CHAPTER – VI
LENDING FOR HEALTH SECTOR IN INDIA

Having gone into the variant phases of the World Bank-India relationship over the years and the reasons of the Bank’s strong interest in lending for India’s social sector in the preceding chapter attention is tuned in the present chapter to aspects related to a specific segment of the country’s social sector. India is the Bank’s biggest client in the Health, Nutrition and Population (HNP) sector. India was one of the first states, where the Bank agreed to lend for the health sector. Since the time the first project was sanctioned in 1972, 28 health sector projects have received Bank funding so far. In all, the Bank has contributed approximately over US$ 3.6 billion to the health sector in the last thirty years of its association.

It may be recalled that the Bank’s first initiatives in the health sector occurred in the late 1960s in response to the growing recognition of the challenges posed by the twin phenomena of general ill-health and rapid population growth to the goals of economic development in countries of the developing world. From a modest involvement in 27 projects during the period 1970-1980, the Bank’s interest and commitment increased subsequently during the eighties and nineties. Its position vis-a-vis other actors in the health sector saw a corresponding rise, surpassing many multilateral institutions in the field of health, including the World Health Organisation (WHO). As a result, the Bank has come to occupy a position of supreme importance on all matters related to health care and management.

In contrast to previous decades, when the Bank adopted a rather passive tone towards health, in the nineties its interventions in the health sector have been increasingly geared towards bringing about adjustments and systemic reforms in the health profile of client states. Policy advice constitutes a major component of
the Bank’s involvement in the health sector. Policy changes proposed by the Bank in the health sector in recent years have been wide ranging. Affecting such varied areas as the provision and financing of health services, the role of the public and private sectors in health care delivery, the responsibilities of the state in health care management - the Bank, has sought to heavily reorient the goals and objectives of health care in client countries.

SECTORAL ANALYSIS OF THE BANK’S HEALTH SECTOR LENDING

The term health sector has been used to include activities in each of the three major sub-sectors – health, nutrition and population. The Bank’s lending in health, in terms of projects sanctioned may, be broken down into specific heads like population, nutrition, specific disease control and help in health systems development. The analysis attempted here follows that categorisation.

Population Projects

Starting with the establishment of the first government family planning clinic in India in 1930 in the old Mysore State, and then moving on to become the first country to institute a state funded national programme in 1952, India has had a long record in population-related programmes and projects. The sub-committee appointed by Nehru on population policy chaired by Dr. Radhakamal Mukherjee, as well as the Health Survey and Development committee (the Bhore Committee) established in 1943 - both recommended a state run “birth control” policy. Two compelling concerns shaped the emergent population policy. The first related itself to national development and the fear that an “uncontrolled growth of population would outstrip the productive capacity of the country”, while the second
concentrated on the benefits accruing to women’s health through a regulated policy of birth control.¹

The Bank’s entry into funding population activities in India, came nearly twenty years after the commencement of the Indian national programme, at a time when the country’s approach to family planning was in fact firmly entrenched. The Bank’s first loan in the field of population came in 1972. In all twelve population projects have been sanctioned to date. Of the above projects ten have been completed, leaving two active projects in the field of population.

The Bank’s work in India, in the field of population, may be divided into roughly two main phases. First, covering the period, 1972-1988, and second the period since 1988. The rationale for identifying these two phases, lies in the Bank’s own assessment of its influence vis-a-vis the Government of India.² In the period, before 1988 the Bank assigned relatively fewer personnel and undertook no comprehensive sector work. It did little to develop alternative approaches and adopted a rather low-key, passive attitude in respect of the programmes that it funded. After the 1987 reorganisation of the Bank, a new and somewhat larger team took over, with a renewed commitment to human resource development. Following the reorganisation, the Bank chalked out a comprehensive sectoral strategy, and agreed to fund projects in consonance with the strategy.³

Early Population Projects (1972-88)

The historical origins of Bank lending for the first population project are interesting. In 1968, the Government of India had asked the United Nations to make an evaluation of its family planning programme. The interim report of the United Nations served as a background paper for discussion on the Indian programme in the forum of the Aid India Consortium. A general dissatisfaction with the results of the Indian programme was apparent. The feeling that India’s family planning programme had peaked in the mid sixties, and had slowed down after that, was evident, and it resulted in a special meeting in November 1969 at Stockholm to discuss the matter. In the meantime, the Government of India’s Ministry of Health and Family Planning (MOHFP) forwarded a request for Bank assistance for a forthcoming project in the field of population.

The first India Population Project (IPP 1), (1972-80) as it came to be known, was significant in several respects. The World Bank had just started funding for population specifically to complement its programme of overall economic development. The project was to be experimental by nature. It was to determine basically whether any alternative strategies could be employed to improve the prospects of family planning within the country. The project consisted of mainly the following components:

- Expansion of health infrastructure,
- Linking the provisions of family planning service with a supplementary nutrition programme,
• Creation of population centres to evaluate performance on a continual basis and to design and operate Management, Information and Evaluation Systems (MIES) and

• Provision of technical assistance.  

The project covered six districts of Uttar Pradesh and five in Karnataka. The project was jointly financed by an IDA credit of US$ 21.2 million and a grant from the Swedish International Development Authority (SIDA). The project spent nearly 50 percent of its budget on civil works; salaries made up for another 35 percent, while another 12 percent went towards meeting procurement costs of goods such as vehicles, furniture, equipment etc. Technical assistance made up for only 0.7 percent, while the nutrition component, operational in two blocks constituted another 3 percent.  

Though the project did not, within the allotted time frame, clearly demonstrate whether improved service had resulted in better performance, it did stress upon components such as management, training, monitoring and evaluation, which were to play an important part in the overall improvement of the programme in the future. In both Uttar Pradesh and Karnataka, given the short time frame coupled with delays in implementation, the impact of the project was relatively insignificant. The Bank’s own evaluation report, published in 1981, described the project as “ambitious, large, complex and experimental” in scope. It admitted that a large part of the project had been designed primarily by the Bank staff itself, who

5 The districts covered were Saharanpur, Rae Bareli, Muzzafarnagar, Sultanpur, Pratapgarh and Lucknow in Uttar Pradesh and Chitradurga, Kolar, Shimoga, Tumkur and Bangalore in Karnataka.
had insufficient knowledge of the Indian situation, leading to initial confusion and delays in implementation. Despite all the above shortcomings, the project was given a “satisfactory” ranking by the Bank, with the advice that the lessons learnt be incorporated into the design of the next population project.

The next (second) population project (IPP 2), (1980-88) was supported by an IDA credit of US$ 46 million. It was operative in three districts of Andhra Pradesh and six of Uttar Pradesh and was undertaken primarily to uplift services in the backward blocks of the selected states. It gave further support to the process of integrating family planning and mother and child healthcare services (MCH), and emphasised on generating a demand for contraceptive services within the selected communities. On its completion however, it was given an “unsatisfactory” ranking by the Bank, for no significant visible difference was evident between the project and non-project districts in general.

The third (IPP 3), (1984-91) was financed by an IDA credit of US$ 70 million. It was operative in six districts of Karnataka and four districts of Kerala. As with the first and second Projects, the goals of the third project were to achieve reductions in fertility through increases in contraceptive use and reductions in infant, young child and maternal mortality and morbidity through increases in quality and coverage of maternal child health services. Construction, equipment, furnishing and staffing of facilities to assist in expanding and strengthening service

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7 Ibid., p.55.
9 The districts covered were Bidar, Gulbarga, Raichur, Belgaum, Bijapur and Dharwad in Karnataka and Mallapuram, Palakkad, Idukki and Waynad in Kerala.
delivery were supported by training, demand generation and programme management components.\textsuperscript{10} On completion the project was given a "satisfactory" ranking.\textsuperscript{11} However, a separate study by the Centre for Development Studies (Trivandrum) stated that despite the sum spent in Kerala, which was otherwise relatively more demographically developed than the rest of India, the project failed to bring about a balance between the more developed and less developed districts of the state. Even among the districts chosen, Waynad and Idukki fared much better than Mallapuram and Palakkad, bringing into focus the importance of socio-economic and cultural variables in determining demographic transitions.\textsuperscript{12}

The fourth (IPP 4), (1986-94) chose four districts of West Bengal (Burdwan, Birbhum, Bankura and Purulia) and was supported by an IDA credit of US$ 51 million. The project was seen as a part of the state family welfare programme and was not designed to have an impact on the ongoing national programme. A substantial amount of importance was given to the meeting of physical and infrastructural needs, with nearly 78.6 percent of the total budget being allocated for such works. Service delivery was supported as in other projects by components of Information, Education, Communication (IEC), population education, training – both pre-service and in-service, and management skills.

\textsuperscript{11} \textit{Ibid.}
\textsuperscript{12} K.C Zachariah, \textit{et al.}, \textit{Demographic Transition in Kerala in the 1980s} (Trivandrum, 1994).
development. Though the Project Completion Report ranked the project as "satisfactory", the Bank labelled future sustainability as "uncertain."

In the fifth population project (IPP 5), (1988-96), the Bank directed its attention for the first time, exclusively to population planning in metropolitan cities. Targetting the slums of Mumbai and Chennai, it sought to bring quality family planning services with an emphasis on maternal and child health, to the urban slum dwellers. It was supported by an IDA credit of US$ 57 million. It sought also to place added attention to birth spacing and the use of contraceptive methods. To meet the above objectives, it focussed therefore on the following:

- Construction, furnishing and staffing of health posts within the slums,
- Training and information, education, communication (IEC),
- Reorganisation of the Health and Family Bureaus and
- Involving NGOs and the private sector in the operation of health posts and training.

The project was ranked as "satisfactory", in the Bank's own assessment. The key to the project's success, according to the Bank, lay in the innovative approach which marked a shift from the traditional focus on sterilisation to processes that motivated couples to have smaller families. For the first time, a substantial amount of attention was devoted to questions of gender in the project design.

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In summing up the Bank’s role during the above period, a recent study by the OED comments upon the rather passive attitude of the Bank during this phase of operations. According to the report, the Bank appeared to “have complied with what the government wanted during this period, even during the Emergency Period of 1975/76 when official promotion of sterilization reached a peak, without a struggle.” The Bank’s role was confined to primarily project appraisal and supervision, whereas in other fields such as identification or preparation assistance, its performance was generally deficient. This aspect of the Bank’s performance was accepted by the organisation itself, in several of its publications.

The Bank had its own critique of the Indian family planning programme. It saw it suffering from four main problems – excessive focus on sterilisation, insufficient attention to programme operations and quality, excessive centralisation and, lastly the neglect of factors that influenced demand for contraception and small families. These deficiencies seemed deeply entrenched, and even districts chosen specifically for World Bank projects, could not escape these general maladies. In comparing both project and non-project districts, “the overall character of the programme was the same, contraceptive prevalence rates increased at roughly the same slow rates, and most indices of MCH performance (e.g., use of clinics, immunization rates) indicated no upward trend.”

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15 Case Study Of World Bank Activities in The Health Sector In India, n.2, p.8.
18 Ibid., p.35.
During this period the Bank experience in population planning was generally limited. Dialogue and sector work was restricted to establishing primarily the negative consequences of rapid population growth. In the context of India, though it emphasised the importance of spacing methods and on moves raising female literacy, there was practically no major work on which it could bank upon. The limited experience of the Narangwal (Punjab) Population Project during 1969-74 was probably one such study.\(^\text{19}\) Otherwise, the Bank had practically no expertise or solutions to offer. The rankings that the Bank gave to its programmes were based on a very rudimentary calculation of the matching of resources to expenditures. A project for example was given a "satisfactory" ranking if audit accounts matched the release of grants; there was very little assessment or monitoring of the actual impact assessment of the project.

The staff inputs were also insufficient. The programme from early 1970s to the mid 1980s for example, operated with only one full time person in Washington, and a series of consultants and staff brought in for short term assignment. In Delhi, a similar malady prevailed. Until as late as 1987, there was practically no one working full time on population matters at the resident mission in Delhi. There was just one senior person looking after population, with several other responsibilities, for practical reasons during this time.\(^\text{20}\) Since the reorganisation in 1987, staff inputs have been substantially increased and a revised approach based on the


previous experience, has come to occupy a central position on all matters related to population lending.

*The Changed Strategy*

The hallmark of the post 1987 revised strategy has been the following:

- Develop greater awareness and understanding at all policymaking levels of broad population issues (such as adverse consequences of rapid growth) and of the need to approach these issues more comprehensively than through family planning alone. Population strategy should be an integral part of national planning and span several sectors, such as those affecting changes in income levels, educational attainment, women's status, employment opportunities for the poor, etc., rather than solely the concern of family planning agencies.

- Adopt a clear statement of population policy, backed by support at the highest levels, by actions to assure that the policy is well understood and backed by effective implementation mechanisms.

- Eliminate governmental restrictions on private sources of family planning services, such as charitable organisations and commercial distributors of contraceptives.

- Provide adequate funding and institutional support for public family planning programmes that foster the spacing of children and that benefit the health of mothers and children.

- Develop and implement policies and services that go beyond child spacing to broaden family planning programmes designed to assist parents to appreciate the advantages of smaller families and to achieve their desired
family size - entailing a full range of family planning services, including contraceptive distribution and counselling through public health facilities and other outlets, as well as outreach efforts to inform, educate, and communicate potential users.

- Reduce existing incentives that favour large families and provide incentives to encourage smaller families, and lastly,

- Increase public spending for family planning programs significantly.  

New Phase of Population Projects (1988 onwards)

In January 1987, India and the Bank signed an agreement accepting the new sector strategy for population. The agreement included as per the revised strategy, a commitment towards the following (a) more emphasis on outreach than on static, facility-based operations, (b) a shift in focus from sterilisation to temporary contraceptive methods, (c) increased attention to maternal and child health care elements of the programme, (d) fewer project resources for expansion of the system and more for enhancing quality of service delivery, training, and information, education and communication, and (e) priority to improving these services in urban slums and backward, high fertility states not covered by previous projects.  

The next two projects (IPP 6), (1989-97) in Uttar Pradesh, Madhya Pradesh and Andhra Pradesh, and (IPP 7), (1990-98) in Punjab, Haryana, Bihar, Gujarat

22 *Case Study of World Bank Activities in The Health Sector In India*, n.2, p.9.
and Jammu & Kashmir were undertaken not at the district level, but statewide. The coverage of these two projects, in terms of population, was therefore immense. The projects differed from their predecessors in some notable ways. They represented the new generation of population projects. In the first five projects, a disproportionate amount was provided for infrastructure, roughly between 40 to 60 percent of the total, leading to the neglect of other crucial inputs.\(^23\) The new projects i.e., IPP 6 and 7 sought to do away with this practice. Their stated goal was to improve components of human resource management, rather than mere expansion of the delivery system. IPP 7 thus made specific, additional funding available for components such as social marketing, NGOs, IEC, and training, considered to be crucial to the overall success of the project.

In addition, maternal and reproductive health became a major concern. IPP 8 (1992-2002), for example, operational in the four metropolitan cities of Delhi, Calcutta, Hyderabad and Bangalore, focussed largely on the issue of reproductive health and maternal health care. The project objectives encompassed the following goals:

- Improving the quality of family welfare, maternal health care services,
- Strengthening of existing health and family welfare delivery services in cities,
- Expanding the coverage of urban poor by establishing new facilities,
- Providing selected family welfare, maternal and child health care services at the doorstep of the urban poor,

\(^{23}\) *Population and the World Bank: A Review of Activities and Impacts from Eight Case Studies*, n.3,p.35.
• Developing close coordination with government agencies involved in water supply, sanitation, child development, female education and employment, and

• Involving community leaders, private voluntary organisations and private medical, practitioners in health education and delivery of comprehensive health services.

IPP 9 implemented in Assam, Karnataka and Rajasthan that was formally completed in 2001 formed the last of the chain of IPP projects. The project aimed to support improved access to and demand for quality family planning services, particularly among the poor, and the tribal populations’ of the states concerned. Its strategy consisted of the following components:

• Strengthen family welfare service delivery, including establishment of first-referral units,

• Improve the quality of family welfare service,

• Strengthen demand-generation activities through improved information, education, and communications planning and activities,

• Strengthen the programme management and implementation capacity and,

• Provide funds for innovative schemes to improve delivery.

The Child Survival and Safe Motherhood Programme (CSSM), launched in 1992, was another project undertaken with the objective of improving the health status of women and children, and reducing maternal, infant and child mortality rates within the country. Supported by an IDA credit of US$ 214.5 million and an additional grant from UNICEF, the project according to a senior GOI official represented, “the first serious attempt at integrating issues pertaining to morbidity,
mortality, and quality of life of pregnant mothers and infants into India’s Family Welfare Program." Under this project apart from the supply of additional equipment, drugs and training of medical and parmedical personnel, new areas of emphasis such as treatment of acute respiratory infections, care of the newborn and strengthening of emergency obstetric care, became the main focus. The project which was completed in 1996, was given a “satisfactory” ranking by the Bank.

The Reproductive and Child Health project, with an allocation of US$ 248.3 million, represents the largest-ever credit given by the Bank for population activities in India. The IDA credit concentrates largely on improving the reproductive health package by improving the availability of inputs such as referral systems, equipping of clinics with essential drugs and equipment, training, IEC, staff mobility and supervision, and an increased focus on community mobilisation. The RCH project has roughly three components. The first is a nationwide policy reform package, including monitoring and evaluation, institutional strengthening, and service delivery. The second seeks to expand the essential package of reproductive health and improve the overall quality, coverage and effectiveness of such services. The last focuses on enhancing the local capacity by investing in health care infrastructure and financing special NGO schemes.

The emphasis on reproductive health represents the thrust area of current policy making. It is widely defined as the “prevention and management of unwanted pregnancies, services to promote safe motherhood and child survival,

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nutrition services for vulnerable groups, prevention and treatment of reproductive tract infections and sexually transmitted infections, reproductive health services for adolescents, health, sexuality and gender information, education and counselling, establishment of an effective referral system. The above aspect of RCH relating to the supply side with its emphasis on quality care, coverage and access to services cannot simply be discounted. However, even with the best of services, and the widest possible coverage, a restrictive definition of reproductive health such as the above, amounts to only half of the problem of reproductive health being tackled. For reproductive health essentially is affected by both a variety of socio-economic and biological factors on the one hand and on the other by the quality of the delivery system and its responsiveness to women’s needs. A broader concept of reproductive health, focussing on the structural conditions of women’s ill health, needs to be reiterated, and the present focus which divorces the concept from the larger concept of public health and narrows it down to obstetric and gynaecological disorders, needs to be seriously questioned.

Findings of Field Survey on IPP 8 in Bangalore

As part of the present study, specific visits to project sites, between 1998 and 1999, where the World Bank's maternal and child health programmes were in operation, were made. The city of Bangalore was chosen specifically for the study. A few clusters were identified, and two visits with a gap of a year in between were made to the sites. The yearly visits helped gather and build a more comprehensive

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picture of the IPP-8 programme that was on, within the city. The emphasis on having a programme exclusively for the urban poor, though novel, brought out at the same time the lacunae prevalent, in the combined RCH programme of the World Bank and the Government of India.

The IPP programme sought to cover approximately 8.5 lakhs, residing in 401 slums, in different parts of Bangalore city. Three Urban Family Welfare Centres (UFWC) were identified within the city, and a survey was carried out in the slums which fell within the domain of these three centres. A prepared questionnaire was supplied to all three centres, while in the slums informal interview were conducted with both the men and the women folk. All the three UFWCs reported having stocks of vaccines, syringes, ORS, condoms, and oral contraceptive pills at all times.

On being asked to list the three most important health problems of the population residing in their area, the following health problems were highlighted:

- **UFWC in Ulsoor**: (1) Malnutrition, (2) Anaemia, Gastroenteritis, and (3) Vitamin A deficiency in children below 10 years along with viral fever and asthma.
- **UFWC in Austin Town**: (1) Nutritional Deficiency, (2) Tuberculosis and (3) Respiratory Tract Infections.
- **UFWC in Ashok Nagar**: (1) Nutrition, (2) Anaemia, (3) Fever.

The visits to the slum clusters confirmed that the above named concerns were among the most prominent health problems facing the people. Moderate

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27 The population of Bangalore between 1981 and 1991 it may be noted grew at approximately 40 percent.
malnutrition was the most common ailment, with very few cases of serious malnutrition. The children, as their parents confirmed, suffered mainly from gastroenteritis and viral fever. For fever and such ailments, the parents reported that they preferred to visit the local private practitioner, instead of the primary health care unit. The average costs per such visits, for fever, came to about approximately Rs. 300. Most parents complained of corruption at the local primary health centre.

The women in nearly all of the 15 clusters visited reported preference for deliveries in the local corporation-run hospitals. The argument given in most cases was roughly that a delivery in a corporation hospital despite the bribes and the corruption worked out much cheaper than a delivery in a private nursing home. For all other non-reproductive health problems, the women preferred to visit the nearby private doctor. Regarding contraceptive use, people with one child or more reported, to be IUD users, whereas a large majority of women with four children and over reported having accepted sterilisation. In all areas, male contraception was found to be low, when compared to female contraception.

Awareness of the IPP 8 programme was also found to be low. Although, there were specific mandates that “she clubs “ be constituted in each cluster, the involvement of the community through link workers in the IPP 8 programme was found to be erratic. More IEC material was in effect prepared than used by health workers working within the community. Involvement of the NGOs and the community was also found to be highly uneven. In Bangalore, as part of the IPP 8 there were nearly twenty non-governmental organisations which had been engaged in the official programme by the Government. Many of them undertook
responsibility of running balwadis and creches. In the area, chosen for the study, an organisation called Sumangali Seva Ashram, undertook explicitly the responsibility of running the balwadis, by making sure the supply of food rations. Another by the name of Society for Economically Rejected Communities (SEROC) ran a creche facility in the M.V. Garden Slum at Ulsoor, with a yearly grant of Rs. 50,000. Some of them (NGOs) were involved also in training women in skills like sewing, typing etc. However, it was noted that there existed no regular method of monitoring and evaluating the work of the NGOs involved.

Another very crucial aspect of the project concerned the division and bifurcation of health care in slums into two groups- one IPP-8 slums and the other those excluded from the programme’s purview. It may be noted that the project did not cover all the slums in Bangalore. The selection of slums was limited with no definite guidelines stating clearly the rationale behind the selection. The IPP 8 were considered to be more privileged due to the infusion of external funds, creating a definite hierarchy between the social order of squatter settlements in the city.

Majority of the residents of the surveyed slum clusters were casual workers such as construction labourers, or vegetable vendors. The women were invariably either daily wage earners or domestic workers. The average monthly salary for the men was between Rs.1,500 –2000, while for the women it was approximately between Rs.1000- 1,500. Interviews with them confirmed the superfluous concern of the present policy makers including that of the World Bank, regarding the subject of reproductive health. It was as some of the women put it - a policy which
was simply content in injecting women with vaccines, rather than giving them adequate food and clean drinking water along with adequate sanitation.

Assessment of the Assistance Undertaken

According to the report of the National Family Health Survey (1992-93), a small percentage of women (all India) receive antenatal care, approximately only 62.3 percent. The percentage of women who choose to deliver in a regular health facility is even lesser - roughly 25.5 percent. According to the survey, the percentage of currently married women using temporary methods of contraception is also equally low- with 27.3 percent of them opting for sterilisation, and only 1.2 percent for pills and approximately 1.9 percent for IUD. The survey confirmed too the low levels of male contraception, with only 2.4 percent of men being condom users. The figure for male sterilisation was equally lower at roughly 3.4 percent.

The current Indian programme and the Bank projects that have supported it, may be criticised for being in the first place, one heavily concentrated on women, in the sense that despite the rhetoric, there is a perceptible bias towards female contraception, with sterilisation too being widely practised. And second, the more disturbing being the exclusive concern and focus of the policies on essentially one aspect of womenhood, namely their role as mothers. The official policy has hardly anything substantive to say or offer on matters related to aspects of non-reproductive women's health. In the context of RCH, even if the Government is able to provide the best of services with the widest possible coverage, which is

30 The recent OED report, *Case Study of World Bank Activities in The Health Sector In India*, n.2,p.1, acknowledges this defect.
what it is trying to do, it would still be tackling only 50 percent of the problem. What the programme just does not address substantively is the existing structural nature of women’s work (domestic as well as non-domestic) which have severe built in hazards for women’s health in general. Supply side interventions such as the IPP programme can at best only mitigate some of the adverse consequences associated with child-birth, they cannot and do not address the fundamental causes of real health problems.

Table 6.1: Strengths and Weaknesses of the World Bank’s IPP 8 Programme

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<th>Strengths</th>
<th>Weaknesses</th>
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<td></td>
<td>• Comprehensive Conceptual Framework – Focus on Family Welfare predominant, other programmes present but ad-hoc and not adequately integrated perhaps even inconsistent</td>
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<td></td>
<td>– Family Welfare, MCH, CSSSM, Water supply and Sanitation, Education, Community Development</td>
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<td></td>
<td>• Involvement of Community through Link Workers, Women’s clubs – Long term sustainability especially regularisation of centre staff not adequately addressed</td>
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<td>• Establishing creches, NFE and vocational training, Involvement of NGOS – Partnership and Liaison of project team with Corporation Health Centres problematic (ownership by Corporation inadequate)</td>
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<td>• Gender sensitivity – IEC more material preparation than field use</td>
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<td>• Flexibility, Eg. Different innovative schemes in Bangalore, Calcutta, Delhi and Hyderabad – Orientation and motivation of doctors not maintained after initial training. Many innovative schemes built upon but not in a sustained way. Lack of effective monitoring and evaluation</td>
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For an elaboration of the known health hazards of some occupations refer to Shramshakti: Report of the National Commission on self-employed women and women in the informal sector (New Delhi, 1998).

NUTRITION PROJECTS

Active involvement of the Bank in the nutrition sector in India began with the sanctioning of the Tamil Nadu Integrated Nutrition Project (TINP) in 1980.\textsuperscript{33} By the second half of the 1970s, India had a variety of public feeding programs. In Tamil Nadu, for example there were 25 different nutrition programs underway costing the government about US$ 9 million annually. However, most of them had certain deficiencies, which TINP chose to cover. These defects were the following:

- The programmes were not targeted on the basis of nutritional criteria, and hence they did not reach their intended beneficiaries. Children at risk were not identified.
- Feeding on site tended to replace meals that beneficiaries would otherwise have eaten at home.
- Food taken home was shared with other family members, reducing the impact on beneficiaries.
- The food given, was too coarse and bulky for the very young to eat.
- Feeding was mainly confined to children who came to centers on a drop-in basis, rather than through active efforts to identify those most at nutritional risk,
- Not enough emphasis was given to nutrition-education for mothers, nor to the complementary health care interventions needed to improve their nutritional status.\textsuperscript{34}

As a result, the government in 1980 launched the Tamil Nadu Integrated Nutrition Project (TINP 1). It covered the rural areas of those districts with the

\textsuperscript{33} The first India Population Project (IPP1) too had a nutrition component, but its scope and operational area was limited to just two specific blocks. TINP can therefore be taken as the first big nutrition project of the Bank in India.

worst nutritional status — about half the state, and a rural population of about 9 million. Its total cost of US$ 81 million was supported by an IDA credit of US$ 32 million. The project objectives revolved around growth monitoring of young children and nutrition counselling for their mothers with targeted interventions such as on-site feeding, health check-ups and services for those found to be nutritionally weak. The project also emphasised on the training and supervision components of community nutrition workers, coupled with systematic project monitoring and evaluation.

The project costs by category were distributed as follows: salaries and allowances (24 percent), civil works (19 percent), vehicles, equipment and furniture (14 percent), food supplement (13 percent), drugs and supplies (12 percent), training (6 percent), vehicle and other operating costs (6 percent), contract services (5 percent) and project management fund (1 percent). The project was executed gradually in a phased manner in select districts of Madurai, Ramanathapuram, Pudukottai, North Arcot, Tirunelveli and Chengalpattu. Designed largely by the Bank staff and its consultants, TINP represented an effort on the part of the Bank to provide an integrated programme of nutritional support. Based on the experiences that the Bank had had in other countries namely, Brazil, Colombia and Indonesia, the design of TINP represented a challenge for the Bank staff. On completion, the Bank gave TINP a “satisfactory” ranking. The Project Completion Report in its findings concluded that:

TINP showed that part time village workers, if properly trained and supported, could substantially improve their community’s nutritional status. Second, the project demonstrated unambiguously that growth monitoring [was] an effective and feasible intervention in large scale nutrition programs. Third, the project showed that targeted supplementation based on growth faltering plus feeding of
all severely malnourished children could significantly reduce severe malnutrition.\textsuperscript{35}

The satisfactory outcome of TINP 1, prompted the Tamil Nadu government shortly to approach the Bank for another loan in the nutrition sector. In 1990, the Second Tamil Nadu Integrated Nutrition Project (TINP2) with an IDA credit of US$ 95.8 million, received sanction. The project was to be operational in 318 blocks of the state. The project extended supplementary nutrition to children in the age 0-6 years, pregnant women and nursing mothers, and pre-school education to children in the age group 3-6 years. The project also covered enhanced inputs in the areas of health, communications, training, project management, operations research, monitoring and evaluation. The design features that distinguish TINP1 from TINP2 were roughly the following:

- Extension of the target group to 0-6 months from 6-36 months.
- Introduction of a new mother-linked child health card to establish a link between births and TINP enrolment.
- Maternal growth monitoring.
- Inclusion of non-formal early childhood education.
- Expansion of services to more children in different stages of malnutrition, and
- More attention to coordination between health and nutrition service delivery.\textsuperscript{36}

\textsuperscript{35} Ibid., p.22.
TINP 2 came to an end in 1998. Preliminary evaluation surveys have however, labelled it as being only “marginally satisfactory.”³⁷ The Government of India around 1990, decided to approach the Bank for another loan supporting the extension of the indigenously designed Integrated Child Development Services (ICDS). The ICDS 1 project sanctioned in 1990, with an IDA credit of US$ 106 million, was thus the third main project in the nutrition sector after TINP 2. The project covered pre-dominantly the tribal and drought prone rural blocks of two states, Andhra Pradesh (110) and Orissa (191).

The ICDS programme initiated in 1975, has been one of the most important child nutrition intervention projects to be undertaken by the Government of India. Started on an experimental basis in 33 blocks, the ICDS programme by 1990, covered nearly 2200 blocks in the country. The ICDS programme aimed basically to achieve the following set of objectives: (1) to improve the health and nutrition status of children 0-6 years by providing supplementary food to beneficiaries 300 days per year and by coordinating with state health departments to ensure delivery of required health inputs, (2) to provide conditions necessary for child psychological and social development through early stimulation and education, (3) to enhance the mother’s ability to provide proper child care through health and nutrition education and lastly to achieve effective coordination of policy and implementation among the various departments.

The Government of India, decided in 1990 to go in for exclusive World Bank funding to support the central scheme. A few changes were brought about and the new ICDS1 project contained certain additional inputs. It emphasised upon

³⁷ Case Study of World Bank Activities in The Health Sector In India, n.2, p.7.
the following: (1) in-service field-based training, supportive supervisory practices and simple monitoring systems to ensure high levels of service quality and coverage, (2) community-based growth monitoring and intensive nutrition education, (3) community mobilisation, particularly of women's groups, (4) increased attention to promotion of behavioural change, and lastly on operational research in alternative modes of therapeutic supplementation. The project also attempted to remedy some of the observed deficiencies of TINP in the areas of health-nutrition worker coordination, referral and nutritional rehabilitation and maternal nutrition. 38

On completion in 1997, however, ICDS 1 was ranked as "unsatisfactory" by the Bank. 39 The Bank had meanwhile sanctioned a second ICDS project for Bihar and Madhya Pradesh for a period of seven years, starting 1993. ICDS 2, with an IDA credit of US$ 194 million, at present, is under implementation in 112 blocks of Bihar and 156 blocks of Madhya Pradesh. The project envisages coverage of all the tribal blocks in both the states and attempts to provide nutritional support to this already disadvantaged section of Indian society. Its main thrust would be on the expansion of ICDS, in its improved form, in these predominantly tribal areas. 40 Preliminary supervisory reports by the Bank have however, labelled the progress made as "unsatisfactory." 41

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39 Case Study of World Bank Activities in the Health Sector in India, n.2, p.7.
In 1998, the World Bank sanctioned another IDA credit worth US$ 300 million towards a third ICDS project. Instead of sticking to the name ICDS, the Bank, preferred to call it the Women and Child Development Project. The project has been sanctioned for a period of five years, and its primary goal is to improve the nutrition and heath of pre-school-aged children and women in states of Kerala, Rajasthan, Tamil Nadu, Maharashtra and Uttar Pradesh. The project aims to specifically address the following sector issues: (1) reduce malnutrition especially of children under three, (2) increase the unit cost of such services, (3) increase the quality of services provided, (4) address the question of poor targetting, by adopting stricter criteria and lastly include lessons learnt from the TINP experience.42

An internal report submitted by the office of the Comptroller and Auditor General (India) has been critical of the functioning of the above mentioned World Bank sponsored ICDS programmes. According to the report submitted, the programme in Orissa for example has “not only not achieved the desired results in the reduction of severe malnutrition of Grade III and IV and increase in proportion of children in normal and Grade I status, the position had in fact worsened.”43 Based on the study conducted by the National Institute of Nutrition, Hyderabad, the report arrived at the conclusion that both in Andhra Pradesh and Orissa the achievements in terms of targets set such as use of oral rehydration by groups, referrral of severely malnourished children, quarterly monitoring of weight of

children below 3 years, food supplementation for at least 20 weeks for registered pregnant women with inadequate nutrition status etc., had been well below the targets fixed. The report also concluded that about 61 percent of the assistance for the ICDS 2 project had remained unutilised till the end of March 1999, with just a year left for the conclusion of the project. Large variations in component-wise provision of inputs and expenditure were also reported. In Madhya Pradesh for example, no expenditure was incurred despite a prescribed amount on the setting up of nutritional rehabilitation centres, or on making available therapeutic food in dispersed tribal hamlets.

Be it the ICDS or the TINP projects, the fact remains, that though moderate cases of malnutrition may be treated by such interventions, the more chronic cases require a definite reorientation in overall policy. The case of starvation deaths in Patalkot, in Chhindwara district of Madhya Pradesh in 1999, which incidentally was a beneficiary district of the ICDS, and reports of deaths in Maharashtra (2001), Rajasthan and Orissa (2002) points out to the larger questions of poverty and deprivation which need to be addressed as part of official policy making on nutrition.44

DISEASE CONTROL PROJECTS

The Bank’s entry into specific disease control projects in India in the early nineties was largely a direct fallout of the concept of “Global Burden of Disease” that emanated out of a joint study co-sponsored by the Bank and the WHO, seeking to quantify the total loss of healthy life on account of prevalent diseases worldwide.45 Based on calculations made, it was estimated that nearly 46 percent of the

44 "Patalkot starvation issue raised in MP Assembly", Hindu (New Delhi edn, June22, 1999).
45 Preliminary findings of the Global Disease Burden report were published by the Bank in its 1993 World Development Report: Investing in Health (New York,
global burden of disease was attributable to various types of communicable diseases, such as tuberculosis, HIV, diarrhoea, respiratory infections etc. Another 42 percent of the global burden was accounted for by diseases of a non-communicable nature, such as cancer, heart disease, nutritional deficiencies etc. Injuries made up for the remaining 12 percent. In case of India, it was estimated that about 51 percent of the country’s disease burden was found to be attributable to communicable diseases, while non-communicable diseases made up for another 40 percent. Taken collectively, the total disease burden of India, was found to be the highest in the world, in terms of individual countries.

India - Tuberculosis Control Project

In India approximately 14 million people are estimated to be suffering from active tuberculosis of which 3-3.5 million are highly infectious. About 0.5 million die of the disease every year and an estimated 2-2.5 million cases, are added nearly annually. Tuberculosis is truly a big killer disease in India, accounting for over nearly 4 percent of India’s total disease burden. The greatest burden of tuberculosis

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1993). The concept was arrived at by first classifying all known diseases into 109 categories, covering thereby all possible causes of death and disability. For each death, the number of years of life lost was then calculated in terms of the difference between the actual age at death and the expectation of life at that age. For calculating disability, the incidence of cases by sex, age and demographic region were obtained by multiplying the expected duration and severity of the disability. The death and disability losses were then combined and disability adjusted life years (DALY) lost by a death at each age were calculated for a given population or region. The sum of DALY lost across all ages, conditions and regions was referred to thus as the global burden of disease. For a detailed analysis of the concept, see Christopher J. L. Murray and Alain D. Lopez, ed., The Global Burden of Disease (Harvard, 1996).

morbidity and mortality is concentrated in adults aged 15 to 59, the majority of whom come from the poorer sections of the society.

The Government of India first launched the National Tuberculosis Programme (NTP) in 1962, making it a part of the general health services. As part of the programme, District TB Control centres (DTCs) were established, which aimed primarily at detecting and treating cases at this level. The programme was to be based on the following major premises:

- Cases of TB were to be diagnosed at rural health institutions by microscopic examination of sputum of those who complained of chronic cough.
- Domiciliary treatment of the diagnosed cases, was to be in the nearby health centres.
- Services of specialised TB institutions were to be made accessible to the rural health institutions, and lastly
- A system of monitoring was to be in place with the DTC maintaining a case register and reporting to the State Tuberculosis Centre.

In 1992, however, the Government undertook a detailed programme evaluation of the NTP, with support from WHO and Swedish International Development agency (SIDA). The joint review called for a significant overhaul of the NTP and the adoption of a new approach to TB control. This new approach was called the Revised National Tuberculosis Control Programme (RNTCP) and was adopted by the Government of India in 1992. In 1997, the World Bank extended a US$ 142.4 million IDA credit explicitly to further the progress of the

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RNTCP within the country. The project intended to cover about a third of the Indian population.

The main features of the RNTCP which differentiated it from NTP were roughly the following:

- focus on patient diagnosis based on sputum analysis rather than X-ray,
- emphasis on cure of infectious or smear positive patients through passive case finding to reduce the risk of infection,
- administration of short-course treatment under directly-observed therapy (DOTS) to prevent development of drug resistance and ensure patient adherence to treatment,
- a rigorous system of patient registration, monitoring and follow up to ensure high cure rates, and lastly
- decentralised service delivery to the periphery to facilitate access to the poor.48

The Indian tuberculosis control project represents the first Bank lending operation to focus solely on tuberculosis control. Experience from Bank lending for TB control has been limited to projects that do not focus on TB alone. For example, Lesotho’s Health and Population Project (1985) or for that matter China’s Infectious and Endemic Disease Control Project (1992). The Indian experience however has not been a gratifying one and both the Bank and the Government of India have been very tight-lipped about its progress. Supervisory

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ratings have ranked the progress of the Indian project as “unsatisfactory.” The reasons for dissatisfaction although not available from official sources have been highlighted in studies conducted by independent organisations.

However, evaluations from voluntary sector throw useful light. A supervisory report by the Voluntary Health Association of India on the tuberculosis programme for example, admits that whereas World Bank funding may have removed some of the constraints in terms of resources – the World Bank money coming directly to the project-via the District TB society meets the costs of all consumables (except drugs and films) – certain pertinent stumbling blocks remain in the implementation of the programme at the ground level. Accessibility of patients to TB centres in terms of average distances in each locality, active surveillance for new cases and continuous treatment of the patients remained largely unfulfilled in the selected districts.49 The above limitations of the tuberculosis project were highlighted in the report submitted by the Comptroller and Auditor General. The report clearly stated:

The programme failed to make use of the available resources which adversely affected its implementation of the programme. Programme activities suffered in as much as the grants released to District Tuberculosis Control Societies (DTCS) were utilised only to the extent of 13 to 27 percent during 1996-97 to 2000-01. Grants to DTCS for assistance to NGOs and IEC activities could only be utilised to the extent of 12 percent and 40 percent respectively.50

India: Malaria Control Project

Malaria, is another parasitic disease, causing substantial death, morbidity among primarily the poor of the Indian society. Official estimates by the

Government, place the number of cases to be about approximately three million yearly, and about a thousand cases of death annually. Malaria makes up for approximately 0.3% of the nation's total disease burden, and is therefore another killer disease confronting the people of India.  

The Government of India initiated the National Malaria Control Programme in 1953. The NMEP as the programme was popularly called, was one of the biggest 'vertical' programmes to be undertaken by the government. In 1995, however, as in the case of tuberculosis, the WHO came up with a revised malaria control strategy. The Government of India approached the World Bank subsequently for help to execute the new revised strategy. In 1997, the Bank sanctioned US$ 119.2 million IDA credit towards this purpose. It sought to target a population of over two hundred million, in states of Andhra Pradesh, Gujarat, Madhya Pradesh, Maharashtra, Bihar, Rajasthan, Orissa and some other states depending on the incidence of cases. The project's main target population were people living in areas severely affected by malaria, and it aimed primarily at providing an overall enhanced package of the following malaria control measures:

- better integrated early detection and treatment;
- personal protection measures;
- selective vector control and diversification;
- epidemic planning and rapid response; and
- institutional and management strengthening.

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52 Debabar Banerji, n.47, p.97.
The Bank's experience in malaria control, has been a limited one. This is
despite the fact that, in the 1980s, the Bank undertook to finance and completed
two exclusive malaria control projects in Brazil and a smaller project in Indonesia.
At present, apart from the Indian project, it is involved in financing on-going
However, as situations differ from place to place and country to country, so must
the Bank's strategies. The situation in India is indeed a challenging one. There is
an urgent need to effectively monitor the spread of P.falciparum (which causes
cerebral malaria0 all over the country. Resistance to chloroquine in P.falciparum
was first reported in the regions of North East/ Assam (1973), but has now slowly
spread to many other parts of the country as well. Preliminary supervisory ratings
of the Indian project, like as in the case of tuberculosis, have however been largely
"unsatisfactory." 54

India: National HIV/AIDS Control Project

The Human Immunodeficiency Virus (HIV) and Acquired Immune
Deficiency Syndrome (AIDS) is fast emerging as a major health problem in India.
According to estimates by the National AIDS Control Organization (NACO), there
are currently about nearly 4 million HIV-infected people within the country. It
accounts for roughly 2.7 percent of the country's total disease burden. 55 HIV
infection is again largely concentrated among the poor, marginalised groups
including commercial sex workers, truck drivers, migrant labour, as well as drug

54 Case Study of World Bank Activities in The Health Sector In India, n.2,p.7.
users. The largest number of cases have been reported from the following places: Andhra Pradesh, Gujarat, Karnataka, Kerala, Maharashtra, Manipur, Nagaland, Tamil Nadu and West Bengal. These nine states currently account for over 75 percent of the new HIV infections in the country.\textsuperscript{56}

The National AIDS Control Programme was launched in 1987. A comprehensive Five Year Strategic Plan was launched during the 8th Plan Period with the assistance from the World Bank to the tune of an IDA credit of US$ 84 million. Preliminary reports of the first AIDS project, by the Bank, have ranked it as being "highly satisfactory." \textsuperscript{57} A second AIDS project, again an IDA credit, to the tune of US$ 140.82 million, has recently received sanction.

The project would try and promote effective interventions such as counselling, condom use, treatment of sexually transmitted infections (STIs), information and treatment of marginalised groups falling in the high risk category, as well as support for preventive measures in the general community. Its thrust would be to shift focus from raising awareness to changing behaviour. While supporting decentralisation, the project would also endeavour to sensitisce service providers regarding the rights of patients, encouraging therefore more voluntary counselling and testing and discouraging mandatory testing.

\textbf{India: National Leprosy Elimination Project}

Leprosy, also called Hansen's disease, is a chronic, slow developing infectious disease caused by Mycobacterium leprae (M.leprae), prevalent mainly

\begin{footnotes}
\item \textsuperscript{57} \textit{Case Study of World Bank Activities in The Health Sector In India}, n.2,p.7.
\end{footnotes}
amongst the poor. India is one of the few countries where leprosy is a major public health problem, accounting for one-third of the global leprosy load. There are approximately 2.2 million people with leprosy in India, with 300,000 new cases arising annually.\textsuperscript{58}

The National Leprosy Control Programme (NLCP) was launched by the Government of India in 1955. In 1978, leprosy was accorded high priority at the Alma Ata Conference. Following this in 1983, when multi-drug therapy was first introduced, the programme was renamed as the National Leprosy Eradication Programme (NLEP). In rural areas, leprosy services were provided by the Leprosy Control Unit while in the urban areas, these activities were carried out by the Urban Leprosy Centre. In regions where leprosy endemicity was less than 5 per 1000, education and treatment centres were established within the framework of existing primary health centres and hospitals.

In 1993, the World Bank extended a US$ 75.93 million IDA credit towards leprosy control in India. The main objective of the project was to eliminate leprosy by the year 2000 by reducing the prevalence from 2.4 per 1,000 to 0.1 per 1,000 nation wide. This was sought to be achieved by treating primarily the people already affected as well as by reducing the overall prevalence. Supervisory missions connected with the Bank, have given the project a "highly satisfactory" ranking.\textsuperscript{59} In March 2001, the Bank approved a second Leprosy control project for the country with an IDA assistance of US$ 30 million.


\textsuperscript{59} \textit{Case Study of World Bank Activities in The Health Sector In India}, n.2, p.7.
India: Cataract Blindness Control Project

The National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100 percent centrally sponsored programme. The goal was to reduce the prevalence of blindness from 1.4 percent to 0.3 percent by year 2000. Roughly 80 percent, or more, of blindness in India results from cataract. Blindness prevalence varies regionally. The states with high prevalence are Tamil Nadu, Rajasthan, Madhya Pradesh, Orissa, Maharshtra, Uttar Pradesh and Andhra Pradesh.

In 1994, the World Bank sanctioned a US$ 117.8 million IDA credit for cataract related blindness control. With the extended funding, it was expected that the Government would be able to cover most of the backlog cases of which 7 million were in the high prevalence states. The project sought to primarily upgrade the quality of cataract surgery and expand coverage of NPCB. Periodic evaluations conducted have revealed that project has had a positive impact on reducing the prevalence of blindness. The Bank’s supervisory missions have also given the project a “satisfactory” ranking.

However, at the same time, certain points raised in the course of evaluations need to be highlighted. Recent reviews of the programme by the Government have admitted that the thrust of the project has been more on the quantitative rather then the qualitative aspects. Evaluations conducted by the Bank and the Government have largely focussed on the quantitative targets whereby the

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ranking of projects as satisfactory and unsatisfactory have largely been determined by the fulfilment of such targets. One particular evaluation of the Cataract Blindness project have also raised pertinent questions about the role and impact of non-governmental agencies in the delivery of services.

The emphasis by voluntary organisations has been on the surgical services alone thereby giving focus on quantitative achievements in terms of surgeries performed which though important, does not necessarily mean restoration of quality vision....the Voluntary Organisations (VOs) preferred to organise surgical eye camps which are quite attractive to people but do not provide good operative and post-operative care. The follow-up was found to be extremely inadequate in camp surgery leading to high failure rate in many instances...It has also been found that involvement of VOs has been restricted to sites where they are familiar with and have been traditionally working in. As a result the coverage of eye care services has become restricted to urban and peri-urban areas and some pockets of rural areas but the underserved population groups particularly tribal and geographically inaccessible areas remain without services.62

HEALTH SYSTEM REFORM PROJECTS

The commitments made by the Indian Government under the Social Safety Net Adjustment Credit to institutionalise an essential package of health reform measures, formed the fundamental basis for the Bank’s active involvement in engineering health sector reforms in the nineties. The debate about the role of government vis-a-vis the private sector in the delivery of health care services formed the essential backdrop for the reforms sought. The public spending on health was sought to be redirected and its responsibility limited to a few certain categories of essential services, which were:

- *Public Health* - constituting an expanded programme of immunisation, school health programmes, tobacco and alcohol control, health, nutrition

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and family planning, information, vector control, STD prevention, monitoring and surveillance.

- **Essential Clinical Services (minimum package)** – consisting of tuberculosis treatment, management of the sick child, prenatal and delivery care, family planning, STD treatment, treatment of infection and minor trauma, assessment and advice, and pain alleviation.

- **Discretionary Clinical Services** – all other health services, including low-cost effectiveness, treatment of cancer, cardiovascular disease and other chronic conditions, major trauma, and neurological and psychiatric disorders.\(^{63}\)

For the Bank investments in health sector reforms, provided the much “long-sought opportunity” to influence more fundamental determinants of how the public health system worked in India.

These projects provide the bank with a long sought opportunity to influence more fundamental determinants of how the public health system works, to do so at the state level where ultimate control of these determinants is lodged and where the Bank can have more leverage than is possible at the national level, and to provide assistance that is more tailored to the vastly different circumstances found in different states.\(^{64}\)

In 1995, the Central Government gave the Bank the opportunity to invest in the first ever health system reform project, by agreeing to the funding of the Andhra Pradesh First Referral Health Systems Project. The project was to be for a period of seven years, with the Bank contributing US$ 133 million as part of an IDA credit. The second state health systems project received sanction in 1996, and

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\(^{64}\) *Case Study of the World Bank Activities in the Health Sector*, n.2, p.7.
was to be operative in three states namely, Karnataka, Punjab and West Bengal. A US$ 350 million IDA credit was extended for this purpose. Orissa became the next state, to receive funding from the World Bank, and in 1998 a US$ 76.4 million IDA was extended to the state government. In April 2000 a US$ 110 million IDA credit was extended to the Government of Uttar Pradesh for the explicit purpose of bringing about reforms in its health system.

The public health system in India is roughly organised along a three tier structure. At the bottom are primary health care facilities where basic health services are provided, with emphasis on preventive and promotive aspects such as family planning, maternal and child health, treatment of minor ailments, malarial treatment and spraying, sanitation and public health education. In the middle are the first referral hospitals or secondary level hospitals, consisting of hospitals of various bed strengths, ranging generally between 30 and 550 beds, at community, area, sub-divisional and district levels. These first referral hospitals provide in-patient and out-patient care with diagnostic and treatment facilities generally not available at the primary level. At the top of the health structure are the tertiary hospitals, including teaching hospitals, which are staffed and equipped to provide more specialised treatments and generally have a capacity of 750 beds.

The specific reforms being recommended by the World Bank in the above structure, are basically the following. The Bank intends to increase state and central spending on primary health care from the current level of 0.65 percent to about 1 percent of GDP by bringing about the following changes:

- redirecting incremental resources almost entirely to primary and secondary health care, particularly preventive and promotive,
• substituting public funds with private funds in secondary and tertiary hospitals by instituting means-tested user-charges,

• implementing full cost recovery from private and government-subsidised insurance schemes as well as enhancing non-tax revenues,

• reducing public subsidies for medical education, and by

• protecting expenditures on preventive and promotive services from fiscal cuts engendered by the stabilisation program.65

It seeks to enhance the role of the private and voluntary sectors in the delivery and management of health services by essentially encouraging (1) contract of select services, and (2) promotion of health care delivery by private and voluntary sectors. In addition, as already mentioned above, the Bank seeks to push for a more rigorous system of user-charges, whereby payments would have to be paid for services provided by the users of such facilities. In this context, the specific system projects would serve as catalysts to the reform process. The projects sanctioned would focus essentially upon (1) improving the institutional framework for policy development, (2) upgrade community, subdivisional and district hospitals – upgrading their capacity to provide clinical and support services, and lastly upgrade and improve access to primary health centres. The supervisory missions for the first three state health system reform projects, have given a “satisfactory” ranking to all three.66


66 Case Study of World Bank Activities in The Health Sector In India, n.2,p.7.
The public health system in India has been organised to finance and deliver curative as well as implement a number of centrally sponsored family welfare and disease control programmes. Public health management in India is affected by structural problems such as overly centralised planning and control of resources, weak management, high levels of political interference, poor quality of health services in terms of health care supervision, maintenance, drugs and supplies. In 1999 the public health infrastructure included about 1,37,000 sub-centres, 28,000 dispensaries, 23,000 primary health centres, 3,500 urban family welfare facilities, 3000 community health centres and an additional 12,000 secondary and tertiary hospitals. 67

Although there are certain merits in the Bank’s thrust of re-organising the public health systems in India, there are however certain issues that need to be paid attention to. For example, the very definition of public health, incorporates within it “the combined practice of promotive, preventive, curative, and rehabilitative services”. But the Bank’s classification of the above categories, seeks to reduce the issue of public health to a set of “essential” clinical services, comprising of pre-natal and post-natal care, along with a few other services such as family planning, etc. Treatment for diseases such as tuberculosis, malaria, leprosy etc., which were earlier part of the general public health activities, too get reduced and are now tabled as clinical services - with the onus of providing the bulk of these, being shifted quietly from the public to the private sector. Though the Bank theoretically grants the possibility of state-run public health programmes where cost-
effectiveness is demonstrated, in reality and actual practice there is very little scope that it leaves for the public sector.

Devoid of curative interventions, public health is thus reduced to primary prevention and promotive activities. The Bank’s logic of equating health services having mostly private benefits, for which there is greater willingness to pay, with curative care - while those with mostly public benefits, for which there is lesser willingness to pay, with preventive care – works to pit curative services versus preventive in a most devious way. The emphasis becomes inevitably on reducing the specific disease burden of death and disability rather than on controlling effectively its prevalence.\(^{68}\) Such an approach is most dangerous for diseases of the communicable type, where control of the total number of infectious cases in a community is relatively more important than cure of the most chronic or the more difficult cases. The dissociation has considerable negative effects on disease-monitoring operations too. Such a myopic conceptualisation, coupled with the withdrawal of public health services, works to the detriment of the overall quality of public health in general.

In India, approximately 69.7 percent of all households have no toilet facility, and roughly about 31.8 percent (households) do not have any access to drinking water from pumps or pipes.\(^{69}\) The prevalence of diseases such as gastroenteritis, fever etc., are therefore self explainable. The overcrowding in cities, with people residing in shanty dwellings also explains the wide spread

\(^{68}\) The Global Burden of Disease thesis and the associated concept Of DALY has been so powerful that even the WHO has taken an about turn on its Alma Ata Declaration. WHO in its *Health for All in the 21\(^{st}\) Century* too supports a similar programme of selective health care as the Bank.

\(^{69}\) Ashish Bose, *India’s Basic Demographic Statistics*, n.28, p.229.
prevalence of cases of tuberculosis, leprosy and malaria (where stagnant water is a common feature). These diseases have an epidemiological basis, and are essentially linked to the structural parameters of the Indian society. To ignore this crucial reality, is to essentially reorient and reduce the very content and scope of the subject of general public health.

In a study carried out by a non-governmental association on the outbreak of malaria in Igatpuri in Nasik district of Maharashtra in 1996, it was exactly the above fallacies in official policy making, which were brought out. Since July 1995, the area had been malaria endemic, and the number of cases had subsequently shot up. The people generally perceived malaria as “fever with chills and correlated it with mosquitoes.” They accepted the need for spraying pesticides as a preventive measure and even used traditional methods such as burning “chullahs” using wood. The local primary health centre infrastructure was relatively good and all malaria drugs were adequately available, yet the casualties in Igatpuri on account of malaria were very high. This was primarily because, as pointed out in the VACHAN report, the patients who suffered hardly had any access to services of the PHC. The first contact care was provided by private practitioners, who didn’t ask for even something as elementary as a blood smear, and instead prescribed medicines that had little effect.70

The loss inevitably affects the poor the most. With no capacity to pay for private health care, the services offered at the local primary health centre are of undoubtedly utmost importance, for this section. The reduced responsibility of the

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primary health centre, in providing health care, in the present reforms agenda, reduces further the access these sections enjoyed of receiving health care at an affordable price. The introduction of user charges, reduction in the number of free beds, removal of subsidies for drugs, and a simultaneous cutting down of services offered, works effectively to reduce the dependence of the poor on public sector health services. Though the Bank reasons out special measures such as differential fee structures for the poor at hospitals, empirical evidence seems to point at the fact that any increase in charges or reduction in services, no matter how "insignificant", ultimately hurts and doubly burdens the poor.

The present thrust on dis-investing the state sector and privatising health care needs to be also scrutinised in detail. In India, the private sector apart from individual practitioners includes numerous private dispensaries, nursing homes and hospitals. Private dispensaries in the Indian context especially in the rural countryside are usually one or two bedded day care centers, while in the urban areas there are some without beds registered as private clinics. Institution wise, hospitals and nursing homes constitute the most frequent and the more significant part of private health care. Historically the private hospital sector has been small in India but with increasing space being provided to private health care, the proliferation in the number of private hospitals has been rapid. Whereas in 1974,  

71 Usually small private hospitals, 5-10 bedded are referred to as nursing homes. Direct and indirect support to the private health sector by the State is one of the main reasons behind increased privatisation. The Government of India provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals. It provides incentives, tax holidays, subsidies to private pharmaceutical and medical equipment industry. The Government also allows highly profitable hospital sector to function as trusts, which are exempt from taxes. See Ravi Duggal, The Private Health Sector in India: Nature Trends and a Critique (New Delhi, 2000) for a comprehensive review of the private health sector in India.

235
private hospitals made up for only 14 percent of the total hospitals in the country, in 1995, the share of such hospitals rose to 68 percent. 73

Taking care of nearly three-fourths of the total health related problems of the country, the private sector in India, is largely an unregulated one. While there are specific laws which have been enacted by the Government for this purpose, the private sector in India functions largely immune, without following any minimum standards in the provision of services. For example, though the law of the country stipulates that Medical Councils assure that only those having the appropriate qualifications be allowed to practice, in reality, there are numerous instances where unqualified persons set up practice or indulge in irrational or other malpractices. The absence of fixed schedules of charges for medical services rendered, is yet another instance of the disparate functioning of private health care providers. Charging more than government hospitals, there are numerous cases again of units in the private sector charging exorbitant fees for even routine tests and services. 74

The lack of insufficient monitoring, regulation and control of the private sector in India, ironically places the consumer of such services at a serious disadvantage.

An OED report on developing the effectiveness of the Bank’s interventions in the health sector has an interesting point to make that holds relevance in the context of the Bank’s attempts to reform the public health system in India.

Bank policy advice and reform strategy are too often insufficiently grounded in empirical evidence or institutional analysis of the country context. The Bank has been better at specifying what needs to be done than why problems persist and how to address them. As a result, the Bank has a tendency to promote standard solutions to health system problems, without giving sufficient attention to local

73 Ibid., p.13.
74 Surveys conducted by the NSSO 1996, Report No.441-52nd Round (New Delhi, 1998) for example found that the expenditure per ailment in the private sector in rural areas was approximately Rs. 58 more than that charged in the public sector. In the urban areas, the difference was still larger-Rs. 89.
The Bank is increasingly engaged in reform issues that have no commonly agreed solutions or universal models, limited evidence about what works, and are areas of limited Bank experience. These include health insurance reform, regulation of the private sector, pharmaceutical policy, health workforce reform, and the appropriate balance between the public and private roles in health service financing and delivery. Incremental approaches may therefore be more appropriate, built on solid research, pilots, and focused efforts to learn from experience.\(^{75}\)

The report significantly recommends the adoption of the principle of strategic selectivity, calling upon the Bank to "do better not more."\(^{76}\)

**SUMMARY OBSERVATIONS**

Being the largest client of the Bank in the health sector, the Indian health must be admitted is diverse. The reach of the Bank in terms of projects funded extends to almost all spheres of health care. Table 6.2 gives a comprehensive list of the health projects sanctioned to date.

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Period</th>
<th>Project Name</th>
<th>Status</th>
<th>Project Cost (US$mn)</th>
<th>Loan</th>
<th>Rating</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1973-80</td>
<td>Population (Karnataka, Uttar Pradesh)</td>
<td>Completed</td>
<td>31.8</td>
<td>21.2 (66.6)</td>
<td>Sat.</td>
<td>-----</td>
</tr>
<tr>
<td>2</td>
<td>1980-89</td>
<td>Tamil Nadu Integrated Nutrition</td>
<td>Completed</td>
<td>66.4</td>
<td>32.0 (48)</td>
<td>Sat.</td>
<td>Likely</td>
</tr>
<tr>
<td>3</td>
<td>1980-88</td>
<td>Second Population (IPP2) (Uttar Pradesh, Andhra Pradesh)</td>
<td>Completed</td>
<td>96</td>
<td>46.0 (49)</td>
<td>Unsat.</td>
<td>Likely</td>
</tr>
<tr>
<td>4</td>
<td>1983-92</td>
<td>IPP3 (Karnataka, Kerala)</td>
<td>Completed</td>
<td>123.5</td>
<td>70.0 (56.6)</td>
<td>Sat.</td>
<td>Uncertain</td>
</tr>
<tr>
<td>5</td>
<td>1985-94</td>
<td>IPP4 (West Bengal)</td>
<td>Completed</td>
<td>89.9</td>
<td>51.0 (56.7)</td>
<td>Sat.</td>
<td>Uncertain</td>
</tr>
<tr>
<td>6</td>
<td>1988-96</td>
<td>IPP5 (Bombay, Madras)</td>
<td>Completed</td>
<td>78.2</td>
<td>57.0 (72.9)</td>
<td>Sat.</td>
<td>Likely</td>
</tr>
<tr>
<td>7</td>
<td>1992-96</td>
<td>Child Survival and Safe Motherhood</td>
<td>Completed</td>
<td>329.6</td>
<td>214.5 (65)</td>
<td>Sat.</td>
<td>Likely</td>
</tr>
<tr>
<td>8</td>
<td>1989-97</td>
<td>IPP6 – Family Welfare Training and Systems (Uttar Pradesh, Andhra Pradesh, Madhya Pradesh)</td>
<td>Completed</td>
<td>182</td>
<td>124.6 (68.5)</td>
<td>Sat.</td>
<td>Likely</td>
</tr>
</tbody>
</table>


| S.No. | Period  | Project Name                                      | Status       | Project Cost (US$ mn) | Loan  | Rating     | Sustainability |
|-------|---------|--------------------------------------------------|--------------|-----------------------|-------|------------|----------------|----------------|
| 9     | 1990-98 | Second Tamil Nadu Integrated Nutrition           | Completed    | 139.1                 | 95.8  | Marginally Sat. | Likely         |
| 10    | 1990-97 | Integrated Child Development Services (ICDS) (Orissa, Andhra Pradesh) | Completed    | 157.5                 | 106.0 | Unsat.     | Likely         |
| 11    | 1990-98 | IPP7 (Training)                                   | Completed    | 141.5                 | 96.7  | Sat.       | Likely         |
| 12    | 1992-94 | Social Safety Net Sector Adjustment Program       | Completed    | 500.0                 | --    | Sat.       | Likely         |
| 13    | 1992-99 | National AIDS Control                             | Completed    | 99.6                  | 84.0  |            |                |
| 14    | 1992-02 | IPP8- Family Welfare (Urban Slums)                | Completed    | 96.6                  | 79.0  |            |                |
| 15    | 1993-00 | National Leprosy Elimination                      | Completed    | 138.3                 | 85    |            |                |
| 16    | 1994-02 | Cataract Blindness Control                        | Completed    | 135.7                 | 117.8 |            |                |
| 17    | 1994-01 | IPP9- Family Welfare (Assam, Rajasthan, Karnataka) | Completed    | 103.8                 | 88.6  |            |                |
| 18    | 1995-02 | Andhra Pradesh First Referral Health System       | Completed    | 159.0                 | 133.0 |            |                |
|       |         | **ACTIVE**                                        |              |                       |       |            |                |
| 19    | 1993-02 | Second Integrated Child Development Services (Bihar, Madhya Pradesh) | Active       | 248.8                 | 194.0 |            |                |
| 20    | 1996-04 | Second State Health Systems Development           | Active       | 416.7                 | 350.0 |            |                |
| 21    | 1997-03 | Malaria Control                                   | Active       | 203.9                 | 164.8 |            |                |
| 22    | 1997-03 | Reproductive and Child Care                       | Active       | 309.0                 | 248.3 |            |                |
| 23    | 1998-04 | Orissa Health Systems Development                 | Active       | 90.7                  | 76.4  |            |                |
| 24    | 1998-04 | Women and Child Development                       | Active       | 422.3                 | 300.0 |            |                |
| 25    | 1998-05 | Maharashtra Health Systems Project                | Active       | 134                   |       |            |                |
| 26    | 1999-04 | Second AIDS Control                               | Active       | 191                   |       |            |                |
| 27    | 2000-04 | Immunization Strengthening                        | Active       | 158.8                 | 142.6 |            |                |
| 28    | 2000-05 | Uttar Pradesh Health Systems Development          | Active       | 127.6                 | 110   |            |                |
| 29    | 2001-04 | Second Leprosy Control                            | Active       | 30                    |       |            |                |

Note: The figures in brackets represent the percentage share of the loan vis-à-vis the total project cost.

Source: Annual Reports of the World Bank

Of the 12 projects where evaluation ratings have been made available by the Bank, it is significant that 9 of them have received a "satisfactory" rating. The "unsatisfactory" rating in 3 cases it may be noted has not really deterred the Bank from expanding the scope of its projects. The Bank for example chose to go ahead
with the series of India Population Projects (nine in all) despite the "unsatisfactory" and "uncertain" ranking accorded to the second, third and fourth projects.

The Bank's experience with innovative projects, sector work and policy dialogue in India offers several important lessons for both the Bank and the Government. The Tamil Nadu Integrated Nutrition Project and the IPP 5 project focussing on urban slums have been two path-breaking projects of the Bank. Both these projects were based on innovations and represented a brave move on the part of both the Government and the Bank to deviate from the standard norm and experiment with new ideas from the standpoint of policy options. One may disagree with the policy content of the Bank's interventions as in the case of the State Health Systems' projects, but it cannot be denied that the Bank has evolved over the years from being a passive to a pro-active actor in the determination of India's health policies.