NRHM, Health & Population Policies

2.1 NATIONAL RURAL HEALTH MISSION (NRHM)

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, 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 to ensure greatest attention where needed. 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. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.

Some of the major initiatives under NRHM are as follows:

2.1.1 ASHAs: More than 8.84 lakh community Health volunteers called Accredited Social Health Activists (ASHAs) have been engaged under the mission for establishing a link between the community and the 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 has increased the utilization of outpatient services, diagnostic facilities, institutional deliveries and inpatient care. Large scale demand side financing under the Janani Suraksha Yojana (JSY) has brought poor households to public sector health facilities on a scale never witnessed before. Over 570.19 lakh women have been covered under JSY so far since its introduction in 2005.

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 that acts as a group of trustees for the hospitals to manage the affairs of the hospital. Financial assistance is provided to these Committes through untied fund to undertake activities for patient welfare. 31694 Rogi Kalyan Samitis (RKS) have been set up involving the community members in almost all District Hospitals, Sub-divisional Hospitals, Community Health Centres and PHCs till date. RKSs are performing various roles like deciding about the procurement issues, rate fixation of the services and renovation plans. RKSs have provided water filters, inverters and other useful services to health facilities.

2.1.3 The Untied Grants to Sub-Centres has given a new confidence to our ANMs in the field who are far better equipped now with Blood Pressure measuring equipment, stethoscope, the weighing machine etc. They can actually undertake a proper ante-natal care and other health care services. The Village Health Sanitation and Nutrition Committee (VHSNC) is an important tool of community empowerment 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, 5.03 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.

2.1.4 Health care service delivery requires intensive human resource inputs. As can be seen from various surveys, there is 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 1.7 lakh health human resources to States including 8,871 Doctors, 2025 Specialists, 76,643 ANMs, 41,609 Staff Nurses etc on contractual basis. Apart from recruitment, NRHM has 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 Anesthesia 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 District Hospitals. A total 11,478 AYUSH doctors have been deployed under NRHM funding support in the States under this initiative.

2.1.5 Many un-served areas have been covered through Mobile Medical Units (MMU). So far 2024 MMUs are operational in 459 districts across the country. Further, to provide free ambulance services in every nook and corner of the country connected with a toll free number and available within 30 minutes of the call, over 12,000 basic and emergency patient transport vehicles have been provided under NRHM.

2.1.6 Upto 33% of NRHM funds in high focus States and 25% in non high focus States can be used for infrastructure development. Detail of new construction/ renovation undertaken across the country under NRHM are as follows:

Facility	Number of facility (RHS 2011)	New Construction		Renovation/ Upgradation	
		Sanc-tioned	Comp-leted	Sanc-tioned	Comp-leted
SC	148124	19811	10639	14434	9879
PHC	23887	1733	781	3695	3009
CHC	4809	471	235	2272	1208
SDH	985	74	45	435	270
DH	613	66	47	546	279
Total	**178418**	**22155**	**11747**	**21382**	**14645**

2.1.7 In order to ensure that enhanced fund allocations to States/UTs and other institutions under the NRHM are fully coordinated, managed, and utilized, the Financial Management Group for NRHM (FMG-NRHM) has been set up to operationalise the following financial management arrangements and funds flow processes for release, monitoring and utilization of funds as per recommendations of the Empowered Programme Committee (EPC).

2.1.8 As part of recent initiatives and further moving in the direction of universal healthcare, Janani Shishu Suraksha Karyakram (JSSK) was introduced last year to provide free to and fro transport, free drugs, free diagnostic, free blood, free diet to pregnant women who come for delivery in public health institutions and sick new-born. In 2012-13, over Rs. 2103.29 crores have been provided to States under JSSK for this purpose. This new initiative has picked up well in most States. Initiatives have also been made to enhance the funding to the States so as to enable the States to move in the direction of providing essential medicines free of cost to everyone coming to a government health facility. An amount of Rs.1301.58 Crores has been provided to States in 2012-13 for drugs. Further, in 2012-13, with a focus to reduce to maternal and child mortality**,** 267 dedicated Mother and Child Health Wings with 100/50/30 bed capacity have been sanctioned in high case load district hospitals and CHCs which would create over 20,000 additional beds for mothers and children.

2.1.9 Progress under National Rural Health Mission (NRHM) (*Status as on 30.09.2012)*

ASHAs

- 8.84 lakh Accredited Social Health Activists (ASHAs) have been selected in the country, of which over 8.09 lakh received training up to 1st Module, 7.77 lakh up to Module II, 7.73 lakh up to Module III, 7.70 lakh up to Module IV, 7.10 lakh up to Module V, 3.50 lakh in round 1 & 1.63 lakh in round 2 & 0.89 lakh in round 3 & 0.11 lakh in round 4 of VI & VII Module.
- Over 8.84 lakh ASHAs have been positioned after training and provided with drug kits.

Infrastructure

- 64 District Hospitals, 426 Community Health Centers (CHCs), 1514 Primary Health Centers (PHCs), and 18630 Health Sub-Centers have been

taken up for new construction. Out of which construction of 49 DH, 189 CHCs, 668 PHCs and 8777 SCs have been completed.(As on 30.6.2012)

- 537 District Hospitals, 2105 Community Health Centers (CHCs), 3542 Primary Health Centers (PHCs), and 13402 Health Sub-Centers have been taken up for upgradation/renovation. Out of which upgradation/renovation of 274 DHs, 1159 CHCs, 2341 PHCs and 9276 SCs have been completed.(As on 30.6.2012)
- 8199 PHCs are made functional round the clock (24x7) and 2552 facilities were operationalised as First Referral Units (FRUs).
- All 1.48 lakh Sub Centers (RHS 2011) in the country have been strengthened with untied fund of Rs. 10,000 each.

Manpower

- 7,382 Doctors, 11,478 AYUSH Doctors, 2,131 Specialist, 66,407 ANMs, 32,278 Staff Nurses, 11,030 Paramedics and 4,894 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 638 districts with 570 District Programme Manager and 573 District Accountant are in position.
- Nearly, 4729 Block Programme Management Unit has been established with 3361 Block Managers in position to support the health system at blocks and below levels.

Mobile Medical Units

- 2024 Mobile Medical Units (MMUs) are operational in different States, providing services in the interior areas covering 459 districts.

Immunization

- Intense monitoring of Polio Progress – Services of ASHA useful.
- JE vaccination completed in 11 districts in 4 states – 93 lakh children immunized during 2006-07. JE vaccination has been implemented in 26 districts of 10 states in 2007. The 11 districts of 4 states where JE vaccination was carried out in 2006 have introduced JE vaccine in Routine Immunization to vaccinate new cohort between 1-2 years of age with booster dose of DPT.
- House tracking of polio cases and intense monitoring.
- Neonatal Tetanus declared eliminated from 7 states in the country.
- Full immunization coverage evaluated at 43.5% at the national level.(NFHS-III)
- Accelerated Immunization Programme taken up for EAG and NE State.

Institutional Delivery

- Janani Suraksha Yojana (JSY) is operationalised in all the States, 7.38 lakh women are benefited in the year 2005-06, 31.58 lakh in 2006-07, 73.28 lakh in 2007-08, 90.36 lakh in 2008-2009, 100.78 lakh in the year 2009-2010, 106.96 lakh in the year 2010-11, 109.37 lakh in the financial year 2011-12 and so far,50.43 lakh in the financial year 2012-13.(upto sept.)

Convergence

- Over 35 lakh in 2006-07, 49.6 lakh in 2007-08, 58.1 lakh in 2008-2009, 58.7 lakh in year 2009-2010, 69.2 lakh in 2010-11, 72.11 lakh in 2011-12 and 35.23 lakh in 2012-13 so far Monthly Health and Nutrition Days being organized at the villages across the country.
- The States have constituted 503025 Village Health and Sanitation Committees. They are being involved in dealing with disease outbreak.
- Convergence with ICDS/Drinking Water/ Sanitation/NACO/PRIs ground work completed.
- Rogi Kalyan Samitis (RKSs) have been registered in 31,694 Health facilities (693 District Hospitals, 4847 CHCs, 1042 facilities other than CHCs above block level, 18,385 PHCs and 6,727 facilities above SC and below block level). A support of Rs. 5 lakh per DH, Rs. 1lakh per CHC and Rs. 1 lakh per PHC is given.
- School health programmes have been initiated in over 26 States.

Health Action Plans

- State PIPs have been received from 31 states during 2006-07, 35 in the year 2007-08, 2008-09, 2009-10 ,2010-11 and 35 State PIPs received in the current year 2011-12 Programme Implementation Plan (PIPs) of the States under NRHM has been apprised and funds being released for the year 2012-13.
- The first cut of Integrated District Health Action Plans (DHAP) has been finalized for 636 districts.

Mainstreaming of AYUSH

- Mainstreaming of AYUSH has been taken up in the State 15,782 AYUSH facilities are available at District and below district level health institutions. AYUSH person are part of State Health Mission / Society / RKS / ASHA training as members.

Trainings

- Trainings in critical areas including Anesthesia, Skilled Birth Attendance (SBA) taken up for MOs/ ANMs. Integrated Skill Development Training for ANMs/ LMV/MOs, Training on Emergency Obstetrics care and No Scalpel Vasectomy (NSV) for MOs, Professional Development Programme for CMOs is on full swing.
- ANM Schools being upgraded in all States.
- New nursing schools taken up.

Health Resource Centres

- National Health Systems Resource Centre (NHSRC) set up at the National level.
- Regional Resource Centre set up for NE.
- State Resource Centre being set up by States.

Monitoring and Evaluation

- *Annual Common Review Mission:* So far 5 Common Review Mission are undertaken and the field visit of the 6th Review Mission was held between 2-9th November, 2012.
- *Joint Review Mission (JRM):* So far 8 JRMs 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 Inter National Institute for Population Studies on NRHM.
- *District Level Vigilance & Monitoring Committee (DLVMC):* States are asked to constituted these committees at district level to monitor the implementation of the Mission.

2.2 NATIONAL URBAN HEALTH MISSION (NUHM)

The National Urban Health Mission (NUHM) as a sub-mission of National Health Mission (NHM) will meet health needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing out of pocket expenses for treatment. This will be done by investing in health professionals, appropriate technology, creating new & upgradation of existing infrastructure and strengthening the existing health care service delivery system.

NUHM would ensure the following:-

- Availability of resources for addressing the health problems in urban areas, especially among urban poor.
- Need based city specific urban health care system to meet the diverse health needs of the urban population with focus on urban poor and other vulnerable sections.
- Partnership with community for a more proactive involvement in planning, implementation, and monitoring of health activities.
- Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.
- Framework for partnerships with NGOs, for profit and not for profit health service providers and other stakeholders.

NUHM would cover all cities/towns with a population of more than 50000. Towns below 50000 population will be covered under NRHM. It would cover urban population including slum dwellers; other marginalized urban dwellers like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers, who may be in slums or on sites.

The existing Urban Health Posts and Urban Family Welfare Centres would be taken as existing infrastructure under NUHM and will be considered for upgradation. All the existing human resources will then be suitably reorganized and rationalized.

2.3 HEALTH POLICY

The social obligation for the government to ensure the highest possible health status of its population and as part of this, ensure that all people have access to quality health care has been recognized by a number of key policy documents. The preamble of the Bhore committee report (1946) began with the opening line-

"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."

This sentiment and aspiration gained international consensus with adoption of the Health for All Declaration at *Alma Ata* in 1978 which declared health as a fundamental human right. To quote: "The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." And further more specifically it calls for "All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors."

The policy directions of the Health for All declaration became stated policy of Government of India with the adoption of the National Health Policy Statement of 1983. Driven by this declaration there was some expansion of primary health care in the eighties. Further, the National Health Policy of 2002 and the Report of the Macro-Economic Commission on Health and Development (2005) were to emphasize a) the need to increase the total public health expenditure from 2 to 3% of the GDP, b) the need to strengthen the role of public sector in social protection against the rising costs of health care and the need to provide a comprehensive package of services without reducing the prioritization given to women and children's health.

2.3.1 Population Policy

The National Population Policy (2000) not only focused on the unmet needs of contraception, but also stressed the need for an integrated service delivery for basic reproductive and child health care. Accordingly, the long terms goals set under this policy envisaged a reduction in Total Fertility Rate (TFR) to replacement levels, Infant Mortality Rate to <30/1000 live births and Maternal Mortality Ratio to <100/100,000 live births by 2010. Thus, an increased focus on basic Reproductive and Child Health Services was ushered in as a thrust area under this policy.

It was in this context that the National Rural Health Mission was launched and this was the main programme of the 11th Plan period. The National Rural Health Mission had as its goal the "Attainment of universal access to equitable, affordable and quality health care, which is accountable and responsive to the needs of the people". The NRHM focus is on strengthening states to achieve comprehensive primary health care- understood to mean all the care provided within district health systems.

To address the primary health care needs of the urban poor, particularly those living in slums and vulnerable populations, the Government of India proposes to launch National Urban Health Mission (NUHM) in the 12th Plan under an overarching umbrella of National Health Mission. This will thus ensure coverage of entire community-including both rural and urban areas. The thrust in the 12th Plan is to strengthen primary health care to move towards the goal of universal health care.

2.4 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. 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.

The National Commission on Population was reconstituted in April 2005 with 40 members under the Chairmanship of the Hon'ble Prime Minster. Minister of Health & FW and the Deputy Chairman of the Planning Commission are Vice Chairmen of the Commission. The present membership also includes the Chief Ministers of the States of Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Jharkhand, Kerala and Tamil Nadu.

The reconstituted National Commission on Population had decided on the following:

- There should be Annual Health Survey of all districts which could be published annually so that health indicators at district level are periodically published, monitored and compared against benchmarks.
- Setting up of five groups of experts for studying the population profile of the States of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh and Odisha to identify weaknesses in the health delivery systems and to suggest measures that would be taken to improve the health and demographic status of the States.

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 (RGI), during 2010-11 in 284 districts of 8 Empowered Action Group (EAG) States namely Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Rajsthan, 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.

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 under the Chairmanship of Prime Minister. The Commission deliberated upon population stabilization issue amongst other issues and after deliberation, the Commission adopted the following resolution with broad consensus recommending the key points for the stakeholders as follows :

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

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

- **Inter – sectoral Co-ordination**

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

- **Other Interventions**

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

2.5 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 as follows:

Prerna Strategy:

The strategy was launched by JSK in 2008 and is in operation in seven high focus states of Odisha, Bihar, Uttar Pradesh, Madhya Pradesh, Chhattisgarh, Jharkhand and Rajasthan.

The strategy recognizes and awards the eligible young BPL couples from backward districts of the country, who have broken the stereotype of early marriage and early child birth and helped change mindsets.

According to this scheme, the girl should have been married after 19 years of age and given birth to the first child at least after 2 years of marriage, the couple will get an award of Rs. 10000/- if it is Boy child or Rs.12000/- if it is Girl child. If the birth of second child is after 3 years of first child birth and either parent voluntarily accept permanent method of family planning within one year of the birth of the second child, couple will get additional Rs. 5000/- if boy child and Rs. 7000/- if girl child. The scheme is only for BPL families. The eligible couples will be awarded up to Rs.19,000/- in the form of National Saving Certificates and given certificate at a widely publicized and well attended function in the District.

The strategy has identified and awarded 219 couples till September, 2012 from remote and backward districts of Chhattisgarh, Uttar Pradesh and Bihar. Many more awaiting for award in the financial year 2012-13.

Santushti Strategy:

Santushti is a Scheme of Jansankhya Sthirata Kosh (JSK) for high populated states of India viz Bihar, Uttar

Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh & Odisha. Under this scheme, 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 (*Quality assurance manual for Sterilization services*), can sign a MoU with JSK. Upon signing the MoU Pvt. Hospitals/NH shall be entitled for incentive, whenever it conducts 10 or more Tubectomy/ Vasectomy cases in a month.

Following are the recent changes of the Santushti Strategy:

1. Accredited Private Hospitals/Nursing Homes, who conduct 10 Tubectomy (Female Sterilisation) and Vasectomy (Male Sterilisation) operations in a month, will be eligible for payment under Santushti Strategy.
2. Private facilities conforming to the aforesaid criteria are entitled to claim Rs.1500/- per case from NRHM funds while additional amount of Rs.500/- per case will be paid by JSK.
3. Now there is also a provision for payment of wage compensation to the clients undergoing sterilisation operations 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	Motivators (Rs.)	Wage compensation to the beneficiaries (Rs.)	Total (Rs)
Tubectomy	Private	1850/-	150/-	600/-	2600/- (1500/- from NRHM Fund & rest amount will be provided by JSK)
Vasectomy	Private	1800/-	200/-	1100/-	3100/- (1500/- from NRHM Fund and rest amount will be provided by JSK)

4. Henceforth, to streamline the functioning, Tripartite MoU will be between Private Health Provider, State Health Society and JSK.
5. All the reputed NGOs working in the state may also be eligible to participate in the Scheme if they will fulfill requisite criteria for quality assurance.
6. For 20 identified districts of Bihar, UP, MP and Rajasthan, Safe abortion and IUCD insertions services have been included. Empanelled Private Health Service Providers providing the Safe Abortion services to the client will be paid Rs.600/- per case. This will be applicable for all types of first trimester abortions inclusive of undertaking resuscitative measures in deserving cases. Similarly, for every IUCD insertions, the providers will be paid Rs.300/-per case while the motivator will be paid Rs.100/-per case after one month follow up of the clients.

2.5.1 National Helpline: Toll Free-1800-11-6555

National Helpline service on reproductive health, mother health, child health, sexual health, adolescents health, infertility, contraception, and family planning etc. aims to reach out to adolescent, about to be married and newly married couples and who do not have easy access to reliable information on the above issues.

Till august, 2012 approximately 5 lakh calls have been received. The maximum numbers of queries being received are on the issues related to contraception, pregnancy, sexual health and infertility. Strict quality checks are in place to ensure high quality service. Extensive publicity has been taken up to promote the Helpline number.

2.5.2 World Population Day, 2012

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 World Population Day, July 11, 2012. The events were organized to capitalize upon the global efforts at the Family Planning Summit in London. These included three key events: a Walkathon and National Conference for

Population Action led by JSK, and in the evening a small Focused Group Discussion with the Members of Parliament to garner their engagement for family planning (FP), organized by JSK in collaboration with Citizens' Alliance.

2.5.3 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. 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.

2.6 FAMILY PLANNING INSURANCE SCHEME

India is the first country that launched a National Family Planning Programme in 1952, emphasizing fertility regulation for reducing birth rates to the extent necessary to stabilize the population at a level consistent with the socio-economic development and environment protection. Since then the demographic and health profiles of India have steadily improved.

2.6.1 Government of India Scheme to Compensate Acceptors of Sterilization for Loss of Wages

With a view to encourage people to adopt permanent method of Family Planning, Government has been implementing a Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilization for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilization.

Under the Scheme compensation for loss of wages to acceptors of sterilization was revised with effect from 31/1/2006 and has been further improved with effect from 7/9/07. Revision in the compensation package to boost to male participation in family planning i.e Vasectomy form existing Rs.800/- to 1500/- and Tubectomy from Rs.800/- to Rs. 1000/- in Public facilities and to Rs.1500/- for both Vasectomy and Tubectomy in accredited private health facilities to all categories in High Focus stated and BPL/SC/ST in accredited private health facilities all population as BPL/SC/ST and Above Poverty Line(APL) and health facilities at public/accredited private institution has been improved.

Apart from providing for cash compensation to the acceptor of sterilization for loss of wages, transportation, diet, drugs, dressing etc out of the funds released to States/ UTs under this scheme, some States/UTs were for treatment of post-operative complications attributable to the procedure of sterilization, as under:-

- **i)** Rs.50,000/- per case of death.
- **ii)** Rs.30,000/- per case of incapacitation.
- **iii)** Rs.20,000/-per case of cost of treatment of serious post operation complication.

Any liability in excess of the above limit was to be borne by the State/UT/NGO/ Voluntary Organization concerned from their own resources.

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) has, *inter alia*, directed the Union of India and States/UTs for ensuring enforcement of Union Government's Guidelines for conducting sterilization procedures and norms for bringing out uniformity with regard of sterilization procedures by:

I. Creation of panel of Doctors/health facilities for conducting sterilization procedures and laying down of criteria for empanelment of doctors for conducting sterilization procedures.

II. Laying down of checklist to be followed by every doctor before carrying out sterilization procedure.

III. Laying down of uniform proforma for obtaining of consent of person undergoing sterilization.

IV. Setting up of Quality Assurance Committee for ensuring enforcement of pre and post-operative guidelines regarding sterilization procedures.

V. Bringing into effect an Insurance Policy uniformly in all States for acceptors of sterilizations etc.

The above directions have all been taken into consideration and consolidated in the updated manuals on Standards and Quality Assurance in Sterilization Services available on the Ministry's website (www.mohfw.nic.in). The Family Planning Insurance Scheme is one of the initiatives launched under direction from the Hon'ble Supreme Court w.e.f from 29th November, 2005.

Under the existing Government Scheme no compensation was payable for Failure of Sterilization, and No Indemnity cover was provided to Doctors/Health Facilities providing

professional services for conducting sterilization procedures etc. There was a great demand in the States for Indemnity Insurance cover to Doctors/Health Facilities, since many Govt. Doctors are currently facing litigation due to claims of clients for compensation due to failure of sterilization. This has led to reluctance among the Doctors/Health Facilities to conduct Sterilization operations.

2.6.2 Family Planning Insurance Scheme w.e.f. 29th November, 2005 (First Year)

With a view to do away with the complicated process of payment of ex-gratia to the acceptors of Sterilisation for treatment of post operative Complications, or Death attributable to the procedure of sterilization, 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 Doctor / Health Facility performing Sterilization procedure, as follows:-

Section I:

Section	Coverage	Limits
a)	Death due to Sterilization in hospital:	Rs.1,00,000/-
b)	Death due to Sterilization within 30 days of discharge from hospital	Rs.30,000/-
c)	Failure of sterilization (including first instanceof conception after sterilization).	Rs.20,000/-
d)	Expenses for treatment of medical complications due to sterilization operation (within 60 days of operations)	Rs.20,000/-*
Total liability of the Insurance Company shall not exceed Rs. 9 crore in a year under each Section.		

*(*To be reimbursed on the basis of actual expenditure incurred, not exceeding Rs.20,000.)*

Section II:

All the doctors/health facilities including doctors/health facilities of Central, State, Local-Self Governments, other public sectors and all the accredited doctors/health facilities of non-government and private sectors rendering Family Planning Services conducting such operations shall stand indemnified against the claims arising out of failure of sterilization, death or medical complication resulting therefrom upto a maximum amount of Rs. 2 lakh per doctor/health facility per case, maximum upto 4 cases per year. The cover would also include the legal costs and actual modality of defending the prosecuted doctor/ health facility in Court, which would be borne by the Insurance Company within certain limits.

2.6.3 Revised Scheme w.e.f. 29th November, 2006 (Second Year)

This scheme was renewed with Oriental Insurance Company w.e.f. 29-11-06 with modification in the limits and payment procedure.

2.6.4 Revised Scheme w.e.f. 1st January, 2012 (Seventh Year)

This scheme has been continuously revised and renewed. Presently, the Insurance Company is ICICI Lombard.

Section		Coverage	Limits
I	IA	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. 2,00,000/-
	IB	Death following sterilization within 8-30 days from the date of discharge from the hospital.	Rs. 50,000/-
	IC	Failure of Sterilization	Rs 25,000/-
	ID	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 Insurance per Doctor/facility but not more than 4 cases in a year.	Upto Rs. 2 Lakh per claim

Total Liability of the Insurance Company shall not exceed Rs.25 crore in a year under Section-I and Rs. 1 crore under Section-II.

2.7 REVISED COMPENSATION SCHEME FOR ACCEPTORS OF STERILIZATION

Government has been implementing a Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilization for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilization. This compensation scheme for acceptors of sterilization services was revised with effect from 31.10.2006 and has been further improved with effect from 07.09.2007. Breakup of compensation scheme provided below:

For Public (Government) Facilities

Category	Breakage of the Compensation package	Acceptor	Motivator	Drugs and dressings	Surgeon charges	Anaesthetist	Staff nurse	OT/ technician helper	Refresh-ment	Camp manage-ment	Total
High focus states	VAS - ALL	1100	200	50	100	-	15	15	10	10	**1500**
	TUB - ALL	600	150	100	75	25	15	15	10	10	**1000**
Non High focus states	VAS-ALL	1100	200	50	100	—	15	15	10	10	**1500**
	TUB (BPL + SC/ ST only)	600	150	100	75	25	15	15	10	10	**1000**
	TUB (APL)	250	150	100	75	25	15	15	10	10	**650**

For Private Facilities

Category	Type of operation	Facility	Motivator	Total
High focus states	Vasectomy (ALL)	1300	200	**1500**
	Tubectomy (ALL)	1350	150	**1500**
Non High focus states	Vasectomy (ALL)	1300	200	**1500**
	Tubectomy (BPL + SC/ST)	1350	150	**1500**

2.8 HEALTH INSURANCE SCHEME

The Government of India has made a provision for development of Health Insurance Scheme for below Poverty Line (BPL) families under the framework of National Rural Health Mission (NRHM). The Ministry of Health and Family Welfare subsidize the cost of the annual premium up to 75% subject to a maximum of Rs. 300 per BPL family for this Scheme.

The Rastriya Swasthya Bima Yojana (RSBY) being administered by Ministry of Labour & Employment provides for smart card based cashless health insurance cover for Rs. 30000 per annum to BPL families (a unit of five) in the unorganized sector. The scheme is presently being implemented in 25 States/UTs.

2.9 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 914 girls as against 927 per thousand boys recorded in 2001 Census. This is the worst dip since 1947.This negative trend reaffirms the fact that the girl child is more at risk than ever before. Except for the states of Himachal Pradesh (906), Punjab (846), Chandigarh (867), Haryana (830), Mizoram (971), Tamil Nadu (946), Andaman & Nicobar Islands (966), the CSR has shown a declining trend in 22 States and 5 UTs. States/ UTs with Child Sex Ratio of 951 and above have reduced from 18 to 9. The steepest fall of 82 points is in J& K and the largest increase of 48 points is in Punjab.

Jammu and Kashmir, Maharashtra and Haryana have had the worst 30 year decline in child sex ratios. Among the larger States, Chhattisgarh has the highest Child Sex Ratio of 964 followed by Kerala with 959. Haryana (830)

is at the bottom followed by Punjab (846). This census saw a declining trend even in North Eastern States except Mizoram. **(Table -1)**

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

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

Reasons for adverse sex ratio

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

Sex determination techniques have been in use in India since 1975 primarily for the determination of genetic abnormalities. However, these techniques were widely misused to determine the sex of the foetus and subsequent elimination if the foetus was found to be female. Easy availability of the sex determination tests that lead to female foeticide are proving to be catalyst in the process, which are further stimulated by pre-conception sex selection facilities. Child Sex Ratio does not only reflect pre-birth elimination of girls but also neglect of the girl child after birth. Gender gap in Infant Mortality Rates and under five Mortality Rates hint to cumulative neglect of female child after birth as well.

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

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

Punishment under the Act

- Imprisonment up to 3 years and fine up to Rs. 10,000
- For any subsequent offences, he/she may be imprisoned up to 5 years and fined up to Rs. 50,000 / 1,00,000.
- The name of the registered medical practitioner is reported by the Appropriate Authority to the State Medical Council concerned for taking necessary action including suspension of the registration if the charges are framed by the court and till the case is disposed off.

Status and Reports from States /UTs

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

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

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

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

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

ii) Amendment to Rules:

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

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

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

iii) Review of implementation of the PC & PNDT Act:

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

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

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

iv) Capacity building:

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

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

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

v) National Inspection and Monitoring Committee (NIMC):

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

vi) Inclusion of the issue under NRHM:

Funds are being made available under NRHM for strengthening infrastructure and augmentation of human resources required for effective implementation of the PC&PNDT Act. In 2012-13 PIP an amount of approximately 22 crores was approved to States/UTs specifically for PNDT cells, PNDT law implementation and IEC activities.

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

vii) Awareness Generation:

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

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

viii) Frequently Asked Questions (FAQs):

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

ix) Website on PNDT:

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

Table: 1
Child Sex Ratio as per Census (1971-2011)

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

Source: Census of India

Table: 2
Rural Urban Child Sex Ratio (0-6 Years) 2001-2011

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

Source: Census of India

Table: 3

STATEWISE IMPLEMENTATION STATUS OF PC& PNDT ACT

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

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

2.10 IMPROVEMENT IN THE QUALITY OF HEALTH CARE

The improvement in the quality of health care over the years is reflected in respect of some basic demographic indicators (Table given below). The Crude Birth Rate (CBR) has declined from 40.8 in 1951 to 29.5 in 1991 and further to 21.8 in 2011. 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 7.1 in 2011. Also, the Total Fertility Rate (average number of children likely to be born to a woman between 15-44 years of age) has decreased from 6.0 in 1951 to 2.5 in the year 2010 as per the estimates from the Sample Registration System (SRS) of Registrar General India (RGI), Ministry of Home Affairs.

The Maternal Mortality Rate has also declined from 437 per one lakh live births in 1992 – 93 to 212 in 2007-09 according to the SRS Report brought *out by RGI.* Infant Mortality Rate, which was 110 in 1981, has declined to 44 per 1000 live births in 2011. Child Mortality Rate has also decreased from 57.3 in 1972 to 13.2 in 2010.

Achievements of Family Welfare Programme

Sl. No.	Parameter	1951	1981	1991	Current level
1	Crude Birth Rate (Per 1000 Population)	40.8	33.9	29.5	21.8 (2011)
2	Crude Death Rate (Per 1000 Population)	25.1	12.5	9.8	7.1 (2011)
3	Total Fertility Rate (Per women)	6.0	4.5	3.6	2.5 (2010)
4	Maternal Mortality Rate (Per 100,000 live births)	NA	NA	437 (1992-93) FHS	212 (2007-09) S.R.S.
5	Infant Mortality Rate (Per 1000 live births)	146 (1951-61)	110	80	44 (2011)
6	Child (0-4 years) Mortality Rate per 1000 children	57.3 (1972)	41.2	26.5	13.2 (2010)

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

Family Planning Methods

The total number of acceptors of different Family Planning methods enrolled in the country during year 2011-12 was 32.09 million. Table below summarizes the position in regard to family planning achievements during 2011-12 and 2012-13 (up to December) at All India Level.

Family Planning Acceptors by methods

(Figures in million)

Sl. No.	Methods	2011-2012	Achievement * 2012-13 (April 2012-December 2012)	2011-12 (April 2011-December 2011)
1.	Sterilisation	04.84	02.76	03.00
2.	IUD Insertions	05.36	03.95	03.99
3.	Condom Users (Equivalent)	15.02	10.91	14.16
	Under Free Distribution Scheme	05.97	05.18	05.95
	Under Commercial Distribution Scheme	09.05	05.73	08.21
4.	Oral Pill Users	06.50	06.00	06.20$
	Under Free distribution Scheme	03.42	02.99	03.46
	Under Commercial Distribution Scheme	03.08	03.01	02.75
	Total Acceptors	**31.72**	**23.62**	**27.35**

Source: HMIS Portal

** Provisional figures*

$ Figure do not match due to round off

Immunization Performance for the year 2011-12 vis-à-vis 2010-11 is given in **Table A**. **Table-B** gives the comparative performance during 2011-12 and 2010-11 for the period April-December of the respective years.

Table A

Assessed Need of Immunisation vis-à-vis Achievement during 2011-12 under RCH Programme (All India)

(Figures in 000's)

Sl. No.	Activity	Assessed Need for 2011-12	Achievement* 2011-12	Achievement* 2010-11	% Achvt. of Need Assessed (2011-12)
1	2	3	4	5	6
A.	**Immunisation**				
i.	Tetanus Immunisation for Expectant mothers	29101	23368	23950	80.3
	Child Immunisation				
ii.	DPT Immunisation	25287	22623	23250	89.5
iii.	Polio	25287	21552	23068	85.2
iv.	B.C.G.	25287	23789	24367	94.1
v.	Measles	25287	22369	22596	88.5
vi.	DT	22894	9675	10208	42.3
vii.	T.T. (10 Years)	23768	14186	14951	59.7
viii.	T.T. (16 Years)	24912	13368	13550	53.7
B.	**Prophylaxis against nutritional anaemia among women**	29101	19040	23726	65.4
C.	**Prophylaxis against blindness due to Vit. 'A' deficiency**				
i.	1st dose (below 1 year+ above 1 year)	25287	20470	23063	81.0
ii	5th dose	23252	14094	18339	60.6
iii	9th dose	22909	11495	13451	50.2

* *Figures are provisional.*

Source: HMIS Portal (Status as on 1st March, 2013)

Table B

Assessed Need of Immunisation Vis-à-vis Achievement During 2012-13 (April, 2012 to December, 2012) under RCH Programme (All India)

(Figures in 000's)

Sl. No.	Activity	Assessed Need for 2012-13	Achievement* 2012-13 (Apr. to Dec. 12)	Achievement* 2011-12 (Apr. to Dec. 11)	% Achvt. of Need Assessed
1	2	3	4	5	6
A.	**Immunisation**				
i.	Tetanus Immunisation for Expectant mothers	29487	16696	17414	56.6
Child Immunisation					
ii.	DPT Immunisation	25621	15483	16330	60.4
iii.	Polio	25621	15895	15648	62.0
iv.	B.C.G.	25621	17635	17706	68.8
v.	Measles	25621	16829	16520	65.7
vi.	DT	23196	7746	7447	33.4
vii.	T.T. (10 Years)	24080	10635	10968	44.2
viii.	T.T. (16 Years)	25241	10269	10273	40.7
B.	**Prophylaxis against Nutritional Anaemia among Total Women**	29487	16190	14178	54.9
C.	**Prophylaxis against blindness due to Vit. 'A' deficiency**				
i.	1st dose (below 1 year+ above 1 year)	25621	17210	15439	67.2
ii.	5th dose	23567	7624	9642	32.4
iii.	9th dose	23211	6628	7682	28.6

2.11 HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

Health Management Information System (HMIS) is a web-based system being implemented by the Ministry. HMIS aims to collect information on some critical indicators related to the health sector. HMIS was launched in October 2008 and initially it was being implemented at District level. More than 99% of the districts are reporting regularly on HMIS portal. However, States / UTs were advised to shift to facility based reporting from April 2011 to facilitate micro planning by States / UTs. While the progress of States / UTs on facility-based reporting is not uniform, more and more Districts are shifting to facility-based reporting. With the consistent efforts of the Ministry, 45% Districts have switched over to facility level reporting on HMIS portal till September 2012. The remaining Districts are still reporting at the District level and Ministry is guiding them to shift to facility-based reporting. The Ministry is providing funds for hiring manpower, procuring computers and creating the necessary infrastructure. In addition to their hand holding, workshops on quality and completeness of data are being regularly held to sort out the issues of States / UTs, share best practices and sensitise the States / UTs about usefulness of shifting to facility-based reporting. The Ministry is using HMIS data in planning process and is encouraging States / UTs to make greater use of HMIS data in their planning processes. The emphasis is on using this information for evidence-based planning and monitoring at all levels.

The first phase of HMIS augmentation project is in progress. This will facilitate States to do analysis of data uploaded by them and look into the quality issues of data reporting. Efforts are being made to incorporate more parameters so that ultimately HMIS provides a single / common reporting platform to meet information needs of Programme Divisions.

2.11.1 Mother and Child Tracking System (MCTS)

Mother and Child Tracking System (MCTS) is a web-based system for collecting information on some key indicators related to the pregnant women and new-borns. When fully functional, MCTS would help in ensuring full ante-natal check-up of the pregnant mothers and immunization of the children. This is expected to reduce the Infant Mortality Rate and Maternal Mortality Rate, as mandated by Goals 4 and 5 of the Millennium Development Goals (MDGs). Besides, States / UTs have the option to collect data on additional indicators of their concern.

In MCTS, while the registration of pregnant women and new-borns is increasing, efforts are on to ensure 100% coverage of new pregnancies and births. The Ministry has been providing training to States / UTs. The status of implementation of MCTS is being monitored centrally for which dashboards have been prepared. Ministry is using MCTS for policy making and is encouraging States / UTs to use MCTS data in their planning processes. States / UTs have been requested to ensure entry of data related to follow-up services. SMSs are being sent to programme managers at all levels about the status of registration, services due during the current month and services given during the previous month.

With a view to validating the data entered in the MCTS, a multi-lingual helpdesk, known as Mother and Child Tracking Helpdesk (MCTH) is being established at National Institute of Health and Family Welfare (NIHFW) by outsourcing the creation of necessary infrastructure and provision of helpdesk services. The Helpdesk Agents (HAs) will validate MCTS data by making out-bound calls to the beneficiaries and health workers. In addition, the helpdesk is expected to create awareness about health programmes and provide guidance to the health workers and beneficiaries. In the meanwhile, States / UTs have been making calls to beneficiaries and health workers to validate the data and get feedback on the programme interventions.

2.12 SURVEYS AND EVALUATION ACTIVITIES

District Level Household Surveys

The District Level household Survey (DLHS -3) was the third in the series of the district surveys, preceded by DLHS-1 in 1998-99 and DLHS 2 in 2002-04. DLHS provides data to the programmes for evaluation of the service quality, review of the programme management and assessment of the impact. DLHS gives estimates on important indicators on maternal and child health, family planning and other reproductive health services. The next round of DLHS ie., DLHS -4 has been initiated during 2012-13 in the 26 States / UTs where Annual Health Survey (AHS) is not being done. Data from AHS and DLHS-4 will be used to prepare national report. Further, the Facility Survey will be conducted in all States / UTs as done in the past. Moreover, the CAB components on nutrition and anaemia etc. as being covered in AHS would also be covered in DLHS-4. The DLHS-4 results in the form of factsheets and reports will be available during 2013-14.

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 2011-12, 119 districts were visited by the RETs.

Annual Health Survey: The Annual Health Survey (AHS) launched by the Ministry aims to prepare District Health Profile of the 284 districts in the EAG States and Assam on an annual basis. The AHS is being conducting through the Registrar General of India (RGI), Ministry of Home Affairs. The AHS is a hybrid model where the field work has been outsourced to external agencies and supervision being done by the RGI staff. The Annual Health Survey aims to provide feedback on the impact of the schemes under NRHM in reduction of Total Fertility Rate (TFR), Infant Mortality Rate (IMR) at the district level and the Maternal Mortality Ratio (MMR) at the regional level. These are important indicators of health which are currently being estimated at the national/state level through the Sample Registration System (SRS) by Registrar General of India. The first round of AHS was completed during 2010-11 and the preliminary results were disseminated in August, 2011. The State Fact Sheets containing detailed results from AHS first round were brought out in July, 2012.The fieldwork for the second round of AHS has been completed in 2012-13. Further, under the AHS, a separate component on Clinical, Anthropometric and Bio-chemical (CAB) tests has been introduced in which data on height & weight measurement, blood test for anaemia and sugar, blood pressure measurement and testing of iodine in the salt used by households would also be collected duirng 2012-13.

National Family Health Survey (NFHS) – 4

a) This Ministry has decided that one integrated survey should be conducted in place of different surveys to provide data at the district level and it may be named as National Family Health Survey (NFHS-4). The periodicity of NFHS would be three years and NFHS-4 would provide comparative data with the earlier round of NFHS.

b) In order to initiate the work of NFHS-4 in 2013-14, the Ministry has designated International Institute for Population Sciences (IIPS), Mumbai as the nodal agency for NFHS - 4 and constituted three committees, namely Steering Committee, Technical Advisory Committee (TAC) and Administrative & Financial Management Committee.

c) Two meetings of the TAC have been organized on 17.8.2012 and 12.10.2012 to deliberate on the technical aspects including content, coverage, design etc of the NFHS-4.

2.13 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 repute. 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.

As a statutory requirement, under Rule 212 (2) of the General Financial Rules 2005, the Annual Reports of 17 PRCs for 2010-11 which received Rs. 25 Lakhs or above as Recurring Grant during 2010-11, alongwith the audited statement of accounts are laid on the table of both the Houses of Parliament.