

Chapter 17

FAMILY WELFARE PROGRAMME

Introduction

Population growth and changes in age structure are inevitable during demographic transition. Over the last four decades there has been rapid fall in Crude Death Rate (CDR) from 25.1 in 1951 to 9.8 in 1991 and less steep decline in the Crude Birth Rate (CBR) from 40.8 in 1951 to 29.5 in 1991. As a result, the annual exponential population growth rate has been over 2% between 1960-1990. In the nineties the growth rate declined below 2% as decline in CBR was steeper than CDR and India entered the demographic opportunity window. The rate of decline in population growth is likely to be further accelerated during next decade. It is a matter of concern that though the decline in CBR and CDR has occurred in all States, the rate of decline in CBR was slower in some States like U.P. and Bihar. There are substantial variations in CBR and Infant Mortality Rate (IMR) among the States and even within the same State there is substantial differences between districts.

Population Projections & Implications to FW programme

2. The population of the country was 846.3 million in 1991 as recorded in the census. As per projections made in the Report of the Technical Group on Population Projections the estimated population in the census years 2001 and 2011 will be 1012.4 million and 1179 million respectively. There are differences between states on their current population as well as their potential to contribute towards increase in country's population during 1996-2016.

3. Five states of Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan and Orissa, which constituted 44% of the total population of India in 1996, will constitute 48% of the total in 2016, according to projections. These states will contribute 55% of the total increase in population of the country during the period 1996-2016. The way these states perform will determine the time and size the country's population will stabilise. In each state there are districts with health indices comparable to the national levels; these experiences have to be studied and replicated to achieve a faster decline in their mortality and fertility rates.

4. In all these five states the performance in the social and economic sector has been poor. The poor performance is the outcome of poverty, illiteracy and poor development – ills that co-exist and reinforce one another. All these states have excellent human, mineral and agricultural potential which have not been fully utilized or realised. It is imperative that all steps are taken to ensure that these states achieve their full potential in the shortest possible time through planned coordinated efforts by all sectors.

5. ***The current high population growth rate is due to:***

- (1) the large size in the reproductive age-group (estimated contribution 60%);
- (2) higher fertility due to unmet need for contraception (estimated contribution 20%); and
- (3) high wanted fertility due to prevailing high IMR (estimated contribution about 20%).

Ninth Plan Objective:**Reduction in the population growth rate by:**

- meeting all the felt-needs for contraception; and
- reducing the infant and maternal morbidity and mortality so that there is a reduction in the desired level of fertility

Plan Strategies :

- Assess the needs for reproductive and child health at Primary Health Centre (PHC) level and undertake area- specific micro planning; and
- Provide need-based, demand-driven high quality, integrated reproductive and child health care.

Paradigm shift envisaged in the Ninth Plan include shift from:

- demographic targets to focus on enabling couples to achieve their reproductive goals and reducing infant mortality to reduce high desired fertility
- method- specific contraceptive targets to meeting unmet needs for contraception to reduce unwanted pregnancies
- numerous vertical programmes for family planning and maternal and child health to integrated reproductive and child health care
- centrally defined targets to community need assessment and decentralized area specific micro planning and implementation of the Reproductive and Child Health (RCH) programme
- quantitative coverage to emphasis on quality and content of care
- predominantly women centered programme to meeting the couples' needs with emphasis on involvement of men in Planned Parenthood
- supply driven service delivery to need and demand driven service with improved logistics for ensuring adequate and timely supplies to meet the need
- service provisions based on providers perception to addressing choices and conveniences of couples

Ninth Plan envisages that efforts will be intensified to enhance the quality and coverage of family welfare services through:

Increasing participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of practitioners of Indian Systems of Medicine & Homoeopathy (ISM&H);

Involvement of the Panchayati Raj Institutions for ensuring inter-sectoral coordination and community participation in planning, monitoring and management; Involvement of the industries, organised and unorganised sectors, agriculture workers and labour representatives.

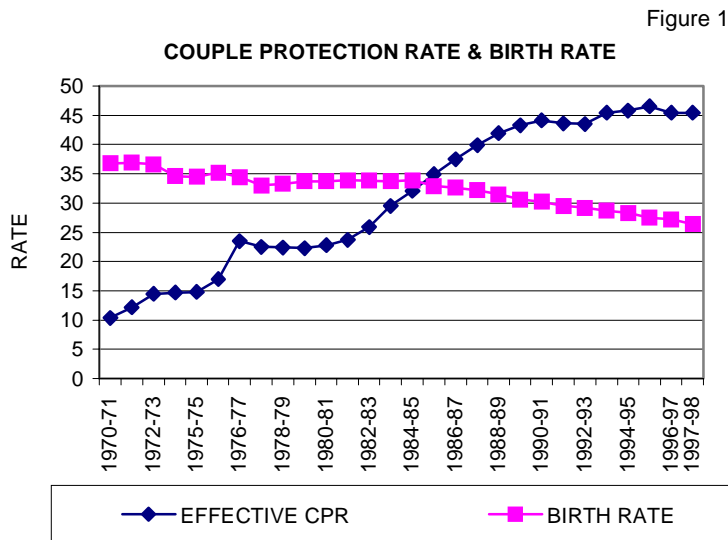
Contraception

Ninth Plan Strategy:

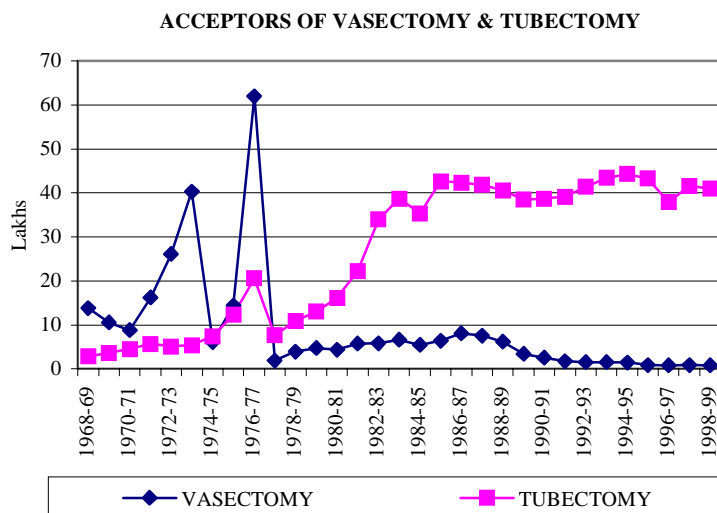
To meet all the unmet needs for contraception by 2002 through improving availability, access and quality of contraceptive care.

Progress & Suggestions

6. Time trends in Couple Protection Rate (CPR) and Birth Rate (CBR) is shown in Figure-1. In spite of the fact that CPR remained unaltered in the Ninth Plan period there has been a steady decline in CBR suggesting that over the years there has been an improvement in the acceptance of appropriate contraception at appropriate time. Currently the FW Programme is focusing its attention on need assessment, balanced presentation of advantages and disadvantages about all the available methods of contraception counseling, provision of appropriate contraceptive at the right time and good follow-up services. Effective implementation of the FW programme and ensuring that all the unmet needs for contraception are met will result in substantial improvement in CPR and enable rapid reduction in CBR.



7. Over the last two decades there has been a steep fall in number of vasectomies (Figure-2). At the moment, over 97% of all sterilisations are tubectomies.

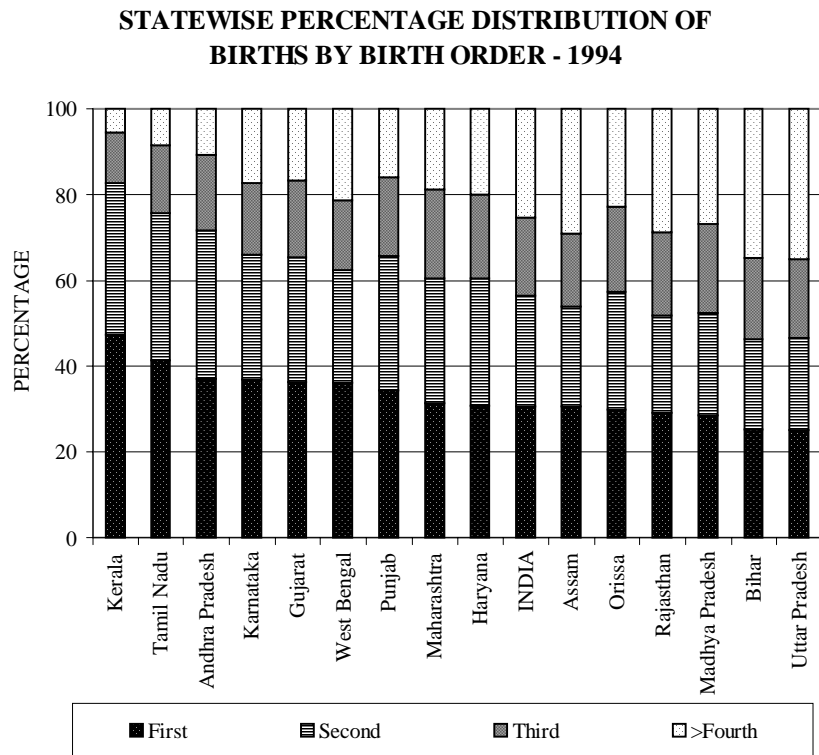


The Department of Family Welfare has initiated steps to re-popularise vasectomy by addressing concerns and conveniences of men and introducing newer techniques. The reported success in some districts in AP has to be replicated in other districts and states. If this were done it will be possible to

improve access to sterilization services in underserved areas and simultaneously achieve reduction in the morbidity associated with sterilisation because vasectomy is a simpler and safer method than tubectomy.

8. Percentage distribution of birth order in major states is shown in Figure-3. It is obvious in most of the poorly performing states over half of the women have two or more children and are likely to require permanent methods of contraception sooner or later. The number of sterilization/ 10,000 unsterilised couples with two or more children is low in Bihar (110), UP (188), Rajasthan (447) and MP (523) as compared to TN (934), Karnataka (1297) and AP (1230).

Fig-3

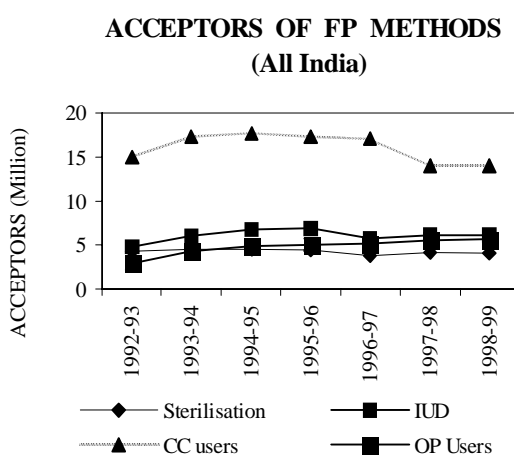


SOURCE : YEAR BOOK, 1996-97 - DEPARTMENT OF FW

There is an urgent need to improve access to contraceptive care including sterilization in poorly performing states. On the other hand in some of the better performing states an increasing number of women may desire to postpone the first or second pregnancy and there may be a progressive increase in the need for spacing methods. Contraceptive need assessment, counseling, improved quality of initial and follow-up care would go a long way in meeting the felt needs of contraception in the population and accelerate the decline in fertility.

9. The data on acceptors of different methods of contraception during the Ninth Plan period is given in the Figure-4. In 1996-97 the Department of Family Welfare abolished the system of centrally determined method-specific targets for Family Planning; the states were requested to undertake a PHC based need assessment and attempt to meet all the felt needs for contraception.

Figure-4



SOURCE:- Department of Family welfare

Comparison of performance between the periods before and after abolition of method-specific targets indicate that at the national level there had been a reduction in the acceptance of sterilization, IUD and conventional contraceptives; only

acceptors of oral contraceptives have shown an increase in number. There are however substantial differences between the service reporting and the coverage evaluation studies. Data from NFHS -2 clearly indicated that there has been improvement in CPR especially sterilization. The reason for the reported differences may have to be looked into and rectified so that service reporting provides dependable method of monitoring the programme

Performance in States with Poor Demographic Indices

10. The performance of four states with poor demographic indices is shown in the Figures-5&6. In UP and Bihar there has been decline in performance even as compared

Figure-5

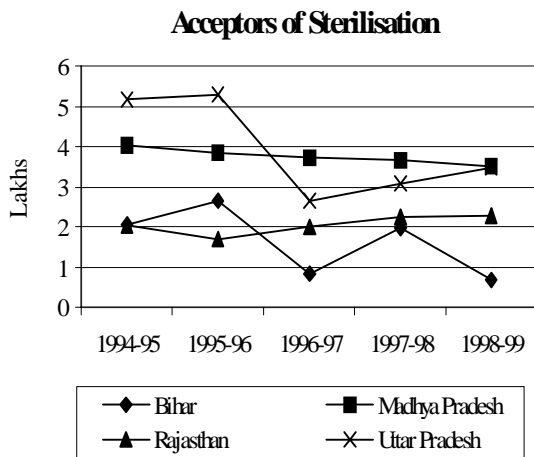
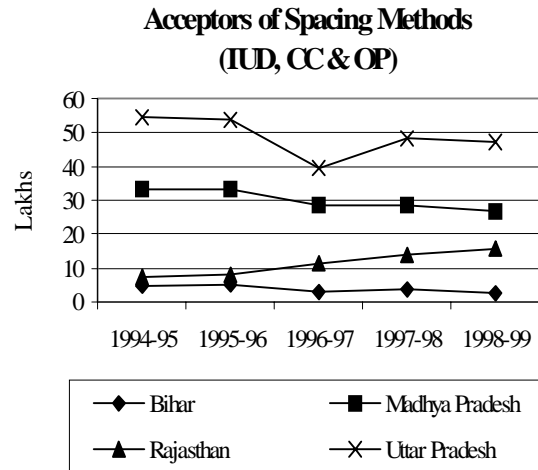


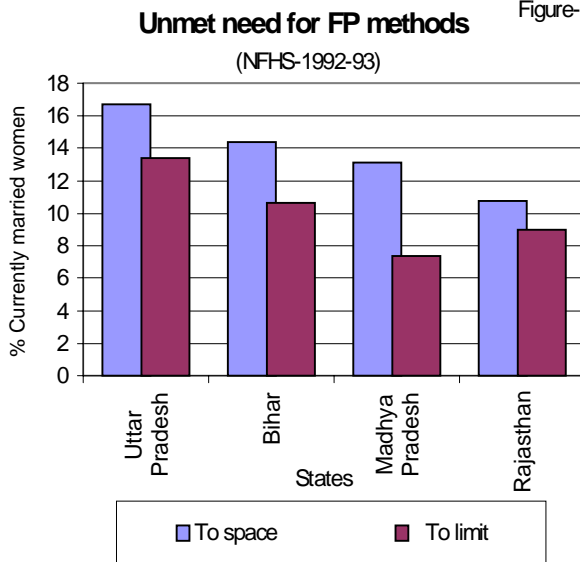
Figure-6



to their past performance. In MP the decline is marginal while in Rajasthan there has been an improvement in both permanent and temporary method use.

11. It is noteworthy that these four states have the largest proportion of unmet needs for family planning both for terminal and spacing methods (Figure-7). This unmet need has to be met by improving availability, access and quality of care.

Figure-7



12. The district surveys conducted by the Department of Family Welfare confirm the available data from census that some districts in these states have birth rate and infant mortality rate well below the national average and substantially below the state level. The states have to study and replicate these successful experiences within the state and also strive to meet all unmet needs in better performing districts.

Medical Termination of Pregnancy (MTP)

Ninth Plan Initiatives:

Efforts are to be made

- to improve access to family planning services and to reduce the number of unwanted pregnancies
 - to cater to the demand/request for MTP
- to improve access to safe abortion services by training physicians in MTP and recognising and strengthening institutions capable of providing safe abortion services

Progress and suggestions

13. Additional MTP training centres are being recognised to accelerate the skill development training of Community Health Centre (CHC)/PHC doctors. Steps are being taken to supply equipment to CHCs/FRUs, send doctors trained in MTP to PHCs/CHCs once a week for improving access to MTP services. Efforts are under way to streamline the procedures for recognition of institutions for MTP and improve reporting of MTP. There is a need to accelerate pace of these processes and monitor the impact both in terms of coverage, number of MTP reported and reduction in number seeking illegal abortion and suffering adverse health consequences.

Maternal Health Programme

14. The prevailing high maternal and prenatal morbidity and mortality is a source of concern. It is noteworthy that there has not been any substantial decline in these indices in the last two decades.

Ninth Plan Aim & Strategy:

Focus on Essential Obstetric care aimed to achieve substantial reduction in maternal morbidity and mortality through:

- Early registration of pregnancy (<16 weeks).
- Screening of all pregnant women at least thrice in pregnancy for detection of risk factors
- Appropriate referral and care for at risk person
- Safe delivery

15. Awareness generation and skill upgradation training are under way to improve utilization of care and to improve quality and contents of care. The states are making efforts to improve antenatal and intra-partum care facilities. Contractual appointment of additional Auxiliary Nurse Midwives (ANM) to improve coverage and Public Health Nurse/Staff Nurse (PHN/SN) to improve institutional deliveries are being taken up in Assam, Bihar, Haryana, Rajasthan, Orissa, Nagaland, Uttar Pradesh, and Madhya Pradesh. In addition, provision for equipment for essential obstetric care has also been made. Safe delivery component of the RCH Programme is specifically being strengthened with provision of disposable delivery Kits and training of Dais in Assam,

Bihar, Rajasthan, Orissa, Uttar Pradesh and Madhya Pradesh where most of the deliveries are still conducted at home. Training of Dais is also continuing in these States.

Initiatives to promote institutional deliveries

- Honorarium to staff who are available round the clock
- Tamil Nadu – 24 hour PHCs with additional Nurse
- Andhra Pradesh – Incentives to Women seeking institutional deliveries

Initiatives to Promote safe home deliveries in poorly performing states

- Screening of all pregnant women to detect and refer high risk group
- Training Traditional Birth Attendants (TBA) regarding danger signals and timely referral
- Promotion of use of disposable delivery kits to reduce infection

16. Tamil Nadu is strengthening PHCs with additional staff so that 24-hour delivery services are available at PHCs. The ANC and deliveries in PHCs are being monitored on a monthly basis; PHCs with low number of deliveries are picked up through this monthly monitoring and appropriate remedial measures are being initiated.

17. Complications associated with pregnancies are not always predictable. Therefore, emergency obstetric care is an important intervention to prevent maternal mortality and morbidity. Under the CSSM programme, 1,748 referral units were identified and strengthened. However, they did not become fully operational due to lack of skilled manpower, adequate infrastructure, equipment and medicines. Under the RCH Programme, the FRUs are being strengthened through supply of drugs in the form of Emergency Obstetric drug kits and equipment kits; the programme provides for hiring of skilled manpower e.g. anesthetist on contractual/part time basis.

Reproductive Tract Infection (RTI) And Sexually Transmitted Infections (STI):
Prevention & Management

Ninth Plan Strategy

STI/RTI prevention, detection and management in women is a priority area as a part of essential RCH care at all levels of health care

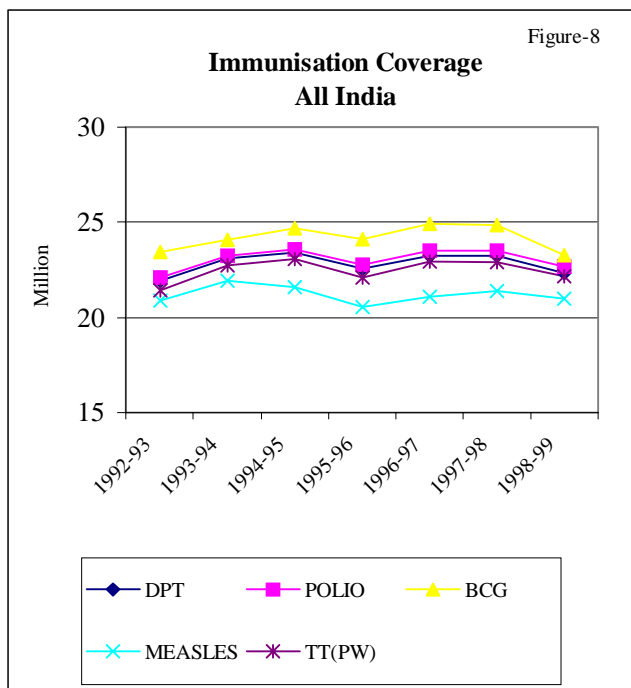
Progress & Suggestions

18. RTI/STI prevention and management component of RCH programme is being planned and implemented in close collaboration with NACO. Guidelines on RTI/STI prevention and detection for paramedical workers like ANMs/ Lady Health Visitors (LHV) have been developed and distributed to all districts of the country to enable the health workers to identify RTI/STI cases for counselling and referral for further treatment. Under the programme, NACO provides assistance for setting up RTI/STD clinics upto the district level and Department of Family Welfare (FW) assists in setting up RTI/STI clinics in selected First Referral Units (FRU) in a phased manner. In addition

Deptt. of FW provides training of personnel and drugs for treatment, similar to those being provided by NACO, to these FRUs under RCH Programme; each district will also be assisted to engage two laboratory technicians for doing routine blood, urine and RTI/STIs tests at FRUs. Funds for appointment of laboratory technician on contractual basis in FRUs have been released to several states. The progress is being carefully monitored.

Universal Immunization Programme

19. Immunization programme began in 1978 with the objective of reducing morbidity and mortality associated with Vaccine Preventable Diseases (VPD). It was taken up as a National Technology Mission in 1986 and covered the entire country during 1989-90. Immunization coverage reported by the Department of Family Welfare during nineties is shown in Figure-8.



20. It is a matter of concern that there has been a fall in routine immunization. It is obvious that the target of 100% coverage for all six Vaccine Preventable Diseases has not been achieved. Several states have reported substantial decline in routine immunization. It is imperative that factors responsible for the decline are identified and corrected so that the target of 100% routine immunization coverage is achieved.

21. Coverage Evaluation Surveys (National Family Health Survey-NFHS, UNICEF 1998) indicate that only about 50% of infants get immunized against 6 VPD in the first year. There are substantial differences between coverage reported by service agencies and observed coverage in evaluation surveys. Though there has been substantial decline in VPD over the last decade, the goal of elimination of polio and neonatal tetanus by 2000 have not been achieved.

22. Reported factors responsible for poor coverage range from vacancy at ANM level (40% in Bihar), poor mobility, poor access, problem in distribution and storage of vaccines, lack of supervision and monitoring, poor cold chain maintenance and ongoing campaign mode programmes disrupting routine activities. It is imperative these are corrected and the goals set are achieved.

Pulse Polio Immunization (PPI)

Strategy for the Ninth Plan

In 1995 Department of Family Welfare initiated the Pulse Polio Programme to eliminate polio by 2000 AD; the strategy was to provide two doses of polio vaccine to all children below 5 years of age in addition to routine immunization for polio under Universal Immunization Programme. It was envisaged that with 100% routine immunization and two rounds of Pulse Polio Immunization, the country will achieve zero polio incidence by 2000.

23. The Central Government reviewed the PPI Programme in 1998 and 1999. Data from the states showed that:

- Under routine immunization programme the coverage is around 90%. In some states like Bihar it is as low as 40%;
- Coverage under PPI is also around 90%;
- There has been a steep decline in polio cases reported; (Figure)
- No state is totally free of cases or wild virus;
- With the present strategy and pace of implementation the country would require 8-10 years to eliminate polio.

24. With a view to accelerating the pace and achieve elimination of polio by 2000 winter, the Expert Group recommended the following strategies for achieving zero incidence of polio by the end of 2000:

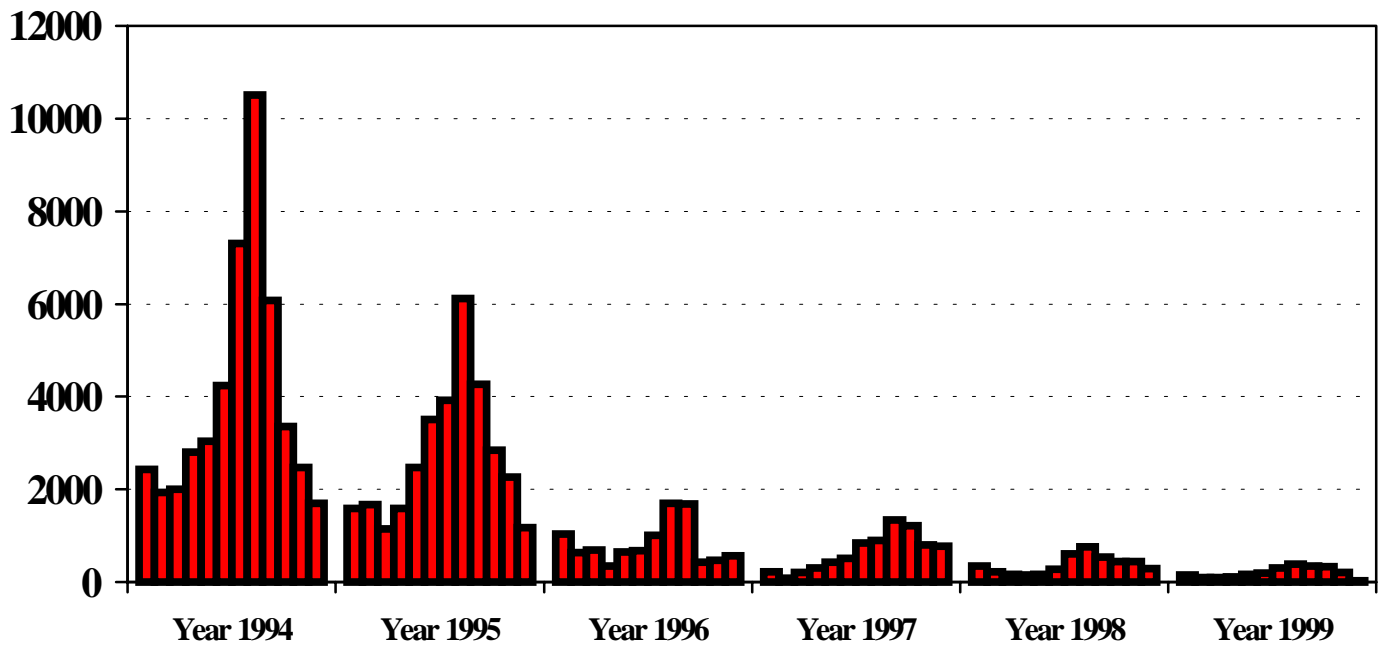
- a. near 100% vaccination for polio under Universal Immunization Programme (UIP).
- b. Four nationwide PPI rounds
- c. two additional PPI rounds in eight states i.e., UP, MP, Bihar, Rajasthan, West Bengal, Gujarat and Orissa. In each round after initial booth based immunization, efforts will be made to identify unimmunized children by house visits and immunize them.
- d. surveillance to detect all cases of polio and
- e. controlling spread of infection around detected polio cases by immunizing all children in the surrounding areas

25. In May 2000 the situation was reviewed. Polio surveillance in all states has shown substantial improvement. There has been a steep reduction in the number of cases reported in the country but inspite of six round of immunisation UP, Bihar, WB and Delhi had not shown a substantial decline in the proven cases of polio. These states contribute over three fourth of the total cases in the country. There has been a fall in routine immunization and reduction in coverage in MCH programmes during the year 1999- 2000. It has been decided that during 2000-2001 there will be two nationwide rounds of pulse polio immunization in December 2000 and January 2001, one sub national round of immunization in the high and mid burden zones and an additional sub national round in the high burden zone. Every effort will be made to improve routine immunization.

National Polio Surveillance Programme (NPSP)

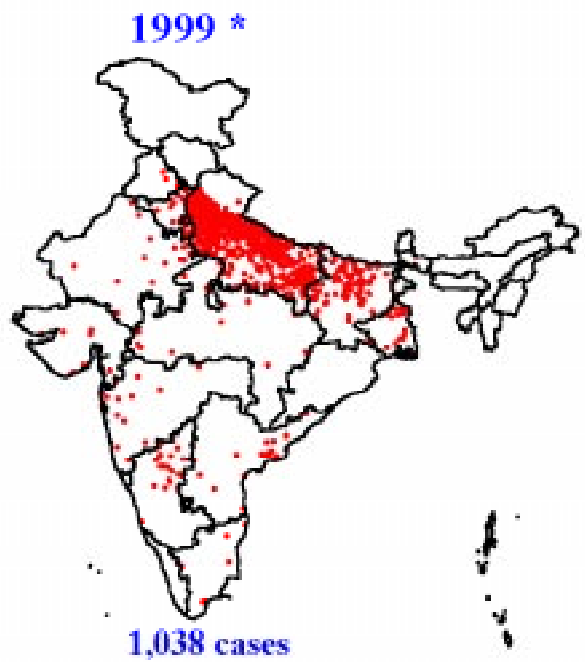
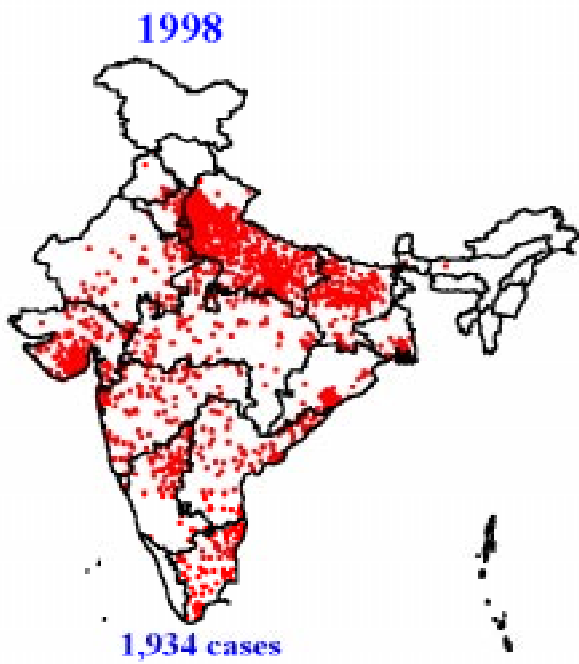
26. National Polio Surveillance Programme was started in 1997 with DANIDA and USAID assistance and is working under the management of World Health Organization (WHO). The programme has helped in detection of cases, case investigations, laboratory diagnosis and mop-up immunization. It is proposed that the management of NPSP is ultimately transferred to the Government of India (GOI). The programme will slowly introduce surveillance of other vaccine preventable diseases. It is a matter of concern that during the nineties there has not been any substantial progress in this regard.

Monthly incidence of polio in India, January 1994 – December 1999 *



Locations of polio virus in India

1 dot = 1 case



* data as on 22nd January 2000

Child Health Programmes

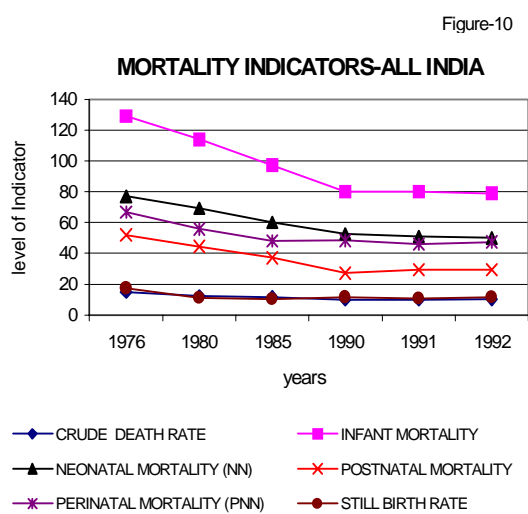
27. In the nineties the reduction in IMR has been slow. Over the last two decades the peri-natal and neo-natal mortality rates have not declined (Figure-10).

Ninth Plan Strategy & Goal:

- To reduce infant and under five mortality and morbidity so that there is a reduction in desired level of fertility.
- In all states reduction in peri- natal and neonatal mortality will be achieved through universal screening for risk factors during pregnancies, labour and neonatal period, identification and referral of 'at risk' mother and neonates to facilities where appropriate care could be provided.
- Simultaneously efforts will be made to reduce IMR due to infections and under nutrition by appropriate interventions

Essential Newborn Care

28. Equipment for essential newborn care has been supplied to all districts in the country under the RCH Programme. Medical officers and para medical personnel are being trained at the district hospitals and medical colleges in the use of the equipment to provide essential newborn care. States have been advised to send proposals for filling the gaps in equipment to augment the available facilities. Proposals received from 8 States are being processed. This component of child health care requires focussed attention during the Ninth Plan so that the goal set can be met. It is important to put into operation this component and achieve reduction in neonatal and peri-natal mortality in all states to achieve further reduction in



Source:- Registrar General India

IMR; This is specially important in states where IMR is below 60/1000.

Diarrhoeal Disease Control

29. Diarrhoea is one of the leading causes of death among children. The Oral Rehydration Therapy Programme was started in 1986-87 and implemented in a phased manner. During 1997-98 and 1998-99 provision was made for supply of 400.50 lakh ORS packets in each year as a part of the sub-centre kits. In order to make Oral Rehydration Solution (ORS) packets widely available, States have been advised to market ORS packets through the Public Distribution System. The programme requires focussed attention in states with high infant mortality; effective implementation of this simple intervention can result in substantial decline in IMR in states with high IMR.

Acute Respiratory Infections Control.

30. Pneumonia is a leading cause of deaths of infants and young children in India, accounting for about 30% of the under-five deaths. The programme includes the training of ANM on recognition of pneumonia and its treatment with cotrimoxazole. The programme is now being implemented in all districts in the country. Rational treatment of ARI and prevention of deaths due to pneumonia is now an integral part of the RCH Programme. There is a need to improve coverage and quality of care under these programmes especially in states where infant mortality continues to be very high.

Health Care For Adolescents

Ninth Plan Strategy

At the moment there are no specific health or nutrition programmes to address the problem of adolescents. Efforts to educate the girl, her parents and the community to delay marriage will receive focussed attention during the Ninth Plan. There is an urgent need to mount programmes for early detection and effective management of nutritional (under-nutrition, anemia) and health (infections, menstrual disorders) problem in adolescent girls.

31. The following initiatives have been taken during the Ninth Plan:

- health care needs of adolescents are being addressed under the RCH Programme
- Inter-sectoral coordination with Integrated Child Development Scheme (ICDS) is being strengthened in blocks where ICDS Centres have an adolescent care programme.
- proposals for specialised counselling and Information Education and Communication (IEC) material to be provided through Non Governmental Organizations (NGOs) are being sought under the NGO programme.

The progress in the efforts will have to be carefully monitored.

Men's Participation In Planned Parenthood Movement

Ninth Plan Strategy

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 are essential pre-requisites for STD as well as pregnancy prevention. Vasectomy which is safer and simpler than tubectomy should be repopularised.

Progress and Suggestions

32. Department of Family Welfare has taken steps to popularise vasectomy including training of surgeon in noscalpel vasectomy technique. Some states like Andhra Pradesh have reported substantial increase in vasectomy in some districts. It is expected that its

acceptance will increase if appropriate IEC strategies are adopted and efforts are made to improve access and address convenience of men. Steps are being taken to increase involvement of men in family welfare activities. These initiatives need to be effectively implemented.

Logistics Support

33. The Central Government 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 for their distribution. As a result there are delays, deterioration in quality and wastage of drugs. Supplies under FW Programme is about Rs.500 crores per annum. It is estimated that the losses due to deterioration and inefficiencies may be to the extent of 20-30%.

Ninth Plan Strategy is to ensure uninterrupted supply of essential drugs, devices, vaccines and contraceptives, adequate in quantity and appropriate in quality.

Progress in Ninth Plan

34. The Department of Family Welfare (DOFW) in collaboration with different donor agencies working in different states has formulated logistic project for each major State through consultants engaged for the purpose. To ensure efficiency, the State Government agency will be paid only on the basis of a percentage of supplies it handles. Logistics project in some states have already been approved. The project requires close monitoring. The facilities being created should handle all 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 has to be monitored and appropriate mid course corrections are to be initiated.

Strategies For Improving Performance

35. A vast infrastructure for delivery of health and family welfare services has been created over the last three decades utilising uniform norms for the entire country. Factors responsible for the sub-optimal performance include:

- a. absence of proper medical hierarchy with well defined functions;
- b. lack of first line supervision and mechanism to bring about accountability;
- c. absence of referral system and lack of functional FRUs.

36. During the Ninth Plan, it is envisaged that efforts will be made to improve efficiency by undertaking task analysis, assigning appropriate duties/ tasks to designated functionaries and training them to act as a multi-professional team; the community, the link worker and the health functionaries will be performing the tasks that they are best suited to do and the implementation of the programme will improve because of effective coordinated functioning of the entire system.

37. DOFW has invested heavily in training of Programme Managers and health service personnel in decentralised district-based planning, implementation, monitoring and mid-course corrections in RCH Programme; managerial aspects are also covered

during the training. It is expected that these will promote effective functioning and improve efficiency.

Monitoring And Evaluation

38. Currently, the following systems are being used for monitoring programmes in the Family Welfare Programme:

- a) Services reporting system;
- b) Sample Registration System (SRS) and Census Data;
- c) Research Studies especially designed to look into specific problems

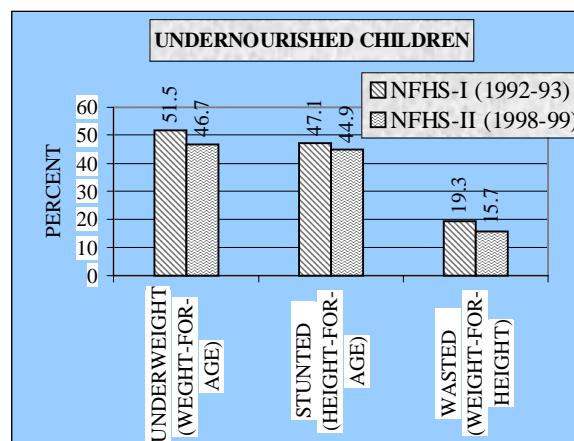
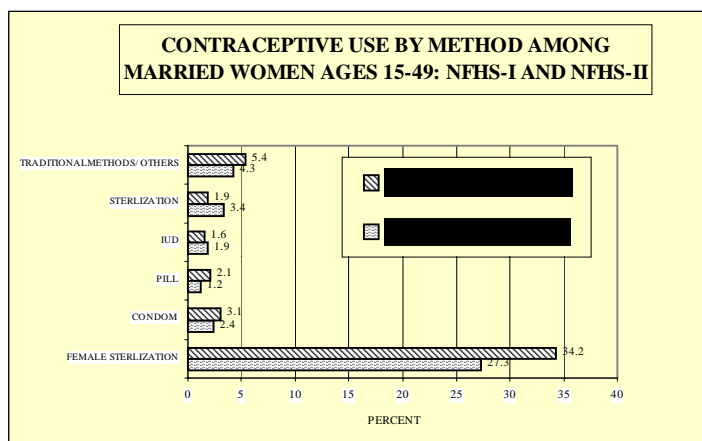
39. DOFW has constituted regional evaluation teams which carry out regular verifications and validate the acceptance of various contraceptives. These evaluation teams will be used to obtain vital data on failure rates, continuation rates and complications associated with different family planning methods.

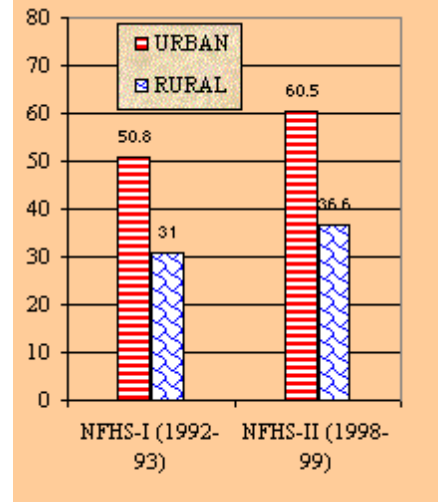
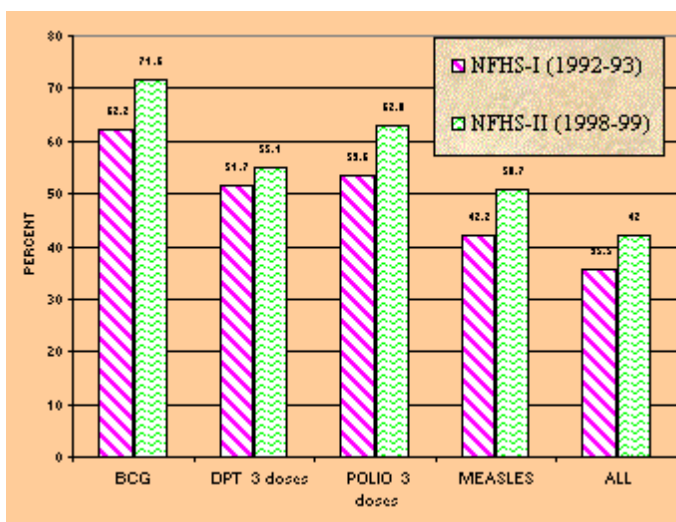
40. At present information about the progress on programme intervention as well as its impact is not available from the independent surveys at district level. DOFW had initiated a rapid household survey to obtain this information. All the districts were covered in a two-year period. The reports are being used to identify district-specific problems and rectify the programme implementation.

41. 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. So far data collection was completed in 101 districts. The survey results are being scrutinised and deficiencies found therein are being brought to the notice of the States and districts concerned for taking appropriate action. Planning Commission and DOFW have developed proforma for monitoring the infrastructure, manpower and equipment mismatch in the primary health care institutions. The format for monitoring the progress and quality indicators has been developed and sent to all the states.

42. DOFW, in collaboration with Registrar General of India (RGI), has set a target of 100% registration of births and deaths by the end of the Ninth Plan. Steps have also been initiated to collect, collate and report these data at PHC/District level on a yearly basis. 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. 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 RCH care annually. In districts where vital registration is over 70%, efforts are being stepped up to ensure that over 90% of births and deaths are reported so that an independent data base is available for planning as well as impact evaluation of PHC-based RCH care.

43. DOFW had conducted a National Family Health Survey in 1992-93 and again in 1998-99; the report of the second round is under finalisation.





44. Preliminary data from the NFHS –2 indicate that between 1992-93 and 1998-99, there was improvement in the couple protection rate, reduction in the unmet needs for contraception, improvement in the immunization coverage and reduction in under-nutrition. These findings of the independent survey on the performance of the FW programme are reassuring. There is apparent difference in the data reported through the service reporting and the NFHS regarding performance of the FW programme in the nineties; perhaps part of the decline in performance seen in the service data could be because the newly introduced reporting formats are not fully put into operation. It is imperative that steps are initiated for improving the service reporting and the information is utilized for monitoring and mid-course correction of the programme at district level.

Participation of NGOs in RCH Programme

45. Under the RCH programme the NGOs are being assisted at three levels:

- (a) **Small NGOs:** At the village, Panchayat and Block level small NGOs are being involved for advocacy of RCH and family welfare practices and for counselling. As these small NGOs have limited resources, they are being assisted through the mother NGOs. In addition, some NGOs are to be assisted for providing spacing or terminal methods of contraception and for counselling.
- (b) **Mother NGO:** DOFW proposes to recognise one mother NGO for every 8 to 10 districts. NGOs with substantial resources and proven competence are being approved as mother NGOs. So far 49 mother NGOs have been identified. The mother NGOs are required to screen credentials of the applicant small NGOs, obtain proposals from them, consider them for sanction, release money and monitor their work and obtain utilisation certificate from them. The mother NGOs are also required to provide training to the staff of the small NGO for both management of the NGO and for management of the programme.
- (c) **National NGOs:** A limited number of National NGOs are being assisted by the Department on project basis for innovative programmes for introducing Baby Friendly Practices in hospitals, for helping in enforcement of Prenatal Diagnostics Technique Act by detecting offending sex determination clinics and collecting evidence to make specific complaints against them to the designated authorities in the State.

46. The concept of small NGOs being supervised by Mother NGOs may dilute their autonomy; however in a technical field such as RCH many NGOs may benefit from the help provided by the experienced larger NGO. The progress in these efforts is being monitored.

Role Of Panchayati Raj Institutions In F.W Programme

The Ninth Plan envisaged involvement of Panchayati Raj Institutions for:

Ensuring inter-sectoral coordination and community participation in planning, monitoring and management of the RCH programme.

Assisting the states in supervising the functioning of health care related infrastructure and manpower such as Sub-Centres (SCs), Primary Health Centres (PHCs) and Aganwadis.

Ensuring coordination of activities of workers of different departments such as Health, Family Welfare, ICDS, Social Welfare and Education etc. functioning at village, block and district levels.

Improving the acceptance of the FW programme through increased community participation.

There are massive differences between states in the implementation; i.e. States like Kerala have embarked on decentralized planning and monitoring programmes utilizing PRIs and have ensured devolution of powers and finances to PRIs. In other states the involvement is mainly in planning and monitoring without devolution of power and finances. In some states the PRIs have not yet participated in the programme. There is a need to constantly review the situation and initiate appropriate interventions.

Inter-Sectoral Coordination in Implementation of the FW Programme

48. Effective implementation of Family Welfare Programme involves a great deal of inter-sectoral coordination.

49. The Departments whose activities have close linkages with Family Welfare Programmes are the **Department of Women and Child Development, Human Resource Development, Rural Development, Urban Development, Labour, Railways, Industry and Agriculture**. All these Departments may involve their extension workers in propagating IEC messages about reproductive and child health care to the population with whom they work. Concerned Central and State departments like Department of Women & Child Development, Human Resources Development, Rural Development etc. may take steps to improve the status of girl child and of women, improving female literacy and employment, raising the age at marriage, generating more income in rural areas etc. Sectors such as Railways and Industry should provide Family Welfare Services to the workers and their families.

Research And Development

50. Under RCH Programme the Department of Family Welfare has constituted two expert committees namely Expert Committee for Research in Reproductive Health and Contraception under Modern System of Medicine and Expert Committee for Research in Reproductive Health and Contraception under ISM & H to examine proposals.

51. Indian Council of Medical Research (ICMR) is currently undertaking research in the following areas:

- a) basic research efforts for the development of newer technology for contraceptive drugs and devices in modern system of medicines and ISM&H to cater to the requirements of the population in the decades to follow.
- b) improving the contraceptive coverage for men and women by operational research
- c) operational research for improving the performance of Family Welfare Programme and socio-behavioural research to improve community participation for increased acceptance of family welfare services.
- d) creation and support of an appropriate institutional mechanism to test and ensure the quality control in products utilised in the programme.
- e) STI/RTI operational research for detection, prevention and management in different situations

National Population Policy

52. One of the major recommendations of the National Development Council (NDC) Sub Committee on Population was that a National Population Policy (NPP) should be drawn up to provide reliable and relevant policy framework not only for improving Family Welfare Services but also for measuring and monitoring the delivery of family welfare services and demographic impact in the new millennium. DOFW has drawn up the National Population Policy 2000. The Cabinet has approved the NPP 2000

53. The National Population Policy 2000 has set the following goals for 2010:

- i) Universal access to quality contraceptive services in order to lower the Total Fertility Rate to 2.1 and attaining two-child norm.
- ii) Full coverage of registration of births, deaths and marriage and pregnancy.
- iii) Universal access to information/ counseling services for fertility regulation and contraception with a wide basket of choices.
- iv) Infant Mortality Rate to reduce below 30 per thousand live births and sharp reduction in the incidence of low birth weight (below 2.5 kg.) babies.
- v) Universal immunization of children against vaccine preventable diseases, elimination of Polio by 2000 and near elimination of Tetanus and Measles.
- vi) Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- vii) Achieve 80% institutional deliveries and increase in the percentage of deliveries conducted by trained persons to 100%.
- viii) Containing Sexually Transmitted Diseases.
- ix) Reduction in Maternal Mortality Rate to less than 100 per one-lakh live births.

- x) Universalisation of primary education and reduction in the drop-out rates at primary and secondary levels to below 20% both for boys and girls.

54. National Commission on Population has been constituted under the Chairmanship of the Prime Minister of India and Deputy Chairman Planning Commission as Vice Chairman on 11th May 2000 to review, monitor and give direction for implementation of the National Population Policy with a view to achieve the goals set in the Population Policy. The first meeting of National Commission on Population was held on 22nd July 2000. Wide ranging discussions in the first meeting of National Commission on Population has given useful suggestions for pursuing the goal of population stabilization. A Strategic Support Group consisting of secretaries of concerned sectoral ministries has been constituted as standing advisory group to the Commission. Nine Working Groups are being constituted to look into specific aspects of implementation of the programmes aimed at achieving the targets set in NPP 2000.

55. To facilitate the attainment of the goals set under NPP 2000 by the National Commission on Population an Empowered Action Group attached to the Ministry of Health & Family Welfare and a National Population Stabilisation Fund are being set up. A seed contribution of Rs.100 Crores has been provided to National Population Stabilisation Fund; corporate, industry, trade organizations and individuals may also contribute to the fund.

Funding Of The National Family Welfare Programme

56. The National Family Welfare Programme is a hundred percent centrally sponsored programme and is being implemented through the state governments. The Department of

Ninth Plan recommended:

1. Rationalisation, restructuring and reorganization of infrastructure and manpower funded by the DOFW
2. Revision of norms for funding so that the arrears payable to the states do not mount

Family Welfare provides funds to the state governments for maintenance of health and family welfare infrastructure and implementation of the programme according to certain fixed norms. The Department reimburses to the states the expenditure after receiving audited statement of Accounts. The plan funds of the Department of Family Welfare are being utilized for meeting the expenditure on salaries, recurrent provision for rent, contingencies etc. which is essentially non-plan in nature.

57. A Consultative Committee constituted by the Department of Family Welfare to revise the norms has been looking into rationalization of infrastructure and manpower created under different programmes at different times so that the Centre and the States both fund the relevant portion of the programme. The programme components which can be handed over to the State Governments but continue to be funded by the Department of Family Welfare at the Centre are being identified. The shifting of the maintenance of infrastructure from the Department of Family Welfare to the States and vice versa is being carefully worked out so that there is no additional financial burden on the States or the Centre during the Ninth Five Year Plan. The proposal and recommendations of the Consultative Committee are being discussed with the State Governments for evolving a

consensus. The recommendations made in the Ninth Plan Document, recommendations of the Consultative Committee and the views of Planning Commission on the reorganization of infrastructure and manpower being maintained by the Department of Family Welfare are at Annexure-I.

58. The outlays for the Ninth Plan and Annual Plans are given in Annexure-II.

**REORGANISATION OF THE INFRASTRUCTURE AND MANPOWER BEING CURRENTLY MAINTAINED BY
DEPARTMENT OF FAMILY WELFARE**

Scheme	Outlay (Rs.Crores)		Recommendation for the Ninth Plan	Recommendations of the Consultative Committee	Comments of Planning Commission to the Recommendations of Consultative Committee
	1998-99	1999- 2000			
Rural F W Centres (Established at all block level PHCs before 1980. There are 5435 such functioning centers)	265.00	350.00	To be made part of the state primary health care infrastructure	The States to take over the maintenance of Rural FW Centres	Planning Commission supports this Recommendations of Consultative Committee
Sub-Centres (Funded by the Deptt. of FW 97757 Funded by States 38782)	340.00	525.00	All ANMs to to fully funded under FW programme	Deptt. of FW to provide for the maintenance of all the SCs.	
Maintenance of Urban FW Centres & Revamping of urban level organization There are 871 health posts functioning in ten states and two UTs There are 1083 Urban FW Centres	64.00	58.00	States to set up well structured urban primary health care infrastructure; Funding from Deptt. of Family Welfare ANMs only; ANMs will come mainly by redeployment & gap, if any will be filled.	To set up: Urban Health Centres per 10000 slum population Urban Primary Health Centres per 50000 slum population	
Post Partum Centres There are 550 district level PP centres and 1012 sub-district level PP centres which provide MCH and family planning services.	100.00	120.00	All district level PP Centres to be taken over by the states and merged with Deptts. of Obst./Gyna. Of the respective hospitals during Ninth Plan Sub-district level PP Centres to be merged with PHCs/CHCs	PP Centres to be continued to be supported by the Deptt. of FW	
Direction & Administration Under the existing norms the central assistance is restricted to 7.5%/ 8.33% of the total allocation to the state/UT under the National Family Welfare Programme in the year 1985-86.	92.00	185.50		The states with more than/less than one crore population will be entitled to 8%/12% of the audited expenditure on the Family Welfare Programmes or the actual expenditure whichever is less.	The Commission supports this recommendation.
Sterilisation beds	1.70	1.70		To evaluate the Scheme for better functioning	
Basic training schools There are 509 ANM Training Schools, 44 LHV Training Schools and 47 Health & Family Welfare Training Centres that provide training to ANMs, LHVs and in-service training to medical and Para-medical personnel at the regional level.	39.95	61.90		To be maintained by the Deptt. of FW as at present	Shift to States as training is their function
Arrears	250.00	200.00			Deptt. of FW to revise norms for the salaries and reimburse to the States actual salary costs based on audited statements of accounts
Total (Infrastructure)	1152.65	1502.10			
Total	2489.35	2920.00			

DEPARTMENT OF FAMILY WELFARE

(Rs. in Crore)

Scheme	Eighth Plan Outlay	1996-97 Approved outlay	Ninth Plan Approved outlay	1997-98 Approved outlay	1998-99 Approved outlay	1999-2000 Approved outlay	2000-2001 approved outlay
1	2	3	4	5	6		8
1 Rural Family Welfare Centres	1040.00	160.00	1500.00	200.00	265.00	350.00	375.00
2 Sub-Centres	1233.30	190.00	2200.00	260.00	340.00	525.00	575.00
3 Maintenance of urban FW Centres	100.00	15.00	120.00	20.00	30.00	27.00	28.00
4 Revamping of urban level organisation	86.70	18.00	130.00	30.00	34.00	31.00	32.00
5 Direction & Administration	304.40	48.60	700.00	57.00	92.00	185.50	116.00
6 Sterilisation beds	8.70	2.00	8.60	2.00	1.70	1.70	1.50
7 Post Partum Centres	328.70	49.00	530.00	70.00	100.00	120.00	120.00
8 Basic Training Schools	179.40	27.45	240.00	30.35	39.95	61.90	63.75
9 Training in No-scalpel vasectomy	----	0.55	0.50	0.50	0.00	0.00	0.00
10 Village Health Guides Scheme	140.00	10.00	50.00	10.00	10.00	10.00	5.00
11 Sterilisation and IUD insertion	666.70	100.00	600.00	90.00	100.00	140.00	120.00
12 Community incentive scheme	----	0.00	265.00		25.00	0.00	0.00
13 Transport	105.30	26.00	150.00	32.00	27.50	43.00	40.00
14 Contraceptives	456.70	143.00	930.00	163.85	172.00	247.50	224.70
15 Procurement of cold chain Equipment	----	0.00	150.00		0.00	50.00	5.00
16 Hindustan Latex Ltd.	3.30	1.25	1.90	1.50	0.10	0.10	0.00
17 Travel of Experts/Conferences /Meetings etc.	----	0.00	16.10	10.10	1.50	1.50	1.00
18 Reseach Institutes	75.40	15.46	124.00	18.90	26.80	25.50	28.45
19 International Contribution	5.34	1.05	6.30	1.10	1.30	1.30	1.30
20 Research & Evaluation	5.56	3.04	4.70	4.70	0.00	20.00	
21 Involvement of NGOs and SCOVA	13.30	8.50	14.50	8.50	6.00	26.00	
22 Information, Education and Communication	127.00	43.00	170.00	60.60	28.00	31.20	30.00
23 Reproductive & Child Health/MCH	635.00	350.10	5000.00	450.00	758.00	630.80	743.00
24 Area Project	400.00	195.00	800.00	150.00	120.00	100.00	250.00
25 USAID Assisted U.P.Project	----	40.00	250.00	40.00	60.00	70.00	60.00
26 WACH Project	----	0.50	0.50	0.50	0.00	0.00	0.00
27 Arrears	500.00	20.00	950.00	79.00	250.00	200.00	700.00

Annexure-II (Contd)

DEPARTMENT OF FAMILY WELFARE

(Rs. in Crore)

	Scheme	Eighth Plan Outlay	1996-97 Approved outlay	Ninth Plan Approved outlay	1997-98 Approved outlay	1998-99 Approved outlay	1999-2000 Approved outlay	2000-2001 approved outlay
	1	2	3	4	5	6		8
28	Others/New Initiatives	48.70	50.85	208.40	38.75	0.50	21.00	
	(a) Logistics Improvement			80.00	1.35	0.50	20.00	
	(b) F.W. Counsellor Scheme			1.00	0.00		1.00	0.00
	(c) School Health Scheme			127.00	37.00			
	(d) Others			0.40	0.40			
29	Flexible Approach Scheme	3.30	15.00					
30	Hepatitis-B Vaccination	----	0.00					
31	FW Programme through central Ministries	33.20	1.65					
32	Maternity Benefit Scheme							1.00
	GRAND TOTAL	6500.00	1535.00	15120.50	1829.35	2489.35	2920.00	3520.00

