CHAPTER – II

HISTORICAL PERSPECTIVE OF PUBLIC HOSPITALS
2.1 INTRODUCTION

Without a sense of history, no man can truly understand the problems of his time. (Sir Winston Churchill). To understand this, we evaluate how far we have progressed and from where we had started. While disease is as old as the inception of life on earth, hospital is as recent as the advent of human civilization on our planet (Das, 2004-05). The story of the birth of hospitals portrays the advent of civilization from individual to family and from family to community. The word 'hotel', 'host' and 'hospital' all come from a common root Hospes (Latin) which means a guest and also a host. The establishment where a guest is received is called the hospitule or hospitale. The word hospital has at different times been used variously to refer to an institution for the aged and disabled, a place of rest and entertainment, university hall or hostel and an institution for the care of the sick and the wounded. The hospital originated as a result of sympathy for the sick and suffering population. To start with, it was a part of religious institutions. Hospital is a residential establishment which provides short-term and long-term medical care consisting of observational therapeutic and rehabilitative services for persons suffering or suspected to be suffering from a disease or injury (WHO, 1963).

Since many health problems require a level of medical treatment and personal care that extends beyond the range of services normally available in the patient’s home or in the physician’s office, modern society has developed formal institutions for patient care intended to help meeting the more complex health needs of its members. The hospital, a major social institution for the delivery of health care in the modern world, offers considerable advantages to both the patient and the society. The development of hospitals as institutions providing medical services for the general public goes in pace with the changing needs, beliefs, values and attitudes of the societies they served. The researcher tries to focus on the evolution of health services and history of hospitals in this chapter.
2.2 EVOLUTION OF INTERNATIONAL HEALTH CARE

Nothing on earth is more international than disease (Park, 2002). Health and diseases have no political or geographical boundaries. History is replete with examples of the spread of pestilences – particularly of plague and cholera along trade routes. In order to prevent the spread of disease from one country to another, many attempts were made in the past by individual states and their rulers to place barriers against infection by detection and isolation of the incoming travellers. In the 14th century, a procedure known as “quarantine” was introduced in Europe to prevent the importation of plague. Ships, crews, travellers and cargo, suspected of harbouring infection, were detained for a 40-days period. The underlying idea was that the passage of time would give dormant disease to manifest itself or die out. Quarantine soon became an established practice in many countries. Different countries adopted different quarantine procedures. This was the origin of international health work which at a later stage went further through various agencies.

2.2.1 International agencies

Opposition to quarantine came from several quarters because the 40-days’ detention caused serious inconveniences to international trade and travel. International agreement and cooperation became necessary on quarantine matters to control communicable diseases. International conferences were held and some organizations have been set up for discussion, agreement and cooperation on matters of international health. Some of the early health organizations at international level which preceded the World Health Organization are given below:

- First International Sanitary Conference (1851),
- Pan American Sanitary Bureau (1902),
- Office International D’Hygiene Publique (1907),
- The Health Organization of the League of Nations (1923),
- The United Nations Relief and Rehabilitation Administration (1943), etc.

2.2.2 World Health Organization (WHO)

The World Health Organization is a specialized and non-political health agency of the United Nations with headquarters at Geneva. In 1946, its constitution
was drafted and was approved in the same year at an international health conference of 51 nations in New York. The constitution came into force on 7th April, 1948 which is celebrated every year as “World Health Day”. A World Health Day theme is chosen each year to focus attention on a specific aspect of public health. The WHO covers some broad areas of activities such as; Prevention and Control of Specific Diseases, Development of Comprehensive Health Services, Family Health, Environmental Health, Health Statistics, Bio-Medical Research, Health Literature and Information, Cooperation with Other Organizations.

WHO has three organs: The World Health Assembly, the Executive Board and the Secretariat. WHO has established six regional organizations.

Table – 2.1

<table>
<thead>
<tr>
<th>Region</th>
<th>Headquarters</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. South East Asia</td>
<td>New Delhi (India)</td>
</tr>
<tr>
<td>2. Africa</td>
<td>Harare (Zimbabwe)</td>
</tr>
<tr>
<td>3. The Americas</td>
<td>Washington D.C. (U.S.A.)</td>
</tr>
<tr>
<td>4. Europe</td>
<td>Copenhagen (Denmark)</td>
</tr>
<tr>
<td>5. Eastern Mediterranean</td>
<td>Alexandria (Egypt)</td>
</tr>
<tr>
<td>6. Western Pacific</td>
<td>Manila (Philippines)</td>
</tr>
</tbody>
</table>


2.2.3 Other United Nations Agencies

Some UN agencies were formed to fill the gaps in health needs of different dimensions over the globe. Some important names are:

- UNDP (United Nations Development Programme) established in 1996.
- UNFPA (UN Fund for Population Activities) established in 1974.
- FAO (Food Agriculture Organization) formed in 1945 with headquarters in Rome.
- ILO (International Labour Organization) established in 1919 as an affiliate of the League of Nations to improve the health, working and living conditions of the working population all over the world.

- World Bank, a specialized agency of the United Nations established to help less developed countries raise their health and living standards.

2.2.4 Bilateral Agencies

The various bilateral agencies working in international health care are shown as under:

- SIDA: The Swedish International Development Agency is assisting the National Tuberculosis Control Programme since 1979.

- DANIDA: The Government of Denmark is providing assistance for the development of services under National Blindness Control Programme since 1978.

2.2.5 Non-Governmental and Other Agencies

The following non-governmental agencies are worth mentioning in the field of international health care:

- **Rockefeller Foundation-1913**

  The establishment of the All India Institute of Hygiene and Public Health at Kolkata was in a large measure due to the cooperation of the Rockefeller Foundation.

- **Ford Foundation**

  Ford Foundation has been active in the development of rural health services and family planning.

- **CARE**

  CARE (Co-operative for Assistance and Relief Everywhere) was founded in North America in the year 1945. CARE-India (1950) focused its attention on food support in the ICDS programme and on the development of programmes in the areas of health and income supplementation.

- **International Red Cross**

  It was founded by Henry Dunant, a young Swiss businessman in 1859 which aimed at serving mankind in war and peace.
Indian Red Cross

The Red Cross Society of India was established by an Act of the Indian Legislature in 1920 with the three objectives, i.e., improvement of health, prevention of disease and mitigation of suffering.

2.3 HISTORY OF HOSPITALS IN INDIA

Hospitals in India have been in existence for a long time from ancient days. Even during the 8th century BC, the times of Buddha, there were a number of hospitals for the crippled and the poor. Charak and Sushruta of ancient India were famous physicians. Medicines based on the Indian system were taught in the universities of Taxilla and Nalanda. The books written by Arabian and European travellers in 6000 AD show that the study of medicine in India was in its days of glory. The decline of Indian system of medicines starts from the Mohammedan invasion in the 10th century AD which was a period of unrest. The Mohammedans brought with them their own physicians called Hakims who followed the Indian (Greek) system of medicines generally termed Unani. The Hakims began to prosper at the cost of the Vaidyas.

The modern system of medicine was introduced by the European missionaries in India in the 16th century. At that time, the Portuguese organized hospitals in Calcutta, Goa and Madras. In the 17th century, the East India Company established its first hospital in 1664 at Madras for its soldiers and in 1668 for the civilian population. Sir Thomas introduced modern medicine in the court of Jehangir in the 17th century. Other princely states also started taking interest and hence, the European doctors started becoming popular in India. During the later half of the 17th and the 18th centuries, there was a steady growth of the modern system of medical practice and hospitals, pushing the indigenous system to the rear seat. Organized medical training however started in the 19th century. The first medical school was started in Calcutta followed by Madras in 1820s. A hospital assistant’s course of 2 years was also started by the army at about the same time. The medical school in Calcutta was converted into a College in 1835.
In the meantime, the British spread their political control over the country. Many hospitals and dispensaries originally started to treat the army personnel were handed over to the civil authorities for treating the civilian population. Local government was encouraged to start dispensaries at taluk and district levels. Some hospitals at provincial headquarters were converted into teaching hospitals and attached to medical colleges. In rural areas, a few rural dispensaries were started. The following list shows the year of establishment of the medical school/college in various cities during the period of 1835 – 1916.

**Table -2.2**

<table>
<thead>
<tr>
<th>Cities</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcutta</td>
<td>1835</td>
</tr>
<tr>
<td>Madras</td>
<td>1835</td>
</tr>
<tr>
<td>Bombay</td>
<td>1945</td>
</tr>
<tr>
<td>Hyderabad</td>
<td>1846</td>
</tr>
<tr>
<td>Travancore</td>
<td>1846</td>
</tr>
<tr>
<td>Agra</td>
<td>1853</td>
</tr>
<tr>
<td>Lahore</td>
<td>1860</td>
</tr>
<tr>
<td>Nagpur</td>
<td>1867</td>
</tr>
<tr>
<td>Patna</td>
<td>1874</td>
</tr>
<tr>
<td>Dacca</td>
<td>1975</td>
</tr>
<tr>
<td>Cuttack</td>
<td>1876</td>
</tr>
<tr>
<td>Indore</td>
<td>1878</td>
</tr>
<tr>
<td>Ludhiana</td>
<td>1875</td>
</tr>
<tr>
<td>Dibrugarh</td>
<td>1900</td>
</tr>
<tr>
<td>Rangoon</td>
<td>1907</td>
</tr>
<tr>
<td>Lucknow</td>
<td>1912</td>
</tr>
<tr>
<td>Delhi</td>
<td>1916</td>
</tr>
</tbody>
</table>

In 1885 there were 1250 hospitals and dispensaries in British India. But the medical aid scarcely reached the requirement of 192 million population. Slow progress continued and on the eve of independence there were 7400 hospitals and dispensaries in the country with 113000 beds giving a bed population ratio of 0.24 per 1000. There were 47000 doctors and 7000 nurses, 19 medical schools and 19 medical colleges in the country at that time.

In 1943, the Government of India appointed a committee called the Health Survey and Development Committee popularly known as Bhore Committee. They submitted their report in 1946 and recommended upgrading of medical relief in the form of primary health centres in the villages, secondary health centers at the taluk level and district hospitals at district headquarters with all the specialist services. It was anticipated that bed population ratio could rise to 1.3 per 1000 in 10 years and 5.6 in 25 years.

In 1959, the Government set up another committee called the Health Survey and Planning Committee (Mudaliar Committee) to review the developments. This committee recommended a more realistic target of 1 bed per 1000 population to be achieved by 1975-76. This was desired to be achieved by establishing district hospitals of 300-500 beds and taluk hospitals of 50 beds each. There are now [1992] 48 doctors per 100000 population and 45 nurses and midwives per 100000 population with the bed population ratio standing at 0.7 per 1000 population. The end of Eighth Five year plan envisages 410800 allopathic doctors and 449351 nurses. 69 per cent of the total hospitals are located in urban areas whereas 74 per cent of the Indian population live in villages. Now a days, the Indian health care delivery system has witnessed large-scale unregulated entry of private hospitals with the private sector contributing 57 per cent of total hospitals in India with a bed capacity of 32 per cent of total available hospital beds. Utilization pattern shows that people generally prefer private health care facilities though no check or accreditation system exists in India for regulating the quality of care offered by private hospitals.
2.3.1 Health Services Development in Independent India

Health service development in India can broadly be divided into three phases. The first phase of development was the post-Independence period which witnessed the growth of health services in the public sector up to the seventies. During this period, investments in the health sector were meagre, but an effort was made to build a network of services in both rural and urban areas. This phase was followed by the second phase, a period from the late seventies to the late eighties, when there were cutbacks on public spending on health and concessions were given to the private sector. During the third phase, the period after 1980, India went for loans from the IMF and the World Bank. This was the period when several state governments received loans for reforming the publicly provided health services. Like many of the newly liberated countries during the 20th century, the leadership of the Indian nationalist movement had committed itself to principles of universality and a nationalized health service system to ensure that all sections of the population get access to health services. The vision at that point of time was to build self-reliance in the economy and social sectors. Hence, in health care, the emphasis was on the development of institutions, manpower, research, pharmaceuticals and technology. The nationalist movement and its commitment to democratic policies played a very important role in ensuring that the needs of the majority were represented (Bhargava, 2000). This understanding received support for a state supported health service system from various sections of civil society including the political parties, big business groups, professional bodies and other bigwigs of the society.

Given the poor health of a majority of Indians, the thrust was to invest on preventive and curative care in addition to improving the overall living conditions of the population. The Bhore Committee report (Government of India, 1946) was an attempt at designing a health service system based on the needs of the majority who belonged to the deprived section of the population. Due to limited private capital, even the representatives of big business houses relied on state investment in education and health. Within the health services, the professional organizations supported state investment, but did not want to interfere with their autonomy to
continue private practice. However, the low levels of investment in health services stunted the growth of the public sector, which provided the space for the growth and expansion of the private sector during the last three decades. Apart from the growing presence of the private sector, the public sector was marked by rural/urban, regional and class inequalities.

Mc Kinlay (1980) (in Milbank Memorial Fund Quarterly, 55,(3), 405-428 has observed that for any substantive analysis of privatization of health services, there needs to be recognition of the role played by large finance capital in the health sector. Large finance capital was largely confined to the pharmaceutical, medical equipment and insurance industries which operated globally. The impact of these industries was very visible in the Indian case during the late eighties and nineties when there was a sharp increase in the import of medical equipments. The real peak was seen during the mid eighties to late nineties with the government offering reduced import duties for medical equipment (Baru, 1998).

The existing health system suffers from inequitable distribution of institutions and manpower with substantial difference between states, districts and different segments of the society with respect to access and utilization of services particularly by the rural populace. This has been exhibited in the table below:

Table-2.3
Heath centres in India during 1999-2000

<table>
<thead>
<tr>
<th>Centre</th>
<th>Population norms designed for</th>
<th>Number of centres created by states</th>
<th>Average rural population served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plains</td>
<td>Hilly/ Tribal area</td>
<td></td>
</tr>
<tr>
<td>Sub-centre</td>
<td>5,000</td>
<td>3,000</td>
<td>1,37,271</td>
</tr>
<tr>
<td>PHC</td>
<td>30,000</td>
<td>20,000</td>
<td>22,975</td>
</tr>
<tr>
<td>CHC</td>
<td>1,20,000</td>
<td>80,000</td>
<td>2,935</td>
</tr>
</tbody>
</table>

Source : Indian Institute of Public Administration, Regional Branch, Bhubaneswar
Facility survey undertaken by the Department of Family Welfare in 1999 showed that most of the PHCs lack essential infrastructure and inputs. Hence, health service in independent India is yet to achieve the desired goals.

2.4 HISTORY OF HOSPITALS IN ORISSA

In Orissa, medical care in the western lines started almost 130 years ago much ahead of other regions due to several reasons; but the most important one seems to be the seat and shrine of Lord Jagannath at Puri for which Orissa always attracted large number of pilgrims round about the year from all over the country. Their protracted journeys to and from the Puri Dham naturally created a lot of health problems due to frequent outbreak of epidemics resulting from the unhygienic conditions of that time. This perhaps necessitated the establishment of some wayside dispensaries and health aid centres. The biggest of such a centre was located in Cuttack at the site where the present S.C.B. Medical College and Hospital is situated.

The small dispensary that existed in the premises of the present S.C.B. Medical College was started during the days of the Marahatta rule in the latter half of the eighteenth century. The sole purpose of that dispensary was to render whatever little medical assistance was then available to the sick pilgrims en route to and fro Puri, especially during the “Car Festival” of Lord Jagannath. This was a regular annual feature for which the Marahatta rulers had thoughtfully established a few roadside small dispensaries to meet the needs of these ailing pilgrims and the one at Cuttack was by far the biggest. This dispensary continued to function till the British occupation of Orissa in 1803 A.D. The British rulers, in due course of time, realized the strategic importance of a dispensary at Cuttack and converted it into a small hospital. Regular financial assistance was made available for its smooth running. Even during the tight financial situation arising out of famine of 1865-66, they did not make this hospital starve of adequate funds. They made substantial provisions for it by pumping sufficient money from the “Annachhatra Fund” so that the hospital could run smoothly. In 1875, a large hearted Briton, Dr. Stewart, the then Civil Surgeon of Cuttack mooted out the idea of starting a medical school utilizing this hospital as the infrastructural nucleus. In this endeavor, he got the kind
support and patronage of the then Lt. Governor, Sir Richard Temple and the Divisional Commissioner, Mr. T.E. Ravenshaw. With an annual grant of Rs.3,000/-, the proposed medical school was born on 15th February, 1876. The school was managed by the medical department of the Government. The course extended over a period of 3 years and on successful completion of the course, the students got L.M.P. (Licentiate Medical Practitioner) Diploma.

For providing higher medical education, i.e., Bachelor's Degree (M.B.B.S.), the first medical college of the state named the 'Orissa Medical College' was born on 1st of June, 1944 under Utkal University. The Orissa Medical College was renamed as the Sriram Chandra Bhanj Medical College (S.C.B. Medical College) in the year 1951 by the Government.

The second medical college, the Veer Surendra Sai (V.S.S.) Medical College, Burla, came up in June, 1959 near Sambalpur. The 3rd medical institution, the Maharaja Krishna Chandra Gajapati (M.K.C.G.) Medical College at Berhampur came into existence in the year 1962. Apart from allopathic medical colleges and hospitals, our state has also developed facilities for alternate medical education and health care in the field of Homeopathy & Ayurved.

Apart from all these institutions of medical education, some allopathic undergraduate medical colleges in the private sector named the Hi-tech Medical College & Hospital, KIIMS, SUM Hospital and Medical college came into operation at Bhubaneswar by the year 2005.

2.5 TYPES OF HOSPITALS IN INDIA

Hospitals can be categorized on various bases such as financial, clinical, levels of health care, number of beds, sectoral basis etc.

2.5.1 Financial basis

On the basis of nature and purpose of financing, hospitals can be grouped into profit and non-profit hospitals.
• **Profit Hospitals**

These hospitals are generally owned by individual doctors or group of doctors or non-medical persons. Such hospitals are set up with the purpose of making profit on investment and serving the people at the same time. Sometimes the profit hospitals are also run under corporate forms which are called corporate hospitals. These hospitals are the large and specialized public limited hospitals which are run on a commercial basis. Such five star hospitals are formed under the Companies Act, 1956.

• **Non-Profit Hospitals**

These hospitals are established for the sole purpose of serving the community. These are registered under the Societies Registration Act 1860 or the Public Trust Act 1882 or under Section 25 of the Companies Act, 1956.

2.5.2 **Clinical Basis**

Hospitals can be classified on their clinical bases as General Hospitals, Specialty Hospitals, Chronic care Hospitals or Teaching Hospitals.

2.5.3 **Levels of Health Care Basis**

On the basis of health care hospital can be classified as below:

(i) Primary Health Care Level- Primary Health Centres, Health Sub-centres, etc.

(ii) Secondary Level- District Hospitals and Community Health Centres.

(iii) Tertiary Level- Specialty Hospitals, Super Specialty Hospitals at regional level and Central level Institutions like AIIMS at central level.

2.5.4 **Number of Beds Basis**

Hospitals can be categorized on the basis of the number of beds as A, B, C, D and E.

- Category A 25-50 beds.
- Category B 51-100 beds.
- Category C 101-300 beds.
- Category D 301-500 beds.
- Category E 501-750 beds.
2.5.5 Sectoral basis

In India, hospitals are represented by some major sectors or agencies which differ from each other by the health technology applied and by their source of funds for operation. These are:

Public Sector
- Primary Health Centres
- Primary Health Sub-centres.
- Community health centres
- Rural hospitals
- District hospital/health centres
- Specialty hospitals and Super specialty hospitals
- Teaching hospitals
- ESI hospitals
- Military/Army hospitals
- Railway hospitals

Private Sector
- (a) Private hospitals, Polyclinics, Nursing homes, and Dispensaries.
- (b) General practitioners and clinics.

Indigenous Sector
- Ayurvedic and Siddha hospitals.
- Unani hospitals.
- Homeopathy hospitals.
- Unregistered practitioners.

2.6 HEALTH SERVICES IN ORISSA

A welfare state is under obligation to provide economical and efficient health services to its citizen. Although the health care system in the state has improved remarkably over the years, communicable and nutrition related diseases continue to be a major problem mostly in the tribal and backward regions as well as in the remote rural areas. Steps have been taken to bring adequate improvement in the
health care system of the State especially in the rural and tribal areas and backward regions.

2.6.1 Major Objectives of Health Sector Programmes

The main objectives of health sector programmes of the state are as follows:

- To provide adequate qualitative preventive and curative health care services to the people.
- To reduce maternal and infant mortality rate and to improve maternal and child health.
- To ensure health care services to all, particularly to the disadvantaged groups like Scheduled Tribes, Schedules Castes, backward classes and women.
- To provide affordable quality health care through allopathic, homeopathic and ayurvedic systems of medicine.
- To impart training to doctors, nurses and other paramedical staff to upgrade their skill and knowledge.
- To ensure greater access to primary health care by providing medical institutions as close to the people as possible or through mobile health units, particularly in the under-served and backward districts.
- To improve hospital services at primary, secondary and tertiary levels in terms of infrastructure, drugs and personnel.
- To eliminate diseases like polio and leprosy from the State and prevent and control other communicable diseases.
- To improve health care facilities in the KBK districts of the State in particular.

2.6.1.1 Objectives in the Eleventh Plan Period

The objectives set by the government in the 11th Plan are given as under:

- To reduce Infant Mortality Rate (IMR) to 37 Maternal Mortality Rate (MMR) to 1.19 per 1000 live birth and to reduce Fertility Rate to 2.1.
➢ To provide clean drinking water for all by 2009 and ensure that there are no slip backs by the end of Eleventh Plan.

➢ To reduce malnutrition among children in the age group 0-3 to half its present level and reduce anemia among women and girls by 50 percent by the end of Eleventh Plan.

As per the Registrar General of India sources, the Crude Birth Rate (CBR) in Orissa lies much below the all India level as well as other bigger States. In 2006, the estimated birth rate in Orissa was 21.9 as against 23.5 at all India level. The birth rate in rural and urban Orissa stood at 22.8 and 16.2 respectively while at all India level it was 25.2 and 18.8 respectively. Highest birth rate has been recorded in Uttar Pradesh (30.1) followed by Bihar (29.9), Madhya Pradesh (29.1) and Rajasthan (28.3). Lowest birth rate was recorded in Kerala (14.9). As per the estimation of Central Bureau of Health Intelligence, Ministry of H & F.W., GOI, the Crude Birth Rate (CBR) in Orissa will be reduced to 18.9 per Thousand live birth during 2006-10 as against 21.3 at all India level.

The Crude Death Rate (CDR) in Orissa, during 2006 was relatively higher, i.e., 9.3 as against 7.5 at all India level. Orissa occupied highest rank followed by Madhya Pradesh (8.9) and Assam (8.7). As per the estimation of CBHI, the CDR in Orissa will be reduced to 8.9 during 2006 – 10.

Though the Infant Mortality Rate (IMR), in Orissa has declined considerably from 83 in 2003 to 73 per thousand in 2006, it is still very high at all India level. The infant mortality rate in the rural Orissa was 76 while in urban Orissa, it was 53. During 2006, the IMR at all India level stood at 57 and in Kerala the lowest IMR has been recorded as 15. The target of 11th plan is to reduce the IMR to 37 as compared to 28 at all India level. Table shows the birth rate, death rate and infant mortality rate in Orissa and at all India level since 1981.

The Maternal Mortality Rate (MMR) in India during 2001-03 was 301 per 1,00,000 live births as against 358 in Orissa. It has been targeted to reduce the MMR to 100 at all India level and 1.19 per thousand live births in Orissa by the end of Eleventh Plan period (2007-12).
Life Expectancy at Birth has increased from 58.6 years for male and 58.7 years for female in 1999-2003 to 60.3 for male and 62.3 for female during 2001-05. As per the report of Technical Group on population projection, the projected level of expectation of life at birth in Orissa for male will be 64.3 and 67.3 for female during 2011-15 as against 67.3 for male 69.6 for female at all India level.

Natural Growth Rate (NGR) of the State in 2006 was 12.6 as against 16.0 at all India level. The natural growth rate in rural Orissa was 13.1 while in urban Orissa it was 9.3 in 2006.

In Orissa, the Decadal Growth Rate (DGR) of population during 1991-2001 was 15.94 percent as against the all India average of 21.34 percent as per 2001 census. Thus the decadal growth rate target fixed for the decade 2001-2011 at the national level has already been realized in the state during the decade 1991-2001.

Table-2.4

Birth rate, death rate and infant mortality rate of Orissa / all India

<table>
<thead>
<tr>
<th>Year</th>
<th>Orissa</th>
<th>All India</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>33.1</td>
<td>13.1</td>
</tr>
<tr>
<td>1991</td>
<td>28.8</td>
<td>12.8</td>
</tr>
<tr>
<td>1995</td>
<td>27.8</td>
<td>10.8</td>
</tr>
<tr>
<td>2000</td>
<td>24.3</td>
<td>10.5</td>
</tr>
<tr>
<td>2001</td>
<td>23.4</td>
<td>10.2</td>
</tr>
<tr>
<td>2002</td>
<td>23.2</td>
<td>9.8</td>
</tr>
<tr>
<td>2003</td>
<td>23.0</td>
<td>9.7</td>
</tr>
<tr>
<td>2004</td>
<td>22.7</td>
<td>9.6</td>
</tr>
<tr>
<td>2005</td>
<td>22.3</td>
<td>9.5</td>
</tr>
<tr>
<td>2006</td>
<td>21.9</td>
<td>9.3</td>
</tr>
</tbody>
</table>

C.B.R. : Crude Birth Rate ; C.D.R. – Crude Death Rate
I.M.R. : Infant Mortality Rate
Source : S.R.S. Bulletin
2.6.2 Medical Institutions in Orissa

Public health care services are given through various types of medical institutions, i.e., Allopathetic, Ayurvedic, Homeopathic, Unani, etc. A brief discussion about these institutions are made as under.

2.6.2.1 Allopathic Medical Institutions

During the year 1951, medical and health care facilities created by the Government were available to the people through a network of 365 medical institutions with 3,112 hospital beds and 1,083 doctors with a doctor-population ratio of 1:13,500. By end of December, 2006, the facilities have been increased to 1,704 Government allopathic medical institutions in the state with 14,166 hospitals beds. Population served per medical institutions being about 23,030 with area served per medical institution being 92 sq.km by the end of 2006. The bed-population ratio, an important indicator of health services, was 1:2770 in 2006-07. Besides, 6,688 no. of health sub-centres are also functioning in the State. State government has taken special steps to provide better health care to rural people belonging to KBK districts. At present, 700 medical institutions are functioning in 118 tribal dominated blocks with 5,705 hospital beds.

2.6.2.2 Ayurvedic and Homeopathic Institutions

State government has taken steps for health care of the people by providing facilities under Indian System of Medicine and Homoeopathy (ISMH). Chronic and complicated diseases like paralysis, arthritis, liver disease, diabetes, asthma, an tuberculosis etc. are being successfully treated with affordable cost through ISM&H process. By the end of 2006-07, there were 4,695 registered Ayurvedic doctors in the state including 121 doctors registered during 2006-07. Similarly there were 3,226 registered Homeopathic doctors in the state during 2005-06. At present 5 Ayurvedic Hospitals with 258 beds and 4 Homoeopathic Hospitals with 125 beds are also rendering health services in the State. Besides, 619 Ayurvedic, 560 Homoeopathic and 9 Unani dispensaries are providing health care services in the state. During 2006-07, about 154.74 lakh patients availed treatment facilities under these hospitals and dispensaries as against 152.44 lakh patients treated in 2005-06.
In the field of Education & Training, three Government Ayurvedic colleges and four Homoeopathic colleges have been imparting teachings for degree courses. Post graduate teaching in seven Ayurvedic disciplines and three homeopathic disciplines are available in the state. Financial assistance has been availed from department of AYUSH to upgrade the status of Gopabandhu Ayurvedic Mahavidyalaya, Puri and Dr. Avinchandra Homoeopathic Medical College, Bhubaneswar as state model institutes. Government Ayurvedic pharmacies colleges at Bolangir and Bhubaneswar have been modernized with assistance of department of AYUSH.

Table-2.5

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of institution</th>
<th>Hospitals</th>
<th>Dispensaries</th>
<th>Doctors</th>
<th>Bed</th>
<th>Patient treated (in lakh)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>Homoeopathic</td>
<td>4</td>
<td>533</td>
<td>494</td>
<td>125</td>
<td>79.9</td>
</tr>
<tr>
<td></td>
<td>Ayurvedic</td>
<td>5</td>
<td>607</td>
<td>611</td>
<td>203</td>
<td>63.1</td>
</tr>
<tr>
<td></td>
<td>Unani</td>
<td>-</td>
<td>9</td>
<td>8</td>
<td>-</td>
<td>0.93</td>
</tr>
<tr>
<td>2005</td>
<td>Homoeopathic</td>
<td>4</td>
<td>560</td>
<td>512</td>
<td>125</td>
<td>82.8</td>
</tr>
<tr>
<td></td>
<td>Ayurvedic</td>
<td>5</td>
<td>607</td>
<td>584</td>
<td>258</td>
<td>68.6</td>
</tr>
<tr>
<td></td>
<td>Unani</td>
<td>-</td>
<td>9</td>
<td>8</td>
<td>-</td>
<td>1.04</td>
</tr>
<tr>
<td>2006</td>
<td>Homoeopathic</td>
<td>4</td>
<td>560</td>
<td>494</td>
<td>125</td>
<td>79.2</td>
</tr>
<tr>
<td></td>
<td>Ayurvedic</td>
<td>5</td>
<td>619</td>
<td>584</td>
<td>258</td>
<td>74.5</td>
</tr>
<tr>
<td></td>
<td>Unani</td>
<td>-</td>
<td>9</td>
<td>9</td>
<td>-</td>
<td>1.07</td>
</tr>
</tbody>
</table>

Source: Directorate of Indian Systems of Medicine and Homoeopathy, Orissa, 2007-08.

2.7 HEALTH PROGRAMMES IN INDIA

In independent India, National Health Programmes, have been launched by the Central Government for the control/eradication of communicable diseases, improvement of environmental sanitation, raising the standard for nutrition, control of population and improving rural health. Various international agencies like WHO, UNICEF, UNFPA and USAID have been providing technical and material
assistance in the implementation of these programmes. A brief account of these programmes which are currently in operation is given below:

(i) National Anti-Malaria Programme-National Malaria Control Programme (NMCP) was launched in India on April 1953, and later renamed it as “National Anti Malaria Programme” in 1999.

(ii) National Filaria Control Programme-It has been in operation since 1955.

(iii) National Leprosy “Eradication” Programme-It has been in operation since 1955 as a centrally aided programme.

(iv) National Tuberculosis Programme-It has been in operation since 1962.

(v) Revised National Tuberculosis Control Programme-The Government of India, WHO and World Bank together reviewed the NTP in the year 1992. Based on the finding, this new Programme was evolved in the same year.

(vi) National AIDS Programme-The Government of India constituted task force in 1985 to look into the control of AIDS and launched this programme.

(vii) National Programme for Control for Blindness 1976.

(viii) Iodine Deficiency Disorders (IDD) Programme, 1962.

(ix) Universal Immunization Programme launched in 1974 jointly with WHO.

(x). Reproductive and Child Health Programme (RCH)

(xi). National Guinea – worm eradication Programme 1984 with technical assistance from WHO.

(xii). Japanese Encephalitis Control Programme-

(xiii). Kalazar Control Programme-

(xiv). Dengue Fever Control Programme-

(xv). National Cancer Control Programme-

(xvi). National Mental Health Programme-

(xvii). National Diabetes Control Programme-

(xviii). National Family Welfare Programme-

(xx). Minimum Needs Programme for Rural Health-

(xxi). 20-Point Programme Including Health for All-
2.8 HEALTH PROGRAMMES IN ORISSA

The Government of Orissa through numerous programmes in the health sector seeks to provide adequate, qualitative, preventive and curative health care to the people of the State as well as to ensure health care services to all. As per the National Health Policy, a number of central plan schemes and centrally sponsored plan schemes are being implemented in the State to ensure better health care services at the primary and secondary levels. Besides, some state plan schemes are also in operation. Some of these are highlighted below.

(a) Revised National Tuberculosis Control Programme (RNTCP)

The Revised National Tuberculosis Control Programme (RNTCP) with Directly Observed Treatment short course Strategy (DOTS) was implemented in the State with DANIDA support from 1996 to 2005. Global Funds for Aids, Tuberculosis and Malaria (GRATM) support through Govt. of India is available from 2006 to 2010 to implement the said programme in the State. The objective of this programme is to achieve 70 percent case detection, 90 percent sputum conversion and 85 percent cure rate by the end of 2005:

Since inception of RNTCP till September 2007, 2,49,031 patients have been detected and treated under DOTS. Government of India provides anti T.B. drugs for patients treated free of cost under DOTS.

(b) National Filaria Control Programme (NFCP)

The National Filaria Control Programme (NFCP), a centrally sponsored plan scheme on a sharing pattern of 50:50 between the Centre and the State, is being implemented through a Filariasis Bureau comprising a research unit at Puri, 15 Filaria Control Units and 15 Filaria clinics in urban areas. The Filaria clinics are conducting night blood survey in a confined area of 50,000 populations and undertake treatment to microfilaria carrier as well as to the diseased.

In order to achieve the national goal of eliminating Lymphatic Filariasis from the country by 2015, Mass Drug Administration (MDA) programme is being implemented in 20 districts of Orissa since 2004 with Govt. of India assistance. It
has been decided to continue M.D.A. programme for the next five years and to include other districts in this programme.

(c) National Programme for Control of Blindness (NPCB)

National Programme for Control of Blindness (NPCB), a World Bank assisted project, was introduced in the State since 1976, with an aim to reduce the prevalence of blindness from 1.4 to 0.3 percent. For this purpose, strengthening of Central Mobile Units, District Mobile Units, upgradation of Medical Colleges, training of Ophthalmic Surgeons and District Blindness Control Society (DBCS) all over the State have been taken up.

The World Bank assistance was received by the State from 1st April 1994 to 30th June 2002. Now the programme is continuing with 100 percent central assistance.

During 2006-07, the cataract operation rate was 286 per one lakh population in Orissa and ranked 18th position at national level as per survey made by Govt. of India.

Besides school eye screening programme is also operating in the State. The achievement made under the programme during 2005-06 to 2007-08 (upto 2nd Qr.) is given in table.

<table>
<thead>
<tr>
<th>Table-2.6</th>
<th>Achievement under NPCB in Orissa</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Item</td>
</tr>
<tr>
<td>Student screened</td>
<td>317897</td>
</tr>
<tr>
<td>Students detected with refractive error</td>
<td>17662</td>
</tr>
<tr>
<td>Free spectacles disturbed</td>
<td>7965</td>
</tr>
<tr>
<td>Health worker trained</td>
<td>3764</td>
</tr>
<tr>
<td>No. of teachers</td>
<td>2222</td>
</tr>
</tbody>
</table>

Source: Directorate of Health Services, Orissa, Bhubaneswar.
National Iodine Deficiency Disorder Control Programme (NIDDCP)

It has been assessed that about 2 billion people are at risk of Iodine Deficiency Disorder (IDD) in the World including 600 million people in South-East Asia region. In India as many as 73 million people are suffering from IDD.

Hence to prevent IDD, the National Iodine Deficiency Disorders Control Programme (NIDDCP) is being implemented in the State since December, 1989 as a Centrally Sponsored Scheme with a goal to bring down goiter prevalence rate to below 10 percent. Year-wise IDD survey conducted in different districts are shown in table.

**Table-2.7**

<table>
<thead>
<tr>
<th>Year of Survey</th>
<th>Name of the District</th>
<th>IDD Prevalency rate</th>
<th>Survey conducted by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>Sundargarh</td>
<td>33.5</td>
<td>DGHS, New Delhi</td>
</tr>
<tr>
<td>1989</td>
<td>Puri</td>
<td>19.34</td>
<td>-do-</td>
</tr>
<tr>
<td>1998</td>
<td>Cuttack</td>
<td>21.61</td>
<td>-do-</td>
</tr>
<tr>
<td>1999</td>
<td>Keonjhar</td>
<td>14.9</td>
<td>-do-</td>
</tr>
<tr>
<td>2001</td>
<td>Nuaapada</td>
<td>14.4</td>
<td>VSS M.C. Bura, SBL</td>
</tr>
<tr>
<td>2001</td>
<td>Balasore</td>
<td>0.83</td>
<td>SCB Med. College, Ctc.</td>
</tr>
<tr>
<td>1995-99</td>
<td>Baragarh</td>
<td>10.8</td>
<td>RMRC, Bhubaneswar</td>
</tr>
<tr>
<td>2002</td>
<td>-do- (Resurvey)</td>
<td>7.66</td>
<td>VSS Med. College, Bura</td>
</tr>
<tr>
<td>2003-04</td>
<td>Ganjam</td>
<td>15.79</td>
<td>MKCG M.C. Berhampur</td>
</tr>
<tr>
<td>2003-04</td>
<td>Kandhamal</td>
<td>27.79</td>
<td>-do-</td>
</tr>
<tr>
<td>2004</td>
<td>Gajapati</td>
<td>21.15</td>
<td>-do-</td>
</tr>
<tr>
<td>2004</td>
<td>Bolangir</td>
<td>8.57</td>
<td>VSS M.C. Bura</td>
</tr>
<tr>
<td>2005-06</td>
<td>Sambalpur</td>
<td>10.04</td>
<td>-do-</td>
</tr>
<tr>
<td>2006</td>
<td>Koraput</td>
<td>22.39</td>
<td>MKCG M.C. Berhampur</td>
</tr>
<tr>
<td>2006</td>
<td>Jagatsinghpur</td>
<td>3.08</td>
<td>SCB Med. College, CTC</td>
</tr>
<tr>
<td>2006</td>
<td>Rayagada</td>
<td>19.7</td>
<td>MKCG M.C. Berhampur</td>
</tr>
<tr>
<td>2006</td>
<td>Sundargarh (Resurvey)</td>
<td>NR</td>
<td>CGS Team, DGHS, New Delhi</td>
</tr>
</tbody>
</table>

M.C. = Medical College,
Source: Directorate of Health Services, Orissa, Bhubaneswar
(e) National Leprosy Elimination Programme (NLEP)

The National Leprosy Elimination Programme (NLEP) is under implementation in the State since 1982-83. The programme is being supported by WHO, World Bank and international donor agencies like Lepra India, HOINA and the German Leprosy Relief Association. The objective of the programme is to eliminate leprosy by detecting all the cases and bring them with "Multi Durg Therapy (MDT)

The diagnosis and treatment facilities of leprosy cases have been extended to all the peripheral health institutions including sub-centres. Re-constructive surgery facility has also been made available at the Leprosy Home and Hospitals, Cuttack, MKCG Medical College, Berhampur and the Mission Hospital Bargarh.

(f) National Vector Borne Disease Control Programme (NVBDCP)

Orissa has a high incidence of malaria with 20 percent of the total affected persons and about 40 percent of the death recorded in the country. The National Anti-Malaria Programme (NAMP) renamed as National Vector Borne Disease Control Programme (NVBDCP) is being implemented in the State since 1953.

This problem is more alarming in tribal areas (158 blocks) which contribute 70 percent cases of the State. The State Government has targeted to bring down malaria death to 50 percent of the current level by 2010. The Enhanced Malaria Control Project (EMCP), assisted by World Bank, is in operation in hyper endemic areas since 1997-98 covering 240 blocks spread over 26 districts. This programme will be extended to all the 30 districts during the current fiscal year.

(g) Pancha Byadhi Chikitsa

The state government has started the Pancha Byadhi Chikitsa in July, 2001, which guarantees free treatment including free medicine for five common communicable diseases viz., malaria, leprosy, diarrhea, acute respiratory infections and scabies. These five diseases constitute approximately 70 percent of the patient load in the primary health institutions and affect a large number of poor people. Currently, T.B. has been included in the list. Diagnosis and treatment service for tuberculosis are available free of cost for all. Under the scheme clinical protocols
have been drawn up and distributed to all doctors and institutions along with the required medicines free of cost. Government is contemplating to extend the scope of the Panchabyyadhi scheme to other common diseases.

(h) **National AIDS Control Programme**

National AIDS control programme Phase-I has been undertaken in the state during 1992-1999 and Phase-II programme is in operation since April, 1999 with the support of NACO and DFID.

National AIDS Control Programme (NACP) Phase-III (2007-12) has been launched from 6th July, 2007. The overall goal to NACP-III is to halt and reverse the epidemic in India over the next 5 years by integrating programmes for prevention, care, support and treatment.

(i) **School AIDS Education Programme (SAEP)**

During 2006-07, as per the decision of National Aids Control Organization, New Delhi, the programme has been undertaken by the department of School and Mass Education of the state with a view to cover all the government secondary and higher secondary schools, which includes formation of red ribbon clubs in the educational institutions.

(j) **Medical Education and Training Programme**

There are three Medical Colleges with hospital facilities in the State. These colleges offer courses leading to MBBS, BDS degrees, post-graduate and post-doctoral courses in about 35 different disciplines. Besides, three private Medical college has also started functioning during 2006-07. There is one Nursing college, one Dental college, One Pharmacy college, three Ayurvedic colleges and four Homoeopathic colleges under Government sector in the State. The State Institute of Health and Family Welfare is functioning as the apex in service training institute with three functional units at the state level and cells / wings at district / block levels for imparting training support under various programmes. During 2004-05, one Nursing college and three Nursing schools have come up in private sector. Super specialized treatment is being provided in all the three Medical College Hospitals through ultra modern diagnostic and therapeutic equipments.
S.C.B. Medical College and Hospital at Cuttack has 1208 beds and is equipped with all types of modern instruments viz., heart-lung machine, equipment for open heart surgery, CT scan etc. MKCG Medical College and Hospital, Berhampur and V.S.S. Medical College and Hospital, Burla are also well equipped with 881 and 772 hospitals beds respectively. For better treatment of heart patients and patients undergoing various surgical operations, it has been decided to establish two ICU, one at VSS medical college, Burla and the other at MKCG medical college, Berhampur. It has been proposed to spent Rs.60.00 crore during 11th five year plan period. During 2006-07, 14 projects of important buildings of 3 medical colleges were taken up with an estimated project cost of Rs.14.00 core, out of which Rs. 7.78 crore was provided and an amount of Rs. 4.62 crore have been sanctioned for 2007-08. Besides, an outlay of Rs. 1.00 crore has been proposed in the annual plan, 2007-08 for extension of building of SCB medical college and hospital to increase the bed strength.

(k) Infant Mortality Reduction Mission

The Infant Mortality Rate (IMR) is a key indicator of the general health status of a population. As per SRS report the IMR in Orissa was 97 per thousand live births during 1999. In order to reduce the IMR from 97 to 60 per thousand live births by 2006. Infant Mortality Reduction Mission was launched in the State on 15th August, 2001. The key activities include:

- Immunization in outreach inaccessible areas.
- Chemoprophylaxis against malaria during pregnancy.
- Institutional delivery to the pregnant women free of cost
- Free treatment service for slum dwellers
- Reimbursement of transport cost for institutional delivery.

Infant mortality rate has reduced from 97 per thousand live births in 1999 to 73 by the end of 2006.

(i) Reproductive and Child Health (RCH) Programme

The Reproductive and Child Health (RCH), a 100 percent centrally assisted programme is being implemented in the State. The Phase-I of this programme was carried out for a period of 5 years from 1997-98 to 2002-03. The total cost of the programme was Rs. 119.75 crore including Rs.15.00 crore for Kalahandi sub project.
The reproductive and child health programme. Phase-II is an ongoing programme under NRHM, with the objective of improving the Reproductive health of men, women and children. The main objective of the programme is to reduce the maternal, child mortality and morbidity. A programme management unit has been set up in the state and the district level to provide support for implementation of NRHM activities in the state.

(m) Integrated Population and Development (IPD) Project

Integrated Population and Development (IPD) Project is being implemented in the 4 districts of the State, namely Rayagada, Malkangiri, Nawarangpur and Koraput with assistance from United Nation's Fund for Population Activities (UNFPA). This project has all the components of the RCH programme and it aims at reducing maternal mortality and infant mortality as well as achieving population control and stabilization of population through education. The project includes components such as provision of new infrastructure (building, up-grading the skill of health personnel including doctors, female health workers, sub-technician etc. through training, provision of facilities in girls hostels and interest-free moped advance to ANMs.

(n) Regional Spinal Injury Centre (RSIC)

RSIC is being functioning in the State since Feb. 2001 with Government of India assistance for a period of 5 years. The centre is functioning in SCB medical college campus with 30 beds for the paralysis patients. Since inception till the date more than one lakh patients have been treated in this centre. The centre also provides supporting appliances to the patients prepared in the institution. Various training and awareness programmes are also being organized for the periphery doctors, medical and para-medical staff as well as the NGOs. As per the commitment given to government of India, the state government proposes to have an outlay of Rs. 80.00 lakh for 2007-08 for running of the centre out of the total provision Rs.3.00 crore for the Eleventh Five Year Plan.
(o) Diagnostic Centres

The Eleventh Finance Commission have recommended for establishment of 8 diagnostic centres in the state during 2000-01 to 2003-04 with a cost of Rs.3.00 crore per centre. Out of this Rs. 3.00 crore, Rs.2.50 crore of purchase of equipments and Rs.0.50 crore towards construction of diagnostic centre building. Regional Diagnostic Centres started functioning at the three medical colleges and hospitals of the state and district head quarter's hospital at Koraput, Sundargarh, Mayurbhanj and Bhawanipatna and Capital Hospital, Bhubaneswar, have been duly equipped with diagnostic equipments.

(p) RLTAP Programme in KBK District

In order to provide basic health care services to the people, 90 Mobile Health Units (MHU) are functioning in 80 blocks of KBK districts. Out of these 90 MHU, 39 are operational with Government vehicles while the remaining 51 Mobile Health Units (MHU) is operating with hired vehicles. Each MHU works with one Medical Officer, one Pharmacist, one Female Health worker, a Driver (for institutional van) and one Attendant. The MHU holds health camp in the remote and inaccessible areas for minimum 24 days in a month and supply medicines worth of Rs.1000/- per camp during their visit.

(q) Family Welfare Programme

The Family Welfare Programme aims at restricting the size of the family to control rapid population growth and is being implemented as a part of the National Population Control Programme. This has been introduced with full Central assistance covering both population control and maternal and child health services.

Under Family Welfare Programme, the strategy has been to motivate eligible couples to limit family size by adopting various family planning methods such as sterilization, contraception and IUD etc. The new technique for male sterilization, namely ‘No Scalpel Vasectomy (NSV) is being popularized with UNFPA assistance. The programme seeks to promote responsible parenthood with focus on the one child norm. The number of green card holders in the State as on 31st March, 2005 was about 4.57 lakh including about 0.02 lakh during 2004-05. Table shows
the achievement of the Family Welfare Programme in the State, during the tenth plan period, i.e., 2002-03 to 2006-07.

**Table-2.8**  
Progress of family welfare programme in Orissa  
(Figures in lakh)

<table>
<thead>
<tr>
<th>Year</th>
<th>Sterilizations</th>
<th>IUD insertion</th>
<th>Conventional Contraceptive users</th>
<th>Oral users</th>
<th>pill</th>
<th>Medical Termination of pregnancy</th>
<th>No. of equivalent Sterilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002-03</td>
<td>0.74</td>
<td>1.44</td>
<td>2.92</td>
<td>1.37</td>
<td>0.35</td>
<td></td>
<td>1.54</td>
</tr>
<tr>
<td>2003-04</td>
<td>0.91</td>
<td>1.45</td>
<td>2.95</td>
<td>1.44</td>
<td>0.36</td>
<td></td>
<td>1.71</td>
</tr>
<tr>
<td>2004-05</td>
<td>1.01</td>
<td>1.63</td>
<td>3.05</td>
<td>1.79</td>
<td>0.39</td>
<td></td>
<td>1.95</td>
</tr>
<tr>
<td>2005-06</td>
<td>0.84</td>
<td>1.62</td>
<td>3.45</td>
<td>1.84</td>
<td>0.43</td>
<td></td>
<td>1.78</td>
</tr>
<tr>
<td>2006-07</td>
<td>0.94</td>
<td>1.62</td>
<td>3.58</td>
<td>1.98</td>
<td>0.41</td>
<td></td>
<td>1.89</td>
</tr>
</tbody>
</table>

Source: Economic Survey (2007-08), Govt. of Orissa, p.15/15.

**(r) Universal Immunisation Programme**

With the objective of reducing infant mortality and maternal mortality rates, the Universal Immunization Programme is being implemented in the State. Under the programme, children below 6 years of age are inoculated for prevention of contagious diseases like T.B. Diphtheria, Whooping Cough, Tetanus, Polio and Measles, etc. The immunization programme has further been strengthened through ICDS projects in the State. The Anganwadi workers posted in ICDS blocks and Auxiliary Nurses and Midwives posted in sub-centres play an active role in this programme. The National Pulse Polio Programme is being implemented throughout the State with a view to make the State Polio-free by immunizing infants and children of 0-5 year’s age. Table indicates the achievements of the immunisation programme in the State during 10th Plan Period, i.e., 2002-03 to 2006-07.
Table-2.9
Progress of immunization programme in Orissa

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TT(PW)</td>
<td>7.91</td>
<td>7.99</td>
<td>8.18</td>
<td>8.14</td>
<td>8.31</td>
</tr>
<tr>
<td>DPT</td>
<td>8.44</td>
<td>8.35</td>
<td>8.12</td>
<td>8.51</td>
<td>8.11</td>
</tr>
<tr>
<td>Polio</td>
<td>8.45</td>
<td>8.37</td>
<td>8.20</td>
<td>8.53</td>
<td>8.12</td>
</tr>
<tr>
<td>BCG</td>
<td>8.55</td>
<td>8.83</td>
<td>8.65</td>
<td>9.26</td>
<td>8.66</td>
</tr>
<tr>
<td>Measles</td>
<td>8.11</td>
<td>7.76</td>
<td>7.90</td>
<td>8.40</td>
<td>7.80</td>
</tr>
<tr>
<td>DT</td>
<td>7.95</td>
<td>7.79</td>
<td>8.97</td>
<td>10.34</td>
<td>9.46</td>
</tr>
<tr>
<td>TT (10 yrs)</td>
<td>8.03</td>
<td>7.69</td>
<td>7.8</td>
<td>8.49</td>
<td>8.78</td>
</tr>
<tr>
<td>TT (16 yrs)</td>
<td>6.69</td>
<td>6.51</td>
<td>6.82</td>
<td>7.59</td>
<td>7.86</td>
</tr>
</tbody>
</table>

Source: Directorate of F & W, Bhubaneswar, Orissa, P = Provisional

(s) National Maternity Benefit Scheme

A wholly centrally funded programme “National Maternity Benefit Scheme” (NMBS) is being implemented in the State under Health and Family Welfare Department since 15th August 1995 with an aim to provide financial assistance to pregnant women of 19 years of age and above belonging to BPL category for the first two live births. Each beneficiary under this programme is being given an amount of Rs. 500/- per pregnancy. Funds under this scheme are being released by Government of India to all district collectors for implementation of the scheme. The Child Development Programme Officer (CDPO) in rural areas and officer in charge of the P.P. Centre in urban areas act as the sanctioning authority under this scheme.

(t) Employees State Insurance Scheme

“Employees State Insurance” (ESI) scheme, an integrated multi dimensional health insurance and Social Security Scheme is being implemented in the State since January 1960. It is one of the most effective and sustainable social security measures available to the workmen employed in industrial and commercial establishments of varying sizes and nature. At present medical care is being provided to 130422 insured persons and their dependent family members through 5 ESI Hospitals, 49 ESI Dispensaries and 2 Annexed Wards functioning in 20 districts of the State with
297 beds and 200 doctors. Besides, one 50 bedded ESI Model hospital at Rourkela is also functioning under the supervision of ESI Corporation.

ESI Corporation has prescribed a ceiling of Rs. 1000/- expenditure on medical care per insured person per annum, shared between ESI Corporation and the State Government in the agreed ratio 7:1 and the expenditure beyond the ceiling is entirely borne by the State Government. During 2006-07, about 8.20 lakh patients including 7241 indoor patients were treated in the ESI hospitals / dispensaries. Besides, immunization and family welfare programme are also performed in these hospitals / dispensaries. The details are given in the table

<table>
<thead>
<tr>
<th>Name of the programme</th>
<th>Achievement during</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Welfare Programme</strong></td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td>40</td>
</tr>
<tr>
<td>Tubectomy</td>
<td>357</td>
</tr>
<tr>
<td>I.U.D.</td>
<td>204</td>
</tr>
<tr>
<td>M.T.P.</td>
<td>248</td>
</tr>
<tr>
<td>Oral Pills</td>
<td>3675</td>
</tr>
<tr>
<td>Nirodh</td>
<td>10120</td>
</tr>
<tr>
<td><strong>Immunization Programme</strong></td>
<td></td>
</tr>
<tr>
<td>B.C.G.</td>
<td>1207</td>
</tr>
<tr>
<td>Polio</td>
<td>10438</td>
</tr>
<tr>
<td>D.P.T.</td>
<td>4329</td>
</tr>
<tr>
<td>T. Toxoid</td>
<td>14384</td>
</tr>
</tbody>
</table>

Source : Directorate of ESI, Bhubaneswar

One AIDS Cell has been set up at ESI Directorate for implementation of AIDS control programme which is fully financed by National AIDS control Organisation (NACO). AIDS awareness programmes are being conducted in
different industrial areas. One S.T.D. laboratory and clinic has been functioning in ESI Hospital, Bhubaneswar since 2004-05 which is being upgraded to VCTC. As per the phased programme, it has been decided to implement ESI scheme in eight new areas namely – Talcher, Damanjodi, Kuanrmunda, Therubali, Duburi, Atharbanki, Kaniha and Laxminagar.

Hospital Waste Management has been entrusted to M/s SANICLEAN(P) Ltd. on contractual basis for ESI hospital at Choudwar (100 beds) and Bhubaneswar (50 beds) as per the guidelines of Orissa Pollution Control Board.

2.9 ACHIEVEMENTS OF NATIONAL RURAL HEALTH MISSION

The National Rural Health Mission (NRHM), a flagship endeavour was launched in the state in June, 2005. It is one of the largest health programme in the state in the last fifty years and aims at improving the access to and availability of quality health services to the under privileged like the women and children, especially the rural poor. The achievement made under the Mission during 2006-07 is as follows.

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The State Health Mission has been established with Hon’ble Chief Minister as the Chairperson to monitor the progress of health activities in the State. NRHM provides a female Accredited Social Health Activist (ASHA) per Anganwadi Centre. The ASHA is a volunteer who works as an interface between the community and the public health system and is accountable to the Panchayat. Against the target to select 34324 nos. of ASHA, 33515 ASHA have been selected by the end of 2006-07. ASHA have started their work in the villages and have been able to motivate rural women for institutional delivery, complete antenatal check-up, sterilization and mobilizing children for immunization.

The goal of the Mission is to reduce IMR and MMR, universal access to Public Health Services, Women Health, Child Health, Sanitation and Hygiene; Immunization and Nutrition, Prevention and Control of communicable and non-communicable diseases. Access to integrated and comprehensive primary health care, population stabilization, gender and demographic balance and promotion of
healthy life style has also been brought about. A numbers of new initiatives have been incorporated in NRHM. Making provision of Accelerated Social Health Activist for every 1000 population in rural area is one of them. At present 12,730 ASHAs are in position.

In order to ensure better management of health services, Rogi Kalyana Samiti have been constituted in the district, sub-district, hospital, CHCs and PHCs taking cross section of the community and local representatives.

The Reproductive and Child Health Programme (RCH) is an ongoing programme under NRHM with the objective of improving the Reproductively Health of men, women and children. The main objective of the programme is to reduce the Maternal, child mortality and morbidity.

Janani Surakhya Yojana is being implemented in the state from August, 2006 with an objective to reduce overall maternal mortality ratio, infant mortality rate; and to increase institutional delivery. By the end of March, 2007 about 2.27 lakh beneficiaries have been assisted under the scheme.

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