CHAPTER 2.10

FAMILY WELFARE

Introduction

2.10.1 India is the second most populous country in the world, sustaining 16.7 per cent of the world population on 2.4 per cent of the world's surface area. Realising that high population growth is inevitable during the initial phases of demographic transition and the urgent need to accelerate the pace of the transition, India became the first country to formulate a National Family Planning Programme in 1952. The objective of the policy was "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 that "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". This statement preceded the International Conference on Population and Development (ICPD) 1994 by four decades.

2.10.2 The focus of India's health services right from the early 1950s has been health care for women and children and provision of contraceptive services. Successive Five- Year Plans have been providing the policy framework and funding for the planned development of nation wide health care infrastructure and manpower. The centrally sponsored and 100 per cent centrally funded Family Welfare Programme provides the states the additional infrastructure, manpower and consumables needed for improving the health status of women and children and to meet all the felt needs for fertility regulation.

2.10.3 Technological advances and the improved quality and coverage of health care resulted in a rapid fall in the crude death rate (CDR) from 25.1 in 1951 to 9.8 in 1991. In contrast, the reduction in crude birth rate (CBR) has been less steep, declining from 40.8 in 1951 to 29.5 in 1991. As a result, the annual exponential population growth rate has been over 2 per cent in the 1971-1991 period. The pace of demographic transition in India has been relatively slow but steady. The 1991 Census

The NDC Sub-Committee on Population recommended that there should be a paradigm shift in the Family Welfare Programme and the focus should be on:

- Decentralised area-specific planning based on need assessment.
- Emphasis on improved access and quality of services to women and children.
- Providing special assistance to poorly performing states/districts to minimise the differences in performance.
- Creation of district-level databases on quality, coverage and impact indicators for monitoring the programme.

The International Conference on Population and Development (ICPD) at Cairo in 1994 advocated a similar approach.

A convergence between national (NDC Sub-Committee) and international (ICPD) efforts improved funding of Family Welfare Programme during the Ninth Plan period.

showed that the population growth rate fell below 2 per cent after three decades. In order to give a new thrust to efforts to achieve a more rapid decline in birth rate, death rate and population growth rate, the National Development Council (NDC) set up a Sub-Committee on Population (1992) and endorsed its recommendations in 1993.

2.10.4 During the Ninth Plan period, the Department of Family Welfare implemented the recommendations of the NDC Sub Committee. Centrally-defined method specific targets for family planning were abolished. The emphasis shifted to decentralised planning at the district level, based on assessment of community needs and implementation of programmes aimed at fulfilment of these needs. State specific goals for process and impact parameters for maternal and child health and contraceptive care were worked out and used for monitoring progress. Efforts were made to improve the quality and content of services through training to upgrade skills for all personnel and building up a referral network. A massive pulse polio campaign was taken up to eliminate polio. The Department of Family Welfare set up a consultative committee to suggest appropriate restructuring of infrastructure funded by the states and the centre and revise norms for re-imbursement by the centre and has started implementing the recommendations of the Committee. Monitoring and evaluation has become a part of the programme and the data is used for mid-course corrections. The Department has drawn up the National Population Policy 2000(NPP 2000), which aims at achieving replacement level of fertility by 2010. A National Commission on Population was constituted in May 2000, in line with the recommendations of the NPP 2000.

2.10.5 Currently some of the major areas of concern include:

- the massive inter-state differences in fertility and mortality;fertility and mortality rates are high in the most populous states, where nearly half the country's population lives;
- gaps in infrastructure, manpower and equipment and mismatch between infrastructure and manpower in primary health centres (PHCs)/ community health centres (CHCs); lack of referral services;
- slow decline in mortality during the 1990s; the goals set for mortality and fertility in the Ninth Plan will not be achieved;
- there has been no decline in the maternal mortality ratios over the last three decades, while neonatal and infant mortality rates have plateaued during the 1990s;
- 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 training to improve skills for the delivery of integrated reproductive and child health (RCH) services, the progress in in-service training has been very slow and the anticipated improvement in the content and quality of care has not taken place;
- evaluation studies have shown that the coverage under immunisation is not universal even in the best performing states while coverage rates are very low in states like Bihar; elimination of polio is yet to be achieved;
- the logistics of drug supply has improved in some states but remains poor in populous states;
- decentralised district-based planning, monitoring and mid-course correction utilising the locally generated service data and Civil Registration has not yet been operationalised.

Approach during the Tenth Plan

3.10.6 During the Tenth Plan, the paradigm shift, which began in the Ninth Plan, will be fully operationalised. The shift was from:

- demographic targets to *focussing on enabling 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 program for 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 meet the needs;*
- service provision based on providers' perception to *addressing choices and conveniences of the couples.*

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

- the large size of the population in the reproductive age-group (accounting for an estimated 60 per cent of the total population growth);
- higher fertility due to the unmet need for contraception (contributing to around 20 per cent of population growth); and
- high wanted fertility due to the prevailing high Infant Mortality Rate (IMR) and other socio-economic reasons (estimated contribution of about 20 per cent to population growth).

2.10.8 The Tenth Plan will fully operationalise efforts to:

- assess and meet the unmet needs for contraception;
- achieve reduction in the high desired level of fertility through programmes for reduction in IMR and maternal mortality ratio (MMR); and
- enable families to achieve their reproductive goals.

2.10.9 If the reproductive goals of families are fully met the country will be able to achieve the National Population Policy goal of replacement level of fertility by 2010. The medium and long term goals will be to continue this process to accelerate the pace of demographic transition and achieve population stabilisation by 2045. Early population stabilisation will enable the country to achieve its developmental goal of improving the economic status and quality of life of the citizens.

2.10.10 Reductions in fertility, mortality and population growth rate will be major objectives during the Tenth Plan. Three of the 11 monitorable targets for the Tenth Plan and beyond are:

- reduction in IMR to 45 per 1,000 live births by 2007 and 28 per 1,000 live births by 2012;
- reduction in maternal mortality ratio to 2 per 1,000 live births by 2007 and 1 per 1,000 live births by 2012; and
- reduction in decadal growth rate of the population between 2001-2011 to 16.2.

Population Projections

2.10.11 The Technical Group on Population Projections under the Chairmanship of the Registrar General, India (RGI) constituted by the Planning Commission in 1996 had made population projections up to the year 2016 based on the results

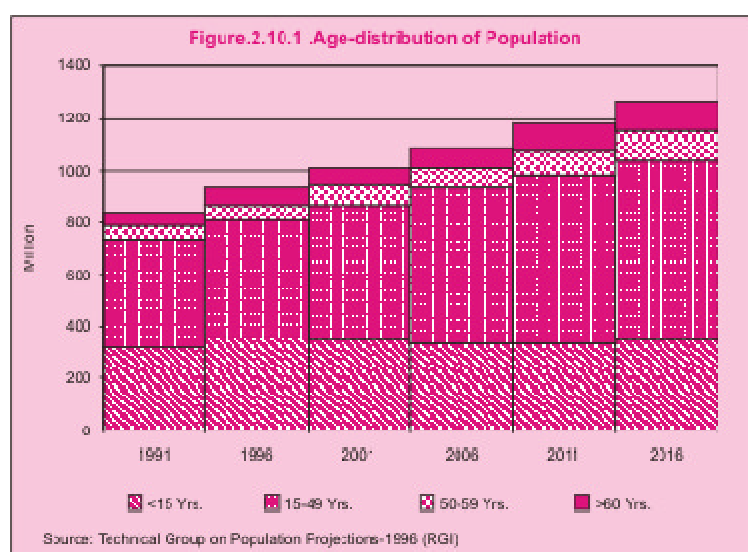


Figure.2.10.1 .Age-distribution of Population

Source: Technical Group on Population Projections-1996 (RGI)

of 1991 Census. The projections for different age groups are shown in Figure 2.10.1. It then estimated the probable year by which the replacement level (Total Fertility Rate) of 2.1 will be achieved by different states if the recent pace of decline in TFR observed during 1981-93 continues. The Group estimated that the country would achieve the replacement level of fertility by 2026. The most populous states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh will achieve the replacement level of fertility by 2039, 2060, 2048 and after 2100 respectively.

Census 2001

2.10.12 The 2001 Census showed that India's population was 1.02 billion in 2001,15 million more than the projections made by the Technical Group on Population Projections. Comparison of the projections with the Sample Registration System (SRS) data indicates that projections regarding both the birth and death rates were substantially lower. The decadal growth rate has declined from 23.86 per cent for 1981-91 to 21.34 per cent for 1991-2001. (Figure2.10.2). Tamil Nadu and Karnataka have attained replacement level of fertility and Andhra Pradesh has shown a remarkable fall in fertility and decadal growth rate during the 1990s. The decadal growth rate in a majority of the states has shown a decline. Only Bihar has shown a substantial increase in the decadal growth rate. The National Population Policy has set the goal that the country will achieve the replacement level of fertility by 2010. If this is achieved, the decade 2001-2011 will witness a very steep decline in decadal growth rate.

Population Projections for the Tenth Plan

2.10.13 Prior to the formulation of the Tenth Plan it is not possible to make full scale projections taking into account the trends during the 1990s as the data on age and sex distribution of the population from 2001 Census is not yet available. The Department of Family Welfare made the necessary 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 (Table 2.10.1).

Interstate Differences

2.10.14 The projected values for the total population in different regions is shown in the Figure 2.10.3. There are marked differences between states in size of the population, projected population growth rates and the time by which TFR of 2.1 is likely to be achieved. If the present trend continues, most of the southern and the western states are likely to achieve TFR of 2.1 by 2010.

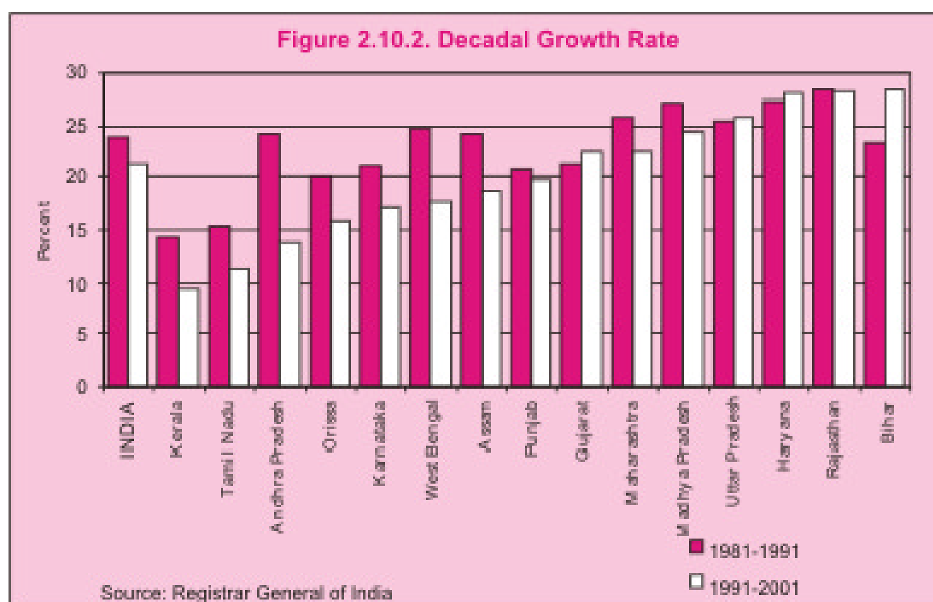
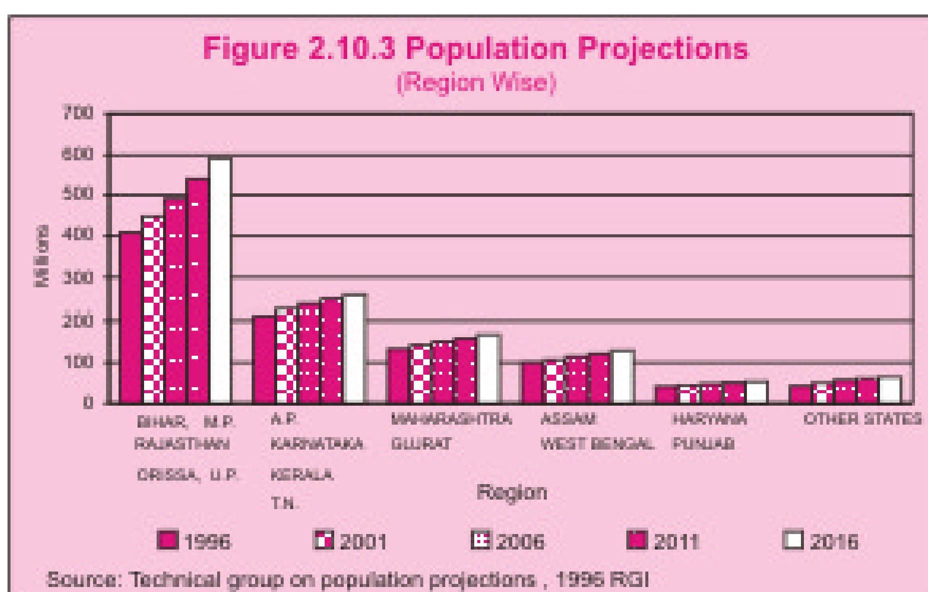


Table 2.10.1
Population Projections Adjusted For The 2001 Census Totals

Year	1997	2002	2007	2012
Population (millions)*	951.18	1028.93	1112.86	1196.41
Population (millions)**	965.28	1044.18	1129.35	1214.14

*Technical Group on Population Projections–1996;
**Adjusted for the 2001 census totals
Source: Deptt of F.W.

Urgent energetic steps to assess and fully meet the unmet needs for maternal and child health (MCH) care and contraception through improvement in availability and access to service are needed in Rajasthan, Orissa, Uttar Pradesh, Madhya Pradesh and Bihar (before division) in order to achieve a faster decline in their mortality and fertility rates. The performance of these states would determine the year and size of the population at which the country achieves replacement level of fertility. It is imperative that special efforts are made during the next two decades to break the vicious self-perpetuating cycle of poor performance, poor per capita income, poverty, low literacy and high birth rate in the populous states so that further widening of disparities between states in terms of per capita income and quality of life is prevented. An Empowered Action Group has been set up to provide special assistance to these states. The benefits accrued from such assistance will depend to a large extent on the states' ability to utilize the available funds and improve services and facilities.



Inter state differences

There are massive inter state differences in population, population growth rates, time by which TFR of 2.1 and population stabilisation will be achieved.

These differences will have a major impact on :

- health and nutritional status.
- education and skill development.
- appropriate employment with adequate emoluments.
- rural – urban and inter state migrations.
- social and economic development.

The effort is to provide adequate inputs to improve performance so that the disparities between states are narrowed.

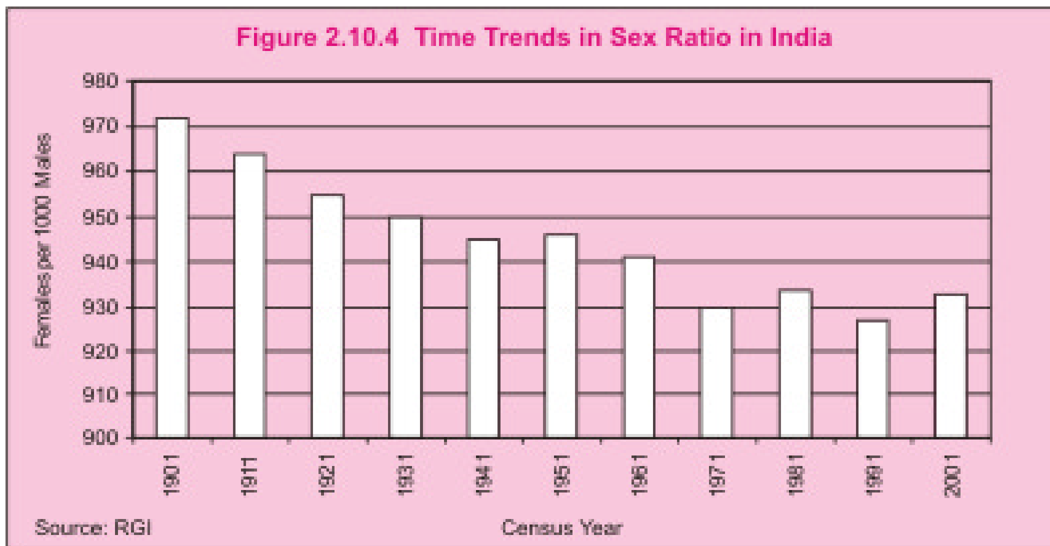


Figure 2.10.4 Time Trends in Sex Ratio in India

Gender Bias

2.10.15 The reported decline in the sex ratio during the current century has been a cause for concern (Figure 2.10.4). The factors responsible for this continued decline are as yet not clearly identified. However, it is well recognised that the adverse sex ratio is a reflection of gender disparities. There is an urgent need to ensure that all sectors collect and report sex disaggregated data. This will help in monitoring for evidence of gender disparity. Continued collection, collation, analysis and reporting of sex disaggregated data from all social sectors will also provide a mechanism to monitor whether girls and women have equal access to these services.

2.10.16 The census based estimates of sex ratio in the 0-6 age group show massive inter-state differences (Figure 2.10.5). In addition, data indicate that over the last three decades there has been a decline in the 0-6 sex ratio. (Table 2.10.2) There had been speculation as to whether female infanticide, sex determination tests and selective female foeticide are, at least in part responsible for this. The Government of India has enacted a legislation banning the prenatal sex determination and selective abortion while female infanticide is a cognizable offence. However, unless there is a change in social attitudes, these legislations cannot achieve the desired change. Intensive community education efforts to combat these practices, especially in

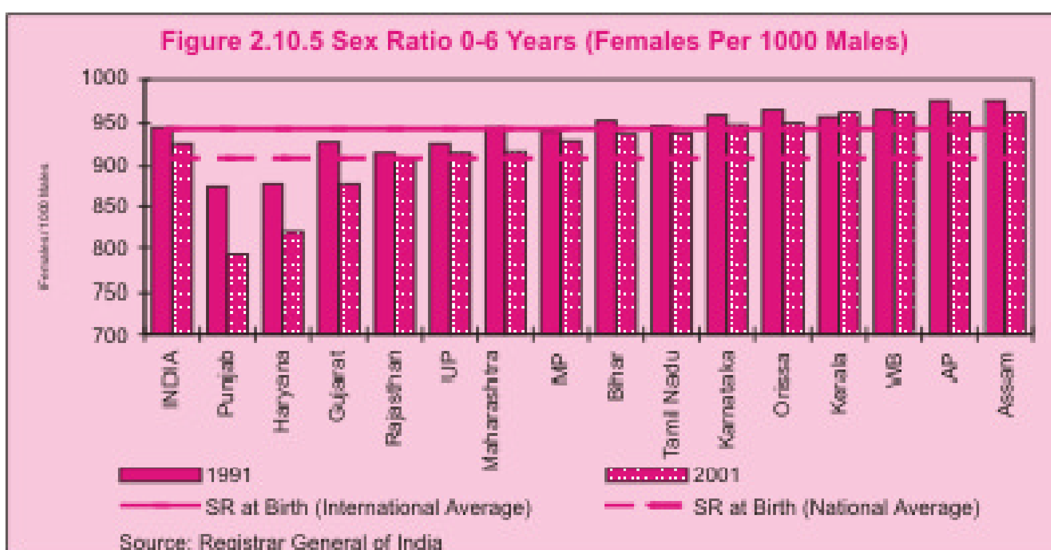


Figure 2.10.5 Sex Ratio 0-6 Years (Females Per 1000 Males)

Table 2.10.2

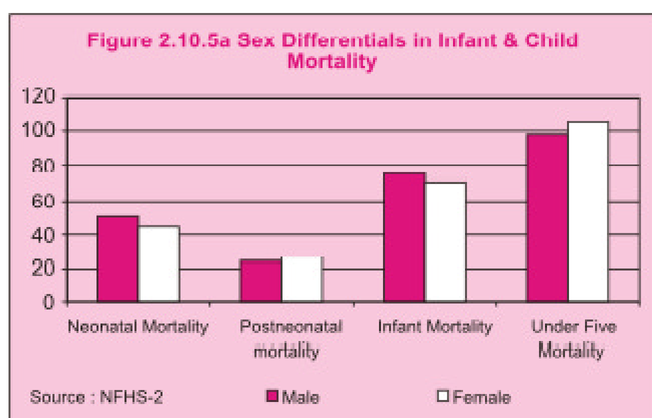
Child sex ratio (Females/1000 Males)

Year	Urban	Rural	Total
1981	931	963	962
1991	935	947	945
2001	903	934	927

Source : RGI

pockets from where female infanticide and foeticide have been reported, are urgently required.

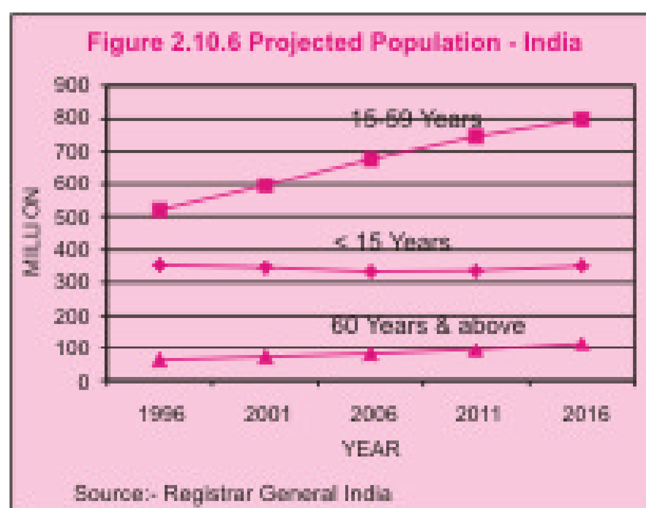
2.10.17 The National Family Health Survey clearly brought out the sex differentials in the neonatal, post neonatal, infant and under five mortality rates . As there is no biological reason for the higher mortality among the girl children these differences are an indication of existing gender bias in caring for the girl child (Figure 2.10.5a).



2.10.18 In the reproductive age-groups, the mortality rates among women are higher than those among men. The continued high maternal mortality is one of the major factors responsible for this. Effective implementation of the RCH programme is expected to result in a substantial reduction in maternal mortality. Currently, the longevity at birth among women is only marginally higher than that among men. However, the difference in life expectancy between men and women will progressively increase over the next decade. Once the reproductive age group is crossed, the mortality rates among women are lower. Women will outnumber men in the over-60 age- group. Departments of Health, Family Welfare and Women and Child Development are initiating steps to ensure that these women get the care they need .

Population Projections and their Implications for the Family Welfare Programme

2.10.19 The projected population of India in the three major age groups (less than 15, 15-59, 60 years or above) between 1996 and 2016 are shown in Figure 2.10.6. In the country as a whole, there will be a marginal decline in less than 15 years of age population (352.7 million to 350.4 million), even though in poorly performing states there will be continued increase in the number of children requiring care. The health care infrastructure will, therefore, not be under pressure to provide care to an ever increasing number of children. They will be able to concentrate on:



Age group < 15 years

There will be no increase in numbers. Focus will be to improve:

- quality and coverage of health and nutrition services and achieve improvement in health and nutritional status
- improve access to education & skill development

- improving quality of care;
- improving on antenatal, intra natal and neonatal care aimed at reducing neonatal morbidity and mortality;

- improving coverage for immunisation against vaccine preventable diseases;
- promoting inter sectoral coordination especially with the ICDS programme so that there is an improvement in health and nutritional status; and
- improving coverage and quality of health care to vulnerable and underserved adolescents.

2.10.20 The economic challenge is to provide needed funds so that these children have access to nutrition, education and skill development. The challenge faced by the health sector is to achieve reduction in morbidity and mortality rates in infancy and childhood, to improve nutritional status and eliminate ill effects of the gender bias.

Age group 15-59 years

The challenge is the massive increase in the number of people in this age group. They will:

- need wider spectrum of services :
  - maternal and child health services
  - contraceptive care
  - gynaecological problems
  - RTI /STD management
- expect better quality of services
- expect fulfillment of their felt needs for MCH/family planning care.

Opportunity is that if their felt needs are met through effective implementation of RCH programme, it is possible to accelerate demographic transition and achieve rapid population stabilisation.

2.10.21 There will be a massive increase of population in the 15-59 age group (from 519 million to 800 million). The RCH care has to provide the needed services for this rapidly growing clientele. The population in this age group is more literate and has greater access to information. These people will, therefore, have greater awareness and expectation regarding both access to a wide spectrum of health care related services and the quality of these services. The Family Welfare Programme has to cater to a wider spectrum of health care needs of this population– including maternal and child health (MCH) care, contraceptive care, management of gynaecological problems; the quality of services also needs to be improved.

2.10.22 There will be a substantial increase in the population more than 60 years (62.3 million to 112.9 million) in the next two decades. Increasing numbers of the population beyond 60 years would necessitate provisions for the management of some of the major health problems in this age group, including early detection and management of cancers.

Evolution of India's Family Welfare Programme

Basic premises of the Family Welfare Programme are:

- acceptance of Family Welfare services is voluntary;
- Family Welfare programme will provide:
  - integrated MCH and family planning services;
  - effective IEC to improve awareness;
  - easy and convenient access to Family Welfare services free of cost.

The 1950s

2.10.23 At the time of Independence, health care services were predominantly urban, hospital-based and curative. General practitioners well versed in maternal and child health and paediatricians and obstetricians provided health care to women and children. While they did provide comprehensive, integrated, good quality services, technology for detection and management of health problems was limited and out reach of services was poor. The majority of the population, especially those belonging to the poorer sections and those residing in rural areas, did not have access to health care, as a result of

which morbidity and morality rates among them were quite high. Many women died while seeking illegal induced abortion to get rid of unwanted pregnancy because they did not have access to contraceptive care. Conceptions that were too early, too close, too many and too late and lack of antenatal care to detect and treat problems in pregnancy resulted in high maternal and infant mortality rates. Antenatal, intrapartum, postnatal and contraceptive care was not readily available to women who required these services desperately.

2.10.24 Obstetricians, who were daily witnessing maternal morbidity and mortality associated with high parity, were willing to persuade their patients who had completed their families to undergo surgical sterilisation. The fact that the technique was simple, safe and effective and could be done soon after delivery under local anaesthesia accounted for the popularity of postpartum tubal sterilisation. The safety, simplicity and efficacy of vasectomy was also well recognised. For couples who had completed their family, sterilisation of one partner resulted in the reduction of maternal morbidity and mortality associated with high parity. To some extent, this was responsible for the decline in maternal mortality rates in urban areas during the 1950s. However, these measures had no impact on the mortality or fertility or the population growth rate of the country as a whole because of poor outreach, especially in rural areas. Thus, in the 1950s, good quality integrated maternal and child health care, and family planning services were available to those who were aware, had access and could afford the services of physicians. There were efforts to improve coverage and extend the services to rural areas as a part of the block development programme. However, resource and manpower constraints were responsible for the slow progress on this front.

The 1960s

2.10.25 In the 1960s, safe, effective vaccines for the prevention of six childhood diseases and effective contraceptives for birth spacing such as Lippe's loop became available. In order to make these available to people, effective programmes for delivery of identified priority services were drawn up by professionals and implemented through the limited health care infrastructure available in rural areas and supplemented by camps. The family planning and the immunisation programmes were among the earliest of such programmes. Subsequently, several other vertical programmes were added to the Family Welfare Programme. In an attempt to improve outreach, the camp approach was adopted for providing care to pregnant women and children and improving access to immunisation. However, these efforts did not result in any marked improvement in the health status of these vulnerable groups because the care was not available when needed and there were no referral services.

2.10.26 The 1961 census showed a rising decadal population growth rate due to declining death rates and unchanged birth rates.The health infrastructure is still predominantly urban-based. During the 1960s, sterilisation remained the focus of the National Family Planning Programme. Efforts were made to popularise vasectomy and to provide services in rural areas through camps. Tubectomy services, however, remained predominantly in urban hospitals. Moving health education out of hospitals into the community through the extension education approach was attempted to improve awareness and increase acceptance of family planning methods. Lippe's loop provided the first reliable birth spacing method for women in India. Following encouraging response in urban clinics, attempts were made to provide this spacing method to the rural population through camps. However, without the infrastructure to provide follow up services, the device fell into disrepute. It became obvious that it will not be possible to achieve any improvement in maternal and child health indices or reduce birth rates without substantial investment into infrastructure and manpower to provide the needed follow up services.

1970s

2.10.27 The 1970s witnessed many initiatives to improve the health and nutritional status of women and children. The Massive Dose Vitamin A programme, the National Anaemia Prophylaxis

Programme and food supplementation to pregnant and lactating women and pre-school children through the Integrated Child Development Services (ICDS) programme were major initiatives to tackle micronutrient deficiencies and under-nutrition and its adverse consequences in women and children. With the improvement in primary health care infrastructure, access to health care improved.

2.10.28 The 1971 Census showed that population explosion was no longer a potential threat but a major problem that needed to be tackled energetically. The Government gave top priority to the family planning programme and provided substantial funds for several new initiatives. Sterilisation, especially vasectomy services were made widely available. Intra-uterine devices (IUD) and condoms were made available through the PHCs. The hospital-based postpartum programme provided contraceptive care to women coming for delivery. The Medical Termination of Pregnancy (MTP) Act, 1972, enabled women with unwanted pregnancy to seek and obtain safe abortion services.

2.10.29 Increasing concern about the rapidly growing population led to the National Family Planning Programme being included as a priority sector programme during the Fifth Plan. The massive sterilisation drive of 1976 did result in eight million persons undergoing sterilisation, but this did not have any perceptible impact on the birth rate, as the cases were not appropriately chosen. There was a steep fall in acceptance in the very next year. In 1978, the Expanded Programme of Immunisation was initiated to improve coverage for the six vaccine preventable diseases. In 1979, the Programme was renamed as the National Family Welfare Programme and increasing integration of family planning services with those of maternal and child health and nutrition was attempted.

The 1980s

2.10.30 The major thrust during the 1980s was to operationalise the WHO's Alma Ata declaration of health for all by 2000 A.D. (1978) by establishing a net-work of centres in urban and rural areas to provide essential primary health care. The network of post partum centres was expanded to improve access to family welfare services. In 1983 the National Health Policy was formulated and provided comprehensive framework for planning, implementation and monitoring of health care services. The Universal Immunisation Programme (UIP), started in 30 districts in 1986, was extended to cover 448 districts by the end of the Seventh Plan.

The 1990s

2.10.31 The 1991 Census showed that India was entering the opportunity window in demographic transition, when larger proportion of the population is in the age group of 20-40 years, when it will be possible to achieve a rapid decline in fertility and mortality. The report of the NDC Sub Committee on Population gave a new thrust and dynamism to the family welfare programme. During the Eighth Plan, efforts were made under the Child Survival and Safe Motherhood initiative and the Social Safety Net programme to improve the access to maternal and child health services. In view of the massive inter-state and intra-state differences in access to services and health indices, the Department of Family Welfare abolished the practice of setting centrally defined, method-specific targets for contraception. It was replaced by decentralised area-specific need assessment (community needs assessment approach), planning and implementing programmes aimed at fulfilling these needs.

2.10.32 In 1997, the Department of Family Welfare initiated the Reproductive and Child Health (RCH) programme aimed at providing integrated health and family welfare services to meet health care needs of women and children. The components of the comprehensive RCH care is indicated in the Text Box. The essential components recommended for nationwide implementation at all levels include:

- prevention and management of unwanted pregnancy;
- services to promote safe motherhood;
- services to promote child survival; and
- prevention and treatment of RTI and sexually transmitted infection (STI).

Components of comprehensive RCH Care:

- Effective maternal and child health care.
- Increased access to contraceptive care.
- Safe management of unwanted pregnancies.
- Nutritional services to vulnerable groups.
- Prevention and treatment of RTI/ STD.
- Reproductive health services for adolescents.
- Prevention and treatment of gynaecological problems.
- Screening and treatment of cancers, especially uterine, cervical and breast cancer.

These services are available in secondary and tertiary care centres in the country.

Efforts are being made to improve the content, quality and coverage of care

2.10.33 Efforts were made to provide adequate inputs to improve the availability and access to RCH services and to improve the programme's performance especially in states/districts with poor health indices. Attempts to reduce disparities between states/districts and achieve incremental improvement in the indices by replication of the strategies adopted by better performing districts were encouraged.

National Population Policy

2.10.34 The immediate objective of the National Population Policy is to meet all the unmet needs for contraception and health care for women and children. The medium-term objective is to bring the TFR to replacement level (TFR of 2.1) by 2010 and, the long-term objective is to achieve population stabilisation by 2045.

2.10.35 The Policy has set the following goals for 2010:

- universal access to quality contraceptive services in order to lower the TFR to 2.1 by adopting the small family norm;
- universal registration of births and deaths, marriages and pregnancies;
- universal access to information/counselling and services for fertility regulation and contraception with a wide basket of choices;
- to reduce the IMR to below 30 per 1,000 live births and a sharp reduction in the incidence of low birth weight (below 2.5 kg.);
- universal immunisation of children against vaccine preventable diseases;
- promote delayed marriage for girls, not earlier than the age of 18 and preferably after 20 years;
- achieve 80 per cent institutional deliveries and increase the percentage of deliveries conducted by trained persons to 100 per cent;
- containing of STD;
- reduction in MMR to less than 100 per 100,000 live births;
- universalisation of primary education and reduction in the drop-out rates at the primary and secondary levels to below 20 per cent for both boys and girls.

2.10.36 Several states/districts have demonstrated that the steep reduction in mortality and fertility envisaged in the National Population Policy are technically feasible within the existing infrastructure and manpower. All efforts are being made to provide essential supplies, improve efficiency and ensure accountability - especially in the states where performance is currently sub-optimal - so that there is incremental improvement in performance. An Empowered Action Group attached to the Ministry of Health and Family Welfare has been constituted in 2001 to facilitate capacity building in poorly performing states/districts so that they attain the goals set in the Policy. If all these efforts are vigorously pursued it is possible that the ambitious goals set for 2007/2010 may be achieved.

National Commission on Population

2.10.37 The National Commission on Population was constituted on 11 May 2000 under the

chairmanship of the Prime Minister. The Deputy Chairman of the Planning Commission is the vice chairman. The Commission has the mandate to:

- review, monitor and give direction for the implementation of the National Population Policy with the view of achieving the goals it has set;
- 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 agencies at the Centre and in the states; and
- develop a vigorous people's programme to support this national effort.

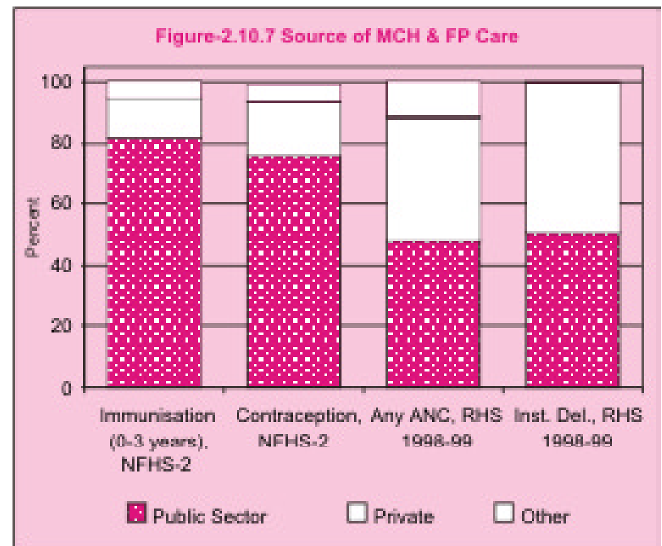
A Strategic Support Group consisting of secretaries of concerned sectoral ministries has been constituted as a standing advisory group to the Commission. Nine working groups were constituted to look into specific aspects of implementation of the programmes aimed at achieving the targets set in the National Population Policy. NCP has allocated funds for action plans drawn up by district magistrates in poorly performing districts to implement programmes aimed at accelerating the pace decline in fertility.

Lessons Learnt in Five Decades

2.10.38 The lessons learnt from the implementation of family welfare programmes in the last five decades are:

- The governmental network provides most of the maternal and child health and contraceptive care services; (Figure 2.10.7)
- adequate financial inputs and health infrastructure are essential prerequisites for the success of the programme;
- providing efficient and effective integrated maternal and child health and contraceptive care helps in building up rapport with the families;

Figure-2.10.7 Source of MCH & FP Care



- IEC and motivation activities are powerful tools for promoting the small family norm;
- the people are conservative but responsible and mature and though their response may be slow, it is rational and sustained.

REVIEW OF PERFORMANCE OF THE FAMILY WELFARE PROGRAMME DURING NINTH PLAN

2.10.39 The decentralised planning and initiatives taken up under the RCH programme during the Ninth Plan were expected to lead to substantial improvement in the coverage and quality of servi-ces. In order to achieve this, the Department of Family Welfare was given additional outlay to enable it to provide adequate financial inputs to the states. Goals for the Ninth Plan were projected on the basis of these newer initiatives and additional inputs provided. Goals set for the Ninth Plan, current status regarding these are in Annexure 2.10.I

2.10.40 A review of the performance during the Ninth Plan suggests that the health systems in the states needed more time to adapt to decentralised planning and implementation of components of the RCH programme. 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 end of 2000 through the massive pulse polio campaign also

had some adverse effect on routine service delivery. As a result, it is unlikely that Ninth Plan goals for CBR, couple protection rate, MMR and IMR will be achieved.

2.10.41 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 within the existing infrastructure, manpower and inputs.

- Andhra Pradesh, Punjab, West Bengal and Maharashtra have shown substantial decline in birth rates and the latter three states are likely to achieve replacement level of fertility, ahead of the projections.
- Punjab has achieved couple protection rate and use of spacing methods far ahead of all other states.
- Tamil Nadu and Andhra Pradesh have achieved significant reduction in home deliveries.
- Kerala, Maharashtra, Punjab and Tamil Nadu improved immunisation coverage.
- Tamil Nadu and Andhra Pradesh had achieved improvement in coverage and quality of antenatal care.

2.10.42 During the Tenth Plan, the pace of implementation of the programme will be accelerated through streamlining of infrastructure; focus will be on improving quality, coverage and efficiency of services so that all the felt needs for family welfare services are fully met. Special attention will be paid to improving access to good quality services to the under-served population living in urban slums, remote rural and tribal areas.

PREVENTION OF UNWANTED PREGNANCY

2.10.43 Efforts to improve the availability of contraceptive care during the 1970s and 1980s resulted in a steep rise in couple protection rates. However, there was no commensurate fall in the birth rate. Service reports on couple protection rate and SRS estimates of CBR indicate that there has been a steady decline in the latter during the 1990s in spite of the fact that the rise in couple protection rate during the decade has been very slow (Figure 2.10.8). This may be because earlier there was over reporting of contraceptive acceptance or there has been an improvement in the quality of services during nineties and appropriate contraceptives are being provided at the appropriate time.

2.10.44 There are massive inter-state differences in couple protection rate and CBR. In states like Bihar, the couple protection rate is low and birth rate is high. In Punjab, couple protection rate is high. Kerala, Tamil Nadu and Andhra Pradesh have achieved substantially lower CBR even while couple protection rate was lower than that of Punjab. (Figure 2.10.9). Age and parity at the time of accepting contraception as well as continuation

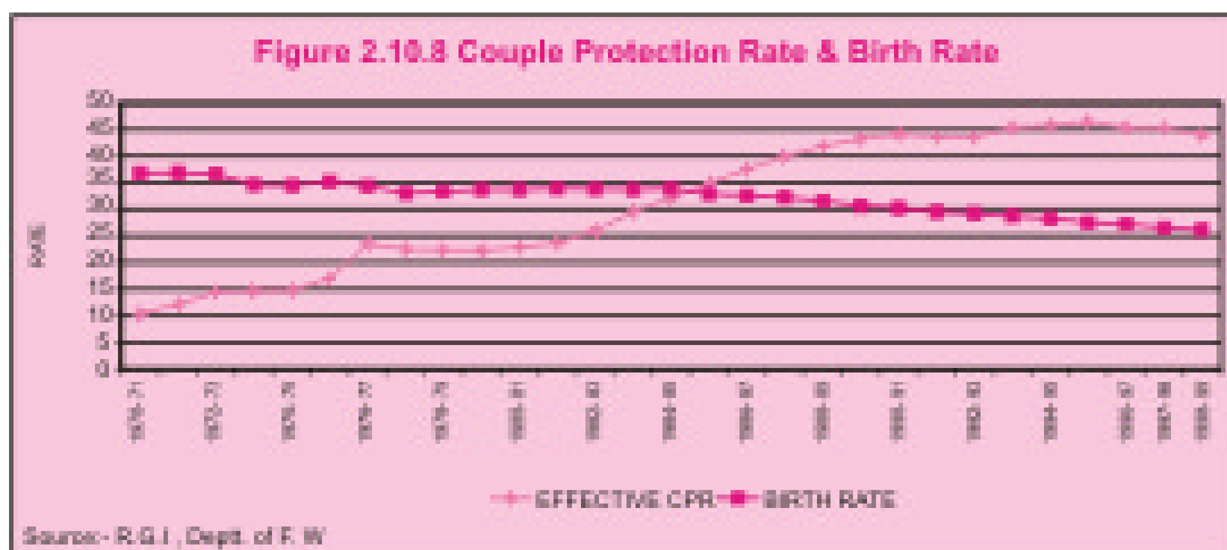


Figure 2.10.8 Couple Protection Rate & Birth Rate

Source:- R.G.I , Deptt. of F. W

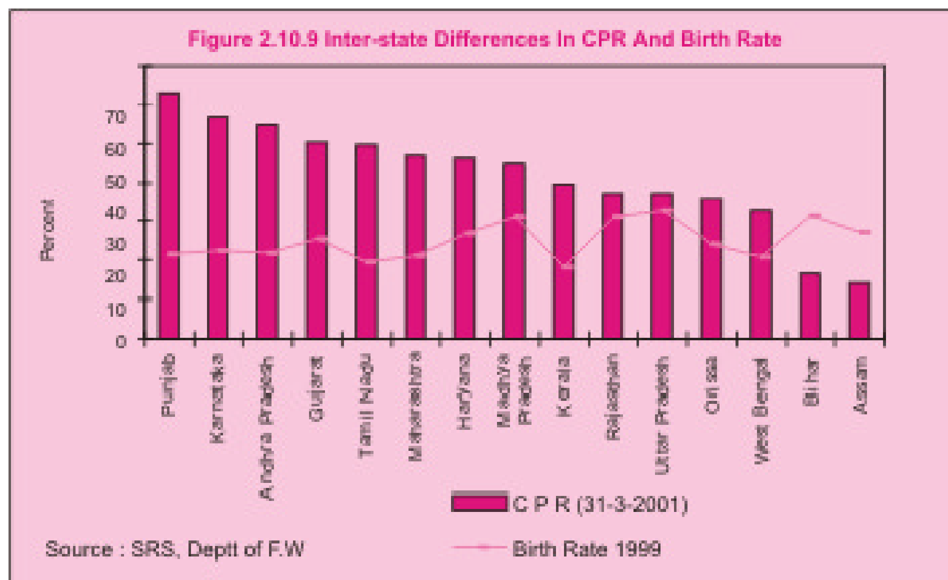


Figure 2.10.9 Inter-state Differences In CPR And Birth Rate

Source : SRS, Deptt of F.W

rates of spacing methods are critical factors that influence the relationship between couple protection rate and CBR. The high acceptance of tubectomy in younger women with two or three children in Tamil Nadu and Kerala and the higher use of spacing methods even among older women with three or more children in Punjab may account for the differences in the couple protection rate and CBR between these states.

2.10.45 Over the years there has been a fall in birth rate in all the states and among all segments of population, but the rate of reduction in the birth rate is higher in some states. Data from 2001 Census and SRS 2000 indicate that:

- eleven states/Union Territories with 11.3 per cent of the population have CBR of below 20;
- twelve states/Union Territories with 38.6 per cent of the population have CBR between 20 and 25;
- seven states with 14.4. per cent of the population have CBR between 25 and 30;
- five states with 35.7 per cent of the population have CBR of more than 30 per 1,000 population.

There is an urgent need to meet all the needs for contraception in the populous states with high birth rate.

2.10.46 Data from service reports during the Ninth Plan period indicate that there has been a decline in acceptors of all types of contraception in the initial years of the Plan, as compared to the level of acceptance in 1994-95. Subsequently, from 1998-99 the decline has been reversed except in the case of IUD (Figure 2.10.10).

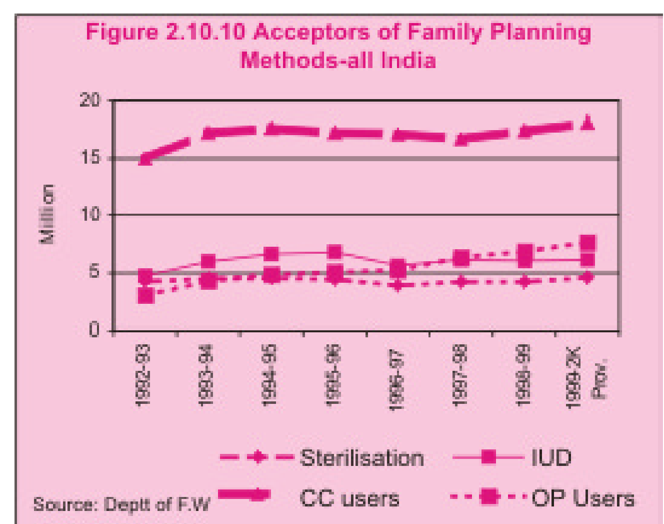


Figure 2.10.10 Acceptors of Family Planning Methods-all India

Source: Deptt of F.W

2.10.47 The NFHS 1 and 2 provided nation-wide data on contraceptive prevalence in 1992-93 and 1998-99. Data from the survey (Figure 2.10.11) indicate that contrary to the performance figures available from the service reports of the Department of Family Welfare, there has been a substantial increase in the sterilisation and oral contraceptive acceptance in the country. Only

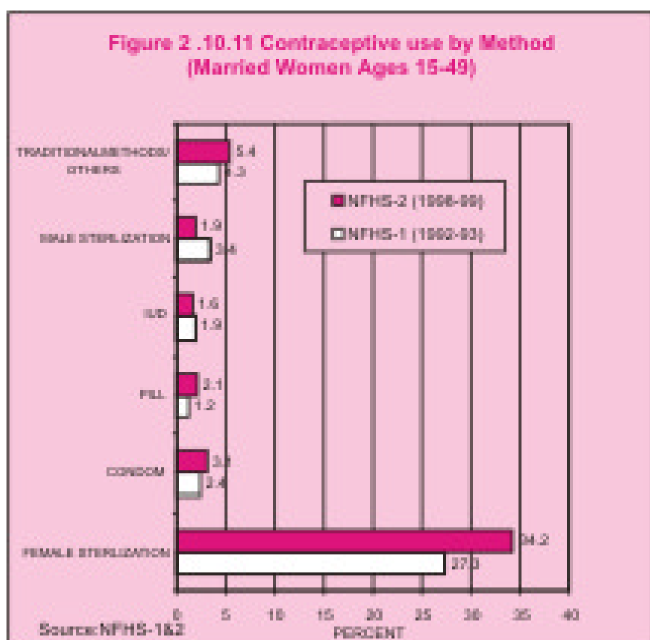


Figure 2 .10.11 Contraceptive use by Method (Married Women Ages 15-49)

IUD and vasectomy use has shown a decline. The improvement in couple protection rate explains the steady decline in the CBR during the 1990s reported by the SRS. The differences in couple protection rate data from service reports of the Department of Family Welfare and NFHS may partly be due to:

- a reduction in the earlier over reporting which was done in an attempt to show that targets have been met; and
- incomplete reporting due to changes in service reporting formats during the current period.

2.10.48 The data from in-built independent surveys and coverage evaluations within the National Family Welfare Programme have been reassuring in that their findings show that there has been no deterioration in the contraceptive prevalence in the 1990s. However, the coverage figures under service reporting for spacing methods, antenatal care and immunisation are still substantially higher than the coverage reported by evaluations. This over reporting needs to be corrected so that service reporting provides a reliable indication of progress achieved in the programme. The narrowing of the gap in coverage figures between the service and evaluation reports can be used as a new indicator for the quality in programme monitoring.

Unmet Need for Contraception

2.10.49 NFHS 1 and 2 (Figure 2.10.12) clearly indicate that there is still substantial unmet need for both terminal methods and spacing methods in all states (Figure 2.10.13). There are inter-state differences in the magnitude of unmet need for contraception. It is imperative that all the unmet needs are fully met within the Tenth Plan period and a substantial reduction in unwanted pregnancy is achieved. Making a balanced presentation of advantages and disadvantages of methods, improving counselling, quality of services and follow up care will enable couples to make appropriate choices regarding contraception, increase couple protection rates and continuation rates and enable the country to achieve the goal of replacement level of fertility by 2010.

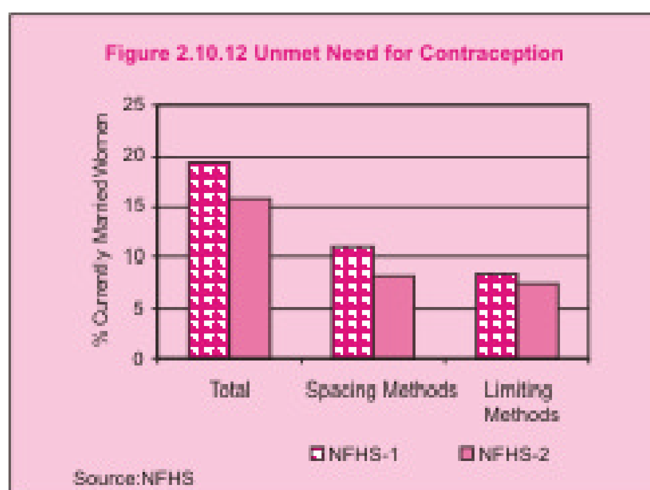


Figure 2.10.12 Unmet Need for Contraception

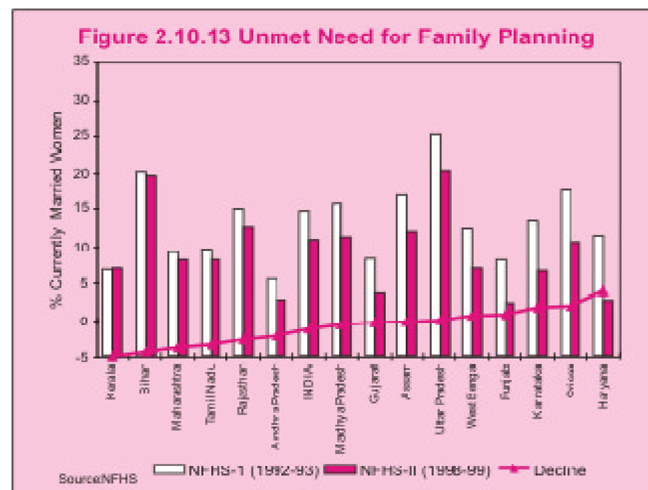


Figure 2.10.13 Unmet Need for Family Planning

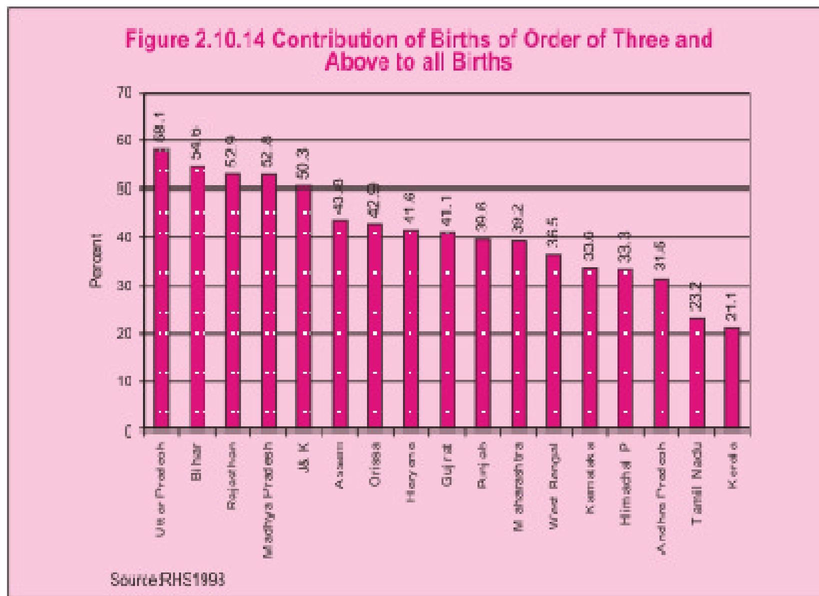


Figure 2.10.14 Contribution of Births of Order of Three and Above to all Births

Monitoring Birth Order

2.10.50 Monitoring reported birth order is an easy method of observing the progress towards achievement of replacement level of fertility. Currently, birth order of three or more account for nearly half of all births. There are massive inter-state and inter-district differences in the contribution of different birth orders (Table2.10.3 and Figure 2.10.14). Based on this information, district-specific differential strategies can be evolved to improve contraceptive prevalence rates, increase inter-birth intervals and reduce higher order of births.

Table 2.10.3
Inter-district variations

(Birth order three or more as percentage of total births)

	No of districts
<20%	27
20-40%	165
>40%	313

Source: RHS (Rapid Household survey 1998)

Terminal Methods of Contraception

2.10.51 Sterilisation has been the most widely used method of contraception in all states. Currently, age at marriage is very low and a majority of the women complete their families during their early 20s. In the current Indian milieu of stable marriages, sterilisation is the most appropriate method of contraception for such couples. There are substantial differences between states and between districts in proportion of eligible couples who have adopted terminal methods of contraception (Table 2.10.4). The 1990s saw some increase in the per centage of currently sterilised persons in all states except Punjab. However, the per centage of women under-going sterilisation is very low in Assam, Bihar and Uttar Pradesh. (Figure 2.10.15). A majority of women in these states opt for sterilisation after bearing three or more children. Improving access to safe, good quality tubectomy/ vasectomy services through RCH camps in CHCs/PHCs may be the most viable and sustainable strategy for meeting the unmet need for sterilisation in these states.

Table 2.10.4
Inter-district variations in the percentage of eligible couple sterilised

	No. of districts
>50	75
40-49	101
30-39	106
<30	223

Source : RHS1998-99

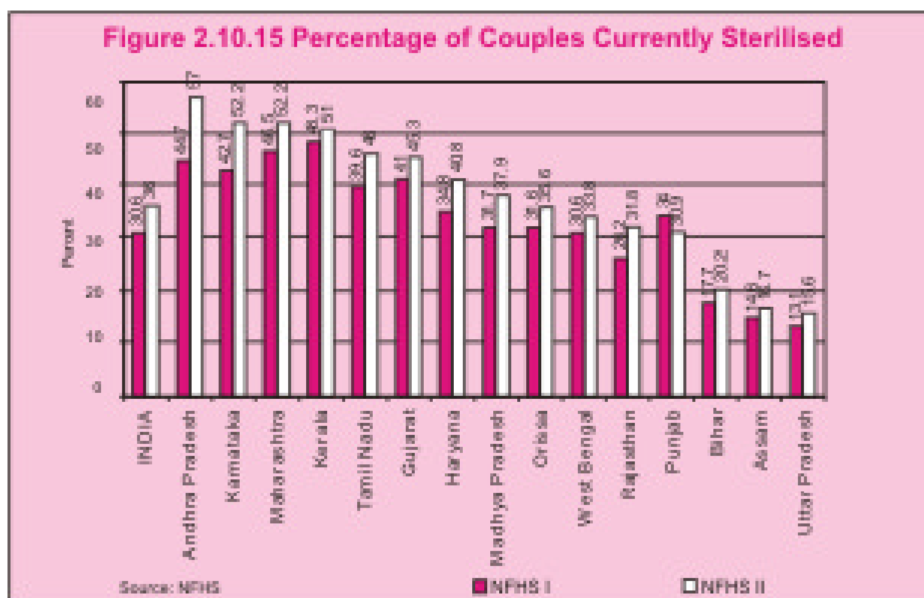


Figure 2.10.15 Percentage of Couples Currently Sterilised

Emerging Needs for Spacing Methods

2.10.52 Data from NFHS clearly shows that in spite of the low use of spacing methods, the mean inter-birth interval is about 30 months. (Figure 2.10.16) This is because of universal prolonged breast-feeding. Exclusive breast feeding during the first six months offers substantial protection against pregnancy. However, once supplements are introduced to breast-fed infants, the contraceptive effect of lactation wanes. The 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 the next pregnancy. Data from NFHS 2 has also shown that there is an emerging need for contraception before first birth. (Figure 2.10.17) This has to be fully met during the Tenth Plan.

Gender–Bias And Acceptance of Contraception

2.10.53 Data from NFHS showed that the preference for a son influenced the acceptance of permanent as well as temporary methods of contraception (Figures 2.10.18 - 19). It is important that appropriate steps are taken by all concerned sectors to minimise and eliminate gender-bias which reduces contraceptive acceptance among those with girl children.

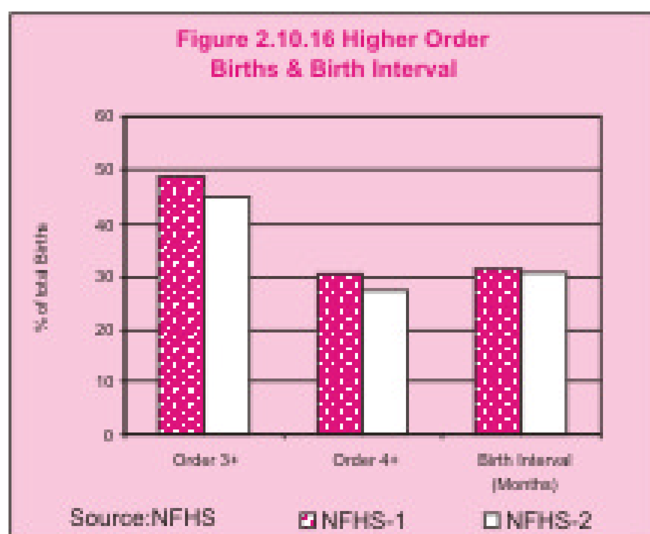


Figure 2.10.16 Higher Order Births & Birth Interval

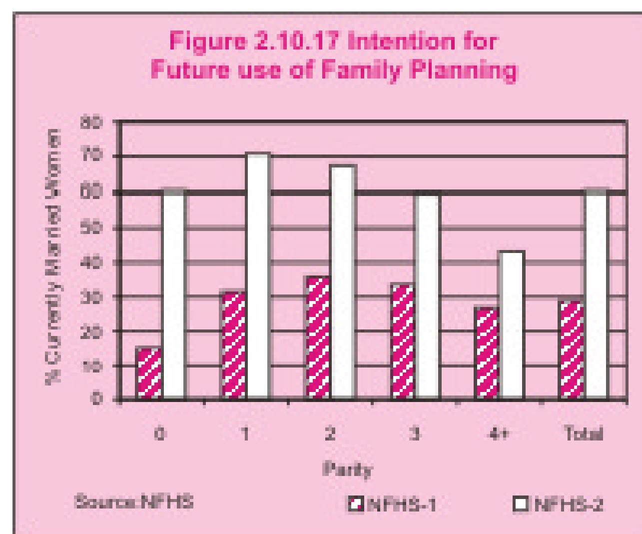


Figure 2.10.17 Intention for Future use of Family Planning

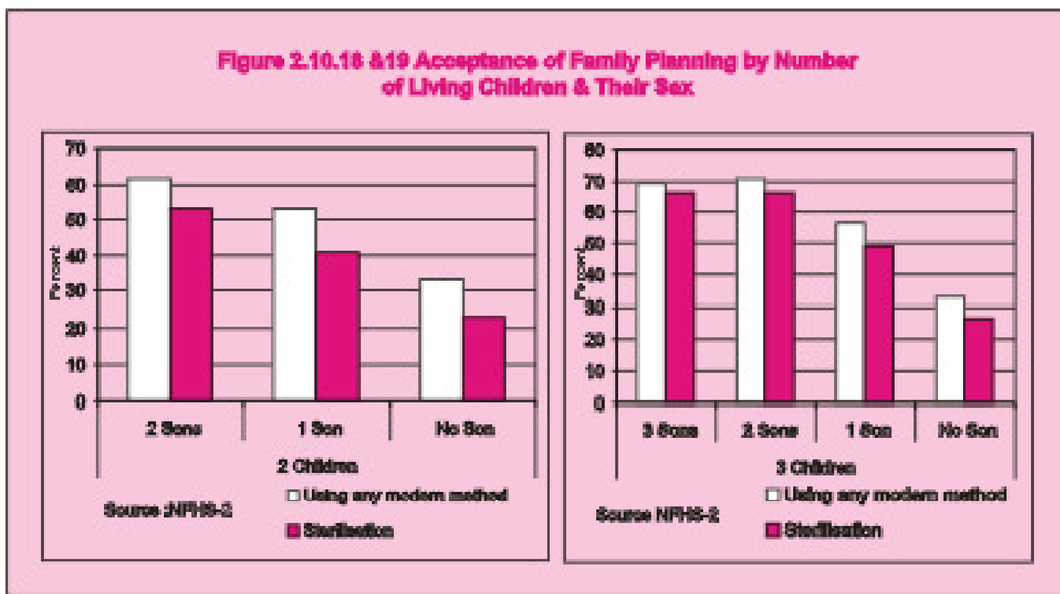


Figure 2.10.18 &19 Acceptance of Family Planning by Number of Living Children & Their Sex

Men's Participation in Planned Parenthood

2.10.54 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 prevention and control of STI/RTI. In condom users, consistent and correct use is an essential pre-requisite for prevention of STI as well as pregnancy. Vasectomy was the most widely used terminal method of contraception in the 1960s and 1970s but since then there has been a steep decline in its use (Figure 2.10.20). It is essential that efforts to re-popularise vasectomy are intensified. Ample data exists to show that vasectomy is safer than tubectomy. Every effort will be made to repopularise vasectomy by improving access to vasectomy services. These services (conventional or no-scalpel) will be made readily available to all at convenient times as an outpatient procedure in all primary, secondary and tertiary care institutions. Follow up care will be provided to all taking into account the existing time constraints and the conveniences of men. Efforts will be made to seek men's active participation in improving utilization of funds provided for emergency transport and ensuring that women and children reach appropriate centers where emergency services are available. Their cooperation will be sought in improving

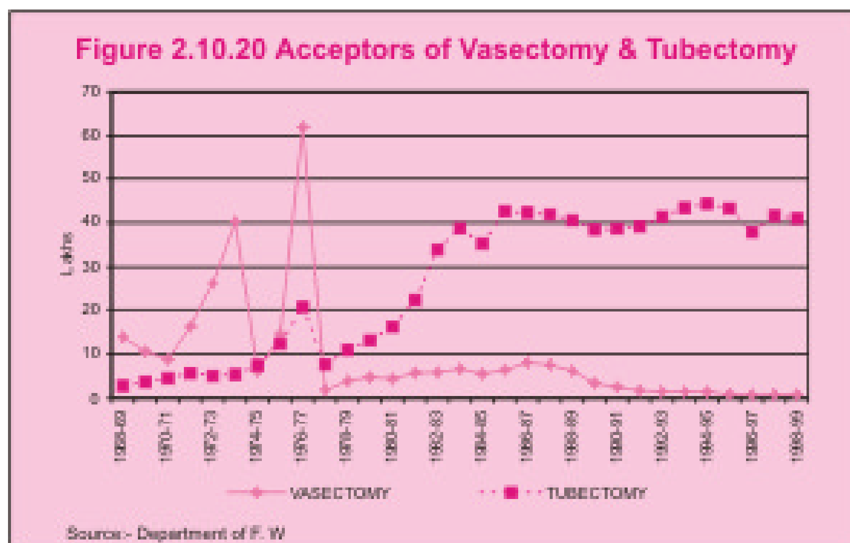


Figure 2.10.20 Acceptors of Vasectomy & Tubectomy

antenatal, child health and immunization care as well as compliance with referrals. Over the next five years efforts will be made to ensure men's participation in every facet of planned parenthood activities.

Tenth Plan Strategy for Meeting the Felt Needs for Contraception

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

In all districts

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

In states/districts where birth order of three or more accounts for over 40 per cent of the births:

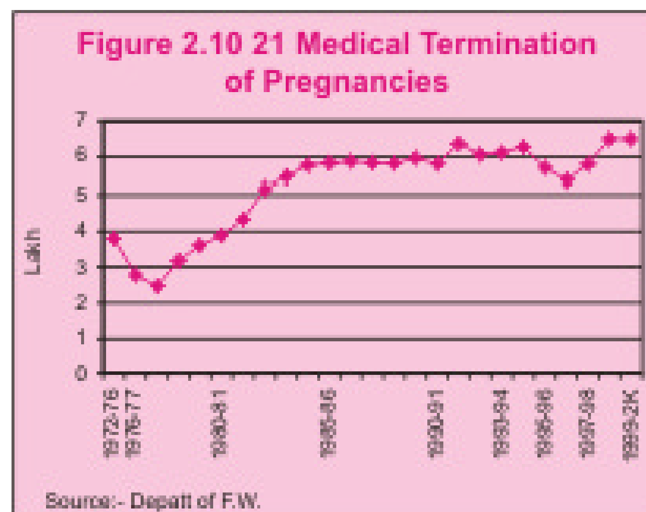
- ensure ready access to tubectomy/vasec-tomy by sending doctors, if necessary, from CHCs/ district hospitals to PHCs/CHCs on fixed days.

In states/districts where birth order of two or less accounts for over 60 per cent of the births

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

MANAGEMENT OF UNWANTED PREGNANCY

2.10.56 It is estimated that in 1998, about 9 per cent of maternal deaths were due to unsafe abortions. Available service data on MTPs indicate that following an initial rise in early 1980s, the number of reported MTP's hovered around 0.5– 0.7 million in the 1990s(Figure-2.10.21). The estimated number of illegal induced abortions in the country is in the range of four to six million. There has not been any substantial decline in the estimated number of illegal abortions, reported morbidity due to illegal abortions or share of illegal abortions as the cause of maternal mortality. The management of unwanted pregnancy through early and safe MTP services as envisaged under the MTP Act is an important component of the ongoing RCH programme.



2.10.57 During the Ninth Plan efforts were made to:

- improve access to family planning services and reduce the number of unwanted pregnancies;
- cater to the demand for MTP;
- improve access to safe abortion services by training physicians in MTP and recognising and strengthening institutions providing these safe abortion services; and
- decentralise registration of institutions to the district level.

2.10.58 In spite of these efforts, there has not been any increase in terms of coverage, number of MTPs reported and reduction in the number of women suffering adverse health consequences of illegal induced abortions.

2.10.59 Tenth Plan strategies for reducing morbidity due to induced abortion include:

- reducing the number of pregnancies by fully meeting the felt but unmet needs for contraception;
- improving access to safe MTP services through:
  - ensuring the availability of MTP services in all institutions where there is a qualified gynaecologist and adequate infrastructure;
  - decentralising registration of MTP clinics to district level;
  - simplifying the regulations for reporting of MTP;
  - training physicians working in well-equipped institutions in the government, private and voluntary sector in MTP so that they also can provide safe abortion services;
  - providing manual vacuum aspiration (MVA) syringes in recognised MTP centers where there is a trained physician but no vacuum aspiration machine;
  - using MVA for performing MTP in CHC/ PHC , when a gynaecologist visits the CHCs/PHCs on a fixed day; and
  - exploring the feasibility and safety of introducing non-surgical methods of MTP in medical college hospitals and extending the service in a phased manner to district hospitals.
- Ensuring that women do accept appropriate contraception at the time of MTP to prevent unwanted pregnancy requiring a repeat MTP.

MATERNAL HEALTH

2.10.60 The prevailing high rates of maternal morbidity and mortality have always been a source of concern, and antenatal and intrapartum care aimed at reducing these have been components of the National Family Welfare programme since its inception. Although data on state/district-specific maternal morbidity/ mortality is not available, available figures from the SRS and the 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 1990s, the SRS and the NFHS 1&2 provided independent data to assess the impact of ongoing programmes on maternal mortality. During the 1990s, there has not been any decline in MMR and more than 100,000 women continue to die each year due to pregnancy-related causes. (Table 2.10.5)

Table 2.10.5

Maternal Mortality Ratio

	1992-93	1997	1998
RGI (Sample Registration Scheme)	NA	408	407
National Family Health	424*	-	540*

*Differences are not statistically significant

Source : RGI and NFHS 1& 2

2.10.61 Data from SRS indicate that the major causes of maternal mortality continue to be unsafe abortions, antepartum and post-partum haemorrhage, anaemia, obstructed labour, hypertensive disorders and post-partum sepsis. There has been no major change in the causes of maternal mortality over years(Table 2.10.6).

Table 2.10.6

Causes of maternal death (%)

Cause	%
Haemorrhage	30
Anaemia	19
Sepsis	16
Obstructed labor	10
Abortion	8
Toxemia	8
Others	8

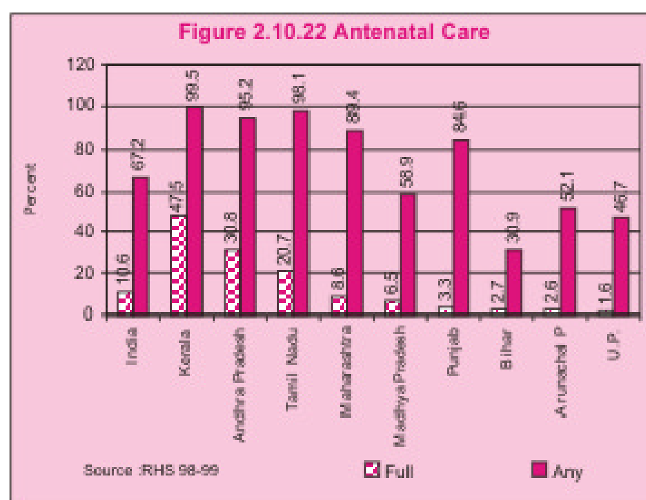
Source: Survey of Causes of Death 1998

Deaths due to abortion can be prevented by increasing access to safe abortion services. Deaths due to anaemia, obstructed labour, hypertensive disorders and sepsis can be prevented by improving the access of essential obstetric care, universal screening for detection of obstetric problems, referral and timely treatment of complications of pregnancy, promoting institutional delivery and postnatal care. Emergency obstetric services will help saving lives of women with haemorrhage during pregnancy or complications during deliveries. 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 centres where appropriate care is available. This, however, has not been operationalised; highest priority will be accorded to operationalise this during the Tenth Plan.

2.10.62 During the Tenth Plan, every effort will be made to:

- ensure 100 per cent registration of pregnancies, deaths and births so that reliable state/district-level estimates of MMR are available on a sustainable basis; and
- improve ascertainment of the cause of death through SRS and hospital records so that it becomes possible to assess time trends and changes in causes of maternal mortality.

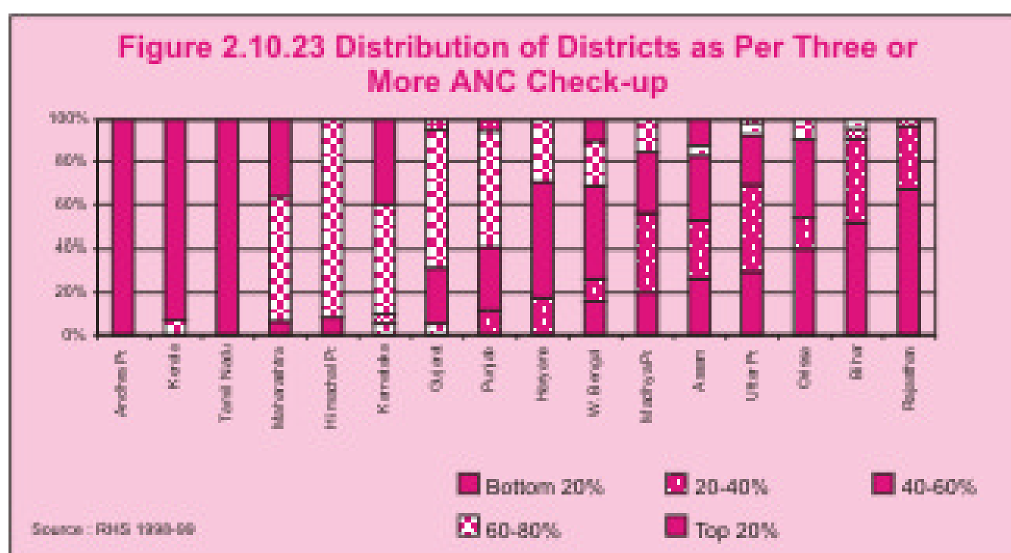
Figure 2.10.22 Antenatal Care



Antenatal Care

2.10.63 Under the RCH programmes, efforts were made to improve the coverage, content and quality of antenatal care in order to achieve substantial reduction in maternal and perinatal morbidity and mortality. Data from the rapid household Survey (RHS), 1998-1999 indicate that at the national level, 67.2 per cent pregnant women received at least one check-up but only 10.6 per cent had three antenatal checkups. Antenatal coverage in populous states with poor health indices such as Uttar Pradesh, Bihar and Madhya Pradesh are very low (Figure-2.10.22). Antenatal coverage was good in almost all districts of Andhra Pradesh, Tamil Nadu and Kerala. Surprisingly, most districts in Punjab reported very low coverage. (Figure 2.10.23)

Figure 2.10.23 Distribution of Districts as Per Three or More ANC Check-up



Antenatal Care

- Early registration of pregnancy (12-16 weeks).
- Minimum three ante-natal check-ups.
- Screening all pregnant women for major health, nutritional and obstetric problems.
- Identification of women with health problems/complications, providing prompt and effective treatment including referral wherever required.
- Universal coverage of all pregnant women with TT immunisation.
- Screening for anaemia ; providing iron folic acid tablets for prevention of anemia; providing appropriate treatment for anemia.
- Advice on food, nutrition and rest.
- Promotion of institutional delivery/safe deliveries by trained personnel; advising institutional delivery for those with health/ obstetric problems .

2.10.64 RHS data clearly indicates that only in 95 districts more than 75 per cent women had three antenatal visits during pregnancy. In as many as 265 districts, less than 40 per cent of the women had three antenatal visits (Figure-2.10.24). In Uttar Pradesh and Bihar, the content and quality of antenatal care was poor as compared to Haryana and Tamil Nadu. Universal screening of pregnant women using appropriate antenatal care is essential for the detection of problems and risk factors during pregnancy and referral to appropriate facility for treatment. (Figure 2.10.25)

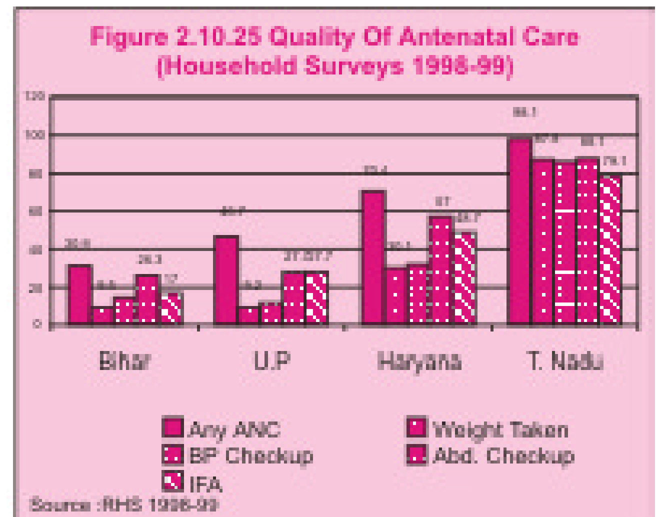


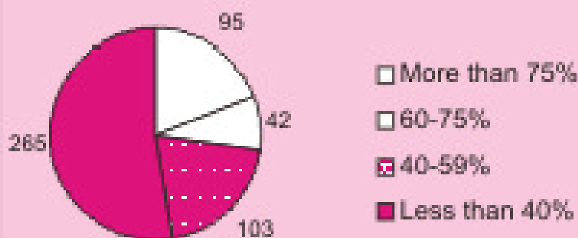
Figure 2.10.25 Quality Of Antenatal Care (Household Surveys 1998-99)

Source :RHS 1998-99

2.10.65 The problem of poor screening is aggravated by the fact that referral linkages for the management of problems are also poor in these states and, as a result, both maternal/perinatal morbidity and mortality continue to be high.

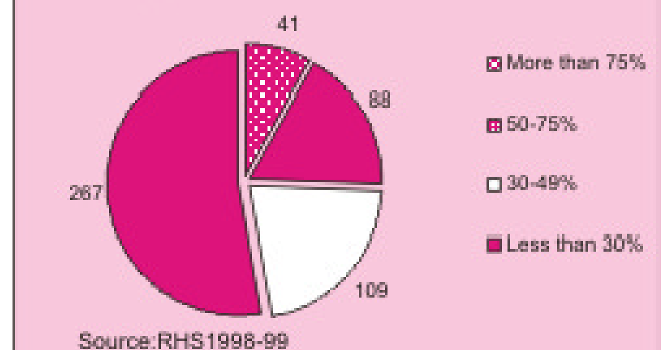
2.10.66 Anaemia is a major cause of maternal mortality in India. The Ninth Plan envisaged universal screening for anaemia in pregnant women and appropriate iron folate treatment. This is yet to be operationalised. In none of the states screening for anaemia was included as a component of antenatal care. RHS data indicated that less than 30 per cent pregnant women had taken iron folic acid tablets in 267 districts (Figure 2.10.26). During the Tenth Plan, every effort will be made to fully operationalise the Ninth Plan strategy for prevention and management of anaemia.

Figure2.10.24Three ANCs during pregnancy



Source:RHS1998-99

Figure2.10.26 Consumption of IFA



Source:RHS1998-99

Problems In Antenatal Care

- training of health personnel in antenatal screening, risk identification and referral had been very slow;
- inadequate coverage under essential obstetric care;
- poor content and quality of antenatal screening, lack of systematic recording of findings; poor referral system; referrals not honoured;
- lack of screening and gatekeeper function and reverse referrals leading to over crowding in hospitals;
- lack of emergency obstetric services – at CHCs/FRUs.

Tenth Plan Strategy for Improving Maternal Health

2.10.67 The initiatives taken under the RCH programmes to provide essential obstetric care to all women will be continued during the Tenth Plan. Training to upgrade the skills of health care providers and improve the content and quality of antenatal care, will be completed expeditiously so that they follow the protocol for screening all pregnant women to identify those with problems. The auxiliary nurse midwife (ANM) is the key person in the screening of pregnant women and she will be given the necessary skill up gradation training and equipment. In order to ensure screening and two way referrals 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. For this purpose an antenatal card was designed and tested in some states during the Ninth Plan. It is essential that these cards, with suitable modifications, if necessary, are made available to all states. The ANM will work closely with the anganwadi worker and will conduct maternal and child health clinics in anganwadis on specified days according to her advance tour programme. She will be the gatekeeper whose referrals will be honoured at PHCs/CHCs. In states where there are inadequate number of ANMs, there is need to strengthen the existing ANM schools. In states/districts with heavy work load/difficulty in transport or communication, additional ANMs may be recruited on a contractual basis, in order to meet all the unmet needs for maternal health.

2.10.68 The CHC/FRU is the critical institution which provides emergency obstetric care and plays a vital role in the referral system. The reported gaps in the number of CHCs/FRUs will be filled by appropriately reorganising the subdivisional hospitals, post-partum centres and block-level PHCs. The required number of core specialists will be posted through appropriate redeployment of the manpower; wherever adequate number of specialists are not available, hiring them on a contractual or part-time basis can also be considered. In order to strengthen the capability of CHCs/FRUs in antenatal and intrapartum care, states can take up training of one of the staff nurses in CHC so that there is someone who has specialised in midwifery available to provide care. Over the next five years, efforts will be made to improve the Emergency Obstetric Care in all CHCs in a phased manner , by ensuring that these CHCs have well equipped operation theatre, access to banked blood, qualified obstetricians, paediatricians and anaesthetists.

2.10.69 In view of the massive differences between districts in the availability and access to essential and emergency obstetric services, and in maternal health indices, the following differential strategies will be adopted for achieving incremental improvement in essential and emergency obstetric care during the Tenth Plan.

In all districts:

- awareness generation to ensure universal screening of pregnant women; identification of women with problems;
- manage/refer women with complications to appropriate institution for care;
- 100 per cent coverage for tetanus toxoid (TT) immunisation;

- screening for and treatment of anaemia;
- provide information on:
  - nearest PHC where women with problems can seek a doctor's advice;
  - nearest FRU with obstetricians and facilities where women with obstetric emergency can seek admission; and
  - how to access the emergency transport system.

In better performing districts focus on:

- improvement in universal coverage and content and quality of antenatal care to enable very early identification of women with any antenatal problems;
- referral of those with problems to CHC/FRU for care.

In poorly performing districts, the focus will be on:

- improving coverage for antenatal screening by an ANM providing antenatal care at least thrice during pregnancy;
- building up a system of RCH camps in PHCs/ CHCs on specific days throughout the year when doctors/specialists will be available to examine women with problems and provide treatment/referral.

Delivery Care

2.10.70 During the Ninth Plan, it was envisaged that efforts will be made to promote institutional deliveries both in the urban and rural areas. Simultaneously, in districts where a majority of the deliveries were taking place at home, efforts were made to train the traditional birth attendants (TBAs) through an intensive Dai Training Programme and to increase the availability of disposable delivery kits. The available data from the NFHS-1 and 2 and RHS-1998 suggest that there has been some improvement in institutional deliveries, especially in states like Tamil Nadu and Andhra Pradesh (Figure2.10.27). However, there are a large number of districts in many states where the situation with regard to safe deliveries is far from satisfactory.

2.10.71 In states like Kerala, over 90 per cent of deliveries are in institutions and neonatal mortality rates are very low.However, neonatal mortality is high in states like Uttar Pradesh, where the majority of deliveries occur at home and are conducted by untrained persons. Efforts to train TBAs and provide

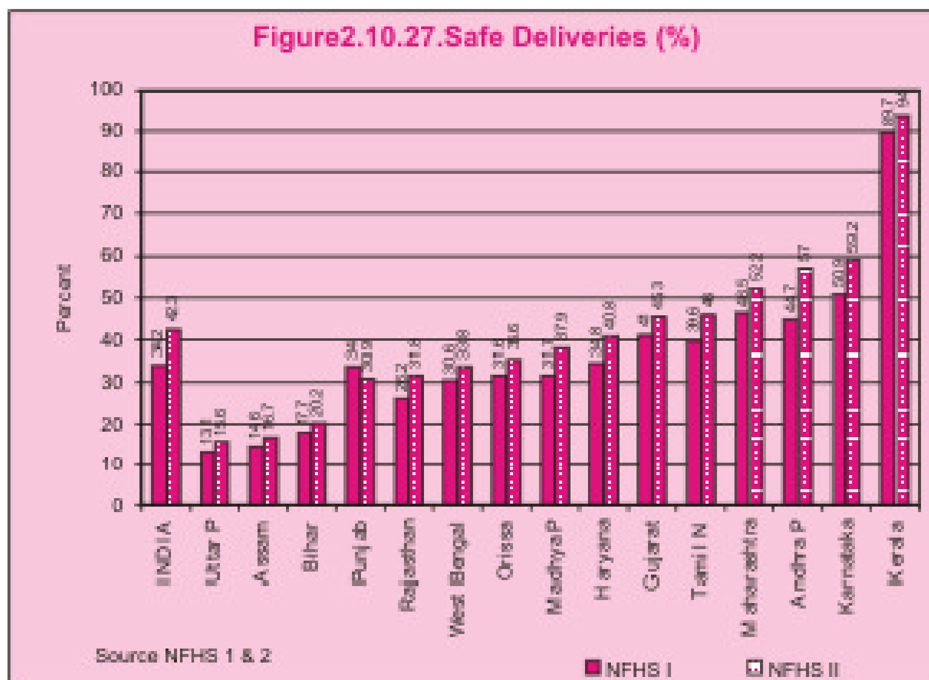


Figure2.10.27.Safe Deliveries (%)

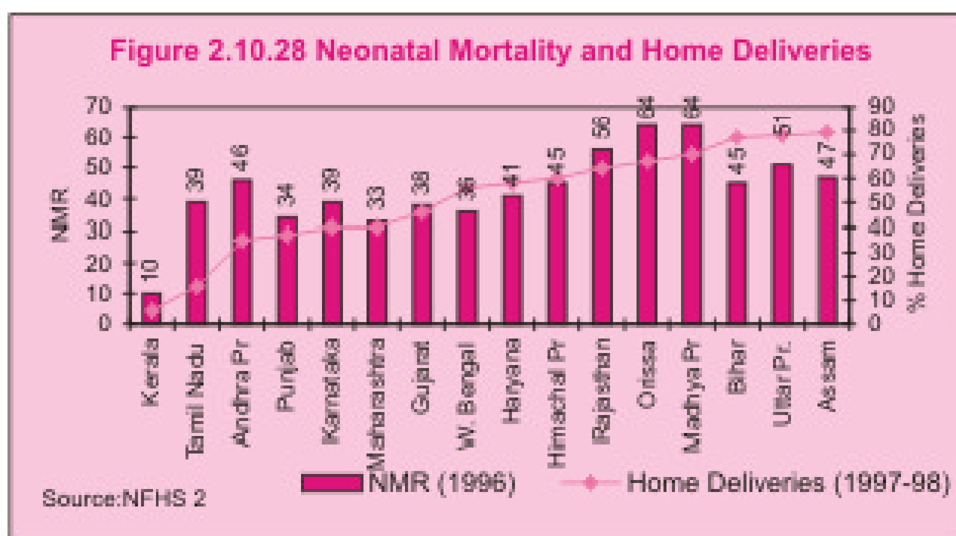


Figure 2.10.28 Neonatal Mortality and Home Deliveries

them with disposable delivery kits have not resulted in substantial decline in the maternal morbidity or neonatal mortality rates. (Figure2.10.28). Data from NFHS-2 showed that even though there has been a steep increase in institutional deliveries in Tamil Nadu and Andhra Pradesh, there has been no commensurate decline in neonatal mortality, indicating the need to improve the quality of intrapartum and neonatal care for those coming for institutional deliveries.

2.10.72 Women with problems like anaemia, malpresentations, suspected cephalopelvic disproportion , hypertensive disorders of pregnancy and gestational diabetes mellitus should not deliver at home. Screening all women during pregnancy to detect those with such problems and referring them at the appropriate time to pre-designated institutions for management and safe delivery will substantially reduce maternal and perinatal morbidity and mortality. The mechanism for screening, as well as referral, will have to be streamlined during the Tenth Plan period. Easy-to-follow protocols for referral will have to be developed and made available to all health care providers. If home delivery is anticipated in low risk cases, provision has to be made for aseptic delivery by trained persons. The TBAs will be trained to recognise women with complications and those in labour longer than 12 hours and refer them to hospitals for delivery. This strategy is expected to result in some reduction in maternal and neonatal deaths and pave the way for good antenatal care and safe institutional deliveries at a later date.

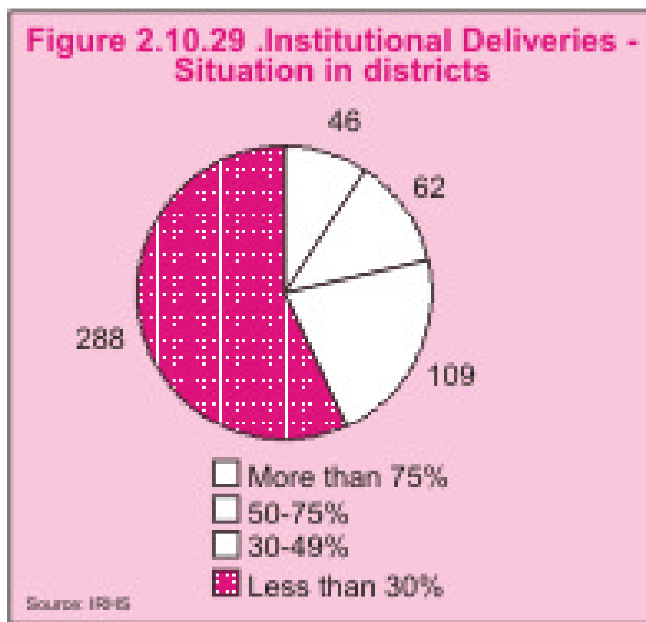
2.10.73 Unpredictable complications can arise even during apparently normal labour and rapid transportation of these women to hospital for emergency obstetric care is essential. In order to assist families in arranging transport to centres where emergency care is provided, the Department of Family Welfare provided funds which will be available at the village level. Panchayats, NGOs and women's organisations and men in villages will play an important role in ensuring that optimum use is made of this fund and timely transport saves life. In the postpartum period, early detection and management of infections, support for breast feeding and nutrition counseling will receive due attention.

Tenth Plan Strategy to Improve Delivery Care

2.10.74 In view of the massive differences between states/districts in the proportion of institutional deliveries (Figures 2.10.29) and neonatal mortality rates, a differential strategy to achieve incremental improvement in maternal and neonatal care will be taken up during Tenth Plan.

In all districts

- efforts will be made to identify women with complications during pregnancy through



antenatal check up and refer them to appropriate institution for safe delivery.

In districts with low institutional delivery, attempt will be made to:

- screen all women in the last four weeks of pregnancy and ensure that those with complications deliver in institutions;
- train TBAs in clean delivery;
- train TBAs to recognise problems that arise during labour and refer those women to hospitals;
- ensure that referrals are honoured; and
- build up community support for transport of women with problems to functional FRUs.

In districts with high institutional delivery, efforts will be made to:

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

2.10.75 Specific efforts will made to strengthen FRUs/CHCs/district hospitals to provide emergency obstetric care for all referred cases. The attempt will be to:

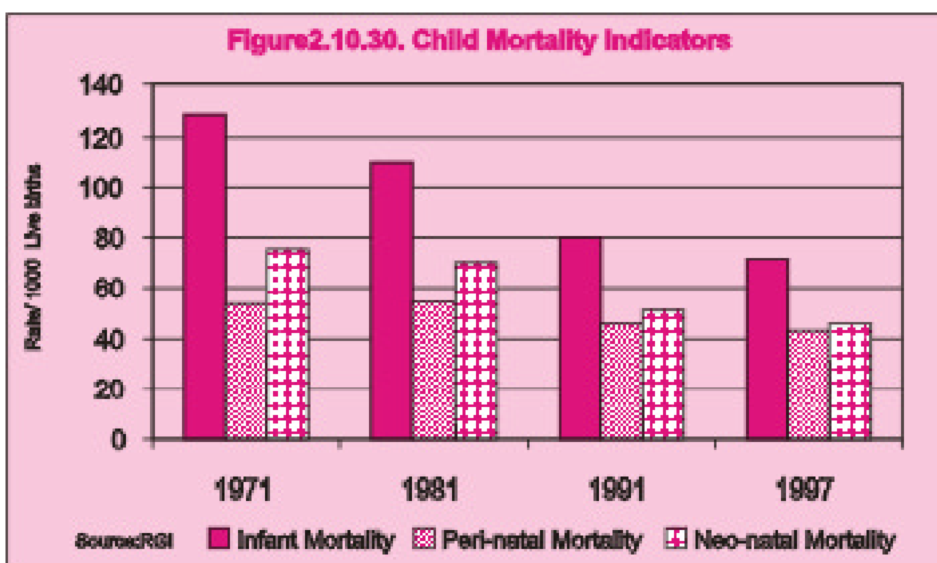
- operationalise adequate number of FRUs/ CHCs by posting specialists in obstetrics, gynaecology/pediatrics in institutions where infrastructure is available;
- provide for funding specialists on contract/part-time basis, if necessary, so that care is available when needed; and
- improve access to anesthetists and banked blood.

CHILD HEALTH

2.10.76 Infant and under-five mortality rates are excellent indicators of the health status of children. In India there is no system for collection and analysis of data on morbidity during childhood. In the absence of this, available mortality data and analysis of causes of death have been utilised for drawing up priority interventions for improving child health. Ongoing major intervention programmes in child health include:

- essential new born care;
- immunization to prevent morbidity and mortality due to vaccine preventable diseases;
- food and micro-nutrient supplementation programmes aimed at improving the nutritional status;
- programmes for reducing mortality due to acute respiratory infection (ARI) and diarrhoea.

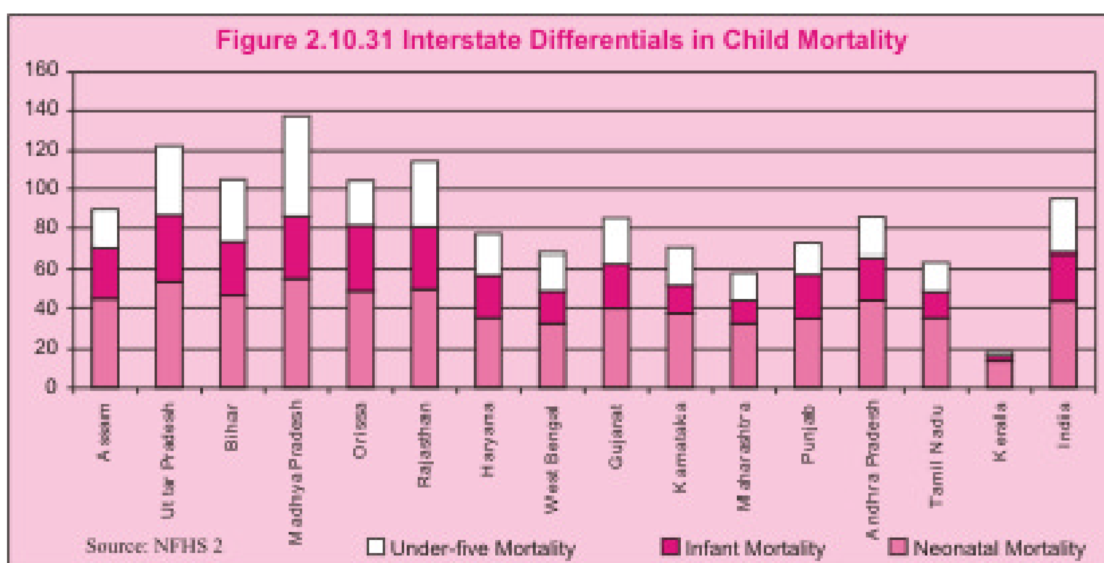
2.10.77 Improved access to immunisation, health care and nutrition programmes have resulted in substantial decline in IMR between 1950-1990. However, it is a matter of concern that the decline in perinatal and neonatal mortality has been very slow (Figure-2.10.30). IMR has remained unaltered in the1990s. There are substantial differences between states in neonatal, infant and under- five mortality



rates(Figure-2.10.31). Higher under-five mortality rates in girls persist, indicating gender bias in child rearing practices Over the last three decades there has not been any substantial change in the major causes of deaths during infancy and childhood.

Inter-Relationship between IMR and CBR

2.10.78 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 inter-state and intra-state differences in birth rates and IMR. In spite of a relatively high IMR, states like Tamil Nadu and Andhra Pradesh have achieved a steep decline in fertility. In states/districts where fertility has declined without a commensurate decline in IMR, there should be a focussed, area-specific situation analysis and intervention to reduce IMR. For this, reliable district-specific data on birth rates and IMR must be available on an annual basis. This can be achieved only though 100 per cent recording of birth and death and collation and analysis of this data at the district level. Such a system would also enable continuous monitoring of the impact of the intervention and mid-course corrections. In order to achieve this, strengthening of the CRS will be given priority during the Tenth Plan period.



Child Health Interventions During the Ninth Plan

2.10.79 Under the RCH programme, comprehensive integrated interventions to improve child health were initiated to address each of the major factors contributing to high IMR and under five mortality.

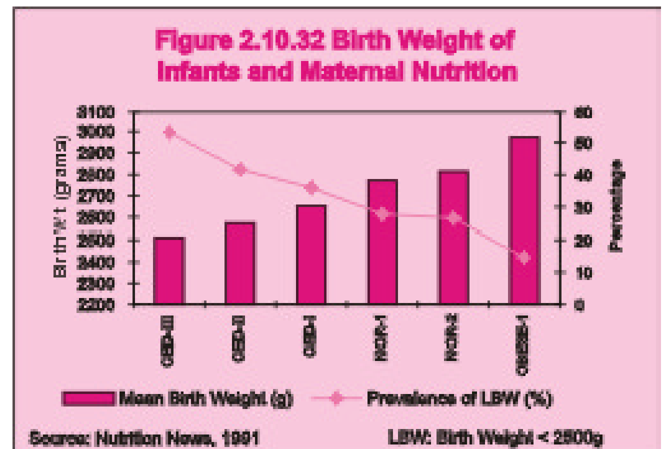
Components of child health care include :

- Essential newborn care
- Immunisation
- Nutrition:
  - exclusive breast-feeding for six months
  - timely introduction of complementary feeding.
  - detection and management of growth faltering.
  - massive dose Vitamin-A supplementation.
  - iron supplementation, if needed.
- Early detection and appropriate management of:
  - acute respiratory infections;
  - diarrhoea.
  - other infections.

Essential New Born Care

2.10.80 India has the dubious distinction of having a very high prevalence of low birth weight. Currently nation-wide data on birth weight in different states and districts is not available because a 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 nearly one-third of all Indian infants weigh less than 2.5 kg at birth. There are differences between states and between economic groups, with incidence of low birth rate being the highest among the low income groups. There has hardly been any change in birth weight trends in the past three decades. A gender difference has been noted in mean birth weights, with female infants tending to weigh lesser than male infants.

Figure 2.10.32 Birth Weight of Infants and Maternal Nutrition



Source: Nutrition News, 1991

LBW: Birth Weight < 2500g

2.10.81 Birth weight is influenced by the nutritional and health status of the mother. There is a good correlation between birth weights and the body mass index (BMI) of the mother (Figure-2.10.32). A significant reduction in birth weight has been observed in anaemic women and the low birth weight rate doubles when Hb levels fall below 8 gms/dl. Some factors, which have significant influence on birth weight, such as the parent's build, are not amenable to short term corrective interventions. On the other hand, factors like anaemia, pregnancy induced hypertension and low maternal weight gain during pregnancy can be corrected and could result in substantial reduction both in pre-term births and birth of small for dates neonates. During the Tenth Plan, efforts will be made to identify women with these problems by ensuring universal antenatal screening; provision of appropriate management including referral services for those with problems may result in improvement in birth weight.

2.10.82 The experience of states like Kerala, Pondicherry and Goa have shown that it is possible to achieve substantial decline in IMR and child mortality rates without any significant improvement in birth weight and reduction in the number of infants born weighing below 2.5 kg.

2.10.83 Available data suggests that only 10 to 15 per cent of all births occur before 37 weeks (pre-term births), about 20 to 25 per cent infants weigh less than 2.5 kg but are mature and thrive under normal care even at home. If all the new born babies weighing below 2.5 kg are considered as being at risk and are sent to hospitals for care, hospitals will get over crowded. Studies conducted over the last three decades have shown that the neo-natal and

infant mortality rates steeply increase only when birth weight falls below 2.2 kg or infants are premature. During the Tenth Plan priority will be accorded to weighing all neonates at or soon after birth and ensuring referral of preterm/ <2.2 kg neonates to the centers where appropriate care could be provided.

2.10.84 During the last three decades efforts were made through antenatal care to reduce low birth weight because:

- it is closely linked to infant (especially neonatal) mortality;
- developing countries have the highest rates of low birth rate;
- developing countries cannot afford the technologies for intensive neonatal care needed to reduce mortality among infants with low birth rate.

- During the last three decades there has not been any major reduction in the proportion of low birth weight babies.
- In most states there has been substantial reduction in IMR even though there is no change in birth weight.
- Reduction in low birth weight is not an essential prerequisite for reduction in IMR.

2.10.85 During the Tenth Plan every effort will be made to:

- screen pregnant women for under-nutrition and anaemia and provide appropriate interventions;
- advise at-risk individuals to have delivery in institutions, which can provide optimal intrapartum and neonatal care and improve neonatal survival;
- have the anganwadi worker check the birth weight of babies as soon after delivery as possible in all home deliveries and refer those neonates with birth weight less that 2.2 kg to hospitals where there is a pediatrician available;
- if these interventions are fully operationalised it will be possible to achieve substantial reduction in the neonatal mortality rate within a short period.

Operationalisation of New Born Care

2.10.86 Two-thirds of all the neonatal deaths occur in the first seven days after birth (Table 2.10.7). The major causes of neonatal deaths are premature birth, asphyxia and sepsis. (Table 2.10.8). If neonates requiring care are identified and referred to an appropriate facility where they can be effectively treated and it will be possible to achieve substantial decline in neonatal mortality.

Table 2.10.7
Components of IMR

	%
Early neonatal mortality	48
Late neonatal morality	17
Post neonatal mortality	35

Source: SRS '1996

Table 2.10.8
Causes of neonatal deaths(%)

Sepsis	52
Asphyxia	20
Prematurity	15
Others	13

Source: RGI

2.10.87 In order to accelerate the decline of IMR, essential newborn care was included as an intervention under the RCH programme. Equipment for essential newborn care was supplied to districts; training was provided for medical officers and other staff at the district hospitals and medical colleges to improve content, quality and coverage of essential newborn care. Operationalisation of newborn care facilities at the primary health care level was initiated in collaboration with the National Neo-natology Forum (NNF). Department of Family Welfare and the ICMR are funding research studies on the feasibility and effectiveness of community-based new born care in reducing neonatal mortality in settings where access to primary health care institutions are not adequate. The focus during

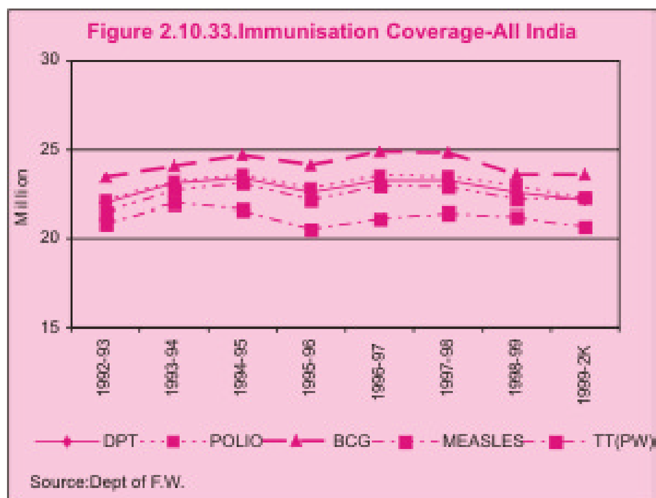


Figure 2.10.33.Immunisation Coverage-All India

Source:Dept of F.W.

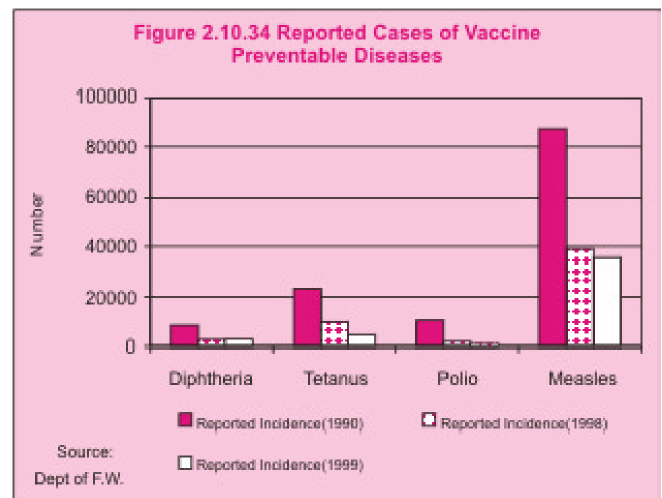


Figure 2.10.34 Reported Cases of Vaccine Preventable Diseases

Source: Dept of F.W.

the Tenth Plan will 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.

Immunisation

2.10.88 The Universal immunization program which was taken up in 1986 as a National Technology Mission, became a part of the Child Survival and Safe Motherhood (CSSM) programme in 1992 and the RCH programme in 1997. Under the programme, infants are immunised against tuberculosis, diphtheria, pertussis, poliomyelitis, measles and tetanus. Reported immunization Coverage during the nineties is shown in Figure 2.10.33. The National Health Policy, 1983, set the goal of universal immunisation against these six vaccines preventable diseases by 2000 , this has not been achieved. However, reported cases of vaccine preventable diseases have declined over the same period (Figure 2.10.34).

2.10.89 Data from NFHS indicate that there has not been any decline in the immunisation coverage in the 1990s. However, none of the states have achieved coverage levels of over 80 per cent; coverage level in states like Bihar, Uttar Pradesh and Rajasthan were very low (Figure2.10.35). The drop-out rates between the first, second and third doses of oral polio vaccine and DPT have been very high in most states. Lower coverage of around 20 per cent is reported for measles as compared to other vaccines. One of the main reasons for not achieving 100 per cent routine immunisation, is the focus on campaign mode programmes in health and family welfare. The Department of Family Welfare has now taken up a scheme for strengthening of routine immunisation. A pilot project on Hepatitis B immunisation has also been initiated.

2.10.90 The Tenth Plan will concentrate on :

- achieving hundred per cent coverage for the six vaccine preventable diseases;
- elimination of polio and neonatal tetanus;
- strengthening routine immunisation programmes and discouraging campaign mode operations which interfere with routine services;
- greater involvement of the private sector;
- improving awareness through all channels of communication;
- improving the quality of care, ensuring injection safety using appropriate, sustainable technology;
- correcting the over-reporting of coverage.
- evaluating on-going pilot projects on the introduction of Hepatitis B vaccine, including those where the vaccine costs are borne by the parents;
- exploring appropriate sustainable models of providing newer vaccines without overburdening the system and programme including charging actual costs for the newer vaccines from people above the poverty line;

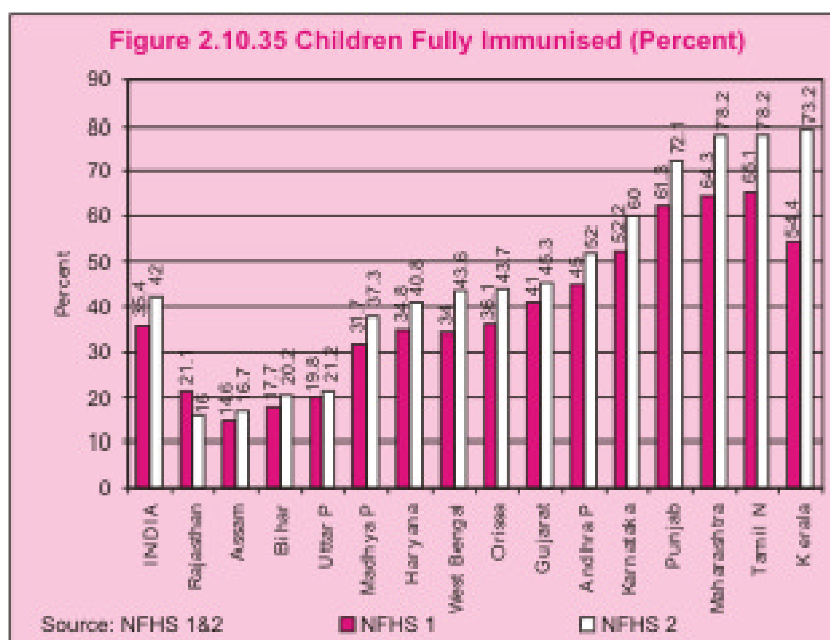


Figure 2.10.35 Children Fully Immunised (Percent)

- expanding on-going polio surveillance to cover all vaccine preventable diseases in a phased manner.

Pulse Polio Immunisation

2.10.91 Under the Pulse Polio initiative, launched in 1995-96, all children under five years of age are to be administered two doses of oral polio vaccine in December and January every year until polio is eliminated. Coverage under the programme has been reported to be over 90 per cent in all states, with over 120 million children taking the vaccine every year. However, it is a matter of concern that over the last five years coverage under routine immunisation has not improved. There are sections of the population who escape both routine immunisation and the pulse polio immunisation. As a result, through there has been a substantial decline in the number of polio cases, this was not sufficient to enable the country to achieve zero polio incidence by 2000.

2.10.92 Confirmed polio cases reported in the last four years is shown in Table 2.10.9. Uttar Pradesh and Bihar account for most of the reported cases. Mop-up immunization is being undertaken following detection of wild poliovirus, including areas with clusters of polio compatible cases and in areas of continued poliovirus transmission. The sub-national immunisation days (SNID) and national immunisation days (NIDs) are being conducted using the combined fixed posts and house-to-house approach in all states. Special efforts are being made to achieve high routine and campaign coverage in under-served communities and remind families about the need for routine immunisation during the pulse polio immunisation campaigns.

2.10.93 The medical goal of polio eradication is to prevent paralytic illness due to polioviruses by the elimination of wild poliovirus so that children need not be immunised perpetually. India will probably achieve zero incidence of polio by 2004. If there are no more cases over the next three years, the country will be declared polio free. When this is achieved, steps will have to be taken to ensure that the disease does not return, by continuing to ensure 100% coverage under routine immunisation for another decade.

Table 2.10.9
No of Polio Cases

Year	No. of cases of confirmed polio
1998	1931
1999	1126
2000	265
2001	268

Source : Dept. of FW

2.10.94 The oral polio vaccine contains live attenuated virus. Recent experiences in Egypt, the Dominican Republic and Haiti have shown that the vaccine-derived viruses can become neuro-virulent and transmissible. Such mutant viruses have caused outbreaks of polio in areas where there was a decline in immunisation coverage. Several countries that have eradicated polio have shifted to injectable killed polio vaccine after elimination of the disease. India, along with other South-Asian countries, may have to consider all these options and prepare appropriate strategies during the Tenth Plan.

Infections in Children

2.10.95 Data from NFHS-2 indicates that 30 per cent of children below three years of age had fever during the two weeks preceding the survey, 19 per cent had symptoms of ARI and another 19 per cent 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

2.10.96 Diarrhoea is one of the leading causes of death among children. Most of these deaths are due to dehydration caused due to frequent passage of stools and can be prevented by the timely and adequate replacement of fluids. The Oral rehydration programme was started in 1986-87 in order to prevent such deaths. Health education aimed at the rapid recognition and appropriate management of diarrhoea has been a major component of the CSSM and RCH program.

2.10.97 The use of fluids available at home and oral rehydration solution (ORS) has resulted in a substantial decline in the mortality associated with diarrhoea, from an estimated one million to 1.5 million children every year prior to 1985 to 600,000 to 700,000 deaths in 1996. In order to further improve access to ORS, 150 packets of ORS are provided as part of the Drug Kit-A, two of which are supplied to all the sub-centres every year under the RCH programme. In addition, social marketing and supply of ORS through the public distribution system are being taken up in some states. However RHS data indicate that ORS was used in more than 50 per cent of cases of diarrhoea in only nine districts (Table 2.10.10). Improving access to and utilisation of home available fluids/ORS for the effective management of diarrhoea will receive priority attention during the Tenth Plan as an inexpensive and effective tool to reduce IMR/under-five mortality.

Table 2.10.10
Children with Diarrhoea
(Percentage treated with ORS)

Percent	Districts
>50	9
25-49	82
<25	413

Source : RHS 1998-99

Control of Acute Respiratory Infections

2.10.98 Pneumonia accounts for around 30 per cent of under five deaths in the country. Under the RCH programme, co-trimoxazole tablets are supplied to each sub-centre in the country as part of Drug Kit-A. Mothers and community members are being informed about the symptoms of ARI, which would require antibiotic treatment or referral. Training of health care personnel in the early diagnosis of ARI and appropriate treatment, including referral, as envisaged under the RCH programme has not yet been completed. This will receive immediate attention during the Tenth Plan period.

Tenth Plan Strategy for Improving Child Health

2.10.99 In view of the substantial differences in the IMR and neonatal mortality rates between states and between districts, a differential strategy will be adopted during the Tenth Plan. Wherever district-specific data is available from CRS, district-specific strategy will be adopted. State-specific strategy will be evolved when such disaggregated data is not available. In states/districts with a high IMR and where early neonatal mortality is less than 50 per cent of the IMR, the focus will initially be on improving post-neonatal mortality. In districts/states

where the IMR is relatively low, and early neonatal mortality accounts for more than 50 per cent of the IMR, the focus will be on antenatal, intra partum and neonatal care.

2.10.100 The strategy adopted for all districts will have the following elements:

At Birth

- essential new born care.
- weighing at birth and referring pre-term babies and neonates weighing less than 2.2 kg to institutions where a paediatrician is available.

Nutrition Interventions

- promote exclusive breast-feeding upto six months.
- introduce semi-solid supplements in the sixth month.
- screen all children to identify those with severe grades of under-nutrition and treat them.
- administer massive dose of vitamin A supplements according to schedule.
- administer iron-folate supplements, if needed.

Health Interventions

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

Use of District-wise Data Generated by CRS for Planning and Monitoring the National Family Welfare Programme

2.10.101 There are huge inter-state and inter-district variations in the access to health care and health indices of women and children. During the Tenth Plan, efforts are being made to rapidly improve the health indices by increasing the availability and utilisation of health care facilities. In order to respond to the changing needs at district level the Department of Family Welfare has introduced decentralised district- based planning and programme implementation, based on district-wise indicators. The data base needed for this can be made available in a sustained fashion only through 100 per cent registration of births and deaths and building up the capacity for data analysis. This task will be taken up on a priority basis during the Tenth Plan.

2.10.102 The country is yet to ensure 100 per cent registration of births and deaths. Available information with the RGI's office indicates that till the mid 1990s, over 90 per cent of all births and deaths are registered in states like Kerala, Tamil Nadu, Delhi, Punjab and Gujarat. Steps have also been initiated in these states to collect, collate and report these data at the PHC/district level on a yearly basis. These data should be used at the district-level for PHC-based planning of RCH care as well as evaluation of the coverage and impact. In districts where vital registration is over 70 per cent, efforts are being stepped up to ensure that over 90 per cent 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. The goal of 100 per cent registration of births and deaths is expected to be achieved by the end of the Tenth Plan.

Health Care for Adolescents

2.10.103 The 1990s witnessed a rapid increase in the adolescent population, a trend that will continue over the next two decades. Under the RCH programme an effort was made to address

Ninth Plan strategy for adolescent health care

- Efforts to educate the girl, her parents and the community on the need to delay marriage.
- Programmes for the early detection and effective management of nutritional (under-nutrition, anaemia) and health (infections, menstrual disorders) problems in adolescent girls.
- Appropriate antenatal care to high risk adolescent pregnant girls.

Inter-sectoral coordination between RCH and KSY programmes is being strengthened in blocks where ICDS centres have an adolescent care programme.

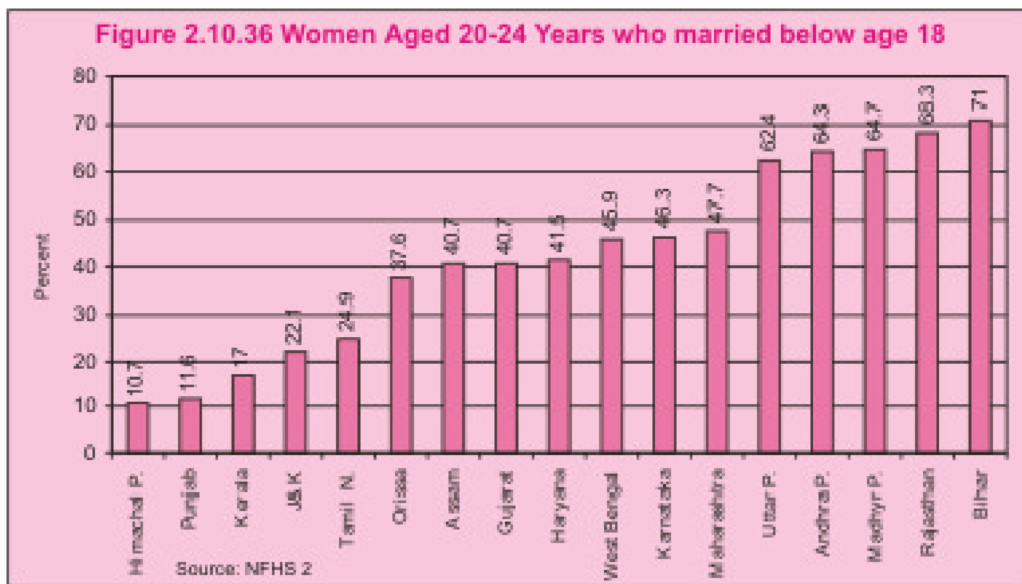


Figure 2.10.36 Women Aged 20-24 Years who married below age 18

some of the the health care needs of adolescents. The Department of Women and Child Development has initiated the Kishori Shakti Yojana (KSY) in selected blocks. Specialized counselling and IEC material to be provided through NGOs, is being prepared. However, coverage under all these programmes has been very low.

2.10.104 Data from NFHS 2 indicate that median age at marriage of girls in India is 16 years and 61 per cent of all girls were married before they were 18 years. The mean age at first birth is 19.2 years. There are massive inter-state differences in proportion of girls who got married before 18 years (Figure2.10.36). Under-nutrition, anaemia and poor antenatal care lead not only to increased morbidity in the mother but also to high incidence of low birth weight and perinatal mortality. Poor child-rearing practices add to the morbidity and under-nutrition in infants, thus perpetuating the inter-generational cycle of under-nutrition an ill health. Appropriate nutrition and health education, for all adolescents, advocacy for delay in age at marriage, optimum health and nutrition interventions during pregnancy in adolescents are some of the inter-sectoral initiatives to break this vicious cycle.

2.10.105 In view of the high prevalence of teenage marriages, in depth investigations have been carried out to document the adverse consequences, of teenage conception in the Indian setting. Data from Indian studies indicate that pregnancy in the early teens before 16 years is associated with an adverse effect on maternal nutrition, birth weight and survival of the offspring. The extra nutritional requirements of pregnancy coming close after the nutritional requirements for adolescent growth spurt might be the major factor responsible for the observed poor nutritional status of girls who conceived before they are 16 years of age.

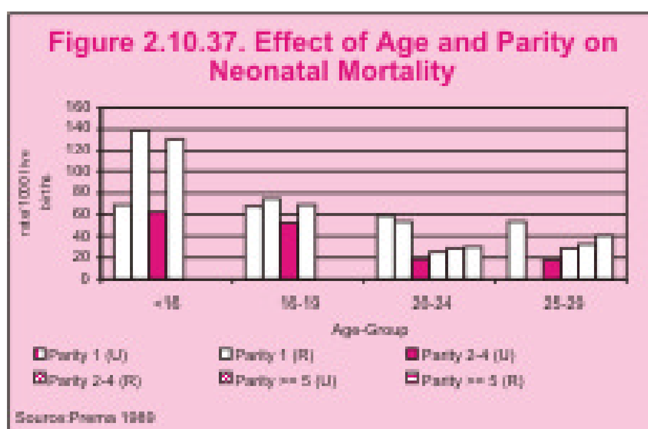


Figure 2.10.37. Effect of Age and Parity on Neonatal Mortality

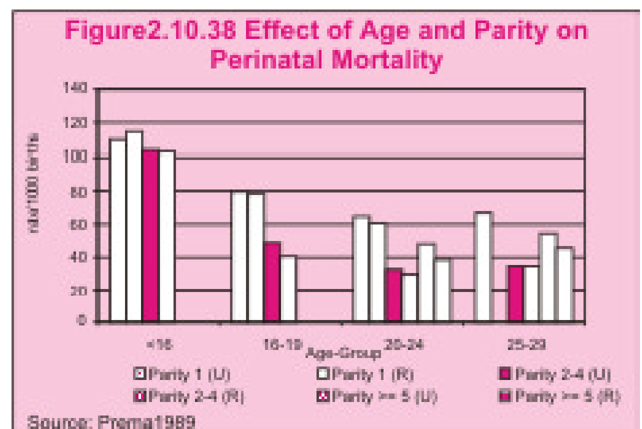


Figure2.10.38 Effect of Age and Parity on Perinatal Mortality

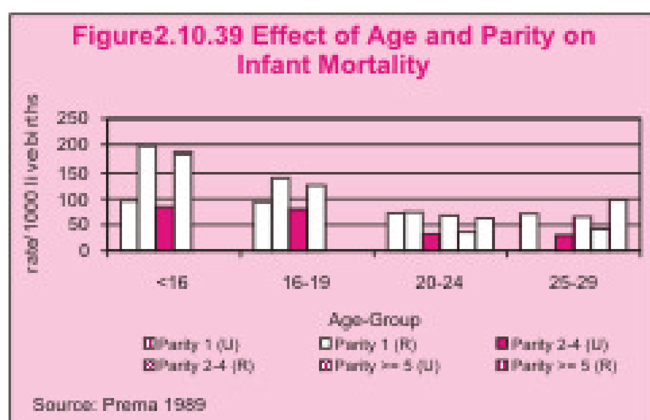


Figure2.10.39 Effect of Age and Parity on Infant Mortality

Source: Prema 1989

2.10.106 Lower maternal body weight, lower pregnancy weight gain, and higher prevalence of anemia and possibly pregnancy-induced hypertension among girls who conceived before they were 16 might account for the observed lower mean birth weight and higher perinatal, neonatal and infant mortality rate in these groups, both in urban and rural areas (Figures 2.10.37, 38 and 39). The higher low-birth weight rates, obvious deficiencies in child-rearing practices of these young girls, and poor availability and utilization of health care services, especially in rural areas, account for the high infant mortality rates.

2.10.107 Undoubtedly, there is a very urgent need to create awareness regarding adverse consequences of early teenage conception and to mobilize social support for strict implementation of laws regarding age at marriage. As and when pregnancies occur in early teenage, these girls should be considered as a very high-risk group and provided with adequate nutritional and health care; their infants should also receive appropriate health care. The health personnel should be sensitized to the needs of this very vulnerable group who are unlikely to seek or utilize available health care that they urgently require.In addition to appropriate education to delay age at marriage, the Tenth Plan will take up nutrition and health interventions to promote optimum health and nutrition in adolescent girls. While adolescent health care will have to be the focus in states where the age at marriage is increasing, effective antenatal and intra-partum care will remain the focus in a majority of the states where teenage pregnancies are common.

Nutrition

2.10.108 The importance of maternal nutrition in determining obstetric outcomes and child nutrition as a determinant of the survival and health of children is well known. The current status and proposed interventions for improving maternal and child nutrition are dealt with in the section under Nutrition.

RTI and STI

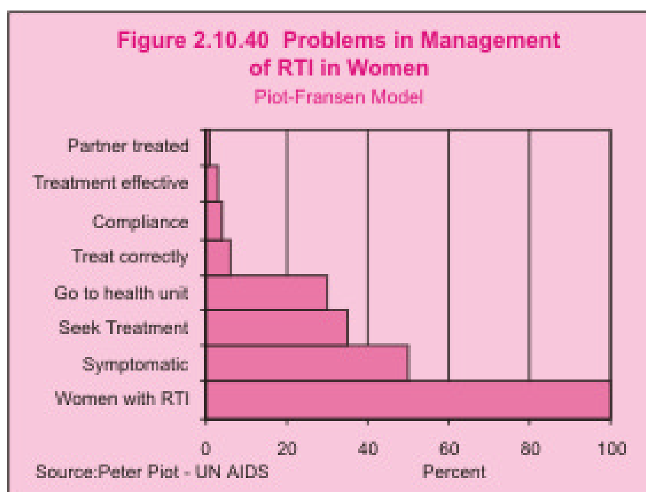
2.10.109 It has long been recognised that RTI and STI are common problems in women in the reproductive age group. During the last two decades, there has been resurgence of interest in the detection and management of RTI/STI. This is partly because clinicians have access to accurate tests for aetiological diagnosis and, are in a position to provide prompt, appropriate treatment for many RTIs/STIs and prevent the long-term health consequences of these infections. The other reasons for the increased focus on RTI/STI are:

- doctors are seeing a large number of patients belonging to a wider spectrum of age (adolescents, women in the reproductive age group and elderly women), and socio-economic strata seeking care for RTI;
- with the availability of antibiotics for treatment of RTI/STI and contraceptives for preventing pregnancy, there has been an increasing prevalence of multi-partner sex and an inevitable increase in RTI/STI;
- in spite of the increasing availability of specific tests for diagnosis and efforts to prescribe appropriate antibiotics, antibiotic resistance is increasing, leading to poor response to therapy and recurrence of infection; and
- available data from research studies suggest that the risk of transmission of HIV infection is increased by RTI.

2.10.110 The importance of prevention, early detection and treatment of RTI/STI is well-recognised. Reliable, easy-to-perform tests for accurate diagnosis are readily available. Most of the

infections still respond to commonly-used antibiotics and chemotherapeutic agents. The management of common lower reproductive tract infection has been included as a component of RCH care; these services are to be provided through the existing primary health care infrastructure. The Department of Family Welfare has provided the necessary drugs and funds to fill gaps in laboratory technician in PHCs/CHCs. However, the training of health care personnel in RTI diagnosis and management has been inadequate in most states. The Department of Family Welfare has coordinated its efforts with the National AIDS Control Organisation (NACO) so that the latter provides the input for diagnosis and management of RTI/STI at the district level and above.

2.10.111 It is important to recognise that there are problems in the current programmes for management of RTI. The Piot and Fransen model of RTI/STI management graphically sums up the problems in treatment of RTI. (Figure 2.10.40.). The model shows that about 40 per cent of women have RTI/STI at any given time but only 1 per cent complete full treatment of both partners even under optimal conditions. It is, therefore, hardly surprising that 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. However, it is important to persist with health education, providing ready access to diagnostic facilities and appropriate treatment.



Infertility

2.10.112 It is estimated that between 5 and 10 per cent of couples are infertile. While provision of contraceptive advice and care to all couples in the 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. The focus at the CHC level will 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. By carrying out simple diagnostic procedures at the primary health care institutions, it is possible to reduce the number of couples requiring referral. Initial screening at the primary health care level and subsequent referral is a cost-effective method for the management of infertility both for the health care system and for those requiring such services.

Gynaecological Disorders

2.10.113 Women suffer from a variety of common gynaecological problems including menstrual dysfunctions at peri-menarchal and peri-menopausal age. Prolapse uterus of varying degrees is yet another major problem in parous women. Facilities for diagnosis of these are available at district hospitals or tertiary care centres. During the Tenth Plan period, the CHCs with a gynaecologist will start providing requisite diagnostic and curative services. The PHCs and CHCs will refer women requiring surgery to district hospitals or tertiary care centres. Cervical cancer is one of the most common malignancies in India accounting for over one-third of all malignancies in women. It can readily be diagnosed at the PHCs and CHCs. Early diagnosis of Stage I and Stage II and referral to places where radiotherapy is available will result in rapid decline in the morbidity and mortality associated with cancer cervix in the near future.

Access to RCH Services

2.10.114 Data from research studies and clinical experience shows that social and economic deprivation lead to poor health outcomes. 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 the vulnerable segments of the population have better access to health and nutrition services and the vicious circle of poverty and ill health is broken. However, in spite of efforts over the last 50 years, better access to public health services continues to elude the poor, whose health care needs are the greatest. While this is true in all states, RHS data brings out some interesting inter-state comparisons. The poorest quintile in Tamil Nadu have better immunisation coverage rates than the richest quintile in Uttar Pradesh suggesting that socio-economic barriers can be overcome through improved awareness and access (Figures 2.10.41 and 2.10.42).

2.10.115 During the Tenth Plan, every effort will be made to improve access to essential primary health care, family welfare services and diseases control programmes totally free of cost. The Centre and the states are evolving and evaluating various options for reducing the financial burden of hospitalisation on the poor.

Logistic Support

Ninth Plan strategy

Improve uninterrupted supply of essential drugs, devices, vaccines and contraceptives, adequate in quantity and appropriate in quality.

2.10.116 Under the Family Welfare program the central government procures and supplies drugs, equipment kits, contraceptives and vaccines to the states. While the drug kits are supplied at district level, vaccines and contraceptives are supplied at the 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 the quality and wastage of drugs. Supplies under the family welfare programme are to the tune of Rs. 500 crore and it is estimated that the losses due to deterioration and inefficiencies may be to the extent of 20 to 30 per cent.

2.10.117 The Department of Family Welfare, in collaboration with different external funding agencies working in different states, has formulated logistic projects for each of the major states. It envisaged that a specialised agency will be created in each state which will manage warehouses at the regional level for each cluster of five to eight districts. These warehouses will receive an indent from each hospital in the area and will ensure delivery of

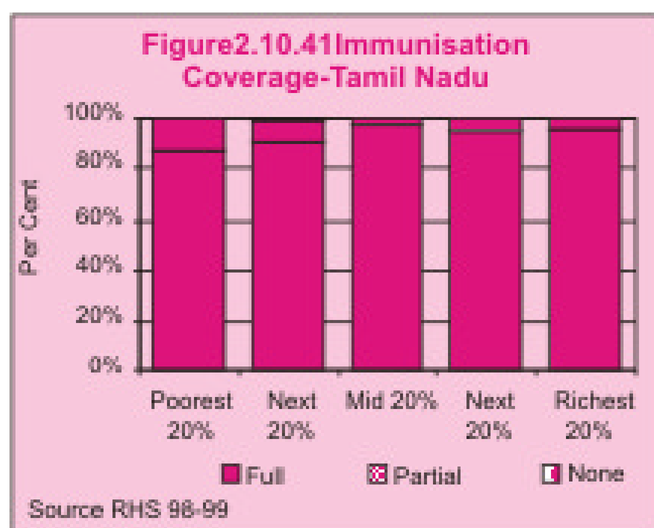


Figure2.10.41Immunisation Coverage-Tamil Nadu

Source RHS 98-99

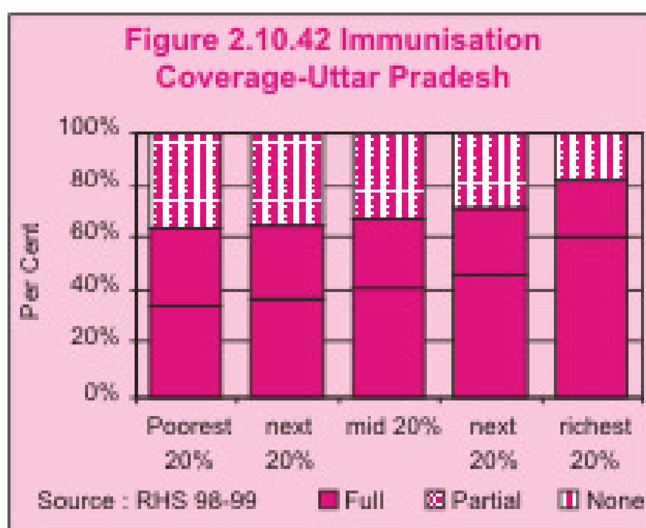


Figure 2.10.42 Immunisation Coverage-Uttar Pradesh

Source : RHS 98-99

supplies within 15 days through a contracted transporter. To ensure efficiency, the state government agency will be paid only on the basis of a per centage of supplies it handles. The logistics project has already been initiated in some states.

2.10.118 During the Tenth Plan, efforts will be made to ensure that facilities which are being created , handle all the drugs/vaccine/devices provided by the central government and state governments for all health care institutions. The progress of this programme and the problem encountered will be monitored and appropriate mid-course corrections initiated.

Private Sector Participation in RCH

2.10.119 Over 80 per cent of the practitioners of modern medicine and a higher proportion of the ISM&H practitioners work in the private sector. It is estimated that while the private sector provides more than three-fourths of all curative health care services, its contribution to maternal and child health and family planning services is less than one-third. The major limitations in private sector participation include:

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

2.10.120 Under the RCH programme, several initiatives were taken to improve collaboration between the public and private sectors in providing family welfare services to the poorer sections, especially in the under-served areas. Efforts were made to increase the involvement of private medical practitioners in RCH care by providing them orientation training and ensuring that they have ready access to contraceptives, drugs and vaccines free of cost. These efforts will be augmented during the Tenth Plan. The private sector has immense potential for improving the coverage and quality of RCH services. The challenge is to find ways to optimally utilise this potential.

Role of NGOs/Voluntary Organisations in the Family Welfare Programme

2.10.121 The National Population Policy 2000 envisages increasing role of NGOs/voluntary organisations in building up awareness about and advocacy for RCH interventions and also in improving community participation. Until recently, only a small number of NGOs were getting funding from the Department of Family Welfare, because a majority of them did not have adequate technical knowledge and the skills required. In an attempt to increase NGOs participation, the Department involved several well-established NGOs such as the Family Planning Association of India and Voluntary Health Association of India in selecting, training, assisting and monitoring of smaller, field-level NGOs for carrying out the following functions:

- advocacy for maternal child health interventions;
- promotion of small healthy family;
- improving community participation;
- counselling and motivating adolescents to delay the age at marriage, young couples to delay first pregnancy and couples with two children to limit their families by the use of appropriate contraceptive methods;
- act as a link between the community and health care providers.

2.10.122 Currently, the Department of Family Welfare funds 97 mother NGOs(larger NGOs looking after smaller ones) covering 412 districts and over 800 NGOs. These NGOs cover all districts in ten states. However, states with high fertility and mortality rates still have a large number of districts without any NGO presence.The state governments have also been trying to involve NGOs in providing services, or by adopting a PHC. The results have been mixed; these experiments need to be carefully monitored.

2.10.123 During the Tenth Plan, NGOs will have a major role in promoting community participation in the following areas:

- gender sensitivity and advocacy regarding providing adequate care for the girl child;
- baby-friendly hospital initiatives and promotion of exclusive breast-feeding for six months; advocacy for the introduction of semi-solids at the right time;
- social marketing of contraceptives, ensuring easy availability of ORS/social marketing of ORS;
- sensitising the community regarding the adverse consequences of sex determination and sex selective abortions.

2.10.124 The Department of Family Welfare has also proposed that the NGOs who have adequate expertise and experience may participate in RCH service delivery. The interventions undertaken by the NGOs will be independently assessed at the end of the project period; funding will be dependent upon mid-term evaluation based on specific bench-marks. Efforts will be made to improve networking between the NGOs, state/district administration as well as PRIs.

Role of Industries and other Organisations

2.10.125 Governmental efforts alone will not be sufficient to achieve the desired goals of the family welfare programme. The organised industrial sector provides health/family welfare services to about 14 per cent of the country's population. Industry can improve acceptance of family welfare services by educating, motivating 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 of factories, especially when they are located in under-served semi-urban and rural areas. They may take up an area-specific approach to improve services available in a block by adopting it. Smaller industries could form a cooperative group for providing health and family welfare services in collaboration with the government. Managerial and other skills available in industry can be made available to improve the efficiency of the government infrastructure. The marketing skills of industry may be useful in improving the IEC and motivation activities and in social marketing.

2.10.126 The labour force in the organised and unorganised sector and their families require coverage in order to achieve rapid improvement in health and demographic indices. Trade unions can expand their role to address the health care needs of workers and their families. During the Ninth Plan period, family welfare projects have been undertaken in the unorganised and semi-organised sectors in Tamil Nadu, plantation workers in West Bengal, beedi workers in Uttar Pradesh, and milk producers in Gujarat. The lessons learnt from these projects will be utilisied to improve access to family welfare services.

2.10.127 During the Tenth Plan, attempts will be made to enhance the quality and coverage of family welfare services through the involvement and participation of the organised and unorganised sectors of industry, agriculture and labour representatives. The problem-solving approach of the corporate sector can be used to improve the operational efficiency of the health care services.

Initiatives to Address the Needs of Under-served Population

2.10.128 Access to health care is poorer in states like Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan. The Empowered Action Group (EAG) constituted by the Department of Family Welfare in 2001 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 a rapid decline in fertility and mortality. During the Tenth Plan, special efforts will be made to upgrade the capacity of the health system in these states/districts so that there is rapid decline in both fertility and mortality. This is an essential step if the ambitious goals for decline in fertility and mortality set in the National Population Policy are to be achieved because these states contribute to over 50 per cent of the country's mortality and fertility.

2.10.129 The tribal population (except in the north-eastern states) faces immense problems in accessing essential health care services and have poor health indices. The Department of Family Welfare has already initiated several programmes

focusing on meeting the health care needs of the tribal population. These will be continued during the Tenth Plan. Special efforts will be made to address the health needs through area-specific programmes and increasing the involvement of NGOs and the tribal community in all activities.

2.10.130 The urban slum population has been shown to have poor maternal and child health indices. In many slums, immunisation coverage is very low and children are undernourished. The Department of Family Welfare and the 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 India Population Project (IPP) V, VIII and Urban RCH Pilot Projects have built up the capacities of the urban health system in several cities. Efforts to rationalise urban health care and improve efficiency so that reproductive care needs of urban population are fully met within the available infrastructure will be continued during the Tenth Plan period.

Strategies for Increasing Efficiency

2.10.131 A vast infrastructure for the 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 poorly because of :

- mismatch between structure and function;
- lack of training to health care personnel to update their knowledge, skills and programme orientation;
- absence of a proper medical hierarchy with well-defined functions;
- lack of first line supervision and mechanism to bring about accountability;
- absence of a referral system and lack of functional FRUs.

All the states have initiated health sector reforms aimed at improving the functional status of the health system, These are discussed in the chapter on Health.

2.10.132 Under the RCH programme, the Department of Family Welfare has invested heavily in training programme managers in managerial aspects for the effective implementation of the programme including decentralised district-based planning, implementation, monitoring and mid-course corrections. Skill upgradation of all categories of health care professionals and para-professionals is envisaged for improving the quality of screening and management of persons with complications, including referral as and when required. It is expected that the training programme will be completed soon and will promote effective functioning of the infrastructure and improve efficiency. These efforts will continue during the Tenth Plan period.

2.10.133 Though all states have shown some improvement in access to health care and in health and demographic indices, the rate of change has been very slow in some states. Efforts during the Ninth Plan to provide more funds to these states to upgrade infrastructure and manpower, and making schemes more flexible to enable private and voluntary sector participation has not been effective in improving access to services. During the Tenth Plan, 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 first link in such a chain will be the village-based workers who will liaise between the people and health functionaries and ensure utilisation of available facilities. The PRIs will participate in the planning of programmes and assist in the implementation and monitoring. The ANM will administer vaccines, screen infants, children and pregnant women, identify and refer the at-risk persons to appropriate institutions. The medical officer at the PHC will undertake PHC-based planning and monitoring of the health and family welfare programmes and provide curative services, organise and supervise preventive and promotive health and family welfare-related activities and develop a viable, functional referral systems. The specialists in the CHCs will provide appropriate emergency care and care for referred patients,

participate in the development of the CHC-based RCH programmes, monitor the activities and initiate mid-course corrections. If this pattern of functioning is followed, the community, the link worker and the health functionaries will be performing the tasks that they are best suited for and the implementation of the programme will improve.

Involvement of PRI in Family Welfare Programme

2.10.134 There are immense differences between states in the involvement of PRIs in the Family Welfare Programme. States like Kerala have embarked on decentralised planning and monitoring programmes utilising PRIs and have devolved powers and finances to PRIs. Rajasthan, Andhra Pradesh and Haryana have implemented their own models for the involvement of the PRIs in the health sector. 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 started participating in the programme. There is a need to continuously review the situation and initiate appropriate interventions.

The Ninth Plan envisaged the involvement of PRIs for:

- Ensuring inter-sectoral coordination and community participation in planning, monitoring and management of the RCH programme.
- Assisting states in supervising the functioning of the health care related personnel including ANM, MMPW and AWW.
- Ensuring coordination of activities of workers of different departments such as health, family welfare, ICDS, social welfare and education etc. functioning at the village, block and district levels.
- Improving the acceptance of the Family Welfare Programme through increased community participation.

2.10.135 The real challenge of the Family Welfare Programme lies in effectively delivering the needed services in the remote and inaccessible areas where the services provided by the government machinery are the weakest and the private sector and NGOs are non-existent. During the Tenth Plan, it is envisaged that mature PRIs with intelligent, service-oriented members will play a key role in making the programme a people's programme and improving access to its services. The health committee of the gram panchayat can plan locally, identify area-specific unmet needs for reproductive health services and ensure that efforts are made to meet them. It can also be entrusted with the task of monitoring the attendance and performance of health care personnel. The PRIs can play a vital role in programme advocacy and monitoring the availability, accessibility and quality of services in government PHCs, NGOs and private practitioners and the cost of services provided by the latter. The PRIs will have the advance tour programmes of the ANM and male multipurpose worker and lists of nearest functioning PHCs with a doctor, nearest FRU/CHC with a peadiatrician, obstetrician, surgeon or physician where persons with complications and those requiring emergency care could be referred. They will monitor the funding of emergency transport provision as well as dispersal of funds under the Balika Samridhi Yojana and the Maternity Benefit Scheme. The active role and supervision of the PRIs is also crucial for ensuring 100 per cent registration of births, deaths, marriages and pregnancies at the village level.

Intersectoral Coordination

2.10.136 Inter-sectoral coordination, especially between the Departments of Health, Department of ISM&H, Women and Child Development, Human Resource Development, Rural Development, Urban Development, Labour, Railways, Industry and Agriculture is critical for increasing the coverage of the Family Welfare Programme and improving implementation. Some of the areas where inter sectoral 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 the girl child and women, 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 - anganwadi workers, TBAs, Mahila Swasthaya Sangh, Krishi Vigyan Kendra volunteers and school teachers - to achieve optimal utilisation of available services.

2.10.137 Suggested areas of convergence of services with Department of Education include:

- inclusion of educational material relating to health, nutrition and population in the curriculum for formal and non-formal education;
- involvement of all zilla saksharata samitis in IEC activities pertaining to the RCH programme;
- involving school teachers and children in Class V and above in growth monitoring, immunisation and related activities in the village at least once a month as a part of socially useful productive work.

2.10.138 Convergence of services with the Department of Women and Child Development include :

- involvement of anganwadi workers in the compilation of births and deaths and the identification of pregnant women;
- involving anganwadi workers in weighing babies as soon as possible after delivery and referring neonates with weight below 2.2 kg to centres where a paediatrician is available;
- utilising the services of the anganwadi worker in improving the coverage of Massive Dose Vitamin A in children when they are 18 months, 24 months, 30 month and 36 months of age and improving the compliance among pregnant women under iron-folic acid medication;
- identification of undernourished pregnant and lactating women and pre-school children to ensure that they get priority in food supplementation programmes under the ICDS and appropriate health care from ANMs and doctors;
- promoting the cultivation of adequate quantities of green leafy vegetables, herbs and condiments in coordination with the PRIs and agricultural extension workers and ensuring that these are supplied to anganwadis on a regular basis to improve micro-nutrient content of food supplements.

2.10.139 The anganwadi worker can assist the ANM in organising health check ups of women and children and immunisation in the anganwadi. She will act as depot holder for iron and folic acids tablets, ORS, condoms and disposable delivery kits. She will be provided with a list indicating the nearest facility to which women and children could be referred so that she can help in organising emergency referral. Intersectoral co-ordination with Department of Health and Department of ISM & H are discussed under respective chapters, co-ordination with Department of Women and Child Development for improving nutritional status are in the chapter of Food and Nutrition Security.

Research and Development

2.10.140 The ICMR is the nodal research agency for funding basic, clinical and operational research in contraception and maternal and child health. In addition, the Council for Scientific and Industrial Research (CSIR), Delhi, Department of Biotechnology (DBT) and the Department of Science and Technology (DST) fund research pertaining to the Family Welfare Programme. The National Committee for Research in Human Reproduction under the Chairmanship of the Secretary, Department of Family Welfare assists in drawing up priority areas of research and ensuring that there is no unnecessary duplication of research activities. Some of the

major institutions carrying out research in this area include the National Institute for Research in Reproductive Health, Mumbai, the National Institute of Nutrition, Hyderabad, the National Institute of Health and Family Welfare, New Delhi and the Central Drug Research Institute, Lucknow. The ICMR undertakes clinical and operational research studies through a network of Human Reproduction Research Centres (HRRCs) in medical colleges. The International Institute of Population Studies, Mumbai, and a network of 18 Population Research Centres conduct studies on different aspects of the Family Welfare Programme and undertake demographic surveys.

2.10.141 Under the RCH programme the Department of Family Welfare has constituted an expert committee for research in reproductive health and contraceptions under modern system of medicine and ISM&H to examine and recommend proposals that require funding. In addition, the Department is making efforts for the creation and support of an appropriate institutional mechanism to test and ensure the quality of products utilised in the programme.

2.10.142 Priority areas of research during the Tenth Plan are:

Basic and Clinical Research

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

Demographic/Operational Research

- ongoing demographic transition and its consequences;
- continuation rates and effectiveness of contraceptives under actual programme conditions;
- operational research to provide integrated delivery of health, nutrition and family welfare services at the village level through the existing infrastructure and manpower;
- testing of the relationship between couple protection rate and CBR and between the reduction of IMR and reduction in birth rate in states in different levels of demographic transition;
- improving access to safe abortion services;
- research aimed at detection, prevention and management of RTI/STI in different levels of health care; and
- socio-behavioural research to improve community participation in increased utilisation of family welfare services;

Monitoring and Evaluation

2.10.143 The recommendation of NDC Sub-Committee on Population for the creation of district-

level databases on quality, coverage and impact indicators for monitoring the programme was implemented during the Ninth Plan period. The following systems are being used for monitoring and evaluation of programmes in the Family Welfare Programme:

- reports from state and implementation agencies;
- Sample Registration System and Population Census;
- Rapid Household Surveys;
- large-scale surveys - NFHS, sample surveys by the NSSO and area-specific surveys by the Population Research Centres;
- other specific surveys by national and international agencies.

2.10.144 The Department of Family Welfare has constituted regional evaluation teams which carry out regular verifications and validate the data on the 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. RHS data about the progress on 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, facility surveys were conducted in 101 districts during 1998-99 and deficiencies found are being brought to the notice of the states and districts concerned. The format for monitoring the process and quality indicators under the RCH programme have been developed and sent to all the states. These may be operationalised during the Tenth Plan and the information generated used for mid-course corrections.

2.10.145 The substantial investments made in evaluation during the 1990s have increased awareness about the need for concurrent impact evaluation. During the Tenth Plan, efforts will be made to consolidate the gain by putting in place a sustainable system of evaluation at the district level in the form of CRS and district surveys. Efforts will also be made to reduce duplication of efforts through appropriate intersectoral coordination .

Reorganisation of Family Welfare Infrastructure

2.10.146 When the Family Welfare Programme was initiated in the early 1970s the infrastructure for providing maternal and child health and family planning services was inadequate at the primary health care level, and sub-optimal in the secondary and tertiary care levels. In order to quickly improve the situation, the Department of Family Welfare created and funded post-partum centres, urban family welfare centres/ health posts and provided additional staff to the then existing PHCs (block level PHC's). In addition, the ANMs in the sub-centres, created after the initiation of the Family Welfare Programme, were also funded by the Department. The Department of Family Welfare also created state and district level infrastructure for carrying out the programmes and set up training institutions for pre/in-service training of personnel. All these activities were being funded through Plan funds.

2.10.147 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 Department of Family Welfare under the scheme of rural family welfare centres and post partum centres are state health services personnel functioning as part of the state infrastructure. In view of this, the Ninth Plan recommended that their funding should be taken over by the state department of Health. States will take over the responsibility of funding staff of post partum centres and rural family welfare centres from 1st April 2002.

2.10.148 Since 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 problems with respect to the ANMs is that while the Department of Family Welfare funded over 97,000

posts, about 40,000 were funded by the state (from non-Plan). The Ninth Plan recommended that this dichotomy in funding should be removed and all the ANMs, as per the norms for the 1991 population should be funded by the Department of Family Welfare. This has been done from 1st April 2002. It is expected that this would ensure that the states do employ the required number of ANMs, streamline their functioning and improve the coverage, content and quality of maternal and child health care.

Zero Based Budgeting

2.10.149 In the past, the Family Welfare Programme has been considered as a single centrally sponsored scheme. As a result, the heads of funding were functional viz. Personnel, Services, Supplies, Transport, Area Development etc. All ongoing programmes including maternal and child health and immunisation, received inputs from these functional heads. In the Ninth Plan, major projects like RCH, pulse polio immunisation and strengthening of routine immunisation were added as schemes with large outlays. The Planning Commission and the Department of Family Welfare carried out an exercise to rationalize the schemes. A revised scheme-wise listing was evolved where, schemes for strengthening of infrastructure, area development project, training, research, programme related activities for contraception, immuninsation, maternal health, child health and nutrition were identified as specific schemes. After this, a zero based budgeting effort was taken up and schemes were identified for convergence, weeding out and transfer to the states. The summary of the zero based budgeting exercise is given in the Table-2.10.11. The scheme- wise outlays and anticipated expenditure during the Ninth Plan are given in Annexure-2.10.2. Yearwise outlay, R.E., and actual expenditure for the Ninth Plan is given in Table 2.10.12.

Path Ahead and Goals Set

2.10.150 Reduction in fertility, mortality and population growth rate are major objectives of the Tenth Plan. These will be achieved through meeting all the felt needs for health care of women and children. The focus will be on improving access to services to meet the health care needs of women and children by:

- a decentralised area-specific approach to planning, implementation and monitoring of the performance and effective 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;

Table-2.10.11

Zero Based Budgeting 2001

Category	No. of Schemes	Outlay for Ninth Plan (Rs. crore)	Anticipated expenditure during Ninth Plan (Rs. Crore)
Schemes to be transferred to the states	3	2,080.00	2,198.00
Schemes to be merged and retained	11/40	7,640.20	7,398.39
Schemes to be weeded out	8	185.85	31.25
Schemes to be retained	43	5,213.95	4,961.33
Total	94	15,120.00	14,588.97
Total No. of schemes to be continued in the Tenth Plan	54	12,854.15	12,359.72

Table 2.10. 12

Outlays, RE and expenditure during the Ninth Plan

(Rs in Crores)

Year	B.E.	R.E.	Actual Expenditure
1997-98	1829.35	1829.35	1822.00
1998-99	2489.35	2253.00	2342.75
1999-2000	2920.00	3120.00	3099.76
2000-01	3520.00	3200.00	3090.11
2001-02	4210.00	3700.00	3596.63
Total	14968.70	14102.35	13951.25

- filling the critical gaps, especially in CHCs, in existing infrastructure through appropriate reorganisation and restructuring of the primary health care infrastructure;
- ensuring that post of specialists in CHCs do not remain vacant; upgrading skills and redeploying 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 RCH services at the primary, secondary and tertiary care levels and improving referral services;
- providing adequate supply of essential drugs, diagnostics and vaccines; improving the logistics of supply;
- well coordinated activities for delivery of services by public, private and voluntary sectors to improve coverage;
- involvement of PRIs in planning, monitoring and mid-course correction of the programme at the local level;
- involvement of industry in the 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 over the counter (OTC) products such as ORT and condoms;
- effective IEC and motivation programmes; and
- effective inter-sectoral coordination.

2.10.151 Tenth Plan envisages reduction in IMR to 45 /1,000 by 2007 and 28/1,000 by 2012, reduction in MMR to 2/1000 live births by 2007 and 1/1,000 live births by 2012 and reduction in decadal growth rate of the population between 2001-2011 to16.2. The steep reduction in mortality and fertility envisaged are technically feasible within the existing infrastructure and manpower as has been demonstrated in several states/districts. It is imperative that the goals set are achieved within the time frame as these goals are essential prerequisites for improving the quality of life and human development. In view of the massive differences in the availability and utilsation of health services and health indices of the population, a differential strategy is envisaged so that there is incremental improvement in all districts. This, in turn, is expected to result in substantial improvement in state and national indices and enable the country to achieve the goals set for the Tenth Plan. Annexure 2.10.1 provides information of present status (as indicated by NFHS-2 and SRS) of process and impact indicators, the goals set for these in the National Health Policy 1983 (for 2000), Ninth Plan (for 2002), Tenth Plan and National Population Policy 2000 (for 2010). Statewise goals have been shown in Annexure 2.10.3. Tenth Plan scheme wise outlays for Department of Family Welfare are in Annexure 2.10.2 and Appendix.

Annexure 2.10.1

Indicator	Present Status	Goals			
		NHP-1983	Ninth Plan	Tenth Plan	NPP 2000
Target Year		**2000**	**2002**	**2007**	**2010**
Crude Birth Rate	25.8 SRS (2000)	21	24	21	21
Total Fertility Rate	2.85*	2.3	2.9	2.3	2.1
Couple Protection Rate (%)	46.2 Dept. of F.W. (2000)	60	51	65	Meet all needs
Maternal Mortality Ratio	540*	Below 200	300	200	Below 100
Perinatal Mortality Rate	-	30-35	-	-	-
Neo Natal Mortality Rate	43.4*	-	35	26	-
Infant Mortality Rate	68 SRS (2000)	Below 60	56	45	below 30
Under five Mortality Rate	94.9*	-	-	-	-
% immunished against 6 VPD (%)	42*	85	65	100	100
- Measles	51*				
- DPT	55*				
- Polio	63*				
- BCG	72*				
Ante-natal care (ANC)					
- % at least 3 ANC	43.8*	100	90	90	100
- % received IFA for 3 or 4 months	47.5*			100	100
- % received two doses of TT	66.8*		95	100	100
Deliveries					
Institutional Deliveries (%)	33.6*	-	35	80	80
Deliveries by trained health personnel & TBA (%)	42.3*	100	45	-	100
Prevalence of low birth weight (%)	30 (Estimated)	10	-	-	-

* ***Source :*** NFHS-2

Annexure 2.10.2

Outlays for Deptt. of Family Welfare

(Rs. in crore)

IX Plan	X Plan	Name of Scheme	Ninth Plan Approved Outlay	Ninth Plan Sum of Annual Outlay	Ninth Plan Ant. Expdt.	Approved Outlay Tenth Plan	Approved Outlay Annual Plan 2002-03
	A	**INFRASTRUCTURE MAINTENANCE**	**6231.90**	**6654.85**	**7506.17**	**12645.64**	**2303.00**
1		Rural Family Welfare Centres	1500.00	1600.00	1600.36		
2	1	Sub-Centres	2200.00	2346.00	2344.60	9663.00	1809.00
3	2	Urban FW Services	250.00	307.00	305.69	580.00	122.00
4	3	Direction & Administration	671.90	541.00	465.25	1100.00	200.00
5		Post Partum Centres	530.00	560.00	557.94		
6		Village Health Guides Scheme	50.00	40.00	39.70		
7	4	Logistics Improvement	80.00	51.85	4.84	90.00	10.00
	5	Contractual Services/ Consultancies	Included in RCH		Included in RCH	1212.64	162.00
8		ANM (Part of Sub-Centres)					
9		Additional ANMs/PHNs/Lab. Technicians					
10		SM Consultant					
11		Aneasthetist					
12		Other Exp. (State/National level Consultants/ Contingency)					
13		Arrears	950.00	1209.00	2187.79		
	B	**INFRASTRUCTURE DEVELOPMENT**	**1050.00**	**1202.35**	**915.76**	**2412.00**	**364.20**
14	6	Area Projects (IPP Projects)	800.00	820.00	637.79	987.00	74.80
15	7	Social Marketing Area Projects		82.35	6.42	25.00	10.00
16	8	USAID Assisted Area Project	250.00	300.00	271.55	400.00	59.40
17	9	Other Externally Aided Infrastructure Development Projects	Included in RCH			Included in RCH	
18	10	EC Assisted SIP Project	Included in RCH		Included in RCH	1000.00	220.00
	C	**TRANSPORT**	**150.0**	**250.50**	**250.65**	**378.00**	**113.00**
19	11	Maintainence of vehicle already available				303.00	98.00
20	12	Supply of Mopeds to ANMs				75.00	15.00
	D	**TRAINING**	**257.35**	**301.28**	**289.29**	**521.00**	**99.60**
21	13	Basic Training for ANM/LHVs	150.00	181.40	182.07	350.00	67.00
22	14	Maintenance & Strengthening of HFWTCs	40.00	48.06	46.94	70.00	14.00
23	15	Basic Training for MPWs Worker (Male)	35.00	37.90	35.76	50.00	10.00
24	16	Strenthening of Basic Training schools				10.00	2.00
25	17	F.W. Training and Res. Centre, Bombay	5.00	5.00	2.53	10.00	1.50
26	18	NIHFW, New Delhi	21.00	21.35	14.52	20.00	3.15
27	19	IIPS, Mumbai	5.70	6.90	6.83	10.00	1.70

Annexure 2.10.2 (Contd/-)

28	20	Assistance to I.M.A.	0.65	0.67	0.64	1.00	0.25
	E	**RESEARCH**	**96.00**	**107.00**	**96.58**	**159.50**	**30.30**
29	21	Population Research Centres	35.00	33.00	22.47	45.00	8.00
30	22	CDRI, Lucknow	8.00	8.00	8.00	12.00	2.30
31	23	ICMR and IRR	53.00	66.00	66.11	100.00	20.00
32	24	Other Research Projects				2.50	0.00
	F	**CONTRACEPTION**	**1541.50**	**1578.70**	**1458.35**	**2727.50**	**483.50**
	25	Free distribution of contraceptives	460.00	491.30	436.83	1045.00	184.00
33		Conventional Contraceptives	265.00	310.00	286.20	800.00	
34		Oral Contraceptives	80.00	78.40	65.66	130.00	
35		IUD	115.00	102.90	84.97	115.00	
36		New Methods					
	26	Social marketing of contraceptives	400.00	428.70	407.40	660.00	115.00
37		Conventional Contraceptives		360.85	339.04	550.00	
38		Oral Contraceptives		67.85	68.36	110.00	
	27	Sterilization	680.20	653.80	610.26	1002.00	180.50
39		Sterilization Beds	8.60	8.60	8.79	12.00	
40		Sterilsation and IUD insertion	600.00	575.00	534.22	900.00	
41		Supply /Procurement of Laparascopes	70.00	68.00	66.75	90.00	
42		Recanalization	1.60	2.20	0.50		
43	28	Testing Facilities	1.30	1.90	1.24	2.50	0.50
	29	Role of Men in Planned Parenthood	Included in RCH	3.00	2.62	18.00	3.50
44		No Scalpel Vasectomy		3.00	2.62	8.00	
45		Other Innovative Schemes *(Male Participation)*				10.00	
	G	**REPRODUCTIVE & CHILD HEALTH**	**5150.00**	**4423.30**	**3753.49**	**6333.86**	**1174.20**
	30	Immunisation	Included in RCH	Included in RCH	Included in RCH	1410.00	226.00
46		Procurement of Vacccines for Routine Immunisation				850.00	
47		Cold Chain					
		(a) Cold Chain Maintenance *(b) Cold Chain Equipment*				35.00 200.00	
48		Surveillence against VPDs					
49		Other Vaccines *(Hepatitis B)*				325.00	
50	31	Routine Immunisation Strengthening	Included in RCH	Included in RCH	Included in RCH	17.86	10.00
51	32	Pulse Polio	Included in RCH	Included in RCH	Included in RCH	1450.00	400.00
		(a) OPV *(b) Operating cost*				870.00 580.00	240.00 160.00

Annexure 2.10.2 (Contd/-)

	33	Child Health	Included in RCH	Included in RCH	Included in RCH	20.00	1.00
52		Essential New Born care *(Home based neonatal care)*				20.00	
53		Diarheal Diseases - Prevention/Treatment					
54		ARI-Prevention/Treatment					
	34	NUTRITION	Included in RCH	Included in RCH	Included in RCH	Included in RCH	Included in RCH
55		Vitamin-A Programme					
56	35	Adolescent Health	Included in RCH	Included in RCH	Included in RCH	50.00	3.00
	36	Maternal Health	Included in RCH	Included in RCH	Included in RCH	1384.00	254.00
57		Ante-natal care					
58		Nutritional Anaemia *(Anaemia Control & De-worming)*				30.00	
59		Home Delivery Care					
		(a) Community based midwives				30.00	
		(b) Dais Training				40.00	
60		Dais Kits *(Drugs, Kits & Equipments)*					
		(a) Drug Kits/FRU Drugs/PHC Drugs/RTI Drugs				704.00	
		(b) MTP/RTI/STI Equipment/Kit/IUD Kit				350.00	
		(c) Equipment for Blood Storage & Lab. Equipment				10.00	
		(d) Needles & Syringes				125.00	
		(e) Neo-Natal Equipment				20.00	
61		Promoting Institutional Deliveries					
		(a) 24 Hour Delivery				25.00	
		(b) Operationalising FRUs for Emergency Obs. & NN Care				50.00	
62	37	MTP Services (Manual Vac. Aspirator for safe abortion)	Included in RCH	Included in RCH	Included in RCH	4.00	1.20
63	38	RTI/ STI prevention and management	Included in RCH	Included in RCH	Included in RCH	35.00	2.00
	39	Other RCH Interventions and services	Included in RCH	Included in RCH	Included in RCH	730.00	122.00
64		Referral Transport				15.00	
65		Out reach Services				130.00	
66		RCH Camps				95.00	
67		Civil Works				350.00	
68		Research (In RCH Activities)				40.00	
69		MIS				90.00	
70		Expdt. At Headquarters				10.00	
71	40	NGOs and SCOVA	Included in RCH	Included in RCH	Included in RCH	130.00	22.00

Annexure 2.10.2 (Concld/-)

	41	Training	Included in RCH	Included	Included in RCH	328.00	53.00
72		RCH Training				265.00	
73		Training of ISM&H				15.00	
74		Training of AWW				48.00	
75	42	Tribal Projects	Included in RCH	Included in RCH	Included in RCH		
76	43	Urban Slums Projects	Included in RCH	Included in RCH	Included in RCH	700.00	5.00
77	44	District Projects	Included in RCH	Included in RCH	Included in RCH	75.00	75.00
78	45	Other Projects under RCH	Included in RCH	Included in RCH	Included in RCH		
	H.	**OTHER FAMILY WELFARE PROGRAMMES**	**643.25**	**450.72**	**318.68**	**1900.50**	**355.90**
79	46	Maternity Benefit Scheme	Transferred from M/o Rural Development	80.00	80.00	500.00	90.0
80	47	Information, Education and Communication	170.00	184.80	160.91	489.50	84.70
		Non-RCH					
		RCH					
81	48	Travel of Experts/Conferences /Meetings etc.	16.10	15.35	2.15	7.00	1.50
82	49	International Contribution	6.30	6.99	6.33	9.00	1.70
83	50	Empowered Action Group		30.00	30.00	250.00	50.00
84	51	Community Incentive Scheme		30.00	5.00	300.00	60.00
85	52	Family Welfare Link Health Insurance Plan		0.01	0.01	250.00	50.00
86	53	Policy Seminars		3.00	3.00	20.00	3.00
87	54	Other Initiatives	265.00	0.03	0.03	75.00	15.00
88		Strengthening of Rural Family Welfare Centres under National Human Development Initiative	Included in Sub-centres (scheme 2)	20.00	Included in Sub-centres (scheme 2)		
89		Other Offices under Direction & Administration	28.10	29.60	29.02		
90		ISM Institutions	7.00	5.02	1.39		
91		Regional Institute of MCH	0.75	0.60	0.31		
92		Hindustan Latex Limited	1.90	1.72	0.13		
93		Family Welfare Counsellor Scheme	1.00	1.00	0.00		
94		School Health Scheme	147.10	42.60	0.40		
	55	Additional RCH activities in the Tenth Plan				25.00	0.30
	56	Other New Initiatives				22.00	6.00
		GRAND TOTAL	**15120.00**	**14968.70**	**14588.97**	**27125.00**	**4930.00**

Goals for the Tenth Plan

Annexure-2.10.3

Sl. No.	Name of State/UT	Couple Protection Rate				Crude Birth rate		Total Fertility Rate		Infant Mortality Rate		Neo Natal Mortality Rate		Safe Delivery		Ante Natal Care (3 ANCs)	
		Current Level (Average of NFHS,RHS)		Expected Level 2007													
		By Ster.	Spacing (Modern)	Permanent	Spacing (Modern)	Current level SRS 2000	Expected Level 2007	Current level SRS 1998	Expected Level 2007	Current level SRS 2000	Expected Level 2007	Current level NFHS-2	Expected Level 2007	Current level NFHS-2	Expected Level 2007	Current level NFHS-2	Expected Level 2007
	INDIA	**35.5**	**8.0**	**50.0**	**15.0**	**25.8**	**21**	**3.2**	**2.3**	**68**	**45**	**43.4**	**26**	**42.3**	**80**	**43.8**	**90**
I.	**MAJOR STATES**																
1	Andhra Pr	57.4	1.4	65.0	10.0	21.3	17	2.4	1.8	65	42	43.8	22	65.2	90	80.1	95
2	Assam	15.1	12.5	35.0	16.9	26.9	22	3.2	2.3	75	50	44.6	30	21.4	55	30.8	80
3	Bihar	20.7	2.2	30.0	10.0	31.9	24	4.3	2.8	62	45	46.5	25	23.4	70	17.8	80
4	Chattisgarh	38.0	5.0	45.0	10.0	26.7	22	NA	2.6	79	50	54.9	38	65.9	95	28.1	85
5	Gujarat	44.0	8.8	60.0	21.2	25.2	20	3.0	2.1	62	40	39.6	22	53.5	80	60.2	95
6	Haryana	40.1	12.9	56.3	26.0	26.9	22	3.3	2.2	67	40	34.9	23	42	80	37.4	95
7	Jharkhand	21.0	2.0	30.0	10.0	26.5	22	NA	2.6	70	50	46.5	35	42.4	60	17.8	80
8	Karnataka	52.5	4.8	60.0	12.7	22.0	20	2.4	2.0	57	40	37.1	21	59.1	85	71.4	95
9	Kerala	50.7	6.3	60.0	10.7	17.9	15	1.8	1.6	14	9	13.8	5	94	100	98.3	100
10	Madhya Pr	38.0	5.1	55.0	17.0	31.2	23	3.9	2.6	88	58	54.9	30	29.7	70	28.1	85
11	Maharashtra	51.4	7.7	66.0	14.9	20.9	17	2.7	2.1	48	34	32	20	59.4	95	65.4	98
12	Orissa	34.8	5.1	55.0	12.9	24.3	21	2.9	2.2	96	68	48.6	35	33.4	70	47.3	90
13	Punjab	31.0	22.8	55.0	30.0	21.5	18	2.6	2.1	52	35	34.3	15	62.6	90	57	95
14	Rajasthan	37.1	6.2	45.0	15.5	31.2	22	4.1	2.7	79	50	49.5	30	35.8	70	22.9	80
15	Tamil Nadu	45.8	4.4	60.0	12.0	19.2	16	2.0	1.7	51	30	34.8	20	83.8	100	91.4	100
16	Uttar Pr	14.9	7.0	35.0	21.0	32.8	24	4.6	2.7	83	58	53.6	35	22.4	75	14.9	80
17	West Bengal	32.9	13.5	50.0	19.4	20.6	17	2.4	2.1	51	38	31.9	25	44.2	80	57	95
II.	SMALLER STATES																
1	Arunachal Pr	18.4	15.0	30.0	20.8	22.3	20	2.8	2.4	44	40	41.8	30	31.9	65	40.5	80
2	Goa	28.6	8.9	45.0	12.4	14.3	12	1.8	1.5	23	9	31.2	20	29.7	75	95.7	100
3	Himachal Pr	51.5	10.1	65.0	19.6	22.1	20	2.4	2.0	60	35	22.1	15	40.2	80	60.9	85
4	J & K	30.3	14.1	40.0	18.5	19.6	17	NA	2.0	50	40	40.3	30	23.4	75	66	80
5	Manipur	12.8	9.8	30.0	15.8	18.3	16	2.4	2.0	23	20	18.6	10	53.9	85	54.4	80
6	Meghalaya	8.6	8.0	30.0	10.8	28.5	23	4.0	2.6	58	50	50.7	40	20.6	50	31.3	80
7	Mizoram	42.3	10.0	56.8	15.5	16.9	16	NA	2.0	21	19	18.8	12	67.5	90	75.8	90
8	Nagaland	12.3	10.7	30.0	14.1	NA	15	1.5	1.5	NA	32	20.1	15	32.8	60	23.1	85
9	Sikkim	23.9	20.2	31.3	28.5	21.8	17	2.5	2.1	49	45	26.3	20	35.1	60	42.6	85
10	Tripura	20.0	20.0	30.0	36.4	16.5	16	3.9	2.6	41	35			48.3	60	51	85
11	Uttaranchal	30.0	10.0	40.0	18.2	20.2	18	NA	2.0	50	40	53.6	30	22.4	80	19.6	80
III.	UNION TERRITORIES																
1	A&N Islands	44.7	13.6	50.0	15.0	19.1	15	1.9	1.7	23	22			71.3	80	92.3	100
2	Chandigarh	21.1	35.9	40.0	35.0	17.5	14	2.1	1.9	28	25			71.2	80	73	85
3	D&N Haveli	29.7	5.7	35.0	10.0	34.9	23	3.5	2.8	58	50			27.6	60	74.6	85
4	Daman & Diu	44.4	6.3	50.0	10.0	23.7	16	2.5	2.1	48	45			70.6	85	80.7	90
5	Delhi	28.7	33.6	40.0	30.0	20.3	16	1.6	1.6	32	25	29.5	20	73.7	85	68.2	85
6	Lakshadweep	7.4	4.1	30.0	10.0	26.1	20	2.8	2.4	27	25			74.1	85	98.3	100
7	Pondicherry	50.6	6.2	65.0	10.0	17.8	16	1.8	1.6	23	20			93.4	100	95.8	100