CHAPTER-III
PROGRAMMES AND POLICIES ON REPRODUCTIVE AND CHILD HEALTH:
A CRITICAL ANALYSIS

Good health and well being is one of the fundamental and essential human rights. It is therefore the liability of every government to ensure adequate health-care facilities without discrimination to the citizens. Every since India became a free country successive central governments and various state governments have been taking legislative steps and launching different schemes to get better the health of the people and avoid the incidence of disease. Thanks to these schemes the average age of Indians has risen steadily from 32 years in 1947 to 65 years in 2012.

This chapter deals with the various schemes and policies concerning reproductive and child health that have been initiated by the government for the welfare of the people of the India. This has been presented in the organization chart given below:
3.1. **FAMILY WELFARE PROGRAMME (1951)**

India was first among the third world countries in 1951 to have launched a National Family Planning Programme. The aim of the programme was to reduce the birth rate so as to maintain the population growth rate at a sustainable level, “to stabilize the population at a level consistent with the requirement of national economy”.(www.mohfw.nic.in)³³⁵ Therefore supply of contraceptive services has been the focal point of India’s family planning programme right from 1947. Thereafter every five year plan has sought to put forward a policy framework and sufficient funds at disposal to ensure planned development of a countrywide healthcare infrastructure and skilled manpower.

In 1977, the priorities of the programme were changed and the new programme was baptized as Family Welfare Programme (FWP). (Mohanty, 2009)³³⁶ Besides hundred percent funding from the Union Budget the new programme aims at strengthening the infrastructure, adding more manpower and consumable items required for improving child health and for meeting the requirements of fertility regulation.(www.planningcommission.nic.in)³³⁷ During the last about fifty years under the auspices of the programme a reasonably vast infrastructure has been built for the delivery of family welfare services to the people both in the government as well as private sectors. Many NGOs too are in the field.

Since its inception in 1951, the family welfare programme in India has been evolving and changing focus throughout its different phases. Making a cautious beginning, when its impact was hardly felt, the programme was strengthened and consolidated in the period 1965-1975. In this phase, the programme was included with mother and child health services, abortion was made legal, ratio of health workers in relation to the population was increased, and the Minimum Needs Programme (MNP) combining health and
nutrition with fertility reduction was brought into effect. A system of incentives was set up to encourage people to go for family planning. It is generally recognised that in India’s FWP there is a disproportionate focus on popularising contraceptives amongst the people and encouraging female sterilisation to achieve targets.

A fresh impetus was added to the programme in the Emergency Era, under the premiership of Mrs Indira Gandhi, in 1975 when the programme became aggressive and coercive. Sterilisation targets were set up for doctors and many instances of forced sterilisation were reported. In the post-emergency period therefore family planning became an anathema and governments went out of their way to emphasize the voluntary nature of the scheme. (Jejeebhoy, 1997) Still the Programme remains heavily biased in favour of sterilisation and seeks to achieve targets through fiscal incentives both in cash and kind.

The programme suffers from two serious defects: one, it is heavily centralised, and two, its focus on achieving population control targets. Instead, the focus of the programme should be on women at the grassroots level – and that it all but ignores both in trying to establish communication with them as well as in service delivery. There is therefore an urgent need to understand the needs of the Indian women and addressing those needs in appropriate and sensitive ways through a comprehensive health and family planning programme. The stress has to be on a holistic approach to the health of the women and not merely family planning which the current programme is doing. Any family planning programme must take into account domiciliary services, obstetric and gynaecological problems of women, mainly those belonging to the inferior sections, and a warm and friendly rather than threatening interaction with service providers.
3.2. **INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) SCHEME (1975)**

The two biggest challenges Indian children face is, one, preschool education and, two, malnutrition, sickness, impaired learning capacity and death. (www.wcd.nic.in) The ICDS Scheme, launched on Gandhi Jayanti, 1975 seeks to meet these challenges. Given the size of India’s population the ICDS is one of the major and most unique programmes in the world and symbolises the country’s commitment to her children like nothing else does. It is a scheme sponsored by the Union Government but implemented by State Governments. The Central Government provides 100% financial assistance except for supplementary nutrition.

The objectives of the ICDS scheme are as follows:

1. Getting better the nutrition and health in the 0-6 years age group of children.
2. Ensuring proper mental, physical and social growth of the child.
4. Reducing the dropout rate from the school.
5. Achieving proper policy-implementation coordination amongst various departments concerned with child development.
6. Providing health education and proper nutrition to the mother to enable her to look after the health of her child. (Shobha I., 2003)

How these objectives are sought to be achieved has been summarized in the table 3.1.
3.2.1. **Nutrition including Supplementary Nutrition**

The two important activities undertaken are (a) monitoring the growth of the child; and (b) keeping a check on the child’s nutritional intake. This is done by weighing children under three years of age once every month and children in the age group three to six every four months. For all children under-six weight-for-age growth cards are maintained to facilitate correction in case growth falters. Children suffering from severe malnutrition are provided additional nutrition and are referred to medical services. Prevention of diseases due to deficiency of vitamin A and anaemia caused by malnutrition is taken care of.

3.2.2. **Immunization**

Six killer diseases, viz. poliomyelitis, diphtheria, whooping cough or pertussis, tetanus, tuberculosis and measles are preventable through immunization of pregnant women and infants. These diseases are the major causes of child mortality, sickness and malnutrition. Tetanus vaccine reduces maternal and neonatal mortality.
3.2.3. Health Check-ups

Regular checkups of children below-six years of age, care of pregnant women before and after delivery are covered under this. Anganwadi workers and medical personnel of Primary Health Centres give such health services for children as recording of weight, vaccination, taking care of malnutrition, prevention and treatment of diarrhoea, de-worming, supply of simple medicines, etc.

3.2.4. Referral Services

Anganwadi workers are trained to detect cases of disability in young children. These workers maintain a list of all cases and refer them to the Medical Officer of the nearest PHC or its Sub-centre. All cases of severe malnourishment that are in need of urgent medical concentration are also referred to a PHC or its Sub-centre.

3.2.5. Non-formal Pre-School Education (PSE)

PSE is an informal way educating under-six children outside the school. Under this scheme parents and communities mainly from the underprivileged sections of society are urged to bring children to the anganwadi centre and keeping them there. The focus of PSE is on the total growth of the child by providing a natural, joyful environment that stimulates optimal growth and development. It is hoped that PSE will lay the base for lifelong cumulative learning and development of children in India.

3.2.6. Nutrition and Health Education (NHED)

One of the crucial aspects of the Behaviour Change Communication (BCC) strategy which has the potential of empowering women in the 15-45 years age group is the work of the anganwadi worker in the field of nutrition, health and education. Once these three elements are taken care of, women
will be able to look after not only their own but also the nutritional and development needs of their children and families.

3.3. **UNIVERSAL IMMUNIZATION PROGRAMME (UIP) (1985-86)**

UIP forms the backbone of every programme related to child survival throughout the world. In 1978, the Government of India expanded the immunization programme to include diphtheria, whooping cough, tetanus and typhoid. In 1979-80 Oral Polio Vaccine and in 1981-82 BCG against tuberculosis programme was added. The period 1985-86 saw the addition of vaccination against measles to the programme. The Pulse Polio Immunization or PPI programme, under which all under-five children in the country are administered polio drops on a fixed date throughout India, was launched in 1995. The programme seeks to eliminate poliomyelitis from the country. (Sharma, 2007)\(^1\)

The seventh vaccine that was included in the UIP was Hepatitis B. It is managed to babies at six, ten and fourteen weeks of age. The vaccine is also offered by many private practitioners at birth but under the UIP the vaccine is not administered at birth. (MOHFW)\(^2\)

While the main thrust of the immunization programmes is to reduce infant and child mortality, the Hepatitis B vaccine provides protection against cancer, liver and related complications of this infection in adults also.

The aim of the UIP is to reduce death and sickness among infants, children and pregnant women by administering to them vaccines to prevent certain fatal diseases. There has been a significant drop in India’s infant mortality rate since the inception of the programme. (www.mohfw.nic.in)\(^3\)

For any immunisation programme to be successful the dropout rate must be monitored and checked. Immunisation dropout is bad for the health of the mother and the children. States reporting
high dropout rate are Arunachal Pradesh, Manipur, Meghalaya, Delhi and Union Territories of Chandigarh and Pondicherry. Special efforts have been made in recent years to improve coverage and extend the programme to identified areas. In order to better routine immunisation State Governments have been urged to avail support of the Immunisation Strengthening Project.

One of the main reasons why there are so many instances of dropout is poor delivery of health services due to shortage of materials, insufficient staff, lack of proper cold chain to preserve vaccines at the desired temperature, absence of supervision and lack of training. Then, lack of information about the location and time of immunisation, lack of awareness of the fact that it is safe to vaccinate even a sick child, lack of coordination so that the parents find the location and time of immunisation inconvenient, lack of faith in immunisation and in some cases doctor’s advice against immunisation keep parents away from any immunisation programme. (www.isid.ac.in)

3.4. DIARRHOEA CONTROL PROGRAMME (1986-87)

Diarrhoea is the main causes of sickness and death among children. A special programme was initiated by WHO in 1980 to control this dreaded disease. In 1986-87 the Indian version of Oral Rehydration Therapy (ORT) was launched as part of the Diarrhoea Disease Control Programme with the objective of preventing death from dehydration caused by diarrhoea in children below five years of age. (Shah et.al., 2012) Both, in CSSM as well as RCH Phase I, spreading awareness to recognise immediately the symptoms of diarrhoea and manage it effectively has been an essential part. (www.India_Country_report.doc)

The World Health Organization advises using oral rehydration salt supplemented with zinc to children suffering from diarrhoea. (www.whqlibdoc.who.int, 2006) In controlling diarrhoea ORT
has been made the first choice to be followed by an increased supply of fluids in order to compensate the loss of fluids. It is also recommended that feeding of the child should not be stopped during an attack of diarrhoea. (WHO, 1989) Every year throughout the country all PHCs and their sub-centres are supplied with ORS sachets along with the kits. To facilitate easy availability of ORS sachets state governments have been advised to distribute them through the PDS (Public Distribution System). Since death from diarrhoea is easily preventable without any financial burden with the help of ORT it has given a new hope to millions of children throughout the country. In fact lack of proper ORT coverage has been cited as a major cause of infant and child mortality due to diarrhoea in India. (Bhattacharya, 2003) In 2005, ORT was made a part of the Integrated Management of Childhood Illness Programme. Effective implementation of ORT will go a long way in reducing Infant Mortality Rate (IMR) in India.

3.5. **CHILD SURVIVAL AND SAFE MOTHERHOOD PROGRAMME (1992)**

The UIP, launched in 1985-86, evolved into Child Survival and Safe Motherhood Programme. This programme was launched in India on 20 August 1992 and its implementation was completed in a phased manner in all the districts of India by 1996-97. (Srivastava et al., 2005) The Programme, developed by the Government of India, is jointly funded by the World Bank and UNICEF. The programme aims at improving the health of women and children and bringing down infant and child morbidity and mortality rates in India.

The programme has a ‘safe motherhood’ component under which TBAs (traditional birth attendants) are given training, aseptic delivery kits are provided, and FRUs (first referral units) are strengthened so that they are in a position to take up emergency
The programme has been successful in the sense that the IMR and MMR have been brought down and there has also been a reduction in the occurrence of vaccine preventable diseases among infants and children. (MOHFW, 2001)

The programme, as mentioned above, seeks to deliver child survival services – such as vaccination, diarrhoea and respiratory infection control, etc. – and safe motherhood services – such as tetanus vaccination, prevention of anaemia, care before and during delivery, promoting institutional deliveries, birth spacing, etc. – through the network of PHCs and SCs in India. There are, however, several shortcomings in the programme. Although care at birth is specified as a ‘service’, the work-plan of Auxiliary Nurse Midwives both at the level of the Primary Health Centre or at the level of the sub-centre did not mention conducting deliveries as one of their critical activities. Thus though the ANM’s responsibility as a community midwife is mentioned in the policy document it was actually not applied in the field. The Programme gave greater importance to routine services such as vaccination and providing care before delivery, and ignored emergency services such as care during the time of delivery. (Vora et.al., 2009)

One of the objectives of the Programme is to improve immunisation services in areas where the performance has been poor while continuing the good work in high immunisation areas. It also seeks to strengthen the ORT programme and to increase the coverage area of the schemes related to prevention of anaemia in pregnant women, and prevention of blindness and of acute respiratory infection (ARI) in children.

3.6. **REPRODUCTIVE AND CHILD HEALTH PROGRAMME (1997)**

An International Conference on Population and Development was held in Cairo in 1994. Based on the recommendations made by this Conference the Government of
India launched the RCH Programme on 15th October, 1997. The objective of this Programme was safe motherhood, better child health, and to deal with problems related with reproductive health. By 1999-2000 all the districts of India were enclosed under this programme. The distinguishing features of the RCH Programme are as follows:

a) To integrate fertility regulation, health of the mother and of the child with that of the man.

b) To offer high quality services according to the demand of the client.

c) To upgrade Reproductive and Child Health facilities and quality of care both at the PHC and Sub-centre level by providing all round emergency delivery and neonatal care. FRUs are sought to be set up at the village level.

d) To upgrade facilities for delivery and neonatal care, Medically Terminated Pregnancies (MTP) and IUD (Intrauterine Device) insertion at the level of PHCs as well as Sub-centres.

e) To improve substantially healthcare services to the poorest sections of society who have been practically denied the benefits of the planning process. In this, it seeks to take the services of NGOs and other voluntary organisations.

f) To reduce infant mortality rate by improving neonatal care in hospitals and homes and at the community level.

g) To ensure that immunisation reaches every village of India and also to ensure delivery by skilled paramedics and efficient ante and postnatal care.

h) To eradicate the polio virus while at the same time selectively introducing Hepatitis B in UIP package. (Goel, 2005)
3.6.1. SERVICES UNDER RCH- I

a). Additional ANMs

In thirty percent of the Sub-centres of C category districts of eight States, namely, Assam, Bihar, Haryana, Madhya Pradesh, Nagaland, Orissa, Rajasthan and Uttar Pradesh were provided with facilities for additional ANMs to ensure better delivery of healthcare services. In the period 1999-2000 the scheme was extended to the remaining six north-eastern States.

b). Public Health/Staff Nurses

Under the auspices of RCH-I, 25 percent of Primary Health Centres in C-category districts and 50 percent in B-category districts were provided with Public Health/Staff Nurses.

c). Laboratory Technicians

Another objective of RCH-I was to increase the capacity of the FRUs to deal with emergency delivery, Respiratory Tract
Infection, and Sexually Transmitted Infection cases by providing two technicians on agreement basis for regular blood and urine tests in their pathology labs.

d). Private Anesthetists

RCH seeks to strengthen FRUs, CHCs and sub-district hospitals by entitling them to hire private anaesthetists at the rate of Rs. 1000/- per case for carrying out emergency operations. Drugs and emergency obstetric kits are also supplied.

e). Safe Motherhood Consultants

Under the programme, the GOI assisted State Governments and Union Territories in hiring doctors trained in techniques of Medical Termination of Pregnancy (Safe Motherhood Consultants), on a fixed day, once a week or once a fortnight, in order to improve the supply of skilled staff in PHCs, CHCs and sub-district hospitals. These doctors, paid at the rate of Rs. 800/- per day, performed antenatal checkups and treated complicated pregnancies.

f). 24 Hours Delivery Services at PHCs/CHCs

One of the aims of RCH-I was to encourage institutional deliveries, i.e. deliveries in hospitals. To achieve this objective provision for extra payment to staff was made so that 24 hour service could be made available at PHCs and CHCs. Provision was made so that at least one medical officer, one nurse and one cleaner were available round the clock.

g). Referral Transport

Recognising the importance of time in emergencies during delivery RCH-I provided for allocation of a fixed amount of money to Panchayats in twenty-five percent of Sub-centres in certain states from which payment could be made to poor families to deal with obstetric emergencies. The disbursal of funds to
Panchayats was to be done through District Family Welfare Offices. After 2001 all the States and Union Territories were covered by the scheme.

h). Integrated Financial Envelope

This scheme, with a corpus of Rs. 2276.26 lakhs, was devised to give flexibility to high performance States so that they could deal with problems of maternal health by creating packages of intervention without having to tie up with national schemes. It was step towards decentralisation.

i). RCH Camps

In 2000-01, a new scheme to extend RCH services was launched under which camps were organised in those remote areas where people were not using the existing facilities at Primary Health Centres. To begin with 102 districts in seventeen States were identified for setting up the camps. By 2002 all the States and UTs were brought within the ambit of the scheme by including 72 more districts.

j). Training of Dais

Recognising the need for at least one trained Dai (midwife) in every village of the country for safe delivery, a scheme was launched in 2001-02 for the training of Dais in 156 districts of 18 States and Union Territories. The districts selected were those in which the percentage of safe deliveries was less than 30 percent. The scheme was extended to the districts of the EAG States on request of State Governments also to Andaman and Nicobar Islands and several districts of Jammu & Kashmir.

k). Safe Abortion Services

Under the RCH Programme the Government of India undertook the training of medics and paramedics in Medical Termination of Pregnancy. The Government is also trying to create awareness
amongst people about the dangers of abortion by quacks. Abortion has been a significant problem both medically as well as socially all over the world. According to one estimate nearly fifty percent of the abortions taking place worldwide are often performed by quacks, leading to sepsis and other complications which are often fatal. Abortions contribute nearly 8.9 percent to maternal mortality every year. (www.mohfw.nic.in)

In the RCH-I project in India, which was completed in 2005; the various components of Reproductive Health Care were covered. These were maternal health services including care before, during and after delivery; newborn care and child health services including prevention and management of acute respiratory infection (ARI), diarrhoea, malnutrition, malaria and vaccine preventable diseases; adolescent health care; contraception; prevention and managing of unwanted pregnancy, and safe abortion services; prevention and managing of RTI, STDs, and HIV/AIDS; care for gynaecological morbidity, investigation and management of infertility, screening for cancer of reproductive organs; and nutritional services. (Roy, 2007)

**Weaknesses in Reproductive Child Health Programme-I**

Some of the identified critical weaknesses in RCH-I was:

1) The so-called paradigm shift in the programme was not backed up with active promotional efforts or activities.

2) Decentralized community-based programme would need a strong decentralized planning and implementation process.

3) Being entirely controlled by the Central Government, the States found it difficult to tailor the project to meet their specific felt needs.

4) There were multiple partners who were supporting independent projects rather than a cohesive national programme.
5) The involvement of the private sector in the delivery of RCH care was limited.

3.6.2. REPRODUCTIVE AND CHILD HEALTH PROGRAMME, PHASE II (2005-2010)

A significant element of the RCH Programme is the Maternal Health Programme. The programme aims at providing essential and emergency care during delivery in order to prevent deaths arising out of various complications. The Maternal Health Programme seeks to bring down the maternal and child death rate while laying emphasis on rural health care.

RCH-I was launched in 1997 as a part of the 9th Plan, while RCH-II was launched in 2002 as a component of the 10th five year plan. Many lessons were learned from RCH Phase I. The design of RCH Phase II specifically sought to address the lessons learnt from RCH Phase I to effectively reach the national long-term goals through flexible, cohesive and strategic planning. (www.whoindia.org)\textsuperscript{157}

(See table 3.2)

<table>
<thead>
<tr>
<th>LESSONS LEARNT FROM RCH-I (1 April 1997-31 March 2005)</th>
<th>IMPROVEMENT IN RCH-II (1 April 2005-31 March 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restricted participation of states and restricted possession by states in RCH Phase-I</td>
<td>States prepared strategy linked to clear outcomes after assessing their own priorities, allowing a needs-based state-specific plan.</td>
</tr>
<tr>
<td>Slow pace of implementation</td>
<td>Bottlenecks in fund flows were removed by simplifying processes.</td>
</tr>
<tr>
<td>Infrastructure to be Non-completion within the project time frame</td>
<td>Outsourcing is being undertaken with agreed institutional mechanisms to manage infrastructure and to ensure accountability and delivery of reliable and quality services. The processes of managing and construction of infrastructure are being simplified.</td>
</tr>
<tr>
<td>Limited managing capacity</td>
<td>There is now a lateral infusion of skilled personnel to improve the management capacity structure at the national, state and district levels, with clearly defined functional responsibilities and roles.</td>
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<tr>
<td>Need to incorporate the system of smooth flow of funds</td>
<td>Financial management systems are being built into the programme management structure.</td>
</tr>
<tr>
<td>RCH Phase I was implemented</td>
<td>RCH is visualized as a long-term programme, oriented</td>
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as a project; there was a need to incorporate well-defined outcome indicators towards achieving ambitious, but realistic health outcomes and improvements.

| RCH Phase I had a 'one size fits all', design' | States will have different requirements, levels of performance and capacities and will be able to take these into account when designing their state Programme Implementation Plan (PIPs). Such a differential approach may be extended to the district level depending upon the performance of districts. |
| Need to move away from “Stand Alone” public health approach | RCH Phase II is adopting a programme approach, bringing in key elements of sector management and reform and strengthening of systems. |
| RCH Phase I focused almost exclusively on the supply side | Whilst RCH Phase II necessarily includes supply side strategies, these are being complemented by an integrated and robust strategy to stimulate demand for services. |
| RCH Phase I was centrally designed with little consultation | RCH Phase II has been designed after wider consultation. |

### 3.6.2.1. Essential Components of RCH-II Programme

The eight essential components of RCH-II Programme are illustrated in graph 3.2.

#### Graph 3.2
Components of RCH - II Programme

The RCH-II, which comes under the NRHM, is the most vital programmes of the Union Government covering reproductive, child and maternal health. The programme has been redesigned to make it result-oriented and to give it a pro-poor emphasis. It seeks to remove the shortcomings and implement the lessons learnt from the experience of
RCH-I. Radical changes have been made to bring it in line with the objectives of NRHM. The RCH-II programme is a major component of the NRHM initiated by the Government of India in 2005.

3.7. **NATIONAL RURAL HEALTH MISSION (NRHM)/RCH-II (2005-12)**

The NRHM was launched on 12\textsuperscript{th} April 2005 by Prime Minister Manmohan Singh, initially in 18 States, namely, Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh. (www.similima.com)\textsuperscript{158}

The NRHM aims at making quality health care easily available to people, especially in the villages, to the poor, and to women and children; to bring down IMR and MMR; to make public health services in good quality available to women and children; to improve sanitation and hygiene; to provide clean drinking water to all; to provide immunisation coverage and nutrition; to control and prevent the spread of communicable and other diseases; to stabilize population and to maintain gender and demographic balance; to make integrated all round primary healthcare available to all; to bring into the mainstream traditional medical systems of India such as Ayurveda, Yoga and Naturopathy, the Unani system, Siddha and Homeopathy (AYUSH); and to spread awareness among the people about healthy lifestyles. (www.mohfw.nic.in, 2005-2012)\textsuperscript{159}

The core strategies of NRHM are as follows:

(i) to decentralize planning and administration at the rural and district level;

(ii) to appoint Accredited Social Health Activists (ASHA) for awareness, for counselling women, and for the mobilization of
community facilities so as to make health related services accessible;

(iii) to strengthen public health service delivery infrastructure;

(iv) to mainstream AYUSH;

(v) to improve the management capacity for organizing health systems and services in public health; and

(vi) to promote non-profit sector to augment social contribution and community empowerment, healthy behavior and inter-sectoral meeting.

The other strategies of NRHM are:

(i) to regulate the private sector, to get better equity and reduce regulation of the private sector by ensuring fair play, and cutting down cash expenses;

(ii) to encourage joint ventures between government and private sectors in order to meet national health goals;

(iii) to reorient medical education; and

(iv) to extend social insurance cover to the poor to provide health security to them making maximum use of local health traditions. (Sharma, 2009)¹⁶⁰

NRHM is a new vehicle of the national government targeting eighteen states where the rural healthcare infrastructure is identified as weak and health status indicators are poor. The mission also serves tribal and under-served areas of other states. One of its major goals is to get higher public spending from 0.9 to 2-3 percent of the GDP. It also plans at ‘architectural correction’ so that the system may absorb the increased allocation to health from the government. Flexible and decentralized planning, community ownership of healthcare facilities, and provision and maintenance of adequate healthcare infrastructure are the major tasks in its attempt to revamp rural healthcare.
The main components of the NRHM are RCH-II; National Disease Control Programme (NDCP) including National Disease Surveillance Programme (NDSP); General Curative Care; AYUSH; Janani Suraksha Yojna; Sobhagyawati Safe Delivery Scheme; Infant and Young Child Breast-feeding; Saloni Swastha Kishori Yojna, etc. (www.pariwarkalyan.up.nic.in)\textsuperscript{161}

The NRHM now seeks to bring into existence a health system that is functional and result-oriented at every level from the rural to the urban, from the village to the district. Thus, the focus has now shifted from formulating narrow schemes to achievement of targets. The NRHM therefore cannot meet its targets unless there is a major overhaul of the health sector. This requires what is known as ‘architectural correction’. This correction revolves around the following five pillars. Each pillar has a number of core strategies that overlap.

**a) Greater Participation and Ownership by the Community**

NRHM aims to ensure greater participation of the community by involving the Panchayati Raj Institutions or PRIs, ASHA, village committees for health and hygiene, more involvement of the public in committees for the development of hospitals, by public participation in watchdog committees to keep an eye on rural health planning and district health societies, and finally through the involvement of non-government organisations (NGOs).

**b) Better Management Capacity**

This is sought to be achieved by, one, making the existing workforce more professional and skilled in public health and management affairs and, two, by recruiting skilled management staff in greater numbers.
c) **Flexible Financing**

This implies providing loose, untied funds to all rural health and hygiene committees, PHCs and SCs, and to CHCs together with district hospitals.

d) **Changes in human resources development for health sector**

The basic challenge before the NRHM is to discover responses to the old problems concerning adequate human resource for the public health system and providing the staff with proper and adequate work. This is sought to be done by filling vacancies immediately on contractual basis, by ensuring local residency of the staff, through incentives to staff to encourage them to work in underserved areas, and by making use of multitasking.

e) **Standards and norms with monitoring**

One of the most important strategy of NRHM is the laying down of norms to be observed in sub-centres at the periphery to district hospitals in districts. This is to ensure that all PHCs and CHCs and other hospitals work to their full potential in quality health care delivery. Surveys to identify weaknesses and gaps are made and funds are allocated to fill the gaps. (MOHFW, 2007)

**3.7.1. Services under NRHM**

Several measures are being implemented to bring down maternal mortality – one of the goals of NRHM. These measures are as follows:

1. a. **Basic care at the time of delivery**

Besides good care of the woman before delivery, it also includes safe delivery and quality after delivery care together with prevention of anaemia. In order to ensure basic 24-hour care during delivery the government of India is training nurses, LHV, ANM at Primary Health Centres.
1. b. **Good Antenatal Care (ANC)**

    Good before delivery care or ANC would include at least four steps. These are, one, early registration together with first antenatal check up in the first three months which would include physical and abdominal check up; two, haemoglobin count and urine test; three, two shots of tetanus toxoid immunisation; and, four, administering IFA tablets for 100 days.

1. c. **Prevention and treatment of Nutritional Anaemia**

    According to the NFHS-III conducted in 2005-06, nearly 55.3 percent of Indian women 15-49 years age group suffer from anaemia, and the percentage increases to 58.7 among those who are pregnant and to 63.2 among the lactating women. NRHM/RCH II programme provides that all expected and lactating women must be administered one 100 mg tablet every day for hundred days of elemental iron and 0.5 mg of folic acid for the same period. Women suffering from acute anaemia must be administered double the dose for hundred days.

    RCH Kit A, supplied by the Government of India to Sub-centres and distributed on Village Health and Nutrition Days (VHNDs) both to women and children, contains IFA in liquid and tablet form. IFA in both forms is also distributed throughout the country by PHCs, CHCs, District Hospitals and other health facilities.

1. d. **Round the Clock Delivery Services at PHCs**

    NRHM/RCH-II seeks to ensure 24-hour service at all CHCs and fifty percent of PHCs by providing them with three to five Staff Nurses (SNs) and one Medical Officer.

1. e. **Care for Mother and Newborn**

    Under NRHM/RCH-II postnatal emergencies must be identified within one day of delivery. Residence visits on the third, seventh and forty-second days are important for identification as well as
management of emergencies. Emergencies identified under the Mission are tackled by ANMs, Lady Health Workers (LHVs) and SNs who are specially trained for this.

2. **Every delivery to be supported by skilled attendance**

NRHM shows the commitment of the Government of India to support every delivery by skilled attendance with the help of trained SNs, ANMs or LHVs for three weeks. To attain this goal, technical guidelines have laid down and curriculum has been revised. This is being implemented throughout the country in every State as well as Union Territory.

3. **Emergency Obstetric and Neonatal Care at First Referral Units (FRUs)**

In order to provide emergency skilled care during and after delivery all FRUs in the country are being made operational. The major thrust at FRUs is to ensure availability of appropriate staff, blood storage units and referral linkages. NRHM links supply of skilled manpower, i.e. Skill Based Training for MBBS doctors, with the functionality of FRUs. To make this happen the following initiatives are underway:

3.a. **Training of qualified doctors in lifesaving anaesthetic skills to deal with emergency obstetric care:**

It is recognised world over that time is the most important factor in saving the lives of expected women likely to expand problems throughout pregnancy or at the time of delivery. EmOC (Emergency Obstetric Care) therefore is of utmost importance and keeping that in mind the functionality of First Referral Units at Community Health Centres is one of the core strategies of NRHM/RCH II. Short supply of gynaecologists and anaesthetists, especially at the sub-district and district levels, has been one of the important factors in rendering the FRUs non-operational.
To deal with this shortage of skilled manpower effectively the Government of India is conducting 18-week programmes for the intensive training of qualified doctors in critical lifesaving anaesthetic skills at FRUs.

3. b. Training in Obstetric Management Skills:

Nearly twenty-five medical colleges and district hospitals have been earmarked for imparting 16-week training sessions in Obstetric Management and Skills. The Government of India has entered into collaboration with the FOGSI (Federation of Obstetric and Gynaecological Society of India) in this.

3. c. Referral Linkages between Communities and FRUs:

Emergencies before, during and after delivery cannot be effectively dealt with unless linkages are established between the community and FRUs. Since it is nearly impossible to predict the occurrence of emergencies such linkages are essential to make health services accessible to all women. Required flexibility has been sanctioned to States to put in place effective referral linkages.

4. Some critical interventions:

4. a. Medical Termination of Pregnancy (MTP):

To deal effectively with the problem of abortions in India the Parliament passed the MTP Act in 1971. The Act was implemented on April 1, 1972 with the aim of reducing maternal death and morbidity rate due to abortions by quacks and other unsafe methods. The Act specifies the conditions and places in which an abortion could be carried out. An amendment to the Act was made in 2003 with a view to extend the network of safe abortions by decentralizing the authority to approve centres for MTP from the State to the District level. The Act also lays down the punitive action to be taken against quacks and unqualified doctors.
performing abortions at places that are not approved by the government.

Due to complications such as sepsis arising out of termination of pregnancies, whether natural or induced, abortions have always remained a serious social and medical problem in India. Unsafe abortions account for nearly eight percent of maternal deaths, something which is entirely preventable.

Provision of safe abortions is one of the important strategies of the National Population Policy 2000. Medical personnel are being trained in techniques of MTP by State Governments so that round the clock MTP services could be provided in all PHCs, CHCs, and FRUs.

4.b. **RTI (Reproductive Tract Infection/STI (Sexually Transmitted Infection Services**

It was only recently, after researches conduct in the last ten years or so revealed the extent of the problem of reproductive morbidity, that RTI/STI came to be recognised as a major public health problem. DLHS-III conducted in 2007-08 revealed that nearly 18.3 percent of women suffered from RTI/STI symptoms. The Survey however does not say anything about the percentage of women who sought treatment. The problem has become even more acute due to the spread of HIV and the role played by RTI/STI in spreading HIV. Thus, the important objective of the RCH programme is the identification and control of RTI.  
(www.healthopine.com)\(^{163}\)

3.7.2. **Major Achievements of the NRHM**

a) **ASHA programme**

ASHA is one of the very important programmes of the NRHM. The Mission has deployed more than 8.84 lakh trained ASHAs with the objective of establishing linkages between the community and the
health services. Women and children belonging to the poor and deprived parts of the community first contact an ASHA to access health services in villages. The programme has been successful in several States in bringing people back into the fold of the Public Health System. The programme has also led to remarkable increase in the utilization of outpatient and diagnostic facilities, and in encouraging people to go in for institutional instead of home deliveries.

b) **Addition in Human resources**

The addition of more than hundred thousand skilled workers to health services resulted in revitalizing the public health system of India by adding to the range of services offered. Among these one lakh workers there are 7,382 doctors, 11,478 AYUSH doctors, 2,131 specialists, 66,407 ANMs, 32,278 Staff Nurses, 11,030 paramedics and 4,894 AYUSH paramedics. These have been deployed under NRHM on contractual basis by State Governments to fill critical gaps.

c) **Communitisation of health services**

The NRHM has unleashed a large number of forums – e.g. establishment of 5,03,025 village health and sanitation committees, creating space for public involvement in committees for hospital development and in district health societies – and activities – such as organising village health and nutrition days with an outlay of Rs. 35.23 crores – which have led to greater community participation.

d) **Health planning at the district level**

Among the steps taken to decentralize health care are (i) effort to institutionalise district health planning, and (ii) the effort to provide resources and monitor programmes at the district level.
Programme Implementation Plans (PIPs) were received from 25 states in the year 2012-13.

e) **Upgrading Facility**

A major achievement of NRHM has been the upgradation of facilities at every level in all the States. As on 30.6.2012, 18,630 sub-centres, 1,514 PHCs, 426 CHC and 64 district hospitals have been taken up for new building. The building of 49 DHs, 189 CHCs, 668 PHCs and 8,777 SCs has been completed. The infrastructure of another 13,402 sub-centres, 3,542 PHCs, 2,105 CHCs and 537 district hospitals was upgraded. The provision of an annual untied fund for initiatives taken at the local level is a step forward in the direction of upgradation of public health facilities. With the induction of new skilled medical personnel more than 8,199 PHCs now function round the clock and 2,552 have been upgraded to FRUs. The infrastructural improvement is evident by the increasing numbers of out and in-patients at public healthcare facilities and the greater number of institutional deliveries in all the States. External assessors working under different quality accreditation schemes have also testified to this upgradation by certifying them.

f) **Better Management**

District Programme Management Units have been set up in 638 districts with nearly 570 District Programme Managers and 573 District Accountants in position. Almost 4729 Block Programme Management Units have been established with 3361 Block Managers to support the healthcare system at the block and lower levels. (www.mohfw.nic.in, 2012-13)\(^{164}\)

3.7.3. **Child Health Programme**

The Child Health Programme under the auspices of the NRHM seeks to improve child health by taking care of factors that bring
down the death rate of infants and children less than five years. The Child Health Programme consists of the following components: (www.mospi.nic.in, 2011)\textsuperscript{165}

(i) Setting up of FIMNCI (Facility-based Integrated Management of Neonatal and Childhood Illness) to take care of new born babies.

(ii) Better care of the mother and the new born infant under the JSSK (Janani Shishu Suraksha Karyakram).

(iii) Establishment of Integrated Management of Neonatal and Childhood Illness (IMNCI) and Pre-Service IMNCI.

(iv) Efficient residence based care of newborn babies.

(v) Bringing into effect universal vaccination.

(vi) Enabling early diagnosis and effective supervision of diseases like acute respiratory infections, diarrhoea, etc.

(vii) Promotion of breastfeeding and proper nutrition for babies and young children.

(viii) Taking care of children suffering from malnutrition.

(ix) Provision of Vitamin A and iron and folic acid supplementation.

(x) Putting in place the School Health Programme.

Measures for improving child health are focused on better training of healthcare workers, making the healthcare infrastructure stronger, and on involving communities by changing behaviour.

\textbf{3.7.4. Janani Shishu Suraksha Karyakram (2011)}

The Janani Shishu Suraksha Karyakram (JSSK) was launched by the Government of India on 1st June, 2011. Under this programme every woman is entitled to no-expense delivery, including caesarean section, in public health institutions. The
programme also provides free diagnostics and free blood when required, and medicines and food up to three days in case of normal deliveries and up to seven days in case of a caesarean section. Free transport from home to institution and between facilities where the case has been referred to a unit and back home is also arranged. Similar facilities are provided for all newborn babies for treatment up to thirty days after birth. (www.nrhm.mis.nic.in, 2013) 166

JSSK will not only benefit an estimated one crore twenty lakh women who visit government healthcare centres for delivery but will also encourage those who prefer home delivery to opt for institutional delivery. These provisions’ of the JSSK are being put into practice in all the States and Union Territories to benefit pregnant women and babies in need of medical attention.

In the year 2012-13, in order to bring down the number of maternal and child deaths 267 Mother and Child Health Wings with 100/50/30 beds have been sanctioned in districts where there is excessive load on district hospitals and Child Healthcare Centres. This would create an additional twenty thousand beds for mothers and children.

3.7.5. Accredited Social Health Activist (ASHA)

ASHA is the most important linkage between the people and health facilities. ASHA aims at appealing women and their families to opt for institutional deliveries by bridging the gap between patients and healthcare units. The target is to provide one activist for every 1000 population in every village.(www.mohfw.nic.in, RFD, 2013-14) 167 In order to qualify to be an ASHA a women must be, one, a primary resident of the village, two, must be educated up to Class VIII and, three, must preferably be in the age group 25-45. These women activists are selected by the Gram Sabha and are
responsible to the Panchayat. They are not paid an honorarium but a performance based compensation. [www.whoindia.org]\(^{168}\)

Various functions have been assigned to the ASHA, the most important being (i) to identify expected women and facilitate their registration for ANC; (ii) to help these women in getting the necessary certificates; (iii) to ensure that they get at least three antenatal checkups with TT injections, and IFA tablets; (iv) to refer them to a government healthcare centre that is operational, or to a government-recognised private nursing home or hospital; (v) to advise women to opt for institutional delivery; (vi) to make sure that a newborn baby is immunized till the age of 14 weeks; (vii) to inform the ANM or MO about the birth or death of the child or the mother; (viii) to visit the mother and newborn baby within seven days of delivery; (ix) to encourage the mother to breastfeed the baby within one hour of birth and continue up to six months; and (x) to promote family planning. [JSY, Government of Orrisa]\(^{169}\)

### 3.7.6. Janani Suraksha Yojana (JSY)

The JSY, a scheme backed up by hundred percent financial support by the Union Government of India, was introduced under the auspices of the NRHM on 12\(^{th}\) April 2005. The scheme aims at reducing the maternal and neonatal death rate. This it seeks to do by encouraging women and their families – especially the poor ones – to go for institutional delivery. [Khan et.al., 2010]\(^{170}\) The scheme provides cash assistance for delivery and post-delivery healthcare. Whether the scheme proves a success or not, would therefore, be determined whether the number of institutional deliveries among the poor increases or not. ASHAs have been introduced as frontline health workers to establish an effectual linkage between the Government and deprived expected women in ten states where the MMR was high. These states are the Empowered Action Group (EAG) States. While the remaining states
are called as High Performing States; these states have been designated as Low Performing States. The scheme has also been introduced in the remaining North Eastern States. (www.mohfw.nic.in, 2nd CRM, 2008)  

In the LPS, the institutional delivery rates are poor. In these states all pregnant women opting for delivery in a government healthcare unit such as a PHC, CHC or SC, FRU, or the general ward of a sub-divisional, district or state hospital or any government recognised private nursing home or hospital is entitled to receive cash Incentive. In the High Performing States all expected women who have attained the age of 19 or more and are Below Poverty Line, SC and ST women are entitled to be given financial aid under the Scheme. (www.mohfw.nic.in, 2006)  

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3.7.6.1. Achievements of JSY

The JSY is now operational throughout India and the number of beneficiaries had gone up from 7.38 lakh women in 2005-06 to 106.57 lakhs in 2012-13. While in 2005-06 the expenditure under the scheme was to the tune of 38 crores, in 2012-13 it had gone up to 1640 crores. According to the survey of National Health Systems Resource Centre the number of institutional deliveries has registered a significant increase thanks to JSY. It has also enabled poor women to avail of public health facilities.

Among the important contributions of the Janani Suraksha Yojana are:
• Increase in cases of institutional deliveries went up from 47% according to DLHS-III, 2007-08 to 72.9% according to Coverage Evaluation Survey, 2009.

• Decline in MMR was from 254 maternal deaths per 1,00,000 live births in 2004-06 to 212 in 2007-09.

• Neonatal Mortality Rate (NMR) went down from 37 per 1000 live births in 2006 to 31 in 2011.

Going by the sheer size of the drive in terms of numbers and demography, the JSY is among the most ambitious incentive programmes ever undertaken by any country in the world to bring about a material change in the mother and child healthcare of a vast population. Therefore the entire process of the manner in which it influences the behaviour of target-women and the extent to which it succeeds in the fulfilment of its aim of bringing down the death rates of mothers and newborn babies needs careful monitoring.

3.7.7. National Urban Health Mission (NUHM)

On 1 May 2013 the Union Cabinet approved the NUHM as a submission of the NHM. The aim of the NUHM is to meet the health needs of urban India with attention on slum dwellers and other deprived sectors of society. (www. planning commission.gov.in, 2010) The programme recognises the fact that healthcare in cities remains inaccessible to large sections of population due to overcrowding in hospitals and due to lack of norms and standards in hospitals. Poverty, lack of information and awareness and absence of assistance in accessing healthcare facilities compounds the problem.

The NUHM therefore aims at making the existing healthcare facilities accessible to people across the board. This it seeks to do by rationalising the existing urban healthcare delivery system, on the one hand, and by increasing its capacity, on the other, so that
it may serve larger number of people. It also seeks to garner the support of the Urban Local Bodies (ULBs). (www.uhrc.in, 2008)\textsuperscript{174}

In its first Phase, the mission covered 430 cities with population in excess of a hundred thousand throughout the country. In the second phase it will cover the remaining districts with a population of less than one lakh. The main focus of the programme will be on the urban poor living in slums and such weak sections as construction labour, street children, rag-pickers, sex workers, brick kiln workers, rickshaw pullers, etc. (MOHFW, 2008)\textsuperscript{175}

NUHM, thus, seeks to take corrective steps to deal with health-related problems of city dwellers, especially of the urban poor. It aims to create a healthcare system which is need-based in partnership with people, charitable hospitals, and NGOs to ensure their involvement in planning, implementation and monitoring of healthcare initiatives.

**Three-tier system of health care:**

(I) Community Level Community Outreach Services, Mahila Arogya Samitees (MAS) and Urban Social Health Activist (USHA).

(II) Urban Health Center Level: Strengthening existing public health facilities, and empanelled private providers.

(III) Secondary /Tertiary Level: Public or private empanelled providers.

It aims to provide community level care with the support of Urban Social Health Activist (USHA) and Mahila Arogya Samitees (MAS). In urban area, it seeks to promote one USHA for 1000-2500 poor population covering about 200 to 500 households and to ensure community participation through community-based institutions through one MAS for 20-100 households and Rogi Kalyan Samitis. (John et.al.
These mechanisms will make sure that the community participates in planning and management.

### 3.8. NATIONAL HEALTH POLICY (NHP) (1983)

The NHP was announced by the Government of India in 1983. The motto of the NHP was ‘Health for All’ by 2000 AD by means of an inclusive primary healthcare service. (Mukharjee, 1991) The measures taken by the Government in this area have yielded some notable results, such as eradication of smallpox, and the near eradication of polio, leprosy, kala azar, and filariasis. The Total Fertility Rate and Infant Mortality Rate have gone down considerably. How far the measures taken by the government in the period 1951 to 2007 have yielded positive results can be judged by many demographic, epidemiological and infrastructural fields. However, in many areas the results have not been as desired. (www.whoindia.org, 3c textbook)

The basic emphasis of NHP was on the development of primary healthcare infrastructure, involvement of voluntary organisations, availability of necessary drugs and vaccines, training of personnel, encouraging medical research and its application to solving the health problem of people, and on bringing about close coordination between services related to healthcare and activities such nutrition, drinking water supply and hygiene. The need to bring about drastic improvement in health and family planning effort was understood.

In spite of the significant development India has made in the field of public health, both morbidity as well as mortality rates remain high as compared to the countries of the West and other developed nations. Over the years, the incidence of some of the infectious diseases like malaria, tuberculosis, HIV/ AIDS, hepatitis and non-communicable diseases like cancers, lifestyle diseases, diabetes, etc. were on the rise and much more dedicated efforts were required if we wish to ensure ‘Health for All’. It is therefore time to take stock of the situation and
march ahead with greater zeal. Accordingly, the NHP 1983 was revised and a new, extensive NHP was enunciated by the Government of India in 2002.

3.8.1. NATIONAL HEALTH POLICY, 2002

Taking into account the advent of new diseases on the scene and the progress medical science has made since 1983, NHP 2002 was formulated. New targets were set to eliminate inequity in the system and to correct the regional imbalances. Steps were taken to strengthen the infrastructure of PHCs throughout the country. The policy has set certain goals to be achieved by 2015 and to make available for all sections of society healthcare of acceptable standards.

3.8.2. Strategies of National Health Policy 2002

The revised strategies adopted by the GOI to achieve the objectives are:

a. Upgrade infrastructure in institutions that are already in existence and establish new ones in areas which are deficient in healthcare infrastructure.

b. To make across-the-board healthcare available to the entire population without discrimination throughout India.

c. To increase the Central Government investment in public healthcare institutions. Also to make public health administration at the state level more efficient.

d. To increase the involvement of the private sector in health sector.

e. To give priority to prevention of outbreak of disease. This must be done at the level of PHCs. First-line curative measures must be strengthened.

f. To rationalise allopathic drug usage.
g. To make the time-tested traditional systems of medicine easily accessible to people.

The National Health Policy acknowledges the need to promote partnership with numerous healthcare providers in order to make technically better and cheaper healthcare services available to all.

NHP-2002 therefore made a realistic attempt, taking into account financial constraints, to broaden the base of healthcare services in India to make it equally available to all sections of society. It therefore sought to lay new strategies to speed up the achievement of goals in public healthcare in the situation of the prevailing socio-economic circumstances in India. (www.mohfw.nic.in/npp2002.htm)

NHP-2002 had certain features in common with the National Population Policy-2000. These features related to (a) controlling the spread of HIV/AIDS and other communicable diseases; (b) vaccinating all children to protect them from major preventable diseases; (c) bridging the gaps in reproductive healthcare services; and (d) strengthening the infrastructure. Any plan to get better the healthcare standards in the country will have to incorporate the strategies of NPP-2000 and NHP-2000.

NHP-2000 recognised the fact that though planning and financing may be done by the Central Government, implementation of plans and policies has to be done by the State Governments, NGOs and diverse institutions of the civil society. It also recognised the importance of population control, clean drinking water, hygiene, nutrition and prevention of outbreak of epidemics in healthcare.


On 15 February, 2000 the Union Cabinet approved a new National Population Policy affirming the Government’s commitment to a voluntary and coercion-free family planning approach based on
informed opinion and consent. Broadly speaking NPP-2000 was formulated with the following objectives:

- **Short term objectives:** The most pressing and urgent objective of the NPP was to bridge the gap between require and provide contraceptives, personnel and integrated service delivery, and to remove weaknesses in infrastructure of reproductive and child healthcare.

- **Medium term objective:** The policy aimed at stabilising the population around 2010 by achieving replacement-level fertility rate of 2.1. It is however now expected that India will achieve this by 2060 when India’s population would be around 165 crore.

- **Long term objectives:** The NPP was to stabilize the population at 145 crore by 2045 commensurate with the needs of sustainable socio-economic growth. (www.populationcommission.nic.in) This however is just wishful thinking as noted above.

According to the policy the following socio-demographic goals should have been achieved by 2010:

- Bridge the gaps in essential reproductive and child healthcare services and supplies, and strengthen the infrastructure.

- Provide without charge and necessary education up to 14 years. Also peg dropout rate at primary and secondary levels to under 20 percent for boys and girls.

- Bring the IMR to less than 30 per 1000.

- Bring the MMR to less than 100 per 100,000 live births.

- Universal child vaccination against all diseases those are preventable.

- Prevent marriage of girls under 18. Preferably they should marry after 20.
• At least 80% of the deliveries to be in hospitals under the supervision of trained medical staff. Ensure 80 percent institutional deliveries and all deliveries by trained personnel.

• Information/counselling/services for fertility regulation and for prevention of unwanted birth to be available to all with plenty of choices.

• Every birth, death, marriage and pregnancy to be registered.

• Control spread of AIDS. Better management of RTI/STI and National AIDS Control Organisation through greater integration.

• Prevention of communicable diseases.

• Integration of ISM (Indian Systems of Medicine), viz. Ayurveda, Siddha, Unani and Yoga with reproductive and child health services and making them accessible to house.

• Promotion of voluntary family planning to achieve TFR (Total Fertility Rate) of 2.1 in order to stabilize population growth.

• Make family planning programme people-centric by integrated implementation of other family welfare programmes that are similar. (www.iloveindia.com/population-of-india)^

The NPP-2000 envisaged constitution of the following bodies:

I. **National Commission on Population**

   In 11th May 2000, the Prime Minister and Deputy Chairman Planning Commission as Vice Chairman, and all chief ministers as members were constituted the National Commission on Population. Its function is to supervise the execution of the Policy.

II. **State/UT Commission on Population**

   In every State/UT there is a Commission on Population, on the pattern of the National Commission, chaired by the Chief Minister, to supervise execution in the concerned State/UT. Recognising the
need to stabilize India’s burgeoning population the NPP seeks to provide the policy framework for the next ten years to set goals and to work out strategies to meet them in order to achieve the replacement levels of fertility and to fulfil the reproductive and child healthcare needs of the people by 2010. It also seeks to deal simultaneously with the problems of child survival, maternal health and birth-spacing – since they are closely related – by creating awareness among people and by making reproductive and child healthcare packages and services accessible to them. (www.fpindia.org)\textsuperscript{182}

Health, family welfare and education were made the liability of Village Panchayats in 1992 by the 73rd and 74th Constitutional Amendment Acts. The institution of Panchayati Raj is central to decentralised planning as far as the NPP-2000 is concerned. Village panchayats first identify the gaps in reproductive healthcare services and then draw plans at the village level best suited to bridge those gaps. The plans thus prepared by panchayats are need-based and provide people-oriented basic reproductive and child healthcare.

Since there are major distinctions in the demographic change among the different States and Union Territories of India the NPP-2000 plans to revitalize family planning in eight of those States in which the TFR hovers around 3.5 as against the desired 2.1. These States are Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Orissa, Jharkhand, Chhattisgarh and Uttaranchal. In order to pay focused attention to these States the Prime Minister formed an EAG within the MOHFW in the very first meeting of the NCP to get better their TFR so as to stabilise the growth of population.

\textbf{3.9.1. STATE POPULATION POLICIES}

Andhra Pradesh (1997), Rajasthan (1999), Madhya Pradesh (2000), Uttar Pradesh (2000), and Gujarat (2002) have made need-based State Population Policies with their own specific strategies,
goals and programmes. The remaining States too have been asked to similarly draft their State Population Policies and constitute State Population Commissions. But the different population policies drafted at the State level must be in accordance with the spirit of the NPP, 2000. The States are guided in the formulation of their policies by a resource committee constituted at the national level.

A revised Community Incentive Scheme is being introduced by the Department of Family Welfare to encourage the involvement of the village communities so that they may, through the panchayats, contribute in the national effort to bring the rise in population under control and to improve their health profile.

The Community Incentive Scheme aims at, one, generating a healthy sense of competition among the various institutions of Panchayat Raj; two, giving recognition to those panchayats that achieve concrete results in bringing down the fertility rates, in improving mother and child health, in preventing child marriage; to create meeting points between the officials of related departments at the district and sub-district levels; and to develop a sense of belongingness among the Panchayat Raj Institutes for such health and welfare programmes that are being implemented in their villages.

Most of NPP’s recommendations are undoubtedly unexceptionable at least on paper, and appear to have been put there to render better and more services to the people. However, the proposal to give incentives to poor couples for sterilization and rewards to local bodies for encouraging people to go in for family planning could encourage coercion in one form or another. Many feminists are also worried about the method of implementation of the ‘intersectoral approach’ and have shown concern whether the contraceptive technology will focus on products that are safe for women and can be controlled by them.
3.10. CONCLUSION

To sum up, we can say that the aim of all programmes and policies run by the Government of India is to decrease maternal and child death and improve maternal care by promoting institutional delivery, to provide medical aid during delivery, to provide aseptic delivery kits, to strengthen FRUs to deal with high threat and EmOC, to integrate health with nutrition, sanitation, hygiene and safe drinking water. The programme emphasizes on reducing poverty and making good healthcare easily available, especially to the poorer sections of society, marginalized women and children. Adopting various strategies, most of the programme, have succeeded in reducing maternal and child mortality. Couples are accepting family planning methods to reduce fertility rate and are also adopting the small family norm. There is a need to create awareness among people of all these programmes so that they may utilize the facilities given by the Government to ensure better health of women and children.