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 know the health status of women so that the causes of ill health are identified, discussed and misconceptions removed. Ill health of women is mainly due to poor nutrition 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 intersectoral coordination at the grassroot levels and involving the NGOs, Civil Societies, Panchayati Raj Institutions and Women's Group in bringing down Maternal Mortality Rate and Infant Mortality Rate.

Several new initiatives have been taken to make the maternal health programme broad based and client friendly to reduce maternal mortality. The major interventions include provisioning of additional ANMs and Public Health/Staff Nurses in certain sub-centres, PHCs/CHCs, Laboratory Technicians, Referral Transport, 24-Hours Delivery Services at PHCs/CHCs, Safe Motherhood Consultants, Safe Abortion Services, Essential 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 (JSY) was launched in April 2005, to enable women especially from the vulnerable sections of the society to access institutional delivery and thereby effect reductions in maternal and neonatal mortality. The scheme provides conditional cash assistance to pregnant women for giving birth in a government health facility by providing access to skilled birth attendance and emergency obstetric care.

The scheme is under implementation in all States and Union Territories (UTs), with a special focus on Low Performing States (LPS). Around 9 lakh Accredited Social Health Activists (ASHAs) are working as an effective link between the government and poor pregnant women who get financial incentive to promote institutional delivery.

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

The number of beneficiaries under the scheme has increased manifold i.e. from 7.38 lakhs in 2005-06 to 1.05 crores in 2013-14. Similarly, expenditure has

increased from Rs. 38.29 crores in 2005-06 to Rs. 1748 crores in 2013-14.

Eligibility for Cash Assistance for Pregnant Women

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

Low Performing States (LPS)	All pregnant women delivering in government health centres or accredited private institutions
High Performing States (HPS)	All BPL/Scheduled Caste (SC)/ Scheduled Tribe (ST) women delivering in a government health centre or accredited private institutions.

Cash Assistance for Institutional (in Rs.)

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

Category	Rural area		Total	Urban area		Total
	Mother's package	ASHA's package*		Mother's package	ASHA's package**	
Low Performing States (LPS)	1400	600	2000	1000	400	1400
High Performing States (HPS)	700	600	1300	600	400	1000

**ASHA incentive of Rs. 600/- in rural area includes Rs. 300/- for ANC component and Rs. 300/- for accompanying pregnant woman for institutional delivery.*

***ASHA incentive of Rs. 400/- in urban area includes Rs. 200/- for ANC component and Rs. 200/- for accompanying pregnant woman for institutional delivery.*

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 regardless of age and number of children preferring to delivery at home are entitled to financial assistance of Rs. 500/-per delivery in all the States/UTs.

19.3 JANANI SHISHU SURAKSHA KARYAKARAM (JSSK)

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

- Capitalizing on the surge in institutional deliveries brought about by JSY to provide service guarantees at health facilities, Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) in 1st June, 2011 to eliminate out of pocket expenditure for pregnant women and sick new-borns on drugs, diet, diagnostics, user charges, referral transport, etc. The scheme entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. Under this scheme, pregnant women are entitled to free drugs and consumables, free diagnostics, free blood wherever required, and free diet up to 3 days for normal delivery and 7 days for C-section. 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. This has now been expanded to cover the complications during ANC, PNC and also sick infants.
- To implement this scheme, more than Rs. 2107 crores have been allocated during the year 2012-13 and more than Rs. 2000 crores have been sanctioned up till now in 2013-14 under RCH and Mission Flexipool.

19.4 MOTHER AND CHILD TRACKING SYSTEM

To catch every pregnant women and every neonates and infants for quality ANC, INC, PNC, FP, Immunization services, the pregnant women and

neonates are being tracked by name. **Web Enabled Mother and Child Tracking System (MCTS)** is being implemented to register and track every pregnant woman, neonate, infant and child by name for quality ANC, INC, PNC, FP, Immunization services. As on March, 2014 more than 6.20 crores women and 5.17 crores children have been registered under MCTS.

A new initiative of prevention of PPH through Community Based Advanced distribution of Misoprostol by ASHAs/ ANMs has been launched in the districts with high home delivery rates.

19.5 RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

This is a new initiative launched in February 2013 which includes provision 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. An estimated 27 crore children in the age group of zero to eighteen (0-18) years are expected to be covered across the country in a phased manner. Child Health Screening and Early Intervention Services will cover 30 common health conditions for early detection and free treatment and management.

Dedicated mobile health teams placed in every block, screen children from birth till 6 years at Anganwadi centres at least twice a year and screen children enrolled in Government and Government aided schools atleast once a year. Newborn are screened for birth defects in health facilities where deliveries take place and during the home visit by ASHA.

- Health screening of children is carried out by block level mobile health teams consisting of AYUSH doctors and paramedics duly trained in the use of necessary tools for screening.
    - o In 2013-14, 11,839 Mobile Health teams have been approved of which till January, 2014, 5,491 teams in 22 States/UTs have been recruited.
- Early Intervention Centres are being operationalized at District Hospitals for management of cases referred from block upwards. Linkages with secondary and tertiary level health services are provided in case higher level of management is required, including surgical interventions, free of cost.
    - o 445 master trainers across States/UTs have been trained. 225 District Early Intervention Centres (DEICs) are being established.
    - o By January, 2014, the number of children screened has exceeded 5.82 crore, (69.80 lakhs children from birth to 6 years and 5.13 crores children enrolled in Government and Government aided school). 1.30 lakh have received free treatment including surgeries for congenital heart disease, cleft lip and correction of club foot etc.
- Through early identification and linkages to care, support and treatment, screening will help in providing a comprehensive package of services to reduce the household expenditure of the poor and marginalized, reduce the disease burden and build health awareness. The scheme will diminish the burden on the health system besides encouraging caregivers/parents to seek health care early for their children. This is likely to translate into economic benefits both for the country and for individual families in the long run.

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

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

Reasons for adverse Sex Ratio

Some of the reasons commonly put forward to explain the consistently low levels of sex ratio are son preference, neglect of the girl child resulting in higher mortality at younger age, female infanticide, female foeticide, higher maternal mortality and male bias in enumeration of population. Easy availability of the sex determination tests and abortion services may also be proving to be catalyst in the process, which may be further stimulated by pre-conception sex selection facilities.

Sex determination techniques have been in use in India since 1975 primarily for the determination of genetic abnormalities. However, these techniques were widely misused to determine the sex of the foetus and subsequent elimination if the foetus was found to be female.

Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994

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

The technique of pre-conception sex selection has been brought within the ambit of this Act so as to 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.

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.

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

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.

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

viii. Considering that almost all states have shown declining trend in child sex ratio, a Ministerial meeting was held under the Chairpersonship of Minister for Health & Family Welfare with Health Ministers of States on 28th September, 2011 at New Delhi to strengthen effective implementation of the PC & PNDT Act.

ix. 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.

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.

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 & FW. 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

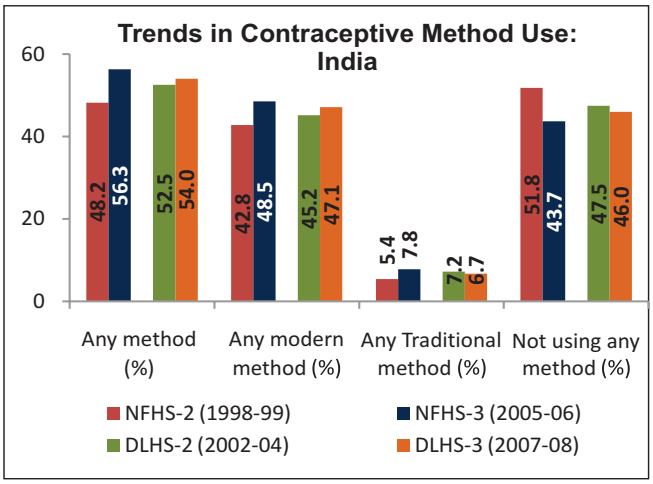
Appendix-II

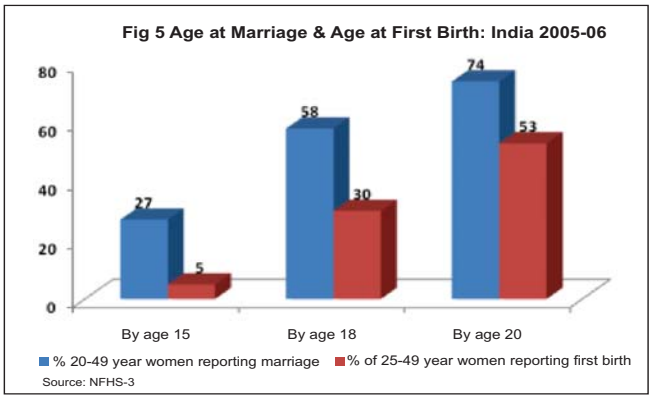
Status of registration, cases and convictions under PC & PNDT Act (up to March, 2014)

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**

19.7 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 Uttarakhandhas shown an increase in use of modern contraceptives.

Current Family Planning Efforts

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

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

Contraceptive services under the National Family Welfare programme

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

Spacing Methods- These are the reversible methods of contraception to be used by 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 .

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 of IUCD:
  - o Cu IUCD 380A (10 yrs)
  - o Cu IUCD 375 (5 yrs)
- New approach of method delivery- postpartum IUCD insertion within 48 hours of delivery by specially trained providers to tap the opportunities offered by institutional deliveries. Service providers and ASHAs accompanying clients are being provided with incentive of Rs. 150/-.

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

A. Female Sterilisation-

- o ***Minilap*** - Minilaparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked. Can be performed by a trained MBBS doctor.
- o ***Laparoscopic*** - Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen. Can be done only by trained and certified Gynaecologist/Surgeon.

B. Male Sterilisation

- Through a puncture or small incision in the scrotum, the provider locates each of the 2 vas deference that carries sperm to the seminal vesicle and cuts and then ties the two cut ends. The procedure is performed by MBBS doctors trained in the procedure. 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 are:
  - o Conventional
  - o 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

- Helps to detect pregnancy as early as one week after the missed period, thus proving an early opportunity for medical termination of pregnancy, thus saving lives lost to unsafe abortions.
- These are available at the sub centre level and also carried by ASHA.

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

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 these 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 Spacing Methods	Service Provider	Service Location
IUD 380 A/IUCD 375	Trained & certified ANMs, LHVs, SNs and doctors	Sub centre& higher levels
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level 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 minilaptubectomy services because of its logistical simplicity and requirement of only MBBS doctors and not post graduate Gynaecologists/Surgeons.
- A rational human resource development plan is in place for provision of IUCD, minilap and NSV to empower the facilities (DH, CHC, PHC, SHC) with at least one provider 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 Indemnity Scheme' under which clients are indemnified 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:

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

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

- o Rs. 500/- to ASHA for delaying first child birth by 2 years after marriage.
- o Rs. 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child
- o Rs. 1000/- in case the couple opts for a permanent limiting method up to 2 children only.

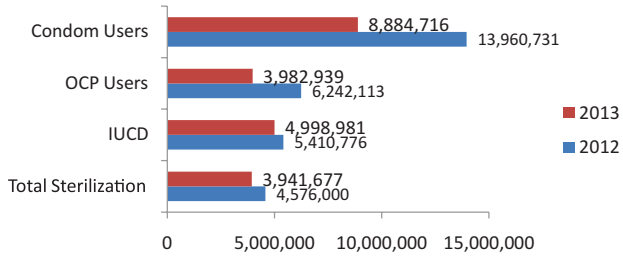
- MoHFW has introduced short term IUCD (5 years effectivity), Cu IUCD 375 under the National Family Planning Programme. Training of state level trainers has already been completed and process is underway to train service providers up to the sub-center level.
- A new method of IUCD insertion (post-partum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

D. Pregnancy Testing Kits

- Nishchay-Home based pregnancy test kits (PTKs) was launched under NRHM in 2008 across the country.
- The PTKs are being made available at subcenters and to the ASHAs.
- The PTKs facilitate the early detection and decision making for the outcomes of pregnancy.

Progress made under Family Planning Programme

Service Delivery 2012-13- The performance of family planning services during 2012 and 2013 (provisional figures) is provided below (source: HMIS):



- Number of IUCDs and sterilisations has remained static in spite of declining CBR and TFR. There is a need to sustain momentum to reach the replacement level fertility.

- Considering the current efforts to focus on spacing, it is expected that IUCD performance would increase in near future.

Promotion of IUCDs as a short & long term spacing method

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

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

19.8 REVISED NATIONAL TB CONTROL PROGRAMME (RNTCP)

Under the Revised National TB Control Programme, facilities are provided free of cost to the TB patients irrespective of sex. 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.

Table1: 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:2 Treatment Outcome (New Smear Positive cases) in Male and Female, 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**	

**The treatment outcomes are reported only after 12-15 months, hence outcomes the cohort of 2012 would only be reported completely henceforth.*

Quantum of funds provided to each private and voluantary organizations as grants-in-aid of Rs. 1 lakh and above but below Rs. 5 lakhs and the purpose for which these were utilized.

Sl no	Name of the recipient	Amount (in lakhs)	Purpose
1	APICON 2012, Coimbatore*	2.0	Annual Conference by Association of Physicians of India
2.	NATCON 2012, Patna	2.0	Annual Conference of Bihar TB Association
3.	Indian Society for Malaria and other Communicable Diseases	1.0	Annual Joint Conference

All Utilization Certificates have been received except from APICON 2012. One time assistance as grants-in-aid of Rs 10 lakhs and above but below Rs. 50 lakhs provided to private and voluntary organizations or societies for which the funds were utilized Nil.

19.9 DEVELOPMENT OF NURSING SERVICES

Nursing Personnel are the largest workforces in a Hospital. They play an important role in the health care delivery system. A sum of Rs. 200.00 crore has been allocated for the year 2013-14 for implementing the New Scheme of Upgradation/Strengthening of Nursing Services for establishing ANM and GNM schools across the country under the scheme of upgradation/ strengthening of nursing services. Nursing personnel are better equipped through this programme to provide quality patient care in the Hospitals and in other settings also. As per the available statistics 95% of the beneficiaries are women only and therefore, the programme will have significant impact on women empowerment.

19.10 NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

Although leprosy affects all irrespective of gender, males are affected more as compared to females. This can be attributed to greater mobility and increased opportunities for contact among the male population. Intensive IEC activities have been carried out through mass media and local media focusing more on the female population for creating greater awareness about the signs and symptoms of the disease among females especially from areas with low literacy rate. ASHAs are also being involved in referring suspect leprosy cases to health facility for diagnosis and for ensuring treatment completion. For facilitating involvement of ASHAs under the programme, an incentive is proposed to be given for referring suspect cases to health facility and follow up of diagnosed for treatment completion. This is expected to help in improving case finding in general and identifying female cases in particular.

Under the programme, state wise disaggregated data on gender is collected on monthly basis. During the year 2012 -13, out of 126,900 new leprosy cases detected, 46839 (36.9%) number of female cases were detected.