EXECUTIVE SUMMARY

Human development and improvement in quality of life are the ultimate objectives of all Planning. This is to be achieved through policies and programmes aimed at promotion of both equity and excellence. Planning takes into account the resources required for human development and human resources available for carrying out the Plan. India, the second most populous country in the world having a meagre 2.4% of the world's surface area sustains 16.7% of the world's population. Realising the inevitable high population growth during the initial phases of demographic transition and the need to accelerate the pace of the transition, India became the first country in the world to formulate a National Family Planning Programme in 1952, with the objective of "reducing birth rate to the extent necessary to stabilise the population at a level consistent with requirement of national economy". The First Five Year Plan stated "The main appeal for family planning is based on considerations of health and welfare of the family. Family limitation or spacing of children is necessary and desirable in order to secure better health for the mother and better care and upbringing of children. Measures directed to this end should, therefore, form part of the public health programme". Thus the key elements of health care to women and children and provision of contraceptive services have been the focus of India's health services right from the time of India's independence. Successive Five Year Plans have been providing the policy framework and funding for planned development of nationwide health care infrastructure and manpower to deliver these services. The centrally sponsored and 100% centrally funded Family Welfare Programme provides the States additional infrastructure, manpower and consumables needed for improving health status of women and children and to meet all the felt needs for fertility regulation.

The technological advances and improved quality and coverage of health care resulted in a rapid fall in Crude Death Rate (CDR) from 25.1 in 1951 to 9.8 in 1991. In contrast, the decline in Crude Birth Rate (CBR) has been less steep, from 40.8 in 1951 to 29.5 in 1991. As a result, the annual exponential population growth rate has been over 2% in the period between 1971-1991. The pace of demographic transition in India has been relatively slow but steady. Census 1991 showed after three decades the population growth rate declined below 2%. In order to give a new thrust and dynamism to the Family Welfare Programme and achieve a more rapid decline in birthrate, death rate and population growth rate in the last decade of the century, the National Development Council (NDC) set up a Sub-Committee on Population and endorsed its recommendations in 1993.

Census 2001

Census 2001 recorded that the population of the country was 1027 million- 15 million more than the population projected for 2001 by the Technical Group on Population Projections. The decadal growth during 1991-2001 was 21.34% (decadal growth in 1981-91 was 23.86%). Analysis of growth rates of the states

from the decade 1951-1961 indicates that it took four decades for Kerala to reach a decadal growth rate of less than 10% from a high growth rate of 26.29% during 1961-71. Tamil Nadu also took 40 years to reduce its growth rate from a high of 23.2% during 1961-71 to 11.2 % during 1991-2001. Andhra Pradesh has shown an impressive fall in growth rate by over 10 percentage points within a short span of a decade during nineties. The growth rate in Bihar has shown an upward swing during 1991-2001; the growth rates in Rajasthan, UP and MP are now at a level where Kerala and Tamil Nadu were 40 years ago.

Population projections

Demographic transition is a global phenomenon. The transition is from high fertility, high mortality, stable population scenario, to low fertility, low mortality and stable population scenario. In India the population growth rate is falling since 1991. Two states have attained replacement level of fertility and one state has shown a remarkable fall in birth rate during the nineties. The National Population Policy has set the goal that the country will achieve the replacement level of fertility by 2010. If this were achieved the decade 2001-2010 will witness a very steep decline in decadal growth rate.

The Technical Group on Population Projections constituted by the Planning Commission in 1996 had made population projections up to the year 2016 based on the results of 1991 census and estimated the probable year by which the replacement level TFR of 2.1 will be achieved by different states in India if the pace of decline in Total Fertility Rate observed during 1981-93 continues in the future years. The Group estimated that the country will achieve the replacement level of fertility by 2026. The most populous states of Bihar, MP, Rajasthan and UP will achieve the replacement level of fertility by the year 2039, 2060, 2048 and after 2100 respectively.

Population projections 1996-2016

The population will increase from 934 million in 1996 to 1264 million in 2016. Between the periods 1996-2001 and 2011-2016 there will be a decline of:

- CBR from 24.10 to 21.41
- CDR from 8.99 to 7.48
- NGR from 1.51% to 1.39%
- IMR
  - Male from 63 to 38
  - Female from 64 to 39

Population projections for the Tenth Plan

Prior to formulation of the Tenth Plan it is desirable to review the available data and make fresh projections in light of the experience during the nineties and the data from census 2001. However as the critical inputs in terms of detailed tabulations regarding age and sex distribution of the population from

the census will not be available for some more months and plan formulation cannot be delayed, the Department of Family Welfare made adjustment for higher actual population in the base year of 1997 in the projections made by the Technical Group on Population Projection for the period 1997-2012 and used this for formulation of their programmes for the Tenth Plan.

For getting the medium and long-term perspective, the Planning Commission requested the Population Foundation of India (PFI) to review the existing data and come up with population projections up to 2050. The PFI made three sets of projections up to 2051 based on different assumptions regarding mortality and fertility. Three alternative assumptions on future trends in fertility were made for each of the 15 larger states on the basis of extrapolation of the past trends in the values of total fertility rates (TFR) and from these national projections are made. Under Alternative I observed TFR for the last two decades was extrapolated into the future years; projection under this alternative indicates that the country will achieve the replacement level of fertility in 2026 if the trend follows an exponential curve. However, if a linear trend is assumed, this goal would be achieved in 2016. The experience from Kerala and Tamil Nadu has shown that once replacement level of fertility is attained further decline in fertility is very slow. In view of this the exponential curves might represent the more realistic picture. Under alternative II it has been assumed that the fertility would continue to decline even below the level of 1.6. The TFR in Kerala and Tamil Nadu has been assumed to be 1.5 in 2001 and thereafter projected to a constant level of 1. Kerala achieved the replacement level of TFR of 2.1 in 1988. Even after 11 years TFR in the state is, hovering around 1.8. Tamil Nadu achieved the replacement level of fertility in 1993 and the 1997 estimates indicate that the level of TFR in the state is 2. Under alternative-III it has been assumed that the fertility goals set in the National Population Policy 2000 and state policy announced by UP, MP and Rajasthan of achieving the replacement level in the years 2010, 2016, 2011 and 2011 respectively will be realized and the fertility will fall to the floor value of 1.6 in these states. The observed trends in TFR in the states of UP and MP would suggest that this may not be a realistic assumption and is unlikely to happen.

Thus the steep decline in TFR in the projections under assumptions II & III unlikely to occur either in the states with high TFR or in those who have already attained replacement level of fertility. This may have implications for the national level projections as well as achievement of the national goals set in the NPP 2000. However, the remarkable decline in fertility in Andhra Pradesh during the nineties has shown if all the unmet needs for contraception are met through well coordinated efforts it is possible to achieve very steep decline in fertility. If this can be replicated in other states, the states and through their efforts the country can indeed achieve the goals set in the state and National Population Policies.

Review of the medium and long term population projection for India by 2000 AD undertaken by several individuals/organizations showed that while

short and medium term projections have been more or less comparable to actual census figures, the long term projections have been widely off the mark. This is perhaps inevitable in view of the massive diversity within the country and extreme rapidity with which different states/strata of society adapt themselves to ongoing demographic transition. Learning from the past experience it would appear that while medium term projections up to 2016 to 2020 may, perhaps, be reliable and accurate, realistic projections for 2050 may not be feasible at the present phase of demographic transition.

Progress achieved during the Ninth Plan

During the Ninth Plan period the Dept. Of Family Welfare has implemented the recommendations of the NDC Sub committee on Population; the centrally defined methods specific targets for family planning were abolished; emphasis shifted to decentralised planning at district level, based on community needs assessment and implementation of programmes aimed at fulfilment of these needs. A massive pulse polio campaign was taken up to eliminate polio from the country. The Department of Family Welfare set up a Consultative Committee to suggest appropriate restructuring and revision of norms for infrastructure funded by the states and the Centre and has initiated implementation of the recommendations. Monitoring and evaluation have become part and parcel of the Family Welfare Programmes and the data is used for midcourse corrections.

Review of the FW programmes have shown that Governmental network provides most of the MCH and contraceptive care (NFHS 1998-99); adequate financial inputs and health infrastructure are essential prerequisites for the success of the programme; providing efficient and effective integrated MCH and contraceptive care helps in building up rapport with the families; Information Education Communication and Motivation activities are powerful tools for promoting the small healthy family norm.

During the Ninth Plan the Dept of Family Welfare embarked on

- decentralised district based area specific need assessment and programmes for fulfilling the needs
- RCH programme aimed at providing integrated good quality maternal, child health and contraceptive care.

It was expected that these initiatives would lead to substantial improvement in the coverage and quality of services. The Department of Family Welfare was given additional outlay to enable them to provide adequate financial inputs to the states so that they can implement the programme as envisaged. Goals for the Ninth Plan were projected on the basis of these assumptions.

The health systems in the states required longer time to adapt to decentralised planning and RCH programme implementation. In an attempt to improve coverage under specific components of the RCH programme, some states embarked on campaign mode operations which took their toll on routine services. Efforts to eliminate polio by the winter of 2000 through massive pulse polio campaign also had some adverse effect on routine delivery services. As a result of all these it is unlikely that Ninth Plan goals for CBR, Couple Protection Rate, Maternal Mortality Ratio and Infant Mortality Rate will be achieved. However, the country is likely to achieve elimination of polio by 2004.

Independent surveys have shown that several states have achieved goals set for some aspect of the RCH programme during the Ninth Plan, demonstrating that these can be achieved with in the existing infrastructure, manpower and inputs. For instance

- Andhra Pradesh, Punjab, West Bengal and Maharashtra have shown substantial decline in birth rates; the latter three states are likely to achieve replacement level of fertility, ahead of the projection made.
- Punjab has achieved couple protection rate and use of spacing methods far ahead of all other states
- Tamil Nadu and Andhra Pradesh have achieved increase in institutional deliveries
- Kerala, Maharastra, Punjab and Tamil Nadu improved immunization coverage
- Tamil Nadu and Andhra Pradesh had achieved improvement in coverage and quality of Antenatal care.

National Population Policy

The National Population Policy was drawn up by the Dept of Family Welfare and was approved by the cabinet in 2000. The immediate objective of the NPP2000 is to meet all the unmet need for contraception and health care for women and children. The medium term objective is to bring the total fertility rate to replacement level (TFR of 2.1) by 2010; the long-term objective of the Policy is to achieve population stabilization by 2045.

National Population Commission:

As envisaged in NPP National Commission on Population was constituted on 11th May 2000 under the Chairmanship of the Prime Minister of India. Deputy Chairman, Planning Commission is the Vice Chairman. The Commission has the mandate to

- review, monitor and give direction for implementation of the National Population Policy with the view to achieve the goals set in the Population Policy
- promote synergy between health, educational, environmental and developmental programmes so as to hasten population stabilization

- promote inter sectoral coordination in planning and implementation of the programmes through different sectors and agencies in center and the states.
- develop a vigourous peoples programme to support this national effort

The first meeting of National Commission on Population was held on 22nd July 2000. There were wide ranging discussions and useful suggestions for achieving the goal of population stabilization emerged. A Strategic Support Group consisting of secretaries of concerned sectoral ministries has been constituted as standing advisory group to the Commission. Nine Working Groups were constituted to look into specific aspects of implementation of the programmes aimed at achieving the targets set in NPP 2000 and their reports are being finalized.

Major Areas of Concern

Some of the major areas of current concern include:

- the massive interstate differences in the fertility and mortality- the rates are high in the states where nearly 50 % of the country's population lives;
- gaps in infrastructure/manpower/equipment and mismatch between infrastructure and manpower in PHC/CHC; lack of referral services;
- decline in mortality during the nineties was slow; the goals set for mortality and fertility in the Ninth plan will not to be achieved;
- there has been no decline in the maternal mortality ratios over the nineties; neonatal and infant mortality rates have remained essentially unaltered in the nineties;
- the routine service coverage has declined perhaps because of the emphasis on campaign mode operations for individual components of the programme;
- in spite of the emphasis on skill up gradation training for delivery of integrated reproductive and child health services, the progress in in-service training has been very slow; the anticipated improvement in the content and quality of care has not taken place;
- evaluation studies have shown that the coverage under immunization is not universal even in the best performing states; coverage rates are very low in states like Bihar; elimination of polio is yet to be achieved;
- logistics of drug supply has improved in some states but remains poor in populous states;
- decentralised district based planning, monitoring and midcourse correction utilising the locally generated service data and CRS has not yet been operationalised fully.

Approach during the Tenth Plan

The current high population growth rate continues to be due to:

- the large size of the population in the reproductive age-group (estimated contribution 60%);

- higher fertility due to unmet need for contraception (estimated contribution 20%);
- and high wanted fertility due to prevailing high IMR and other socio-economic reasons (estimated contribution about 20%).

During the Tenth Plan the paradigm shift which began in the Ninth plan from:

- demographic targets to *focus on enabling the couples to achieve their reproductive goals;*
- method specific contraceptive targets to *meeting all the unmet needs for contraception to reduce unwanted pregnancies;*
- numerous vertical programmes for family planning and maternal and child health to *integrated health care for women and children;*
- centrally defined targets *to community need assessment and decentralised area specific microplanning* and implementation of health care for women and children to reduce infant mortality and reduce high desired fertility;
- quantitative coverage *to emphasis on quality and content of care;*
- predominantly women centred *programmes to meeting the health care needs of the family with emphasis on involvement of men in Planned Parenthood;*
- supply driven service delivery to *need and demand driven service; improved logistics for ensuring adequate and timely supplies to met the needs;*
- service provision based on providers perception *to addressing choices and conveniences of the couples.*

will be fully operationalised .

During the Tenth Plan efforts should continue to be to assess and meet the unmet needs for contraception, to achieve reduction in the high desired level of fertility through programmes for reduction in IMR/MMR and to enable the families to achieve their reproductive goals. Approach Paper to the Tenth Plan has indicated that reductions in fertility, mortality and population growth rate will continue to major objectives during the Tenth Plan; three of the eleven monitorable targets for the Tenth Plan and beyond are:

- reduction in IMR to 45 /1000 by 2007 and 28/1000 by 2012,
- reduction in maternal mortality ratio to 2/1000 live births by 2007 and 1/1000 live births by 2012 and
- reduction in decadal growth rate of the population between 2001-2011 to16.2.

The focus will have to be on improving access to services to meet the health care needs of women and children by:

- decentralised area specific approach to planning , implementation and monitoring of the performance and effecting mid course corrections;
- differential strategy to achieve incremental improvement in performance in all states/districts;

- special efforts to improve access to and utilisation of the services in states/districts with high mortality and /or fertility rates;
- filling the critical gaps (especially CHCs) in existing infrastructure through appropriate reorganisation and restructuring primary health care infrastructure;
- ensuring that post of specialists in CHC/FRU do not remain vacant; skill upgradation and redeployment existing manpower to fill other critical gaps;
- streamlining the functioning of the primary health care system in urban and rural areas; providing good quality integrated reproductive and child health services at primary, secondary and tertiary care and improving the referral services;
- providing adequate supply of essential drugs, diagnostics and vaccines; improving the logistics of supply;
- well co-ordinated activities for delivery of services by public, private and voluntary sectors to improve coverage;
- involvement of the PRI in planning, monitoring and midcourse correction of the programme at local level;
- involvement of the industries, organised and unorganised sectors, agriculture workers and labour representatives in improving access to RCH services;
- effective use of social marketing to improve access to simple OTC products such as ORT and condoms;
- effective Information , Education, Communication and Motivation;
- effective intersectoral co-ordination between concerned sectors.

SPECIFIC COMPONENTS OF THE REPRODUCTIVE AND CHILD HEALTH CARE PROGRAMME

Prevention of unwanted pregnancy

Efforts to improve availability and access to contraceptive care in India during the seventies and early eighties resulted in a steep rise in couple protection rates. However, there was no commensurate fall in the birth rate. There are massive inter -state differences in CPR and CBR. In states like Bihar CPR is low and birth rate is high; in spite of high CPR in Punjab, CBR is still relatively high. Kerala, Tamil Nadu and Andhra Pradesh have achieved substantially lower CBR while CPR was still lower than that reported currently in Punjab. Age and parity at the time of accepting contraception as well as continuation rates of spacing methods are critical factors that influence the relationship between CPR and CBR. Over years there has been a fall in birth rate in all the states, among all segments of population; but the rate of reduction in the birth rate is higher in some states. There is an urgent need to meet all the needs for contraception in the populous states with high birth rate.

Data from service reports during the Ninth Plan period indicate that as compared to the level of acceptance in 1994-95, there has been a decline in acceptors of all types of contraception in the initial years of the Ninth Plan;

subsequently the decline has been reversed except for IUD. The National Family Health Survey 1992-93 and 1998-99 provided nationwide data on contraceptive prevalence. Data from the Survey indicate that contrary to the performance figures available from the service reports of the Department of Family Welfare, there has been substantial increase in the sterilisation and OC acceptance in the country. Only IUD and vasectomy use has shown a decline. The improvement in CPR explains the steady decline in the CBR during the nineties reported by the SRS. The inbuilt independent surveys and coverage evaluations within the Family Welfare Programme have provided the reassuring findings that during the decade of the nineties, there has not been any deterioration in the contraceptive prevalence. The coverage figures under service reporting for spacing methods, antenatal care and immunisation are still substantially higher than the coverage reported by evaluations. NFHS 1 and 2 clearly indicate that there is still substantial unmet need for both terminal methods and spacing methods in all states. There are interstate differences in magnitude of unmet need for contraception.

Monitoring reported birth order is an easy method of monitoring the progress towards achievement of replacement level of fertility. Currently in India birth order of 3 or more contribute to nearly half of all the births. There are massive interstate/inter district mural differences in the contribution of different birth orders. Based on data on birth order district specific differential strategy can be evolved to improve contraceptive prevalence rates, and reduce higher order of births.

Sterilization has been the most widely used method of contraception in all states in India. Currently age at marriage is very low and majority of the women complete their families during early twenties. In the current Indian milieu of stable marriages, sterilization is the most appropriate method of contraception. There are substantial differences between states and between districts in different states in couples who have adopted terminal methods of contraception. During nineties there has been some increase in percentage currently sterilized persons in all states except Punjab. However, percentage of women undergoing sterilisation is very low in Assam, Bihar and UP; majority of women in these states undergo sterilisation after they have three or more children.

Data from NFHS clearly shows that inspite of low use of spacing methods the mean inter-birth interval is about 30 months. This is because of universal prolonged breast-feeding. Exclusive breast feeding during the first six months offers substantial protection against pregnancy; but once supplements are introduced to breast fed infants, the contraceptive effect of lactation wanes; introduction of appropriate contraception at this time will ensure adequate spacing between births and prevent deterioration in maternal and infant nutrition due to too early advent of next pregnancy. Data from NFHS II has also shown that there is an emerging need for contraception before first birth; this has to be fully met during the Tenth Plan.Data from NFHS demonstrated the role of son

preference both in relation to the acceptance of permanent and temporary methods of contraception. It is important that appropriate steps are taken by all concerned sectors to minimize and later eliminate gender-bias which reduces contraceptive acceptance among those who have girl children.

Men play an important role in determining education and employment status, age at marriage, family formation pattern, access to and utilisation of health and family welfare services for women and children. Their active co-operation is essential for the success of STD/RTI prevention and control. In condom users, consistent and correct use is essential pre-requisites for STD as well as pregnancy prevention. Vasectomy was the most widely used terminal method of contraception in the sixties and seventies but since then there has been a steep decline in vasectomy acceptance. It is essential that efforts are intensified to re-popularize vasectomy.

Recommended Tenth Plan strategy to meet all the felt needs for contraception would include:

In all districts

- improve access to services to ensure effective implementation;
- counselling and balanced presentation of advantages and disadvantages of all available methods of contraception to enable the family to make the right choice;
- good quality services in the vicinity of their residence;
- good follow up care.

In states/districts where birth order three or more is over 40% of the births

- ensure ready access to tubectomy/vasectomy by sending, if necessary doctors from CHCs/District hospitals to PHC/CHC on fixed days

In states/districts where birth order two or less is over 60% of the births

- meet all the unmet needs for spacing methods on a priority basis and also continue to provide terminal methods.

Management of unwanted pregnancy

It is estimated that in 1998 about 9% of maternal deaths are due to unsafe abortion. Available service data on MTPs indicate that following an initial rise, the number of MTPs have remained around 0.5 – 0.7 million in the last decade. The estimated number of illegal induced abortions in the country is in the range of 4-6 million. There has not been any substantial decline in estimated number of illegal abortions, reported morbidity due to illegal abortions or share of illegal abortions as the cause of maternal mortality. Inspite of the efforts made during the Ninth Plan to address the above issues there has not been any increase in terms of coverage, number of MTPs reported and reduction in

number of women suffering adverse health consequences of illegal induced abortions. During the Tenth plan the recommended strategy for reducing morbidity due to induced abortion is to:

- reduce the number of pregnancies by fully meeting the felt but unmet needs for contraception;
- improve access to safe MTP services including non surgical methods of MTP; and
- ensure that women do accept appropriate contraception at the time of MTP so that there is no recurrence of unwanted pregnancies requiring a repeat MTP.

Maternal Health

Prevailing high maternal morbidity and mortality has always been source of concern and antenatal and intrapartum care aimed at reducing maternal morbidity and mortality have been components of the Family Welfare programme since inception. In India data on state/district specific maternal morbidity/mortality data is not available. However available data from SRS and survey of causes of death provide sufficient information on mortality rates and causes of death so that rational programmes could be evolved to combat major health problems in women. In the nineties the SRS and the National Family Health Surveys have provided independent data to assess the impact of ongoing programmes on the maternal mortality. During nineties there has not been any decline in MMR; more than 100,000 women die each year due to pregnancy related causes.

During the Tenth Plan every effort will have to be made to ensure 100% registration of pregnancies, deaths and births so that reliable district level estimates of MMR is made available on a sustainable basis; simultaneously, there should be efforts to improve ascertainment of the cause of death through SRS and from hospital records so that some reliable estimates on changes in causes of maternal mortality over time are available. These data will be of use to access and carry out mid-course corrections; impact of ongoing interventions on maternal mortality can be assessed and appropriate interventions initiated. The Ninth Plan envisaged universal screening of all pregnant women, identification of women with health problems, problems during pregnancy and appropriate management including referral to centers where appropriate care is available. This, however, has not been operationalised. Highest priority has to be accorded for operationalization of this during the Tenth Plan.

Antenatal care

Data from the Rapid Household survey (1998-1999) indicate that at the national level, 67.2% pregnant women received at least one check-up but only 10.6% had three antenatal checkups. Antenatal coverage in populous states with poor health indices such as UP, Bihar, MP are very low. In Andhra Pradesh, Tamil Nadu and Kerala antenatal coverage was good in almost all the districts. UP, Bihar and surprisingly Punjab had reported very low coverage figures in most districts. The quality and content of antenatal care is poor in most of the states. Anaemia is major cause of maternal mortality in India. The Ninth Plan envisaged universal screening for anaemia in pregnant women and appropriate iron folate medication. In none of the states were services for anaemia included as a component of antenatal care. The strategy of the universal screening, identification of women with problems and referral is yet to be operationalised.

Recommended Tenth Plan Strategy for improving Maternal Health

The Steering Committee recommended that the initiatives taken under the RCH programmes will have to be continued during the Tenth Plan. Every effort should be made to ensure that the skill up gradation training which is critical for improving the content and quality of antenatal care is taken up and completed so that all the healthcare providers at primary, secondary and tertiary care follow the protocol for screening all pregnant women for identification of those with problems. ANM is the critical person in the screening of pregnant women; she should be given necessary skill upgradation training, needed equipment. In order to ensure that the findings at antenatal screening are recorded accurately and reference back and forth becomes a standard practice, it is essential to ensure that findings are recorded in a standard format in an antenatal card which is retained by the woman who takes it with her where ever she gets referred to.

CHC/FRU is the critical institution which provides emergency care and plays vital role in the referral system. Currently reported gaps in number of CHC/FRU will be filled by appropriately reorganizing the sub-divisional hospitals, post partum centers and block level PHCs . The required number of core specialists will be posted through appropriate redeployment of the manpower; wherever adequate number of specialist are not available, contractual/part time appointments may be considered. In order to strengthen the capability for antenatal and intrapartum care at CHC/ FRU all the states may take up training of one of the staff nurses in CHC/FRU at district hospital, so that a nurse specialised in midwifery is available at CHCs/FRUs to provide antenatal and intrapartum care. Over the next five years efforts will be made to improve the availability of all facilities to manage emergencies at least in selected CHCs by improving availability of anaesthetist and access to banked blood .

In view of the massive differences between districts in availability and access to services, and maternal health indices the following differential

strategy is recommended for achieving incremental improvement in antenatal care during the Tenth Plan.

In all districts:

- awareness generation to ensure universal screening of pregnant women; identification of women with problem;
- manage/ refer women with complications to appropriate institution for care;
- 100% coverage for Tetanus toxoid;
- screening for and treatment of anaemia;
- provide information on:
  - nearest PHC where women with problems can seek doctor's advice;
  - nearest FRU with obstetrician and facilities where women with obstetric emergency can seek admission;
  - how to access emergency transport system funds.

In better performing districts focus on

- ensure universal coverage and improve content and quality of ANC to enable very early identification of women with any antenatal problem;
- referral of those with problems to PHC/ FRU for care.

In poorly performing districts focus will be on

- improving coverage for AN screening by ANM providing ANC at least thrice during pregnancy;
- building up system of RCH camps in PHC/CHC on specific days through out the year when doctors/specialists will be available to examine women with problems and provide treatment/referral.

Delivery care

During the Ninth Plan, it was envisaged that efforts will be made to promote institutional deliveries both in urban and rural areas; simultaneously in districts where majority of the deliveries were taking place at home, efforts were made to train the TBAs through intensive Dai's Training Programme. The available data from the NFHS-I and II and Rapid Household Suvey-1998-99 suggest that there has been some improvement in the institutional deliveries, especially in states like Tamil Nadu and Andhra Pradesh; there are, however, in a large number of districts in many States where the situation with regard to safe deliveries is far from satisfactory. Unpredictable complications can arise even during apparently normal labour; rapid transportation of these women to hospital for emergency obstetric care is essential to reduce morbidity and mortality during delivery. In order to assist families in arranging transport to centres where emergency care can be provided, the Department of Family Welfare allocated funds which will be available at the village level. This has to be optimally utilised to improve emergency referral and ensure improved maternal and perinatal outcome.

Recommended Differential Strategy to improve delivery care during the

Tenth Plan:

In all districts

- Efforts will be made to identify women with complications early through AN check up and refer them to appropriate institution for safe delivery.

In districts with low institutional delivery

- screen all women late in pregnancy and ensure that those with complications deliver in institutions;
- train traditional birth attendants (TBAs) in clean delivery;
- train TBAs to recognise problems that arise during labour and refer those with problems to hospitals;
- ensure that referrals are honoured;
- build up community support to transport of women with problems to FRU.

In districts with high institutional delivery

- improve quality of services available;
- address problems and needs of the women in labour seeking institutional deliveries;
- aim at universal institutional delivery by make institutions people friendly;
- medical audit for monitoring progressive improvement in quality.

Specific efforts will have to be made to strengthen FRU/ CHC/District hospitals to provide Emergency obstetric care for all referred cases. Efforts will be to:

- operationalise adequate number of FRU/CHC by posting specialists in obstetric, Gynaecology/pediatrics in institution where infrastructure is available;
- if necessary provide for funding specialists on contract basis (part time) so that care is available when needed;
- improve access to anaesthetist and banked blood.

Child Health

Infant and under five mortality rates are excellent indicators of health status of the children. In India there is no system for collection and analysis of data on morbidity during childhood. In the absence of morbidity data, available mortality data and analysis of causes of death have been utilised for drawing up priority interventions for improving child health. Improved access to immunization, health care and nutrition programmes have resulted in substantial decline in IMR over the last five decades. However it is a matter of

concern that the decline in perinatal and neonatal mortality have been very slow. IMR has remained unaltered in the last few years. It is estimated that under nutrition and anaemia are contributory factors in over 50% of under five deaths. There are substantial differences in the neonatal, infant and under five mortality rates between states. The gender differences in IMR and under five mortality rates persist. There is no biological reason for a higher mortality rate in females in the age group 0-4 years. The social factors, which adversely affect the mortality rate of girls, need to be tackled.

Access to family welfare services and contraceptive care is a critical determinant of infant mortality and birth rate. In spite of the fact that health and contraceptive care are provided by the same personnel the decline in these indices do not always go hand in hand. There are massive differences in the birth rates and IMR mortality rates not only between states but also between districts in the same states. In spite of relatively high IMR states like Tamil Nadu and Andhra Pradesh have achieved steep decline in fertility. In States/districts in which fertility has declined without commensurate decline in IMR there should be focused area specific situation analysis and intervention to reduce IMR.

Essential new born care

Birth weight is influenced by the nutritional and health status of the mother. Currently nation wide data on birth weight in different states and districts is not available because majority of births occur at home and these infants are not weighed soon after birth . Estimates based on available data from institutional deliveries and smaller community based studies suggest that about 1/3 of all Indian infants weigh less than 2.5 Kg at birth. There are interstate and inter economic group differences in birth weight. There has hardly been any change in birth weight in the past three decades . A gender difference has been noted in mean birth weights, female infants tending to be lighter than male counterparts.

Two third of all the neonatal deaths occur in the first seven days after birth. Major causes of neonatal deaths are prematurity, asphyxia and sepsis. If neonates requiring care are identified and referred to appropriate facility they can be effectively treated and it will be possible to achieve substantial decline in neonatal mortality. Steering Committee recommended that the focus during the Tenth Plan should be to operationalise the appropriate essential new born care in all settings so that there is substantial reduction in the early neonatal mortality both in institutional deliveries and home deliveries. During the Tenth Plan:

- every effort should be made to screen pregnant women for undernutrition and anaemia and provide appropriate intervention;

- at risk individuals will be advised to have delivery in institutions which can provide optimal intrapartum and neonatal and improve neonatal survival;
- in all home deliveries AWW worker should check the birth weight as soon after delivery as possible and refer those neonates with birth weight less that 2.2 kg to hospitals where there is a pediatrician is available; FRU/ CHCs should honour the referrals.

If these interventions are fully operationalised it will be possible to achieve substantial reduction in the neonatal mortality rate within a short period.

Immunisation

Data from NFHS indicate that there has not been any decline in the immunization coverage over the nineties. However none of the states have achieved coverage levels over 80%; coverage level in states like Bihar, UP and Rajasthan were very low. The drop out rates between the first second and third doses of oral polio vaccine and DPT have been very high in most of the states. Lower coverage (over 20%) is reported for measles as compared to other immunisations. It has been suggested that one of the major reasons for not achieving 100% routine immunisation is the focus on campaign mode programmes in Health and Family Welfare. The Dept of Family Welfare has now taken up a scheme for strengthening of routine immunization. A pilot project on Hepatitis B immunization and injections safety has also been initiated.

Steering Committee recommended that during the Tenth Plan every effort should be made to:

- achieve 100% immunization coverage against six vaccine preventable diseases;
- eliminate Polio and neonatal tetanus;
- strengthen routine immunisation programmes;
- discourage campaign mode operations which interfere with routine services;
- ensure greater involvement of the private sector;
- improve awareness through all channels of communication;
- improve quality of care including ensuring injection safety by using appropriate, sustainable technology;
- correct over reporting of coverage under service reporting through supervision; the concept that the reduction in the disparity between service reporting and coverage evaluation service is an indication of an improvement in quality will be introduced;
- evaluate ongoing Pilot projects on introduction of Hepatitis B vaccine including those where vaccine costs are borne by the parents;
- explore appropriate sustainable models of providing newer vaccines without overburdening the system and programme (including charging actual costs for the newer vaccines from persons above poverty line);

- expand on-going polio surveillance to cover all VPD in a phased manner.

Pulse Polio Immunization

India initiated the Pulse polio programme in 1995-96. Under this programme all children under five years are to be administered two doses of OPV in the months of Dec and Jan every year until polio is eliminated. Pulse Polio Immunization in India has been a massive programme covering over 12 crores of children every year. Coverage under the pulse polio immunization has been reported to be over 90% in all States. However, it has been a matter of concern that over the last 5 years coverage under routine immunization has not improved; in fact in some states there has been a substantial decline. There are segments of population who escape both routine immunization and the pulse polio immunization. As a result of all these, the decline in number of polio cases, though substantial, was not sufficient to enable the country to achieve zero polio incidence by 2000. National Polio Surveillance Programme (NPSP) was started in 1997 with DANIDA and USAID assistance and is working under the management of WHO. The management of NPSP will ultimately transferred to GOI. The programme has helped in detection of cases, case investigations, laboratory diagnosis and mop up immunization.

The medical goal of polio eradication is to prevent paralytic illness due to polioviruses by elimination of wild polovirus the virus so that the countries of the world need not continue to immunize all children perpetually. India will probably achieve zero incidence of polio by 2003. If for the next three years there are no more cases the country will be declared polio free. As and when this is achieved the country will have to take steps to ensure that the disease does not return. The oral polio vaccine contains live attenuated virus. Recent experiences in Egypt, Dominican Republic and Haiti have shown that the vaccine derived viruses can become neurovirulent and transmissible. Such mutant viruses have caused outbreaks of polio when immunization coverage drops. It may, therefore, not be possible to discontinue polio immunization. Several of the countries which have eliminated polio have shifted to injectable killed polio vaccine after elimination of the disease. India along with other developing countries of South Asia may have to consider all these options and prepare appropriate strategies during the Tenth Plan.

Infections in children

NFHS-2 collected information on the prevalence and treatment of fever, Acute Respiratory Infection (ARI), and diarrhoea which are three major causes of mortality in young children; 30 percent of children under age three had fever during the two weeks preceding the survey, 19 percent had symptoms of ARI, and 19 percent had diarrhoea. About two-thirds of the children who had symptoms of ARI or diarrhoea were taken to a health facility or health-care provider. Knowledge of the appropriate treatment of diarrhoea remains low.

Diarrheal Disease Control Programme

The Oral Rehydration Therapy (ORT) Programme was started in 1986-87. The main objective of the programme is to prevent death due to dehydration caused by diarrheal diseases among children under 5 years of age. Health education aimed at rapid recognition and appropriate management of diarrhea has been a major component of the CSSM. Use of home available fluids and ORS has resulted in substantial decline in the mortality associated with diarrhoea from estimated 10-15 lakh children every year prior to 1985 to 6-7 lakhs in 1996. In order to further improve access to ORS packets 150 packets of ORS are provided as part of the drug kit-A. Under the RCH programme two such kits are supplied to all sub-centres in the country every year. In addition social marketing and supply of ORS through the PDS are being taken up in some states. However RHS data indicate that in only 9 districts in the country ORS was used in more than 50% of cases of diarrhoea. Improving access to and utilization of home available fluids/ORS for effective management of diarrhoea should receive priority attention during the Tenth Plan as an inexpensive effective tool to reduce IMR /under five mortality in the country.

Acute Respiratory Infections Control

Pneumonia is a leading cause of deaths of infants and young children in India, accounting for about 30% of the under-five deaths. Under the RCH Programme, Tablet co-trimoxazole is supplied to each sub-Centre in the country as part of Drug Kit-A. Mothers and community members are taught to recognize severe ARI which would require antibiotic treatment or referral. Skill upgradation training for early diagnosis of ARI and appropriate treatment including referral envisaged under RCH programme has not yet been completed. This should receive immediate attention during the Tenth Plan period.

Recommended Strategy for child health during the Tenth Plan

In view of the substantial differences in the IMR/NNMR between states and between districts, differential strategy should be adopted during the Tenth Plan . Where ever data on district specific IMR and NNMR is available from CRS district specific strategy and where ever these are not available state specific strategies will be adopted. In states/districts with high IMR where early neonatal mortality rate (ENNMR) is less than 50% of the IMR focus will initially be on improving postneonatal mortality through appropriate interventions. In districts /states where IMR is relatively low and ENNMR forms more than 50% of the IMR the focus will be on antenatal and intra partum and neonatal care. Differential strategy for child health would include:

For all districts

At Birth

- essential new born care;
- weighment at birth and referral for preterm babies and neonates weighing less than 2.2 kg to institutions where paediatrician is available.

Nutrition Interventions

- promote exclusive breast-feeding upto 6 months;
- introduce semi-solid supplements at 6th month;
- screen all children to identify those with severe grades of under-nutrition and treat them;
- administer massive dose of vitamin A supplements as per schedule;
- administer iron-folate supplements if needed.

Health Interventions

- universal immunisation against the 6 vaccine preventable diseases;
- early detection and management of ARI/diarrhoea.

Use of District Wise Data Generated By CRS For Planning And Monitoring FW Programme

Department of Family Welfare has introduced decentralized district based need assessment, planning implementation and monitoring of the performance. Differential strategy has been drawn up based on the district wise indicators,CBR, IMR being two of the important ones. The data base needed for this can be made available in a sustained fashion only through 100% registration of births and deaths, building up the capacity for data analysis, interpretation and responding to the changing needs at district level. This task will have to be taken up on a priority basis during the Tenth Plan period.

The country is yet to ensure 100% registration of births and deaths. Available information with RGI's office indicates that as of mid-nineties over 90% of all births and deaths are registered in states like Kerala, Tamil Nadu, Delhi, Punjab and Gujarat. Steps to collect, collate and report these data at PHC/District level on a yearly basis have also been initiated. In these States these data should be used at district-level both for PHC-based planning of RCH care as well as evaluation of the coverage and impact of RCH care annually. In districts where vital registration is over 70%, efforts should be stepped up to ensure that over 90% of births and deaths are reported so that independent data base is available for planning as well as impact evaluation of PHC- based RCH care. The Tenth Plan has set the goal of 100% registration of births and deaths and of CRS data and their use for planning and monitoring of the programme in all districts by 2007.

Health Care For Adolescents

Data from NFHS –2 indicate that median age at marriage of girls in India is 16 years; 61% of all girls were married before they are 18 years. There are large inter-state variations in age at marriage. The mean age at first birth is 19.2 years. Under-nutrition, anaemia and poor antenatal care inevitably lead not only to increased morbidity in the mother but also to high low birth weight and perinatal mortality. Poor childrearing practices of these girls add to the morbidity and under-nutrition in the infant thus perpetuating intergenerational cycle of under nutrition. The Steering Committee on Family Welfare recommended that during the Tenth Plan, in addition to appropriate education, nutrition and health interventions, IEC efforts to delay the age at marriage and to promote optimum health and nutrition in adolescent girls should be taken up through inter-sectoral coordination to break this vicious cycle.

Reproductive Tract Infections (RTI) and Sexually Transmitted Infections (STI)

It has long been recognised that RTI and STI are common problems in women during reproductive age group. During the last two decades, there has been resurgence of interest in detection and management of RTI/STI. Part of this is because the clinicians to day have access to accurate diagnostic tests for aetiological diagnosis, are in a position to provide prompt, appropriate treatment for many RTI/STI and prevent long term health consequences of these infections. Prevention, early detection and effective management of common lower reproductive tract infection has been included as a component of the essential RCH care to be implemented through existing primary health care infrastructure. In spite of all the current efforts to improve treatment of RTI/STI patients, gynaecologists and public health professionals feel that there has not been any substantial improvement in the situation over the last decade. It is important to persist on health education and providing ready access to diagnostic facilities and appropriate treatment for STI/RTI so that there is steady improvement over time.

Infertility

It is estimated that between 5 to 10% of couples are infertile. While provision of contraceptive advice and care to all couples in reproductive age group is important, it is equally essential that couples who do not have children have access to essential clinical examination, investigation, management and counseling. During the Tenth Plan, the focus at the CHC level should be to identify infertile couples and undertake clinical examination to detect the obvious causes of infertility, carry out preliminary investigations such as sperm count, diagnostic curettage and tubal patency testing. Depending upon the findings, the couples may then be referred to centres with appropriate facilities for diagnosis and management.

Gynaecological Disorders

Women suffer from a variety of common gynaecological problems including menstrual dysfunctions at peri-menarchal and peri-menopausal age. Facilities for diagnosis of these are at the moment available at district hospitals or tertiary care centres. It is recommended that during the Tenth Plan period the CHCs, with a gynaecologist, will start providing requisite diagnostic and curative services.

Access to RCH services

Data from research studies and clinical experience shows that social and economic deprivations are associated with poor health outcome. Poor health in turn results in deterioration of economic status partly due to loss of wages and partly due to cost of health care. Specific efforts have been made to focus on health and nutrition interventions so that these vulnerable segments have better access to health and nutrition services and the vicious circle of poverty and ill health is broken. Steering Committee recommended that during the Tenth Plan:

- every effort should be made to improve access to essential primary health care, services under the family welfare and diseases control programmes by providing these services free of cost to all;
- states/centre should evolve and evaluate various options for reducing the financial burden posed by hospitalization among the poor.

Logistic support

The Government of India procures and supplies drugs, equipment kits, contraceptives and vaccines to states for use in Family Welfare programme. While the drug kits are supplied at district level, vaccines and contraceptives are supplied at State or regional level. The states have so far not created any specialised or dedicated system for receiving such supplies, storing them in acceptable conditions and distributing them. As a result there are delays, deterioration in quality and wastage of drugs. Supplies under FW Programme is about Rs.500 crores; it is estimated that the losses due to deterioration and inefficiencies may be to the extent of 20-30%. During the Tenth Plan efforts should be made to ensure that the facilities which are being created handle all the drugs/vaccine/devices etc. provided by central govt. (Health, Family Welfare, ISM&H) and state governments for all health care institutions. The progress in the efforts and problem encountered should be monitored and appropriate mid course corrections instituted.

Private Sector Participation in RCH

Over 80% of the practitioners of modern medicine and higher proportion of the ISM&H practitioners work in private sector. It is estimated that the private sector provides more than three quarters of all curative health care

services; their contribution to MCH and family planning services however less than a third. The major limitations in the private sector include the following:

- the focus has till now been mainly on curative services;
- the quality of services is often variable;
- poorer sections of population cannot afford to pay for these services.

Under the RCH programme several initiatives were taken to improve collaboration between public and private sector in providing FW services to the poorer segments of population especially in underserved areas. Private sector represents an untapped potential for improving coverage and quality of reproductive and child health services in the country. The challenge is to find ways and means to optimally utilise their potential. The Steering Committee on Family Welfare recommended that the efforts made to increase the involvement of private medical practitioners in RCH care should continue and get augmented during the Tenth Plan.

Role of NGOs/VOs in FW programme

The National Population Policy envisages increasing role of NGOs/Voluntary Organisations (VOs) in building up awareness and advocacy for RCH interventions and also in improving community participation to ensure optimal utilization of available services. Under the RCH Programme the activities under the NGOs are increasingly getting streamlined. Currently the Department of Family Welfare has 97 Mother NGOs covering a total of 412 districts; over 800 field NGOs are getting funds from the RCH programme. In 10 states these NGOs cover all districts. However, in the states which are having high fertility and mortality, a large number of districts are still without any NGO.

During the Tenth Plan NGOs should play a major role in sensitizing the community in the following areas:

- gender sensitivity and advocacy for adequate care for girl child;
- baby-friendly hospital initiative and promotion of exclusive breast-feeding for six months in the community; advocacy for introduction of semi-solids at the right time;
- social marketing of contraceptives, ensuring easy availability of ORS/social marketing of ORS;
- sensitizing the community regarding the adverse consequences of prenatal sex determination and sex selective abortions;
- improving networking between the NGOs, State district administration as well as Panchayati Raj institutions.

Role of other organisations

The Governmental efforts alone will not be sufficient to achieve the desired goals of the Family Welfare Programme. The organised sector covers

about 14% of the country's population. Industry can improve acceptance of Family welfare services by educating, motivating their workers and improving access to services. Industries which provide health care to their personnel and their families can extend these facilities to the people living in the vicinity especially when the industrial units are located in underserved peri-urban and rural areas. Managerial and other skills available in the industry can be made available to improve efficiency of service provided by the government infrastructure. The marketing skills of industry may be useful in improving the IEC&M activities and in social marketing.

Labour force in the organised and unorganised sector and their families require coverage to achieve rapid improvement in health and demographic indices. Trade unions can expand their role to cover health care of workers and their families. The Steering Committee recommended that during the Tenth Plan attempts should be made to enhance the quality and coverage of Family Welfare services through involvement and participation of organised and unorganised sectors of industry, agriculture, trade/labour , agriculture workers and labour representatives.

Initiatives To Address The Needs Of Underserved Population

Access to health care is poorer in the States like Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan. The Empowered Action Group (EAG) constituted in the Department of Family Welfare reviews the available infrastructure, performance of the health system and health indices and suggests steps for improving access to health care so that there is rapid decline in fertility and mortality. During the Tenth Plan special efforts should be made to upgrade the capacity of health system in these states/districts to meet all the felt needs for care so that there is rapid decline in both fertility and mortality.

Tribal populations (except in the northeastern states) face problems in accessing essential health care services and have poor health indices, Department of Family Welfare has already initiated several programmes to meet the health care needs of tribal population. These will have to be continued and augmented during the Tenth Plan.

Urban slum population has been shown to have poor maternal and child health indices. In many slums immunization coverage is very low and children are undernourished. The Department of Family Welfare and Department of Health have been investing in improving urban primary health care infrastructure and ensuring that they are linked to existing secondary and tertiary care institutions. The IPP V, VIII and Urban RCH Pilot Projects have build up capacities of urban health system in several cities. Efforts to rationalise urban health care and improve efficiency so that reproductive care needs of the growing urban population are fully met within available infrastructure will have to be continued during the Tenth Plan period.

Strategies for Increasing Efficiency

A vast infrastructure for delivery of health and family welfare services has been created over the last three decades based on uniform norms for the entire country. Evaluation studies have shown that they are functioning suboptimally. The RCH Programme has invested heavily in training of Programme Managers in managerial aspects for effective implementation of RCH programme through decentralised district-based planning, implementation, monitoring and mid-course corrections. It is expected that these efforts will promote effective functioning of the infrastructure and improve efficiency. Steering Committee recommended that these efforts to make the health system effective and efficient will have to continue during the Tenth Plan period.

During the Tenth Plan, efforts should be made to improve quality of care through appropriate skill upgradation of all functionaries, assigning appropriate duties/ tasks to designated functionaries and training them to act as a multi-professional team. Simultaneously efforts should be made to improve referral linkages. In such a chain, the first link will be provided by the village-based workers who will act as a liaison person between the people and health functionaries and ensure utilisation of available facilities.

Involvement of PRI in the Family Welfare Programme

The Panchayati Raj Institutions are expected to participate in the planning and assist in the implementation and monitoring of the programme. The real challenge of family welfare programme lies in effectively delivering the needed services in the remote, inaccessible, hilly, tribal and desert areas where the services provided by the government machinery are the weakest and private/NGOs Sectors are non-existent. During the Tenth Plan it is envisaged that mature Panchayati Raj Institutions with intelligent, service oriented members committed to the rapid population stabilization will play a key role making the family welfare programme a people's programme and improving access and utilization of FW services.

Intersectoral Coordination

Intersectoral coordination especially with Department of Health, Department of ISM & H Department of Women and Child Development, Human Resource Development, Rural Development, Urban Development, Labour, Railways, Industry and Agriculture is critical for increasing the coverage and improving implementation of Family Welfare Programme. Some of the areas where intersecrtoral coordination is envisaged during the Tenth Plan include:

- involvement of the extension workers of these Departments in propagating IEC messages pertaining to reproductive and child health care to the population with whom they work;

- efforts to improve the status of girl child and woman, improving female literacy and employment, raising the age at marriage, generating more income in rural areas, improving nutritional status of women and children;
- coordination among village-level functionaries - namely Anganwadi workers, Mahila Swasthaya Sangh (MSS), Traditional Birth Attendant (TBA), Krishi Vigyan Kendra (KVK) Volunteers, School teachers - to achieve optimal utilisation of available FW services.

Research And Development

The ICMR is the nodal research agency for funding basic, clinical and operational research in contraception and MCH. In addition to ICMR, CSIR, DBT and DST are some of the major agencies funding research pertaining to Family Welfare Programme.

Priority areas of research during the Tenth Plan include:

Basic and clinical research

- development of newer technology for contraceptive drugs and devices in modern system of medicines including immunological methods for fertility to cater to the requirements of the population in the next few decades;
- exploration of the safety and efficacy of ISM & H products;
- identification , characterisation genes/gene products and elucidation of their functional role of in reproduction and health of women and children;
- development and testing of new drug delivery systems for the delivery of contraceptive steroids;
- safety and efficacy studies on newer vaso-occlusive methods, spermicides based on plant products such as neem oil, saponins and other plant based substances, safety and efficacy of contraceptives used in ISM &H and by tribal population;
- clinical studies on use of emergency contraception and non-surgical methods of MTP;
- diagnosis and management of STI/RTI;
- innovative methods for improving neonatal care at primary health care level including assessment of simple methods for diagnosis and management of sepsis, asphyxia and hypothermia in the new born;
- studies on prevention detection and management of infections in children;
- early detection and management of obstetric problems.

Demographic studies and Operational research

- ongoing demographic transition and its consequences;
- continuation rates and use effectiveness of contraceptives under programme condition;

- operational research on providing integrated delivery of health, nutrition and family welfare services at village level through existing infrastructure and manpower;
- testing and validation of relationship between couple protection rate and crude birth rate and testing relationship between reduction of infant mortality rate and reduction in birth rate in the states in different levels of demographic transition;
- Improving access to safe abortion services;
- STI/RTI - research aimed at for detection, prevention and management in different levels of health in care;
- socio-behavioural research to improve community participation for improving utilization of family welfare services.

Monitoring And Evaluation

The NDC Committee on Population recommended creation of district level databases on quality, coverage and impact indicators for monitoring the Family Welfare programme. Department of Family Welfare has constituted regional evaluation teams which carry out regular verifications and validate the data on acceptance of various contraceptives. These evaluation teams can be used to obtain vital data on failure rates, continuation rates and complications associated with different family planning methods. Data generated by rapid household survey about the progress of programme interventions as well as its impact are being used to identify district specific problems and rectify them. To assess the availability and the utilisation of facilities in various health institutions all over the country, facility surveys have been done during 1998-99 in 101 districts. The deficiencies found during the survey are being brought to the notice of the States and districts concerned so that they are rectified. The format for monitoring the process and quality indicators have been developed and sent to all the states. These may have to be operationalised during the Tenth Plan and used for monitoring the programme and making mid term corrections . During the Tenth Plan, efforts should be made to consolidate the earlier gains by putting in place a sustainable systems of evaluation at district level in the form of CRS and district surveys; efforts have to be made to ensure reduction in duplication of evaluation efforts through appropriate intersectoral coordination.

Reorganisation of Family Welfare Infrastructure

Over the last three decades there has been considerable expansion and strengthening of the health care infrastructure by the state. Family welfare services are now an integral part of services provided by primary, secondary and tertiary care institutions. The staff funded by the Dept of Family welfare under the scheme rural family welfare centre and post partum centres are personnel belonging to the state health services who are functioning as part of

the state infrastructure. In view of this the Ninth Plan recommended that the funding should be taken over by the State health Dept. Steering Committee recommended that from 1.4.2002; the states should take over the responsibility of funding staff in post partum centers and rural family welfare centers.

ANMs are crucial for increasing the outreach of the Programme; it is important to ensure that the posts of ANMs are filled and steps taken to ensure that they are available and perform the duties they are assigned. One of the major problem with respect to the ANMs was that while the Dept of family welfare funded over 97 thousand posts of ANM about forty thousand ANMs were funded by the state from Non-Plan budget. The Ninth Plan recommended that this dichotomy in funding should be removed and the Department of Family Welfare should pay the salaries of all the AMNs as per norms for the 1991 population. The Steering Committee on Family Welfare recommended that the Department of Family Welfare should take over the funding of all the ANMs from 1st April 2002. It is expected that this step would ensure that the States do employ the required number of ANMs, streamline their functioning and achieve improvement in coverage, content and quality of maternal and child health and contraceptive care.

Zero Based Budgeting

Family Welfare Programme in the past has been considered as a single centrally sponsored scheme. As a result the heads of funding were functional such as personnel, services, supplies, transport, area development; all ongoing programmes including , maternal health , child health, immunization received inputs from these functional heads; in the Ninth Plan major projects of reproductive and child health, pulse polio initiative and routine immunization strengthening were added as schemes with large outlays. The Planning Commission and the Department of Family welfare carried out an exercise of rationalization of the schemes. A revised scheme- wise listing was evolved where in addition to schemes for strengthening of infrastructure, area development project, training, research, programme related activities for contraception, immuninsation, maternal health, child health, nutrition are identified as specific schemes. After this, a zero based budgeting effort was taken up and schemes for convergence, weeding out, and transfer to the States identified. The recommendations made in the zero based budgeting exercise will be implemented during the Tenth Plan.

Goals for the Tenth Plan

The Steering Committee reviewed all the available data on process and impact indicators for assessing the progress in implementation of the Family Welfare Programme, the goals set for these in the National Health Policy -NHP 1983 (for 2000), Ninth Plan (for 2002), NPP 2000 (for 2010) and Approach Paper to the Tenth Plan. While there has been steady improvement in indicators, the pace of improvement is slow. During the Tenth Plan, the pace of

implementation of the Programme will have to be accelerated through streamlining of infrastructure, improving efficiency of services, quality, content and coverage under the programmes so that all the felt needs for family welfare services are fully met. Special attention will have to be paid to improving access to good quality services to the underserved population in urban slums, remote rural and tribal areas. There is an urgent need to take full advantage of the current phase of demographic transition, substantial improvement in literacy , age at marriage and other favourable factors. If these were done it is technically feasible to achieve the ambitious goals set for the process indicators and perhaps even the impact indicators in the NPP2000 and in the Tenth Plan. Striving to achieve these goals is essential in order to enable the country to achieve the goals set for improvement the quality of life and human development within the time frame .This would enable the country to rapidly reach the developmental goals and improve the quality of life .