Chapter 19

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 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 due to 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 inter-sectoral coordination at the grassroot level 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 Obstetric 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, a demand promotion scheme for reduction of MMR and IMR has led to steep increase in Institutional Delivery in government health facilities.

Cash incentive are provided to promote institutional delivery. The number of beneficiaries has increased from 7.38 lakhs in 2005-06 to more than 1.09 crores in 2011-12. Expenditure increased from Rs 38.29 crores in 2005-06 to Rs 1552.85 crores in 2011-12.

Janani Suraksha Yojana (JSY), a safe motherhood intervention under the National Rural Health Mission (NRHM), was launched on 12th April 2005 to promote institutional delivery among the poor pregnant women. The Yojana is being implemented in all States and Union Territories. JSY is a 100% centrally sponsored scheme.

The scheme focuses on the poor pregnant women with special dispensation for States having Low institutional delivery rates, namely, the States of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha and Jammu & Kashmir. While these states have been classified as Low Performing Status (LPS) the remaining States have been named as High Performing States (HPS).

Besides maternal care, the scheme provides cash assistance to all eligible mothers for delivery care. The scheme has identified ASHA, the Accredited Social Health Activist as an effective link between the health facility and the community.

Eligibility for cash Assistance for pregnant women

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

States	Eligibility
Low Performing States (Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Odisha, Rajasthan, Assam and Jammu & Kashmir	Available to all women regardless of age and number of children in public health facilities
High Performing States (All remaining States/UTs)	Available to only BPL/ SC/ST women aged 19 years or above up to two live births, in public health facilities

Cash Assistance for Institutional Delivery

The cash entitlement for mothers is as follows:

Category	Rural Area		Urban Area	
	Mother's package	ASHA's package	Mother's package	ASHA's package
Low Performing States	Rs.1400	Rs.600	Rs.1000	Rs.200
High Performing States	Rs.700	Rs.200	Rs.600	Rs.200

Further, ASHAs are also entitled to Rs. 600/- per delivery for facilitating institutional delivery in the North Eastern States (excluding Assam) and in respect of rural tribal woman in the tribal areas notified by the Ministry of Tribal Affairs in the High Performing States of Andhra Pradesh, Karnataka, West Bengal, Himachal Pradesh, Gujarat, Maharashtra, Tamil Nadu, Kerala, A&N Islands, Dadra and Nagar Haveli, Daman & Diu and Lakshadweep.

Subsidizing cost of Caesarean Section

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

Assistance for Home Delivery

All BPL pregnant women aged 19 years and above, preferring to deliver at home are entitled to cash assistance of Rs. 500/- per delivery, up to two live births in all the States/UTs.

19.3 JANANI SHISHU SURAKSHA KARYAKARAM (JSSK)

- Government of India has launched Janani Shishu Suraksha Karyakaram (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 up to 3 days during normal delivery and up to 7 days for 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 have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth.
- The scheme is estimated to benefit more than 12 million pregnant women who access Government health facilities for their delivery. Moreover it will motivate those who still choose to deliver at their homes to opt for institutional deliveries.
- All the States and Union Territories have initiated implementation of free entitlements under JSSK both to the pregnant women and sick neonates upto 1 month of age.
- In the year 2012-13, a sum of Rs 2107 crores have been allocated to the States for the implementation of free entitlements under JSSK.

19.4 NAME BASED TRACKING OF PREGNANT WOMEN

MCTS: Name Based web enabled tracking of pregnant women and children to ensure and monitor preventive, promotive and curative health services to them.

- An online MCTS has been made operational for all the States and UTs. After entering the data, work plan is being generated for the ANMs and ASHAs to deliver the health services during any point of time. MCTS call centre has been setup to call the beneficiaries and validate their data.
- SMS of mother and child count are sent to various officials, ANM/ASHA which are registered on MCTS server to validate their names, mobile numbers and location details with the purpose ultimately to send work plans to them through SMS. Now SMS has started being sent to the pregnant women reminding her of impending visits for her due services.
- Data for around 3.17 crore pregnant women have been captured and for 2.41 crore children have been captured on the MCTS central server till 19.11.12.

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

Adverse Child Sex-ratio in India

The Child Sex Ratio for the age group of 0-6 years as per the 2011 census (provisional) has dipped further to 914 girls as against 927 per thousand boys recorded in 2001 Census. This is the worst dip since 1947.This negative trend reaffirms the fact that the girl child is more at risk than ever before. Except for the states of Himachal Pradesh (906), Punjab (846), Chandigarh (867), Haryana (830), Mizoram (971), Tamil Nadu (946), Andaman & Nicobar Islands (966), the CSR has shown a declining trend in 22 States and 5 UTs. States/ UTs with Child Sex Ratio of 951 and above have reduced from 18 to 9. The steepest fall of 82 points is in J& K and the largest increase of 48 points is in Punjab. Jammu and Kashmir, Maharashtra and Haryana have had the worst 30 year decline in child sex ratios. Among the larger States, Chhattisgarh has the highest Child Sex Ratio (CSR) of 964 followed by Kerala with 959. Haryana (830) is at the bottom followed by Punjab (846). This census saw a declining trend even in North Eastern States except Mizoram. (**Table-1**)

Half of the districts in the country showed decline in the CSR greater than national average. Districts with Child Sex Ratio of 950 and above have reduced from 259 to 182. Rewari (784), Jhajjar (774), Mahendragarh (778) and Sonepat (790) districts of Haryana, and Samba (787) & Jammu (795) districts of Jammu and Kashmir indicate a Child Sex Ratio of below 800.

The urban child sex ratio is 902 as compared to 919 in rural areas as per Census 2011, showing a difference of 17 points. Rural child sex ratio has shown steep decline from 935 in 2001 to 919 in 2011 where as urban child sex ratio has decreased from 906 in 2001 to 902 in 2011 Census. It is therefore evident that the problem of declining child sex ratio in the country has become widespread across different socio-economic groups, class, religion etc. **(Table-2)**

Reasons for adverse sex ratio

Reasons for neglect of girl child and low levels of sex ratio are son preference, low status of women, social and financial security associated with sons, socio-cultural practices including dowry and violence against women. Small family norm may be a catalyst in the declining child sex ratio.

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. Easy availability of the sex determination tests that lead to female foeticide are proving to be catalyst in the process, which are further stimulated by pre-conception sex selection facilities. Child Sex Ratio does not only reflect pre-birth elimination of girls but also neglect of the girl child after birth. Gender gap in Infant Mortality Rates and under five Mortality Rates hint to cumulative neglect of female child after birth as well.

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 Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 has since been amended to make it more comprehensive. The amended Act and Rules came into force with effect from 14.2.2003 and the PNDT Act has been renamed as "Pre-conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994" to make it more comprehensive.

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 for Health and 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 for minimizing 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 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

- 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 fined up to Rs. 50,000 / 1,00,000.
- 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 off.

Status and Reports from States /UTs

As per Quarterly Progress Reports received from States /UT's, 46062 bodies using ultrasound, image scanners etc. have been registered under the Act.

A total of 1272 cases have been filed in the Courts for various violations of the law. Though most of the cases (428) are for Non-maintenance of records, 244 cases relate to non-registration of the centre/clinic, 114 cases relate to communication of sex of foetus, 41 cases relate to advertisement about pre-natal/conception diagnostic facilities and 83 cases relate to other violations of the Act/Rules. 980 ultrasound machines have been sealed and seized for violation of the law. **(Table-3)**

A total of 111 cases of conviction have been secured in various States/UTs against violations of the PC & PNDT Act. The rate of convictions in Haryana, Punjab & Maharashtra is the highest in the country.

The concerned State governments are regularly requested to take effective measures for speedy disposal of the ongoing cases.Ministry of Health and Family Welfare has taken a number of steps for the implementation of the Act. The major steps taken for implementation of the Act are as follows:

i) Central Supervisory Board (CSB)

Central Supervisory Board (CSB) under the Act has been reconstituted and regular meetings are being held. The Board reviewed progress made by the States in respect of the implementation of the Act, approved amendments in the Rules and strategies to meet the challenge of female foeticide.

ii) Amendment to Rules

a) As per the decisions taken in the 19th meeting of the CSB, held on 20th July 2012, three committees have been constituted for review of the existing provisions of the PC & PNDT Act, rationalization of Form-F and drawing up of a code of conduct for Appropriate Authorities under the Act, respectively.

b) Amendment regulating the use of portable ultrasound equipment has been notified vide Notification GSR.

80(E) Dated 7th February, 2012 to provide for use of portable ultrasound machine only within the premises it is registered, bedside services to the patients and as part of a mobile medical unit, offering a bouquet of other health and medical services.

c) Rule 3 A (3) has been inserted in the PC & PNDT Rules,1996 vide Notification GSE.418(E) dated 5th June 2012, restricting the registration of medical practitioners qualified under the Act to conduct ultrasonography in maximum of two ultrasound facilities within a district, enhancement of registration fees for Genetic Clinics, Genetic Counselling Centres, Genetic Laboratories, has been increased to Rs. 20000/- & 35000/- under Rule 5(1),etc. The matter is currently sub-judice.

iii) Review of implementation of the PC & PNDT Act

1. Desk reviews have been under taken with State Nodal Officers of UP, Rajasthan, HP, Odisha, AP, Haryana, Chhattisgarh, Jharkhand and will be continued on a regular basis.

2. An advisory has been issued to States/UTs to check malpractices in registration of clinics under the Act and to ensure scrutiny-based renewal of registration of facilities.

3. Communication has been addressed to States Appropriate Authorities to examine Block/ Panchayat /village /ward wise census data on child sex ratio and proactively focus on those areas with low child sex ratio and monitor relevant ultrasound clinics and track pregnancies particularly in those areas.

iv) Capacity building

a) A two day national level capacity building program on strengthening effective implementation of the PC & PNDT Act was organized for State Appropriate Authorities and Nodal Officers for PNDT from 35 States/UTs, in New Delhi on 27th -28th, February 2012.

b) State level capacity building program on enforcement of the Act have also been organized for district PNDT Officers in the states of Rajasthan, Gujarat, West Bengal, Maharashtra and Bihar.

c) Capacity building programmes for judicial officers and public prosecutors have been conducted in judicial academies of Chandigarh, Andhra Pradesh and Rajasthan.

v) National Inspection and Monitoring Committee (NIMC)

National Inspection and Monitoring Committee (NIMC) has been reconstituted. The committee has members from Ministries of Health, Women and Child Development and Law, Central Supervisory Board(CSB) members and NGOs. The CSB has now authorized the committee to ensure that court cases are filed in the court against erring doctors. Inspections have been carried out in the States of Chhattisgarh, Maharashtra, Delhi, Haryana, Uttar Pradesh, Madhya Pradesh, Odisha, Punjab, Andhra Pradesh, Bihar and Rajasthan, Gujarat and Uttarakhand. A total of 73 clinics have been inspected, 25 clinics sealed and 19 cases filed between Jan – October 2012.

vi) Inclusion of the issue under NRHM

Funds are being made available under NRHM for strengthening infrastructure and augmentation of human resources required for effective implementation of the PC&PNDT Act.

In 2012-13 PIP an amount of approximately 22crores was approved to States/UTs specifically for PNDT cells, PNDT law implementation and IEC activities.

Conditionalities have been included in state PIP under NRNM including constitution/ reconstitution of all statutory bodies under the PC &PNDT Act, setting up of dedicated PNDT cells, capacity building of programme officers.

vii) Awareness Generation

It is nevertheless recognized, that legislation alone is not enough to deal with this problem that has roots in social behavior and prejudices. Various activities have been undertaken to create a comprehensive awareness campaign against the practice of pre-natal determination of sex and female foeticide through Radio, Television, and print media. Workshops and seminars are also organized through Voluntary Organizations.

Grant-in–Aid has been released to non-governmental organisations in key focus states for awareness generation and community mobilisation on the issue of discrimination against the girl child and declining child sex ratio.

viii) Frequently Asked Questions (FAQs)

The Ministry of Health and Family Welfare, in collaboration with the United Nations Population Fund(UNFPA), have developed 'Frequently Asked Questions' about the PNDT Act which will be useful to the lay persons, medical community and to the Appropriate Authorities in understanding the provisions of the Act for better implementation.

ix) Website on PNDT

In addition to the Union Health & FW Ministry's website (www.mohfw.nic.in), an independent website, 'pndt.gov.in' for PNDT Division was launched by Hon. Union Minister on 28.04.2008.This website, in addition to containing all relevant information relating to PNDT Act, Rules, activities etc. enables online submission of Form- F, by clinics/facilities offering ultrasound diagnostic facilities and their retrieval at the District, State and National levels.

Table: 1

Child Sex Ratio as per Census (1971-2011)

S.No.	States/UTs	1971	1981	1991	2001	2011
	India	**964**	**962**	**945**	**927**	**914**
1	Jammu & Kashmir	959	964	NA	941	859
2	Himachal Pradesh	981	971	951	896	906
3	Punjab	899	908	875	798	846
4	Chandigarh	892	907	899	845	867
5	Uttrakhand	NA	NA	949	908	886
6	Haryana	899	902	879	819	830
7	Delhi	909	926	915	868	866
8	Rajasthan	932	954	916	909	883
9	Uttar Pradesh	923	935	927	916	899
10	Bihar	964	981	953	942	933
11	Sikkim	1087	978	965	963	944
12	Arunachal Pradesh	968	997	982	964	960
13	Nagaland	991	988	993	964	944
14	Manipur	986	986	974	957	934
15	Mizoram	NA	986	969	964	971
16	Tripura	977	972	967	966	953
17	Meghalaya	992	991	986	973	970
18	Assam	1002	NA	975	965	957
19	West Bengal	1010	981	967	960	950
20	Jharkhand	NA	NA	979	965	943
21	Odisha	1020	995	967	953	934
22	Chhattisgarh	NA	NA	984	975	964
23	Madhya Pradesh	976	977	941	932	912
24	Gujarat	946	950	928	883	886
25	Daman & Diu	NA	NA	958	926	909
26	Dadra & Nagar Haveli	1021	995	1013	979	924
27	Maharashtra	972	956	946	913	883
28	Andhra Pradesh	990	992	975	961	943
29	Karnataka	976	974	960	946	943
30	Goa	964	965	964	938	920
31	Lakshadweep	929	964	941	959	908
32	Kerala	978	970	958	960	959
33	Tamil Nadu	974	967	948	942	946
34	Puducherry	978	975	963	967	965
35	Andaman & Nicobar Islands	978	978	973	957	966

Source: Census of India

Table: 2

Rural Urban Child Sex Ratio (0-6 Years) 2001-2011

S.No.	India/State/UTs(#)	2001			2011		
		Total	Rural	Urban	Total	Rural	Urban
	India	**927**	**934**	**906**	**914**	**919**	**902**
1.	Jammu & Kashmir	941	957	873	859	860	854
2.	Himachal Pradesh	896	900	844	906	909	878
3.	Punjab	798	799	796	846	843	851
4.	Chandigarh #	845	847	845	867	862	867
5.	Uttarakhand	908	918	872	886	894	864
6.	Haryana	819	823	808	830	831	829
7.	NCT of Delhi #	868	850	870	866	809	868
8.	Rajasthan	909	914	887	883	886	869
9.	Uttar Pradesh	916	921	890	899	904	879
10.	Bihar	942	944	924	933	935	906
11.	Sikkim	963	966	922	944	952	917
12.	Arunachal Pradesh	964	960	980	960	964	944
13.	Nagaland	964	969	939	944	932	979
14.	Manipur	957	956	961	934	929	945
15.	Mizoram	964	965	963	971	966	978
16.	Tripura	966	968	948	953	955	945
17.	Meghalaya	973	973	969	970	972	957
18.	Assam	965	967	943	957	957	955
19.	West Bengal	960	963	948	950	952	943
20.	Jharkhand	965	973	930	943	952	904
21.	Odisha	953	955	933	934	939	909
22.	Chhattisgarh	975	982	938	964	972	932
23.	Madhya Pradesh	932	939	907	912	917	895
24.	Gujarat	883	906	837	886	906	852
25.	Daman & Diu #	926	916	943	909	925	903
26.	Dadra & Nagar Haveli	979	1003	888	924	961	878
27.	Maharashtra	913	916	908	883	880	888
28.	Andhra Pradesh	961	963	955	943	942	946
29.	Karnataka	946	949	940	943	945	941
30.	Goa	938	952	924	920	924	917
31.	Lakshadweep #	959	999	900	908	888	915
32.	Kerala	960	961	958	959	960	958
33.	Tamil Nadu	942	933	955	946	937	957
34.	Puducherry #	967	967	967	965	957	969
35.	A & N islands #	957	966	936	966	975	947

Source: Census of India

Table: 3

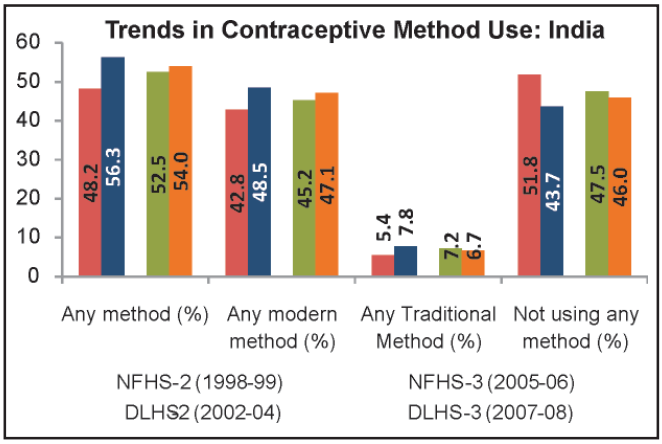
State wise Implementation Status of PC& PNDT Act

Status of Registration, on-going Court Cases and Convictions under PC & PNDT Act (up to June 2012)

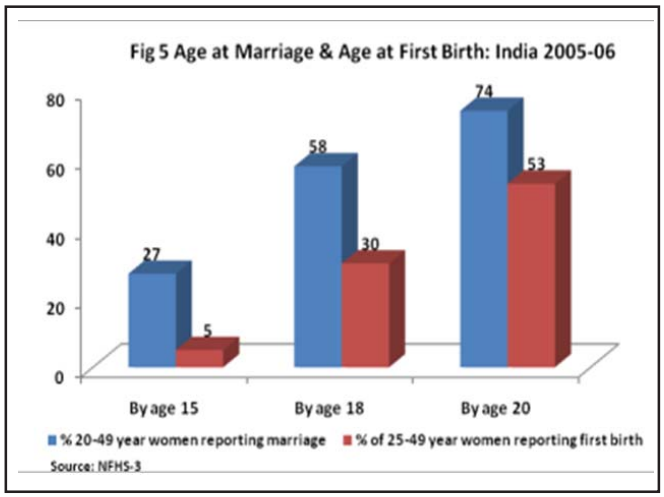
S.No.	States/ UTs	No. of Bodies Registered	No. of on-going Court Cases	No. of Convictions Secured	No. of Medical Licenses Suspended	No. of machines sealed
1	Andhra Pradesh	4513	21	0	0	3
2	Arunachal Pradesh	23	-	0	0	-
3	Assam	507	2	0	0	6
4	Bihar	1090	10	0	0	1
5	Chhattisgarh	528	7	0	0	
6	Goa	140	7	0	0	-
7	Gujarat	3859	109	4	0	3
8	Haryana	1350	70	30	4	-
9	Himachal Pradesh	243	0	0	0	-
10	Jammu & Kashmir	148	1	0	0	4
11	Jharkhand	677	0	0	0	0
12	Karnataka	2878	45	0	0	-
13	Kerala	1510	-	0	0	-
14	Madhya Pradesh	1587	24	5	2	0
15	Maharashtra	8711	367	45	17	535
16	Manipur	55	0	0	0	0
17	Meghalaya	36		0	0	-
18	Mizoram	39	0	0	0	-
19	Nagaland	34	0	0	0	0
20	Odisha	638	22	3	0	0
21	Punjab	1310	120	24	1	0
22	Rajasthan	1864	274	0	9	321
23	Sikkim	25	0	0	0	0
24	Tamil Nadu	4933	77	0	0	72
25	Tripura	63	-	0	0	-
26	Uttarakhand	508	4	0	0	-
27	Uttar Pradesh	4790	41	0	0	31
28	West Bengal	2019	7	0	0	4
29	A & N. Island	9	-	0	0	-
30	Chandigarh	67	2	0	0	-
31	D. & N. Haveli	15	-	0	0	-
32	Daman & Diu	12	-	0	0	0
33	Delhi	1794	62	0	0	0
34	Lakshadweep	18	-	0	0	-
35	Puducherry	69	-	0	0	-
	TOTAL	**46062**	**1272**	**111**	**33**	**980**

19.6 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:

- All the states except Uttarakhand has shown an increase in use of any modern contraceptive method.
- The increase has mainly been on account of increase of female sterilisation, which means there has not been much improvement in other methods of family planning.

Current Family Planning Efforts

National Policies recognize that lowering Total Fertility Rate would help to stabilize India's population growth, which in turn spurs the economic and social progress. Greater investments in family planning can 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. It has been estimated that meeting unmet needs for family planning can avert around 50 lakhs child deaths over 8 years in India. Especially in areas with poor health infrastructure, family planning is a cost-effective and feasible way to reduce maternal deaths, as it does not rely on complex technology. It is estimated that if the current unmet need for family planning could be fulfilled over the next 5 years, we can:

- Avert 35,000 maternal deaths
- Avert 1.2 million infant deaths
- Save more than Rs. 4450 crores
- Saving of Rs. 6500 crores, if safe abortion services are coupled with increased family planning services.

Considering the above, a new strategic direction has been developed for family planning programme wherein, it has been repositioned to not only achieve population stabilization but also to reduce maternal mortality as well as infant and child mortality. This strategic direction would be the guiding principle in implementation of family planning programme in future.

Government of India has redesigned its family planning programme to have more focus on spacing methods, especially, IUCD (both post-partum and interval). To strengthen the spacing services, it is envisaged that states would ensure the fixed day service delivery up to the SHC level for IUCD insertions so as to enable clients to avail the services in close vicinity of their community. Services of ASHAs would also be utilized for counselling clients to promote delay in first child birth and healthy

spacing between 1st and 2nd child birth. The interventions, activities and performance in the arena of family planning are as follows:

Contraceptive services under the national family welfare program

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 couples who wish to have children in future. These include:

A. Oral contraceptive pills

- 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[1].

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:
  - Cu IUCD 380A (10 yrs)
  - 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:
  - **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.
  - **Laparoscopy** - 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:
  - Conventional
  - Non- scalpel vasectomy – no incision, only puncture and hence no stiches.

Emergency Contraceptive Pill

- 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

- These are vital for the success of family planning programme. Very simple method which helps detect

[1] In 233 pilot districts of 17 states, Condoms are not available at SHC and PHC level and supplied by ASHA at doorstep.

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.

- If a woman wants to continue the pregnancy then she may get registered for antenatal care and thus reap benefits of care throughout the pregnancy.
- These are available at the Sub-Centre 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 of:

Family Planning Method	Service Provider	Service Location
SPACING METHODS		
IUD 380 A	Trained & certified ANMs, LHVs, SNs and doctors	Sub-Centre & higher levels
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub-Centre & higher levels
Condoms	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level 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 minilap tubectomy 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 each 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 MoHFW provides compensation for loss of wages to the beneficiary and also to the service provider (& team) for conducting sterilisations.
- 'National Family Planning Insurance Scheme' (NFPIS) under which clients are insured in the eventualities of deaths, complications and failures following sterilization. The providers/ accredited institutions are indemnified against litigations in those eventualities.
- 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

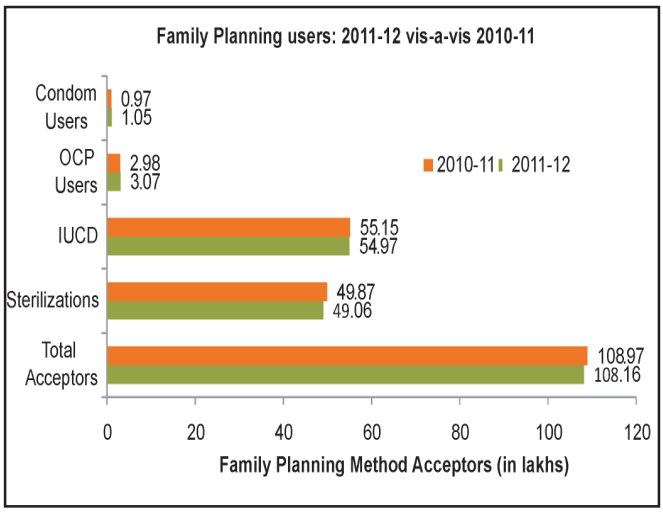
- A new scheme has been launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries. Scheme is being implemented in 233 districts of 17 states. ASHA is charging a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep i.e. Re 1 for a pack of 3 condoms, Re 1 for a cycle of OCPs and Rs 2 for a pack of one tablet of ECP.
- Under a new scheme launched by the 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, NE and Gujarat and Haryana). ASHA would be paid following incentives under the scheme:
  - Rs. 500/- to ASHA for delaying first child birth by 2 years after marriage.
  - Rs. 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child
  - Rs. 1000/- in case the couple opts for a permanent limiting method up to 2 children only
- 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.

Progress made under Family Planning Programme

Service Delivery 2011-12: The performance of family planning services during 2011-12 is provided below (source: HMIS)

- Number of IUCDs and sterilisations have 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.



Promotion of IUCDs as a short & long term spacing method

In 2006, GoI launched "Repositioning IUCD in National Family Welfare Program" 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 actions taken and achievements in different Family Planning methods in chapter-9 on Family Planning)

19.7 REVISED NATIONAL TB CONTROL PROGRAMME

TB affects all irrespective of age and sex. Under the Revised National TB Control Programme, facilities are provided free of cost to the TB patients. Thus the benefits of the Programme are uniformly available for all including women and girls. For providing DOTS to the TB patients, women self-help groups are encouraged to work as DOT providers. ASHAs, Anganwadi workers, Mahila Mandals etc are particularly involved for this purpose.

Under the Revised National TB Control Programme, gender based data in respect of TB cases detected and put on treatment and their outcome is monitored. Information on male to female ratio in different types of cases and treatment outcome is given below. However a constant feature of the RNTCP pulmonary TB case notifications is that more male patients are detected than female patients, with the ratio being 2.2:1. A number of community based epidemiological studies have consistently demonstrated that in all age groups, pulmonary TB is predominantly a male disease. The provision of country-wide available and accessible TB services as close to the patients as possible is important to ensure that the services under the programme are available.

Table: Males to Females ratio in different type of TB cases registered in year 2012

Patients Registered (2012)	Male	Female	Male: Female Ratio
NSP	435396	194193	2.2:1
NSN	199820	117796	1.7:1
NEP	119756	114273	1.1:1
Others	1244	895	1.4:1
RELAPSE	79775	26688	3.0:1
Total	**835991**	**453845**	**1.8:1**

NSP: New Smear Positive
NSN: New Smear Negative
NEP: New Extra Pulmonary

Table: Treatment Outcome (New Smear Positive cases) in Males and Females, 2011

	Male	%	Female	%	Total	%
Cured	371986	83.9%	172745	87.4%	544731	84.9%
Treatment Completed	13126	3.0%	5518	2.8%	18644	2.9%
Died	19828	4.5%	6313	3.2%	26141	4.1%
Failure	9116	2.1%	3173	1.6%	12289	1.9%
Defaulted	26317	5.9%	8762	4.4%	35079	5.5%
Transferred	3187	0.7%	1208	0.6%	4395	0.7%
Total	**443560**		**197719**		**641279**	

19.8 DEVELOPMENT OF NURSING SERVICES

Nursing Personnel are the largest workforces in a Hospital. They play an important role in the health care delivery system. 95% of the beneficiaries of this program are women only. Nursing Personnel are better equipped through this program to provide quality patient care in the Hospitals and other settings also. A sum of Rs. 90.96 crore has been released for establishing 6 ANM and 19 GNM schools across the Country under the Scheme of Upgradation/ strengthening of nursing services which will have a significant impact on women empowerment.

19.9 NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

Under the programme, disaggregated data on female population collected through monthly reports from States/ UTs. During the year 2011-12 the proportion of female amongst new cases was 37.01% during the year 2012-13 (Upto August 2012) 20259 female cases were detected among new patients.