CHAPTER II
CHAPTER - II

CONCEPTS AND REVIEW OF LITERATURE

The purpose behind review of concepts is to make known the important concepts which are used in this study to the readers and review of literature facilitates a meaningful understanding and appreciation of the subject matter. In this chapter, the concepts used are explained in the first part followed by a review of literature in the second part of the study.

II.1. CONCEPTS

Health

"Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity" \(^1\)

Health Care

Health care is an expression of concern for fellow human beings. It is defined as a “multitude of services rendered to individuals, family or communities by the agents of the health services or profession, for the purpose of promoting, maintaining, monitoring or restoring health” \(^2\).

Health Policy

A National Health policy is an expression of goals for improving the health situation, the priorities among these goals and the main directions for attaining them. \(^3\)

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Primary Health Care

This is the first level of contact between the individual and health system where "essential" health care (primary health care) is provided. A majority of prevailing health complaints and problems can be satisfactorily dealt with at this level. This level of care is closest to the people. In the Indian context, this care is provided by the primary health centres and their sub-centres, with community participation.4

Primary Health Centre

The Bhore committee in 1946 gave the concept of a Primary Health Centre as a basic, health unit, to provide, as close to the people as possible, an integrated curative and preventive health care to rural population with emphasis on preventive and promotive aspects of health care to the rural population. PHCs are manned by one to three doctors supported by auxiliary medical staff. The National Health Plan proposed, one PHC for every 20,000 population in hilly, tribal and backward areas for more effective coverage and one PHC for every 30,000 rural population in the plains. The PHCs mainly provide out-patient facilities, but also contain six beds for emergencies, maternity cases and family planning operations. Drugs are supplied free in the PHCs.5

Institutional Normal Delivery

Normal Delivery takes place naturally, without any medical or surgical help. The mother is allowed to rest in bed on the first day after delivery. From the next day, she is allowed to be up and about. The current

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practice is to discharge the women after 5 days lying-in bed after a normal delivery.  

**Caesarean Delivery**

The last one of these is now the only one frequently performed as caesarean section is usually preferred to more traumatic high and mid cavity operation.

**Forceps Delivery**

Forceps delivery is a means of extracting the foetus with the aid of obstetric forceps when it is advisable or impossible for the mother to complete the delivery by her own effort. Forceps can also be used to assist the delivery of the head after coming out of the breech and on occasion to with draw the head up and out of pelvis at caesarean section.

**Domiciliary Delivery**

Mothers with normal obstetric history may be advised to have their confinement in their own homes, provided the home conditions are satisfactory. In such cases, the delivery may be conducted by the health worker, female or trained Ahahs.

**Immunization**

Immunity is defined as the resistance against an infecting organism. Immunization is something like insurance as it removes the element of risks, But immunization is better than insurance. Insurance

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7. ibid, p.450.
8. ibid, p.451.
compensates for loss or tragedy, while immunization prevents the tragedy in the first place.¹⁰

**Oral Polio Vaccine (OPV)**

Oral polio vaccine was described by Sabin in 1957. It contains live attenuated virus grown in primary monkey kidney or human diploid cell cultures. Ideally each virus type should be given separately as monovalent vaccine but for administrative convenience, rather than efficacy. It is given as trivalent vaccine.¹¹ The vaccine contains.

1. over 3,00,000 TCID 50 of type 1 polio virus
2. over 1,00,000 TCID 50 of type 2 virus, and
3. over 3,00,000 TCID 50 of type 3 virus per dose

**B.C.G. Vaccination**

Bacille Calmette Guerin or BCG which was harmless yet capable of conferring a state of immunity when administered by vaccination. The aim of BCG vaccination is to induce or begin, artificial primary infection which will stimulate an acquired resistance to possible subsequent infection with virulent tubercle bacille. BCG can be given soon after birth. The National immunization policy is to give BCG with any one of the three doses of DPT and oral polio.¹²

**D.P.T. Vaccine**

For immunizing infants, the preparation of choice is DPT. The infant can be immunized simultaneously against three disease viz. (Diptheria,

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¹⁰. Ibid, p.97.
¹¹. Ibid, p.143.
¹². Nancy Ropher; *Churchill Living Stone Medical Dictionary*, p.32.
pertussis and Tetanus) by administering 3 doses 45 days-I dose, 75 days-II dose, 105 days-III dose, of DPT vaccine.  

**Measles - 9 Months**

Measles is best prevented by active immunization. Only live attenuated vaccines are recommended for use, they are both safe and effective. Immunization later than 9 – months means that a significant proportion of children will contract measles in the interval between wearing off natural protection and the introduction of the vaccine. The most effective compromise is immunization as close to the age of 9-months as possible.

**DT- 5 - Years**

Diphtheria tetanus is for immunizing 5 to 6 year age group children. It can immunize simultaneously against two disease viz. Diphtheria and Tetanus one dose of DT gives acceptable level of protection.

**Tetanus Toxiod**

Tetanus is best prevented by active immunization with tetanus toxiod. Tetanus toxiod will protect both the mother and the child. The infants born to the mother who have not previously received 2 doses of tetanus toxiod are exposed to the risk of neonatal tetanus. They can be protected by injection of antitoxin. It is administered with in 6 hours of birth.

**TT-10 - Years**

For immunizing 10 year age group of children, they are immunized against tetanus with TT-10 year I-Dose, T T 16-year II dose

Tetanus Toxiod. It gives no doubt acceptable level of protection interval of 1 of 4 weeks between the doses. 17

**Infant Mortality Rate**

Infant mortality rate is defined as “the ratio of death under 1 year of age in a given year to the total number of live births registered in the same year, usually expressed as a rate per 1000 live births.” 18

**Neo-Natal Death (8 to 28 Days)**

A neo-natal death is one occurring in the first 28 days of life. Neo-natal death is divided into early neonatal death or perinatal death which occurs in the first 7 days of life and late neo-natal death which occurs during the next 21 days. The reason is that the causes of early death are similar to those of still birth while the causes of later death are different. The rate of neonatal death is calculated per 1000 live births 19.

**Post Neo-Natal Death (29 to 365 Days)**

An infant death is one occurring in the first year of life. By definition this includes all neo-natal death and the remainder is termed post neo-natal death, the infant mortality rate is calculated per 1000 live births. 20

**Maternal Mortality Rate**

Maternal death is defined as “the death of a women while pregnant or with in 42 days of termination of pregnancy irrespective of the duration and site of pregnancy, from any cause related to or aggravated by

17. ibid., p. 320.
18. ibid., p. 331.
20. ibid.
the pregnancy or its management but not from accidental or incidental causes^{21}

**Ante-Natal Care**

Ante-natal care is the care of the women during pregnancy. The primary aim of antenatal care is to achieve at the end of a pregnancy, a healthy mother and a healthy baby. Ideally this care should begin soon after conception and continue throughout pregnancy.^{22}

**Post-Natal Care**

Care of the mother (and the new born) after delivery is known as post-natal (or) post parental care. Broadly this care falls into two areas. Care of the mother and care of the new born.^{23}

**Natal Care**

Natal Care is a term and is spontaneous on set with the foetus presented by the vertex. The process is completed with in 18 hours and no complication arises.^{24}

**Vaccines**

Vaccine is an immuno-biological substance designed to produce specific protection against a given disease. It stimulates the production of protective antibody and other immune mechanisms.{^25

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22. ibid, p.315.
23. ibid, p.318.
25. ibid., p.90.
Contraceptive methods

Contraceptive methods are, by definition, preventive methods to help women avoid unwanted pregnancies. Contraceptive that is safe, effective, acceptable, inexpensive, reversible, simple to administer, independent of coitus, long-lasting enough to obviate regent administrative requiring little or no medical supervision.  

Condom

Condom is the most widely known and used barrier device by the males around the world. It is receiving new attention today as an effective, simple spacing methods of contraception, without side effects.  

Intra-uterine Devices (I U D)

The control of conception is by introducing a foreign body in to the uterus. There are two basic types of IUD : non-medicated and medicated. Both are usually made of polyethylene or polymers; in addition, the medicated or bioactive IUDs releases either metal ions (Copper) or hormones (progestogens).  

Oral pills

Oral pill is one of the major spacing methods of contraception. It containd no more than 30-35 mcg of a synthetic oestrogen and 0.5 to 1.0 mg of a progestogen. The pill is given orally for 21 consecutive days beginning on the 5th day of the menstrual cycle. 

26. ibid, p. 293.
27. ibid, p. 294.
28. ibid., p.295.
29. ibid., p.299.
Vasectomy

Male sterilization or vasectomy being comparatively simple operation, it is customary to remove a piece of vas at least 1 cm after clamping. The ends of are ligated and then folded back on themselves and sutured into position so that cut ends face away from each other. This will reduce the risk of recanalization at a later date.  

Laproscopy

This is a technique of female sterilization through abdominal approach with a specialized instrument called laproscopy.

Crude Death Rate

The simplest measure of mortality is the crude death rate, it is defined as “the number of deaths (from all causes) per 1000 estimated mid-year population in one year, in a given place”. It measures the rate at which deaths are occurring from various causes in a given population, during a specified period.

II.2. REVIEW OF LITERATURE

The purpose of this study is to review all the relevant materials which have a bearing on the “Problem selected”. This part is being helpful in surveying the relevant materials related to the present research work.

30. ibid., p. 295.
31. ibid, p. 295.
32. ibid., p. 49.
II.2.1. Studies Related to PHC’s Services in India

Bhowmick expressed that for a better quality of service of the MPW scheme, the population and the area which one MPW is supposed to cover intensively appears rather high, that is, 5,000 population as envisaged, but in reality this figure exceeds up to 8,000-10,000. The government should draw its attention to check this trend, otherwise the level of achievement would not be up to expectation.\(^3\)

It would be better if female MPWs alone are made to work for family planning and women health education. On the other hand, male workers may be given more responsibilities to carry out other multipurpose activities rigorously and to cover more beneficiaries.

Multi-purpose health workers are lacking in professional skills for conducting their duties efficiently. There should be more doctors including lady doctors at the PHC level. More visits should be made by the PHC doctors to the sub-centre level which is the major source of the delivery of health services. Government doctors should not be allowed to carry on private practice.

Finally, to motivate doctors for staying in the rural areas, there should be orientation courses on sociological inputs for medical practitioners, so that they can perceive society in a better way and get attuned to the tough realities in relation to health care activities.

Shantha Ramamurti et al, opined that in developed states, villagers use private doctors on payment due to convenient timings of their

Clinics, less cost involved compared to PHC use by way of travel, loss of wages etc. Moreover the staff of PHC are burdened by twelve vertical preventive programmes imposed by the centre like malaria, filarial, T.B. leprosy, STD, AIDS, blindness and immunization programmes, in addition to family planning programmes. Thus these three factors—lack of resources, shortage of personnel, equipment and drugs, unequal distribution between urban and rural areas; and the burden of vertical programmes fail to serve the poor.  

Sanyal declared that the result of extremely low utilization of PHCs leads to increased load of patients on the first level of referral hospitals (district) and there from on the secondary and even the tertiary level hospitals. The emphasis on PHCs ironically was somewhat effective in the urban areas complementing the urban bias in the expansion to higher level medical care. The surveys thus bring out this foremost inefficiency in the public system, the root cause of which is well known—the paucity of adequate number of physicians and nurses in the PHCs.

Abhimanyu Singh and Usha Singh are of the opinion that the health staff showed lack of commitment and the programme was being conducted in a routine manner. Instances of corruption were also reported. The health staff charged Rs. 100 for attending to each delivery and Rs.10 for giving each dose of immunization. The poor are not able to afford this and


are deprived of these services. Such levies were not possible in camps or
during visits to village. So the health staff expected the villagers to come to
the centre. The irregular attendance of health staff at the PHCs discouraged
the women from going there. Instead, they preferred to go to the sub-
divisional or district hospitals. More than 50% of the children also
complained of acute respiratory infection, 8% of blocked nose and sleeping
difficulty, 30% had fever and 15% had breathing difficulties. These cases
did not receive the same urgent attention as diarrhoea. Children in Ranchi
and Saharsa districts suffered the most.

Krishnan reveals that household economic status is one of the
major determinants of health status. Though the public health system is able
to provide basic health facilities especially in rural areas through the primary
health care, due to inefficiency as well as insufficiency in the system it may
not be able to fulfil the complete health needs of the people. In poverty
stricken households, fulfilling day-to-day food requirements itself is a tough
task and considerable allocation for health is a distant dream. It has been
proved and well established that health and poverty are closely related.
Indian health system is very regressive where the distribution of the burden
of treatment is unfavourable to the poor and it contributes to the aggravation
of poverty especially in rural India.37

Ray has made use of the ideas based on the experience of the
ICDs project in East U.P. The data were collected in November –December
1984. An attempt has been made here to understand the functioning of the
23 Anganwadi Centres (AWC). the performance of immunization, health
check-up and medical care is very poor. For the last five years almost in 50
per cent of the AWCs no immunization or health check-up activities were

conducted by the health staff. In the case of polio vaccine and other kinds of immunization the course remained incomplete due to various reasons. A list of ANM Sub-Centres was supplied by the MO but during our visit we found that in several villages the sub-centres are working either in the office records or in the house of ANM. A discussion with the MO, Dy.CMO and CMO of the district revealed that this fact is known to the higher officials. The LHVs, who are in charge of supervising the activities of the ANMs, rarely visited the sub-centres and villages within their circles. In fact, the existing health service itself has proved to be very poor and the extra responsibility added is one of the important weaknesses of this scheme.\textsuperscript{38}

Nayar opined that the most important finding of the study is that utilization of health centres was influenced by the ability to deliver the complete package of services. Variation in the availability of specialists, Para-medical staff, facilities for medical investigations, physical infrastructure and the complimentary nature of these inputs were found to be responsible for the differential utilization rates. The study points out that non-availability of one or more elements in this package could affect the utilization rates. It is significant that despite all the constraints in the existing delivery system, a large majority of the households in the sample expressed their strong preference for public health care system as against the private facilities. Only about 11 per cent of beneficiaries were dissatisfied with all the services of the centres in the eight states, while around 43 per cent were satisfied with the services, another 45 per cent were partly satisfied. The dissatisfaction was largely because of non-availability of medicines or lack of proper attention. The logic of completeness in the package of services that

was responsible for the differential utilization of PHCs could also be applied to the PHC as well.\textsuperscript{39}

\textbf{Prema Ramachandran} viewed that improvement in the health status of the population has been one of the major thrust areas for the social development programmes of the country. This was to be achieved through improving the access to and utilization of Health services with special focus on under-served and under-privileged segments of the population. The extent of access to and utilization of health care varied substantially between states, districts and different segments of society; this to a large extent, is responsible for substantial differences between states in health indices of the population. Unlike the earlier era, the technologies for diagnosis and therapy are becoming increasingly complex and are expensive. It is likely that larger investments in health will be needed even to maintain the current health status, because the technology required for tackling resistant infections and non-communicable disease are expensive and this will inevitably lead to escalating health care costs.\textsuperscript{40}

\textbf{Fred Arnold et al}, echoed the view that the percentage of children under three years of age who are underweight is very high in India, although the percentage has declined somewhat over time, from 52 per cent in 1992-93 (NFHS-1) to 47 per cent in 1998-99 (NFHS-2). This reduction of about 0.8 per cent per year is similar to the percentage reduction observed in other developing countries where the improvement is largely attributed to overall development rather than to the effect of nutrition intervention programme National Nutrition programme with successful

\begin{footnotesize}
\footnote{Prema Ramachandran, “Health Care during the Tenth Plan” \textit{Yojana}, January 2003, pp.60-67.}
\end{footnotesize}
nutrition interventions tend to record reductions in under-nutrition more in the order of 2-3 per cent per year.\(^{41}\)

Ratha Krishnan and Ravi are of the view that the overall reduction in malnutrition has been very slow. About half of the population, particularly children and women and women-the most vulnerable groups suffer from various forms of malnutrition and a greater of them suffer from severe malnutrition. Malnutrition is seriously retarding improvements in human development and further reduction of child mortality. The risk of malnutrition is higher among children whose mother suffer from chronic energy deficiency. Mother present nutritional status in turn depends on her childhood nutritional status. Concerted efforts are needed to break the vicious circle (mother-child-mother) of malnutrition among poor. It needs to be emphasized that reduction of child malnutrition would greatly depend on delivery of effective and sustainable interventions to children and their mother. Improvement of incomes of the poor and supply of environmental and health services are the long term solution to the eradication of malnutrition.\(^{42}\)

Deepa Sankar and Vinish Kathuria in their study attempt to analye the performance of rural public health systems of 16 major states in India using the techniques from stochastic production frontier and panel data literature. One of the most important findings here is that health outcomes in the rural areas of Indian states is positively related to the level of health infrastructure in terms of access to the facilities and availability of


skilled professionals such as doctors. At the outset, it is indeed a positive aspect that India’s health outcomes have improved over time, as revealed in the decline of infant mortality rates from 146 per thousand live births in the Mid-1950’s to 72 in late 1990’s. This has been made possible by extending promotive, preventive and curative services to all segments of society, including those residing in rural areas.43

**Rameshan and Shailendra Singh** expressed that the results reveal that the services rendered by PHCs are deficient in many respects in the perception of customers and community members of the villages and that the doctors and the staff are unable to redress adequately the grievances raised by villagers. It is essential to improve the utilization of available facilities. For this, the doctor and the staff must be made more committed by changing their attitude and mindset. Therefore, proper training and incentives for the doctors and the staff are the need of the hour. Further, adequate community support and local participation are necessary in making PHCs’ services effective and people-oriented.44

**Kalapana Sharma** in her recent study on the status of health care in three Maharashtra districts by the Centre for Enquiry into Health and Allied Themes (CEHAT) found that almost half of the PHCs had no doctor, 75 per cent did not have medicines and only 18 per cent had ambulances. Even if the PHCs had ambulances, 40 per cent had no driver. In rural

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hospitals, one step up from the PHC, which are supposed to provide specialist care, only 20 per cent had pediatricians and just one third had anaesthetists. Only two out of the 19 rural hospitals surveyed could perform an operation. There are 24 villages under the PHC with a population of 27,000 and only 930 of the 2,915 children below the age of five are normal. About 32 are severely malnourished, while the remaining 1,271 are in grade one and 684 are in grade two of malnutrition. All the women walk five to six km to the PHC everyday with their malnourished children.45

Duggal and Antia point out that the curative services are not a priority in the PHCs and sub-centres network, family planning and immunization work taking most of the time of the staff. If the PHCs could be energized for curative services, the cost of treatment could be brought down.46

To Government of India that state responsibility in India in health delivery has always had a pronounced focus on curative rather than preventive care, and has always had a strong urban bias, even as primary health care in the country has still a long way to go in terms of quality and coverage, and the vast majority of Indians still live in rural areas. The primary health care network in the country, consisting of community health workers, village health workers, anganwadi workers, primary health centres and sub-centres, auxiliary nurse midwives, male multipurpose workers and PHC doctors, has failed to cater to the health needs of the rural populace. Absence of accountability, inefficient planning and inadequate resource have rendered PHCs and sub-centres built across country in many ways non-

Functional; they often lack doctors and medicines. Poor infrastructure across rural India compounds the people’s hardships. In this context, the work of non-governmental agencies, many of which have a long record of dedicated, innovative community health services, with an emphasis on preventive care and community participation, assumes much significance. 47

**Durgaprasad** is of the view that the problems of health care are enormous. Access to primary health care is inadequate to the majority of the population because of non-availability of basic preventive and promotive health care packages, clinics, doctors, drugs, and paramedical personnel in rural areas. Consequently, 60-80 per cent of expenditure on medical and health care are borne by people themselves in our country, which is too high a proportion for our levels of poverty, and Health for All by 2000 AD appears to be a distant dream as a result. Supplementation of allopathic medical facilities by indigenous and traditional systems as in Kerala and Tamil Nadu can be attempted. Greater stress on preventive health care, medicine and health education should be laid improvement in drinking water and sanitation need to be doubled. Nutritional interventions should be followed up with promotive health care programmes. Health literacy efforts should be made integral to preventive, promotive curative and rehabilitative health care. Meaningful involvement of the private sector in all these endeavors would go a long way in evolving a people oriented and a sustainable health care system.48

**Emmel** stated that the strategy of PHC has been rejected. Primary health services are considered to be a list of technical measures


which add up to second-rate provision for the poor. The DALY approach implies that expensive curative services will become increasingly inaccessible to the poor and available only to the privileged few. The Alma Ata Declaration was a document which emerged out of a strong desire for social justice and equity. The community was emphasized as the agent of change which, appropriately mobilized, could insist upon better health care and better development. It was a call for mass struggle. The WHO has rejected PHC. Its approach is efficiency rather than equity; the market rather than social justice; the expert with a magic bullet rather than interacted and inter-sectoral health care provision; the disease rather than social, economic and political development. Health for all for the 21st century is a document which reflects neo-liberal, right wing prescriptions at the expense of the poor. It is a return to economic trickle down and disease control.

II. 2.2. Studies on Women’s Health

Ramamani Sunder said that some of the results of National Council of Applied Economic Research NCAER’s Household Survey of Medical Care have important policy implications. The reported lower prevalence rate of illness for which medical treatment was sought for women and the female children indicate that the “perceived need” for medical aid is much smaller for the weaker sex. The health status of the female can be improved only by changing their health perception. This can be achieved by enhancing the status of women.


Another important finding of the survey is the greater reliance on private-sector medical care in both rural and urban areas of the country. One of the reasons for this was the availability of private medical care at a shorter distance. The study also brought out the disparity between the rich and the poor in their dependence on private vs. public health care facilities. In order to achieve the goal of health for all, the government has to ensure the availability of primary health care at a reasonable distance and cost for all sections of the population.

Imranna Qadeer in his public health perspective explains that the two things are clearly needed. First, within reproductive health, priorities should be clearly articulated and reflected in the budgetary allocations. Secondly, maternal and child health, nutrition, contraceptive services, and communicable disease control must be integrated. Within the sphere of the health service system this will provide a solid foundation for women’s health including their reproductive health. Handling reproductive health in isolation is not only an inefficient way of dealing with the problem of women’s reproductive health but it also robs them of their dignity. An integrated approach alone can give optimal results by handling women’s health as an entirety. To achieve the best results the health service system needs supportive social, economic and legislative action favouring women.  

Swapna Mukhopadhyya is of the view that women’s health per se has never held the center stage in official thinking and policy design in India, except in the limited context of women’s child-bearing functions. The alarmingly high levels of maternal mortality and morbidity cited in the reports of the Bhore Committee and a number of other committees

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appointed by the government around the time of independence prompted the government to subject maternal and child health to separate programmatic action under the five-year plans. In terms of the percentage of budget allocation for health, however, MCH has been a very insignificant component.\textsuperscript{52}

\textbf{Aliva Mohanty and Tripathy} are of the view that Health is fundamental to human progress. Women's health status affects their productivity and thereby affects their social roles in society and development. Productivity affects health, the effects of women's work, income or socioeconomic status. Nutrition is closely interlinked with health. Low nutritional status of woman makes her more prone to several diseases—a hazardous health status. It assumes special significance in the cases of women, because they bear and rear children. According to them child health is also affected by the ill health of the mother\textsuperscript{53}.

\textbf{Rashmi Mishra} viewed that the question of women's health is intricately woven into the process of development of any nation. Greater health for women impacts positively on the health of other family members. Changes in the status of livelihood both in quality and quantity are visible significantly in Orissa viz., (a) birth rate which was 39 per thousand in 1968 has declined to 25.7 in 1998. Death rate which was 15.3 in 1968 has come down to 11.1 in 1998, (b) life expectancy at birth for female which was 49.5 during the period 1980 has gone up to 61 during 2001. (c) child marriage is no more in vogue, (d) infant mortality rate which stood at 149 in 1979 has declined to 98 in 1998, (e) Universal immunization programme is being


implemented successfully and (h) incidence of severe malnutrition among 0-3 year children has reduced from 3.78 per cent in January 1998 to 2.65 per cent in September 1999. In spite of all these measures gender differentials in the matter of nutrition and healthcare especially in case of pregnant women and nursing mothers are still prominent. Antenatal care, safe deliveries with medical paramedical personnel and post-partum monitoring are the main factors behind safe motherhood. The proportion of pregnant women receiving antenatal care (at least twice) and those who have had deliveries under medical attention are highly correlated. Accordingly, Safe Motherhood Index (SMI) is constructed for each state by taking simple average of these two proportions, separately for rural and urban areas.$^{54}$

II.2.3 Studies on Child Health Improvement and Immunization

Thiruvenkitaswamy examines the health status of children both in rural and urban areas of Maharashtra. The results show that the State is far ahead of all Indian States except Kerala and Tamil Nadu. But the variation between the rural and urban areas in terms of child health is very large. Poor economic status of the households is the major cause for poor status of child health along with poor literacy, lack of infrastructure, insufficient public health services, etc. Hence radical policy changes on allocation of resources and power is an immediate concern for the improvement of child health and to reduce the rural and urban disparities.$^{55}$


Abusalch Shariff conducted a survey which provides information regarding the percentage of immunized children in the 1 to 2 year age group and 0 to 2 year age group against DPT, Polio, BCG, and Measles, and also regarding those who were immunized against all possible disease. About 50 per cent of the children (1 to 2 years of age) were fully immunized in rural India although the proportion of partly immunized children (i.e., immunization against Polio or BCG or Measles) was relatively higher at 64 per cent. The proportion of both fully immunized and partly immunized children was higher among the economically developed states of Haryana, Gujarat, Maharashtra, and Punjab, and among the southern states of Kerala, Tamil Nadu, and Andhra Pradesh. Immunization (full and part) was low in Rajasthan (only 21 per cent of the total children) followed by the states in the North-eastern region and Bihar. This may be attributed to the better availability of health care infrastructure that plays a dominant role in higher levels of immunization among children.56

Franciszavier expressed that in the country as a whole, 65 per cent of the women reported that they had received Antenatal Care (ANC) during the last pregnancy, but the regional estimates suggest a range of variation from 22 in the extremely arid region of Rajasthan to 100 per cent in the central coast of Kerala. The level of Antenatal Care was over 80 per cent in most areas of peninsular India. In coastal areas and in the extreme south, the levels crossed the 90 per cent mark.57


The immunization indicator shows the percentage of fully immunized children among those who were aged 12 to 23 months at the time of survey. Children who had a BCG vaccination, three polio drops, three DPT and one measles vaccination at any time before the interview have been taken to be fully immunized.

In the 76 regions the percentage of fully immunized children varied from 12 in Nagaland to 79 in Bisht Doab of Punjab. All regions of Maharashtra and Tamil Nadu showed high levels of immunization, but none of the regions had reached universal immunization.

Padmanathan says that The Much-Talked-about year 2000 (Y2K) has dawned but the commitment made 25 years ago by the member nations of the World Health Organization at Alma Ata to ensure health for all by 2000 is yet to be fulfilled. India is no exception, despite the fact that a well-designed plan and structure to reach health care to all the people was visualized even 50 years ago based on the Report of the Bhore Committee. If the nation cannot achieve a goal in a span of five decades it is indeed a sad commentary. It is not that there has been a lack of commitment; nor has the policy and programme back-up been wanting. Successive governments, irrespective of the party in power have pronounced that health of the people is an important factor of national development and needs to be accorded the highest priority. However, translation of these into action at the ground level has turned out to be far below expectations. Particularly in respect of health care delivery to rural population and urban slum-dwellers. In fact, this led the Government to re-state in the Eighth Plan its goal as “Health for Under-privileged by 2000”. But even this has become elusive.58

Shivani Dharmarajan opined that the health of a nation can best be judged by the health status of its people. So far, experts have considered general mortality, infant mortality and expectation of life at birth to be the primary determinants of improved health status. However, studies on fertility, morbidity, the impact of health programmes and the use of health services, have recently been introduced to assess the health status of a population. Mortality data, nevertheless, still remain an integral part of health situation analysis. Historically speaking, at the time when India won its independence, the health situation in the country was extremely dismal. However, considerable progress has been made over the last five decades; this is reflected in the improvement in some health indicators (like the crude death rate, infant mortality rate and life expectancy). Overall, mortality (in particular, infant mortality) has declined dramatically and life expectancy at birth has increased to 62 years.\(^\text{59}\)

Anant Kumar says that as malnutrition amongst the child population in the country is widely prevalent, it follows that a moderate to severe degree of malnutrition would persist among girl child too. As a consequence, the malnutrition persists throughout adolescence and in pregnancy. As a result, the growth and development of unborn child is affected, giving rise to low birth weight. About 30% of the total births in the country constitute low birth weights and this in turn leads to high infant and child mortality and morbidity. According to the NNMB data (National Nutrition Monitoring Bureau) a very high proportion of girls are at obstetric risk as they enter the 14\textsuperscript{th} - 15\textsuperscript{th} year of life with a height less than 145 cm and weight less than 38 kg. Adolescent girls need to be considered as a

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special target group by schemes and development programmes. They need a package of services/facilities, which will enhance their capacity for advancement and enable them to become capable citizens.\(^{60}\)

**II.2.4 Studies on Women and ANC Services**

**Ministry of Health and Family Welfare** expressed the view that the number of antenatal check-ups and the timing of first check-up are important for the health of the mother and the outcome of the pregnancies. The conventional recommendation is to schedule the first check-up within six weeks of the women’s last menstrual period. The reproductive and child health programme includes the provision of at least three antenatal care visits for pregnant women and requires that each pregnancy should be registered in the first 12-16 weeks. Thus the first antenatal check-up should take place at the latest during the second trimester of pregnancy.\(^{61}\)

**Pattanaik** has rightly remarked that although government programmes in India have gone a long way in reducing the number of women dying from maternity related causes, the number of pregnancy-related deaths in rural areas in the country are still among the world’s highest. Moreover, many studies have shown that rural women engaged in hard physical labour during pregnancy delivered low weight babies.\(^{62}\)

**Arvind Pandey et al,** are of the view that women living in urban areas are more likely to go for ANC services compared with their rural counterparts. Similarly, women with lower birth order are more likely to use

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ANC services than women with higher birth order. The same study shows that women with higher birth order utilize less delivery care services than women with lower birth order. These findings suggest that there is need to appraise rural women and those with higher birth order about the importance of ANC services in all the three states studied. Moreover, promotion of better health care practices among women could be enhanced by better participation of private, public, and non-governmental organizations working in the area of health and development.63

II.2.5. Studies on Family Planning

Bhattacharjee reveals that the family planning acceptance was by and large selective. Overtime, there had been a large-scale expansion in the health delivery system including infrastructure facilities in order to provide services particularly the MCH and family planning. This infrastructure facilities along with large number of medical and paramedical staff and substantial funds were put into action to achieve higher rate of family planning acceptance. This specific push in the programme has succeeded in breaking the socio-cultural barriers to achieve its size. It has been observed that there are some specific advantages of higher age at marriage such as lower number of pregnancies by reducing the span of fertile union, better health of mother and child etc. Many population experts have demonstrated from the analysis of various survey data and with hypothetical situation that increase in the age at marriage would reduce the birth rate both

in the long term and in the immediate short term. The range of variation is estimated to be at 10 per cent to 30 per cent in reducing birth rate. 64

Mishra et al, endorsed the fact that in India, empirical evidence illustrates that the integration of family planning and health services, especially maternal and child health services, has a positive bearing on the family planning programme, which eventually improves the health of the mother and her child. 65

Special Correspondent viewed that according to the Reproductive and child Health Survey 1998, the unmet needs for contraception are high in Bihar (42 per cent), Uttar Pradesh (38 per cent), Rajasthan (28 per cent) and Madhya Pradesh (27 per cent). About 60 per cent of the growth can be attributed to the large size of population in the reproductive age group, which is often referred to as the 'momentum' factor. Another 20 per cent of the growth in population is due to the high unmet needs for contraception and the remaining 20 per cent due to socio-economic factors such as high infant mortality, low status of women, preference for son, illiteracy and poverty. 66

Special Correspondent maintained that however, the main problem relating to population stabilization is the high levels of unmet needs for contraception, maternal and child health care services prevailing in high – fertility states such as Uttar Pradesh, Bihar, Rajasthan, Madhya


Pradesh, Chhattisharh, Jharkhand, Uttaranchal and Orissa. The National population Policy (NNP) 2000, aims to fully meet the unmet needs for basic reproductive and child health services at the earliest.

II.2.6. Studies on Institutional Delivery

Dinesh Paul stated that in spite of our national commitment, the present status of the child in India is unsatisfactory. There are millions of children suffering from malnutrition and infection, which results in their stunted physical and mental growth. These children require care, support and services to provide them with a healthy normal life.

The birth rate in the country declined from 36.9 per 1000 population in 1971 to 27.2 in 1997. The goals to be reached are to reduce the birth rate to 21.0 by the year 2000, the infant mortality rate is also to be reduced from the current 71 per thousand live births to less than 60 by 2000. In 1998-99, 22.36 million children received three doses of DPT, while 12.18 million were immunized in 1984-85. The coverage of BCG vaccination, DPT and polio immunization is around 23 million children for 1998-1999. This means that the services have to be strengthened to meet the objectives of the universal coverage by 2000.

The existing data on the proportion of mothers receiving antenatal care clearly indicates that it may not be feasible to attain 100% coverage with minimum package of antenatal care as specified below. Moreover, the manner in which this data has been obtained seems to be

67. Special correspondent, ibid.
incorrect. It is therefore, recommended that the data required to define a beneficiary for ante-natal care needs to be defined.

At present half of the deliveries are conducted by untrained birth attendants in India. Therefore, with full confidence it can be said that the target of 100% coverage by trained birth attendant is also not feasible.

The Ministry of Health should try to promote institutional deliveries under RCH programme and one lady Doctor may be posted in each Primary Health Centre for conducting deliveries in areas where MMR is more than two. The safe disposable delivery kit should be given to the mother during antenatal examination at the time of third trimester to achieve 100% coverage of deliveries by birth attendants, using safe delivery kit.

Jejeebhoy found that unsafe motherhood is still a reality in much of India and particularly in its rural areas. Few women have access to antenatal care, high risk cases go undetected, anemia is acute during pregnancy, deliveries are conducted largely by untrained attendants in unhygienic conditions and knowledge of health and nutrition needs during pregnancy and the post-natal period are poorly understood. Deliveries are largely conducted by untrained personnel and in unhygienic conditions, both of which contribute significantly to poor maternal health. Maternity benefits are woefully absent for the large majority of women in the unorganized sector, a factor which compounds maternal ill-health; the recent talk of restricting maternity benefits in the organized sector to two children has serious implications for both maternal and child health. The health delivery system has been largely insensitive to the reproductive health care needs of women and the constraints they face in expressing these—let alone the constraints they face in obtaining services. Doorstep services are essential for secluded women and these are rarely undertaken and where undertaken,
focus largely on contraception rather than on reproductive health in general. Despite the fact that the large majority of births continues to take place and attended by untrained personnel, the incorporation of trained traditional dais (TBAs) in the provision of ante natal and natal services has not been a priority in the health system. Since younger generations are unwilling to become dais, there is the likelihood of a serious shortage of delivery attendants.  

Srinivasan is of the view that a vast network of rural health institutions has been developed. Rapid expansion has, however, resulted in a considerable drop in the quality of functioning of health institutions. For several reasons, the quality of services and work done by various health institutions and by different categories of health personnel are poor, resulting in low credibility among the rural community. Moreover, for want of quality, the efficiency and effectiveness of the programmes and services have been limited and the causes of non-utilization and or underutilization of health services and facilities by the people, especially the rural communities. For making rural health care services more meaningful to the rural community, it is needed to bring about fundamental changes in the focus and approach to the entire health care delivery system in general and rural health care, in particular.

Special correspondent declared that according to Deputy Director, Health, delivery of children under the care of doctors and with all facilities, has increased in Thanjavur district thanks to the DANIDA- aided scheme.


being implemented in the district. Institutional delivery had touched 97 per cent in the district. Delivery in health sub-centres had increased by 300 this year as against last year. The number of patients visiting primary Health Centres had increased by 10,000 this year as against last year.\(^7\)

II.2.7. Studies on Infant Mortality and Maternal Mortality

Reddy and Gopal argued that the provision of health services is necessary but not sufficient to improve the health status of people. Defining health as one thing and identifying indicators of health status of people is another. Expectation of life at birth is the most widely accepted indicator of health status of people. Sometimes, infant mortality rate and crude death rate are taken as additional indicators of health status of people.

For infant mortality rate, the most important determinant is percentage of workers engaged in non-agricultural activities, followed by female literacy rate, general literacy rate and male literacy rate. This is perhaps because very few couples adopt temporary family planning methods to space their children allowing children and mothers to recoup their health; and,(female) sterilization is the most commonly accepted method and it is accepted at older ages after passing through most of the risk pregnancies.\(^7\)

Dhanalakshmi says that in general, neo-natal mortality seems to occupy top position among infant deaths during the years 1980 to 1990 (S.V.R.R. Hospital records). Major causes of infant deaths were gastrointestinal diseases (diarrhoea, dehydration and dysentery) followed by

\(^7\) Special correspondent “Institutional delivery goes up in Thanjavur district” The Hindu, April 3, 2003, p.10.

prematurity, Caste Hindus have high incidence of mortality for the first birth order followed by second and third.  

Venkatesan is of the view that not only the medical attention and childcare mechanisms are to be strengthened for saving the infants, but also there are other crucial measures which help reducing infant mortality to a greater extent. Achieving higher literacy level among women, compulsory schooling of the girls in rural areas and modifying the curriculum suitably to help the poor girls to be aware of the basic health education could help reducing infant and maternal mortality. School education not only should focus on the curriculum prescribed but impart health education incorporating the importance of basic health, hygiene, sanitation, nutrition and environment. Can we at least achieve single digit infant mortality rate during Ninth Five Year Plan in India?

Nayar expressed that the strength of India’s health care system is its elaborate network of infrastructure which is being systematically undone in recent years despite the claim that external assistance has been used to improve primary health care infrastructure. However, apart from buildings there have been no improvements in the quality of services. In fact, the focus during the Eighth plan was on strengthening health care infrastructure aimed at improving the quality and outreach of services.

The dramatic decline in the infant mortality rate, a sensitive indicator of health status, occurred only during the pre-reform period. The


rates have been rising, stagnating or the decline has slowed down in most of the vulnerable states of India. Even in Kerala the IMR has been showing a rising trend. In Karnataka, the rate has not declined much over the last 10 years. The situation warrants effective intervention. As a beginning, the comprehensive review of public health system in the country undertaken by the planning commission should now be discussed in an open forum to enlist the view of public health scholars from different parts of the country before any major reformulation in the national policy and revision in the public health strategies as proposed in the perspective are initiated.

**Measham Krishna et al,** are of the view that the higher levels of female education and access to good health care are important correlates of lower infant mortality and fertility rates, along with income. In sum, while income growth is significant for lowering infant mortality and fertility, improved performance on non-income factors appears to be more important. 76

**Mitra and Chakraborty** argued that even though adult mortality has been declining in India, infant and child mortality rates continue to be high. Advancements in medical science as far as maternal and child health are concerned have mainly benefited a few urban areas. The majority of Indian population remains deprived, resulting in continuing high child mortality rates. 77


Compared to the pre-independence period, there has been little improvement in child mortality after independence. During the 1960s and '70s the rate was around 130 and in 1986 it was 96 which was 105 for rural and 62 for urban. The experience of India was echoed in a large number of countries as well despite a rise in the rate of child immunization and inoculation, general lack of community health programmes was identified as one of the chief reasons behind the consistently high rate of child mortality in the country. Whatever advancements were made in the field of child survival benefited a few urban areas only majority of the Indian population remaining outside the circle of benefits from investments made in these fields.

Mari Bhat viewed that the application of sisterhood method to the data from the Human Development profile Survey (HDPS, 1994) yields an estimate of maternal mortality of 544 deaths per one lakh births in rural India for a period roughly 12 years before the survey. It also shows that maternal mortality ratio was more than 600 in East and North-Central India, while it was between 300 to 400 in North-western and southern India. The survey results also show that maternal mortality levels were high among Scheduled Tribes and Scheduled Castes and surprisingly low among Muslims. Maternal mortality was also found to be strongly related to amenities and infrastructure available in the village. However its relationship with poverty and educational levels of respondents were found to be weak perhaps because the characteristics of respondents were not ideal surrogates for their sister's attributes.  

Special correspondent revealed that with at least 140 out of every 100,000 women dying during delivery in Tamil Nadu, the state Government has set itself the target for making at least one government hospital and one private hospital in every district ‘Women and child-friendly’, providing round-the-clock emergency obstetric care. Launched by the UNICEF, the “women and baby friendly” scheme has now been “adopted” by the state Government, which was keen on reducing the stagnant infant mortality rate (for every 1,000 children born, 51 die in Tamil Nadu) and the unimpressive maternal mortality rate (MMR). Though Tamil Nadu’s MMR is better than the country’s average of 407 per 100,000 Kerala has achieved a lower rate of 87 per 100,000 and Sri Lanka has brought it down to 33 per 100,000.79

Nageswara Rao declared that the rapid decline in birth rate indicates the effectiveness of birth control programmes and family welfare efforts made by the Government in the last two decades. The decline in the death rate indicates the improved quality of health facilities that control death from communicable diseases. However, the stagnant or marginally negative infant mortality rate during 1990-2000, particularly in rural areas, is a matter of greater concern that needs to be addressed immediately. The growth rate of expenditure on public health and the number of hospitals did not succeed in reducing the birth rate particularly in the rural areas of Andhra Pradesh as their budget allocations are found proportionately inadequate particularly. The infant mortality rate is high in rural areas, which implies that the availability of medical services is inadequate and unsatisfactory. Large scale

of availability, of effective public health facilities in rural areas is important to raise life expectancy.  

Staff Reporter said that the IMNCI programme would be useful for Tamil Nadu because of the stagnating IMR in the state. According to statistics presented at the meeting, the IMR in Tamil Nadu has been hovering around the mark of 50 child deaths per 1,000 live births for the last decade, though most deliveries take place in hospitals. “Fifty percent of child deaths happen in the first month though the causes are few and can be managed”, the Joint Director (Immunisation), Directorate of public Health and preventive Medicine, K. Subramani, said. Listed as key causes of infant mortality are asphyxia, congenital malnutrition, prematurity and infections like sepsis, meningitis, diarrhoea or pneumonia. The state would aim to limit the IMR to 30 per 1,000 live births in the next five years.

II.2.8. Studies on State and Health Care

Kulkarni expressed that at present in most of the districts civil surgeons/ chief medical officers do have a system of monthly meeting to review all health programmes in the district. Similarly monthly meetings are held by medical officers of PHCs to review all health programmes at the PHC level, which all health workers and supervisors attend. In a majority of these meetings administrative matters like staff not getting salary arrears,


constraints in achieving physical targets (like family planning targets), malaria cases detected, immunization targets achieved, etc, are discussed. Little time is left to discuss managerial and programmatic problems like why certain categories of women (e.g., slum women) are not bringing their children, why dropouts for certain antigens are not coming down, why in certain pockets disease trends are not coming down despite high coverage levels of immunization, etc. These programmatic stock-taking of immunization has implications for sustaining UIP since it serves the purposes of management audit of the programme, and thus help improved implementation.

In some PHCs smart medical officers have used these monthly meetings to retrain, motivate and recharge the managerial capabilities of health workers. In those PHCs having reached high coverage levels of immunization, the efforts of health workers have to be directed towards, what the experts in smallpox eradication programme call a surveillance containment strategy.\textsuperscript{82}

\textbf{Laxmi Devi} stated that all countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and not later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include; family-planning counseling, information, education communication and services; education communication and services for prenatal care safe delivery, and post-natal care, especially breast feeding,

infant and women’s health care; prevention and appropriate treatment of infertility.

Reproductive health-care programmes should be designed to serve the needs of women including adolescents and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services. Governments and other organizations should take positive steps to include women at all levels of the health-care system. All countries should take steps to meet the family-planning needs of their population as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice.

Dreze and Amartya Sen are of the view that a direct consequence of inadequate official attention to health matters is that the Indian population continues to be exposed to a high incidence of communicable diseases and readily preventable illnesses. Communicable diseases are seen to be responsible for more than half of the ‘burden of disease’ in India. Many basic illnesses that have radically declined in large parts of the developing world in recent decades (such as tetanus, measles, pneumonia, leprosy, malaria, hepatitis, tuberculosis, to name a few) continue to be common in India. Critical analyses of India’s health care system have been dominated by two very special diagnoses, which deserve comment. According to one school of thought, India made the cardinal mistake of

following the ‘western model’ of health care, instead of promoting indigenous approaches. Another view holds that health care in India has been undermined by the chronic inefficiencies of public services, and greater reliance on the private sector.  

To some extent it is natural for the public sector to focus heavily on services such as immunization and family planning, since private provision of such services is unlikely to work without additional incentives as well as skilful regulation.

Tamil Nadu has achieved the largest proportionate reduction in child mortality among all major Indian states other than Kerala. Today, Tamil Nadu has the third-lowest child mortality rate among major Indian states and the second-lowest maternal mortality rate.

Pant expressed the view that over the last five decades massive infrastructure manned by a large number of medical and paramedical persons has been created by the Government, voluntary and private sectors to provide primary, secondary and tertiary level health care services to urban and rural population. Resulted in the steep decline in the Crude Death Rate from 25.1 in 1951 to 9.0 in 1996. life expectancy rose from 32 years in 1947 to 61.1 years in 1991-96.  

The morbidity due to common communicable and nutrition related diseases continues to be high. Morbidity due to non-communicable diseases is showing progressive increase because of increasing longevity and alterations in life style. India perhaps has the largest primary health care


85. KC. Pant, “Health & Family Welfare,” India’s Development Scenario Next Decade and Beyond, Published in 2003 by Academic Foundation, New Delhi, pp.135-136.
network manned by professionals and paraprofessionals. However, there are substantial differences between the states and between districts in the same state in the availability and utilization of the health care services and health indices of the population. The emphasis in the coming years should be to optimize the coverage and quality of care by identifying and rectifying the critical gaps in existing infrastructure, manpower, equipment, essential diagnostic reagents and drugs.

**Ghosh and Kmodal** are of the view that the Programme managers and policymakers working in the public health department would be keen to know the factors contributing to mortality and morbidity of children under-five in India under different socio-economic and environmental settings. The results from this analysis indicate that the government should strengthen the awareness campaign. One can argue why the childhood morbidity of the female child is significantly higher than that of the male child in urban slums. It is quite evident from the analysis that immunization significantly reduces childhood morbidity. Hence, the public health sector should act suitably to increase the immunization coverage, particularly among underprivileged population. The probability of dying before attaining the age of five should also draw attention. Working mothers, particularly those working in the informal sector, return to their jobs soon after delivery because of impecunious conditions. As a result, they spend less time on childcare. As part of the programme, the department of health and family welfare, along with the help of NGOs, should discourage more births and longer birth intervals.  

**Chahal** declared that to promote healthcare facilities in rural areas, the public health centre should play a commanding role. The quality

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of health care services depends on behaviour of physicians, supportive medical staff, atmospherics and operational factors. The research results reveal that the satisfactory variable perceived by patients does not provide high degree of satisfaction in the four aforesaid factors. The patient oriented approach will help the rural health care service providers in linking the various dimensions identified with the unserved needs of the patients. The various dimensions evolved from the findings for enhancing patient satisfaction are availability of physicians; availability of essential facilities and drugs, promptness in delivering the service. Proper grievance redressal system, responsiveness to consumers, need and expectations, performance of physical and supportive medical staff, good level of communication and maintenance of information record about patients.87

Priya et al, are of the view that the goal of strengthening ‘primary health care’ requires effective and affordable comprehensive primary health care services becoming accessible and user friendly for all sections and in all regions of the country. Merely increasing funding for the current programmes will do little to improve health if structure, content and functioning of the public services are not revamped. We need to set priorities and the most cost–effective ways to address them, ensuring that issues of quality are not undermined in the name of cost cutting and feasibility.88

Varatharajan et al, are of the opinion that the poor can not always afford health care that would improve their productivity and well-being. Publicly financed health care services would help the poor to reduce


poverty or alleviate its consequences. Some actions that promote health are pure public goods or create large positive externalities private markets would not produce them at all or would produce too little. Market failures in health care mean that government intervention can raise welfare by providing how markets function.  

Sujatha Rao is of the view that improvements of the public health sector through a process of reform requires an outright increase in investment, away from the traditional incrementalism, and accompanied with a range of intervention related to establishing institutions, systems and governance aimed at optimizing overall functioning and linked to measurable outputs related to health status of the people.

Simen Mahamud is of the opinion that reducing socio-economic inequalities in health outcomes and improving aggregate health indicators further, as set out in the poverty reduction strategy will be extremely difficult without significant transformation in quality of care and management of service provision. In short, the policy of “more of the same” will not work. The challenge of sustaining and consolidating gains in the health and population sector and for achieving further progress,
thus, forms part of the broader governance challenge facing "Bangladesh to day".\textsuperscript{91}

\textbf{Nayar} is of the opinion that it is time to recognize that utter neglect of primary care and primary health care institutions has influenced the utilization of health services and contributed to the worsening epidemiological profile in the country in recent years. In the present form, the proposed rural health mission adds to the confusion about the country's approach to health care. The rural health mission would greatly benefit if it follows the vision of those that scripted India's health service system based on an integrated and unified approach as against the selective interventions being proposed in recent years.\textsuperscript{92}

\textbf{Devi} viewed that public health needs to concentrate and demand to bring communicable disease in centre-stage. Integration of general health and vertical programmes, converting a family planning programme a genuine service programme supported by comprehensive primary Health care services The secondary level has to be strengthened for coverage and proper treatment of the referral case from primary level. States need to hold the role and responsibility by saving resources by cutting on welfare investment to cater to those who are capable of keeping market alive. The policy makers can do so reaching the poor of the health services through comprehensive primary Health care by changing the pattern of health services and also by the roles of professionals where


public health plays an important role in approaching the collectivist of society with people's participation for solving the health problems.93

Rakhal Gaitonde is of the view that the Government of India has made great efforts to develop health care infrastructure of the country. This has been done in isolation from manpower, drugs and finances. Moreover, the sub-centres, PHCs and CHCs continue to be inaccessible to the people. The most common reasons for the continuing inaccessibility are; lack of personnel; perceived poor quality of care; corruption; rude behaviour of the personnel; almost coercive focus on family planning, and long distance from the hamlet. All these points obviously affect women more than men94.

Reddy and Manjunath are of the view that there are villages without sufficient physical infrastructure for primary health centres (PHCs). In villages where physical infrastructures for PHC's exist there is a lack of manpower in the PHC. As there is a threshold to health beyond which productivity and functioning are seriously impaired a greater emphasis on the country's health is necessary. Therefore, the state should view the causes for health inequalities seriously and take appropriate measures. Since health is an important determinant of productivity, countries like India, which depend on "human capital" for their rapid economic progress must accord higher value


to having a healthier work force to hasten the process of economic development.\(^{95}\)

**Kamalamma** identified that in order to achieve the goal of “Health for all by 2000 AD” rural health services should be expanded on a massive scale and they must be acceptable, accessible, adoptable and affordable by the rural people. In this connection, the Chinese model of “barefoot doctors” is worth examining. Keeping in view the large number of educated graduates and post-graduates in the rural areas government may think of giving them training in providing first aid and propagating health and nutrition education to the rural people.\(^{96}\)

**Santerre and Neun** expressed their view that like other goods and services, health is subject to the law of diminishing marginal utility. This law stipulates that each additional unit of health provides less marginal utility than the previous unit.

The making, or production, of health is influenced by a variety of factors, including the amount of medical care consumed. The positive relation between health and medical care, however, is nonlinear due to the law of diminishing marginal productivity. This law underlies a fundamental production relation that states that health increases at a decreasing rate with additional amounts of medical care, holding other inputs constant. Some of the other factors determining health are the individual’s initial endowment of health, socioeconomic status, lifestyle, and environmental factors. The empirical evidence for both infants and


adults medicates that good health depends only moderately on the consumption of medical care. Socioeconomic status and lifestyle appear to play a much greater role in the production of good health. 97.