CHAPTER- III
REPRODUCTIVE HEALTH

3.1. Concept of reproductive health

The oldest definition of health is the absence of disease. In recent years, it has been realized that health is an integral part of development and also an important measure of any society’s development progress. Health is defined in WHO’s constitution as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Reproductive health is also a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life. The International Conference on Population and Development Programme of Action states that "reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so”. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Reproductive health includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases”.

Reproductive health is a crucial part of general health and a central feature of human development. It is a reflection of health during childhood, and crucial during adolescence and adulthood. It sets the stage for health beyond the reproductive years for both women and men, and affects the health of the next generation. The health of the newborn is largely a function of the mother’s health and nutrition status and of her access to health care. Though reproductive health is a universal concern, it is of special importance for women particularly during the reproductive years. Although
most reproductive health problems arise during the reproductive years, during old age
general health continues to reflect earlier reproductive life events. Men too have
reproductive health concerns and needs, though their general health is affected by
reproductive health to a lesser extent than is in the case for women. However, men
have particular roles and responsibilities in terms of women's reproductive health
because of their decision-making powers in reproductive health matters. At each stage
of life individual needs differ. Failure to deal with reproductive health problems at
any stage in life sets the scene for later health and developmental problems. Because
reproductive health is such an important component of general health it is a
prerequisite for social, economic and human development. The highest attainable
level of health is not only a fundamental human right for all, it is also a social and
economic imperative because human energy and creativity are the driving forces of
development. Such energy and creativity cannot be generated by sick, tired people,
and consequently a healthy and active population becomes a prerequisite of social and
economic development (DLHS- 2 INDIA, Reproductive and Child Health District
Level Household Survey, 2002- 04).

Reproductive health does not start out from a list of diseases or problems -
sexually transmitted diseases, maternal mortality - or from a list of programmes -
maternal and child health, safe motherhood and family planning. Reproductive health
instead must be understood in the context of relationships: fulfilment and risk; the
opportunity to have a desired child or alternatively, to avoid unwanted or unsafe
pregnancy. Reproductive health contributes enormously to physical and psychosocial
comfort and closeness and to personal and social maturation. Poor reproductive health
is frequently associated with disease, abuse, exploitation, unwanted pregnancy, and
death. The most significant achievement of the Cairo Conference was to place people
firmly at the centre of development effort as protagonists in their own reproductive
health and lives rather than as objects of external interventions. The aim of
interventions is to enhance reproductive health and promote reproductive rights rather
than population policies and fertility control. This implies the empowerment of
women (including through better access to education); the involvement of women and
young people in the development and implementation of programmes and services;
reaching out to the poor, the marginalized and the excluded; and assuming greater
responsibility for reproductive health on the part of men.
Programmes dealing with various components of reproductive health exist in some form almost everywhere. But they have usually been delivered in a separate way, unconnected to programmes dealing with closely interdependent topics. For example, the objectives, design and evaluation of family planning programmes were largely driven by a demographic imperative, without due consideration to related health issues such as maternal health or STD (Sexually Transmitted Disease) and their prevention and management. Evaluation was largely in terms of quantity rather than quality - numbers of contraceptive acceptors as opposed to the ability and opportunity to make informed decisions about reproductive health issues. In general, such programmes exclusively targeted women, taking little account of the social, cultural and intimate realities of their reproductive lives and decision-making powers. They tended to serve only married people, excluding, in particular, young people. Services were rarely designed to serve men even though they have reproductive health concerns of their own, particularly with regard to STD. Moreover, the involvement of men in reproductive health is important because they have a major role to play as family decision-makers with regard to family size, family planning and use of health services. A reproductive health approach would differ from a narrow family planning approach in several ways. It would aim to build upon what exists and at the same time to modify current narrow, vertical programmes to ones in which every opportunity is taken to offer women and men a full range of reproductive health services in a linked way. The underlying assumption is that people with a need in one particular area - say treatment of sexually transmitted diseases - also have needs in other areas - family planning or antenatal/postpartum care. Such programmes would recognize that dealing with one aspect of reproductive health can have synergistic effects in dealing with others. For example, management of infertility is difficult and expensive but it can be largely prevented through appropriate care during and after delivery and prevention and management of STDs. Promotion of breast-feeding has an impact on reproductive health in many ways - it helps prevent certain postpartum problems, delays the return to fertility, may help prevent ovarian and breast cancer, and improves neonatal health. Another important difference between existing programmes and those developed to respond to the new concept of reproductive health is the way in which people - particularly women and young people who are the most affected by reproductive health concerns- are involved in programme development,
implementation and evaluation. When women become more involved in programmes it becomes clearer that they have health concerns beyond motherhood and also that dealing with reproductive health involves a profound rethinking of the behavioural, social, gender and cultural dimensions of decision-making which affect women's reproductive lives.

The reproductive health needs and concerns and the programmes and policies to address them vary from country to country. Globally, both the epidemiological data and the expressed wishes of diverse constituencies indicate that reproductive health interventions are most likely to include attention to the issues of family planning, STD prevention and management and prevention of maternal and perinatal mortality and morbidity. Reproductive health should also address issues such as harmful practices, unwanted pregnancy, unsafe abortion, reproductive tract infections including sexually transmitted diseases and HIV/AIDS, gender-based violence, infertility, malnutrition and anaemia, and reproductive tract cancers. Appropriate services must be accessible and include information, education, counselling, prevention, detection and management of health problems, care and rehabilitation. Reproductive health strategies should be founded first and foremost on the health of individuals and families. In the operationalization of the strategies all reproductive health services must assume their responsibility to offer accessible and quality care, while ensuring respect for the individual, freedom of choice, informed consent, confidentiality and privacy in all reproductive matters. They should focus special attention on meeting the reproductive health needs of adolescents.

3.2. Factors affecting reproductive health

Reproductive health affects and is affected by the broader context of people's lives, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships and the traditional and legal structures within which they live. Sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors. Therefore, the attainment of reproductive health is not limited to interventions by the health sector alone. Nonetheless, most reproductive health problems cannot be significantly addressed in the absence of health services and medical knowledge and skills. The status of girls and women in society and how they are treated or mistreated, is a
crucial determinant of their reproductive health. Educational opportunities for girls and women powerfully affect their status and the control they have over their own lives and their health and fertility. The empowerment of women is therefore an essential element for health. There are several factors influencing the reproductive health:

(i) **Status of women**: Maternal mortality and maternal morbidity are the most sensitive indicators of the status of women in a society. The status of women is related to awareness, knowledge and practice of family planning. Education is the key element for improving the status of women. Education helps women to read information regarding family planning, birth control, advantages of small family from commonly available media such as TV, poster, newspaper etc. Exposure to mass media is considered as most important factor, which have indirect effect on fertility.

(ii) **Family planning**: Family planning is now called family welfare is a mixed programme for women. Since its inception, the programme has undergone various efforts to control fertility level. Family planning is the conscious efforts of couples to limit the number of births and spacing of births. Female sterilization is the most popular contraceptive method among all the communities. Same is the case with Boro-Kachari tribe. Lack of proper knowledge of family planning and misconception about the family planning methods precludes them to use non-terminal methods. Some expressed their beliefs about the side-effects of operation that it could cause physical weakness and dizziness. Due to emphasis on terminal methods, most women remain unprotected from closely spaced births. Some of the user complained their suffering from side effects of contraceptives. Poor spacing depletes the health of mother. So the popularization of spacing methods of contraception is an important necessity for promoting maternal health and chances of child survival.

(iii) **Maternal care and safe motherhood**: Maternal mortality in developing countries is more than 100 times higher than the industrialized countries. Pregnancy is one of the most critical and unique period in a woman’s life cycle. In India, many women die from a pregnancy related causes and child birth. The six major causes of maternal mortality are anaemia, haemorrhage,
eclampsia, obstructed labour, infection or abortion. Except obstructed labour, the other five causes are the most important causes of maternal deaths in developing countries. All these causes are preventable. The main purpose of maternal health care is to provide all necessary facilities to pregnant women during pregnancy period and delivery, which help them to have a safe delivery and also to deliver a normal and healthy baby. The various components of maternal and child health care are antenatal care, natal care, post-natal care, breast feeding, weaning and nutrition of the mother and child. Antenatal care is the care of the women during pregnancy. The aim of antenatal care is to promote, protect and maintain the health of the mother. The post natal care is the care of the mother and the new born.

(iv) **Abortion:** Abortion is one of the most important components of reproductive health. In India, the Medical Termination of Pregnancy (MTP) act was passed in 1971. The aim of the act was to reduce maternal mortality and morbidity due to illegal abortion.

(v) **Infertility:** Infertility refers to the inability to have a live birth. Infertility may be primary or secondary. In India, emphasis on fertility control reduces the study of infertility, which is a serious aspects of reproductive health and it has some bad consequences. In some societies the problem of infertility often leads to marital violence. The cost of treatment of infertility is beyond the capacities of poor and treatment takes long time. Women’s poor health and nutrition status may be the cause of repeated miscarriages and foetal wastage.

(vi) **Infant and child health:** Infant and child mortality are sensitive indicators of the physical well being of population and it reflects the socio-economic development of a society. Infant and child mortality are closely associated with national socio-economic development as well as the social class of the parents. A united Nation Panel (1971) reported that in developing world malnutrition is an important cause of infant and young child mortality (Dutta, 2004).

(vii) **Nutrition:** Nutrition may be defined as the science of food and its relationship to health. The word Nutrient or food factor is used for specific dietary constituents such as proteins, vitamins and minerals. Nutrient availability to the child as well as to the mother during pregnancy and lactation is an
important factor for determining the nutritional status of the child. Good nutrition means maintaining a nutritional status that enables one to grow well and enjoy good health.

(viii) **Adolescent reproductive health and sexuality:** Adolescent fertility refers to fertility in the adolescent age i.e., in the age group of 15-19. It is very important to study adolescent reproductive health because it has numerous consequences in different aspects. The study on adolescent reproductive health is very little in India. High adolescent fertility results in high overall fertility. Reproductive tract infections are a major health problem. Millions of young people around the world become infected with sexually transmitted diseases every year. Many rural women believe that reproductive tract infections are caused due to diet or promiscuity. Actually the reason of sexually transmitted reproductive tract infections is the effect of increased sexual abuses and sexual violence. They even have no idea about sexually transmitted diseases like HIV and AIDS.

3.3. **Reproductive health problems: its impact on women**

Women bear by far the greatest burden of reproductive health problems. Women are at risk of complications from pregnancy and childbirth; they also face risks in preventing unwanted pregnancy, suffer the complications of unsafe abortion, bear most of the burden of contraception, and are more exposed to contracting, and suffering the complications of reproductive tract infections, particularly sexually transmitted diseases (STDs). Among women of reproductive age, 36% of all healthy years of life lost are due to reproductive health problems such as unregulated fertility, maternal mortality and morbidity and sexually transmitted diseases including HIV/AIDS. By contrast, the equivalent figure for men is 12%. Biological factors alone do not explain women's disparate burden. Their social, economic and political disadvantages have a detrimental impact on their reproductive health. Young people of both sexes are also particularly vulnerable to reproductive health problems because of a lack of information and access to services.
3.4. Reproductive system diseases in women

Reproductive System Disease is a genetic term that refers to all the diseases that affect the organs of reproductive system in human beings. This includes all the inherited or acquired diseases, abnormal functioning of the glands related secretion of sex hormones, infections and other diseases erupting from unknown causes. Reproductive system diseases need immediate attention as the chances of transmission of the diseases to healthy individuals is high, if the disease happens to be a sexually transmitted one. Given below is the list of reproductive system disorders in women.

i. Amenorrhea

It refers to a condition in which an individual fails to menstruate. It is classified in to two types, primary amenorrhea and secondary amenorrhea. Primary amenorrhea is the abnormal delay for the menstrual cycle to initiate, where as secondary amenorrhea is the abrupt cessation of menstrual cycle after years of regular menses. Secondary amenorrhea accurs in women who have not yet reached perimenopausal age.

ii. Cervical Erosion

Cervical erosion is the condition in which ulcers are formed in the cervix region. It is characterized by bright red, pink spots around the cervical opening. During the onset of the disease, patches of mucous are shed by the body.

iii. Cervicitis

It is basically an inflammation of uterine cervix. Many mucous glands are present in this region which constantly keeps the vagina well lubricated. However, this creates a conductive environment for the growth of bacteria and other microbes. Thus vaginal infections can be transmitted to the uterine cervix, leading to cervicitis.

iv. Oligomenorrhea

It is a condition characterized by prolonged gap between two menses. Typically, a woman menstruates every 25 to 30 days, however in oligomenorrhea; the woman only menstruates for 4 to 9 times in a year. Oligomenorrhea may cause due to estrogen deficiency and may lead to infertility.
v. Puerperal fever

It is also called child bed fever as it mostly occurs within 10 days of child birth or miscarriage. The raw placenta, after separation becomes very prone to infections and lacerations. This disease is characterized by a very high fever, which must be reported to the physician (Dutta, 2004).

3.5. National Rural Health Mission: Role and function

Health care is one of the most important interventions in the process of economic and social development and improved quality of life of the citizens. The Government of India after experimentations of various programmes to improve the quality of health including improved nutrition, sanitation, and hygiene and safe drinking water has launched the National Rural Health Mission (NRHM) on 1st April of 2005. The main objective of the Mission is to carry out necessary architectural correction in the basic health care delivery system. It aims at provision of comprehensive and integrated primary health care to the people, especially to the rural poor, women and children. It also aims at mainstreaming the Indian System of Medicine to facilitate health care. The expected national outcomes from the Mission are- Reduction of Infant Mortality Rate (IMR), Reduction of Maternal Mortality Rate (MMR), Reduction of Total Fertility Rate (TFR), Reduction of Malaria Mortality Rate etc. National Rural Health Mission will provide effective health care to the rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralisation. It covers the entire country, with special focus on 18 states where the challenge of strengthening poor public health systems and thereby improve key health indicators is the greatest. These are Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu and Kashmir, Assam, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura. NRHM is not a new programme of Govt. of India but NRHM is the combination of national programmes, namely, the Reproductive and Child Health II project, (RCH II) the National Disease Control Programmes (NDCP) and the Integrated Disease Surveillance Project (IDSP).
NRHM will also enable the mainstreaming of Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health (AYUSH).

While providing a broad framework for operationalisation, NRHM lists a set of core and supplementary strategies to meet its goals. The core strategy of NRHM will include decentralisation of villages and district level Rural Planning and Management and to appoint ASHA for creation of awareness, to counsel women and for the mobilisation of community facilities for accessing health related services. ASHA is supposed to escort pregnant women for delivery to institutions as PHC/FRU. The Ayurvedic system will improve management capacity to organise health system and Public Health Services.

Supplementary Strategies include regulation of the private sector to improve equity and reduce out of pocket expenses, foster public–private partnerships to meet national public health goals, re-orienting medical education, introduction of effective risk pooling mechanisms and social insurance to raise the health security of the poor, and taking full advantage of local health traditions. A Task Group on Urban Health is being constituted to recommend strategies for urban poor.

The Union Minister for Health & Family Welfare will provide policy guidance and operational oversight at the National level. Secretary of Planning Commission, Rural Development, HRD, H&FW, H&FW Secretary of 4 states and 10 Public Health professional nominated PM will be members of Mission steering group. At the State level, the State Health Mission shall be led by the Chief Minister. It shall be co-chaired by the Health Minister with the State Health Secretary, as convenient, and representation from related Departments, NGOs, private professionals etc. The District Health Mission shall be led by the Chairman, Zila Parishad, and be convened by the District Head of the Health Department. It shall have representation from all relevant Departments, NGOs and private professionals.

The role of the State Governments under the NRHM:

- The mission covers the entire country. The 18 high focus state are Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu and Kashmir, Assam, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura.
rest of the states have to follow the pattern of high focus states for programme management units and upgradation of SC, PHC and CHC through integrated financial envelope.

- NRHM provides board conceptual framework. States would project operational modalities in their State Action Plans, to be decided in consultation with the Mission Steering Group.

- NRHM would prioritise funding for addressing inter-state and intra-district disparities in terms of health infrastructure and indicators.

- States would sign Memorandum of Understanding with Government of India, indicating their commitment of increase contribution to Public Health Budget (preferably by 10% each year), increased devolution to Panchayati Raj Institutions as per 73rd Constitution (Amendment) Act. and performance benchmarks for release of funds.

For developing the Village Health Plan with the support of the ANM, ASHA, AWW and Self Help Groups, Block level Panchayat Samitis will coordinate the work of the GP in their jurisdiction and will serve as link to the DHM. The major role of Panchayat is to select ASHA preferably from there village.

Broadly speaking, the common activities under NRHM, which are uniformly applicable across all states/UTs over and above those proposed under ongoing programmes like RCH and National Disease Control Programmes are as follows:

i. Constitution of State and District Health Missions

ii. Merger of Health and Family Welfare Societies

iii. Preparation of State Action Plan, which identifies sectoral needs and priorities

iv. Finalising performance benchmarks for MOU

v. Signing of MOU between State and GOI


vii. Upgrading two CHCs in every district to the level of Indian Public Health Standards, including the provision for two rooms in these CHCs for bringing AYUSH practitioners under the same roof.
viii. Formation of Rogi Kalyan Samitis

ix. Immunisation strengthening through induction of Auto Disabled Syringes and arrangement for alternate vaccine delivery at immunisation sites.

x. Organising mobile medical services at district level.

xi. Organising Health Camp at AWW level on a fixed day in a month for assured services for women and child health care.

xii. Provision of household toilets.

xiii. Strengthening institutional delivery under Janani Suraksha Yojana (JSY) through provision of escort and referral services by ASHA & subsidised hospital services for BPL women.

xiv. Establishing systems to increase accountability of health systems to PRIs.

xv. Selection and training of ASHA, including provision of drug kits

xvi. Organising Health Melas as a platform to inform and educate the public on NRHM

xvii. Provision of generic drugs, both AYUSH and allopathic, at village, SC/PHC/CHC level, for common ailments.

These activities as mentioned above shall be specially funded in the 18 high focus States (Rapid Appraisal of National Rural Health Mission Implementation Supported by Ministry of Health & Family Welfare, Govt. of India, New Delhi, District: Jorhat, Assam, 2009).

**Role and function of state and centrally sponsored schemes under NRHM**

a. **Janani Suraksha Yojana (JSY)**

JSY is a safe motherhood intervention under NRHM being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. The scheme provides cash assistance to mothers who have delivered in Govt. health institutions and accredited pvt. hospitals. A mother from rural area get Rs. 1400/- and mother from urban area get Rs. 1000/- as a cash assistance through this scheme.
Table III.1: Year wise break up of JSY beneficiaries in Assam

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<th>Year</th>
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<td>1,82,873</td>
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b. Janani Sishu Suraksha Karyakram (JSSK)

Implemented from February, 2012 JSSK is a National initiative to make available better health facilities for women and child. The new initiative of JSSK would provide completely free and cashless services to pregnant women including normal deliveries and caesarean operations and sick new born (up to 30 days after birth) in Govt. Hospitals and accredited Pvt. Hospitals in both rural and urban areas.

Entitlements for pregnant women: Free and cashless delivery, free caesarean-section, free drugs and consumables, free diagnostics tests such as blood test, urine test etc.

Free nutritional diet during stay in health institutions (up to 3 days for normal delivery and 7 days for caesarean sections). Under this scheme free nutritional supplement such as horlicks to the mothers, free ultra sonography, free tests required for blood transfusion, free conveyance from home to health institution, between health institutions in case of referral, and free drop back home after delivery under the ‘Aadarani Scheme’.

Entitlements for newborn till 30 days after birth: It includes free treatment at the public health institutions, free drugs and consumables, free diagnostics such as blood test, urine examination, and free tests required for blood transfusion, exemption from all kinds of user charges.
c. **Mamata**

The Mamata scheme seeks to reduce Infant Mortality Rate and Maternal Mortality Rate, by insisting on a post-delivery hospital stay of 48 hours of the mother and the newborn. Any complication that may arise during this period is addressed by skilled doctors available at Govt. health institutions or accredited pvt. hospitals. During discharge from hospital, the mother receives a gift hamper called the ‘Mamata Kit’. This kit contains essential products for baby viz. baby powder, baby oil, a mosquito net, a flannel cloth etc. After 48 hours of stay in government hospital, the mamata kit is given to the mother.

d. **Village Health and Nutrition Day (VHND)**

The main objectives of Village Health and Nutrition Day are to ensure safe motherhood, child care and awareness generation among the rural masses right at the village level. On that day, routine immunization of children aged between 0-9 months and vaccination of pregnant women are done at the village itself. These services are also available at the Sub-centres. Organized on a predetermined and publicized date every month, the VHND allows people to get in touch with health workers and discuss health related issues. ASHA organizes VHND in her village in a Wednesday once in a month in cooperation with the Village Health & Sanitation Committee wherein ANMs deliver the services.

e. **Mamoni**

Cash assistance to pregnant women for nutritional support @ Rs. 1000/- is to be given in two installments. ‘Mamoni’ is a scheme of the Government of Assam that encourages pregnant women to undergo 3 ante-natal checkups which identify danger sings during pregnancy (needing treatment) and offer proper medical care. Under this scheme, at the time of registration, every pregnant woman receives a booklet on tips on safe motherhood and newborn care titled ‘Mamoni’. During subsequent ANC checkup, the pregnant women are provided with an amount of Rs. 1000/- (in two instalments, first for 2\(^{nd}\) ANC and second for 3\(^{rd}\) ANC) for expenses related to nutritional food and supplements. Every Govt. health institution offers these services for the women who have registered in their place. The source of fund is given by Assam Bikash Yojana, State Govt., sponsored schemes under Health & Family Welfare Department.
f. Majoni

Social assistance to the entire girl child born in the family up to second order is given a fixed deposit of Rs. 5,000/- for 18 years. On her 18th Birthday, the girl will be able to encash the fixed deposit. In case she is married before attaining 18 years of age, the fixed deposit will be forfeited. This scheme is applicable to families who are limiting themselves to two children. Under Majoni, every time a girl is born in a Government-run hospital in Assam, a fixed deposit account of Rs. 5,000/- will be opened in her name to be encashed when she is 18. Source of fund is given by Assam Bikash Yojana, State Govt., sponsored schemes under Health & Family Welfare Department.

g. Family Planning

Through this scheme people can be benefited in these ways like fixed day sterilization in all the District Hospitals, special monthly sterilization camps in CHC/PHC, IUCD insertion facility in all Govt. hospital and Sub-centre, No Scalpel Vasectomy (NSV) camp cum training are held time to time in District Hospitals, CHC, PHC. The family planning compensation are- for male sterilization Rs. 1100/- to be the beneficiary and Rs. 200/- to the motivator. And for female sterilization Rs. 600/- to the beneficiary and Rs. 150/- to the motivator. This facility can be availed in all health facilities.

h. Mobile Medical Unit

The MMU is an initiative under the National Rural Health Mission, Assam to bring health care to the doorstep of rural people with basic diagnostics facilities and specialists. The MMU will carry out the services like Curative Care, Reproductive and Child Health Services, Family Planning Services, Diagnostic, Specialized facilities & Services, Emergency Service & Care in times of disaster. The Sub-divisional level MMU was recently launched in 23 sub divisions of Assam to increase the services. Every month the DHS arranges camps in far-flung areas of the District to provide quality health care services.

i. ‘108 Mrityunjoy’ Emergency Referral Services

This scheme includes free transportation to the entire sick person including the pregnant women and sick new born. Looking at the demand for comprehensive emergency system in the year 2008-09 the state has implemented Emergency Referral
Service through public private partnership with Satyam Foundation, a non profit organization providing emergency services in the state. These ambulances are being strategically placed in the district and they cater to any type of emergency. The EMRI functions 24X7 with dedicated team members. It has a toll free emergency number ‘108’ which lands at Emergency Response Centre (ERC), this centre located in Guwahati and caters to the entire state. At present there are total 280 ambulances are operational in the state and they are providing emergency referral transport on 24X7 basis. From 2008 this service launched in Assam.

j. Sarathi 104 - Health Information Help Line

Sarathi 104 is a one stop health information helpline for resolving all health related issues of the citizens of Assam in a time bound manner. Any citizen dialing 104 from any corner of Assam will have access to the following: medical advice and counseling help line for ASHA workers, relief and remedy against the following like medical negligence, inaction, delayed treatment, improper or wrong treatment, non availability of medicines, lapses in implementation of health schemes of the government etc.

k. Menstrual Hygiene Programme for Adolescent Girls

To promote menstrual hygiene behavior among adolescent girls in the age group of 10 to 19 years. Low cost sanitary napkin at Rs. 6/- per packet is sold by ASHA to adolescent girls. It was implemented in 2011-12 in 7 districts of Assam viz. Dhubri, Goalpara, Barpeta, Kamrup (Metro), Kamrup (Rural), Nagaon and Morigaon.

l. Distribution of free Iron tablets

Anaemia is characterized by a low level of haemoglobin in blood. Anaemia usually results from a nutritional deficiency of iron, folate, vitamin B_{12}, or some other nutrients. It may become an underlying cause of maternal mortality and perinatal mortality. In India 100 iron and folic acid tablets are provided by free to pregnant women in order to prevent anaemia during pregnancy. Free iron tablets are also provided by adolescent girl also.

3.6. Family welfare planning

The aims of family welfare planning are:

i. To bring down population growth, so as to ensure a better standard of living.
ii. From economic and social point of view: already existing nearly 900 million are deficient in their basic needs of food, clean water, clothing, housing, education and proper health care. Spacing of birth and small family norm will improve the health of the mothers and their children so that a healthier society can emerge.

iii. To reduce the maternal and infant mortality rates- there are about 600,000 maternal deaths each year throughout the globe of which 99% occur in the developing world. Maternal mortality and morbidity could be reduced significantly by effective use of contraception. Nearly six million infant deaths might be avoided if all pregnancies occurred to women between the ages of 18-35; if the intervals between pregnancies were at least two years and if no women had more than four children.

iv. To prevent pregnancies that are too early, too frequent and too many and the number of unsafe abortion.

3.7. Contraception control

i. To bring down the birth rate to a realistic minimum during a given period of time. There are about 168 million eligible couples in India according to census 2001. The term ‘eligible couple’ is applied to couples with wives in the reproductive age group of 15-49 years and who require the use of some sort of family planning method. Latest report shows that about 44% of the eligible couple in India is practicing effective method of contraception.

To bring about certain social changes like-

a. To educate and motivate the sexually active and fertile couple to accept the small family norm.

b. To increase the literacy rate especially among women in rural areas.

c. To raise the marriageable age of both boys and girls. Low age of marriage not only contributes to the increased birth rate but adversely affects the health of the women. In 1978, the Indian Parliament approved the bill fixing the minimum age of marriage at 21 years for men and 18 years for women.

d. To maximize the access of good quality, wide variety, client oriented family planning services and to fulfill unmet need of contraception.
3.8. **Maternity and child health services**

i. Maternity services are to be extended through antenatal, intranatal and postnatal care with immunization against tetanus and prevention and correction of anaemia.

ii. Children are to be protected through an immunization schedule and vitamin supplementation programme.

3.9. **Other services**

These include:

i. Sex education and marriage guidance

ii. Research and evaluation of the programme; research about normal reproduction; investigation and treatment of infertility and recurrent abortion.

It also includes evaluation of pregnancy termination (safe abortion) as a method of family limitation.

Health seeking behaviour is an important factor in health management, but this is often ignored while considering schemes for providing health facilities to people. As a result, new schemes for providing health care do not get the desired acceptance of the community, and are therefore rendered unsuccessful. The decision makers in the health sector are recognising the need for understanding the health seeking behaviour of the community and its acceptance and usage of traditional and modern methods, as also the perception of the community regarding the service delivery (Singh, 2005). This becomes especially relevant among traditional and preliterate societies.

Of late, the focus of health services, especially RCH services, is shifting towards better quality of service delivery. The concepts of Quality of Care (QOC) and Total Quality Management (TQM) are gaining wider acceptance among the health professionals (Singh, 2005). Major efforts are under way to improve the quality of services. One of the aspects of quality care demanding attention is how the client perceives the quality of service delivery. Since the efforts being put in by health professionals are meant for the community at large, it becomes crucial to understand its perception of quality and its viewpoint on the organisations and the personnel providing health services (Singh, 2005).