Chapter 2

NHM, HEALTH & POPULATION POLICIES

2.1 THE NATIONAL HEALTH MISSION (NHM)

The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the newly launched National Urban Health Mission (NUHM). The main programmatic components include Health System Strengthening in rural and urban areas- Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs.

National Rural Health Mission (NRHM): NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

National Urban Health Mission (NUHM): NUHM seeks to improve the health status of the urban population particularly urban poor and other vulnerable sections by facilitating their access to quality primary health care. NUHM would cover all state capitals, district headquarters and other cities/towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with population below 50,000 will be covered under NRHM.

Major initiatives under NRHM:

2.1.1 ASHA: More than 8.94 lakh community health volunteers called Accredited Social Health Activists (ASHAs) have been engaged under the mission to work as a link between the community and the public health system. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas. ASHA Programme is expanding across States and has particularly been successful in bringing people back to Public Health System and increase in the utilization of their out-patient services, diagnostic facilities, institutional deliveries and in-patient care.

2.1.2 Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society is a simple yet effective management structure. This committee is a registered society whose members act as trustees to manage the affairs of the hospital and is responsible for upkeep of the facilities and ensure provision of better facilities to the patients in the hospital. Financial assistance is provided to these Committees through untied fund to undertake activities for patient welfare. 31,109 Rogi Kalyan Samitis (RKS) have been set up involving the community members in almost all District Hospitals (DHs), Sub-District Hospitals (SDHs), Community Health Centres (CHCs) and Primary Health Centres (PHCs) till date.

2.1.3 The Untied Grants to Sub-Centres (SCs) has given a new confidence to our ANMs in the field. The SCs are far better equipped now with Blood Pressure measuring equipment, Hemoglobin (Hb) measuring equipment, stethoscope, weighing machine etc. This has facilitated provision of quality antenatal care and other health care services.

2.1.4 The Village Health Sanitation and Nutrition Committee (VHSNC) is an important tool of community empowerment and participation at the grassroots level. The VHSNC reflects the aspirations of the local

community, especially the poor households and children. Untied grants of Rs. 10,000 are provided annually to each VHSNC under NRHM, which are utilized through involvement of Panchayati Raj representatives and other community members in many states. Till date, 5.12 lakh VHSNCs have been set up across the country. In many states, capacity building of the VHSNC members with regards to their roles and responsibilities for maintaining the health status of the village is being done.

2.1.5 Health care service delivery requires intensive human resource inputs. There has been an enormous shortage of human resources in the public health care sector in the country. NRHM has attempted to fill the gaps in human resources by providing nearly 1.69 lakh additional health human resources to states including 7,659 GDMOs, 2,973 Specialists, 71,946 ANMs, 38,339 Staff Nurses etc. on contractual basis. Apart from providing support for health human resource, NRHM has also focused on multi skilling of doctors at strategically located facilities identified by the states e.g. MBBS doctors are trained in Emergency Obstetric Care (EmOC), Life Saving Anaesthesia Skills (LSAS) and Laparoscopic Surgery. Similarly, due importance is given to capacity building of nursing staff and auxiliary workers such as ANMs. NRHM also supports co-location of AYUSH services in health facilities such as PHCs, CHCs and DHs. A total of 12,357 AYUSH doctors have been deployed in the states with NRHM funding support.

2.1.6 Janani Suraksha Yojana (JSY) aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health facilities. Under the scheme, cash assistance is provided to eligible pregnant women for giving birth in a government health facility. Since the inception of NRHM, 7.04 crore women have benefited under this scheme.

2.1.7 Janani Shishu Suraksha Karyakarm (JSSK): Launched on 1st June, 2011, JSSK entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. This marks a shift to an entitlement based approach. The free entitlements include free drugs and consumables, free diagnostics, free diet during stay in the health institutions, free provision of blood, free transport from home to health institution, between health institutions in case of referrals and drop back home and exemption from all kinds of user charges. Similar entitlements are available for all sick infants (up to 1 year of age) accessing public health institutions. All the 35 States and Union Territories are implementing this scheme. In 2012-13, Rs. 2107 crore was provided to states under JSSK and in 2013-14 more than Rs. 2000 crore has been approved for implementing the free entitlements under JSSK.

2.1.8 National Mobile Medical Units (NMMUs): Support has been provided in 418 out of 640 districts for 2127 MMUs under NRHM in the country. To increase visibility, awareness and accountability, all Mobile Medical Units have been repositioned as "National Mobile Medical Unit Service" with universal colour and design.

2.1.9 National Ambulance Services: NRHM has supported free ambulance services to provide patients transport in every nook and corner of the country connected with a toll free number. Over 16,000 basic and emergency patient transport vehicles have been provided under NRHM. Besides these, over 4,769 vehicles have been empanelled to transport patients, particularly pregnant women and sick infants from home to public health facilities and back. 28 states have set up a call centre for effective patient transport system.

2.1.10 Upto 33% of NRHM funds in High Focus States can be used for infrastructure development. Details of new construction and renovation/upgradation works undertaken across the country under NRHM are as follows:

Facility	New Construction		Renovation/ Upgradation	
	Sanctioned	Completed	Sanctioned	Completed
SC	23492	13150	17146	12053
PHC	1797	993	8802	4504
CHC	683	324	3117	1701
SDH	88	40	612	378
DH	94	41	811	510
Other*	709	160	849	654
Total	**26863**	**14708**	**31337**	**19800**

** These facilities are above SCs but below block level.*

2.1.11 In order to ensure that enhanced fund allocations to States/UTs and other institutions under the NRHM are fully coordinated, managed and utilized, Financial Management Group for NRHM (FMG-NRHM) has been set up.

2.1.12 Mainstreaming of AYUSH: Mainstreaming of AYUSH has been taken up by allocating AYUSH facilities in 8425 PHCs, 2374 CHCs, 324 DHs, 3715 health facilities above SC but below block level and 512 health facilities other than CHC at or above block level but below district level.

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

MCTS relies heavily on information technology tools and techniques and promotes its usage by grass roots level health service providers and even by the beneficiaries at large. MCTS is a centralized web based application, which facilitates in real time entry of the information related to pregnant women and children and subsequent health care services provided to them. This tool also facilitates in generation of work plan for the field level health care service providers, to ensure timely and full range of services to them. MCTS employs mobile based SMS technology to alert health service providers and beneficiaries about the service delivery and for providing the due services on time. The system also facilitates with status note and actionable messages to policy makers, health managers and health administrators at different tiers of health care delivery system for necessary action on time.

A total of 2,06,77,184 pregnant women were registered in MCTS during 2013-14 as on 31st March, 2014, which indicates a registration of 69.43 % as against estimated number of pregnant women in 2013-14. A total of 1,64,10,571 children have been registered in MCTS during 2013-14 as on 31st March, 2014, which indicates a registration of 60.61% as against estimated number of infants in 2013-14.

2.2 NEW INITIATIVES

i. **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 2013-14, an allocation of over Rs. 1100 crore under NRHM for 11839 RBSK Mobile Health Teams and 225 Districts Early Intervention Centre have been approved.

ii. **Rashtriya Kishor Swasthya Karyakram (RKSK):** This is a new initiative, 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.

iii. **Mother and Child Health Wings (MCH Wings):** 100/50/30 bedded Maternal and Child Health (MCH) Wings have been sanctioned in public health facilities with high bed occupancy to cater to the increased demand for services. More than 28,000 additional beds have been sanctioned across 470 health facilities across 18 states.

iv. **Free Drugs and Free Diagnostic Service:** Extremely high out of pocket expenditure on health care due to high cost of drugs and diagnostics have proved to be a deterrent in provision of accessible and affordable healthcare for all. To address this, Ministry introduced an incentive to the extent of 5% of the state's Resource Envelope under NRHM for those states that implemented free essential drugs scheme for

all patients accessing public health facilities. Under the National Health Mission - Free Drug Service Initiative and Free Diagnostics Service Initiative, substantial funding is being provided to state that implement these initiatives. States notifying policy for provision of free essential drugs and/or diagnostics to all patients accessing public health facilities, creates a robust procurement, logistics & supply chain system that is IT backed, has differential facility wise Essential Drug List/Diagnostic List depending on the nature of the facility, has sound drug regulatory and quality assurance system, Standard Treatment Guidelines and provides for prescription audits to ensure rational use of drugs.

In 2012-13, Rs. 1540 crore was provided under NHM to states to support free drugs alone. In 2013-14, this support is about Rs. 2000 crore.

v. **National Iron+ Initiative** is another new initiative to prevent and control iron deficiency Anaemia, a grave public health challenge in India. Besides pregnant women and lactating mothers, it aims to provide IFA supplementation for children, adolescents and women in reproductive age group. Weekly Iron and Folic Acid Supplementation (WIFS) for adolescents is an important strategy under this initiative. The operational guidelines for the same were unveiled in February 2013. WIFS (10-19 years) has already been rolled out in 32 States and UTs under the National Iron Plus Initiative. WIFS covered around 3 crore beneficiaries in December 2013.

vi. **Reproductive, Maternal, Newborn, Child and Adolescent Health Services (RMNCH+A):** A continuum of care approach has now been adopted under NRHM with the articulation of strategic approach to Reproductive Maternal, Newborn, Child and Adolescent health (RMNCH+A) in India. This approach brings focus on adolescents as a critical life stage and linkages between child survival, maternal health and family planning efforts. It aims to strengthen the referral linkages between community and facility based health services and between the various levels of health system itself.

vii. **Delivery Points (DPs):** Health facilities that have a high demand for services and performance above a certain benchmark have been identified as "Delivery Points" with the objective of providing comprehensive reproductive, maternal, newborn, child and adolescent health services (RMNCH+A) services at these facilities. Funds have been allocated to strengthen these DPs in terms of infrastructure, human resource, drugs, equipments etc. Around 17,000 health facilities have been identified as "Delivery Points" for focused support under NRHM.

viii. **Universal Health Coverage (UHC):** Moving towards Universal Health Coverage (UHC) is a key goal of the 12th Plan. The National Health Mission is the primary vehicle to move towards UHC. India has charted a path that depends largely on provision of affordable, quality health care by the public health system as its main form of social protection, with supplementation from the private sector to close gaps. UHC pilot projects would be supported in at least one district of each state. Guidelines of the same have been issued to the states along with essential service package. The pilots are expected to demonstrate how access to care and social protection against the costs of care can be meaningfully expanded in the most cost effective manner, while at the same time reducing health inequity.

ix. **Mother and Child Tracking Facilitation Centre (MCTFC):** MCTFC has been operationalized from National Institute of Health and Family Welfare (NIHFW). It is being operated by 80 Helpdesk Agents (HAs). It will validate the data entered in MCTS in addition to guiding and helping both the beneficiaries and service providers with up to date information on Mother and Child Care services through phone calls and Interactive Voice Response System (IVRS) on a regular basis. MCTFC will create awareness about Government mother and child health related programmes and seek feedback on services being provided.

In addition, a module has been provided in the Mother and Child Tracking System (MCTS) portal

so that States / UTs may utilise it to make calls for validation of MCTS data, getting feedback and raising awareness.

x. **Quality Assurance (QA):** The present strategy is shift in focus from fragmented approach of different quality systems to one comprehensive approach of Quality Assurance. Based on best practices of existing quality system such as NABH, ISO, JCI and other scientific literature, comprehensive operational guidelines on Quality Assurance has been launched wherein National Quality Assurance standards have been published. The road map for QA envisages development of a robust institutional mechanism within the states to make States self- sufficient and to have more sustainable system than existing systems. A total of 8 major areas of concerns- Service provision, Patient right, Inputs, Support Services, Clinical Services, Infection Control, Quality Management and Outcome have been identified. Standards have been developed for each area of concern and detailed checklist has been laid down to ensure conformance to these standards. All Public Health Facilities would be assessed, and Quality scored in a phased manner. Besides clinical care, due weightage has been given to issues of patients' right, confidentiality, privacy, compliance to National Health Programme Guidelines, cleanliness at health facilities, etc. The facilities having a credible system of quality assurance (verified through district & state assessment) would be assessed for National Level Certification. On successful attainment of the National certification, facilities would be given incentives and QA certification.

xi. **ASHA Certification:** A proposal for certification of ASHAs to enhance competency and professional credibility of ASHAs by knowledge and skill assessment has been approved recently. The certification of ASHAs would be done by National Institute of Open Schooling (NIOS). The following components of the programme, namely, the Training curriculum, State Training Sites/District Training Sites, Trainers and ASHAs and ASHA Facilitators would be taken up for accreditation/certification. The Certification of ASHAs and accreditation of associated agencies involved in ASHA Training is intended to enhance competency and professional credibility of ASHAs, improve the quality of training and ensure desired programme outcomes, provide an assurance to the community on the quality of services being provided by the ASHA besides promoting a sense of self recognition and worth for ASHAs.

xii. **NGO Guidelines:** Guidelines for NGO involvement under NHM during Twelfth Five Year Plan have been issued recently. The new guidelines envisage greater state ownership for NGO led programmes and are intended to provide a broad framework to the States to partner with NGOs and facilitate their participation in capacity building, support for community processes service delivery, develop innovations through research and documentation, advocacy, and for supplementing capacities in key areas of the public health system to improve health care service delivery.

2.2.1 Progress under National Rural Health Mission (NRHM)(Status as on 30.06.2013)

ASHAs

- 8.89 lakh Accredited Social Health Activists (ASHAs) have been selected in the country, of which over 8.25 lakh received training upto 1st Module, 7.96 lakh upto Module II, 7.92 lakh upto Module III, 7.84 lakh upto Module IV, 7.63 lakh up to Module V, 5.12 lakh in round 1 & 3.34 lakh in round 2 & 1.41 lakh in round 3 & 1.06 lakh in round 4 of VI & VII Module.
- Over 8.06 lakh ASHAs have been positioned after training and have been provided with drug kits.

Infrastructure

- 63 District Hospitals (DHs), 451 Community Health Centers (CHCs), 1594 Primary Health Centers (PHCs), and 21,524 Health Sub-Centers have been taken up for new construction.

Construction work of 35 DHs, 287 CHCs, 936 PHCs and 12,068 SCs has been completed.

- 471 District Hospitals, 2,394 Community Health Centers (CHCs), 4,649 Primary Health Centers and 16,454 Health Sub-Centers have been taken up for upgradation/renovation, out of which upgradation/renovation of 264 DHs, 1,289 CHCs, 3,125 PHCs and 11,451 SCs has been completed.
- 8,236 PHCs are made functional round the clock (24X7) and 2,641 facilities were operationalized as First Referral Units (FRUs).
- All 1.48 lakh Sub Centers (RHS 2012) in the country have been strengthened with untied funds of Rs. 10,000 and AMG of Rs. 10,000 each.

Manpower

- 8,129 Doctors, 11,925 AYUSH Doctors, 2,007 Specialist, 70,608 ANMs, 34,605 Staff Nurses, 13,725 Paramedics and 4,785 AYUSH Paramedics have been appointed on contract by States to fill in critical gaps under NRHM.

Management Support

- District Programme Management Unit has been established in 654 districts, 589 District Programme Manager and 610 District Accountant are in position.
- Nearly, 5,352 Block Programme Management Unit has been established with 3,526 Block Managers in position to support the health system at blocks and below levels.

Mobile Medical Units

- 2,028 Mobile Medical Units (MMUs) are operational in different States, providing services in the interior areas covering 427 districts.

Institutional Delivery

- Janani Suraksha Yojna (JSY) is operationalized in all the States, 7.38 lakh women are benefited in the year 2005-06 and 106.57 lakh in the year 2012-13. 19.57 lakh women received benefits in the year 2013-14 upto June 2013.

Convergence

- Over 64.7 lakh VHNDs were organized in 2012-13 and 12.9 lakh VHNDs were organized in 2013-14 in the villages across the country.
- The States have constituted 5,11,670 Villages Health Sanitation & Nutrition Committees that facilitate convergence with ICDS/Drinking Water/ Sanitation and PRIs. They are also being involved in dealing with disease outbreak.
- Rogi Kalyan Samitis (RKSs) have been registered in 31,358 Health facilities (722 District Hospitals, 4,922 CHCs, 1,048 facilities other than CHCs above block level, 18,685 PHCs and 5,981 facilities above SC and below block level).

Training

- Training in critical areas including Life Saving Anesthesia Skills (LSAS), BEmoC (Basic Emergency Obstetric Care), FBNC, F-IMNCI and NRC and No Scalpel Vasectomy (NSV) etc has been taken up for MOs. Skill Development Training including training on SBA, IMNCI and NSSK has been taken up for ANMs. Similarly, IMNCI, F-IMNCI, NSSK, FBNC etc. have been taken up for the Staff Nurses. Professional Development Programme for CMOs is also on full swing.
- Upgradation of ANM Schools is being supported.

Health Resource Centers

- National Health System Resource Center (NHSRC) has been set up at the National level.
- A Regional Resource Center has been set up in Guwahati for NE.
- State Resource Centre is being set up in many states.

Monitoring and Evaluation

- *Annual Common Review Mission-:* So far 6 Common Review Missions have been undertaken.
- *Joint Review Mission (JRM)-:* So far 8 JRM were held focusing on maternal and child health.

- *Financial & Physical Monitoring System-:* A Quarterly Financial & Physical Monitoring System has been instituted at national level to monitor the implementation of the Mission.
- *Concurrent Evaluation-:* A Concurrent evaluation study was done by International Institute for Population Studies (IIPS) on NRHM.
- *District Level Vigilance & Monitoring Committee (DLVMC) -:* States have been asked to constitute these committees at district level to monitor the implementation of the Mission.

Free Drugs Service

- Extremely high out of pocket expenditure on health care due to high cost of drugs and diagnostics have proved to be a deterrent in provision of accessible and affordable healthcare for all. To address this, Ministry introduced an incentive last year to the extent of 5 % of the State's Resource Envelope if the state implemented free essential drugs scheme for all patients coming to public health facilities. 28 States/UTs have so far notified Free Drugs policy.
- Further, it has also been decided to provide substantial support for implementing the Free Drugs initiative under the "NHM-National Free Drugs Service" provided the State meets the following requirements:

  a. It notifies or has a clearly notified policy of providing free essential drugs to all patients coming to public health facilities, at least upto district hospital level.

  b. It creates a robust procurement, logistics & supply chain system that is IT backed.

  c. It has a differential facility wise Essential Drug List/ Diagnostic List depending on the nature of the facility.

  d. It has a sound drug regulatory and quality assurance system.

  e. It sets up prescription audit system.

2.3 NATIONAL URBAN HEALTH MISSION (NUHM) (NEW SCHEME)

The National Urban Health Mission (NUHM) as a sub-mission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013.

NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development.

NUHM would endeavour to achieve its goal through:-

- Need based city specific urban health care system to meet the diverse health care needs of the urban poor and other vulnerable sections.
- Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.
- Partnership with community and local bodies for a more proactive involvement in planning, implementation, and monitoring of health activities.
- Availability of resources for providing essential primary health care to urban poor.
- Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders.

NUHM would cover all State capitals, district headquarters and cities/towns with a population of more than 50000. It would primarily focus on slum dwellers and other marginalized groups like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers.

The centre-state funding pattern will be 75:25 for all the States except North-Eastern states including Sikkim

and other special category states of Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for whom the centre-state funding pattern will be 90:10. The Programme Implementation Plan (PIPs) sent by the states are appraised and approved by the Ministry.

In the 12th Plan an allocation of Rs. 15,143 crores has been made for National Urban Health Mission.

2.4 HEALTH POLICY

The National Health Policy (NHP) of 2002 guides the strategy adopted by the Government for the health sector. The NHP 2002 evolved from the National Health Policy of 1983. Guidance was provided by the Bhore Committee Report (1946) wherein the main underlying principles for future health development of the country inter-alia included that "No individual should fail to secure adequate medical care because of inability to pay for it. In view of the complexity of modern medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment." Policy directions of the 'Health for All Declaration' at Alma Ata in 1978 became the stated policy of Government of India with adoption of the National Health Policy Statement of 1983. The Report of the Macro Economic Commission on Health and Development 2005 contributed further to the policy direction and roadmap of the Government.

Some of the salient aspects of the NHP 2002, inter-alia, include: making good the deficiencies in availability of health facilities, narrowing the gap between various states as also the gap across the rural urban divide in attainment of health goals and reducing the uneven access to and benefits from the public health system between the better endowed and the more vulnerable sections of society. Accordingly consistent with the primacy given to equity a marked emphasis has been provided for expanding and improving the primary health facilities. Emphasis has been laid on the implementation of public health programmes through local self-Governments. The need to ensure improved standard of medical education, alleviate the shortage of specialists in Public Health and Family Medicine, need for an improvement in the ratio of nurse vis-à-vis doctors/beds, the need for basing treatment regimens on a limited number of essential drugs of a generic nature and progressively strengthening the food and drugs administration are among the various aspects emphasized in the policy.

The Five Year Plans outline the strategy for implementing the policy, bearing in mind the dynamics of a developing economy. Accordingly, the Twelfth Five Year Plan for the health sector envisages transformation of the National Rural Health Mission into a National Health Mission covering both rural and urban areas. It envisages providing public sector primary care facilities in selected low income urban areas, expansion of teaching and training programmes for health care professionals particularly in the public sector institutions giving greater attention to public health, strengthening the drug and food regulatory mechanism, regulation of medical practice, human resource development, promoting information technology in health and building an appropriate architecture for Universal Health Care. The Twelfth Plan strategy is to strengthen initiatives taken in the Eleventh Plan to further expand the reach of health care with focus on vulnerable and marginalized sections of population and therefore, envisages substantial expansion and strengthening of the public health systems and provision of robust primary health care.

2.5 NATIONAL COMMISSION ON POPULATION

In pursuance of the objectives of the National Population Policy 2000, the National Commission on Population was constituted in May 2000 to review, monitor and give directions for the implementation of the National Population Policy (NPP), 2000 with a view to meeting the goals set out in the Policy, to promote inter-sectoral co-ordination, involve the civil society in planning and implementation, facilitate initiatives to improve performance in the demographically weaker States in the country and to explore the possibilities of international cooperation in support of the goals set out in the National Population Policy.

The first meeting of the Commission was held on 23.07.2000 and the then Hon'ble Prime Minister had announced the formation of an Empowered Action Group within the Ministry of Health and Family Welfare

for paying focused attention to States with deficient national socio-demographic indices and establishment of National Population Stabilization Fund [Jansankhya Sthirata Kosh] to provide a window for canalizing monies from national voluntary sources to specifically aid projects designed to contribute to population stabilization.

2.5.1 Annual Health Survey (AHS)

The first round of Annual Health survey (AHS) was got conducted by the Ministry of Health & Family Welfare through the Office of Registrar General of India, during 2010-11 in 284 districts of 8 Empowered Action Group (EAG) States namely Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Odisha and Assam.

Key results on some of the AHS indicators have been released in the form of State wise Bulletins by the Office of RGI on 10-08-2011, which contain district level data on Crude Birth Rate, Crude Death Rate, Infant Mortality Rate, Neo-Natal and Post Neo-Natal Mortality Rate, Under 5 Mortality Rate, Sex Ratio at birth, Sex Ratio (0-4 years) and overall sex Ratio. In addition, the Maternal Mortality Ratio has also been released for a group of districts in each of the State.

The Survey was conducted during 2010-11; the reference period for the data is 2007-09.

2.5.2 Expert Groups

Five groups of experts were constituted for studying the population profile of the States of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh and Odisha. The draft reports of the expert groups have been received in the Commission and examined for correctness of the demographic data and then sent to the concerned five States for the following: -

- Commenting on the report of the expert group.
- Provide an update on what they are doing for stabilization of population under NRHM.
- Prepare a presentation on their work on Population Stabilization for the next meeting of the NCP.

The Commission has been providing policy support to the population stabilization efforts under overall framework of implementation of NRHM by the states. The Commission has come out with a number of publications in collaboration with Registrar General of India and Institute of Economic Growth, which provides valuable inputs on future demographic trends, challenges and suggestive measures for achieving population stabilization as envisaged in NPP 2000 and NRHM goals.

The second meeting of the Commission was held on 21st October 2010 adopted the following resolution with broad consensus recommending the key points for the stakeholders as follows:

➢ **According Priority**

- Population Stabilization should be accorded high priority.
- Chief Ministers should provide leadership to the promotion of small family norm.
- Social experts, social scientists and communication experts should be involved.
- A safe motherhood campaign should be carried out on the lines of pulse polio programme with focus on population issues.

➢ **Programmatic Interventions**

- IEC Campaign should be revitalized vigorously.
- Undertake strategy to meet the unmet need for family planning services.
- Strengthen Public Health services and facilities like clean toilets, water, electricity, etc.
- Strengthen Post-Partum family planning services at all centres where deliveries takes place.
- Focus to be on Delay of age at marriage, delay in birth of first child and promotion of birth spacing between children.
- Availability of medicines at all Public Health Facilities.
- Involve AYUSH Doctors in family planning programmes.

➢ **Inter - sectoral Co-ordination**

- Ministries of HRD, WCD and Panchayati Raj

should be actively involved in population stabilization programmes.

- Utmost attention to be given for education, particularly of girls.
- Education regarding family life including reproductive and sexual health issues at a younger age be given to adolescents to further empowerment of women.
- Interventions to improve nutritional status, particularly pregnant mothers to be strengthened.
- Institutions and Hospitals run by institutions like ESI, Railways and Defence Services should be involved in family planning services.

➢ **Other Interventions**

- Rising of legal age at marriage of girls be considered.
- Gender to be included in medical education.
- NGOs working among members of Muslim Community may be actively involved in enhancing awareness regarding small family norms.
- Emphasis on research to develop more innovative contraceptives to expand available contraceptive choices.
- Availability of funds for health sector, as well as for family planning should be increased.

2.6 JANSANKHYA STHIRATA KOSH (JSK)

The National Population Stabilisation Fund was constituted under the National Commission on Population in July 2000. Subsequently it was transferred to the Department of Health and Family Welfare in April 2002. It was renamed and reconstituted as Jansankhya Sthirata Kosh (JSK) under the Societies Registration Act (1860) in June 2003.The General Body of JSK is chaired by the Minister for Health and Family Welfare, while the Governing Board is chaired by Secretary (H & FW). The Executive Director is the Chief Executive Officer of the Kosh.

JSK has undertaken a number of initiatives for population stabilization which in brief are:

PRERNA Strategy:

In order to help push up the age of marriage of girls and space the birth of children in the interest of health of young mothers and infants, Jansankhya Sthirata Kosh (National Population Stabilization Fund)has launched PRERNA, a *Responsible Parenthood Strategy* in seven focus states namely Bihar, Uttar Pradesh, Madhya Pradesh, Chhattisgarh, Jharkhand, Odisha, and Rajasthan.

The strategy recognizes and awards couples who have broken the stereotype of early marriage, early childbirth and repeated child birth and have helped change the mindsets of the community.

In order to become eligible for award under the scheme, the girl should have been married after 19 years of age and given birth to the first child after at least 2 years of marriage. The couple will get an award of Rs.10,000/- if it is a Boy child or Rs.12,000/- if it is a Girl child. If birth of the second child takes place after at least 3 years of the birth of first child and either parent voluntarily accept permanent method of family planning within one year of the birth of the second child, the couple will get an additional award of Rs.5,000/- (Boy child) / Rs.7,000/- (Girl child). The amount of award is given in the form of National Saving Certificate (NSC). The scheme is meant only for BPL families.

The strategy has been identified and awarded 244 couples till September, 2013 from districts of Bihar, MP and Chhattisgarh. Many more awaiting for award in the financial year 2013-14.

SANTUSHTI Strategy:

Santushti is a strategy of Jansankhya Sthirata Kosh (JSK) for high populated States of India viz Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh & Odisha. Under this strategy, Jansankhya Sthirata Kosh, invites private sector gynecologists and vasectomy surgeons to conduct operations in Public Private Partnership mode.

According to this Scheme, an accredited private Nursing Home/Hospital can sign a tripartite (State Health Society as 1st party, accredited private health facility 2nd party

while JSK is third party) MoU with JSK. Upon signing the MoU Pvt. Hospitals/Nursing Home shall be entitled for incentive, whenever it conducts 10 or more Tubectomy/Vasectomy cases in a month.

Requisites for the strategy:

- Accredited Private Hospitals/Nursing Homes, who conduct 10 or more Tubectomy (Female Sterilization) and Vasectomy (Male Sterilization) operations in a month, are eligible for payment under Santushti Strategy.
- Private facilities conforming to the aforesaid criteria are entitled to claim Rs.1500/- per case from NRHM funds while an additional amount of Rs. 500/- per case will be paid by JSK.
- JSK will also pay wage compensation to the clients undergoing sterilisation operation equal to the sum paid to them in the public facility. i.e. Rs.600/-for Tubectomy and Rs 1100/- for Vasectomy clients.

Type of Service	Type of facility	Incentive to the Providers by JSK (Rs.)	Wage compensation to the beneficiaries provided by JSK (Rs.)	Amount from NRHM Fund (Rs.)
Tubectomy	Private	500/-	600/-	1500/- (includes Motivation money)
Vasectomy	Private	500/-	1100/-	1500/- (includes Motivation money)

- All the reputed NGOs working in the state are eligible to participate in the Scheme if they full-fill the requisite criteria for quality assurance.
- NGOs are also permitted to utilize infrastructure of PHCs, CHCs for related activities as many of these facilities have good infrastructure but are not optimally utilized due to lack of manpower.

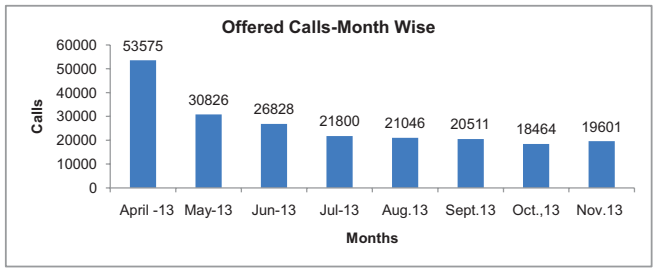
Total no. of 7757 cases has been sterilized till November, 2013 from Rajasthan under the strategy.

2.6.1 National Helpline- Toll Free (1800-11-6555)

Jansankhya Sthirata Kosh initiated a first of its kind National Helpline in India on Reproductive, Sexual Health, Family Planning and Infant and Child Health etc.

The aim of National Helpline is to provide reliable information on reproductive health, sexual health, contraception, pregnancy, child health and related issues. It is specifically for adolescents, newly married and about to be married persons from the high focus States of Bihar, U.P. Rajasthan, Madhya Pradesh, Jharkhand and Chhattisgarh.

Till 30 November, 2013 approximately 2,12,612 calls have been offered from entire country. The maximum numbers of queries being received are on issues related to contraception, pregnancy, sexual health and infertility. Month-wise break-up of these calls are as under:



2.6.2 World Population Day 2013

As part of its awareness and advocacy efforts on population issues, Jansankhya Sthirata Kosh (JSK) organized a series of advocacy events on the occasion of the World Population Day on 11th July, 2013. Walk towards Population Stabilization which was flagged off by Hon'ble Union Minister of Health and Family Welfare. Over 2000 youth from various schools of Delhi, students from Medical Colleges and several other organisations were in the walk to endorse their support for the cause of population stabilisation. The "Walk" was an effort to build momentum and raise awareness around issues like low female literacy, early age at marriage and early child besides among a host of other challenges to be dealt with to address the issue of population stabilisation. Carrying placards with slogans supporting the cause of population stabilisation, everyone joined to advocate for the cause.

2.6.3 Geographical Information System (GIS)Mapping

As part of this initiative, JSK mapped 450 districts in India through a unique amalgamation of Geographical Information System (GIS) maps and Census data in 2006. The mapping gives a picture of each district, its sub-divisions and the population of every village along with the distance to the health facility. The maps highlight inequities in coverage down to the village to enable resources to be targeted where they are needed the most. These maps are being revised as per 2011 census.

2.6.4 Virtual Resource Centre

JSK has established a Virtual Resource Centre with regular updating which provides access to resource material like films, posters, photos on subjects like gender, maternal and infant mortality, declining sex ratio, adolescent health, spacing and other related issues. The material is hosted on JSK's website and is a useful resource for NGOs, schools, students, government bodies, medical colleges, Institutes of Public Health, universities, researchers and the media.

2.7 FAMILY PLANNING INDEMNITY SCHEME

As per the Hon'ble Supreme Court of India in its order dated 1.3.2005 in Civil Writ Petition No. 209/2003 (Ramakant Rai v/s Union of India), the Family Planning Insurance Scheme (FPIS) was introduced w.e.f. 29th November, 2005 with Oriental Insurance Company to take care of the cases of failure of sterilization, medical complications or death resulting from sterilization, and also provide Indemnity Cover to the doctors/health facilities performing sterilization procedure.

With effect from 1st April,2013 it has been decided that States/UTs would process and make payment of claims to acceptors of sterilization in the event of death/ failures/complications /indemnity cover to doctors/health facilities. It is envisaged that States/UTs would make suitable budget provisions for implementation of the scheme through their respective State/UT Programme Implementation Plans (PIPs) under the National Rural Health Mission (NRHM) and the scheme may be renamed **"Family Planning Indemnity Scheme"**. The scheme is uniformly applicable for all States/UTs. A letter to that effect has already been sent to all States/ UTs vide No N.23011/68/2011-FW(Ply) dated 27th December, 2012.

The States/UTs may plan for the payment of compensation to sterilization acceptors as per the scheme, under Budget Head A.3.5.4 -Other Strategies/activities Sub-Head A.3.5.4.1.

Current Scheme (Part of State Programme Implementation Plans (PIPs) w.e.f. 1st April, 2013):

The available benefits under the Family Planning Indemnity Scheme are as under:

Section	Coverage	Limits
I A	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 lakh
I B	Death following sterilization within 8 - 30 days from the date of discharge from the hospital	Rs. 50,000/-
I C	Failure of sterilization	Rs 30,000/-
I D	Cost of treatment ***in hospital and*** **upto 60 days** arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge Actual not exceeding	Rs. 25,000/-
II	Indemnity per Doctor/ Health Facilities but not more than 4 in a year	Upto Rs. 2 Lakh per claim

A Comprehensive Manual for "Family Planning Indemnity Scheme" was launched in the "National Family Planning Summit" held on 3rd October, 2013 in New Delhi. The soft copy of the manual would soon be made available on the Ministry's website: www.mohfw.nic.in click www.nrhm.gov.in and then click http://nrhm.gov.in/nrhm-components/rmnch-a/family-planning/schemes.html

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

2.8.1 Adverse Child Sex-Ratio in India

The Child Sex Ratio (CSR) for the age group of 0-6 years as per the 2011 census (provisional) has dipped further to 919 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), 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 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.

2.8.2 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.

2.8.3 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 preempt 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 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 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.

2.8.4 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
- 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.

2.8.5 Implementation of PC & PNDT Act in States/UTs

As per the Quality Progress Reports (QPRs) submitted by States/UTs 49998 bodies have been registered under the PC & PNDT Act. So far a total of 1682 machines have been sealed and seized for violations of the law. A total of 1945 ongoing court cases and 201 convictions have been secured under PC & PNDT Act and following the conviction the medical licenses of 97 doctors have been suspended/cancelled. (Appendix-II)

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

PROGRESS CARD

	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

2.8.6 Recent 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 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.

- 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.

The above two (3 & 5) recent amendents to PC & PNDT Rules have been challenged in various High Courts and the Supreme Court and the matter is sub-judice.

- 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 GSR 77 (E) dated 31st January 2014. The received format is more simplified as the invasive and non-invasive portions have been separated.
- Rules for Code of conduct for Appropriate Authorities has been notified vide GSR 119 (E) dated 24th February, 2014. Legal, monitoring, administrative and financial procedure have been explicitly laid down to facilitate appropriate authorities in the course of effective implementation of the PC & PNDT Act.

2.8.7 Monitoring and review of the implementation scaled up

i. 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. Important amendments to the PNDT Rules have been approved and notified.

ii. 14 states with the most skewed child sex ratio have been identified for concerted attention. A meeting of Health Secretaries of these States was convened on 20th April 2011. As the primary responsibility for implementing the Act rests with the states, they have been asked to take the following steps:

- Constitute State Supervisory Board, conduct its regular meetings and send quarterly progress report to the Central Supervisory Board as per the Act
- Notify District Collectors as District Appropriate Authority
- Constitute State Inspection and Monitoring Committees (SIMC)
- Identify districts with skewed Child Sex Ratio and focus on them
- Conduct regular surveys, update registrations and renewals to avoid multiple registrations
- Ensure analysis and scrutiny of Form -F (which provides detailed information on the pregnant woman and copy of which has to be sent to the District Appropriate Authority every month under the Act)
- Obtain regular information from ultrasound manufacturers regarding the sale of machines which is also mandatory as per the Act.
- Conduct workshops and training for judiciary and public prosecutors.
- Give training to appropriate authorities for building strong cases against offenders
- Strengthen inter-state coordination for regulating ultrasound clinics across borders.

iii. 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.

iv. Inspections by the National Inspection and Monitoring Committee (NIMC) have been scaled

up. Inspections have been carried out in 34 districts of 16 states including Gujarat, Uttar Pradesh, Rajasthan, Maharashtra, Madhya Pradesh, Delhi, Bihar, Odisha, Haryana, Punjab, Andhra Pradesh, Chhattisgarh, Uttarakhand, Himachal Pradesh, Karnataka, Jammu & Kashmir and Jharkhand. A total of 114 clinics were inspected and 45 clinics were sealed from August 2011 Sept. 2013. 23 cases have already been filed in court.

v. The intensification of the drive against sex determination through effective implementation of the Act is being reviewed regularly in State meetings. Five regional review workshops for North, West, Central, North-East and Southern regions have been organized to evaluate and review the progress of implementation of PC & PNDT Act in the country.

vi. Hon'ble Prime Minister of India has urged Chief Ministers of all states to provide personal leadership to reserve the declining trend in child sex ratio and address the neglect of the girl child through focus on education and empowerment.

vii. Considering that almost all states have shown declining trend in child sex ratio Minister of Health and Family Welfare has written to all states on 30th May, 2011, emphasizing the need to strengthen implementation of the Act and take timely steps to stop misuse of medical technology for illegal sex determination.

viii. Union Health Secretary has addressed all Chief Secretaries to take effective measures and regularly monitor implementation of the PNDT Act.

ix. A Ministerial meeting was held under the Chairpersonship of Minister of Health & Family Welfare with Health Ministers of States on 28th September, 2011 at New Delhi to strengthen effective implementation of the PC & PNDT Act.

x. Status of Implementation of PC & PNDT Act was included in the TORs of the Joint Review Mission (JRM), Common Review Mission (CRM) and Integrated Monitoring Visits for the current year so that teams can assess the situation on the ground.

2.8.8 Capacity building programme for all stake holders

- 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.
- The National workshop for State Appropriate Authorities and State Nodal Officers of PNDT was organized 27th & 29th Feb. 2012 by Ministry of Health & Family Welfare in collaboration with UNFPA. The 2nd National workshop was held 28th & 29th November, 2013 in Pune.

2.8.9 Other initiatives taken by MoHFW

- Four expert committees have 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, simplification of Form-F, lay down code of conduct and to evolve regulatory mechanisms on sale & operations of USG machines.
- 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.
- PNDT has been Included under NRHM and states have been asked to take advantage of funding available under NRHM for strengthening infrastructure and augmentation of human resources required for effective implementation of the Act. Rs. 2935.79 lakh and Rs.1731.56 lakh have been allocated under NRHM during 2012-13 and 2013-14 respectively.

- 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 for Health & Family Welfare. This website contains all the relevant information relating to the Act and the Rules.
- Minister for 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)
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**	**919**	**8**

Note: (-) shows negative sign

Appendix-II

Status of registration, cases and convictions under PC & PNDT Act (up to March, 2014)

S.No.	States/ UTs	No. of bodies registered	No. of on-going Court/ Cases	Machines Seized / Sealed	Convictions	No. of suspension/ cancellation of medical license
1	Andhra Pradesh	5003	52	132	0	0
2	Arunachal Pradesh	35	0	0	0	0
3	Assam	692	5	2	0	0
4	Bihar	1418	6	6	11	0
5	Chhattisgarh	656	7	0	0	0
6	Goa	155	18	1	0	0
7	Gujarat	4318	127	3	6	1
8	Haryana	1573	97	241	49	8
9	Himachal Pradesh	253	0	0	1	0
10	Jammu & Kashmir	300	6	72	1	0
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	9002	481	709	61	59

16	Manipur	77	0	0	0	0
17	Meghalaya	38	0	0	0	0
18	Mizoram	47	0	0	0	0
19	Nagaland	45	0	0	0	0
20	Odisha	685	24	6	3	0
21	Punjab	1400	127	0	28	4
22	Rajasthan	2199	578	384	37	21
23	Sikkim	24	0	0	0	0
24	Tamil Nadu	5494	77	72	0	0
25	Tripura	66	0	0	0	0
26	Uttarakhand	531	22	4	0	0
27	Uttar Pradesh	5248	154	34	1	0
28	West Bengal	2185	18	14	0	0
29	A & N. Island	10	0	0	0	0
30	Chandigarh	104	2	0	0	0
31	D. & N. Haveli	13	0	0	0	0
32	Daman & Diu	12	0	0	0	0
33	Delhi	1794	62	0	1	2
34	Lakshadweep	18	0	0	0	0
35	Puducherry	78	0	0	0	0
	TOTAL	**49998**	**1945**	**1682**	**201**	**97**

2.9 IMPROVEMENT IN THE QUALITY OF HEALTH CARE

The improvement in the status of health care over the years in respect of some of the basic demographic indicators is given in Table 1. The Crude Birth Rate (CBR) has declined from 40.8 in 1951 to 29.5 in 1991 and further to 21.6 in 2012. Similarly there was a sharp decline in Crude Death Rate (CDR) which has decreased from 25.1 in 1951 to 9.8 in 1991 and further to 7.0 in 2012. Also, the Total Fertility Rate (average number of children likely to be born to a woman aged 15-49 years) has decreased from 6.0 in 1951 to 2.4 in the year 2012 as per the estimates from the Sample Registration System (SRS) of Registrar General & Census Commissioner, India, Ministry of Home Affairs.

The Maternal Mortality Rate has also declined from 437 per one lakh live births in 1992 - 93 to 178 in 2010-12 according to the SRS Report brought out by RGI. Infant Mortality Rate, which was 110 in 1981, has declined to 42 per 1000 live births in 2012. Child Mortality Rate has also decreased from 57.3 in 1972 to 11.5 in 2012.

Table 1 : Achievements of Health & Family Welfare Programme

Sl. No.	Parameter	1951	1981	1991	2001	2012 (Latest available)
1	Crude Birth Rate (Per 1000 Population)	40.8	33.9	29.5	25.4	21.6
2	Crude Death Rate (Per 1000 Population)	25.1	12.5	9.8	8.4	7.0
3	Total Fertility Rate (Per women)	6.0	4.5	3.6	3.1	2.4
4	Maternal Mortality Rate (Per 100,000 live births)	NA	NA	437 (1992-93) NFHS	301 (2001-03) S.R.S.	178 (2010-12) S.R.S.
5	Infant Mortality Rate (Per 1000 live births)	146 (1951-61)	110	80	66	42
6	Child (0-4 years) Mortality Rate per 1000 children	57.3 (1972)	41.2	26.5	19.3	11.5

Source: Office of Registrar General & Census Commissioner, India, Ministry of Home Affairs.

Family Planning Methods

The total number of acceptors of different Family Planning methods enrolled in the country during 2013-14 was 26.88 million. **Table 2** below summarizes the position in regard to Family Planning achievements during 2013-14 and 2012-13 (April to March) at All India Level.

Table 2: Family Planning Acceptors by methods-All India

(Figures in millions)

Sl. No.	Methods	Achievement*	
		2013-14 (April 2013-March 2014)	2012-13 (April 2012-March 2013)
1.	Sterilisation	03.94	04.58
2.	IUD Insertions	05.00	05.41
3.	**Condom Users (Eq.)**	12.49$	13.96$
	i. Under Free Distribution Scheme (Equivalent)	04.51	05.30
	ii. Under Commercial Distribution scheme (Equivalent)	07.99	08.67
4.	**Oral Pill Users**	05.44	06.24
	i. Under Free Distribution Scheme ((Equivalent))	03.02	03.09
	ii. Under Commercial Distribution Scheme (Equivalent)	02.42	03.15
	Total Acceptors	**26.88$**	**30.19**

Note: Data during the year 2013-14, decreased as compared to last year after Districts shifted to facility level reporting.
Source: HMIS Portal (Status as on 25th April, 2014)
**: Provisional figures*
Eq -Equivalent
$:-Total does not match due to round off.

Immunisation Performance for the year 2013-14 vis-à-vis 2012-13 is given in **Table 3**.

Table 3:Assessed Need of Immunisation and Achievement during 2013-14 vis-a-vis Achievement during 2012-13 under RCH Programme (All India)

(Figures in 000's)

Sl. No.	Activity	Assessed Need for 2013-14	Achievement*		% Achvt. of Assessed Need 2013-14
			2013-14	2012-13	
1	2	3	4	5	6
A.	**Immunisation**				
	i. Tetanus Immunisation for Expectant mothers	29576	23256	22739	78.6
	ii. DPT Immunisation for Children	25760	19072#	21383	74.0
	iii. Polio	25760	22802	22278	88.5
	iv. B.C.G.	25760	23626	23657	91.7
	v. Measles	25760	22505	22725	87.4
	vi. DT Immunisation for Children	23503	10854	10171	46.2
	Vii T.T. (10 Years)	24398	14326	14123	58.7
	viii T.T. (16 Years)	25573	13760	13559	53.8
B.	**Prophylaxis against nutritional anaemia among women**	29576	23331	21317	78.9
C.	**Prophylaxis against Blindness due to Vit. 'A' deficiency $**				
	i. 1st dose	25760	18292	17229	71.0
	ii. 5th dose	23883	15199	11723	63.6
	iii 9th dose	23520	13279	10151	56.5

** Provisional figures*
 # Decline due to introduction of Pentavalent vaccine
Source: HMIS Portal (Status as on 25th April, 2014)

2.10 HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

Health Management Information System (HMIS) is a web-based Monitoring system that has been put in place by Ministry of Health and Family Welfare (MoHFW) to monitor its health programmes and provide key inputs for policy formulation and interventions.

It was launched in October 2008 and States / UTs were initially reporting district wise data on HMIS portal. To make HMIS more robust, effective and to facilitate local level monitoring, all States/UTs were requested to shift to "facility based reporting" from April, 2011. At present, 602 districts (out of 659) are reporting facility wise data while rest are uploading District Consolidated figure on the HMIS web portal. The data is being made available to various stakeholders in the form of standard & customized reports, factsheets, score-cards etc. HMIS data is widely used by the Central / State Government officials for monitoring and supervision purposes.

MoHFW is also conducting periodic review meetings, workshops, training etc. to discuss data quality,

conceptual issues and the latest developments including new reports, features available on the portal. To enhance the analytical capabilities of National and State level users, they have been provided SAS WRS and SAS-VDD software. The process to make the HMIS as GIS enabled is in progress.

2.10.1 National Health Portal (NHP)

In pursuance of recommendations of National Knowledge Commission (NKC), Ministry of Health and Family Welfare (MoHFW) has decided to set up and operationalize National Health Portal (NHP) which will provide easy access to health related information for various stake holders like common man, health professionals, academicians, Government Departments, etc. in Hindi, English and other major regional languages. The project is being implemented as a pilot project initially for a period of two years after which a decision on its continuation / ups-scaling will be taken by the Ministry. A Steering Committee for NHP (SCNHP) has been constituted to direct, advice and manages the NHP. Centre for Health Informatics (CHI) of the National Health Portal (NHP), one of the main entities under NHP, has been set up. Creation of other entities mentioned in the Detailed Project Report (DPR) is in process. Layout of NHP has been designed, some content has been created and the portal has been made live for beta testing since 15th November, 2013.

2.11 SURVEYS AND EVALUATION ACTIVITIES

2.11.1 Large Scale Surveys: The Ministry has been conducting large scale surveys periodically to assess the level and impact of health interventions. These surveys include National Family Health Survey (NFHS), District Level Household Survey (DLHS), Annual Health Survey (AHS) etc. The main aim of these surveys is to assess the impact of the health programmes and to generate various health related indicators at the District, State and National level.

2.11.2 District Level Household Survey: The District Level Household and Facility Surveys (DLHS) were initiated with a view to assess the utilization of services provided by health facilities and people's perception about the quality of services. DLHS -3 (2007-08), the third in the series of the district surveys was preceded by DLHS-1 in 1998-99 and DLHS 2 in 2002-04. DLHS is designed to provide district level estimates on important indicators on maternal and child health, family planning and other reproductive health services and important interventions of National Rural Health Mission (NRHM).

The fourth round of DLHS has been taken up with the objective of estimating reliable indicators of population, maternal & child health and family planning at District and State Level. As part of the Survey, a number of Clinical Anthropometric and Biochemical (CAB) tests are carried out to produce district level estimates for nutritional status and prevalence of certain life style disorders. The major constituents of the CAB component are height, weight and blood pressure, estimation of hemoglobin (Hb), blood sugar and test for iodine content in the salt used by households. The key survey results are expected to be available in May, 2014.

2.11.3 Annual Health Survey (AHS): Three rounds of Annual Health Survey (AHS) were approved for providing district level estimates on major programme indicators, besides estimates of impact indicators like Total Fertility Rate (TFR), Infant Mortality Rate (IMR), Under Five Mortality Rate (U5MR), Maternal Mortality Ratio (MMR), etc. Office of RGI is the nodal organisation for conducting AHS. Under the AHS, 284 districts in the nine States, i.e., Assam, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Odisha, Uttar Pradesh and Uttarakhand were covered. The AHS was conducted during 2010-11, 2011-12 and 2012-13 and the results are now available. Further, under the AHS, a separate component on Clinical, Anthropometric and Bio-chemical (CAB) tests has been introduced to collect data on height & weight measurement, blood test for anaemia and sugar, blood pressure measurement and testing of iodine in the salt used by households. Fieldwork of CAB component is under progress.

2.11.4 National Family Health Survey (NFHS): Three rounds of National Family Health Surveys were carried out in 1992-93 (NFHS-1), 1998-99 (NFHS-2) and 2005-06 (NFHS-3) under the stewardship of the

Ministry of Health and Family Welfare, Government of India, with the International Institute for Population Sciences (IIPS), Mumbai, serving as the nodal agency for conducting the survey. The Ministry has decided to integrate all surveys and to conduct one survey (i.e. National Family Health Survey) to provide district level data with a periodicity of three years. Accordingly, fourth round of the Survey (NFHS-4) will be conducted during 2014-15 to provide essential data up to district level on Health and Family Welfare. Three Committees have been constituted namely Steering Committee, Technical Advisory Committee (TAC) and Administrative & Financial Management Committee to facilitate decisions regarding policies, planning and procedure of the survey. The sampling design and questionnaire of this survey have been finalized and the selection of agencies for conducting field work is under progress.

2.11.5 Regional Evaluation Teams: There are 7 Regional Evaluation Teams (RETs) located in the Regional Offices of the Ministry which undertake evaluation of the NRHM activities including Reproductive and Child Health Programme (RCH) on a sample basis by visiting the selected Districts and interviewing the beneficiaries. These teams generally visit two adjoining districts in a state every month and see the functioning of health facilities and carry out sample check of the beneficiaries to ascertain whether they have actually received the services. Reports of the RETs are sent to the States/UTs for taking corrective measures on issues highlighted in the reports. During 2013-14, 86 districts were visited by the RETs.

2.12 POPULATION RESEARCH CENTRES (PRCS)

The Ministry has established 18 Population Research Centres (PRCs) in various institutions in the country with a view to carry out research on various topics pertaining to population stabilization, Demographic and other Health related programmes. While 12 of these PRCs are located in Universities, the remaining six are located in the Institutes of national reputed. The Ministry of Health & Family Welfare provide 100% financial grant-in-aid to all PRCs on a year to year basis towards salaries of staff, books and journals, TA/DA, data processing/stationary/contingency etc. and other infrastructure requirement.

Annual Report of 18 PRCs along with the audited statement of accounts is laid on the table of both the Houses of Parliament.

2.13 NATIONAL HEALTH SYSTEMS RESOURCE CENTRE (NHSRC)

The National Health Systems Resource Centre (NHSRC) was set up in 2007, as a technical support and knowledge management agency for the National Rural Health Mission (NRHM), Ministry of Health and Family Welfare (MoHFW). NHSRC is committed to lead as a professionally managed technical support organization to strengthen public health systems and facilitate creative and innovative solutions to address the challenges that this task faces. The Regional Resource Center, North East (RRC-NE) a branch of the NHSRC serves as the technical support organization for the states of the North East.