CHAPTER

2

Evolution of Health Reforms and Health Policy Development in India

"A policy is as good as its implementation"

DEVELOPMENT OF PUBLIC HEALTH POLICY AND SERVICES IN INDEPENDENT INDIA

OVERLAPPING REFORMS IN HEALTH SYSTEM

1. **The first generation health reforms and development of health systems:** Commenced way back in 1946, following outstanding policy recommendations of "Health Survey and Development Commitee" (Bhore Committee). In this phase, efforts were directed through successive Five Years Plans, to establish and develop a sustainable three-tier "Healthcare Delivery System" in India to cover its vast population. This policy continued in various plans. Health was considered as development function. Primary health centres were part of "Community Development Programme", i.e. all-round development movement started way back in 1952.
2. **In the second generation health reforms,** India developed minimum needs programme. India continued to pursue the development programmes through Five Years Plans, however, the results of planned development did not trickle down the rural poor and disadvantaged sections of the society. The measures for providing larger employment and income to these sections, therefore, were considered necessary for bringing them up to at least certain minimum nationally acceptable standards. Therefore, as part of policy shift, Minimum Need Programme (MNP) was initiated with the objective of establishing a network of basic minimum services including education, health, nutrition, drinking water, sanitation improvement of urban slums, etc.
3. **During the third generation health reforms,** India framed a "National Health Policy" to achieve "Health for All" "through Universal Primary Healthcare Model".
4. **In the fourth and fifth phases** of development of healthcare delivery system, various reforms in health sector were undertaken to achieve Millennium Development Goals and rolling out of "Universal Health Coverage" in 12th plan period and beyond to achieve 'Health in all', and sustainable Development Goals by 2030.

The Indian Health System

Health in India is a state responsibility with overall health policy established at the centre. There has been a consistent evolution of this policy, oriented at meeting the health needs of the masses, since independence.

Health development in independent India can be divided into following phases of development.[1,2]

Phase I (1947–1972)

1. Health was considered as development function and a part of community development programme. Community development programme started in 1952.
2. One primary health centre was established in each community development block.
3. Expansion of primary healthcare infrastructure occurred in this phase.
4. Family planning needs and services were recognized as priority problem and National Family Planning Programme commenced on voluntary basis in 1952.
5. A separate department of family planning was set-up in the Ministry of Health and Family Welfare (MOH and FW).
6. Many national health/disease control/eradication programmes were launched as vertical programmes.

Notable of these were-malaria, tuberculosis, leprosy, smallpox, goitre, immunization, nutrition, water supply and sanitation and maternal and child health.

2

Phase II (1972–1977)

During this phase, India launched:

1. Minimum Needs Programme.
2. Multipurpose Health Workers Scheme.
3. Health guides were introduced.
4. Dais training programme was stepped up.
5. Integrated Child Development Services (ICDS).

Phase III (1977–1996)

Important developments during this phase were:

1. Smallpox eradicated in 1978.
2. Alma-Ata Declaration on "Health for All" 1978.
3. National Health Policy was formulated in 1983.
4. National Education Policy was adopted in 1986.
5. Universal Immunization Programme was initiated in 1985.
6. Child Survival and Safe Motherhood Programme (CSSM) started in 1992.[3]
7. 73rd and 74th Constitutional Amendments Act, 1992.
8. International Conference on Population and Development at Cairo in 1994.

Phase IV (1997–2012)

1. A paradigm shift in policy: Reproductive and Child Health (RCH) Programme was launched. Target free approach (Community Needs Assessment Approach) adopted.
2. National Population Policy of 2000 was adopted.
3. Millennium Development Goals were adopted in 2000.
4. Revised National Health Policy of 2002 was launched.
5. National Rural Health Mission was launched in 2005.
6. Department of Family Planning integrated with health department.

Phase V (2012–2017 and beyond)

1. Rolling out a system of 'Universal Health Coverage'.
2. Transformation of NRHM to National Health Mission.
3. National urban health mission launched.
4. Phase IV of National AIDS Control Programme started.
5. National Health Policy 2017 launched.
6. Achieve Sustainable Development Goals of United Nations by 2030.
7. NITI Aayog constituted and replaced 5 year plans.
8. COVID-19 PANDEMIC and health

Major Health Policy Recommendations

1. ***Bhore Committee 1946 (Health Survey and Development Committee):*** One of the most outstanding efforts in health services planning and policy in this country has been the Health Survey and Development Committee (1943–1946), popularly known as Bhore Committee, which guided the development of health services in India. The major recommendations of this committee were:
   - No individual should fail to secure adequate medical care because of inability to pay for it.
   - Health services should provide all consultant, laboratory and institutional facilities for proper diagnosis and treatment.
   - The health services should be placed as close as possible to the people in order to ensure maximum benefit to the communities to be served.
   - Health consciousness should be stimulated by providing health education on a wide basis as well as by providing opportunities for individual participation in local health programmes.
   - Medical services should be free to all without distinction.
   - Three-tier system—Subcentre, PHC, Subdistrict and District level healthcare model, be set-up.
   - The establishment of one primary health centre for 10,000 to 20,000 population in the long-term perspective and one centre for 40,000 population in the short-term perspective.
   - One bed for 175 persons, one doctor for 1600 and one nurse for 600 persons. One 650-bedded hospital at *Taluka* (3 lakh population) and one district hospital of 2500 beds. It recommended 15% of government expenditure on healthcare.
2. ***Mudaliar Committee 1961 (Health Survey and Planning Committee):*** The major policy recommendations were:
   - Integration of curative and preventive services.
   - Establishment of one primary health centre for 40,000 population.
   - One bed for 1000 population and one doctor for 3000 population.
   - One 50-bedded hospital with specialist services for each *Taluka* and 500 beds hospital at district level.
   - One medical college for 5 million population.
3. ***Chadha Committee 1963***
   - Integration of maintenance phase of malaria with general health services in the country,

consisting of subcentres, primary health centres and district level organizations.

- Designating the malaria surveillance workers as basic health workers at the scale of 1 per 10,000 population.
- One sanitary inspector/health inspector at the rate of 1 per 20–25,000 population.
- One laboratory technician at the level of PHC.
- One family planning field worker at the rate of 1 per 30,000 population for intensification of family planning measures.
- Utilization of extension educators for all national health programmes.

4. ***Mukherjee Committee 1966: Recommendations***

- One family planning field worker (FPFW) for every two subcentres or 20,000 population.
- One lady health visitor for 40,000 population.
- One part-time worker for motivating population for acceptance of IUD be appointed with honorarium.
- Campaign for opinion leader (opinion leaders training camps) for intensification of motivation campaign for acceptance of family planning services.
- Incentives to government doctors and practitioners.

5. ***Jain Committee 1966: Recommendations***

- One bed per 1000 population.
- One 50 beds hospital at *Taluka* level.
- Enhancing maternity facilities at each level.
- Health insurance for larger population coverage.

6. ***Kartar Singh Committee 1974: Recommendations***

- Change of uni-purpose workers to multipurpose health workers.
- Integration of health services and programmes.
- One male and one female multipurpose health workers for each subcentre.
- One supervisor for 4 ANMs or four health workers.
- One PHC for 50,000 population.

7. ***Srivastava Committee 1975 (group on medical education and support manpower)***

- Health guides at the community level one for 1000 population.
- One male and one female health worker per 5000 population.
- One additional doctor and nurse at PHC for MCH services.
- Reorientation of medical education (ROME) and establish medical and health education commission.
- Increase in PHC drug budget.
- Compulsory national service of two years at PHC by every doctor.
- Integration of various health systems.

8. ***ICMR-ICSSR joint panel 1980 (Ramalingaswami Committee recommended)***[4]

Formulation of comprehensive national health policy.

- Development of health system should be integrated with overall plans of socioeconomic development.
- To ensure access to adequate food, provide environment conducive to health and adequate immunization where necessary.
- Devise an educational programme for health.
- To replace the existing model of healthcare services by an alternative new model of healthcare which will consist of:
  - Village or community health volunteer/health guide for 1000, subcentre for 5000 population, community health centre for 100,000 population, district health centre for one million population.
  - The specialist centre for 5 million population.
  - Combining the best elements in the tradition and culture of the people with modern science and technology.
  - Integrating promotive, preventive and curative functions.
  - Democratic, decentralization and participatory model.
  - Oriented to the people, i.e. providing adequate healthcare to every individual and taking special care of the vulnerable groups.
  - Firmly rooted in the community and involving people.

9. ***National Health Policy (NHP) 1983: Health for All***

- Provision of universal, comprehensive primary healthcare services.
- Involvement of private practitioners and NGOs to expand coverage of services.
- Transfer of knowledge and simple skills to village-based workers.
- Evolving a decentralized system of healthcare and establishment of a referral system.
- Establish nationwide chain of epidemiological stations.

- Encourage private investment in health sector to reduce government burden.
- Specification of 17 health and demographic indicators to be achieved by the year 2000.

10. ***National Population Policy (NPP) 2000***
    a. Immediate goal is to meet the unmet needs of contraception.
    b. Medium-term goal is to achieve total fertility rate of 2.1 by 2010.
    c. Long-term goal is to have stable population by 2050.
    - Sociodemographic and health goals for 2010 with the primary aim of bringing the total fertility rate (TFR) to replacement level.
    - Increased outreach and coverage of comprehensive package of reproductive and child health (RCH).
    - A one-stop, integrated service delivery to be provided at the village level.
    - Expand public health infrastructure.
    - Decentralized planning and programme implementation with involvement of Panchayati Raj Institutions (PRIs).
    - Promote intersectoral approach between a number of key government departments.[5]
11. ***Revised National Health Policy 2002:*** The objectives of NHP 2002 were to:
    - Achieve an acceptable standard of good health in general population.
    - To ensure more equitable access to health services.[6]

Approach:

- To increase access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the existing institutions.
- To increase public health investment through substantially increased contribution by the central government.
- To enhance participation of non-governmental organizations.
- To increase public–private partnership (PPP).
- To invest 55% of public health investment in primary healthcare, 35% for secondary and 10% for tertiary care to achieve equity.
- To provide *essential drugs* and equipment at primary health centre by the central government.

12. ***National Rural Health Mission (NRHM) 2005–2012***

The objectives were:

- To raise public spending on health from 0.9% of GDP to 2–3% of GDP.
- To strengthen subcentres, PHCs, CHCs and districts health services.
- To achieve convergence of services of various sectors like health, nutrition, water supply and sanitation at various levels.
- To enhance community participation by enhancing capacity of PRIs.
- To promote access to healthcare through Accredited Social Health Activist (ASHA).[7, 8]
- National Commission on Macroeconomic and Health constituted in 2005.

13. ***National Urban Health Mission (NUHM) 2008:*** To address the health needs of the urban poor, mission document on National Urban Health Mission (NUHM) was approved in 2008.
14. ***National Health Mission (NHM) 2012–2017:*** National Health Mission (NHM) envisages universal access to equitable, affordable and quality healthcare services that are accountable and responsive to people's needs. NHM has two submissions, the National Rural Health Mission and the National Urban Health Mission. The programme components include health system strengthening in rural and urban areas, reproductive maternal, newborn, child and adolescent health, control of communicable and non-communicable diseases.

National Five Years Plans: "1st plan to 12th five-year plan (2012–17): Raising public spending on health from 1.04 to 1.87% of GDP" and cashless OPD healthcare in government hospitals as also accelerating universal health coverage (UHC).[9]

NITI Aayog

The National Institution for Transforming India, (NITI) also called NITI Aayog, was formed via a resolution of the Union Cabinet on January 1, 2015. NITI Aayog is the premier policy 'Think Tank' of the Government of India, providing both directional and policy inputs. While designing strategic and long-term policies and programmes for the Government of India, NITI Aayog also provides relevant technical advice to the Centre and states.

The Government of India, in keeping with its reform agenda, constituted the NITI Aayog to replace the Planning Commission instituted in 1950. This was

done in order to better serve the needs and aspirations of the people of India. An important evolutionary change from the past, NITI Aayog acts as the quintessential platform of the Government of India to bring states to act together in national interest, and thereby fosters cooperative federalism.

At the core of NITI Aayog's creation are two hubs—**Team India Hub** and the **Knowledge and Innovation Hub.** The Team India Hub leads the engagement of states with the central government, while the Knowledge and Innovation Hub builds NITI's think-tank capabilities. These hubs reflect the two key tasks of the Aayog.

NITI Aayog is also developing itself as a State of the Art Resource Centre, with the necessary resources, knowledge and skills, that will enable it to act with speed, promote research and innovation, provide strategic policy vision for the government, and deal with contingent issues.

After the end of 12th plan on March 2017, India would have a 15 years vision document to realize long-term goals. People's aspirations and priorities as determined by every "Gram Sabha and equivalent urban bodies" of the country shall be the basis of planning process. It would be a "Planning by the people, for the people and with the people".

References

1. NIHFW. Management Training Modules for Medical Officer, PHC. New Delhi: NIHFW; 1987.
2. GOI: Health manpower, planning, production management. Report of expert committee. New Delhi: MOH and FW GOI; 1987.
3. MOH and FW. National Child Survival and Safe Motherhood Programme—Module for health workers. New Delhi: GOI; 1992.
4. ICSSR and ICMR. "Health for all" an alternative strategy— report of a study group. Pune, India: Indian Institute of Education; 1981.
5. GOI; 2000: National Population Policy 2000. New Delhi.
6. GOI; National Health Policy 2002. New Delhi; GOI; 2002.
7. GOI; National Rural Health Mission—New Delhi; GOI; 2005.
8. GOI; Towards Faster and More Inclusive Growth. An Approach Paper to 11th Five-Year Plan; Govt. of India, Planning Commission, Yojna Bhawan, New Delhi, Dec 2006.
9. GOI; 12th five year plan 2012–17—Health Sector-High Level Expert Group on Universal Health Coverage.

NATIONAL POPULATION POLICY (NPP) 2000

2

Milestones in evolution of the population policy in India:

1. Bhore Committee report was submitted in 1946.
2. National Family Planning Programme was launched in 1952.
3. Statement on National Population Policy was made in 1976.
4. Policy statement on Family Welfare Programme was made in 1977.

   Both (3 and 4) statements were laid on the table of the house in Parliament but never discussed or adopted.
5. National Health Policy of 1983 emphasized the need for securing the small family norm, through voluntary efforts and moving towards goal of population stabilization while adopting the health policy, parliament emphasized the need for a separate National Population Policy.
6. The National Development Council (NDC) appointed a committee on population with Shri Karunakaran as chairman in 1991. The report of this committee was endorsed by NDC in 1993.
7. An expert group headed by Dr MS Swaminathan was asked to prepare a draft of a National Population Policy.
8. Another draft of National Population Policy was finalized and placed before the cabinet in 1999. National Population Policy (NPP) was finally adopted in the year 2000.

Policy

Policy means statement of intentions and time frame to achieve the set goals.

Major goal: To improve quality of life and stabilize population.

Objectives of NPP

- The immediate objective of NPP 2000 was to address the "unmet needs" of contraception, healthcare infrastructure, and healthcare personnel and to provide integrated service delivery for basic reproductive and child healthcare.
- The medium term objective was to bring total fertility rate (TFR) to 2.1 (replacement level).
- Long-term objective was to achieve a **stable population** by 2045 at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.[1]

NATIONAL SOCIODEMOGRAPHIC GOALS

1. Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
2. Make school education up to age 14 free and compulsory, and reduce dropouts at primary and secondary school levels to below 20% for both boys and girls.
3. Reduce infant mortality rate to below 30 per 1000 live births.
4. Reduce maternal mortality ratio to below 100 per 100,000 live births.
5. Achieve universal immunization of children against all vaccine preventable diseases.
6. Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
7. Achieve 80% institutional deliveries and 100% deliveries by trained persons.
8. Achieve universal access to information/counselling, and services for fertility regulation and contraception with a wide basket of choices.
9. Achieve 100% registration of births, deaths, marriages and pregnancies.
10. Contain the spread of acquired immunodeficiency syndrome (AIDS), and promote greater integration between the management of reproductive tract infection (RTI) and sexually transmitted infections (STI) and the national AIDS control organization.
11. Prevent and control communicable diseases.
12. Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.
13. Promote vigorously the small family norm to achieve replacement level of TFR.
14. Bring about convergence in implementation of related social sector programmes so that family welfare becomes a people-centered programme.

STRATEGIC THEMES

- Decentralized planning and programme implementation: 73rd and 74th Constitutional Amendment Act, 1992 made *health*, *family welfare* and *education* a responsibility of village Panchayats and Nagarpalikas, respectively. The Panchayati Raj Institutions (PRIs) are important means of decentralized planning and programme implementation in the context of NPP 2000. Delegate administrative and financial powers to PRIs.
- Convergence of service delivery at village level.
- Empowering women for improved health and nutrition.
- Child health and survival.
- Meeting the unmet needs for family welfare services.
- Underserved population groups—(a) urban slums, (b) tribal communities, hill area population and migrant population, (c) adolescents, (d) increased participation of men in planned parenthood.
- Diverse healthcare providers.
- Collaboration with and commitments from non-governmental organizations (NGOs) and the private sector.
- Mainstreaming Indian System of Medicine and Homeopathy.
- Contraceptive technology and research on reproductive and child health.
- Providing for the older population.
- Information, education and communication.

LEGISLATION

As a motivational measure, in order to enable state governments to fearlessly and effectively pursue the agenda for population stabilization contained in the NPP-2000, one legislation is considered necessary. It is recommended that 42nd Constitutional Amendment that freezes till 2001, the number of seats to the Lok Sabha and Rajya Sabha based on 1971 census be extended up to 2026.

Public Support

Enlisting support for small family norm by political, community, business, professional and religious leaders, media and film stars, sports personalities and opinion makers will enhance its acceptance.

NEW STRUCTURES

Population problem is multisectoral endeavour. This requires multisectoral coordination of planning and implementation between health and family welfare on the one hand, along with schemes for education, nutrition, women and child development, safe drinking water, sanitation, rural roads, communications, transportation, housing, forestry development, environmental protection and urban development. The following structures are recommended:

- National Population Commission.
- State/UT Commissions on Population.
- Coordination Cell in Planning Commission.
- Technology Mission in the Department of Family Welfare.

FUNDING

In order to implement immediately the action plan, it would be necessary to double the annual plan budget of the Department of Family Welfare to enable government to address the shortfall in unmet needs of healthcare infrastructure, services and supplies. The annual budget of Family Welfare for the year 1999–2000 was 2920 crores, half of this gets spent on non-plan activities (recurring expenditures for maintenance of healthcare infrastructure in the states and UTs, and towards salaries). Only 50% is available for genuine plan activities including procurement of supplies and equipment.

PROMOTIONAL AND MOTIVATIONAL MEASURES FOR ADOPTION OF SMALL FAMILY NORMS

The following promotional and motivational measures will be undertaken:

1. Rewarding Panchayat and Zila Parishad for exemplary performance.
2. The ***"Balika Samridhi Yojna"*** run by department of Women and Child Development to promote survival and care of girl child, will continue. A cash incentive of ₹500 is awarded at birth of the girl child of birth order 1 or 2.
3. ***Maternity Benefit Scheme:*** Cash incentive of ₹500 to mothers who have their first child after 19 years of age for birth of first and second child only.
4. Family welfare health linked insurance plan for couples below poverty line.
5. Setting-up of revolving fund for income generating activities by village self-help groups.
6. Opening-up of crèches and child-care centres.
7. Enlarging the basket of contraceptives.
8. Facilities for safe abortion will be strengthened and expanded.
9. Strict Enforcement of Child Marriage Restraint Act, 1976.
10. Strict Enforcement of Prenatal Diagnostic Technique Act, 1994.
11. Soft loan to ensure mobility of ANMs.
12. Social marketing schemes for contraceptives.
13. Ambulance services to transport referral high-risk women to encourage village level organization by providing soft loans.

The vast number of people in India can be its greatest asset, if they are provided with means to lead healthy and economically productive lives. In the new millennium, nations are judged by the well-being of their people, by level of health, nutrition and education, by civil and political liberties. Success will be achieved, if the action plan contained in the NPP-2000 is pursued as a national movement.

NATIONAL POPULATION POLICY 2000 (ACTION PLAN)

Decentralization Planning and Programme Implementation and Convergence of Services at Village Level

2

Since 33% of elected Panchayat seats are reserved for woman, representative committees of Panchayats (headed by elected woman member should be formed to promote gender sensitive, multisectoral agenda for population stabilization, that will "think, plan and act locally, and support nationally").

1. By utilizing self-help groups to organize and provide basic services for reproductive and child health (RCH) with ongoing integrated child development services scheme (ICDS).

   Once a fortnight these *self-help acceptor groups* meet and provide at one place 6 different services for (i) registration of births, deaths, marriages and pregnancy; (ii) weighing of children under five years and recording the weight on standard growth chart; (iii) counselling and advocacy for contraception, plus free supply of contraceptives; (iv) preventive care with availability of basic medicines for common ailments: antipyretics for fevers, ORT/ORS for childhood diarrhoea together with standardised indigenous medicines; (v) nutrition supplements; and (vi) advocacy and encouragement for the continued enrolment of children in school up to age 14. One health staff appointed by Panchayat will be suitably trained to provide guidance.
2. Meaningful decentralization will result, only if the **convergence** of the national family welfare programme with the ICDS programme is strengthened. At village level, the Anganwadi centre may become the focal point for basic care activities, contraceptive counselling and supply, nutrition education and supplementation as well as preschool activities. The Anganwadi centre can also function as depot for ORS/basic medicines and contraceptives.
3. Establishment of maternity hut in each village for safe delivery. Panchayat may appoint competent and mature midwife.
4. Trained birth attendants as well as vast pool of traditional dais should be made familiar with emergency and referral procedures. This will greatly assist the ANMs.
5. Provide a wider basket of choices of contraception.

Empowering Women for Improved Health and Nutrition

- Cluster services for women and children at the same place.
- Open more child-care centres in rural areas and urban slums, i.e. establish Anganwadis or crèches where woman can leave her children in safe hands for care and development. This will encourage women to participate in development process.
- To empower women to pursue programme of social afforestation to facilitate easy access to firewood, fodder. Increased access to potable water. This will reduce long absence from home and need for a large number of children to perform such tasks.
- Promote energy saving devices, such as solar cookers, provision of sanitary latrines, or extension of telephone lines; this will empower woman and households.
- Strengthen the referral network between SC, PHC, CHC and district hospital in management of obstetric and neonatal complications to reduce maternal and infant mortality.
- Establish mechanism of maternal and perinatal death audit from village level upwards.
- Ensure adequate transportation from village level upwards of mothers having obstetrical complications.
- Improve the accessibility and quality of maternal and child health services—through deployment of community midwives and additional health providers at village level, training, improved supervision and provision of standard equipment and medicines and physical facilities.
- Monitoring of maternal and child health services at each level. ANM should be responsible for registering every pregnancy and childbirth in her area.
- Providing universal antenatal and postnatal services.
- Improve technical skills of maternal and child healthcare providers by on the job training to all category of workers and birth attendants.
- Improve information education and communication at community level.
- Universalization of ICDS and convergence of maternal and child health services.
- Include STD/RTI and HIV/AIDS prevention, screening, and management in maternal and child health services.
- Develop health package for adolescents.
- Expand the availability of safe-abortion services at PHC level and CHC level. District civil surgeon should be the authority to register abortion clinics. Provide MTP training to medical officers and include MTP in the curriculum of all categories of workers and doctors.
- Establishing first referral unit at subdistrict level and community health centre and make them functional.
- Ensure the efficient functioning of first referral units, i.e. 30-bedded hospital at block levels (CHC) to bring down maternal mortality and IMR. Augment availability of specialists in these units by increasing seats in medical institutions and acquiring postgraduate qualifications through National Board of Examination and open universities like IGNOU. As an incentive, seats will be reserved for those in-service medical graduates who are willing to abide by a bond to serve for 5 years at FRU after completion of PG course. State would sanction the posts of specialists at FRUs.
- Create national network of public–private and NGO centres identified by a common logo for delivering RCH services free to any client. The provider will be compensated for the service provided. The end user can choose the provider of service.

CHILD HEALTH AND SURVIVAL

- Essential neonatal care at community level and at PHC, CHC and hospitals.
- Set-up national technical committee on neonatal care to align programme and project interventions with newly emerging technologies in neonatal and perinatal care.
- Train health personnel for integrated management of childhood illnesses (IMCI).
- Pursue rigorously the Pulse Polio Campaign to eradicate polio.
- Ensure 100% coverage of routine immunizations in particular tetanus and measles.
- Promote delayed marriage of girls not earlier than 18 years and preferably after 20 years of age by compulsory education of girls and vocational training for girls.
- Reduction of maternal malnutrition, morbidity and mortality by ensuring availability of supplies equipment at village level and subcentre.
- Expand the ICDS to include children between 6 and 9 years of age to promote 100% of school enrolment particularly for girls.

MEETING THE UNMET NEEDS FOR FAMILY WELFARE SERVICES

- Unmet need for contraceptive which was estimated at 28% has declined to 9.4% in 2021.
- Establishing adequate number of subcentres, PHCs, CHCs as per norms to complete their deficiency, provide manpower, equipment, medicines and supplies (contraceptives, laparoscopes, tubal ring, vaccines and RCH drugs).
- Formulate and implement social marketing schemes.
- Improve facilities for referral transportation at Panchayat, Zila Parishad and PHCs. Increase mobility of ANMs to increase coverage.
- Encourage local level organization and NGO to start ambulance services for transportation of women needing emergency care.
- Opening up of chemist shops at village level through loan facility.

UNDERSERVED POPULATION GROUPS

Urban Slums

Finalize comprehensive *urban health* strategy. Facilitate service delivery centres in *urban slums* to provide comprehensive basic health, reproductive and child health services by NGOs and private sector including corporate sector.

- Promote network of retired government doctors, paramedicals and non-medical personnel who may function as healthcare providers on remunerative terms.
- Initiate specially targeted information education and communication activities in urban slums.
- Promote intersectoral coordination in urban slums to enhance services.
- Streamline the referral systems and linkages between primary, secondary and tertiary levels of healthcare in urban areas.

Tribal Communities, Hill Area Population and Displaced and Migrant Populations

NGO sector may be encouraged to organize system of preventive and curative healthcare in these areas. Promote indigenous system of medicine. Sensitization of providers to the needs of tribal areas.

Adolescents

Ensure for adolescent's access to information, counselling and services including reproductive health services. Strengthen PHCs and subcentres to provide counselling to adolescents on spacing and right age of marriage.

- Provide for adolescents the package of nutrition services available under ICDS programme.
- Enforce the Child Marriage Restraint Act, 1976 to reduce incidence of teenage marriages.
- Provide integrated intervention in pockets with unmet needs in the urban slums, remote rural areas, tribal area and border districts.

Increase Participation of Men in Planned Parenthood

- Currently over 99% sterilizations are tubectomies. Repopularize vasectomies in particular-no-scalpel vasectomy.
- Focus attention on men in the information and education campaign to promote small family norms.
- Continuing education and training at all levels to promote use of no-scalpel vasectomy. Include this in the syllabi.

DIVERSE HEALTHCARE PROVIDERS

Public–Private Partnership (PPP)

Involve private practitioners and assign satellite population of 5000 to provide RCH services and compensate them adequately for providing these services. One year contract at a time be given.

- Revival of licentiate of medical practitioners.
- Include RCH strategies into the curriculum of under-/postgraduates, nursing and paramedical professional courses, syllabi and curriculum.

Collaboration with and Commitment from Non-Government Sector

Collaboration with voluntary sector and NGO in clinical services, for motivation of village level self-help groups and social marketing will be encouraged.

Collaboration with and Commitment from Industry

Collaboration with industrial sector for strengthening of the management information system in seven most deficient states at PHCs and subcentre level by electronic data entry machines, to reduce the load on ANMs, in social marketing of RCH services, transportation, providing RCH services to their own employees, managing primary schools for children and outreach of basic reproductive and child care services.

Mainstreaming of Indian Systems of Medicine and Homeopathy

Providing orientation and training in respect of RCH programme for qualified doctors in Indian system

of medicine and utilize their services, institutions and their time-tested practices and medicines.

Contraceptive Technology and Research on RCH

2

Promote RCH research in consultation with Indian Council of Medical Research and the network of academic and research institutions. The International Institute of Population Sciences and the Population Research Centres will continue to review the programme and monitor the indicators of RCH services to provide feedback to the programme. Research areas would include contraceptive technology, CNAA approach, new models of neonatal care, convergence of services, public–private partnership, and newer technologies in vaccines.

Providing for Older Population

Sensitize, train and equip rural and urban health centres and hospitals towards providing geriatric healthcare. Encourage NGOs and voluntary organizations to make the elderly economically self-reliant. Tax benefits could be explored as an encouragement for children to look after their aged parents.

Information Education and Communication

Converge IEC efforts across the social sectors. Achieve coordination between family welfare and education sector to promote cause of literacy.

Involve all other departments like rural development, social welfare, transport, cooperative and education with special reference to schools to improve clarity and focus on the IEC efforts. Coverage and outreach of IEC activities can be extended by using elected leaders, opinion makers and religious leaders. Utilize radio and television as also indigenous media on the issues of small family norms. National communication strategies in RCH have been evolved and presented elsewhere.

Jansankhya Sthirata Kosh (JSK)

The objective of JSK is to facilitate the attainment of the goals of National Population Policy 2000 and support projects, schemes, initiatives and innovative ideas designed to help population stabilization both in the government and voluntary sector.[1] It can generate resources through government and voluntary sectors contributions (from individuals, industry, trade organizations and other legal entities) in furtherance of the national cause of population stabilization.

JSK has Undertaken a Number of Initiatives for Population Stabilization:

- *PRERNA strategy:* Aim is to delay the age of marriage of girls and space the births 3 years apart. Girls married after 19 years of age and giving birth to first child after at least 2 years of marriage are given incentive of ₹10000 to ₹12000. The scheme is meant for BPL families.
- *SANTUSHTI strategy:* Accredited private nursing home/hospital can sign a tripartite (state health society as first party, accredited private health facility as second party and JSK as third party) memorandum of understanding. Such hospitals and nursing homes are entitled for incentives for performing tubectomy and vasectomy operations.
- *JSK* has also set up National Helpline in India to provide reliable information on reproductive, and sexual health, contraception, pregnancy and child health issues.

Reference

1. Government of India. National Population Policy 2000 GOI MOH and FW New Delhi.

SOCIAL MARKETING PROGRAMME (SMP) IN HEALTH AND FAMILY WELFARE

The NPP 2000 stressed the need to formulate and implement Social Marketing schemes for advocating "Products and Services" through partnerships between the voluntary sector, non-governmental organization and the private corporate sector, Government, Panchayati Raj Institutions and the community. This will reduce the unmet needs of contraceptives and family welfare services.

What is Social Marketing?

Social marketing applies commercial marketing skills and technologies to the analysis, planning, execution and evaluation of programmes designed to influence the voluntary behaviour of target groups in order to improve their personal well-being and that of their society.[1]

Objectives

i. Objective of SMP is to increase the number of outlets of services or products, such as condoms, oral pills, ORS, MTP and Cu-T.
ii. To improve the quality of services and products.
iii. To involve or enhance partnership between government and private sector.
iv. To improve the access to services of family welfare.

Scope

SMP techniques are used to promote the products and services of family welfare.

Apart from this, the SMPs are also used to change the attitudes and behaviour in areas like smoking, use of seat belts, drug abuse, heart disease and other chronic diseases associated with lifestyles.

Approach

The SMP recognizes the 'Consumer' as 'king' of services and ensures consumer consultation about the product and services suiting to his/her need. It analyses the needs of consumers, their felt needs, likes and dislikes and satisfaction level. This early 'consumer consultation' is called feed-forward by Manoff. It attempts to define in what the consumer is interested, what do they think and what are their reactions about presentations of products or idea or service.

The viewpoint and concern of clients is ascertained through various techniques, such as focus group, discussions, interviews and surveys.

In conclusion, it is the *precise delivery* of *precise product* or *service*, *precise idea*, to *precise client* at the *precise time* of their *precise need*. This is social marketing's primary tactic, a focus on priority need, when, where and for whom it is essential. In SMP, primary *focus* is on the *consumer*—on learning what people want and need in terms of social behaviour and services.

In government service set-up, this approach is seldom stressed and this sector most of the time considers only providing services, ideas, products, *pushing these as directives*, seldom consults the consumer and works on a strategy to "take or leave it basis".

SOCIAL MARKETING AND INFORMATION, EDUCATION AND COMMUNICATION (IEC)

While IEC creates health seeking behaviour, social marketing facilitates the practice of such behaviour by promoting, distributing and selling socially beneficial tangible products, services, ideas at affordable cost to low income group people. Consumer can access these through wide range of private outlets.

Planning of Social Marketing Programme in India

Planning of SMP requires a consumer focus by addressing the different elements of the 'marketing mix', i.e. *the concept of product, its price, distribution place, its promotion, partnership involved and policy environment (six Ps)*.

Product

People must perceive the problem and need of contraception. The SMP analyses such needs and perception of clients and thereafter SMP for RCH provides a diverse range of products, such as condoms, oral pills, sanitary napkins for girls and services, medical termination of pregnancy and to promote best practices—breastfeeding, and oral rehydration therapy (ORT). The product under SMP is distinguished and bears a special label or logo.

Price

Price of product should be affordable by the poor both in rural and urban settings.

Place

Place of selling or outlets of products must be identified and known to people. It could be through *Mahila Swasthya Sangh* in RCH or through women's organization or through grocery shops or a pharmacy or chemist.

Promotion

Promotion of sale of product is through mass-media–advertisement, publicity and interpersonal communication. The focus is to create sustained demand.

Partnership Involved

The partnership in SMP under RCH is essential as no single agency in a diverse country like India can provide or make impact. Key partnership between private sector, NGOs and government is essential.

Policy Environments

The government policy must encourage and support the SMP to sustain the practice or behaviour initiated by SMP.

Achievements of SMP in India[1, 2]

1. The social marketing of condoms increased from 16 million pieces in 1968–69 to 507.46 million pieces in 2019–20. Condoms marketed under SMP represent one-third of the total condoms distributed in India.
2. The social marketing of oral contraceptive pills (OCP) increased from 7.24 lakh cycles in 1987–88 to 147.10 lakh cycles in 2019–20, i.e. one-third of the total oral contraceptives distributed annually in India through social marketing.
3. Since the introduction of the SMP in 1968, for condom promotion and that for oral pills in

1987, awareness regarding condoms and oral contraceptive pill has substantially increased, and is reflected in declining total fertility rates and increased contraceptive prevalence rates from 10.4% in 1951 to 66.7% in the year 2019–21.

4. SMP has helped to change the choices and options within each product [condom and the oral contraceptive pills (OCP)], for the consumer.
5. Social marketing pilot project in rural India: In Madhya Pradesh, a trust of Hindustan Latex Limited, and in Uttar Pradesh, by the State Innovation in Family Planning Services Agency (SIFPSA) have been successful in demonstrating the feasibility of social marketing in rural area. A lot of fields are open in rural area for SMP.
6. The brand name "NIRODH" (GOI-owned brand) also distributed through social marketing, has become a generic name for condom in India.
7. National Aids Control Programme is promoting use of condoms through SMP.

National Strategies of SMP in India[1]

- Maximal use of public health infrastructure in rural and urban areas. As till now SMP largely confined to urban areas—make use of subcentres, PHCs, CHCs and Indian system of medicine as outlets for SMP.
- Expand the basket of products—add diverse brands of condoms, low dose oral pills because usage of contraceptive in India has been quite low; this step may increase usage of spacing methods.
- Enhance partnership between private, NGO and government for SMP products.
- ***Introduce services:*** Social franchises: In India private sector provides higher profit curative services only. Motivate this sector to support national health goals and provide preventive services to weaker sections at affordable cost.
- Promote information, education and communication for SMP. The overall thrust of SMP is to accelerate achievement of sociodemographic goals of National Population Policy (NPP) 2000.

Under the social marketing programme, both condoms and oral pills are made available to people at highly subsidized rates, through diverse outlets. The social marketing organizations are given Deluxe NIRODH condom at ₹5 per packet of 5 pieces. One cycle of oral pills is given to social marketing organization at ₹5 for MALA–D.

References

1. Government of India. National Strategy for Social Marketing. Department of Family Welfare. MOH and FW Government of India. Draft 5th March 2001.
2. GOI MOH and FP Annual report 2019–20.

REVISED NATIONAL HEALTH POLICY (NHP) 2002

The policy means statement of intentions. First National Health Policy (NHP) was formulated in 1983. The broad objectives of 1983 policy were to provide "Health for All" by the year 2000 AD, through "Universal Primary Healthcare". Attempt was made to restructure and reorganize the healthcare infrastructure to universalize primary healthcare. It was intended:

- To provide at least one trained birth attendant and one health guide (health volunteer) at village level or per 1000 population.
- One subcentre for 5000 population in plain areas and 3000 in tribal/hilly/difficult areas with one multipurpose health worker female and one MPHW male.
- To set-up one PHC for 30,000 population in plain area and 20,000 in tribal area with 4–6 beds manned by medical officer.
- One community health centre for 1,00,000–1,20,000 population in plain area and 80,000 population in tribal area with 30 beds to be manned by health specialists.
- Establishment of well-worked out referral system.
- Setting-up of speciality and superspeciality services.

There were significant achievements through the years but much remain to be done.

The morbidity and mortality levels in the country were still unacceptably high. The incidence of malaria stabilized at high level in 1990s. Over the years increasing levels of insecticide resistance have developed in the malaria vectors in many parts of the country, while the incidence of the more deadly *P. falciparum* malaria has risen to about 50% in the country as a whole. In respect of TB, the public health scenario has not shown any significant decline in the pool of infection in the community and there has been increasing trend of drug resistance in tuberculosis. A new and extremely virulent communicable disease—HIV/AIDS has emerged on the health scene since the declaration of NHP 1983. The common water-borne infections—gastroenteritis, cholera and

hepatitis continue to contribute a high level of morbidity in the population.

'The lifestyle diseases'—diabetes, cancer and cardiovascular diseases burden has increased since 1983. The increase in life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem and micronutrient deficiency diseases are persisting at high level. In view of these developments after 1983 and many other developments, Health Policy was revised and NHP 2002 formulated.

Under the constitutional structure, health is the responsibility of the states. Principal contribution for the funding of public health services will be from the resources of the state. Financial condition of the state is very poor.

Under the 2002 policy, it was planned to increase health sector expenditure to 6% of GDP, with 2% of GDP being contributed as public health investment by the year 2010 and beyond. The state government would also need to increase the commitment to the health sector. In the first phase, by 2005, the state would be expected to increase the commitment of their resources to 7% of their budget and in the second phase by 2010 to increase it to 8% of the budget. With the stepping up of the public health investment, the Central Government's contribution would rise to 25% from the existing 15% by 2010.

FUNDAMENTAL DETERMINANTS WHICH IMPACT ON GOALS OF HEALTH POLICY

Financial Resources

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 increase the sectoral outlay in the primary health sector. Such outlets afford access to vast number of individuals, and also facilitate preventive and early stage curative initiative, which are cost-effective. NHP 2002 sets out increased allocation of 55% of total public health investment for the primary healthcare sector, followed by 25% for secondary and 10% for tertiary health sector.

SPENDING ON HEALTHCARE

Despite years of strong economic growth in India, the total spending on healthcare in 2013–14 was about 4% of GDP. Global evidence on health spending shows that unless a country spends at least 5–6% of its GDP on health, and the major part of it is from government expenditure, basic healthcare needs are seldom met. The government spending on healthcare in India is only 1.15% of GDP, i.e. <30% of total health spending. Perhaps the single most important policy pronouncement of the National Health Policy 2002 articulated in the 10th, 11th and 12th five year plans and the NRHM framework was the decision to increase public health expenditure to 2–3% of GDP. Public health expenditure rose briskly in the initial years of the NRHM, but at the peak of its performance it started stagnating at about 1.04% of GDP. The failure to attain minimum levels of public health expenditure remains the **single most important constraint.** While it is important to recognize the growth and potential of rapidly expanding private sector, international experience shows that health outcomes and financial protection are closely related to absolute and relative levels of public health expenditure (Table 2.1). Brazil, Thailand and Sri Lanka have achieved close to universal health coverage. Thailand has almost the same total health expenditure as India but its proportion of Public Health Spending is 77.7% of total expenditure, and this is spent through a form of strategic purchasing in which about 95% is purchased from Public Healthcare facilities which is what gives it such a high efficiency. Brazil spends 9% of its GDP on health but of this public health expenditure constitute 4.1% of the GDP (45% of total health expenditure). It would be ambitious if India could aspire to public health expenditure of 4% of the GDP but national health policy of 2017 commits 2.5% of GDP on health as public health expenditure.

At such level of expenditure, "purchasing" has to be mainly from public providers for efficient use of health resource with purchasing from private providers only for supplementation.

Table 2.1: Government health spending on health in different countries

Country	*Total health exp. as % of GDP 2011*	*Government health exp as % of total health exp. 2011*	*Life expectancy 2011*
India	4.0	28.6%	68
Thailand	4.1	77.7%	75
Sri Lanka	3.3	42.1%	75
Brazil	8.9	45.7%	74
USA	17.7	47.8%	79
UK	9.4	82.8%	81
Russia	6.1	59.8%	69

2

Role of States

Decentralization

Under constitutional provisions, 'States' have the primary responsibility to provide healthcare to its people. However, the healthcare delivery system in many states remains largely centralized at the departmental level in spite of the strong and effective presence of institutions of local self-government at village, block and district levels. *Decentralized management* of health institutions especially those at the primary level through Panchayati Raj Institutions (PRIs) is strongly advocated in NHP 2002. Flow of central funds to states for public health programmes should be effectively linked to performance of the states in the area of decentralization of programme management to the PRIs.

Decentralization of programme management should also be reinforced by convergence of all vertical public health programmes at the district level and below. This would avoid duplication of efforts in areas like IEC, training, supervision, etc.

NATIONAL HEALTH POLICY 2017

The National Health Policy of 1983 and the National Health Policy of 2002 have served well in guiding the approach for health sector in five-year plans. Now 15 years after the last health policy, the situation has changed in five major ways. First, the health priorities are changing. There is growing burden of non-communicable diseases and some infectious diseases. The second important change is the emergence of a robust healthcare industry. The third change is growing incidence of catastrophic health expenditure due to healthcare costs, leading to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Fifth important change is Sustainable Development Goals set by United Nations. Therefore, new health policy responsive to these contextual changes is required. NHP 2017 builds on the progress made since the last NHP of 2002 and 1983. A policy is as good as its implementation. Health is a state responsibility. States are to play key role in implementation of the stated health policy.

1. National Health Policy 2017—Goal and Objectives

Goals

The attainment of the highest possible level of "Health and well-being for all at all ages" and achieve "Sustainable Development Goals" of United Nations by 2030.

Objectives

- Progressively achieve **Universal Health Coverage**
  a. Assuring availability of free comprehensive primary healthcare services, for all aspects of reproductive, maternal, child and adolescent health and for most prevalent communicable and non-communicable diseases and occupational diseases in population.
  b. Improved access to affordable, quality secondary and tertiary healthcare through combination of public and private providers.
  c. To achieve reduction in out of pocket expenditure and catastrophic health expenditure.
- Reinforcing trust in public healthcare system.
- Align the growth of private care sector with public health goals.

2. National Health Policy (NHP) 2017—Specific Objectives

The specific objectives of NHP are in line with Sustainable Development Goals of UNs.

A. Health Status and Programme Impact by 2025

- Increase life expectancy at birth from 67.5 to 70 years.
- Reduction of total fertility rate to 2.1.
- Reduce under five mortality rate to 23.
- Reduce MMR from current level to 100.
- Reduce infant mortality rate to 28.
- Reduce neonatal mortality rate to 16 and "stillbirth rate to single digit".

Reduction of Disease Burden (Prevalence and Incidence)

- HIV—achieve global target of 90 : 90 : 90.
- Achieve and maintain elimination of leprosy, kala-azar and lymphatic filariasis by 2017 and 2018.
- TB: Achieve cure rate of over 85% in new sputum positive patients, reduce incidence and reach elimination by 2025.
- To reduce prevalence of blindness to 0.3%.
- To reduce premature mortality from cardio-vascular diseases, cancer, diabetes and chronic respiratory diseases, by 25%.

B. Health Systems Performance

- Increase utilization of public health facilities by 50% from current levels of 30%.
- Achieve antenatal care coverage above 90%.

- Skilled attendance at birth above 90%.
- Coverage of fully immunized infants above 90%.
- Meet family planning needs above 90%.
- 80% of known hypertensives and diabetics at household level maintain controlled disease status.

Health-Related Cross-Sectoral Goals

- Reduce prevalence of tobacco use by 15% by 2020 and 30% by 2025.
- Reduce prevalence of stunting by 40% in under-five children.
- Access to safe water and sanitation to all by 2020.
- Reduction of occupational injuries by half from current levels of 334 per lakh.

C. Health System Strengthening—Health Finances

- Increase health expenditure by government as percentage of GDP from existing 1.15 to 2.5% by 2025.
- Decrease in proportion of households facing catastrophic health expenditure from the current levels by 25% by 2025.
- Increase state health sector spending to >8% of their budget.

D. Health Infrastructure and Human Resources

Paramedicals and doctors as per IPHS or national norms in priority districts.

E. Health Management Information System

Ensure district level electronic database and strengthen surveillance system.

3. Policy Thrust Areas

Raising public health expenditure to 2.5% of GDP in time bound manner.

Preventive and Promotive Health

"Health in all" as complement to "Health for All" the policy identifies **seven** priority areas to address social **determinants** of **health** through intersectoral coordination.

Seven Priority Areas

1. The Swachh Bharat Abhiyan (reduction of water, excreta and vector-borne diseases).
2. Balanced healthy diets and regular exercises.
3. Addressing tobacco, alcohol and substance abuse.
4. *Yatri Suraksha*: Preventing deaths due to rail, road traffic accidents.
5. *Nirbhay Nari*: Action against gender violence.
6. Reduced stress and improved safety at workplace.
7. Reduce indoor and outdoor air pollution.

Organization of Public Healthcare Delivery

The policy proposes seven **key policy shifts** in organizing healthcare services:

i. In primary healthcare—from selective care to assured **comprehensive primary healthcare** with linkages to referral hospitals for continuity of services.
ii. In secondary and tertiary care—from an **input-oriented** budget line financing to an **output-based** strategic purchasing from public/private hospitals.
iii. In public hospitals—from **user fees** and **cost recovery** to **assured free drugs, diagnostic** and **emergency services** to all.
iv. In infrastructure and human resource development—from **normative approach** to **targeted approach** to reach underserved areas.
v. In Urban Health—from **token interventions** to on-scale **assured interventions,** to organize primary healthcare delivery and referral support for urban poor. Collaboration with other sectors to address wider determinants of urban health is advocated.
vi. In national health programmes—**Integration with health systems** for programme effectiveness and in turn contributions to strengthening of health systems for efficiency.
vii. In AYUSH services—from **stand-alone to** a three-dimensional **mainstreaming** (co-location of AYUSH, availability of standard medicines and protocols and YOGA).

Strategies of Care

a. Free primary healthcare provision by **public sector**.
b. **Strategic purchase** of secondary care, hospitalization and tertiary care services from both public and from non-government sector to fill critical gap would be the **main strategy**.
c. Mainstreaming of different health systems (AYUSH).

Spectrum of Services

a. ***Free primary care services and continuity of care***

- Upgradation of existing subcentres and reorientation of PHCs to "Health and Wellness Centers" to provide package of comprehensive preventive, promotive, curative and rehabilitative services.
- Linking every family/household to primary healthcare facility package anywhere in the country (healthcare to every family).

- Two-way systemic linkages between primary, secondary and tertiary services to ensure continuity of care.
- *Screening*: Early detection and response to early childhood development delays and disability.
- Adolescent and sexual health education.
- Behaviour change with respect to tobacco, alcohol and drugs and physical inactivity.
- Counselling for primary prevention and secondary prevention for common chronic illness—both communicable and non-communicable diseases.
- School health, occupational health, tribal health to cover 100 million tribal population, urban health, and control of zoonotic diseases.

b. Secondary care services

- To provide most of the secondary care at district and sub-district level hospitals.
- Two beds per thousand population distributed in such a way that it is accessible within golden hour rule, by having efficient emergency transport system. Ten categories of specialist services/skills be available at district and 4–5 at sub-district hospital level.
- *Reorienting public hospital*: Public hospitals would provide universal access to progressively wide array of free drugs, diagnostics and emergency services of high quality.
- *Closing infrastructure and human resources/skill gaps*: The policy follows road map of 12th five year plan for managing human resources for health as per Indian Public Health Standards/National norms.
- *Urban healthcare*: Establish urban health centres, urban community health centres for urban poor/slum areas for comprehensive urban primary health services. Give primacy to local bodies.

4. NATIONAL HEALTH PROGRAMMES (NHPs)

- **Example:** RMNCH+A, communicable and non-communicable diseases, mental health, trauma centres and occupational health. Integration of NHPs with health systems for effectiveness and in turn strengthening of health systems for efficiency.
- *Population stabilization*: Improve static services for family planning and **increase men participation** from <1% currently to 30% (sterilizations).

5–6. Women's Health and Gender Mainstreaming

Enhanced provision for reproductive morbidities and health needs of women beyond reproductive age group (40+), orientation of staff to gender sensitive and women friendly services and provide free services with dignity to victims of gender violence.

7. Supportive Supervision

Supporting innovative measures of supportive supervision in more vulnerable districts.

8. Emergency Care and Disaster Preparedness

Better response to disasters both manmade and natural. Life support ambulances and trauma management centres one for 30 lakh in urban and one for 10 lakh in rural areas.

9. Mainstreaming Potentials of AYUSH

Bridge courses for AYUSH doctors to prepare workforce of mid-level care providers at the level of subcentre.

10. Tertiary Healthcare Services

The policy affirms that tertiary care services are best organized along line of regional, zonal and apex referral centres. Government should set up new medical colleges, nursing institutions and AIIMS like institutions. Purchase select tertiary healthcare services from non-government sector hospitals to assist the poor.

11. Human Resources in Health

- Medical and paramedical education be integrated with the service delivery system so that students learn in the real environment and not just in confines of medical schools.
- Medical education—strengthening existing medical colleges and converting district hospitals to new medical colleges to increase number of doctors and specialists.
- Revision of curriculum of UGs and PGs.
- Develop a cadre of mid-level service providers.
- Nursing education—improve regulations.
- Paramedical skills—training courses and curriculum for super speciality paramedical care.
- Public health management cadre—creation of public health management cadre in all states.
- Human resource governance and leadership: Human resource management and continuing medical and nursing education and policies on recruitment, selection, promotion, posting, and transfer and leadership skills for good governance.

12. Financing of Health Services

- Allocation of major proportion of up to 67% or more of resources to primary healthcare followed

by secondary and tertiary care. Public health account in health has been set up.
- Strategic purchasing of secondary and tertiary healthcare to fill the critical gaps in services.

13. Collaboration with Non-Government Sector/Engagement with Private Sector

The policy advocates positive and proactive engagement with private sector for critical gap filling, towards achieving national public health goals.

Areas: Outsourcing of training of teachers, as corporate social responsibility (CSR), primary healthcare services, engaging private hospital for skill development in collaboration with national council for skill development, mental healthcare programme, disaster management, strategic purchasing of secondary and tertiary care from private sector, diagnostic services, ambulance services, referral services, immunizations, disease surveillance and notification, and various national health programmes and other areas like health information system and outsourcing of diagnostic and tertiary care, etc. Private sector should be supported for skill upgradation and rational drug use and use of standard treatment protocols as also "Make in India".

14. Regulatory Framework

Regulation of professional education—six professional councils, clinical establishments, food safety, drug regulation, medical devices, vaccines safety, medical technology, etc.

15. Essential Drugs and Diagnostics

Promoting generic drugs and technologies besides well-developed procurement system of drugs.

16. Health Research

Increase investment in health research in the areas of health system and services research, medical product innovation, fundamental research, translational research, etc.

17. Governance

Role of centre and state governments and their accountability; directorates to be strengthened by HR (human resources) policies, those from public health management cadre must hold senior positions in public health. Involve PRIs and local bodies, encourage community monitoring system.

18. Implementation Framework

Put in place the implementation framework. A policy is only as good as its implementation.

Reference

1. Ministry of Health and Family Welfare National Health Policy 2017 GOI, New Delhi.

2

HEALTH SECTOR REFORMS IN POLICY AND STRATEGIES THROUGH RCH AND NATIONAL HEALTH MISSION

MOVING TO A REPRODUCTIVE AND CHILD HEALTH APPROACH

In the year 1994, landmark International Conference on Population and Development (ICPD) was held at Cairo where 180 countries of the world participated and recommended that the spectrum of FWP services be enlarged, to cover total reproduction period and this conference recommended the strategy of "reproductive and child health". India launched reproductive and child health (RCH) programme in the year 1996 to carry forward the process of integration of services. **RCH means integration** of **CSSM + family planning + prevention and treatment** of **reproductive tract infections including sexually transmitted infections, HIV/AIDS +** adolescent **health.** Phase I of RCH was launched in 1997 and then came the National Population Policy in 2000.

Revised National Health Policy was adopted in the year 2002. In the year 2005, phase II of reproductive and child health was launched to achieve the stated goals of 10th plan, Millennium Development Goals (MDGs), goals of National Health Policy of 2002. Revised MDGs-2008 included "universal access to reproductive health by 2015".[1–3]

Based on the assessment of status of implementation of the programme of action of ICPD the framework of actions for the follow up programme of ICPD beyond 2014, it highlights to further strengthen health systems to provide universal access to sexual and reproductive health and rights and understanding of the implications of population dynamics as critical foundations for sustainable development goals (SDGs).

Paradigm Shift

The Government of India made historical reform in family planning (FP) programme and thereby

2

continued the process of reforms in health sector. It was a *turning point* in FP programme. The major policy shift was announced in 1996 (Table 2.2). The salient features of historical landmark shift in policy were:

1. **Target free approach:** Doing away targets allocation for family planning by the Central Government/ State Government.
2. **Decentralization of planning, training and funding** Delegation of responsibilities to local bodies (Panchayats and Nagarpalikas) and delegation of authority and funds to local bodies. It was reversal of 'top down' to 'bottom up' approach (Fig. 2.1).
3. **Community needs based planning:** Community needs assessment approach (CNAA): Community

Table 2.2: Paradigm shift

Family welfare approach	*RCH approach*
• Top down approach	• Bottom up approach (community needs assessment approach)
• Target and technology driven	• Human and social development centred
• Centralized planning	• Need-based decentralized and participatory planning—act locally and support nationally
• Promoted contraceptive specific method (mainly sterilization)	• Helps clients to help themselves to space or limit the number of children
• Method centred	• Consumer or client centred
• Quantity centred to inflate targets and to achieve numbers and targets	• Quality centred to improve client satisfaction by providing quality services
• Single objective to reduce fertility as quickly as possible	• Concern for quality of life
• Focus on targets	• Focus on unmet needs and demands
• Focussed on contraceptives and limited range of maternal and child health services	• Focused on "life cycle approach" and full range of reproductive and child health services
• Gender insensitive	• Gender sensitive to promote men's participation in contraception
• Accountability to the bureaucracy	• Accountability to clients, community and workers

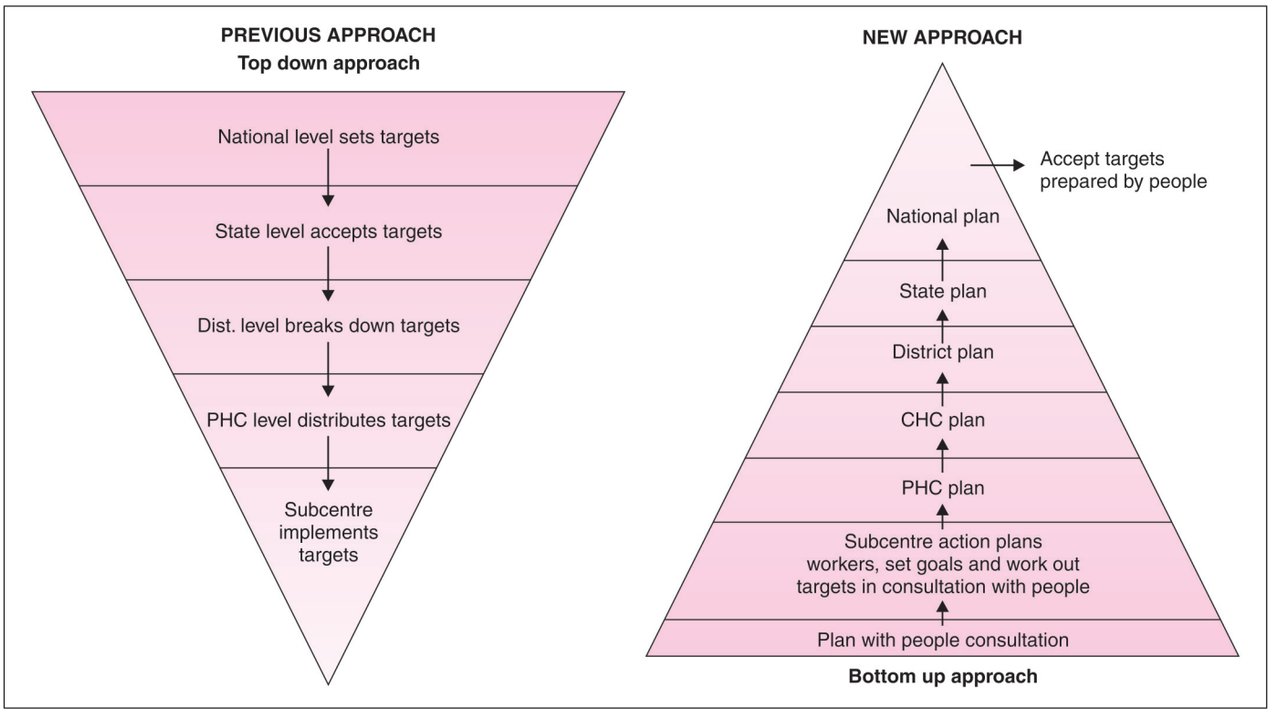

Fig. 2.1: Paradigm shift in policy

consultation or consultation of people or clients by health workers to ascertain their needs and work out targets themselves at local level.

4. **Improved quality** of clinical services and **coverage**.
5. **Sustainability** of infrastructure and work-force to provide benefits for the present as well as future.
6. **More efficient financial management** especially ways of linking funding to performance, i.e. perform an activity or achieve work completion or benchmarks and get money or funds.
7. **Client satisfaction**, i.e. focus on consumer or client.
8. **Full range of maternal and child** health services including RTIs/STIs and HIV/AIDS and adolescent health by 'life cycle approach'.
9. **Listening** to client and accountability to clients. Helping them to achieve small family norms themselves.
10. Family planning performance in district was not to be used to rank or assess the administration.

Essentially, the *paradigm shift* means need-based, client centered, demand-driven quality services, planning with consultation of people, local planning and funds available with the people or at the lowest level (district, block, PHC and subcentres) for immediate action. It is planning with the people, by the people and for the people. *Coverage*, *quality* of services and *client satisfaction* are the hallmark of such a shift. *Spectrum* of services has been enlarged and access to services increased.

Programme Interventions

The RCH programme has been implemented based on differential approach as it has been realized that a 'one size fits all' may not suffice. Inputs in all the districts have not been kept uniform because efficient delivery will depend on the capacity of the health system in the district. Therefore, basic facilities are strengthened and streamlined specially in the *weaker districts* as the better-off districts already have such facilities and the more sophisticated facilities are proposed for the relatively advanced districts which have acquired the capability to make use of them effectively. All the districts have been categorised into categories A (58), B (184) and C (265), on the basis of **crude birth rate** and **female literacy rate** which reasonably reflect the RCH status of the district. The districts have been covered in a phased manner over three years.

COMPONENTS OF REPRODUCTIVE AND CHILD HEALTH PROGRAMME

Components of RCH programme:

1. Community needs assessment approach (CNAA) and decentralized participatory planning (DPP).
2. Integrated package of services for mother and child
3. MTP services at PHC and safe abortion
4. Control and prevention of RTI/STI
5. Adolescent health
6. Services in urban slums and tribal areas
7. Improving quality of services
8. Unmet needs and family planning
9. Communication strategy in RCH
10. Gender sensitiveness
11. Greater involvement of Panchayati Raj institutions, non-governmental organizations and community
12. Civil works, Dai training and RCH camps.

COMMUNITY NEEDS ASSESSMENT APPROACH (CNAA) OR TARGET FREE APPROACH

Target free approach has been renamed "Community needs assessment approach". In this approach, under RCH programme, the health workers work out the targets for themselves by a process of consultation with clients and community in their respective areas. Health workers plan the services at village level every year and submit subcentre action plans to respective primary health centre. The aggregation of village plans lead onto subcentres action plan, aggregation of subcentres action plans constitute "Primary health centre plan" and aggregation of PHCs plans lead onto CHCs plan and district action plan is an aggregate of all CHCs plans. These plans will help to work out the requirements of all materials and supplies physical facilities and manpower for the population to be served at each level.

Subcentre action plans are vital as the process of CNAA begins at the level of village and subcentre. This is decentralized participatory planning (DPP). In fact now Village Health Sanitation and Nutrition Committee initiates Village Health Plan, with the help of ASHA, ANM and MO of PHC.

How the Needs of RCH are Assessed by Workers?

Generally, the health needs are assessed on the basis of epidemiological information, such as contraceptive prevalence rates/acceptance levels, number of births, number of eligible couples and their status of acceptance of contraceptive services, number of pregnant

women, lactating mothers and children below five years of age apart from disease burden. These events need to be continuously updated by *surveillance mechanism*. Health workers must ensure registration of all marriages, pregnancies, births and eligible couples on continuous basis in the assigned area. It is most desirable that the registration of pregnancy, births and deaths should be 100% and the total area population must be covered. Needs are also determined by utilization of services by the clients, as also from the past year performance.

Health workers assess the needs of pregnant women, infant and young children, nursing mothers and eligible couples by way of regular contacting and identification of these beneficiaries, registration of beneficiaries and their continuous updating by home visits, periodic surveys, as and when they get an opportunity to contact these beneficiaries during outreach session and subcentre clinic or at Anganwadi centre. Needs of each and every family are assessed by the health workers by **household survey**.

Community needs: The prime needs of community are, safe water, safe excreta disposal, waste water disposal, garbage disposal, all weather roads, health facility, schools, and veterinary services.

Health needs are felt by people and expressed in the form of demands. The people demand hospitals, health centres, doctors, drugs, and other facilities. The felt needs must be met, through adequate and quality services. The best compromise is to start where the felt needs and real needs overlap.

Generally, the **priority** demands with the people are roads, electricity, water, schools, veterinary services for cattle and hospitals/**health** services **come last of all.**

Preparation of Subcentre Action Plan—Decentralized Participatory Planning (DPP)

People first: *Planning* of services actually begins at grassroot levels in consultation with households, families and village Panchayat, *Mahila Swasthya Sangh* (MSS), school teachers, village birth attendant, Anganwadi workers and registered practitioners.

The first step in the process is to work out the service *needs* or *requirements* on the basis of information as elaborated above.

The *needs* or *requirements* of maternal and child health, family planning and services for CCDs and NCDs can be ascertained by:

i. Preparing **household records** of all families in the area by annual surveys on household register. The **household surveys** are conducted once in a year in the month of February or March.

ii. From the household surveys, the health workers work out the total population, eligible couples, pregnant women, infants and young children, and target population (30–65) years for NCDs services/screening. One time survey is not enough as marriages, pregnancy and births, disease and death events go on occurring in the population or area and these events needs to be continuously recognized and registered (*surveillance*) by the health teams working at the level of village and subcentre.

The subcentre action plan is most important document and has sound epidemiological basis of planning work, determining the workload, work schedule, coverage of services, reporting of services, monitoring of services, self-evaluation of performance and improvement of work.

Subcentre may have 4–10 villages under its jurisdiction, all events are to be registered and recorded **village-wise** to determine the number of clients who need our services. Knowing only the number of clients is not enough. It must be known where they are? In which household they are? Who are the young couples? How many eligibles couples belong to weaker section? Hence contacting clients in their *homes/household on regular basis* to meet their needs is an essential step. Home visits on regular basis to locate clients and contacting them for varied MCH services forms the basis of action plan at subcentre. Action plan should ensure contact with all clients with *fixed schedule* on *regular basis*. One such practical method evolved over the time is 'home visits' to cover the entire area in 3–4 months time.

The second method to contact the clients is through 'outreach session' on immunization. Yet, another method of contact is receiving clients at *subcentre clinic* or meeting clients at Anganwadi centre or meeting them during intensive campaigns or on Village Health Sanitation, and Nutrition Day. Sustained contacts on regular basis are essential to know the clients and their needs to meet their needs and to develop confidence and their satisfaction.

iii. Through these methods (*survey, surveillance* and *regular contacts*), workers are able to develop annual subcentre action plan and project the number of clients to be provided services during the year.

iv. The workers themselves give or allot targets to themselves for immunizations, *family planning* and *maternal and child health*. Every month, they report the coverage and performance.

v. Since the task of preparing of subcentre action plan by workers themselves is a new beginning, it is a challenging work for health workers and medical officers, who are not used to such things. All along and throughout their life they have worked on the basis of what is told to them or whatever targets come and plan comes from above or higher levels. They have developed a culture to obey and do whatever comes from higher level. This is a new beginning to plan for themselves and use the *science of epidemiology* at local level to evolve a sensible action plan.

vi. Developing functional linkages with ICDS system (Anganwadi workers) helps to assess the community needs as also validate the subcentre action plans. Developing linkages with traditional birth attendants, ASHAs and village Panchayats (village Chowkidar) helps to register events timely for appropriate actions. Health workers would prepare better action plans, if they work with and work through Anganwadi workers and ICDS system, which is now universal in India. Having joint home visits, joint surveys and joint reports, integrated work schedule means better action plan and better work and better quality of services for mother and child.

vii. Since, this is a new culture, the medical officers, health supervisors and health workers have temptations to work out the magic figures of clients by application of formulae to assumed population, which should be avoided and discouraged, workers should use their own data.

Adequate training and retraining of medical officers and health team on "Community needs assessment approach" is essential.

District training teams need to be oriented well. Subcentre action plans have not taken off well in the RCH phase I, hopefully these are put to operation in the phase II of RCH. Decentralized action plans at the subcentre level are vital and all efforts must be made to revitalize these. The concept of subcentre action plan should be included in the basic curriculum of multipurpose health workers (female and male) as also in the curriculum of under-graduates. Village health sanitation and nutrition committee under NRHM will initiate village health plan for each village and aggregation of village plans will lead to subcentre, PHC and block plan. The block plans would eventually converge into district action plans (DAP) which would thereafter converge into State plans.

NEW AREAS/COMPONENTS AND STRATEGIES IN RCH II

Differential approach is adopted for implementation of RCH II programme in EAG states based on the level of infant mortality rate, and institutional deliveries. Strengthening of the health systems will be the focus to close the gaps. Newer interventions/ strategies under RCH-II were as under:

Strategies/New Interventions

i. Integrated management of neonatal and childhood illness (IMNCI) introduction in phased manner.

ii. Adolescent reproductive and sexual health initiative for adolescent friendly health services and counselling during routine subcentre clinics and once a week clinic at PHC/CHC on fixed day.

iii. Strengthening of social marketing of contraceptives in rural areas, through rural health practitioners and community mobilization through satisfied acceptor couples.

iv. Urban RCH: Provision of quality integrated primary healthcare services to urban poor by establishing urban health centre—1:100,000 population.

v. Tribal RCH will be given primacy.

vi. Establishing newborn care corner in phased manner in the existing FRUs/CHCs/PHCs/ subcentres and priority will be given to Empowered Action Group States.

vii. Hospital generated waste management/infection management and environment protection.

viii. Incorporation of new areas (adolescent health, urban primary healthcare infrastructure, tribal health, adverse sex ratio in different states, PNDT Act) in the matrix of priorities for *behaviour change communication* (BCC) strategy.

ix. Revamping of training in RCH at various levels especially training under newer areas incorporated under RCH II.[4, 5]

IMPROVING QUALITY OF SERVICES IN RCH

Provision of good quality care is the crux of RCH progrmme. Quality has not been given adequate attention in family welfare programme. This is one of the reason that why people have not availed family welfare services to the desired extent. Good quality

of care ensures satisfied clients, who in turn come back for services if they are satisfied (Table 2.3).

What is quality of care: Quality care means care as per specific standard or norm or quality of care is what we want for ourselves and our family. The manner in which the client is treated determines quality of care. The following factors determine the good quality care:

2

i. *Access to services:* Physical access near to home, economic access means affordability and social access means acceptability of service.

ii. *Service delivery:* Promoting informed choice. Let the client choose the service after adequate information and knowledge. Need-based service delivery and providing follow-up care improves quality.

iii. *Interpersonal communication:* Listening to client is essential and spending time with client is essential, friendly and cooperative attitude of health workers and consultants, caring for clients privacy and dignity enhances quality of care.

Table 2.3: Recommended management interventions to strengthen the family welfare programme and improving the quality and client satisfaction

Interventions	*Can it be done?*	*Is it low cast?*
Improve access to services		
Make work routines more efficient		
Review and revise tour programmes	Yes	Yes
Develop systems for prioritizing clients	Yes	Yes
Cut time and recording and reporting	Yes	Yes
Give auxiliary nurse-midwives more help from other workers		
Expand the community link worker scheme	Yes	Yes
Increase the contribution of male multipurpose workers	Yes	Fairly
Make sure workers are resident		
Discipline or terminate nonresident staff	Yes	Yes
Convert badly located subcenters into clinics	Yes	Yes
Make sure workers are mobile		
Suply a jeep for every community and primary health center	Yes	No
Raise petroleum, oil, and lubricant allowances	Yes	No
Supply bicycles or mopeds for auxilary nurse midwives with large service areas make sure transport allowances are paid	Yes	No
Hire more female workers		
Hire more auxiliary nurse midwives for large service areas	Yes	No
Contract key primary health center services to female private sector doctors	Yes	No
Respond to client needs		
Listen to clients' needs (two-way information, education, communication)	Yes	Yes
Develop district plans that meet local needs	Yes	Yes
Capitalize on opportunities of Panchayati Raj	Yes	Yes
Launch in information, education, communication campaign on the concept and importance of reproductive health	Yes	Yes
Supply matching grants for reproductive health initiatives	Yes	Fairly
Form partnerships to produce joint district plans	Yes	Yes
Define ways Panchayats can help to improve programme quality	Yes	Yes
Support the frontline workers		
Broaden the range of performance measures in the management information system	Yes	Yes
Improve the quality of inservice and preservice training		
Improve the skills of trainers	Yes	Yes
Improve training in work planning and interpersonal information, education, and communication	Yes	Yes
Improve training in clinical skills	Yes	No
Redesign the content of inservice training	Yes	Yes
redesign the focus of supervision to on-the-job training	Yes	Yes
Improve the referral system		
Train field staff in recognizing referral needs	Yes	Yes
Strengthen the network of first referral units	Yes	No
Strengthen the network of primary health centres	Yes	No

iv. Technical factors: Technical competence of service providers, usage of good quality equipment and drugs, maintain highest standards of hygiene.

v. Social factors: Gender sensitive service provision, more Lady doctors encouraging male participation in contraception, increased role of men in the programme.

vi. Client's perspective: Waiting time of client should be minimum, the reception facility and waiting time should be well utilized. There should be good seating and physical arrangements such as water and toilet.

Example: Registration of pregnant women will be measured not in numbers registered but the numbers registered before 12 weeks of pregnancy.

Quality will be judged if accurate abdominal examination and palpation done, accurate BP recorded and pregnant mother weighed, fundal height recorded accurately and appropriate advice given.

Indicators of quality have been used in RCH programme in terms of number of pregnant women given four antenatal check ups, number of children fully immunized, percentage of institutional deliveries, number of high-risk mother referred, ORS use rate, exclusive breastfeeding rates, etc.

Promotion to Quality under RCH—Strategies

RCH programme has imparted skill-based training provided standard medicine kits and equipment, besides standard treatment protocols at various levels, promotes institutional deliveries and has done away the targets, emphasized on client consultation and people participation in planning. All these measures tend to enhance the quality of MCH and family welfare services. Accountability is to the people now. Indian Public Health Standards have been prescribed now to improve quality of services at all levels.

References

1. WHO. World Health Report 2003. Shaping the future. Geneva: WHO; 2003.
2. Planning Commission. Tenth five-year plan 2002–07. Vol II. New Delhi: Planning Commission GOI; 2002.
3. GOI. National Population Policy 2000. New Delhi: MOH and FW GOI; 2000.
4. NFHS-3 to 5 IIPS, Mumbai, India, 2005–06, 2015–16 and 2019–21.
5. GOI. RCH II and family planning—programme implementation plan (PIP). New Delhi: MOH and FW GOI; 2004.

NATIONAL RURAL HEALTH MISSION (NRHM) 2005–2012 PUBLIC HEALTH MANAGEMENT CHALLENGES

With the launch of NRHM since 2005, several public health management challenges have emerged for implementation of healthcare delivery system and national health programmes. The National Rural Health Mission (2005–12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

NHRM is a flagship programme of Government of India. Under its umbrella, it integrates all related and stand alone programmes in the health sector including: RCH phase II, National Vector-borne Diseases, National Leprosy Eradication, National Iodine Deficiency Disorders, Revised National Tuberculosis Control Programme, National Blindness Control, Integrated Diseases Surveillance, AYUSH schemes in hospitals and dispensaries and thrust areas under NRHM (ASHA, Village Health Sanitation and Nutrition Committees, strengthening of subcentres, PHCs, CHCs, subdistrict and district hospitals, untied grant at village, SC, PHC, CHC, besides annual maintenance grant, state and district health societies, community monitoring, essential drugs at SC, PHC, CHC, intersectoral convergence, mobile medical units and facility and household surveys, district health action plan, etc.).

Aim: The NRHM *aims* to provide accessible, affordable, accountable quality healthcare through a functional public health system. It also seeks to reduce maternal mortality ratio, infant mortality rate and total fertility rate. The key features of NRHM include: *Fully functional* health facilities within the public health system accountable to the community, *human* resources management, community involvement, decentralization, rigorous monitoring and evaluation against Indian Public Health Standards, convergence of health and related programmes form village level upwards, innovations and flexible financing as also interventions for improving the health indicators.[1]

The NRHM represents a major departure from the past, in that Central Government health financing is now directed to the development of *state health systems* rather than being confined to a select number of national health programmes. NRHM provides a unique opportunity to states to build a partnership and carry out necessary **reforms** in health sector with more resources.

2

District and state programme implementation plans (PIPs) form the basis to suit the diverse needs of states and regions. NRHM has set a new standard of partnership with states where it is the state that determines what is needed to **reform** the public sector health system. The 'architectural corrections' envisaged under NRHM are organized around **five pillars** each of which is made-up of a number of overlapping following **core strategies**.

NRHM—5 MAIN APPROACHES

a. **Increasing participation and ownership by the community (decentralization):** This means transfer of funds, functions and control of functionaries to Panchayati Raj institutions (PRIs). One of the core strategy of the National Health Mission is to enhance capacity of Panchayati Raj institutions (PRIs) to own; control and manage public health services. State would involve PRIs in implementation of health and family welfare programmes by progressive transfer of funds, functions and functionaries. They will be trained, and empowered to manage and supervise the functioning of healthcare infrastructure and manpower. Further PRIs will coordinate the activities of different departments, such as health and family welfare, social welfare, education, agriculture and development which have their functionaries in the village and block levels. This is sought to be achieved through (i) an increased role for PRIs in the ASHA programme, (ii) village health sanitation and nutrition committee, (iii) constitution of *Rogi Kalyan Samitis*/hospital development committee or users groups, (iv) *district health society* for decentralized district and village health action planning with PRIs and people, and (v) community monitoring system and through a greater space for NGOs participation.

b. **Indian public health standards (IPHS):** The prescription of the IPHS marks one of the most important core strategies of the NRHM. Once the norms and standards are in place, the challenge lies in identifying facility wise gaps in infrastructure, human resources, equipment, drug supplies and above all service outcomes. The *facility survey* is done to identify the *gaps* in healthcare delivery system and funding is directed to *closing* the *gaps* so identified. IPHS have been adopted for subcentres, primary health centres, community health centres and district hospitals. The objectives of IPHS are:

   i. To ensure minimum package of assured services.
   ii. To achieve and maintain acceptable standards of quality of services.
   iii. To make the services more responsive and sensitive to the needs of the community to enhance client satisfaction.

   IPHS now specify what services would be delivered, what physical infrastructure (building and space for service) is needed, what manpower is required, what equipment and essential drugs and materials are needed. These standards would thus help monitor progress and improve the functioning of the facility. The IPHS have been worked out on the basis of population norms, patient/client load per day and levels of utilization of services, e.g. bed occupancy rate and coverage level of services. The setting up of standards is a dynamic process, if the level of utilization goes up and bed occupancy increases, the norms can be revised. *Standard treatment protocols* for national health programmes and locally endemic diseases are the 'heart' of quality and cost of the care. Challenge is to involve private sector.

c. **Improved management through capacity building:** The core of this is professionalizing management by building up **management** and **public health** skills in the existing workforce, supplemented by inclusion of management personnel into the system (states/district programme manager, IT professionals and account professionals). Programme management units at state, district and block levels have been set-up by engaging programme managers with MBA qualification, chartered accountant and data entry operators for improved programme management—right from the national level, NRHM visualizes a sustained process of capacity development of management of programme through National Health System Resource Centre, and State Health System Resource Centre, who help as technical resource for capacity building in district planning process and improving service delivery in health sector.

d. **Flexible financing:** 'The supply side financing' means government spends on health as being provider of health services. In NRHM, flexible financing is the hallmark so that service guarantee as spelled out in IPHS can be made available. The central strategy of this pillar is the provision of untied funds to every level—to the village health and sanitation committee, to the subcentre, to the

PHC, to the CHC and district hospital. Even the strategy of providing resource envelope to each district and state which the district/state is to use against an approved plan that it develops is an unprecedented level of financial flexibility.[2] *Financial packages for demand side financing* and various forms of risk pooling where money follows the patient are also major strategies declared by the NRHM. The *Janani Suraksha Yojna* is one major, almost overwhelming example of "demand side financing option" where the funding is to the user of services. The beneficiary is free to choose between private sector provider or public sector provider. While the private insurance companies would be encouraged to bring in innovative insurance products, the mission would strive to set-up a risk pooling system, where the centre, states and local community would be partners. It is envisaged that the hospital care system moves towards a fully funded universal social health insurance scheme. The programmes under erstwhile Department of Health and Family Welfare and Department of AYUSH were not being run in an integrated manner. As a result, the *transfer of funds* to the states *under different budget* heads at different points of time vertically hampered flexibility. It also led to duplication of efforts, and thereby wastage of scarce resources. From XIth plan onwards, instead of different budget heads the state would get budget under *single NRHM budget head*. This would provide the states much needed flexibility to direct the funds to those areas where they are needed most.

e. **Innovations in human resources management for health sector:** *Contractual appointment* route to immediately fill human resource gaps as well as ensuring availability of locally resident health staff/workers, incentives to staff posted in difficult and underserved areas, multi-skilling of doctors and staff, mainstreaming and integration with AYUSH are examples of innovations that seek to find new solutions to old problems for optimal use of human resources. Accreditation and developing public–private partnership in healthcare is yet another approach under NRHM. Expansion of technical and professional education and increasing access to weaker sections to such education is also a core strategy.

Vision

- To provide effective healthcare to rural population throughout country with special focus on 18 states having weak infrastructure. These 18 states are Arunachal Pradesh, Asom, Bihar, Chhattisgarh, Himachal Pradesh, Nagaland, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, MP, Odisha, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh.[2]
- To raise public spending on health from 0.9% of GDP to 2–3% of GDP.
- It aims to undertake architectural correction of the health system to enable it to handle the increased allocation as promised under the National Common Minimum Programme (CMP) and promote policies that strengthen public health management and service delivery in the country.
- Provision of accredited social (female) health activist (ASHA) in each village health team.
- To revitalize local health traditions and mainstreaming of AYUSH (Indian System of Medicine—Ayurveda, Unani, Siddha and Homeopathy).
- Effective integration of health concerns with determinants of health like sanitation and hygiene, nutrition, and safe drinking water through district plan of health.
- Decentralization of programmes for district management of health.
- To improve access to rural people, especially poor women and children to equitable, affordable, accountable effective primary healthcare.

Goals

- NRHM would help achieve goals set under National Health Policy, Population Policy, the Millennium Development Goals and Vision 2020.
- Reduction of child and maternal mortality.
- Reduction of total fertility.
- Universal access to public health services, such as women health, child health, water, sanitation and hygiene, immunization and nutrition.
- Prevention and control of communicable and non-communicable diseases including locally endemic diseases.
- Access to integrated comprehensive primary healthcare.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstreaming of AYUSH.
- Promotion of healthy lifestyles.

These are similar to essential elements of primary healthcare.

Most of these goals are stated in NPP 2000 and NHP 2002, also in RCH II, 10th five-year plan, 11th five-year plan and vision 2020.

Core Strategies of NRHM

- Training and enhancing capacity of Panchayati Raj institutions (PRIs) to own *control* and *manage* public health services.
- Promote access to improved healthcare at household level through accredited social health activist (ASHA).
- Health plan for each village through *Village Health* and *Sanitation Committee* (VHSC).
- Strengthening of subcentres through an untied fund to enable local planning and action and more multipurpose workers (MPWs)/subcentres as per population norms.
- Strengthening of existing PHCs and CHCs and provision of 30–50 bedded CHC per lakh of population for improved curative care to a normative standard (Indian Public Health Standards—defining personnel, equipment and management standards).
- Preparation and implementation of intersectoral district health action plan prepared by the district health mission including drinking water, sanitation, hygiene and nutrition.[2]
- Integration of vertical health and family welfare programmes at national, state, district and block levels.
- Technical support to national, state and district health missions for public health management.
- Strengthening capacities for data collection, assessment and review for evidence-based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of human resources for health.
- Developing capacities for preventive healthcare at all levels for promoting healthy lifestyles, reduction in consumption of tobacco, alcohol, etc.
- Promoting non-profit sector in underserved areas.
- Mobile medical units in every district to improve outreach services in unserved and underserved areas.

Supplementary Strategies

- Regulation of private sector including the informal rural practitioners to ensure availability of quality services to citizens at reasonable cost.
- Promotion of public–private partnership for achieving public health goals.
- Mainstreaming of AYUSH—revitalising local health traditions.
- Reorienting medical education to support rural health issues including regulation of medical care and medical ethics.
- Effective and viable risk pooling and *social health insurance* to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

Plan of Action for NRHM

The plan of action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, rationalization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system and operationalization of CHCs into FRUs meeting public health standards in each block of the country. Ten components of NRHM are as follows.

Components of NRHM

i. Accredited social health activist (ASHA).
ii. Strengthening of subcentres.
iii. Strengthening of PHCs.
iv. Strengthening of CHCs, sub-districts and district hospitals.
v. District Health Action Plan.
vi. Convergence with other departments.
vii. Strengthening disease control programmes.
viii. Public–private partnership.
ix. New health finance mechanism
x. Reorienting health/medical education.

Accredited Social Health Activist (ASHA)—Community Health Volunteers

- Every village will have a female accredited social health activist (ASHA) of age group 25–45, educated minimum up to eighth class, resident of the same village, chosen by and accountable to village panchayat to act as the interface between the community and the public health system.[3]
- ASHA would be trained women community health volunteer at village level for 1000 population in rural area and 2500 population in urban area.
- ASHA would act as a bridge between the ANM and the village and be accountable to panchayat.
- She will be honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and the other national healthcare delivery programmes.

- Her work schedule is flexible and she works 3–4 hours per day on about 4–5 days a week.
- ASHA will take steps to create awareness and provide information to the community on determinants of health, such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health and family welfare services by regular home visits for up to 2 hours everyday.
- She will counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including reproductive tract infection/sexually transmitted infection (RTI/STI, HIV/AIDS) and care of the young children.
- ASHA will mobilize the community and facilitate them in accessing health and health-related services available at the village/subcentre/primary health centres, such as immunization, antenatal check-up (ANC), postnatal check-up (PNC), family planning services, ICDS, sanitation and other services being provided by the government on VHSN Day once a month.
- As a member secretary, and convener she will work with village health sanitation and nutrition committee to develop a comprehensive village health plan and provide leadership and guidance for convergent actions on social determinants of health.
- She will arrange escort/accompany pregnant women and children requiring treatment/admission to the nearest pre-identified health facility, i.e. primary health centre/community health centre/first referral unit (PHC/CHC/FRU).
- ASHA facilitator, 1 per 20 ASHAs supports and supervises the work of ASHAs along with support of ANM, AWW and VHSNC and Block facilitator.
- Untied Grant of ₹10000 per year to each VHSNC is provided for local actions. Chairperson and ASHA (member secretary) maintain a joint account in a Bank.

Records: ASHA maintains household survey register, eligible couple, ANC, immunization, births and deaths, and stock registers. Pregnancy testing kits, oral pills, emergency contraceptive pills and conventional contraceptives, menstrual hygiene packets and iron and folic acid tablets have been supplied to her. She gets performance-based incentive. ASHA provides home-based newborn care and postnatal care besides care for limited common ailments. She coordinates her activities with AWW, and ANM (Table 2.4)

Mobile Academy

It is a free audio training course designed to expand and refresh the knowledge base of accredited social health activists (ASHAs) and improve their communication skills. Mobile academy offers ASHAs a training opportunity via their mobile phones which is both cost-effective and efficient. It reduces the need to travel and ASHAs learn at their own pace at times they find convenient.

Together kilkari and mobile academy are improving family health—including family planning, reproductive, maternal and child health, nutrition, sanitation and hygiene—by generating demand for health services.

HEALTH AND NRHM IN 12TH FIVE-YEAR PLAN, 2012–17 UNIVERSAL HEALTH COVERAGE

Rolling Out Universal Health Coverage (UnHC)—A New Strategy: 12th Plan strives to establish system of UnHC over the next two plans periods which will "Ensure equitable access for all Indian Citizens in any part of the country, regardless of income level, social status, gender, caste or religion to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as services addressing wider determinants (water, sanitation, nutrition and education) of health delivered to individuals and population with the government being guarantor and enabler, although not necessarily the only provider of health and related services".

Various UnHC models will be pilot tested by the states (at least one district of each state). Cashless delivery of an **Essential Health Package** (EHP) to all, ought to be the basic component of all the models. Out-patient care and medicines (essential medicines) will be a priority and every UnHC model will include for full and free access to essential drugs. EHP of national health programmes will be entirely funded and provided by the government and no fee of any kind will be levied on primary healthcare services.

- EHP will be delivered by mix of government and private providers. Private sector will be contracted only for critical gaps filling.
- Define **clinical services** at different levels in an Essential Health Package (EHP) which the

Table 2.4: Role coordination between the ASHA, ANM and AWW

Activity	*Role of ASHA*	*Auxiliary nurse midwife*	*Anganwadi worker*
Home visits	• Enumeration of the population and creation of family folder/ health card • Community based assessment check list for screening of NCDs • Primary focus is on health education, care in illness, prioritising visits to households with a pregnant woman, a newborn (and post-natal mother), children under two, a malnourished child and marginalised households	• Prioritising those families with whom the ASHA is having difficulty in motivating for changing health seeking behaviours, those who do not attend VHND; providing home based services for postpartum mothers; sick newborn and children who need referral but are unable to go • Ensuring that there is an ASHA assigned to every household and they are aware of it. Supportive supervision through joint visits with ASHAs	• Primary role on nutriion counselling, and supportive role on childhood illness • Providing take home ration to those who are unable to come to AWC
VHND (Village Health Sanitation and Nutrition Day)	**Primary Focus on social** mobilization for women and children to attend the VHND, through motivation and counselling. Special emphasis on marginalized groups, and enable access to healthcare and entitlements	**Service provider who delivers** immunisation, antenatal care, identification of complications, and family planning services • On a Fexed day in a week ANM assisted by ASHA would screen for Htn, DM and oral, breast and crvical cancer	Anganwadi Centre (AWC) is the venue and Anganwadi Worker (AWW) enables the support in making this possible. She weights all children below 5 years of age, maintains growth chart and provides Take Home Ration to pregnant and lactating mothers and for children under three. On non VHND days identifies and provides care for registered children in AWC
VHSNC (Village Health Sanitation and Nutrition Committee Meetings)	• Convener of the meeting; preparation of Village Health Plans • Providing leadership and guidance for convergent action of all public services	**Supports ASHA** In convening the meetings and village health planning	**Supports ASHA** In convening the meetings and village health planning
Escort services	**Voluntary function** to be done by ASHA on the basis of requirement and feasibility however to be compensated for travel and day wages		
Record maintenance	Maintains a drug kit stock card, a diary to record her work, maintain a village register that assists her in organizing and prioritizing her work and for those who need her services	**Primary responsibility** Maintain a tracking register and record of service delivery for the services she delivers	**Primary responsibility** Maintains a tracking register to record service delivery for pregnant and lactating mothers and children, weighs and maintains growth charts for children under 5 years of age

government would finance and ensure provision through public health system supplemented by contracted in private providers.

- The universal provision of high impact, preventive and public health interventions which the government would universally provide (including all national health programme services).

- **National Health Mission (NHM):** The NHM is the primary vehicle to move towards Universal Health Coverage. It has two sub-missions—National Rural Health Mission and National Urban Health Mission. After the success of the NRHM, the nation now wants to expand the scope of health services in towns also (for urban poor in urban areas). The

NRHM has been converted into National Health Mission, which would cover all villages and towns in the country. The NHM now extends all over the country both in urban and rural areas and promotes universal access to continuum of cashless health services from primary to tertiary care. Services will be delivered with seamless integration between primary, secondary and tertiary levels of care.

The gains of the flagship programme of NRHM will be strengthened under the umbrella of NHM which will have universal coverage. The focus or thrust on covering rural areas and rural population will continue. Paradigm shift due to NRHM is elaborated in Table 2.5.

- 12th Plan envisages increase in public spending on **core health** from 1.04% of GDP in 2011–12 to 1.87% of GDP by the end of 12th Plan with 70% of the budget to be spent for primary healthcare (HLEG). Principal source of financing would be general tax revenues, supplemented by partnership with private sector and contribution by corporates as a part of their Corporate Social Responsibility (CSR).[4–6]

The NHM will incorporate the following core principles:

Universal health coverage, achieving quality standards by adopting revised Indian Public Health Standards, continuum of care by networking of institutions like medical colleges, district hospitals, CHC, PHC and SCs linked with each other, decentralized planning at district, block, CHC, PHC and village level and prioritization of services (maternal and child health, universal immunization coverage, family welfare, communicable and non-communicable disease control and prevention, focus on dedicated public health cadre in states, and behaviour change communication).

Table 2.5: Paradigm shift due to NRHM

Moves from	*To*
1. Current public expenditure on health 0.9% of GDP	1. Increased public expenditure 2–3% of GDP by 2012. States will also make a matching increase
2. Inflexible financing	2. Flexible financing—untied grant at village, subcentre PHC, CHC and district level for local actions and full packages for plans developed at district level.
3. Dysfunctional health infrastructure	3. Fully functional health facilities at village, subcentre, PHC, CHC and district hospital
4. No standards prescribed for quality	4. Indian Public Health Standards for physical infrastructure, human resources, equipment, drugs and supplies and service outcomes
5. Central Govt. financing confined to select **programmes or programme** disease centric—fragmented approach	5. Financing now is directed to development of state **health systems**. System centric approach
6. Time consuming recruitment system and inadequate provision of human resources	6. Contractual appointments, local residency and incentives to staff working in difficult areas, additional human resources
7. Low level of community participation	7. Increasing community participation by way of village health and sanitation committee, ASHA programme, hospital Management Committee or *Rogi Kalyan Samiti* and Funds, Functions and Functionaries given to people with citizen's charter at each facility
8. Poor management capacity	8. Improved management capacity by building up management and public health skills in existing workforce along with induction of management personnel into the system
9. Lack of convergence	9. Integrating vertical health and family welfare programmes at national, state, block and district level
10. Centralized planning and evaluation	10. Decentralized district health action plans are the major instruments to achieve intersectoral coordination, implementation, monitoring and evaluation of programme

The Mission is expected to achieve the goals set under the National Health Policy, National Population Policy, Goals of Xth and XIth Five-Year Plans and Millennium Development Goals besides vision 2020.
NRHM tries to achieve these goals by making the health system fully functional and credible at all the levels by decentralized district action plans with full participation of community, user groups and NGO; with substantial financial support at all levels.

12th Plan and NHP 2017 lay stress on effective governance system by use of structure of NHM, accountability for outcomes at all levels, adequate human resources for healthcare delivery, conversion of district hospitals and CHCs as knowledge centres/teaching centres, enhancing community participation and strengthening of health systems and mainstreaming of AYUSH systems.

2

IMPROVING MATERNAL AND CHILD HEALTH THROUGH RMNCH+A APPROACH

Life cycle approach adopted under National Rural Health Mission is referred to as RMNCH+A approach. RMNCH+A stands for—reproductive, maternal, newborn, child and adolescent health.

Five Principles of RMNCH+A

1. **Health system strengthening:** Infrastructure, human resources, drugs commodities and transport.
2. **Evidence-based interventions:** High impact simple interventions for various stages in life cycle.
3. **Convergence with other sectors:** Women and child development, education, water and sanitation and nutrition.
4. **Priority of interventions in 184 high burden** districts.
5. **Integrated monitoring through** Mother and Child Tracking System and Score cards.

The RMNCH+A approach in fact renews its commitment to the strategies adopted under National Health Mission and Reproductive and Child Health (RCH: Phase I and Phase II) to achieve speedily the millennium development goal 4 and 5, vision 2020 and goals of 12th plan period as elaborated above.

The Critical Life Points

The critical life points for service delivery are—adolescence, pre-pregnancy, pregnancy, birth, post-partum, neonatal, infancy and childhood.

The Essential Package and Services/Interventions

The high impact simple interventions to save lives of newborn and mothers within the continuum of RMNCH+A approach include:

i. Adequate nutrition: Girls and women must receive adequate nutrition **from birth** through **childhood** and into **adolescence,** womenhood and their potential childbearing years.
ii. Antenatal care package (4 ANCs).
iii. Skilled assistance at **delivery.**
iv. Basic and comprehensive emergency obstetric and newborn care.
v. Postnatal and newborn care: Home-based and facility-based (at newborn stabilization unit and special newborn care units).
vi. Integrated management of, neonatal and childhood illness.
vii. Universal immunization prog services
viii. Management of RTI/STI
ix. Improved household practices and behaviours (healthy practices for mother and newborn care): Clean delivery—clean cord, clean hands, promotion of early initiation and exclusive breastfeeding and appropriate infant and young child feeding practices.
x. Child health screening and early intervention services (Rashtriya Bal Swasthya Karyakram).
xi. Family planning interventions—contraception (spacing and terminal methods and comprehensive abortion care services) as also management of RTI/STI.
xii. Convergence with determinants of health: Water, sanitation, hygiene, nutrition, education and empowerment of women.

Focus: RMNCH+A approach essentially focuses on major causes of mortality among women and children as well as delay in accessing and utilization of healthcare services.

Priority: 184 low performing districts have been identified as high priority districts—where the burden of maternal and child mortality is high. The other priority is most vulnerable populations/areas—hilly and remote places, tribal and desert areas, weaker sections and urban poor to ensure equity.

- **The key delivery modes for services are:** Family/household and community, outreach and outpatient and health facilities (PHC, CHC, district level, medical colleges, etc.).
- **The supportive environment:** This requires respect and rights of women and children; quality education; a decent standard of living; protection from abuse, exploitation, discrimination and violence; equal participation in home, community, social and political life; empowerment of women; and greater involvement of men in maternal and child care.
- **Continuum of care under RMNCH+A—across time and location:** Continuum of care aims to integrate maternal, newborn, and child healthcare. Its central premise is essential services for mothers,

newborns and children are most effective when these are delivered in an integrated package at critical points in the life cycle of mother and children in a dynamic health system.

An effective continuum of care connects essential maternal newborn and child health packages through pregnancy, childbirth, postnatal and newborn periods, and into childhood and adolescence. The advantage is that each stage builds on the success of the previous stage. For example, providing integrated services to adolescent girls means fewer unintended or poorly timed pregnancies. Skilled care before, during and immediate after birth reduces the risk of death and disability for both mother and the baby. Continued care for children supports their right to health. An effective continuum of care also addresses gaps in care, whether at home, community, health centre or hospital. To be effective continuum of healthcare must forge strong links between the household/family, the community and quality outreach and clinical services at primary health facilities which in turn have strong connection to a district hospital.

The household and community are places where child care and maternal care practices and care seeking behaviours are learned and supported by community. Delivering comprehensive healthcare for mother and children requires preventive measures as well as management/treatment of illness.

Prevention essentially requires **behaviour changes** that **begins** in the **household** and family and can gain support of community. At a later stage, the behaviour is influenced by peers in school and in company of preschool children, neighbour and friends. For example, improvement in nutrition, are often the result of breastfeeding practices and infant and young child feeding in the family. Use of sanitary latrines, hygienic practices, such as washing hands, gender discrimination begins at family, learned by individual and reinforced by community. Mobilizing the community to support improved health practices, demand generation for quality health services and ownership of programme; can go a long way to reduce morbidity and mortality in children and mothers.

The first response to illness like diarrhoea, cough and difficult breathing comes through mother and family or caregivers and similarly seeking early care during pregnancy, deciding place of birth and hygienic practices during and after delivery rest with family, *hence integrating household/family and community with the dynamic system of healthcare is an imperative in continuum* of RMNCH+A approach.

The success of (RMNCH+A) depends upon delivering essential services and implementing improved practices at key points in life cycle, linking mothers, newborns and their households and communities with dynamic healthcare system.

2

POLICY ON NUTRITION PROGRAMMES/ INTERVENTIONS

MOTHER'S ABSOLUTE AFFECTION (MAA) PROGRAMME FOR PROMOTION OF BREASTFEEDING 2016

Breastfeeding within an hour of birth could prevent 20% of neonatal mortality, the substantial increase in institutional deliveries (over 88%) following launch of JSY and Janani Shishu Suraksha Karyakram has provided an excellent opportunity for ensuring early initiation of breastfeeding. However, only 41.6% of mothers initiate breastfeeding within 1 hour of birth in spite of the fact about 88% deliver in institutions. Further 54.9% babies are exclusively breastfed during first 6 months and 42.7% of children between 6 and 8 months received solid/semisolid food and breast-milk. There is need to improve these rates and practices at community and institutional level. MAA programme supports promotion, protection of breastfeeding practices by intensified communication activities at all the levels of healthcare.

Exclusive breastfeeding for first 6 months and appropriate infant and young child feeding practices are being promoted in convergence with Ministry of Women and Child Development. Ministry of Health and Family Welfare launched "MAA—Mother's Absolute Affection" Programme in August 2016 for improving breastfeeding practices:

a. Initiate breastfeeding within 1 hour of birth.
b. Universal exclusive breastfeeding up to 6 months.
c. Complementary breastfeeding up to 2 years of age. MAA is primarily a communication strategy to promote breastfeeding through mass media and capacity building of healthcare providers in health facilities as well as in communities.

PROBLEM OF LOW BIRTH WEIGHT BABIES

In India, 22% of babies born have low birth weight (<2500 g).

LBW babies fall under two categories:

a. Small for gestational age, i.e. they are full term babies and have IUGR.
b. Preterm babies born before 37th weeks of gestation.

2

Low-birth weight is a predominant cause of infant mortality. Causes of low birth weight babies in India are:

i. Adolescent and maternal under nutrition (anaemia).
ii. Early marriages and teenage pregnancies.
iii. Less spacing between births.
iv. High birth orders.
v. Lack of antenatal care service or poor utilization of antenatal care, besides inadequate diet and IFA consumption.

POLICY ON PREVENTION AND CONTROL OF SOIL-TRANSMITTED HELMINTHS

NATIONAL DEWORMING DAY (NDD)

Ministry of Health and Family Welfare had adopted a single day strategy called National Deworming Day (NDD) in 2015 to combat soil-transmitted helminths (STH) infections in children. During NDD, a single dose of albendazole 400 mg is administered to the children of 1–19 years age by school teachers and Anganwadi workers. In the year February 2016, NDD reached to 250 million children in 34 states/UTs.

Ministry of Health and Family Welfare has also established STH (soil-transmitted helminths) surveillance mechanism across the country under the aegis of National Centre for Disease Control. Based on STH prevalence data, MOH and FW conducted 2nd round of deworming in 27 states and UTs where STH prevalence is high. About 150 million children were covered in August 2016. This programme along with biweekly iron and folic acid to children 6–59 months and weekly iron and folic acid tablets to children between 5 and 10 years will improve the nutritional status of young children along with promotion of sanitary latrines and education on nutrition and personal hygiene. Soil-transmitted helminths STH are neglected tropical diseases.

Potassium Bromate Banned

A harmful additive cancer causing chemical—potassium bromate has been banned in bread by Ministry of Health in India. The chemical was being used to enhance the texture of the bread. The FSSA (Food Safety and Standard Act of India) has approved and published standards for food additives and ingredients.

Haryana Demonstration Project on Wheat Flour Fortification to Improve Iron, Folate, and Vitamin B_{12} Status

The burden of iron deficiency anemia and neural tube defects (NTDs) is high in India. Iron and folic acid supplementation programmes have not been very successful in addressing these concerns adequately. Some states in India have already initiated wheat flour fortification to address micronutrient deficiencies. Average NTDs prevalence in India is about 41 per 10,000 live births.

The Haryana government has committed to introduce wheat flour fortification as a pilot programme to demonstrate the health impact of fortified wheat flour. Prior to the state-wide introduction of fortification, this pilot programme will be launched in the rural areas of two blocks of Ambala (Naraingarh and Barara) in 3 phases over a five-year period. The purpose of the Haryana Demonstration Project is to assess the feasibility, sustainability, and health impact of fortifying wheat flour using India's existing open market and government systems in Ambala district.

Fortification is adding vitamins and minerals to foods to prevent nutritional deficiencies. The nutrients regularly used in grain fortification, prevent diseases, strengthen immune systems, and improve productivity and cognitive development. Fortification is successful because it makes frequently eaten foods more nutritious without changing the food habits. Wheat flour fortification has been introduced and proven successful in many countries to address NTDs and iron deficiency anaemia.

Vitamins and minerals often used in wheat flour fortification and their role in health include:

- Iron, folic acid, vitamin B_{12} help prevent nutritional anaemia which improves productivity, maternal health, and cognitive development.
- Folic acid (vitamin B_9) reduces the risk of neural tube birth defects.
- Vitamin B_{12} maintains functions of the brain and nervous system.

NATIONAL NUTRITION MISSION (NNM) (POSHAN-ABHIYAN) 2017–20 AND MISSION POSHAN 2.0

NNM has been set up in the year 2017

It is PM's overarching scheme for holistic nourishment, with Ministry of Women and Child Development its nodal ministry. The purpose is to improve nutritional status of women, adolescents and children.

GOAL

I. To reduce stunting, wasting and low birth weight by 2% per annum and anaemia among children, women and adolescent girls by 3% per annum.
II. Reduce stunting from 38.4% in 2016 to 25% by 2022.

The mission will supervise, monitor and fix targets for the existing anti-malnutrition plans to steer them in right direction. These schemes include—ICDS, JSY, mid-day meal and National Food Security Mission. The NNM will bring in convergence of different ministries apart from technology-based real-time monitoring growth of children as well as check the pilferage of food/ration provided at Anganwadis. Services delivered by ANMs, AWWs, ASHAs will be monitored and SMS alert sent to parents on progress of child health and nutrition for early actions.

Components

I. Information Communication Technology Enabled Real Time Monitoring of Schemes (ICT-RTM). It includes mobile application for field functionaries preloaded on mobile phones and a dashboard for desktops to be used at block, state and national level. It enables timely collection of information on ICDS services and their impact on nutrition outcomes of beneficiaries on regular basis.
II. Training and capacity building: Incremental learning by doing approach (ILA).
III. Community mobilization and behavior change communication.
IV. Innovation—by pilot projects on convergent actions.
V. Performance incentives to states.
VI. Flexi-pool funds for local planning.

- **Monitoring and Implementation:** By National Council on India's Nutritional challenges.
- **Anaemia Mukt Bharat:** Intensified National Iron Plus Initiative (I-NIP) has been launched in April 2018 as a part of Poshan Abhiyan to get rid of anaemia.
- Comprehensive National Nutrition Survey 2016–18. The first 1000 days from conception to age 2 years is considered the most important period to intervene to prevent lifelong damage caused by malnutrition. Trends of stunting, wasting, underweight, MAUC <125 mm in under 5 children show marginal improvement of nutritional status as per evidence of NFHS-5 and CNNS surveys in 2019–21 and 2018 respectively.

ENVIRONMENTAL HEALTH

Air pollution was the leading risk factor for premature deaths in India in 2019, accounting for nearly 18% of all deaths (>1.67 million per year).

AIR POLLUTION

About 90% of people are breathing poor quality of air. Air pollution is a global public health emergency. Over 41% of people in India use unprocessed biomass fuel for cooking which leads to indoor air pollution. NFHS 5 data indicate that 58.6% of households in India use clean fuel. WHO database of air quality in over 3000 cities in 2018 indicates 15 out of 20 most polluted cities of the world are in India with Gurgaon, Ghaziabad, Faridabad, Noida and Bhiwadi in the top six, Delhi is on 11th spot. To combat climate change, 197 countries agreed to phase out hydrofluorocarbons (HFC) use by 85% by 2045 as per Kigall Amendment to Montreal Protocol, and freezing production and consumption of HFC.

Revised WHO Air Quality Guideline Values

Particulate matter: Annual mean values of 20 µg/m^3 (for PM10) and 10 µg/m^3 (for PM2.5). WHO has revised these guidelines values as indicated in Table 2.6.

Table 2.6: Recommended AQG levels by WHO 2005 and 2021 and National Standards

Pollutant	*Averaging time*	*AQG level 2005*	*AQG level 2021*	*National* standards 2009*
$PM_{2.5}$, µg/m^3	Annual	10	5	40
	24 hour[a]	25	15	60
PM_{10}, µg/m^3	Annual	20	15	60
	24 hour[a]	50	45	100
O_3, µg/m^3	Peak season[b]	60	60	–
	8 hour[a]	100	100	100
NO_2, µg/m^3	Annual	40	10	40
	24 hour[a]	200 one hour	25	80
SO_2, µg/m^3	24 hour[a]	20	40	80
CO, mg/m^3	24 hour[a]	10 eight hours	4	02 (8 hours)

[a] 99th percentile (i.e. 3–4 exceedance days per year).
[b] Average of daily maximum 8 hour mean O_3 concentration in the six consecutive months with the highest 6 months running-average O_3 concentration.
* National standards have legal value and are under revision. In addition to guidelines values interim targets are given for each pollutant by WHO.

LIFE-SAVING COMMODITIES IN RMNCH+A PROGRAMME

2

With a strong focus on the reproductive, maternal, newborn and child health (RMNCH) 'Continuum of Care', the UN Commission identified and endorsed an initial list of 13 overlooked life-saving commodities that, if more widely accessed and properly used, could save the lives of more than 6 million women and children.

RMNCH continuum of care	*Commodity*	*Usage*
Reproductive health	• Female condoms	Family planning/ contraception
	• Implants	Family planning/ contraception
	• Emergency contraception	Family planning/ contraception
Maternal health	• Oxytocin	Postpartum haemorrhage
	• Misoprostol	Postpartum haemorrhage
	• Magnesium sulphate	Eclampsia and severe pre-eclampsia toxaemia of pregnancy
Newborn health	• Injectable antibiotics	Newborn sepsis
	• Antenatal corticosteroid (ANCS)	Respiratory distress syndrome for preterm babies
	• Chlorhexidine	Newborn cord care
	• Resuscitation equipment	Newborn asphyxia
Child health	• Amoxicillin	Pneumonia
	• Oral rehydration salts (ORS)	Diarrhoea
	• Zinc	Diarrhoea

Criteria

The commission looked at three criteria to identify these commodities:

1. *High-impact, effective commodities*: In general, high-impact commodities are those commodities that effectively address avoidable causes of premature death and disease among children under five years old and women during pregnancy and childbirth.
2. *Inadequate funding*: Selected commodities are not funded by existing mechanisms such as The Global Fund to fight AIDS, tuberculosis and malaria, Global Alliance for Vaccines and Immunization (GAVI), Scaling-up Nutrition (SUN) and UNAID.
3. *Untapped potential*: Innovation and rapid scale-up in product development and market shaping (including potential for price reduction and improved stability of supply) arising from the work of a UN Commission could rapidly improve access to the selected commodities.

India Newborn Action Plan

Goals

Two specific goals of INAP are:

1. Ending preventable newborn deaths to achieve single digit "Neonatal mortality rate" to <10 by 2030 from the current level of 29.
2. Ending preventable stillbirths to achieve single digit stillbirth rate to <10 by 2030 from the current level of 22.

Strategies

Strategies listed under RMNCH+A are high impact interventions grouped into six packages corresponding to the various life stages of newborn. High coverage (90%) of available package by 2025 could prevent almost 75% of newborn deaths (Lancet every newborn series), one-third of stillbirths and half on maternal deaths. The package includes:

1. Care during labour and child birth—provide basic emergency and comprehensive obstetric care, skilled attendance at birth and corticosteroids use to manage preterm births.
2. Care of small and sick newborn—at facility.
3. Care of healthy newborn.
4. Immediate care of newborn.
5. Pre-conception and antenatal care.
6. Care beyond newborn survival.

Daksh: Five National and 30 state 'skills labs' have been set up with the support from maternal health division GOI, and Liverpool School of Tropical Medicine. These labs will enhance the quality of training and capacity building of different cadres of service providers in the states.

REFORMS IN HEALTH SECTOR THROUGH RCH AND NRHM STRATEGIES

NRHM: Public Health and Management Challenges: The Reproductive and Child Health (RCH), and National Rural Health Mission (NRHM), following National Health Policy Framework of 2002 initiated several reforms in the health sector. These reforms proved to be a milestone in developing health systems in the country. These reforms which related

to health policy, systemic, structural, operational and management components of health systems at various levels were as under:

- Target free approach (community needs assessment approach), a historical paradigm shift for **decentralized planning of health services**—at village—subcentre, PHC, CHC and district health action plans.
- Setting up of state and district health societies for easy and speedy fund flow and decentralized planning of services at district level.
- Increasing public expenditure on core health from 0.9% of GDP to 2–3% of GDP to strengthen the public health system.
- Decentralized programme management to PRIs including financial management.
- Enhanced community participation.
- User charges from APL and retention of these at local level for improving health services/spectrum of services.
- Client-centred, demand-driven, high quality need-based services.
- Reforms in health management information system
- Untied grants at various levels and performance-based expenditure/budget.
- Contractual staff appointment by district health societies to fill gaps in human resources.
- Under NRHM, the stress has been laid on 'fully functional health facilities' and 'architectural correction' to improve the structure of health system besides systemic and operational aspects of the system. Architectural corrections related to:
  a. Capacity building of PRIs to own, control and manage—public health services.
  b. Increased public health spending: 2–3% of GDP.
  c. Setting norms and standards and achieving service guarantee to monitor progress.
  d. Innovations in human resources management.
  e. Improved management through capacity building by building up management and public health skills in the existing workforce.
  f. Flexible financing.

These reforms have been explained in details under RCH and NRHM.

Challenges

- While substantial progress has been made, some challenges are real.
- Village health plans have not taken off. Involvement of PRIs in management of public health system is inadequate.
- Out of pocket (OOP) expenditure on healthcare is still very high—48.8% of total health expenditure.
- Referral system not fully developed.
- Shortfall of specialists at CHCs and FRUs to the extent of 80%.
- Management skills in public health not adequate. Qualified/trained epidemiologists or public health specialists at state, district and CHC level are insufficient.
- Decentralized planning process is slow and there is great deal of inertia. Mindsets have not changed much.
- Partnership with medical colleges and schools of public health and other academic and research bodies is weak.
- Community monitoring processes are sporadic and poorly sustained.
- Health data management and its use for local planning is a challenge.

References

1. GOI. National Rural Health Mission (NRHM) document. New Delhi: MOH and FW GOI; 2005.
2. GOI. Broad framework for preparation of District action plans August 2006. MOH and FW GOI. New Delhi.
3. GOI. Accredited Social Health Activist (ASHA). Guidelines, New Delhi: MOH and FW GOI; 2005 and 2012.
4. GOI: MOH and FW Annual Report 2007–08, NRHM.
5. GOI. NRHM five years of NRHM, 2005–10 Bringing people back to public system. MOH and FW GOI, New Delhi, April 2010.
6. Planning Commission 12th Five-year plan 2012–17.