

**INDIA'S 'FAMILY WELFARE' PROGRAM IN THE CONTEXT of A REPRODUCTIVE &
CHILD HEALTH APPROACH**
A Critique and a Viewpoint

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This note was presented at a meeting in Washington in December 1995 where a review of India's family welfare program was done in the context of the 'new' reproductive and child health approach, which is being promoted by the World Bank. At the meeting were present representatives of the Government of India from the Department of Family Welfare, experts from the World Bank, from a number of US NGOs, a few from Indian NGOs and some from other international agencies concerned with health and population issues. At the meeting the World Bank document Report No. 14644-IN titled 'India's Family Welfare Program: Towards a Reproductive and Child Health Approach' was the main agenda item to be debated. The meeting was organised by the Health and Development Policy Project of the Tides Foundation and the Population Council.

During the last decade or so the women's movements the world over, and especially in the west, have brought to centre stage women's' reproductive health concerns, the origins possibly being the abortion debate in the United States of America. Add to this the threat from Acquired Immuno Deficiency Syndrome (AIDS) and the population control lobby's supposed population bomb ticking away in third world countries and you have a new health policy prescription for countries who are seemingly endangering the world with their high fertility. India is one such country whose health policy is being reshaped in this new global context.

Another set of global programming for the third world countries is the cutting down of state expenditures for welfare like health, education, social security etc... The prescription here for the state is to narrow down its focus to providing essential services only and that too for a select population of the extremely poor. Thus, in the health sector there has been a downgrading of goals from basic health care for all in the fifties and sixties to primary health care for all in the seventies and eighties and now in the nineties it is selective essential health care for a selective population. The consequence has been that the health policy in the third world countries is increasingly being narrowed down to fertility reduction.

This development and its consequences are of crucial concern because even in India adverse effects are very visible. Health care investment and expenditures in the public sphere are declining and people are increasingly being pushed into seeking care in the private sector even if they can't afford it.

INDIA'S FAMILY WELFARE PROGRAM

At the outset it must be stated that 'family welfare' as a title is highly misleading because the entire effort of the concerned department is family planning, and that too mostly tubectomies. Other concerns of this department like child immunisation, antenatal care, abortions, deliveries, postnatal care etc.. are only marginal - occasional spurts of activity like universal immunisation using a mission approach did change things temporarily but as routine set in it could not be sustained and is again marginalised. One doesn't have to give the gory details of statistics to show how miserable health care in general and specifically for women and children is. It should suffice to mention that access to basic services like basic medical care, facilities for child birth, abortion services, contraceptive services, pregnancy care, immunisation etc. are just not there when clients visit the primary health centres or other provider units.

While in the nineteen fifties the state did put in efforts at building an infrastructure to deliver basic health care, these were abandoned sometime in the sixties when population control started to become the cornerstone of India's health policy. The first casualty of this new approach was the maternal and child health program with which the family planning program was integrated on the advice of a United Nations Advisory Mission to accommodate the loop program (the first ever IUCD program). The mch program had at that time just taken off in the rural areas with the setting up of subcentres and a large scale appointment of auxiliary nurse-midwives but both were hijacked by the newly created family planning department. From then on there was no looking back and population control kept getting an ever-increasing share of attention of health policy, planning and resource allocations. This might appear to be an exaggeration because 'only' about 15% of the budget of the ministries of health goes to family planning, and hospitals and medical care get about 'as much as' 40% of the budget share. But it is not, because 80% of the 15% on family planning is spent in the rural areas and 85% of the 40% on medical services goes to the urban areas, which have only one-fourth of the country's population. Further, the entire health team working in the rural health infrastructure (as also those from other government departments who have FP targets to fulfil) spend an overwhelming proportion of their time on family planning related activities - this means they are forced to encroach on their time for other health care tasks.

The fate of all subsequent programs, like the minimum needs program and integration of health workers under the multipurpose worker scheme, the child survival and safe motherhood program, the community health volunteer scheme, universal immunisation program etc. was the same - all ended up serving more the interests of the population control program than adhering to its own objectives. And it is this that makes up the misery and tragedy of health care, and specifically women's' health, in India. If each of these programs had been implemented genuinely as vertical programs like the small pox eradication program or the malaria control program of the sixties (even though I am against the concept of vertical programs) some significant achievements in women and child health care would have taken place. I fear that the fate of the proposed reproductive and child health approach will not be different and it will end up being a mere change in nomenclature. Also, given the fact that it will be directed largely at women it is in all likelihood going to further strengthen the targeting of women for fertility reduction and again keep men outside the frame of responsibility for reproduction.

Further, it is said by many supporters of the family-planning program that if it were not for the aggressive family planning program fertility would have been much higher in India. While one recognises the contribution of the family planning department in promoting contraception and increasing people's awareness about them it is too far fetched to give the credit of fertility reduction to the program. Fertility reduction has its own logic and worldwide it has come about only with change in people's objective reality, that is improved conditions of living, livelihood and social security. Conditions of poverty and large-scale inequities will normally not lead to the desired demographic transition. History bears witness to this!

SAYING NO TO A SEPARATE REPRODUCTIVE HEALTH APPROACH

While the elements defined in the package for reproductive and child health services are essential and must be provided it cannot by itself be an essential program. It must of necessity be part of a basic health and medical care program. Good quality basic health and medical care must be the starting point for meeting health care needs of a population and it must be made available universally and not linked in anyway to the ability to pay for it. One must also move away from the tendency of romanticising health care as was done with the community health approach (demystification, peoples health in peoples hand, non-medical model etc...). A basic medical model is essential and desirable (not over-medicalised as in the USA) and its social components must be constructed on such a base - doctors and nurses must form the base and paramedics and others must provide the

support to give it a social and people-centred character, that is standing the classical community health model on its head ! I will come back to this later.

Thus, while recognising the importance of reproductive health, especially in a country like India which still has relatively high fertility, an overwhelming proportion of deliveries being conducted at home, often under unhygienic conditions, a supposed unconcern for gynaecological morbidities, an embarrassingly high proportion of abortions being done outside the legal framework, etc... it becomes even more important to emphasise the need for making available comprehensive health services to all, and especially to women as a group for their special needs. And as mentioned earlier the danger of beginning with reproductive health (as a separate or special program) is narrowing down the focus to the uterus, precisely what the women's health movement wants to avoid. Thus the demand must begin with provision of easily accessible and free of cost (at the point of care) comprehensive health care for all, with a clear recognition and provision for special needs of women, as well as of other vulnerable groups like children, the aged, tribals etc.

Thus, fitting the suggested reproductive health services, which have been well thought out, within a comprehensive basic health system should be the essential goal and not fitting it into the current family welfare framework. Hence one cannot but agree with the recommendations in the report about five specific actions to be taken - define a package of essential services; improve access to good quality services; make services more responsive to client needs; make sure that the frontline workers have the skills, support and supplies they need; and strengthen the referral system. But such a package, we emphasise again, must be one of comprehensive basic health care in which the package suggested by the report becomes an essential part.

It is important to emphasise a comprehensive package of total health and medical care because India's experience with separate programs for each major area of health problem has not only shown major failures but also resulted in wastage of the already small amount of resources which the public health sector is allocated from the state finances. Hence, its time that structural changes are made in provision and financing of health care and not by adding another set of special programs for a select group of population. We have done the latter for too long and wasted public money on programs which have been not only unable to fulfill their objectives but also have alienated people from the public health system, especially in the rural areas.

BASIC HEALTH CARE

While this is not the forum to discuss a detailed plan of action we can at least define the provisions which should go into this comprehensive package in the context of the five specific actions stated in the Report under review. First, a list of services which comprehensives primary (or basic) care should include:

- ▶ general practitioner / family physician services for personal health care
- ▶ first level referral hospital care and basic specialist services - paediatrics, gynaecology and obstetrics, general medicine, general surgery, dental
- ▶ services and ophthalmology, including special diagnostics
- ▶ immunisation services for vaccine preventable diseases
- ▶ maternity services for safe pregnancy, abortion, delivery and postnatal care
- ▶ pharmaceutical services - supply of only rational and essential drugs as per accepted standards
- ▶ epidemiological services, including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures
- ▶ contraceptive services
- ▶ health education and information
- ▶ ambulance services

The above must be viewed as a single package of minimum care which must be available universally and without any direct payment. They must be supported by secondary and tertiary levels of care, which are already quite well developed in India and only need to be reorganised in the new context. The provision of such care of necessity has to be a public-private mix (given the fact that India probably has the world's largest private health sector), with monopoly buyer/s, which need not be the state alone. This also means regulation, control and audit, none of which presently exist vis-a-vis the private health sector. And it goes without saying that special needs of women, including their reproductive health needs as discussed in the World Bank document will be an integral part of this package with each service available at the appropriate level.

THE PRIVATE HEALTH SECTOR

The private health sector as it exists today is not fit for collaboration in such a venture but its sheer size necessitates its planned and regulated involvement. The state has to start a process of planning for and involving the private health sector in the same manner in which it does with regard to many areas of economic activities. The myth of the private health sector being more efficient and of providing better quality care has already been adequately exploded in India and the time is ripe now to start the overdue need for its regulation, control and audit. In an organised public-private mix of health care services the private sector will play a dominant but regulated role at the first level of care, that is family physician services, as also participate in terms of its capacity at other levels.

FINANCING

With regard to financing it must be pointed out that vis-a-vis the overall budget the amount allocated to family welfare (over 17%, in 1994-95 Rs. 13.5 billion or \$ 0.42 billion) is a substantial amount. And we must remember that with the current orientation of health services, resources from other sub-sectors of the public health system are also used for the family planning program, especially human resources. It is understandable that this amount is far less than what is required for the suggested reproductive health approach, but what is worse is that the overall health care budget is far more inadequate than what is needed to meet peoples' basic health care demands. We have to demand the overall increase of resources for the public health sector close to the WHO recommendation of 5% of the GDP. And we must remember that any provision within the limit of this ratio can in no way be termed as high cost. And we must also emphasise that presently all this cannot come from tax revenues and hence other avenues of financing, especially from the organised sector (employers and employees), farm incomes of the middle and rich peasantry etc. need to be tapped through insurance, social insurance, health care taxes and cesses etc. and not user charges which is by now an ancient concept. Thus the role of the state in organising the finances for such a system will be crucial and its responsibility of prime importance especially for the poor.

ALTERNATE RECOMMENDATIONS VIS-A-VIS THE WORLD BANK

To sum up the discussion above we list out our recommendations as against those of the World Bank being pedalled with the government of India.

OVERALL RECOMMENDATIONS

World Bank: Reorient the Family Welfare Program, as quickly as possible, to a reproductive and child health approach that meets individual client health needs and provides high quality services.

Alternate: Drop Family Planning as a separate program and strengthen provision for basic health care under a universal organised health care system to meet needs and demands of

people (in which reproductive and child health care and contraception will be important components).

POLICY RECOMMENDATIONS

World Bank: Eliminate method specific contraceptive targets and incentives. Replace them with broad reproductive and child health goals and measures. Increase the emphasis on male contraceptive methods and broaden the contraceptive method mix.

Alternate: Restructure and organise the public health system to provide universal basic health care with supportive referral services in basic specialities, which would be sensitive to special needs of vulnerable groups like children, women, elderly, tribals etc.. Remove targets from all health programs and introduce measures of social audit and accountability.

PUBLIC SECTOR RECOMMENDATIONS

World Bank: Improve access to reproductive and child health services. Respond more effectively to client needs, for example, by listening to clients' preferences, and by improving service quality. Increase support for the frontline workers, for example, by enhancing the quality of training, and providing adequate supplies. Improve the referral system, especially for essential obstetric care, by strengthening the Primary Health Centres and First Referral Units.

Alternate: Improve access to basic health care by strengthening provision, especially of non-salary inputs. Respond more effectively to client needs by making available basic services which they need and by improving service quality. Strengthen basic medical manpower in primary care and increase support for them and other frontline workers through provision of adequate supplies, improved training, better working conditions, removal of targets etc.. provide opportunities for staff to upgrade their skills, for example, ANMs could undertake intensive courses to become full fledged nurses, and nurses similarly could become doctors, which in the long run would help women to get both better access to health care and better attention of their health needs as women. Improve the referral system by strengthening the Primary Health Centres as above, as well as strengthening the basic specialities at the First Referral Unit (Rural Hospital or Community Health Centre).

PRIVATE SECTOR RECOMMENDATIONS

World Bank: Increase the role of the private sector, especially by : a) revitalising the social marketing program and adding health and nutrition products, b) expanding the use of private medical practitioners in the provision of reproductive and child health services, and c) continuing to encourage experimentation with an expanded role for the private sector in implementing publicly funded programs; monitoring the experiments and identifying best-practice for dissemination system-wide.

Alternate: Involve the private sector by: a) organising them under a single umbrella to provide basic health care under a public-private mix system, b) linking them with various preventive and promotive public health programs in a socially meaningful way, and c) creating mechanisms to regulate them as a measure for social accountability and public benefit.

FINANCE RECOMMENDATIONS

World Bank: Increase the budget for reproductive and child health, to meet the staffing and other critical gaps, to enhance service quality, and to offer an essential reproductive health package; and use funding as a performance incentive to reorient the program towards a reproductive and child health approach by taking steps to improve state level finances.

Alternate: Increase the overall budget for basic health care to meet basic health needs / demands of people and use monopoly financing as a tool to both regulate the system as well as integrate the public and private provision of health care. The allocations to various

program heads should be based on expressed demands of the people, especially those in presently underserved areas. Using innovative methods to enhance resources by targetting indirectly people with capacities to pay and doing away with all forms of user-charges at the point of seeking care.

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