

CHAPTER III EVOLUTION OF THE FAMILY WELFARE PROGRAMME

The fifties

At the time of Independence the health care services in India were predominantly urban, hospital based and curative. General practitioners well-versed in maternal and child health and paediatricians and obstetricians provided health care to women and children who came to them. They did provide comprehensive, integrated, good quality services but technology available for detection and management of health problems was limited and out reach of services was poor. Majority of the population especially those belonging to the poorer segment and those residing in rural areas did not have access to health care. Consequently the morbidity and mortality rates in them were quite high. Many women died while seeking illegal induced abortion to get rid of unwanted pregnancy because they did not have access to contraceptive care for preventing pregnancies. Conceptions that were too early, too close, too many and too late and lack of antenatal care to detect problems in pregnancy and treat them, resulted in high maternal and infant mortality rates. Antenatal, intrapartum, postnatal and contraceptive care was not readily available to women who required these services desperately.

Basic premises of the Family Welfare Programme are:

- Acceptance of FW services is voluntary,
- FW programme will provide:
 - Integrated Maternal and Child Health (MCH) and FP services
 - Effective IEC to improve awareness
 - Ensure easy and convenient access to FW services free of cost

Obstetricians, who were daily witnessing maternal morbidity and mortality associated with high parity, were ready and willing to persuade their patients who had completed their families, to undergo surgical sterilisation. The fact that the technique was simple, safe and effective and could be done soon after delivery under local anaesthesia accounted for the popularity of postpartum tubal sterilisation. The safety, simplicity and efficacy of vasectomy were also well recognised. For a couple who had completed their family sterilisation of one partner resulted in the reduction of maternal morbidity and mortality associated with high parity. To some extent this was responsible for the substantial drop in maternal mortality rates observed in the urban areas during the 1950s. However, these measures had no impact on the fertility rate or the population growth rate of the country because of poor outreach in urban and rural areas. Thus in fifties good quality integrated maternal and child health care, and family planning services were available to those who were aware, had access and could afford the services of the physicians. There were efforts to improve the coverage of the population and extend the services to rural areas as a part of the block development programme; resource and manpower constraints were responsible for the slow progress in this effort.

The sixties

The sixties witnessed a sea change with availability of safe effective vaccines for prevention of six childhood diseases and effective contraceptives for birth spacing such as Lippe's loop. In order to reach the benefits of these technological innovations to the population, effective programmes for delivery of identified priority services were drawn up by well knit team of professionals; implementation at the periphery was done through the limited health care infrastructure available in rural areas supplemented by camps. The Family Planning and the immunisation programme were among the earliest of such programmes; subsequently several other vertical programmes were added. In an attempt to improve the out reach, camp approach was taken up for providing care to pregnant women and children and improving access to immunisation; these efforts however did not result in any marked improvement in health status of these vulnerable groups because the care was not available when needed and there were no referral services.

Rapid growth of the population in the previous decade, reported in the 1961 census, stimulated the Government to form a Department of Family Planning, with a modest budget. The health infrastructure was still predominantly urban based. During the 1960s, sterilisation remained the focus of the National Family Planning Programme. Efforts were made to popularise vasectomy and to provide vasectomy services to rural areas, using a camp approach. Tubectomy services, however, remained based predominantly in urban hospitals. Extension education approach to improve awareness and increase acceptance of F.P. methods were also included. Lippe's loop provided the first reliable birth spacing method for women in India. Following encouraging response in urban clinics, attempts were made to provide this spacing method to the rural population through camp approach. However, without infrastructure to provide the follow up services the device fell into disrepute. It was obvious that without substantial inputs into infrastructure and manpower to provide the needed follow up services, it will not be possible to achieve any substantial improvement in Maternal and Child Health indices or reduce birth rates.

Seventies

The seventies witnessed many initiatives to improve the health and nutritional status of women and children. The massive dose Vit.A programme aimed at prevention of nutritional blindness, the anaemia prophylaxis programme aimed at reducing anaemia and associated ill health and food supplementation to pregnant and lactating women and pre-school children through ICDS were major initiatives to tackle under nutrition and its adverse consequences in women and children. With the improvement in primary health care infrastructure access to health care improved.

The census of 1971 showed that population explosion was no longer a potential threat but a major problem to be tackled. The government gave top priority to the Family Planning programme and provided substantial funds for several new initiatives. Sterilisation, especially vasectomy was widely available. IUD and condoms were made available through the Primary Health Centres. The hospital based Postpartum Programme provided contraceptive

care to women coming for delivery. The MTP act enabled women with unwanted pregnancy to seek and obtain safe abortion services.

Increasing concern about rapidly growing population led to the Family Planning Programme being included as a priority sector programme during the Fifth Plan. The massive sterilisation drive of 1976 did result in eight million persons undergoing sterilisation, but this did not have any perceptible impact on the birth rate, as the cases were not appropriately chosen. The very next year showed a steep fall in the acceptance. In 1978 the Expanded Programme of Immunization was initiated with the view of improving coverage for the six vaccine preventable diseases. In 1979 the Programme was renamed as Family Welfare Programme and increasing integration of family planning services with those of MCH and Nutrition was attempted.

Eighties

The major thrust during the eighties was to operationalise the Alma Ata declaration by establishing a net work of primary health care infrastructure in urban and rural areas to provide essential primary health care; network of post partum centres were expanded to improve access to family welfare services. In 1983 the National Health Policy was formulated and provided comprehensive framework for planning, implementation and monitoring of Health care services. The Universal Immunisation Programme, started in 30 Districts in 1985-86, was extended to cover 448 districts in the country by the end of the Seventh Plan.

Nineties

Census 1991 showed that India was entering the opportunity window in demographic transition when it will be possible to achieve rapid decline in fertility and mortality. The report of the NDC Sub committee on population gave a new thrust and dynamism to the Family Welfare programme. During the Eighth Plan under the Child Survival and Safe Motherhood initiative and the Social Safety Net programme efforts were made to improve the access to maternal and child health services in the country. In view of the massive differences in the access to services and in health indices of the population between states and between districts in the same states, the Dept of Family Welfare abolished the practice of setting centrally defined method specific targets for contraception and embarked on decentralised area specific need assessment (community needs assessment approach) and planning programmes aimed at fulfilling these needs.

Reproductive and Child Health Programme

In 1997 Dept. of Family Welfare initiated the Reproductive and Child Health programme aimed at providing integrated health and family welfare services to meet the felt needs for health care for women and children. The components of the comprehensive RCH care is indicated in the text box.

Essential components recommended for nationwide implementation include:

- Prevention and management of unwanted pregnancy,
- Services to promote safe motherhood,
- Services to promote child survival,
- Prevention and treatment of RTI/STD.

Efforts were made to provide adequate inputs to improve availability and access to RCH services and to improve performance especially in states/ districts where access to essential services are suboptimal. Attempts to reduce disparities between states/ districts and achieve incremental improvement

in the indices by replication of better performing districts were encouraged.

Components of comprehensive RCH care:

- Effective maternal and child health care;
- Increased access to contraceptive care;
- Safe management of unwanted pregnancies;
- Nutritional services to vulnerable groups;
- Prevention and treatment of RTI/ STD;
- Reproductive health services for adolescents;
- Prevention and treatment of gynecological problems;
- Screening and treatment of cancers, especially that of uterine cervix and breast.

These services are available in secondary and tertiary care centers in the country .

Efforts are being made to improve the content, quality and coverage of care

National Population Policy

The National Population Policy was drawn up by the Dept of Family Welfare and was approved by the cabinet in 2000. The immediate objective of the NPP2000 is to meet all the unmet need for contraception and health care for women and children. The medium term objective is to bring the total fertility rate to replacement level (TFR of 2.1) by 2010, the long-term objective of the Policy is to achieve population stabilization by 2045. The National Population Policy 2000 has set the following goals for 2010:

- Universal access to quality contraceptive services in order to lower the Total Fertility Rate to 2.1 by adopting small family norm.
- Full coverage of registration of births, deaths and marriage and pregnancy.
- Universal access to information/counselling and services for fertility regulation and contraception with a wide basket of choices.
- To reduce Infant Mortality Rate to below 30 per thousand live births and sharp reduction in the incidence of low birth weight (below 2.5 kg.) babies.
- Universal immunisation of children against vaccine preventable diseases.
- Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- Achieve 80% institutional deliveries and increase in the percentage of deliveries conducted by trained persons to 100%.
- Containing of Sexually Transmitted Diseases.
- Reduction in Maternal Mortality Rate to less than 100 per one-lakh live births.

- ☛ Universalisation of primary education and reduction in the drop out rates at primary and secondary levels to below 20% both for boys and girls.

The NPP identified 12 strategic themes which must be simultaneously pursued in "stand alone" or inter-sectoral programmes in order to achieve the national socio-demographic goals for 2010. These are:

- ☛ Decentralised Planning and Programme Implementation
- ☛ Convergence of Service Delivery at Village Levels
- ☛ Empowering Women for Improved Health and Nutrition
- ☛ Child Health and Survival
- ☛ Meeting the Unmet Needs for Family Welfare Services
- ☛ Meeting the needs of Under-Served Population Groups such as Urban Slums or Tribal Communities, Hill Area Populations, Displaced and Migrant Populations and Adolescents
- ☛ Increased Participation of Men in Planned Parenthood
- ☛ Utilise Diverse Health Care Providers
- ☛ Collaboration With and Commitments from Non-Government Organisations and the Private Sector to improve access
- ☛ Mainstreaming Indian Systems of Medicine and Homeopathy
- ☛ Contraceptive Technology and Research on Reproductive and Child Health
- ☛ Providing for the Older Population
- ☛ Information, Education, and Communication

Several states/districts have demonstrated that the steep reduction in mortality and fertility envisaged in the NPP 2000 are technically feasible with in the existing infrastructure and manpower. All efforts are being made to provide essential supplies, improve efficiency and ensure accountability - especially in the states where performance is currently sub- optimal - so that there is incremental improvement in the performance. To facilitate capacity building in the states/ districts where performance is currently sub-optimal they attain of the goals set under NPP-2000 an Empowered Action Group attached to the Ministry of Health and Family Welfare has been constituted. If all these efforts are vigorously pursued it is possible that the ambitious goals set for 2007 may be achieved and enable the country to improve the quality of life and human development rapidly.

National Population Commission

As envisaged in NPP National Commission on Population. National Commission on Population was constituted on 11th May 2000 under the Chairmanship of the Prime Minister of India. Deputy Chairman, Planning Commission is the Vice Chairman. The Commission is to review, monitor and give direction for implementation of the National Population Policy with a view to achieve the goals set in the Population Policy. The first meeting of National Commission on Population was held on 22nd July 2000. The Commission has the mandate to

- review, monitor and give direction for implementation of the National Population Policy with the view to achieve the goals set in the Population Policy
- promote synergy between health, educational environmental and developmental programmes so as to hasten population stabilization
- promote inter sectoral coordination in planning and implementation of the programmes through different sectors and agencies in center and the states.
- develop a vigorous peoples programme to support this national effort

There were wide ranging discussions and useful suggestions for achieving the goal of population stabilization emerged. A Strategic Support Group consisting of secretaries of concerned sectoral ministries has been constituted as standing advisory group to the Commission. Nine Working Groups were constituted to look into specific aspects of implementation of the programmes aimed at achieving the targets set in NPP 2000 and their reports are being finalised

Review of performance during the Ninth Plan

Goals set for the Ninth Plan, current status regarding these are in Annexure 3.2 During the Ninth Plan the Dept of Family Welfare embarked on

- decentralised district based area specific need assessment and programmes for fulfilling the needs
- RCH programme aimed at providing integrated good quality maternal, child health and contraceptive care.

It was expected that these initiatives would lead to substantial improvement in the coverage and quality of services. The Department of Family Welfare was given additional outlay to enable them to provide adequate financial inputs to the states so that they can implement the programme as envisaged. Goals for the Ninth Plan were projected on the basis of these assumptions.

The health systems in the states required longer time to adapt to decentralised planning and RCH programme implementation. In an attempt to improve coverage under specific components of the RCH programme, some states embarked on campaign mode operations which took their toll on routine services. Efforts to eliminate polio by the winter of 2000 through massive pulse polio campaign also had some adverse effect on routine delivery services. As a result of all these it is unlikely that Ninth Plan goals for CBR, Couple Protection Rate, Maternal Mortality Ratio and Infant Mortality Rate will be achieved. However, the country is likely to achieve elimination of polio by 2002-03.

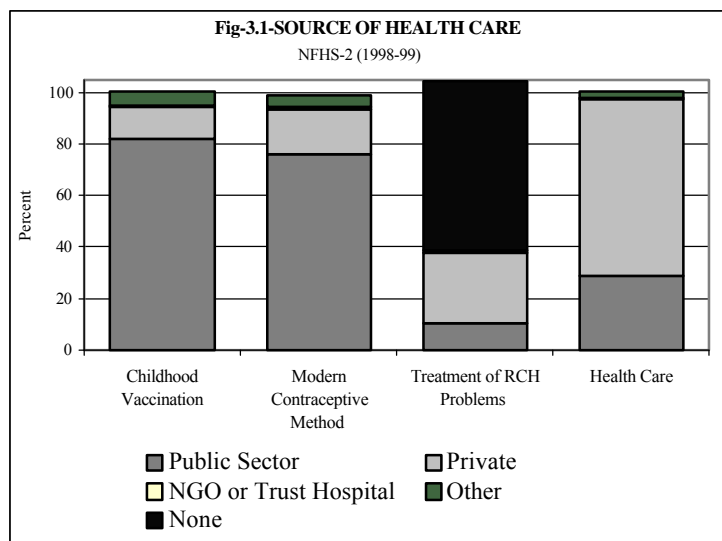
However, independent surveys have shown that several states have achieved goals set for some aspect of the RCH programme during the Ninth Plan, demonstrating that these can be achieved with in the existing infrastructure, manpower and inputs. For instance

- Andhra Pradesh, Punjab, West Bengal and Maharashtra have shown substantial decline in birth rates; the latter three states are likely to achieve replacement level of fertility, ahead of the projection made.
- Punjab has achieved couple protection rate and use of spacing methods far ahead of all other states
- Tamil Nadu and Andhra Pradesh have achieved increase in institutional deliveries
- Kerala, Maharashtra, Punjab and Tamil Nadu improved immunization coverage
- Tamil Nadu and Andhra Pradesh had achieved improvement in coverage and quality of Antenatal care.

NFHS 1 & 2 have shown that there has been some improvement in the performance under all components of RCH programme (Annexure 3.1)

Some of major areas of continuing concern include:

- The massive interstate differences in the fertility and mortality- the rates are high in the states where nearly 50 % of the country's population lives.
- Gaps in infrastructure/manpower/equipment and mismatch between infrastructure and manpower in PHC/CHC; lack of referral services.
- Decline in mortality during the nineties was slow; the goals set for mortality and fertility in the Ninth plan will not to be achieved.
- There has been no decline in the maternal mortality ratios over the nineties; neonatal and infant mortality rates have remained essentially unaltered in the nineties.
- The routine service coverage has declined perhaps because of the emphasis on campaign mode operations for individual components of the programme.
- In spite of the emphasis on skill up gradation training for delivery of integrated reproductive and child health services , the progress in in-service training has been very slow; the anticipated improvement in the content and quality of care has not taken place.
- Evaluation studies have shown that the coverage under immunization is not universal even in the best performing states; coverage rates are very low in states like Bihar; elimination of polio is yet to be achieved
- Logistics of drug supply has improved in some states but remains poor in populous states.
- Decentralised district based planning, monitoring and midcourse correction utilising the locally generated service data and CRS has not yet been operationalised



fully.

Lessons learnt during implementation of FW programme during the last five decades (Fig-3.1):

- Governmental network provides most of the MCH and contraceptive care;
- Adequate financial inputs and health infrastructure are essential prerequisites for the success of the programme;
- Providing efficient and effective integrated MCH and contraceptive care helps in building up rapport with the families;
- Information Education Communication and Motivation activities are powerful tools for promoting the small healthy family norm;
- The population is conservative but responsible and mature; their response may be slow but it is rational and sustained.

Recommendations for the Tenth Plan

The current high population growth rate continues to be due to :

- the large size of the population in the reproductive age-group (estimated contribution 60%);
- higher fertility due to unmet need for contraception (estimated contribution 20%); and
- high wanted fertility due to prevailing high IMR and other socio-economic reasons (estimated contribution about 20%).

During the Tenth Plan efforts to :

- assess and meet the unmet needs for contraception;
- achieve reduction in the high desired level of fertility through programmes for reduction in IMR/MMR;
- enable the families to achieve their reproductive goals.

will continue. If the reproductive goals of families are fully met it is possible to achieve the NPP goal of replacement level of fertility by 2010. The medium and long term goals will be to continue this process accelerate the pace of demographic transition and achieve population stabilisation by 2045. Early population stabilisation will enable the country to achieve its developmental goal of improvement in economic status and quality of life of the citizens.

During the Tenth Plan, the paradigm shift which began in the Ninth plan from:

- Demographic targets to focus on enabling the couples to achieve their reproductive goals.
- Method specific contraceptive targets to meeting all the unmet needs for contraception to reduce unwanted pregnancies.
- Numerous vertical programmes for family planning and maternal and child health to integrated health care for women and children.
- Centrally defined targets to community need assessment and decentralised area specific microplanning and implementation of health care for women and children to reduce infant mortality and reduce high desired fertility.
- Quantitative coverage to emphasis on quality and content of care

- Predominantly women centred programmes to meeting the health care needs of the family with emphasis on involvement of men in Planned Parenthood.
- Supply driven service delivery to need and demand driven service; improved logistics for ensuring adequate and timely supplies to meet the needs.
- Service provision based on providers perception to addressing choices and conveniences of the couples

should be fully operationalised.

Reductions in fertility, mortality and population growth rate will continue to major objectives during the Tenth Plan; three of the eleven monitorable targets for the Tenth Plan and beyond are:

- reduction in IMR to 45 /1000 by 2007 and 28/1000 by 2012;
- reduction in maternal mortality ratio to 2/1000 live births by 2007 and 1/1000 live births by 2012; and
- reduction in decadal growth rate of the population between 2001-2011 to 16.2.

The focus will have to be on improving access to services to meet the health care needs of women and children by:

- decentralised area specific approach to planning, implementation and monitoring of the performance and effecting mid course corrections;
- differential strategy to achieve incremental improvement in performance in all states/districts;
- special efforts to improve access to and utilisation of the services in states/districts with high mortality and /or fertility rates;
- filling the critical gaps (especially CHCs) in existing infrastructure through appropriate reorganisation and restructuring primary health care infrastructure;
- ensuring that post of specialists in CHC/FRU do not remain vacant; skill upgradation and redeployment existing manpower to fill other critical gaps;
- streamlining the functioning of the primary health care system in urban and rural areas; providing good quality integrated reproductive and child health services at primary, secondary and tertiary care and improving the referral services;
- providing adequate supply of essential drugs, diagnostics and vaccines; improving the logistics of supply;
- well co-ordinated activities for delivery of services by public, private and voluntary sectors to improve coverage;
- involvement of the PRI in planning, monitoring and midcourse correction of the programme at local level;
- involvement of the industries, organised and unorganised sectors, agriculture workers and labour representatives in improving access to RCH services ;
- effective use of social marketing to improve access to simple OTC products such as ORT and condoms;

- effective Information, Education, Communication and Motivation(IECM);
- effective intersectoral co-ordination between concerned sectors.

During the Tenth Plan, the pace of implementation of the Programme will have be accelerated through streamlining of infrastructure, improving quality, coverage and efficiency of services so that all the felt needs for family welfare services are fully met. Special attention will have to be paid to improving access to good quality services to the underserved population in urban slums, remote rural and tribal areas. If these were done it is technically feasible to achieve the ambitious goals set for the process indicators and perhaps even the impact indicators in the NPP2000 and in the Tenth Plan (Annexure 3.2). Striving to achieve these goals is essential in order to enable the country to achieve the goals set for improvement the quality of life and human development within the time frame.

Annexure – 3.1

Performance of Family Welfare Programme in the Nineties

Sl.No.	Indicators	NFHS – I (1992-93)	NFHS – II (1998-99)
1	Female Literacy	43.3	51.4
2	Percentage of Girls below 18	54.2	50.0
3	Children fully immunized (%) (BCG, Polio 3, DPT 3, Measles)	35.4	42.0
3 (a)	1. Coverage of Individual Antigens		
	BCG	62.2	72.0
	Polio3	53.4	63.0
	DPT	51.7	55.0
	Measles	42.2	51.0
4	Infant Mortality Rate	78.5	67.6
5	3 or more Antenatal Check up for Women	44.0	44.0
6	2 or more doses of TT	55.0	67.0
7	Iron Folic Acid Supplementation	52.0	58.0
8	% Safe Delivery	34.2	42.3
9	Percentage of births of order 3 and above	48.5	45.2
10	Contraceptive Prevalence Rate	40.6	48.2
11	Sterilisation	31.0	36.0
12	Spacing Methods (Modern)	6.0	7.0
	Spacing Methods (Traditional)	4.0	5.0
13	Total Fertility Rate	3.4	2.9
14	Percentage of women with any anaemia	NA	52.0
15	Percentage of children with any anaemia	NA	74.0

Indicator	Present Status	Goals			
		NHP-1983	Ninth Plan	Tenth Plan	NPP 2000
Target Year		2000	2002	2007	2010
Crude Birth Rate	25.8 (SRS2000)	21	24	21	21
Total Fertility Rate	2.85*	2.3	2.9	2.3	2.1
Couple Protection Rate	46.2% (2000)	60	51	65	Meet all needs
Maternal Mortality Ratio	540 *	Below 200	300	200	100
Perinatal Mortality Rate	-	30-35	-		
Neonatal Mortality Rate	43.4*	-	35	26	
Infant Mortality Rate	68 SRS(2000)	Below 60	56	42	below 30
Under 5 Mortality Rate	94.9*	-	-		
% Immunization of infants (six VPD)	42*	85	65	100	100
▪ - Measles	51*				
▪ - DPT	55*				
▪ - Polio	63*				
▪ - BCG	72*				
Ante-natal care (ANC)					
% at least 3 ANC	43.8*	100	90	90	100
% received IFA for 3 or 4 months	47.5*				
% received 2 TT Vaccine	66.8*				
Deliveries					
Institutional Deliveries%	33.6*	-	35	80	80
Deliveries by trained health personnel including trained birth attendants(%)	42.3*	100	45		100
Prevalence of low birth weight babies (%)	30 (Estimated)	10			

*Source: NFHS -- 2