UNIT 4 HEALTH AND POPULATION POLICY

Structure

4.1 INTRODUCTION

People are a county's greatest resource. They make singular contributions to development And, therefore, governments formulate and implement policies and programmes that are aimed at improving the quality of their human resources. While population is a crucial factor with respect to development, the health of the people plays a critical role in transforming them into a qualitative human resource. That is why policies relating to health and population are considered very important. The aim of this unit is to discuss health and population policies adopted in India during pre- and post-independence periods. This unit also discusses the National Health Programmes in the country.

Health has been accepted as a fundamental right of every one in the constitution of the World Health Organization (WHO). The Universal Declaration of Human Rights also incorporates it under Article 25. In view of this, formulation of national health care policies by individual countries becomes imperative. This is said because health care by the public sector is weaved through the state, central and local governments. They enunciate polices, establish health care delivery systems, set up goals with the major objective of economic and social development, and improve the quality of life of the people.

In the Indian context, strategies towards preventative, curative and promotive health care delivery system were initiated during pre-independence days. After independence, a number of committees were set up to concretize ideas and strategies for attaining health goals. Since the inception of the planning process in the country, successive Five Year Plans have been providing the framework within which the states are free to develop their health service infrastructure and facilities for medical education. However, it took 36 years after independence to formulate a comprehensive National Health Policy which was first announced in 1983. Subsequently, in keeping with public expectations, available financial resources, and an increase in public health administrative capacity, the National Health Policy, 2002 was formulated and put into practice, like health, population

issues have also been an area of major concern for Indian policy makers. Rapid population growth has been a major concern in the context of plans and policies adopted for overall development of the country. In fact, a number of social scientists hold the view that the large size of population is the mother of all the problems in the country, and once the issue of rapid population growth is dealt with, all other problems will automatically get solved. The country, thus, has a lengthy history of t population policy. In 1952, the Government of India began, in a modest way, one of the earliest national government sponsored family planning efforts. A National Population Policy statement was released by the Government of India on 16th April, 1976. The population strategies adopted after independence went through many changes. It was only in 2000, that a comprehensive National Population Policy was announced by Government of India.

After studying this unit you should be able to

- explain National Health Policies
- narrate National Population Policies

4.2 NATIONAL HEALTH POLICIES: CONCEPT AND EVOLUTION

4.2.1 National Health Policy: The Concept

A health policy is an expression of what a health care system should be, so that it can meet the health care needs of the people. The World Health Organization's concept of healthy public policy is placing health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions, and to accept their responsibilities for health (WHO 1986). Governments are ultimately responsible for providing or organizing how the health services will be provided to their citizens. Health policies are dynamic, and thus, need to be reviewed on a regular basis to ensure that these are a reflection of government's vision and priorities taking into account the changing realities and socio-cultural circumstances of the country.

Health is a state subject in India. As India has a federal system of government, its Constitution provides for a clear division of powers between States and the Centre through three Lists, The Union List, the State List and the Concurrent List. The State List consists of subjects of local interest such as Public Health, Police, etc. However, health, today, forms an integral part of the national socio-economic planning providing a holistic understanding of health with the framework that States need to pursue to achieve the goals of development. A beginning was made even during the colonial days. After independence, India adopted the welfare state approach, wherein a national health system was envisaged. The State's role was to be central to providing services to the population. The health activities for the State were formulated through the five year plans. Each plan period had a number of schemes and every subsequent plan added a few more and dropped a few others.

4.2.2 National Health Policy: The Evolution

The current National Health Policy has emerged from the continuous process of reviews by various committees constituted at intervals to provide guidelines to the government for national health planning. These committees are as follows.

The Health Planning and Development Committee Report, popularly known as Bhore Committee Report, 1946, were on the lines of Britain's National Health Service Scheme. Sir Joseph Bhore made recommendations that formed the basis for organization of basic health services in India. He made a case for social orientation of medical practice coupled with high a level of public participation.

The following were the salient recommendations of the Bhore Committee

- Integration of preventive and curative services at all administrative levels
- Formation of Village Health Committees
- Provision of Social Doctor
- Intersectoral approach to development of health services
- Three month training programmes in preventive and social medicine to prepare social physicians

Taking a clue from the Bhore Committee Report, a beginning was made in 1952 to set up primary health centres to provide integrated promotive, preventive, curative, and rehabilitative services to the entire rural population of the country.

i) Health Survey and Planning Committee Report or Mudaliar Committee Report, 1962 stressed on developing health services infrastructure and the health cadre at the primary level. It also recommended setting up of grassroots level workers in the form of auxiliary nurse midwife.

ii) Chadha Committee Report (1963) called for adoption of the malaria eradication programme.

iii) Mukerji Committee Report (1966) worked out the details of the Basic Health Services to be provided in rural and urban areas.

iv) Jungalwalla Committee Report (1967) recommended integration of all variety of health services.

v) Kartar Singh Committee Report (1973) gave recommendations on procedure for the distribution of health cadres at the primary level.

vi) Srivastava Committee Report (1975) on Medical Education and Support Manpower recommended creation of bands of para professionals and semi professional health workers from within the community, e.g., school teacher and postmasters, to provide simple promotive, preventive, and curative health services needed by communities. On the pattern of the University Grants Commission, the establishment of a Medical and Health Education Commission for planning and implementing reforms needed in health and medical education was recommended.

Besides these committees, the implementation of a Rural Health Scheme, initiated in 1977, made contributions to the improvement of health infrastructure and services. Under this scheme medical colleges were involved in imparting total health care to the selected PHCs, with the aim of reorienting medical education to the needs of the rural people, and, also to provide training to multipurpose workers engaged in the control of various communicable disease programmes.

Finally, with the widespread disillusionment with vertical programmes, worldwide, and, the need to provide universal health services, came the Primary

Health Care Declaration at Alma Ata in 1978, which India was a signatory to. Accordingly, steps were taken to promote education concerning prevailing health problems; ensure adequate supply of safe water and basic sanitation; provide maternal and child health care including family planning, and immunization; ascertain prevention and control of locally endemic diseases; effect appropriate treatment of common diseases and injuries; promote mental health; and, provide essential drugs. On the whole, it emphasized an integration of preventive, promotive, curative and rehabilitative health services that had to be made accessible and available to the people. Evidently, by the end of 1980s, India had built up a vast health infrastructure and initiated several national health programmes, commissions, constituted and the Central Council of Health and Family Welfare. However, there was a growing realization that public health initiatives in the country did not meet with the desired success. In 1983, the government made a major move in the health sector by announcing a National Health Policy as a corrective measure.

In this section, you read the basic concept and evolution of the National Health Policy in India. Now attempt the questions given in Check Your Progress-1.

Check Your Progress 1

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit.

1) Write a brief note on Health Committees constituted in India.

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4.3 NATIONAL HEALTH POLICY – 1983

The Alma Ata Declaration of 1978 propounded the concept of 'Health for All' by Year 2000. It was signed by 134 countries, including India, and 67 agencies. The declaration advocated the provision of first contact services and basic medical care with the framework of an integrated health services. The Declaration affirmed that it is the responsibility of the State to provide comprehensive primary health care to its people. This led to the formulation of India's first National Health Policy (NHP) in 1983. The major goal of NHP-1983 was to provide universal, comprehensive primary health care services. It also underlined the role of private and voluntary organizations towards integration of health services.

4.3.1 Feature of NHP-1983

Some of the important features of National Health Policy 1983 are

i) Need for providing primary health care with special emphasis on the preventive, promotive and rehabilitative aspects.

ii) Population stabilization- the policy emphasized small families through voluntary efforts and moving towards the goal of population stabilization.

iii) Medical and Health Education- emphasis was laid on the effective delivery of health care services that would depend largely on the nature of education, training, and appropriate orientation towards community health for all categories of medical and health personnel, and their capacity to function as an integrated team.

iv) Re-orientation of the existing health personnel- The policy emphasized changes and innovation that were required to be brought about in the entire approach to health and manpower development, ensuring the emergence of fully integrated bands of workers functioning within the " Health Team" approach.

v) Practitioners of indigenous and other systems of medicine and their role in healthcare- the policy envisaged that the country has a large stock of health manpower comprising of private practitioners in various systems such as Ayurveda, Unani, Sidha, Homeopathy, Yoga, Naturopathy, etc. These resources have not so far been adequately utilized. The practitioners of these systems enjoy high local acceptance and respect at the community level. It is, therefore, necessary to initiate organized measures to enable each of these systems of medicine and healthcare to develop in accordance with its genius.

4.3.2 Implications of NHP

In pursuance of this policy, an effective and efficient health care system for its citizens, particularly for the vulnerable groups like women, children and the underprivileged, was proposed to be established. This noteworthy initiative aimed at reaching the entire population with a package of primary health care. Stress was placed on the creation of an infrastructure for primary health care covering related services and activities like nutrition, drinking water supply, and sanitation; active involvement and participation of voluntary organizations; provision of essential drugs and vaccines; qualitative improvement in health and family planning services; and provision of adequate training and medical research. The slogan of NHP-1983 'Health for All by 2000 AD' could not be achieved due to constraints of financial resources and inadequate capacity of health infrastructure. However, the policy was successful in eradication of small pox and guinea worm disease. Polio came on the verge of being eradicated. Leprosy, kala azar and filariasis were expected to be wiped out in the foreseeable future. Meanwhile, the deadly communicable disease- HIV/AIDs appeared on the scene. An improvement in the life expectancy increased the requirement of care of older people. A high incidence of macro and micro nutrient deficiencies, especially among women and children persisted. Achievements in health services infrastructure were quite high as an outcome of NHP-1983, but the system continued to suffer from widening inequities in access to health care and quality of care. Whenever public facilities for medical care were used, urban hospitals are preferred (NSS, 1987, NCAER, 1992). The objectives of decentralization were achieved to some extent but community participation was missing. Epidemiological surveillance services, which the NHP, 1983 had strongly recommended, were not adequately addressed. It became imperative to work on another policy document which addresses the health concerns of the people through more holistic and effective guidelines.

4.4 NATIONAL HEALTH POLICY – 2002

4.4.1 Goal of NHP

The country could not achieve most of the goals in NHP-1983, despite some notable gains made in health outcomes, and vast improvements in the availability of health infrastructure. The second National Health Policy was announced in 2002. Demographic changes, transitions in the occurrence of new diseases, technological advancements, rising aspirations of communities, and the rise in the impact of globalization on the country necessitated the adoption of a new policy. The major objective put forth by NHP-2002 is to achieve an acceptable standard of good health among the general population. It aims to identify deficient areas, establish requisite infrastructure, and ensure equitable access to health services across the social and geographical expanse of the country. It expects to strengthen the public health system at state level; encourage private sector involvement in service delivery, particularly for the population groups that can afford to pay; increase allocation to preventive services, strengthen curative initiatives at the primary health level, and work for rational use of drugs.

The NHP-2002 specified several time-bound goals.

Major goals to be achieved	Year
Eradicate polio and yaws	2005
Eliminate leprosy	2005
Eliminate *kalaazar*	2010
Eliminate lymphatic filariasis	2015
Achieve zero level growth of HIV/AIDS	2007
Reduce mortality by 50 per cent on account of TB, Malaria, Other Vector and Water Borne Diseases	2010
Reduce prevalence of blindness to 0.5 per cent	2010
Reduce IMR to 30/1000 and MMR to 100/lakh	2010
Increase utilization of public health facilities from current level of < 20 per cent to > 75 per cent	2010
Establish an Integrated System of Surveillance, National Health Accounts and Health Statistics	2005
Increase health expenditure by government as a per cent of GDP from the existing 0.9 per cent to 2 per cent	2010
Increase share of central grants to constitute at least 25 per cent of total health spending	2010
Increase state sector health spending from 5.5 per cent to 7 per cent of the budget	2005
Further increase to 8 per cent	2010

4.4.2 Features/Measures of NHP-2002

The goals of NHP -2002 were to be addressed through following measures

i) **Financial Resources**: the policy prescribes the role of Central government in augmenting public health investments and ensuring a fiscal health of the public delivery system.

ii) **Role of Private Sector**: the policy hails the role of private sector in primary, secondary and tertiary sectors. Private health insurance packages are proposed to be encouraged. The use of telemedicine for enhancing the capacity of professionals is favoured.

iii) **Impact of Globalization on the Health Sector**: in order to provide affordable access to the medical and other associated facilities, the policy envisages a national patent regime for the future, under its patent laws. It also sets out that the Government will bring its full influence to contain the adverse effects of the Trade Related Intellectual Property Rights (TRIPS) on health sector.

iv) **Role of Local Self-Government Institutions:** different levels of the local self-government are being enabled through the NHP-2002 to supervise and ensure effective implementation of the health sector.

v) **Role of Civil Society**: the policy highlights the roles of NGOs and other institutions of the civil society in the health sector. It also simplified the procedures for augmenting the role of such institutions in supplementing the public health services.

vi) **Equity**: an uneven divide is evident amongst the population in rural and urban areas, and across different economic groups in terms of health indices, including the population below the poverty line, infant mortality rate, under five mortality, maternal mortality rate, leprosy, and malaria. To address this issue, NHP-2002 prescribes increased allocation of 55 per cent of the public investment in health in the primary health care sector, 35 per cent to the secondary sector, and the remaining 10 per cent to the tertiary sector.

vii) **Extending Public Health Services:** the private practitioners are also to contribute towards the underserved areas and the rural areas. In order to ensure the availability of trained manpower in underserved areas, the policy empowers the States to simplify the recruitment procedures. The State governments may enforce a mandatory two-year rural posting before awarding of the graduate degree. An effort to Indian System of Medicine is also to be attempted through NHP-2002.

viii) **The State of Public Health Infrastructure:** NHP 2002 will assess the quality and efficiency of the existing public health system in the field. The rural health staff is required to be trained and reoriented to perform better. While greater emphasis has been laid on strengthening of primary health infrastructure, the policy recognises the need for levying reasonable user charges for certain secondary and tertiary public health care services for those who can afford to pay.

ix) **Medical Ethics**: the policy calls for adoption of a contemporary code of ethics by the Medical Council of India to ensure that patients are not subjected to profit-driven medical treatment.

x) **Enforcement of Quality Standards for Food and Drugs**: the policy proposes strengthening of food and drug administration in terms of both laboratory facilities and technical experts.

xi) **Regulation of Standards in Paramedical Disciplines**: the policy recognizes the need for the establishment of statutory professional councils for paramedical disciplines to register practitioners, maintain standards of training, and monitor performance.

xii) **Norms for Health Care Personnel**: deficiencies with respect to the deployment of doctors and nurses are to be effectively managed through the statuary norms prescribed under the Indian Medical Council Act and Indian Nursing Council Act.

xiii) **Education of Health Care Professionals:** the policy recommends setting up a Medical Grants Commission for funding new government medical and dental colleges in different parts of the country. A need to modify the existing curriculum is also underlined.

xiv) **Nursing Personnel**: the policy calls for improving the ratio of nurses *vis-à-vis* doctor/and beds, and strengthening their skill levels.

xv) **Need for Specialists in Public Health and Family Medicine:** highlighting the role of Public Health and Family Medicine specialist's *vis-à-vis* the clinical specialists in a developing country like India, the policy recommends an allocation of a reasonable number of seats for public health and family medicine candidates.

xvi) **Use of Generic Drugs and Vaccines:** the policy favours the production of low cost and high quality indigenously manufactured generic drugs and vaccines. It envisages that not less than half of the vaccines are supplied through public sector institutions.

xvii) **Urban Health:** the policy envisages setting up of an organized urban primary health care structure, particularly for the slum localities. It also suggests measures to reduce mortality associated with accidents.

xviii) **Mental Health:** the policy intends to remove deficiencies in the existing physical infrastructure and manpower related to mental health.

xix) **Women's Health**: the policy favours health programmes meant for women. Such programmes are to be given funding on a priority basis by the Central government.

xx) **Information, Education and Communication:** the policy highlights the need to evolve an IEC policy, especially by inculcating health promoting behaviour among school children.

xxi) **Health Research**: the policy looks for an increase in the government funding of health research from a level of 1 per cent of total spending in 2005 to 2 per cent by 2010. Cost effective applied research is noted as a critical area. Research programmes need to be conducted in mission mode.

xxii) **Health Statistics**: NHP-2002 lays emphasis on generating accurate data-base for various diseases for framing suitable strategies. The policy suggests the establishment of national health accounts.

xxiii) Delivery of National Public Health Programmes: NHP-2002 envisages the gradual convergence of all health programmes. It attempts to define the role of the Central Government and the State Governments in this regard.

xxiv) National Disease Surveillance Network: The policy attempts to put in place disease control network to manage seasonal outbreaks of diseases more effectively. The intention is to promote timely spread of information from institutions outside public system.

xxv) Environmental and Occupational Health: The policy observes that the environmental policies and other related programmes should be framed in such a way that these take care of the health of citizens. A periodic screening of workers engaged in high risk labour activities is suggested.

xxvi) Providing Medical facilities to Users from Overseas: The policy favours provisions of health services to overseas patients in secondary and tertiary sectors to earn foreign exchange.

Thus, the new Health Policy-2002 highlights the need of improving the access to health services among all social groups and in all areas. This is to be done by setting up new facilities in deficient areas and improving the existing ones. Recognizing that women and other underprivileged groups are most affected by poor access to health care, it calls for special treatment to them. NHP-2002 proposes a substantial increment in government expenditure on health care. It, however, represents a retreat from the fundamental concept of 'Health for All' by 2000 as laid down by NHP 1983. In contrast, NHP-2002 has omitted the concept of comprehensive and universal health care. In fact, primary health care has been reduced to primary level care. Nonetheless many of its formulations paved the way for greater privatization of the system.

In this section, you read two national health policies 1983 and 2002. Now, answer the question given in Check Your Progress 2.

Check Your Progress 2

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit.

1) What are the objectives of NHP-2002?

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4.5 NATIONAL POPULATION POLICIES: CONCEPT AND EVOLUTION

4.5.1 Evolution

Rapid population growth was identified as matter of concern even before India became independent. The National Planning Committee set up by the Indian National Congress in 1935, under the Chairmanship of Pt. Jawahar Lal Nehru, had strongly supported propagation of the knowledge and practice of family planning. The Bhore Committee, constituted in 1946 voiced concern when it observed that the public health system, as it existed in the country, would not be able to meet the demands posed by growing population, and advocated a need for limiting the family size.

After independence, the Planning Commission, Government of India, highlighted the urgency of the problem of family planning and population control. This constituted a vital component of the First Five Year Plan. In 1952, India launched the National Family Planning Programme. The overall emphasis was on family planning for lowering the birth rate in order to 'stabilize the population at a level consistent with the requirements of national economy'.

Observance of the small family norm by all, thus, became the goal to be achieved through family planning. In the beginning, modern contraceptive methods of family planning methods were not inducted. Various efforts were made to make people aware about the benefits of small family size through activities focused on maternal and child health care. Adoption of natural methods of contraception for limiting the family size was favoured.

This programme achieved limited success. The majority of the family planning clinics established were located either in urban areas or in large villages, leaving a sizeable population uncovered. Taking into account the shortcomings associated with this, the clinic based approach was replaced in 1963 by the extension approach. In the new approach, the Auxiliary Nurse Midwife (ANM) was to visit the houses of married couples in order to provide family planning services at their doorsteps. New methods of contraceptives were introduced.

The year 1966-67 marked a paradigm shift in the Family Planning Programme when method-specific family planning targets were fixed and allocated. A number of officials from the health department, along with other departments, were assigned family planning targets to be achieved on an annual basis with the prime goal of lowering the birth rate. However, this led to certain distortions. The programme was plagued with fake reporting of the family planning achievements by different officials in order to escape penalties associated with non-compliance of fixed targets. The 1971 Census revealed that the demographic goals, set up in 1962, had not been achieved.

The experience of two years, 1975-77, during the period termed, The Emergency, were monumental in the context of shaping of India's population policy. In 1976, the first statement towards National Population Policy spread its net beyond family planning measures, which included measures like raising the marriageable age limit, promoting female literacy, providing employment opportunities to women, and reducing high infant mortality rate. The opening paragraphs of the National Population Policy statement argued that

i) Reducing the rate of population increase "will be treated as a top national priority and commitment"

ii) "To wait for education and economic development to bring about a drop in fertility is not a practical solution"

iii) Population control must play a crucial role in the movement towards independence and social transformation.

In actual fact, the Policy Statement on the Family Welfare Programme came in 1977. It encouraged state governments to pass legislations to enhance community participation for promoting small family size norms. Such statements, tabled in parliament were neither discussed nor adopted. There were political implications of reduction of birth rate at the state level. Since political representation in Parliament was determined by a State's population size, a fear was expressed that its slower population growth rate would result in a loss of relative influence through a drop in the number of seats in the national parliament. To safeguard against this possibility, representation in parliament, as also in state legislatures was frozen up to the year 2001, retaining the population enumerated at the 1971 Census as the base.

Motivation, which had been a part of the family planning programme, was supplemented by coercion and with the use of incentives, and later with harsher measures. In 1975, earnest efforts were made for the promotion of male-centred vasectomy to slow the rate of population growth. A coercive campaign was adopted to sterilize couples who already had three or more children. The programme got a severe setback due to the overemphasis on vasectomies. The programme suffered due to the ill effects of a coercive strategy. The number of vasectomy acceptors sharply declined after 1976-77, making it more or less a female oriented programme.

In 1977-78, the Government of India took measures to shift away from coercive actions, and the programme was to be implemented as an integral part of family welfare, based on mass education and motivation. The name of the programme was changed from National Family Planning Programme to National Family Welfare Programme.

In another damage control exercise, the National Health Policy-1983 stressed the need for adhering to small family norms through voluntary efforts. For attaining the goal of population stabilization, the goal to achieve the replacement level by 2000 was targeted. This has guided the Family Planning Programme since then.

In the year 1992 population policy initiatives were adopted. The 73rd and 74th Constitutional Amendments were introduced enabling the *Panchayati Raj* Institutions (PRIs) and urban local bodies (ULBs), among others, to carry out the task of primary health care and primary education. The provision of basic amenities including the drinking water and roads, became the responsibility of PRIs and ULBs. The focus of the programme shifted from population control to community outreach services.

In 1994, the Swaminathan Committee was assigned the task of framing the new population policy. The draft National Population Policy incorporated a number of suggestions made at the International Conference on Population and Development (ICPD) held in Cario in 1994. Unlike the earlier population policy statements of 1976 and 1977, the draft of the National Population Policy was widely circulated among the members of Parliament and others. This was discussed by the cabinet, followed by discussion in Parliament. Most notably, method specific contraceptive targets were abolished in 1996 and were replaced by the Target-Free Approach, later renamed as Community Needs Assessment Approach (CNAA). The agenda shifted from

population control to reproductive and child health (RCH) in 1997. In particular, women's empowerment gained momentum.

The draft national population policy was approved by the Cabinet with the direction that this be placed before Parliament. Several suggestions were made during the deliberations. On that basis, a fresh draft was submitted to the Cabinet. Finally, in 2000 the National Population Policy was announced.

4.6 NATIONAL POPULATION POLICY – 2000

The goals, objectives and strategies of the National Population Policy (2000) centre on family planning and maternal and child health. It envisages development of one-stop integrated and coordinated service delivery at the village level on these two parameters. This involves partnership of the government with non-government voluntary organizations.

The NPP 2000 has laid down objectives at three times frames: immediate, medium term, and long term. The immediate objective is to cater to the unmet need for contraception, health infrastructure, and health personnel, and to integrate service delivery for basic reproductive and child health care.

The medium term objective is to effectively implement inter sectoral strategies to bring down the total fertility rate (TFR) to a replacement level by 2010. The long term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and eco-conservation.

A) National Socio-Demographic Targets to be achieved by 2010: Fourteen such targets, as follows, were set to be achieved.

i) Fulfil the unmet need for basic reproductive and child health services, supplies and infrastructure.

ii) Make school education free and compulsory for children up to 14 years, and reduce the dropout rate for both boys and girls at primary and secondary school levels to below 20 per cent.

iii) Bring infant mortality rate below 30 per 1000 live births.

iv) Bring maternal mortality ratio to below 100 per 100,000 live births.

v) Achieve 100 per cent immunization of children against all vaccine preventable diseases.

vi) Encourage the increase in age-at—marriage of girls, not earlier than age 18, and, preferably, after 20 years of age.

vii) Increase institutional deliveries to 80 per cent and deliveries by trained persons to 100 per cent.

viii) Achieve universal access to information/counselling, and services for fertility regulation and contraception with a wide basket of choices.

ix) Increase registration of births, deaths, marriage and pregnancy to 100 per cent.

x) Enhance the IEC coverage for RTIs/STIs/AIDS to wider population.

xi) Prevent and control communicable diseases.

xii) Integrate allopathic medicine with Indian Systems of Medicine (ISM) for better provision of reproductive and child health services, and for reaching out to households.

xiii) Encourage strongly the small family norm to achieve the replacement level of TFR.

xiv) Coordinate the implementation of related social sector programs to make family welfare programme people-centric.

B) Strategies for NPP-2000: the strategy for NPP includes the following 12 measures.

i) Decentralization of the Plan and Programme Implementation

ii) Convergence of service delivery points in villages

iii) Empowering women for mitigating health and nutrition problems

iv) Strengthening child health and survival care

v) Fulfilling the unmet need for family welfare

vi) Meeting the needs of the vulnerable and underserved population groups constituting urban slums, tribal communities, hill area populations, displaced and migrant populations, adolescents and men in planned parenthood

vii) Providing encouragement and incentives to diverse health care providers

viii) Collaborating with the Commitments from NGOs and private sector

ix) Channelling Indian Systems of Medicine and Homeopathy

x) Strengthening contraceptive technology and research on RCH

xi) Providing for older population

xii) Improving information, education, and communication technology for health care services.

C) New Structures to be established under NPP-2000: four new structures, as follow, were established under the policy.

i) National Commission on Population

ii) State/UT Commissions on Population

iii) Coordination Cell in the Planning Commission

iv) Technology Mission in the Department of Family Welfare

i) National Commission on Population: as recommended by NPP-2000, the National Commission on Population was constituted on 11th May 2000, the day when India reached one billion population marks. It has the Prime Minister of India as its Chairman, Deputy Chairman Planning Commission as Vice Chairman, Chief Ministers of all states, Ministers of the concerned Central Ministries, Secretaries of the concerned Departments, eminent demographers and representatives of the civil society as members. The

mandate of the Commission was to guide the implementation of the National Population Policy in achieving the goals, to hasten population stabilization by promoting synergy between health, educational environmental and developmental programmes, to promote inter sectoral coordination in planning and implementation of the programmes at the Centre and States, and to facilitate the development of a vigorous people's movement in support of this national effort.

ii) **State/UT Commissions on Population**: State Population Commissions have also been commissioned in as many as 21 States/ UTs. The initiation of the process of policy formulation undertaken at the state level is expected to achieve the goals setup in NPP – 2000 (MOHFW, 2008-2009).

iii) **Coordination Cell in the Planning Commission**: in place of a coordination cell, a policy convergence has been set up.

iv) **Technology Mission in the Department of Family Welfare**: in place of a Technology Mission in the Department of Family Welfare, an Empowered Action Group (EAG) has been created.

D) Legislation

For pursuing the agenda for population stabilization of NPP-2000, the 42nd Constitutional Amendment has frozen the number of seats in Lok Sabha and Rajya Sabha till 2026, with the 1971 Census as the base.

E) Adoption of Small Family Norm Promotion Measures: twenty such measures are summarized below.

NPP-2000 does not include disincentives. Rather, it has measures for promotion and motivation for achieving the small family norm. In the past, the incentives were linked with sterilizations. In the policy, these incentives are liked to poverty, delayed marriage, delivery care, birth registration, birth of a girl child, and immunization.

- Incentives to *Panchayats* and *Zila Parishads* for achieving small family norms, especially by reducing infant mortality.
- Couples below the poverty line undergoing sterilization after two children to be given health insurance
- Improving the status of women by giving some incentives at the birth of girl child Contraceptive choice to be widened and made more accessible
- Safe abortion facilities to be expanded and strengthened
- Strict enforcement of legal reforms, including Child Marriage Restraint Act, 1976 and Pre-Natal Diagnostic Techniques Act, 1994

NPP recognized that there is a large need to augment and strengthen health care services as well as to cater to the unmet needs for contraception. Though the NPP-2000 mentioned sustainable development, quality of life, education, equity, gender issues, and raising the age at marriage, the emphasis remained primarily on the family planning programme. As such, the specific goal of achieving replacement level fertility by the year 2010 appears quite unrealistic.

4.7 STATE POPULATION POLICIES

In the spirit of NPP-2000, 17 States/ UTs including Andhra Pradesh, Bihar, Chhattisgarh, Gujarat, Haryana, Madhya Pradesh, Rajasthan, Tamil Nadu, Uttar Pradesh, Uttaranchal, Mizoram, Tripura, Andaman & Nicobar Islands, Chandigarh, Dadar and Nagar Haveli, Daman and Diu, and Lakshadweep, have formulated their own State Specific Population Polices, defining the strategies and programmes to be followed to attain the goals set that have been outlined.

In this section, you studied the concept and evolution of population policies followed at national as well as state level. Now, answer the questions given in Check Your Progress 3.

Check Your Progress 3

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

1) What are the major objectives of the National Population Policy-2000?

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2) What are the new structures recommended by NPP-2000?

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4.8 LET US SUM UP

With the growing realization that public health initiatives had not met with the desired success, a National Health Policy, in 1983, was adopted as a corrective measure. NHP-1983 adopted the slogan 'Health for All by 2000 AD'. This goal, too, could not be achieved due to constrained financial resources and inadequate capacity in the public health sector. The policy was, however, successful in the eradication of small pox and guinea worm disease. Achievement of an acceptable standard of good health for all became the hallmark of NHP-2002. Within three years of its adoption, NRHM, a strategic framework to implement NHP-2002, was launched in 2005 to provide effective health care to the rural population. It adopted the key guidelines of NHP-2002.

It was realized that not much headway was likely to be made in improving the health of people unless the population was stabilized. In order to achieve the desired growth

rate of population, a series of declarations on population issues were enunciated. A formal National Population Policy was articulated in 2000. It underlined goals, objectives and strategies centred around family planning and maternal and child health. As envisaged in the policy, the National Commission on Population was set up in 2000 at the Centre. By now State and Union Territories Commissions on Populations have also been put in place in as many as 21 States and Union Territories.

4.9 REFERENCES AND SELECTED READINGS

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4.10 CHECK YOUR PROGRESS: POSSIBLE ANSWERS

Check Your Progress 1

1) Write a brief note on Health Committees constituted in India?

Ans. The various health committees constituted in India since independence. Health Survey and Planning Committee Report or Mudaliar Committee Report, 1962 laid stress on developing health services infrastructure and the health cadre at the primary level. It also recommended setting up of grassroots level workers in the form of auxiliary nurse midwives. Chadha Committee Report (1963) called for the adoption of malaria eradication programme. The Mukerji Committee Report (1966) worked out the details of the basic health services to be provided in rural and urban areas.

Check Your Progress 2

1) What are the objectives of NHP-2002?

Ans. The major objective of NHP-2002 is to achieve an acceptable standard of good health among the general population. It aims to identify deficient areas, establish requisite infrastructure, and ensure equitable access to health services across the social and geographical expanse of the country. It expects to strengthen the public health system at the state level; encourage private sector involvement in service delivery, particularly for the population groups that can afford to pay; increase allocation to preventive services, strengthen curative initiatives at the primary health level, and work for rational use of drugs.

Check Your Progress 3

1) What are the major objectives of the National Population Policy-2000?

Ans. The NPP 2000 has laid down objectives at three time frames: immediate, medium term, and long term. The immediate objective is to cater to the unmet need for contraception, health infrastructure, and health personnel, and to integrate service delivery for basic reproductive and child health care. The medium term objective is to effectively implement inter sectoral strategies to bring down the total fertility rate (TFR) to a replacement level by 2010. The long term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and eco-conservation.

2) What are the new structures recommended by NPP-2000?

Ans. Four new structures, including the National Commission on Population, State/UT Commissions on Population, Coordination Cell in the Planning Commission, and Technology Mission in the Department of Family Welfare were proposed to be established under the NPP-2000. The National Commission on Population was set up in 2000. State Population Commissions have also been commissioned in as many as 21 States/UTs. In place of a coordination cell, a policy convergence has been setup. In place of a Technology Mission in the Department of Family Welfare, an Empowered Action Group (EAG) has been created.