DEVELOPMENT OF NATIONAL HEALTH POLICIES AND PROGRAMS: A HISTORICAL PERSPECTIVE

Excavation in the Indus-valley (Mohenjo-Daro and Harappa) showed relics of planned cities with drainage, houses and public baths built of baked bricks. This illustrates the fact that importance of hygiene and sanitation was known to our ancestors even millennia ago.\(^1\) Similar conclusion regarding their health-consciousness can be drawn from the fact that it was during this period the beginning of the Indian system of medicine was discerned. Ayurveda and Siddha streams of therapeutics came into existence. Ayurveda or the science of life developed a comprehensive concept of health.\(^2\) The Manu Samhita prescribed rules and regulations for personal health, dietetics and hygienic ritual at the time of birth and death. It also emphasized the unity of the physical, mental and spiritual aspects of life. Atharva Veda also mentions the twin aims of medical sciences as health and longevity as well as curative treatment. Post Vedic Period (600 B.C.-600 A.D.) was dominated by the religious teachings of Buddhism and Jainism. Medical education was introduced in the ancient universities of Taxila and Nalanda, leading to the titles of Pranacharya and Pranavishara\(^3\) – indicating the formation of structured hierarchy therein. A hospital system was developed during the time of Buddha with provisions for men and women as well as for animals. This system was continued and expanded during the reign of King Ashoka. After the arrival of Muslim rulers circa 1000 AD, but especially during the Mughal period (1526-1857 A.D.), the Arabic system of medicine, popularly known as Unani system, was introduced and popularized. The origin of this system is traced to Greek medicine which became a part of Indian medicine.\(^4\)

---

1. B.T. Basavanhappa, *Community Health Nursing* (New Delhi: Jaypee Brothers Medical Publishers (P) Ltd. 1998) 584
4. Kaushiki Sundar Rao, *SC UP*
By the middle of the 18th century, the British had established their rule in India which lasted till 1947. In 1859, a Royal Commission was appointed to investigate the causes of extremely unsatisfactory health conditions in the British Army stationed in India. The Commission recommended the establishment of a commission of public health in each Presidency. It also pointed out the need for the protection of water supplies, construction of drains and prevention of epidemics in the civil population for safeguarding the health of the British Army. Sanitary commissioners were appointed in three major provinces—Bombay, Madras and Bengal in 1864. After an outbreak of plague in India, the government, appointed a commission in 1896. The Plague Commission in its report submitted in 1904 recommended that (a) public health departments should be reorganized and expanded and (b) There should be laboratory facilities established for purposes of research and production of sera and vaccine. The Indian Research Fund Association (now I.C.M.R) was established for the purpose of research in 1911, followed by the nutrition research laboratory at Coonoor in 1918. The Montague-Chelmsford Constitutional Reforms led to the transfer of the portfolios like public health, sanitation and vital statistics to the provinces under the control of an elected minister. This was the first step towards decentralization of health administration in India. In 1930, the All India Institute of Hygiene and Public Health was established in Calcutta with aid from the Rockefeller Foundation. The Child Marriage Restrain Act (Sarda Act) came into effect in 1930 fixing the minimum age of marriage at 14 years for girls and 18 years for boys.5

The health survey and Development Committee (Bhore Committee) was appointed by the Government of India in 1943 to survey the existing position with regard to health conditions and health organization in the country. The Bhore Committee in its report submitted in 1946 recommended that a short term and long term program for the attainment of reasonable health services based on the concept of modern health practices should be initiated. Although the Bhore Committee’s recommendations did not

form part of a comprehensive plan for national socio-economic development, the committee’s report continues to be a major national document, and has provided guidelines for national health planning in India. At the time of India’s independence, the healthcare services in India were predominantly urban, hospital based and curative. India joined the World Health Organization as a member state in 1948 and the South East Asia Regional Office of the W.H.O. was established in New Delhi in 1949.

NATIONAL POLICIES RELATED TO HEALTH

Policy is a system which provides the logical framework and rationality to decision-making for the achievement of intended objectives. It is also a guide for provision of funds and allocations of resources for the pre-stated purpose. The overall allocation of amount is a statement of commitment to certain areas of concern; the distribution of the amount shows the priorities of decision makers. In short, policy sets priorities and guides resource-allocation. For the development of any nation the framing of policy is very vital. The national policy is also termed as public policy, i.e., the policy at any level of government that may be formal or in the form of a legal precedence over others. Policy may be set by heads of government, legislatures, and regulatory agencies empowered by other constitutional authorities.

Health policy aims at the improvement of the conditions under which people live. Adequate provision of sustainable livelihoods, and healthy lifestyles and environments, including provision of such services as housing, education, nutrition, childcare, reproductive healthcare, transportation, information and communication, necessary community and personal social and health facilities. Since health of the people gets affected by various factors that lie within the domain of other sectors of the government, it becomes necessary to have different relevant policies at the national level that enable promotion and protection of people’s health

---

6 Govt of India, Report of the Health Survey and Development Committee (Simla: Govt of India Press, 1946)
7 J Kishore, National Health Programmes of India (New Delhi: Century Publications, 2005) 302
8 ibid
In the post-independence period till 1983, the policy intent and framework, and the strategies were provided by the Constitution of India, legislated by the parliament, and executed through the national development council, the planning commission, several advisory bodies, consultative committees and the ministry of health and family welfare. In view of the national commitment to attain the goal of health for all by 2000 the Government of India formulated National Health Policy in 1983. This policy laid stress on preventive as well as promotive public health and rehabilitation aspects of healthcare. The policy underscores the establishing of comprehensive primary healthcare services in order to reach the needy population in the remote areas of the country. The National Health policy focuses on health and human development as a vital component of national development. The NHP (1983) provided a comprehensive framework for planning, implementation, monitoring of health services and goals to be achieved by 2000. Some of the policy initiatives outlined in the NHP-1983

---

9 Basavanthappa B.T. op. cit. p.607
10 Govt of India, Health Information of India (New Delhi: DGHS, 1992)
have yielded results, while in several other areas the outcome has not been up to the expectations. The Ninth Plan recommended a review of the National Health Policy (1983) in view of the ongoing demographic and epidemiological transition, expansion of healthcare infrastructure, changes in healthcare seeking behavior, availability of newer technologies for management and rising expectations of the population, as well as escalating costs of healthcare.11

NHP-1983, in a spirit of optimistic empathy for the health needs of the people, particularly the poor and under-privileged, had hoped to provide ‘Health for All by the year 2000 AD’, as mentioned earlier, through the universal provision of comprehensive primary healthcare services. In retrospect, it is observed that the financial resources and public health administrative capacity fell far short of what was necessary for achieving such an ambitious and holistic goal. Against this backdrop, it was felt that it would be appropriate to pitch NHP-2002 at a level consistent with realistic expectations regarding financial resources and the likely increase in the administrative capacity for managing public health. The changed circumstances relating to the health sector since 1983 gave rise to a situation in which it became necessary to review the field, and to formulate a new policy framework which eventually came up as the National Health Policy-2002. The NHP-2002 attempts to set out a new policy framework for the accelerated achievement of public health goals in the socioeconomic circumstances currently prevailing in the country.12

OBJECTIVES

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in existing institutions. Overriding importance would be given to

12 Ibid
ensuring a more equitable access to health services across the social and geographical expanse of the country. Emphasis will be laid upon increasing the aggregate public health investment through a substantially increased contribution by the Central Government. It is expected that this initiative will strengthen the capacity of the public health administration at the State level for rendering effective service delivery. The contribution of the private sector in providing health services would be much enhanced, particularly for the population group which can afford to pay for services. Primacy will be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation. Emphasis will be laid upon rational use of drugs within the allopathic system. Increased access to tried and tested systems of traditional medicine will be ensured. Within these broad objectives, NHP-2002 endeavors to achieve the time-bound goals mentioned in table 2.2.

Table 2.2

<table>
<thead>
<tr>
<th>Goals to be Achieved by 2000-2015</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eradicate Polio and Yaws</td>
<td>2005</td>
</tr>
<tr>
<td>Eliminate Leprosy</td>
<td>2005</td>
</tr>
<tr>
<td>Eliminate Kala Azar</td>
<td>2010</td>
</tr>
<tr>
<td>Eliminate Lymphatic Filariasis</td>
<td>2015</td>
</tr>
<tr>
<td>Achieve Zero level growth of HIV/AIDS</td>
<td>2007</td>
</tr>
<tr>
<td>Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases</td>
<td>2010</td>
</tr>
<tr>
<td>Reduce Prevalence of Blindness to 0.5%</td>
<td>2010</td>
</tr>
<tr>
<td>Reduce IMR to 30/1000 And MMR to 100/Lakh</td>
<td>2010</td>
</tr>
<tr>
<td>Increase utilization of public health facilities from current Level of &lt;20% to &gt;75%</td>
<td>2010</td>
</tr>
<tr>
<td>Establish an integrated system of surveillance, National Health Accounts and Health Statistics</td>
<td>2005</td>
</tr>
<tr>
<td>Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%</td>
<td>2010</td>
</tr>
<tr>
<td>Increase share of Central grants to Constitute at least 25% of total health spending</td>
<td>2010</td>
</tr>
<tr>
<td>Increase State Sector Health spending from 5.5% to 7% of the budget</td>
<td>2005</td>
</tr>
<tr>
<td>Further increase to 8%</td>
<td>2010</td>
</tr>
</tbody>
</table>
NHP-2002 - POLICY PRESCRIPTIONS

Policy prescriptions of NHP-2002 can be discussed under the following headings.

FINANCIAL RESOURCES

The paucity of public health investment is a stark reality. Given the extremely difficult fiscal position of the State Governments, the Central Government will have to play a key role in augmenting investments in public health. Taking into account the gap in healthcare facilities, it is planned under the policy to increase the health sector expenditure to 6 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010. The State Governments would also need to increase their respective financial commitments to the health sector. In the first phase, by 2005, they were expected to increase the commitment of their resources to 7 percent of the Budget; and, in the second phase, i.e., by 2010, to increase it to 8 percent of the Budget. With the stepping up of the public health investment, the Central Government’s contribution would rise from the existing 15 percent to 25 percent by 2010. The provisioning of higher public health investments will also be contingent upon the increase in the absorptive capacity of the public health administration so as to utilize the funds gainfully.

EQUITY

To meet the objective of reducing various types of inequities and imbalances – inter-regional; across the rural-urban divide; and between economic classes – the most cost-effective method would be to increase the sectoral outlay in the primary health sector. Such outlets afford access to a vast number of individuals, and also facilitate preventive and early stage curative initiatives, which are cost effective. In recognition of this public health principle, NHP-2002 sets out an increased allocation of 55 percent of the total public health investment for the primary health sector; the secondary and
tertiary health sectors being targeted for 35 percent and 10 percent respectively. The Policy projects that the increased aggregate outlays for the primary health sector will be utilized for strengthening existing facilities and opening additional public health service outlets, consistent with the norms for such facilities.

**DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES**

This policy envisages a key role for the Central Government in designing national programs with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. However, to optimize the utilization of the public health infrastructure at the primary level, NHP-2002 envisages the gradual convergence of all health programs under a single field administration. Vertical programs for control of major diseases like TB, Malaria, HIV / AIDS, as also the RCH and Universal Immunization Programs, would need to be continued till acceptable levels of prevalence are reached. The integration of the programs will bring about a desirable optimization of outcomes through the convergence of all public health inputs. The Policy also envisages the implementation of programs through autonomous bodies at the state and district levels. The role of State Health Departments may be limited to the overall monitoring of the achievement of program targets and other technical aspects. The relative distancing of the program implementation from the State Health Departments will give the project team greater operational flexibility. Also, the presence of State Government officials, social activists, private health professionals and MLAs/MPs on the management boards of the autonomous bodies will facilitate well-informed decision-making.

The Policy also highlights the need for developing the capacity within the State Public Health administration for scientific designing of public health projects, suited to local conditions.
The Policy envisages that apart from the exclusive staff in a vertical structure for the disease control programs, all rural health staff should be available for the entire gamut of public health activities at the decentralized level, irrespective of whether these activities relate to national programs or other public health initiatives. It would be for the Head of the District Health Administration to allocate the time of the rural health staff for various programs, depending on the local needs. The NHP-2002 recognizes that to implement such a change, not only would the public health administrators be required to change their mindset, but the rural health staff would need to be trained and reoriented.

THE STATE OF PUBLIC HEALTH INFRASTRUCTURE

As has been highlighted in the earlier part of the Policy, the decentralized Public health service outlets have become practically dysfunctional over large parts of the country. On account of resource constraints, the supply of drugs by the State Governments is grossly inadequate. The patients at the decentralized level have little use for diagnostic services, which in any case would still require them to purchase therapeutic drugs privately. In a situation in which the patient is not getting any therapeutic drugs, there is little incentive for the potential beneficiaries to seek the advice of medical professionals in the public health system. This results in there being no demand for medical services, so medical professionals and paramedics often absent themselves from their place of duty. It is also observed that the functioning of the public health service outlets in some States like the four Southern States – Kerala, Andhra Pradesh, Tamil Nadu and Karnataka – is relatively better, because some quantum of drugs is distributed through the primary health system network, and the patients have a stake in approaching the public health facilities. Given this backdrop, the Policy envisages kick-starting the revival of the Primary Health System by providing some essential drugs under Central Government funding routed through the decentralized health system. It is expected that the provisioning of
essential drugs at the public health service centers will create a demand for other professional services from the local population, which, in turn, will boost the general revival of activities in these service centers. In sum, this initiative under NHP-2002 is launched in the belief that the creation of a beneficiary interest in the public health system will ensure a more effective supervision of public health personnel through community monitoring than has been achieved through the regular administrative line of control.

This Policy recognizes the need for more frequent in-service training of public health medical personnel, at the level of medical officers as well as paramedics. Such training would help to update the personnel on recent advancements in science, and would also equip them for their new assignments, when they are moved from one discipline of public health administration to another.

Global experience has shown that the quality of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of investment through public funding in the primary health sector. Table 2.3 gives statistics which clearly show that standards of health are more a function of the accurate targeting of expenditure on the decentralized primary sector (as observed in China and Sri Lanka) than a function of the aggregate health expenditure.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>%population with income of &lt;$1/day</th>
<th>Infant mortality rate/1000</th>
<th>%Health expenditure</th>
<th>%Public expenditure on health to total health expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>44.2</td>
<td>70</td>
<td>5.2</td>
<td>17.3</td>
</tr>
<tr>
<td>China</td>
<td>18.5</td>
<td>31</td>
<td>2.7</td>
<td>24.9</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>6.6</td>
<td>16</td>
<td>3</td>
<td>45.4</td>
</tr>
<tr>
<td>UK</td>
<td>-</td>
<td>6</td>
<td>5.8</td>
<td>96.9</td>
</tr>
<tr>
<td>USA</td>
<td>-</td>
<td>7</td>
<td>13.7</td>
<td>44.1</td>
</tr>
</tbody>
</table>

Table 2.3 Public Health Spending in Select Countries
Therefore the Policy, while committing additional aggregate financial resources, places great reliance on the strengthening of the primary health structure for the attaining of improved public health outcomes on an equitable basis. Further, it also recognizes the practical need for levying reasonable user-charges for certain secondary and tertiary public health care services, for those who can afford to pay.

EXTENDING PUBLIC HEALTH SERVICES

This policy envisages that, in the context of the availability and spread of allopathic graduates in their jurisdiction, State Governments would consider the need for expanding the pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian Systems of Medicine and Homoeopathy. Simple services/procedures can be provided by such practitioners even outside their disciplines as part of the basic primary health services in under-served areas. Also, NHP-2002 envisages that the scope for the utilization of paramedical manpower of allopathic disciplines in a prescribed functional area as adjunct to their current functions would also be examined for meeting simple public health requirements. This would be on the lines of the services rendered by nurse practitioners in several developed countries. These extended areas of functioning of different categories of medical manpower can be permitted, after adequate training, and subject to the monitoring of their performance through professional councils.

NHP-2002 also recognizes the need for States to simplify the recruitment procedures and rules for contract employment in order to provide trained medical manpower in under-served areas. State Governments could also rigorously enforce a mandatory two-year rural posting before the awarding of the graduate degree. This would not only make trained medical manpower available in the underserved areas, but also would offer valuable clinical experience to the graduating doctors.
ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS

NHP-2002 lays great emphasis upon the implementation of public health programs through local self-government institutions. The structure of the national disease control programs will have specific components for implementation through such entities. The Policy urges all State Governments to consider decentralizing the implementation of the programs by involving such Institutions by 2005. In order to achieve this, financial incentives, over and above the resources normatively allocated for disease control programs, were to be provided by the Central Government.

NEED FOR SPECIALISTS IN ‘PUBLIC HEALTH’ AND ‘FAMILY MEDICINE’

In order to alleviate the acute shortage of medical personnel with specialization in the disciplines of ‘public health’ and ‘family medicine’, the Policy envisages the progressive implementation of mandatory norms to raise the proportion of postgraduate seats in these discipline in medical training institutions, in order to reach a stage wherein 1/4th of the seats are earmarked for these disciplines. It is envisaged that in the sanctioning of post-graduate seats in future, it shall be insisted upon that a certain reasonable number of seats be allocated to ‘public health’ and ‘family medicine’. Since the ‘public health’ discipline has an interface with many other developmental sectors, specialization in public health may be encouraged not only for medical doctors, but also for non-medical graduates from the allied fields of public health engineering, microbiology and other natural sciences.

USE OF GENERIC DRUGS AND VACCINES

The National Program for Universal Immunization against Preventable Diseases requires to be assured of an uninterrupted supply of vaccines at an affordable price. To minimize the danger arising from the volatility of the global market, and thereby to ensure long-term national health security, NHP-
2002 envisages that not less than 50% of the requirement of vaccines/sera is sourced from public sector institutions.

**URBAN HEALTH**

NHP-2002 envisages the setting up of an organized urban primary healthcare structure. Since the physical features of urban settings are different from those in rural areas, the policy envisages the adoption of appropriate population norms for the urban public health infrastructure. The structure conceived under NHP-2002 is a two-tiered one: the primary center is seen as the first-tier, covering a population of one lakh, with a dispensary providing an OPD facility and essential drugs, to enable access to all the national health programs; and a second-tier of the urban health organization at the level of the government general hospital, to which reference is made from the primary centre. The Policy envisages that the funding for the urban primary health system will be jointly borne by the local self-government institutions and State and Central Governments.

**INFORMATION, EDUCATION AND COMMUNICATION**

NHP-2002 envisages an IEC policy, which maximizes the dissemination of information to those population groups which cannot be effectively approached by using only the mass media. The focus would therefore be on the inter-personal communication of information and on folk and other traditional media to bring about behavioral change. The IEC program would set specific targets for the association of PRIs/NGOs/Trusts in such activities. In several public health programs, where behavioral change is an essential component, the success of the initiatives is crucially dependent on dispelling myths and misconceptions pertaining to religious and ethical issues. The community leaders, particularly religious leaders, are effective in imparting knowledge which facilitates such behavioral change. The program will also have the component of an annual evaluation of the performance of the non-governmental agencies to monitor the impact of the programs on the
targeted groups. The Central/State Government initiative will also focus on the development of modules for information dissemination in such population groups who do not normally benefit from the more common media forms.

NHP-2002 envisages giving priority to school health programs which aim at preventive-health education, providing regular health check-ups, and promotion of health-seeking behavior among children. The school health programs can gainfully adopt specially designed modules in order to disseminate information relating to ‘health’ and ‘family life’. This is expected to be the most cost-effective intervention as it improves the level of awareness, not only of the extended family, but also the future generations as well.

**HEALTH RESEARCH**

This Policy envisages an increase in government-funded health research to a level of 1 percent of the total health spending by 2005; and thereafter, up to 2 percent by 2010. Domestic medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and Malaria, as also on the sub-types of HIV/AIDS prevalent in the country. Research programs taken up by the government in these priority areas would be conducted in a mission mode. Emphasis would also be laid on time-bound applied research for developing operational applications. This would ensure the cost-effective dissemination of existing/future therapeutic drugs/vaccines in the general population. Private entrepreneurship will be encouraged in the field of medical research for new molecules / vaccines, inter alia, through fiscal incentives.

**THE ROLE OF THE PRIVATE SECTOR**

In principle, this Policy welcomes the participation of the private sector in all areas of health activities – primary, secondary and tertiary. However, looking at past experience of the private sector, it can reasonably be expected that its contribution would be substantial in the urban primary sector and the
tertiary sector, and moderate in the secondary sector. This Policy envisages the enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/medical institutions by 2003. Also, statutory guidelines for the conduct of clinical practice and delivery of medical services are targeted to be developed over the same period. With the acquiring of experience in the setting and enforcing of minimum quality standards, the Policy envisages graduation to a scheme of quality accreditation of clinical establishments/medical institutions for the information of the citizenry. The regulatory/accreditation mechanisms will no doubt also cover public health institutions. The Policy also encourages the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages.

In the context of the very large number of poor in the country it would be difficult to conceive of an exclusive government mechanism to provide health services to this category. It has sometimes been felt that a social health insurance scheme, funded by the government, and with service delivery through the private sector, would be an appropriate solution. The administrative and financial implications of such an initiative are still unknown. As a first step, this policy envisages the introduction of a pilot scheme in a limited number of representative districts to determine the administrative features of such an arrangement, as also the requirement of resources for it. The results obtained from these pilot projects are expected to provide the necessary information on the basis of which future public health policy can be based.

NHP-2002 envisages the co-option of the non-governmental practitioners in the national disease control programs so as to ensure that standard treatment protocols are followed in their day-to-day practice.

This Policy recognizes the immense potential of information technology applications in the area of tele-medicine in the tertiary healthcare sector. The
use of this technical aid will greatly enhance the capacity for the professionals to pool their clinical experience.

THE ROLE OF CIVIL SOCIETY

NHP-2002 recognizes the significant contribution made by NGOs and other institutions of the civil society towards making available health services to the community. In order to utilize their high motivational skills on an increasing scale this Policy envisages that the disease control programs should earmark not less than 10% of the budget in respect of identified program components, to be exclusively implemented through these institutions. The policy also emphasizes the need for simplifying procedures for the government–civil society interface in order to enhance the involvement of civil society in public health programs. In principle, the state would encourage the handing over of public health service outlets at any level for management by NGOs and other institutions of civil society, on an ‘as-is-where-is’ basis, along with the normative funds earmarked for such institutions.

HEALTH STATISTICS

The Policy envisages the completion of baseline estimates for the incidence of the common diseases – TB, Malaria, and Blindness – by 2005. The Policy proposes that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling, under an appropriate statistical methodology. The policy also recognizes the need for establishing, in a longer time-frame, baseline estimates for non-communicable diseases like CVD, Cancer, Diabetes; and accidental injuries, and communicable diseases like Hepatitis and JE. NHP-2002 also envisages that, with access to such reliable data regarding various diseases on the incidence, the public health system would move closer to the objective of evidence-based policy-making.
Planning for the health sector requires a robust information system, which, inter-alia, covers data on service facilities available in the private sector. NHP-2002 emphasizes the need for early completion of an accurate data-base of this kind.

In an attempt at consolidating the data base and graduating from a mere estimation of the annual health expenditure, NHP-2002 emphasizes the need to establish national health accounts conforming to the 'source-to-users' matrix structure. Also, the policy envisages the estimation of health costs on a continuing basis. Improved and comprehensive information through national health accounts and accounting systems would pave the way for decision makers to focus on relative priorities, keeping in view the limited financial resources in the health sector.

WOMEN’S HEALTH

NHP-2002 envisages the identification of specific programs targeted at women’s health. The Policy notes that women, along with other under-privileged groups, are significantly handicapped due to a disproportionately low access to healthcare. The various Policy recommendations of NHP-2002, in regard to the expansion of primary health sector infrastructure, will facilitate the increased accessing by women of basic healthcare. The Policy commits the highest priority of the Central Government to the funding of the identified programs relating to women’s health. Also, the policy recognizes the need to review the staffing norms of the public health administration in order to meet the specific requirements of women in a more comprehensive manner.

MEDICAL ETHICS

NHP–2002 envisages that, in order to ensure that the common patient is not subjected to irrational or profit-driven medical regimens, a contemporary code of ethics be notified and rigorously implemented by the Medical Council of India.
By and large, medical research within the country in the frontier disciplines, such as gene-manipulation and stem cell research, is limited. However, the policy recognizes that a vigilant watch will have to be kept so that the existing guidelines and statutory provisions are constantly reviewed and updated.

ENFORCEMENT OF QUALITY STANDARDS FOR FOOD AND DRUGS

NHP – 2002 envisages that the food and drug administration will be progressively strengthened, in terms of both laboratory facilities and technical expertise. It also envisages that the standards of food items will be progressively made more stringent at a pace which will permit domestic food handling / manufacturing facilities to undertake the necessary upgradation of technology so that they are not shut out of this production sector. The Policy envisages that ultimately food standards will be close, if not equivalent, to Codex specifications; and that drug standards will be at par with the most rigorous ones adopted elsewhere.

IMPACT OF GLOBALISATION ON THE HEALTH SECTOR

The Policy takes into account the serious apprehension, expressed by several health experts, vis-à-vis the possible threat to health security in the post-TRIPS era, as a result of a sharp increase in the prices of drugs and vaccines. To protect the citizens of the country from such a threat this policy envisages a national patent regime for the future, which, while being consistent with TRIPS, avails of all opportunities to secure for the country, under its patent laws, affordable access to the latest medical and other therapeutic discoveries. The policy also sets out that the government will bring to bear its full influence in all international fora – UN, WHO, WTO, etc. – to secure commitments on the part of the international community to lighten the restrictive features of TRIPS in its application to the healthcare sector.13

---

The NHP-2002: Some Constraints

The NHP-2002 is indeed a well thought out and comprehensive document. It has highlighted various reasons of failure in the past and has set various goals and objectives that are needed to be achieved in a given time frame. This document has described detailed review and gains of the national health policy 1983. NHP-2002 has got the opportunity to refer many documents and reports like World Development Report 1993, National Family Health Survey 1993-94 and 1998-99, the Census of India 2001, World Health Report 2000, and favorable environment like support of international health agencies, economic and political reforms particularly 73rd and 74th amendments to the Constitution of India. However, there are many constraints in the implementation of this policy like the existence of 35 percent illiterate population and one quarter of the total population being below the poverty line, unstable government, and reactive response to health related problems and disasters.

The NHP-2002 is a desirable and positive step for the betterment of people’s health. A substantial achievement has been acknowledged by the government as far as the targets are concerned. The need of the time is to provide quality healthcare with the help of cost-effective methods, which are also feasible, applicable and easy to implement. Despite the policy’s plus points one cannot ignore its following minus points:

- This policy does not refer to the Women’s Empowerment Policy 2001 while describing measures to ensure women’s health. There is a need to coordinate effectively with the Ministry of Social Justice and Empowerment, while dealing with vulnerable sections of the society like children, elderly people, scheduled caste, scheduled tribes, etc.

- Women’s health has not received enough attention in the policy; similarly child health, adolescents, gender discrimination and violence should have received adequate concerns.

---

• This policy does not address the question: how to control duplication of delivery of health services in many states? Integration of vertical program activities with general health service ensures sustainability. Shifting the role of the workforce from a single program to several general priorities often leads to complacency and non-accountability. States may not be able to support the integrated workforce, with the result that they may neither be keen at filling up the vacancies of these workers nor interested in creating new posts, even where these may be necessary. The present plight of ‘multipurpose worker male’ is an eye opener in this regard (Nair 2002).

• There is only a passing comment on strengthening primary healthcare. The policy does not specify the manner in which this may be achieved. It is also silent on the topic of village health workers.

• The policy fails to bring anganwadi and other grassroots level workers on one platform;

• It does not give importance to population control. However, it blames the population explosion for nullifying the impact of advancement of public health.

• The impact of globalization may affect the basic philosophy of equity. Heavily subsidized primary healthcare, as it exists in India, would suffer the most. The rural marginalized and poor would be the worst sufferers.

• The increase in funding from 0.9 percent to 2 percent of GDP expenditure on health is still low. This falls short of the 5 percent of GDP that has been a long-standing demand of those associated with the health movement and is also recommended by the WHO long ago.

• The policy should have allocated funds and other resources that can be made available from the health sector in case of disaster or natural calamities.

• Lacks strong steps to ensure sustainability of various programs.
• All national programs demand strong community involvement so that they can be sustained. The policy is rhetorical on community participation but prescribes ‘top-down’ approach to many national health programs. This is contrary to the decentralization process that is so necessary for the success of such programs. This policy also emphasizes good governance at all levels with pure intention to empower people, and, once again, the policy needs dedicated efforts of the people to make it a reality.

• Emphasizing the diversity of healthcare provider should not lead to an uncontrolled legitimization of large number of health providers having dubious credentials especially in the rural areas. Focus should be on providing workable incentives for trained health providers. It is also not true that sufficient number of health professionals is not available. Large number of doctors, nurses and technicians are unemployed and should be appropriately utilized otherwise dissatisfaction among them may affect the entire medical system.

• Discriminatory approach: Provision of less qualified health personnel like ANMs and ill-trained local practitioners for rural area to deliver healthcare services,

• How to control duplication of delivery of health services in many states? Integration of vertical program activities with general health service ensure sustainability. Shifting the role of the workforce from a single program to several general priorities often leads to complacency and non-accountability. States may not be able to support the integrated workforce, with the result that they may neither be keen in filling up the vacancies of these workers not interested in creating of new posts, if necessary. The present plight of ‘multipurpose worker male’ is an eye opener in this regard (Nair 2002).

To sum up, the health needs of the country are enormous and the financial resources and managerial capacity available to meet them, even on the most optimistic projections, are discernibly inadequate. In this situation, NHP-2002 has had to make hard choices between various priorities and operational options. NHP-2002 does not claim to be a roadmap for meeting all the health needs of the populace of the country. Further, it has to be recognized that such health needs are dynamic, as threats in the area of public health keep changing over time. The Policy, while being holistic, undertakes the necessary risk of recommending varied emphasis on different policy components. Broadly speaking, NHP-2002 focuses on the need for enhanced funding and organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. Also, the Policy is focused on those diseases which are principally contributing to the disease burden, viz., TB, Malaria and Blindness from the category of historical diseases; and HIV/AIDS from the category of ‘newly emerging diseases’. This is not to say that other items contributing to the disease burden of the country will be ignored; but only that the resources, as also the principal focus of the public health administration, will recognize certain relative priorities. It is unnecessary to labor the point that under the umbrella of the macro-policy prescriptions in this document, governments and private sector program planners will have to design separate schemes, tailor-made to the health needs of women, children, geriatrics, tribals and other socio-economically under-served sections. An adequately robust disaster management plan has to be in place to effectively cope with situations arising from natural and man-made calamities.

One nagging imperative, which has influenced every aspect of this policy, is the need to ensure that ‘equity’ in the health sector stands as an independent goal. In any future evaluation of its success or failure, the progenitors of NHP-2002 would wish it to be measured against this equity norm, rather than any other aggregated financial norm for the health sector. Consistent with the primacy given to ‘equity’, a marked emphasis has been
provided in the policy for expanding and improving the primary health facilities, including the new concept of the provisioning of essential drugs through central funding. The policy also commits the Central Government to increased underwriting of the resources for meeting the minimum health needs of the people. Thus, the Policy attempts to provide guidance for prioritizing expenditure, thereby facilitating rational resource allocation.

This Policy broadly envisages a greater contribution from the Central Budget for the delivery of Public Health services at the State level. Adequate appropriations, steadily rising over the years, would need to be ensured. The possibility of ensuring this by imposing an earmarked health cess has been carefully examined. While it is recognized that the annual budget must accommodate the increasing resource needs of the social sectors, particularly in the health sector, this policy does not specifically recommend an earmarked health cess, as that would have a tendency for reducing the space available to Parliament in making appropriations according to the circumstances prevailing from time to time.

The Policy highlights the expected roles of different participating groups in the health sector. Further, it recognizes the fact that, despite all that may be guaranteed by the Central Government for assisting public health programs, public health services would actually need to be delivered by the State administration, NGOs and other institutions of civil society. The attainment of improved health levels would be significantly dependent on population stabilization, as also on complementary efforts from other areas of the social sectors – like improved drinking water supply, basic sanitation, minimum nutrition, etc. - to ensure that the exposure of the populace to health risks is minimized.

Any expectation of a significant improvement in the quality of health services, and the resulting enhanced health status of the citizenry, would depend not only on increased financial and material inputs but also on a more empathetic and committed attitude among the service providers, whether in
the private or public sectors. In some measure, this optimistic policy document is based on the understanding that the citizenry is increasingly demanding more by way of quality in health services, and the health delivery system, particularly in the public sector, is hard pressed to respond. Against this backdrop, it needs to be recognized that any policy in the social sector is critically dependent on the service providers treating their responsibility not as a commercial activity, but as a service, albeit a paid one. In the area of public health, an improved standard of governance is a prerequisite for the success of any health policy.¹⁷

**Health and Five Year Plans**

Successive five year plans have been providing the policy framework and funding for not only planned development of nationwide healthcare infrastructure and manpower but also ensuring availability of drugs, devices and other essential items for improving health status of mothers and their children. **In the First Five Year Plan (1951-55), 'Family Planning Program' (1952) was taken as an integral part of development plans.** The family planning program adopted by the Government of India was the first of its kind in the world. A family planning cell was created in April, 1952 in the planning and development section of Directorate General of Health Services. The main objectives set out in the first five year plan were to discuss suitable techniques of the family planning and suggest methods for wide dissemination of knowledge regarding these techniques and to make advice on family planning an integral part of the services of government hospitals and public health agencies. The nation wide programs for the control of malaria and filaria were also commenced as part of the first five year plan. During this plan period, the total outlay was Rs.1960 crores of which Rs.65.20 crores was allotted for health. Although nationwide family planning programme had started in the early fifties, its performance during the first five year plan period was limited to

---

creating favourable atmosphere and providing advice through clinics. To some extent conventional contraceptives were made available.\textsuperscript{18}

The specific objective of the Second Five Year Plan (1956-61) was the establishment of institutional facilities to serve as a basis for rendering services to the people both in the local and surrounding areas. A high powered family welfare board was constituted on September 1, 1956 to give advice on the policy and programs relating to family planning. The national malaria control program was converted into national malaria eradication program in 1958. The second plan also laid great stress on the need for population control to achieve economic growth. Emphasis was laid on increasing the number of service clinics. Sterilization of both males and females was introduced into the program during the second plan period. The Government of India offered 100 percent central assistance to state governments for providing sterilization facilities all over the country. Dais / Traditional birth attendants' training program in aseptic delivery was also introduced during this plan. Approximately, there were about 415209 users of conventional contraceptives (Condoms) during the period 1956-62. A total of 148890 sterilization operations were done of which 67471 were on males and 81419 on females during 1956-60. During this plan period, the total plan investment was Rs.4672 crores of which Rs.140.80 crores was allocated for health and 2.20 crores for family welfare.\textsuperscript{19}

The objectives of the Third Five Year Plan (1961-66), were in tune with the first and second five year plan except for the fact that public health was integrated with maternal and child welfare, nutrition and health education. Stress was also laid on social measures like education, particularly for women, employment and rural water supply. The family planning programs were reorganised in October, 1965. The strategy of ‘Clinic based’ approach’


\textsuperscript{19} Govt. of India, \textit{Second Five Year Plan, 1956-61}. (New Delhi: Planning Commission, 1956).
was revised, to ‘Extension approach’, which meant educating the people and providing the knowledge and information about various aspects of family planning through family planning workers who would be approaching them at their door steps. This plan also emphasized upon honorary family planning education leaders to address meetings, arrange group discussion, mobilize public opinion in favor of family planning and form networks of local voluntary groups in different places to carry the message of family planning. The third five year plan was crucial in the Indian family planning program as it shifted the emphasis from the clinic approach to the field or extension approach. Intra-uterine Contraceptive Device (IUCD) properly known as Lippe’s Loop was introduced in the program as a measure of conception control and as a step towards a new strategy (April, 1965). The use of loops, condoms and sterilization as a family planning measure became quite popular. To maintain the voluntary nature of family planning program the ‘cafeteria approach’ was adopted which meant that the choice of the contraception method was left to the individuals concerned. The use of loop became quite popular. During January, 1965-66, 812713 women accepted the Lippe’s Loop as a contraceptive. During this period the total plan outlay was Rs.8576 crores out of which 225 crores were allotted for health and 24.90 crores were for family welfare.20

The fourth five year plan which was to commence from April, 1966 was postponed till 1969 due to uncertain economic situation in the country (due to Indo-Pak War). This intervening period (1966-69) was covered by annual plans. During Annual Plans (1966-69), family planning program was converted into centrally sponsored program and it was decided that the states would be given 100 percent assistance for family planning services. All India hospitals post-partum program, a maternity centered hospital based approach to family welfare, was initiated in 1966 with the aim of encouraging women within the reproductive age group (15-44 years) and their husbands for

adoption of small family norms; this was done through education and motivation particularly during antenatal and postnatal period. Targets were fixed for Lippe’s Loop (IUCD) insertion and sterilization operations. During this period IUCD insertion declined from 9,09,726 in 1966-67 to 4,78,731 in 1968-69. The acceptance levels for sterilization amongst people increased significantly during the inter-plan period. During this period the total plan outlay was Rs.6625.40 crores out of which 140.20 crores were allotted for health and 70.50 crores were for family welfare. 21

The Fourth Five Year Plan (1969-74) in relation to health was based on certain objectives set by the Mudaliar Committee (1962). The objectives were: to strengthen the primary health centers, to provide an effective base for health services in rural areas, district hospitals to provide effective referral services for primary health centers and expansion of medical and nursing education as well as training of paramedical personnel to meet the minimum technical manpower requirements. Efforts were made to strengthen the primary health centre complex in rural areas for undertaking preventive and curative health services and for ensuring the sustenance of the communicable diseases and eradication programs. It was also decided to provide certain facilities for married couples during their reproductive period by bringing about group acceptance and personal knowledge of family planning methods, and ready availability of supplies and services. Special schemes for maternal and child health viz. immunization and prophylaxes against blindness were made target oriented. 22 Total plan investment was of the order of Rs.15,778.80 crores, out of which 335.50 crores were earmarked for health and 284.40 crores for family welfare. 23

22 The target for DPT immunization was 72.50 lakhs, of which 29.93 lakhs were immunized. 12.86 lakhs antenatal women was the target for antenatal tetanus toxoid immunization of which 9.80 lakh received it. 182.30 lakhs mothers and children were the target for prophylaxis against blindness caused by Vitamin ‘A’ deficiency; 87.55 lakhs children was the target for prophylaxis against blindness caused by Vitamin ‘A’. 85.41 lakhs were given Vitamin ‘A’. 23 Govt. of India, Fourth Five Year Plan, 1969-74 (New Delhi: Planning Commission, 1969)
The primary objective of the Fifth Five Year Plan (1974-79) was to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups especially children, pregnant women and feeding mothers. During this plan's duration essential package, namely the national program of minimum needs, especially for the rural areas was introduced. The United Nations designated 1974 as a World Population Year. The Ministry of Health and Family Planning also issued a major policy declaration in the form of a statement entitled National Population Policy (1976). Main features of the statement were: The raising of the minimum age of marriage to 18 years in case of girls and 21 years in case of boys; India became totally free of small pox on 5th July 1975 and the same was officially confirmed in April 1977 by the international commission; Expanded program of immunization (EPI) launched in India in January, 1978 to protect children against six vaccines-preventable diseases, namely diphtheria, whooping cough, tetanus, polio, tuberculosis and measles; The Minimum Needs Program also introduced in the first year of the fifth five year plan to combat poverty.

In addition to the five year plan and programs, in 1975 the Government of India initiated a special activity known as the 20 Point Program. In 1979, the World Health Assembly endorsed the declaration of Alma Ata on primary healthcare and in the same year the name of the Family Planning program was changed to Family Welfare program. During this period the total plan investment was Rs.39, 322.00 crores out of which 682.00 crores were allotted for health and 497.40 crores were for family welfare.24

During the Sixth Five Year Plan (1980-85) the focus was on strengthening of maternal & child health and family welfare program. More stress was laid on various components of MCH program to reduce maternal and infant morbidity and mortality rates. Higher targets for different components of the MCH program were fixed and the expanded program on

24 Govt of India, Draft Fifth Five Year Plan, 1974-79, (Delhi: GOI, Planning Commission, 1974)
immunization (EPI) implementation was pursued vigorously. One of the most significant things that happened during the sixth five year plan was the approval of National Health Policy (1983) by the parliament. Healthcare programs were restructured and reoriented in order to be in consonance with this policy. Priority was given to the extension of rural health infrastructure through a network of community health centers, primary health centers, and sub-centers, on liberalized population norm. Efforts were also made to develop promotive and preventive services along with curative facilities. High priority was given to the development of primary healthcare located as close to the people as possible. On August 20, 1986, the existing 20 point program was restructured. Out of 20, 8 points were related directly or indirectly to health. Total plan investment during this period was Rs.97,500.00 crores out of which 1821.05 crores were allotted for health and 1010.00 crores for family welfare.25

In the Seventh Five Year Plan (1985-90), the major thrust was laid on consolidation of the health infrastructure already developed. The various programs for promotion of maternal and child health were implemented during this period. Universal immunization program was introduced with a view to cover all beneficiaries by the end of 1989-90. The Sterilization & IUD program continued with higher targets and became very popular. Control of Acute Respiratory Infection (ARI) program was initiated as a pilot project in 14 districts in 1990. Diarrhoeal disease control program, initiated during the sixth five year plan, was merged with maternal and child health activities in the seventh five year plan. During this period the total plan investment was Rs.180,000.00 crores out of which 3,392.89 crores were earmarked for health and 3,257.26 crores for family welfare.26

One of the objectives of the Eighth Five Year Plan (1992-97) was to provide facilities for all. The ‘health for all’ paradigm not only takes into

---

26 Govt. of India, Seventh Five Year Plan, 1985-90 (New Delhi: Planning Commission, 1985)
account high risk vulnerable groups, but also focuses sharply on the underprivileged segments. During the eighth plan more stress was laid on the involvement of NGO’s to supplement and complement the government efforts in motivating the people to adopt small family norms. Family planning program was made target free from 1st April 1996. The focus of the program was shifted to quality improvement and client satisfaction. The total plan investment during this period was Rs. 798000.00 crores out of which 7575.92 crores were allotted for health and 6500.00 crores for family welfare.27

During the Ninth Five Year Plan (1997-2002), it was observed that inappropriate location, poor access, poor maintenance, gaps in critical manpower, mismatch between personnel and equipment, lack of essential drugs and diagnostic equipment, and poor referral linkages are some of the factors responsible for sub-optimal functions of primary healthcare institutions. The plan in general focused on the improvement of the health-status of the population by optimizing coverage and quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents and drugs. Further, the emphasis was laid on the assessment of the requirements for reproductive and child health facilities at PHC level, and undertaking areas specific micro planning and providing need based client centered, demand-driven high quality, integrated reproductive and child healthcare. During the ninth plan universal screening of women during pregnancy, labor and screening of neonates for high risk factors, identification and management of at-risk individuals was given priority so as to achieve reduction in maternal and neonatal morbidity and mortality. The plan had further proposed the coverage of family planning services through participation of general medical practitioners working in voluntary, private and joint sectors as also the active cooperation of practitioners of ISM&H and involvement of Panchayati Raj institutions and NGO’s. Total plan investment during this period was Rs. 859200.00 crores out of which 10818.40 crores were allotted for health and 15120.20 crores for family welfare.28

70

Govt of India, Eighth Five Year Plan, 1992-97 (New Delhi Planning Commission. 1992)

Govt of India, Ninth Five Year Plan, 1997-2002 (New Delhi Planning Commission. 1997)
The Tenth Five Year Plan (2002-07) provides an opportunity, at the start of the new millennium, not only to build upon the gains of the past but also to address the weaknesses that have emerged. The areas of the concern in the tenth plan include reorganization and restructuring of existing healthcare infrastructure at primary, secondary and tertiary levels so that they may have appropriate referral linkage with each other. Further, the plan commits to provide essential primary care and emergency life-saving services free of cost to individuals, based on their needs and not on their ability to pay. During this period the total plan investment was Rs. 921291.00 crores out of which 9253.00 crores were allotted for health and 27125.00 crores for family welfare. The targets for the tenth five year plan and beyond, which are capable of being monitored, are (a) reduction in the decadal rate of population growth between 2001 and 2011 to 16.2 percent; (b) increase in literacy rate to 75 percent within the plan period; (c) reduction of infant mortality rate to 45 per 1000 live births by 2007 and to 28 by 2012; and (d) reduction of maternal mortality ratio to 2 per 1000 live births by 2007 and to 1 by 2012.29

Table 2.4
Investment in Different Plan Periods (in Crores)

<table>
<thead>
<tr>
<th>Period</th>
<th>Total Plan Investment</th>
<th>Health</th>
<th>Family Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Plan (1951-56)</td>
<td>1960.00</td>
<td>65.20</td>
<td>0.1</td>
</tr>
<tr>
<td>II Plan (1956-61)</td>
<td>4672.00</td>
<td>140.80</td>
<td>2.20</td>
</tr>
<tr>
<td>III Plan (1961-66)</td>
<td>8576.00</td>
<td>225.00</td>
<td>24.90</td>
</tr>
<tr>
<td>Annual Plans (1966-69)</td>
<td>6625.40</td>
<td>140.20</td>
<td>70.50</td>
</tr>
<tr>
<td>IV Plan (1969-74)</td>
<td>15,778.80</td>
<td>335.50</td>
<td>284.40</td>
</tr>
<tr>
<td>V Plan (1974-79)</td>
<td>39,322.00</td>
<td>682.00</td>
<td>497.40</td>
</tr>
<tr>
<td>1979-80 Outlay</td>
<td>11,650.00</td>
<td>268.20</td>
<td>116.20</td>
</tr>
<tr>
<td>VI Plan (1980-85)</td>
<td>97,500.00</td>
<td>1821.05</td>
<td>1010.00</td>
</tr>
<tr>
<td>VII Plan (1985-90)</td>
<td>180,000.00</td>
<td>3,392.89</td>
<td>3,257.26</td>
</tr>
<tr>
<td>VIII Plan (1992-97)</td>
<td>798000.00</td>
<td>7575.92</td>
<td>6500.00</td>
</tr>
<tr>
<td>IX Plan (1997-2002)</td>
<td>859200.00</td>
<td>10818.40</td>
<td>15120.20</td>
</tr>
<tr>
<td>X Plan (2002-07)</td>
<td>921291.00</td>
<td>9253.00</td>
<td>27125.00</td>
</tr>
</tbody>
</table>

Source: Records of Planning Commission, New Delhi.

29 Planning Commission, Tenth Five Year Plan (2002-2007), Sectoral Policies and Programs (Health) (New Delhi: Planning Commission Govt. of India)
Genesis of Reproductive and Child Health Program

Having a health worker with midwifery skills present at childbirth, backed-up by transport in case emergency referral is required, is perhaps the most critical intervention for making motherhood safer. In ancient India, care of women and practice of midwifery were totally in the hands of indigenous village dais. With the onset of British rule in India, in the middle of the eighteenth century, the authorities found measures for prevention and treatment of diseases far from adequate. Women were subject to the Parda System and could interact very little with outsiders, especially with men. For those in labor, the village dai was the only source of help at the time of delivery. These indigenous dais not only helped during child birth but also acted as consultants for any birth-related condition of the mother. They were ‘midwives’ in the literal sense. The occupation of dais was hereditary. They belonged to the lower caste as the period of childbirth was considered a time of impurity and the worst room in the household was allotted for delivery. Dais gained their skills through observation and practice. No formal training was given. As long as it was a normal delivery and everything went smoothly they did not have a problem but when they came across a complicated case, the dais could not handle the situation and serious morbidity and mortality resulted. Since dais were unable to deal with difficult deliveries and pregnancies, the rates of maternal and neonatal mortality were very high in British India. When medical missionary women from England came to India they pointed out that the “Child Welfare and Maternity Work” was one of the most pressing needs and more attention was to be given to it. In one village they heard that ten babies were born but all died one after the other due to tetanus. They had been attended by the same dai. While writing about preventive medicine in a mission hospital, a missionary doctor wrote in 1927, “Ever since medical women came to India to work, their chief work has been in the field of obstetrics and gynecology”. Various milestones of the RCH program are shown in Table 2.5.

---

Table 2.5
Milestones of the Reproductive and Child Health Program

<table>
<thead>
<tr>
<th>Year</th>
<th>Milestone or Events/Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1880</td>
<td>Establishment of Training of dais in Amritsar.</td>
</tr>
<tr>
<td>1902</td>
<td>First Midwifery Act. to promote safe delivery.</td>
</tr>
<tr>
<td>1930</td>
<td>Setting up of Advisory Committee on maternal mortality. The committee scrutinized causes leading to maternal deaths and recommended course of actions to prevent such deaths.</td>
</tr>
<tr>
<td>1946</td>
<td>Bhore Committee recommended comprehensive and integrated healthcare to be built on the foundations of preventive care and referral services.</td>
</tr>
<tr>
<td>1949</td>
<td>Establishment of Family Planning Association of India.</td>
</tr>
<tr>
<td>1952</td>
<td>Primary Health Centre network came up as a result of the National Family Planning Program.</td>
</tr>
<tr>
<td>1956</td>
<td>MCH centers became integral part of PHCs.</td>
</tr>
<tr>
<td>1972</td>
<td>Medical Termination of pregnancy Act made abortion legal.</td>
</tr>
<tr>
<td>1974</td>
<td>Family Planning Services incorporated in MCH care.</td>
</tr>
<tr>
<td>1978</td>
<td>Expanded program on Immunization.</td>
</tr>
<tr>
<td>1985</td>
<td>Universal Immunization program.</td>
</tr>
<tr>
<td>1992</td>
<td>Child Survival and Safe Motherhood program.</td>
</tr>
<tr>
<td>1994</td>
<td>India became Signatory to ICPD Plan of Action.</td>
</tr>
<tr>
<td>1996</td>
<td>Withdrawal of target approach.</td>
</tr>
<tr>
<td>1997</td>
<td>Reproductive and Child Health program.</td>
</tr>
</tbody>
</table>

For training of indigenous dais the women medical missionaries were pioneers and as early as in 1877 Miss Hewlett, an English Missionary of Zenana Missionary Society, started the first training school for dais in 1880 at Amritsar. Young girls, who had studied up to the middle school level, were selected to undergo this training.31

---

The first ever Midwifery Act to promote safe delivery was enacted in 1902 and advisory committee on maternal mortality was set up in 1930. This committee scrutinized the causes leading to maternal deaths and recommended the course of action to be adopted for preventing such deaths. The Bhore Committee (1946) reports, "Lack of skilled services by qualified midwives plays an important part in the prevalence of high rates of maternal morbidity and of infantile deaths in the first month after birth." This committee, which laid the foundation for public health planning in India, had greatly stressed upon the need for qualified midwives and health-visitors. The Shetty Committee (1995) appointed by the Government of India, recommended training and posting of ANMs in health centers for maternal and child health services provided there were adequate number of health visitors to supervise them. Since independence tremendous changes have been brought about in the nursing education in the country. The first step that the Indian Nursing Council took, after its inception in 1947, was to combine the Nursing and Midwifery courses into a single course. The course was designed to be of three and a half years duration, with entry qualification being class X. The second change was to replace the diploma in midwifery course with an auxiliary nursing and midwifery (ANM) course of 2 years duration with basic qualification being class VIII. These auxiliary nurse midwives were specially trained in midwifery and child care services in order to be posted at the primary health centers, mainly to look after mothers and children and also conduct deliveries. However, with the inception of multi-purpose health workers scheme in 1975, on the recommendation of the popularly known Kartar Singh Committee, the two year ANM course was shortened by 6 months and a broad curriculum was designed providing a wide range of experience in community health with entry qualification being class X.

---

32 C M Hicks. Undertaking Midwifery Research: A basic guide to design and analysis (New York: Churchill Livingstone 1996)
33 Reena Bose, and M Prakashamma, op. cit, p 7-8
The multipurpose health workers were registered as ANMs and were designated as female health workers. They were posted at sub centers to look after about 5000 people in rural areas to take care of mothers and children and conduct deliveries in their areas as well as supervise the deliveries conducted by dais. During this time the supervisory support was weakened because the Lady Health Visitors (L.H.V.) course was discontinued and a promotional training course of only six months duration was launched. From the skill oriented one year diploma in midwifery to the two year ANM course, and finally to the 18 months multipurpose health worker female (F) training, there has been a clear watering down of midwifery skills in the training of material and child health care providers.34

For the past few years now, there has been a strong realization that the PHCs have not served the vital function due to the lack of qualified obstetricians who could handle obstetric emergencies. The launching of reproductive and child health program and the shift in policies from demographic targets to comprehensive reproductive health services provides the right atmosphere to make a positive change in the type and quality of midwifery personnel in the country.35 The direct indicator, the maternal mortality rate, could be used for monitoring the progress achieved in reducing maternal mortality only for countries with comprehensive vital registration systems. However, other countries will have to depend on the process indicator, data on skilled attendants of deliveries.36 Midwifery Training, practice, regulation and standard setting processes are undergoing rapid changes in neighboring countries with success stories from Sri Lanka, Thailand and Bangladesh and the attempts at making progress in Nepal, Indonesia & Bhutan.37 But India has yet to start building an efficient and skilled cadre of midwives for fighting maternal mortality. There is no clear policy for building an efficient midwifery science in the country. The maternal

37 Ibid. 15
health status of women and maternal mortality are closely related to the
presence of trained attendants at birth. As the percentage of birth attended by
trained personnel goes up the maternal mortality ratio goes down. Relevant
eamples are available in Asia itself (UNFPA, 1997). The figure 1.1 shows
the inverse relationship between the births attended by trained health
personnel and the maternal mortality rate, except in Maldives (see Chapter – 1).

The high maternal, infant and childhood morbidity and mortality, the
low life expectancy and high fertility as well as the associated high morbidity
rates have been a source of concern for health professionals right from the
pre-independence period. The Bhore Committee report, 1946, which laid the
foundations of health services planning in India, gave high priority to the
provision of maternal and child health services. The Family Planning
Association of India was established in 1949 and India was the first country to
have family planning program at national level since 1952. Sterilization
remained the focus of the National Family Planning Program and efforts were
made to provide vasectomy services in rural areas using the camp
approach. Community development program was launched on October 2nd
1952 for overall development of the rural areas. Since then primary health
centre networks came up and, in 1956, MCH centers became integral part of
PHCs. The introduction of the Lippe’s Loop in 1985 necessitated a major
structural reorganization of the program, leading to creation of a separate
department of family planning in 1966 in the Ministry of Health. In the Fourth
Five Year Plan (1969-74), the Government of India gave “top priority” to the
program and it was made an integral part of MCH activities of PHCs and their

---

Organization, Regional Office for South-East Asia, 2001)
41 M.E. Khan, op. cit., p.75.
42 M.K. Ray, op. cit.
43 K. Park, op. cit., p. 506
In 1970, the All India Hospital Postpartum Program provided contraceptive care to women coming for delivery. Mass vasectomy camp approach introduced in 1971 was finally stopped in 1973. The medical termination of pregnancy act (MTP) enabled women with unwanted pregnancy to seek and obtain safe abortion services were introduced in 1972. A major setback to the family planning program occurred during the Emergency [1975-77] when coercion was applied for spreading sterilization. Nevertheless, overall the experience gained amply established that the health of women in the reproductive age group and of children of up to five years of age is of crucial importance for effectively tackling the problems of growth of population. This resulted in the change in approach from family planning to family welfare.

Experience with smallpox eradication program showed the world that immunization was the most powerful and cost-effective weapon against vaccine preventable diseases. The Government of India launched its expanded program on immunization in 1978 with the objective of reducing the mortality and morbidity resulting from vaccine preventable diseases during childhood. The program was revised and renamed as Universal Immunization Program (UIP) in 1985 focusing more on infants and pregnant mothers. UIP was later merged with child survival and safe motherhood program in 1992 and with RCH program in 1997. The National Diarrhoeal Diseases Control Program was started during the sixth five year plan to bring down diarrhea related mortality. The oral dehydration therapy (ORT) was also started in view of the fact that diarrhea was a leading cause of deaths among

---

45 M.K. Ray, op. cit, p 37.
46 Govt. of India, ‘Bulletin on Rural Health Statistics in India’, (New Delhi: Rural Health Division, DGHS, 2002).
47 M.E. Khan, op. cit., p 75.
48 S. Grewal, MTP: its status, achievements and lacunae. (WHO Workshop on implementation of pregnancy termination at district hospitals and block levels, 1975).
Various other programs under maternal and child health (MCH) were also implemented during the 7th plan. The objectives of all these programs were convergent and aimed at improving the health of mothers and young children and to provide them facilities for prevention and treatment of major disease conditions. While these programs did have a beneficial impact the separate identity for each program was causing problems in its effective management adversely affecting the outcome to some extent. Goals of national health policy (9 out of 17 goals) related to maternal and child health also reflect that the care of ‘mother and child’ occupies a paramount place in the health service delivery system. Therefore, during the nineties i.e. in the 8th Plan, these programs were integrated under Child Survival and Safe Motherhood (CSSM) program which was implemented during 1992-93. Efforts were made to provide integrated antenatal, intranatal and postnatal care to women, the child healthcare component included immunization, diarrhea and acute respiratory infection prevention and management programs. CSSM goals for pregnant women and children were as follows:

**For Women:**

- Immunization against TT – 100 percent coverage.
- Anemia prophylaxis – 100 percent coverage.
- ANC checkup (at least 3 checkups) – 100 percent coverage.
- Referral of complicated cases
- Care at birth – promotion of “clean” delivery.
- Birth timing and spacing

**For Children:**

- Newborn care at home (warmth and feeding).

---

Population growth was one of the six major concerns of the eighth five year plan. Recognizing the fact that reduction in Infant and Child Mortality is essential prerequisite for acceptance of the small family norm. The Government of India has attempted to integrate MCH and family planning as part of family welfare services at all levels. The National Development Council (NDC) approved the modified Gadgil-Mukherjee formula which for the first time gave equal weightage to performance in MCH sector (IMR reduction) and family planning sector (CBR reduction) as a basis for computing central assistance to non-special category states. This initiative ensured that the inter linkage between family welfare program and development was kept in focus in the state plans. In order to give a new thrust and dynamism to the ongoing family welfare program the National Development Council set up a sub-committee on population to consider the problem of population stabilization and come up with relevant recommendations. The report of the sub-committee was considered and the recommendations were endorsed by the NDC in its meeting in September, 1993. The NDC committee on population had recommended that family welfare program should take cognizance of the area specific socio-economic, demographic and healthcare availability differentials and allow requisite flexibility in program planning and implementation. For this purpose the NDC committee recommended that there should be (a) decentralized planning based on the assessment of need; (b) emphasis on improved access and quality of services to women and children; (c) efforts to remove or minimize the inter and intra-state differences; and (d) creation of district level database on quality and coverage indicators for monitoring of the program. Further; the International Conference on
Population and Development was held in Cairo in 1994 and India became signatory to the ICPD plan of action. The recommendations of the ICPD are essentially similar to the recommendations of the NDC committee on population. Major recommendations of the ICPD were (a) holistic reproductive healthcare should be made available through primary health care system; (b) efforts should be made by all the States to reduce infant mortality by one-third and maternal mortality by 50 percent by 2000 A.D.; and (c) need assessment and need fulfillment should be treated as key elements for improving reproductive health.54

In view of the above recommendations, India withdrew the target-free approach from 1st April 1996 and adopted the changed approach based on community need assessment, planning and implementation of family welfare program.55 Keeping in view an integrated approach towards RCH program which is being implemented in the country, it is quite evident that integrated RCH approach helps in reducing the cost of input to some extent because overlapping of expenditure would no longer be necessary. The integrated approach would also optimize outcomes at the field level. Eventually the RCH program was launched on 15th October 1997. The RCH program incorporates the components relating to child survival and safe motherhood and includes two additional components – one relating to sexually transmitted infections (STI) and the other relating to the reproductive tract infection (RTI). The Reproductive and Child Health (RCH) has been defined as a state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and childbirth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and wellbeing; and couples are able to have sexual relations free from the fear of unwanted pregnancy or contracting diseases. This means that every couple should be able to have the child whenever they want and that the pregnancy is uneventful; safe delivery services are available and at the end of the

54 M.K. Ray, op. cit., p. 5.
55 M.E. Khan, op. cit., 75
pregnancy the mother and the child are safe and well and that contraceptives of choice are available to prevent unwanted pregnancy as also sexually transmitted diseases.56

The highlights of the RCH program are as given below:

1. The Program integrates all interventions of fertility regulation, maternal and child health with reproductive health of both men and women.
2. The services to be provided will be client centered, demand driven, of high quality and based on the needs of the community. These will be provided through decentralized participatory planning using the target free approach.
3. The Program envisages up-gradation of the level of facilities for providing various interventions and enhanced quality of care. The First Referral Units (FRUs) being set up at sub-district level will provide comprehensive emergency obstetric and infant care services. Similarly RCH facilities in PHCs will be substantially upgraded.
4. The Program will improve the community’s access to various services which are commonly required. It is proposed to provide facilities for MTP at the SCs.
5. Special facilities for prevention/cure/management of STD and RTI will be available in all district hospitals and in a fair number of sub-district level hospitals.
6. The Program aims at improving the scope and range of services particularly for the vulnerable groups of population who have until now substantially been left out of the planning process. Special programs would be taken up for urban slums, tribal population and adolescents; non-governmental organizations will be involved in a much larger way to improve the range and make it people’s program. Skills of practitioners of ISM will be upgraded through training.

56 Govt. of India, Reproductive and Child Health Programme, scheme for implementation. (New Delhi: Ministry of Health and Family Welfare, Oct. 1997) 3
development in ISM will be supported in order to improve the range of RCH services; and the Panchayati Raj System will have a greater role in planning, implementation and assessment of client satisfaction.57

Objectives of the RCH Program

The RCH program is an integrated and comprehensive program with definite objectives, strategies, components and indicators for monitoring and evaluation. The RCH program has the following two objectives:

- To meet all the felt needs for contraception.
- To reduce the infant and maternal morbidity, so that there is reduction in the desired level of fertility.58

The Recommended Package of Services

For the mothers:

- Tetanus Toxoid Immunization
- Prevention and treatment of anemia
- Antenatal care and early identification of material complications
- Deliveries by trained personnel
- Promotion of institutional deliveries
- Management of obstetric emergencies
- Birth spacing

For the children:

- Essential newborn care
- Exclusive breast feeding and proper weaning practices
- Immunization
- Appropriate management of diarrhea

57 ibid, p.4-5.
• Appropriate management of Acute Respiratory Infections.
• Vitamin A prophylaxis
• Treatment of Anemia

For eligible couples:

Prevention of occurrence of frequent pregnancies

• Safe abortion
• Prevention and treatment of reproductive tract infection (RTI) and sexually transmitted infection (STI)

Importance of care of girl child
Optimal timing & spacing of births

• Counseling on Small family norms
Use and choice of contraceptives
Prevention of RTI/STI

• Information on MTP Services
availability of Intra-Uterine Devices & sterilization services

Condom distribution

• Family Planning Oral Contraceptives
IUD

Women of reproductive age must receive:

• Services for recognition & referral of RTI/STIs
• Adolescent Health

---

59 "Overview of Reproductive and Child Health Programme" Indian Journal of Public Health XXXVI. 3 (July - September 2002) 95-96
THE COMPONENTS OF RCH PROGRAMME

Effective maternal and child health care to promote the following:

- Effective maternal and child healthcare to ensure safe motherhood and child survival.
- Increased access to contraceptive care to prevent unwanted pregnancies.
- Effective nutritional services to vulnerable groups.
- Prevention and treatment of RTI/STD.
- Reproductive health services for adolescents.
- Prevention and treatment of gynecological problems including infertility, menstrual disorders and prolapsed uterus.
- Screening and treatment of cancers, especially that of uterus, cervix & breast.
- All these services are being provided in all secondary and tertiary care hospitals.

Essential Reproductive and Child Health Services include:

- Prevention and management of unwanted pregnancy.
- Services to provide antenatal, intranatal and postnatal as well as neonatal care.
- Services to promote child health and survival.
- Prevention and treatment of RTI/STD.
- Adolescent health has also been included in the essential package.

These services are being provided in primary healthcare settings throughout the country in a phased manner.60

60 Govt. of India. Reproductive and Child Health Programme, scheme for implementation. (New Delhi: Ministry of Health and Family Welfare, Oct. 1997) 3
ESSENTIAL OBSTETRIC CARE PACKAGE

Maternal Health

1. Early registration of pregnancy (within 12-16 weeks)
2. Provision of minimum three antenatal checks by an ANM or a medical officer.
3. Promotion of institutional delivery and provision of safe delivery at home.
4. Provision of three postnatal checkups.61

The RCH II continues with the aforementioned approach. It is being viewed as a program and not as a project. A long term vision for RCH II (period of five years spanning 2004-09) has been deemed as a project for convenience. The components comprise population stabilization, maternal health, newborn care, child health, adolescent health, RTI/STI treatment and control, urban health, and tribal health; these also include other priority areas like targeting of services, strengthening of service delivery, infrastructure and maintenance, supply of drugs and equipment as well as strengthening of healthcare providers. The focus of RCH will be on reducing maternal mortality ratio, infant mortality rate, and gross fertility rate and on increasing the couple protection rate and the coverage of children through immunization.62

61 ibid.
62 J.Kishore, op. cit., p.22.