing method**

In 2006, Govt. of India (GoI) launched "Repositioning IUCD in National Family Welfare Programme" with an objective to improve the method mix in contraceptive services and has adopted diverse strategies including advocacy of IUCD at various levels; community mobilization for IUCD; capacity building of public health system staff starting from ANMs to provide quality IUCD services and intensive IEC activities to dispel myths about IUCD. Currently, increased emphasis is given to promotion of IUCD insertion as a key spacing method under Family Planning Programme.

**"Alternative Training Methodology in IUCD"** using anatomical, simulator pelvic models incorporating adult learning principles and humanistic training technique was started in September 2007 to train service providers in provision of quality IUCD services. *(Details of action methods in Chapter-9 on Family Planning.)*

## 19.9 DEVELOPMENT OF NURSING SERVICES

Nursing Personnel are the largest workforces in a Hospital. They play an important role in the healthcare delivery system. A sum of Rs. 200.00 crore was allocated for the year 2014-15 for implementing the centrally sponsored scheme of Upgradation/ Strengthening of Nursing Services for establishing ANM and GNM schools across the Country. 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.