CHAPTER – 1

INTRODUCTION
Health is an important dimension of well-being. Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population’s health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health. Strengthening health equity – globally and within countries – means going beyond contemporary concentration on the immediate causes of disease. More than any other global health endeavor, the study focuses on the “causes of the causes” – the fundamental structures of social hierarchy and the socially determined conditions these structures create in which people grow, live, work and age – the social determinants of health. The time for action is now: not just because better health makes economic sense, but because it is right and just. The outcry against inequity has been intensifying for many years from country to country around the world. These cries are forming a global movement.

Health is the creative process - creative in the sense of overcoming the Constraints - of ensuring the survival, growth and accomplishing well being. Health conceived as physical, mental and social well being by World Health Organization (WHO) is true at the outcome level. For humans, this health process is considered as a bio-psycho-social process. Evolution of health care system in every parts of the world, though in different forms, can be an evidence of the social process of health.

“Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine, like education, is then no longer a trade - it becomes a public function of the State.”

The Preamble of the World Health Organization’s constitution states “Health is a state of complete physical, mental, social well-being, and not merely the absence of disease or infirmity.” This positive and broad definition of health is the bedrock on which the claim of the Right to Health as a fundamental right can be established. This definition helps to capture the notion that health is quintessentially relative, “depending on individual and medical perceptions of what is ‘normal’ or ‘habitual’.” Medical sociologists have observed that individual perceptions of health and illness not only depend on personal, physical or
psychological attributes, but on cultural expectations as well. Thus, the Western biomedical concept of health as a pure correlation between disease and medicine should be propagated with caution when it comes to a diverse country like India.

To give space to the diverse worldview that exists in the Indian context, the present attempt is not to arrive at a universal definition of health, but to focus on the:
1. Objective criteria like health status of the society by relying on a series of indicators with special emphasis on health status of vulnerable groups.
2. The understanding of the specific configuration of traditional culture and subjective understanding of the community’s need and its notion of well-being and illness.

The status of health is an important indicator reflecting social development and the quality of human life. Further, health care is one of the most basic human rights, vital for preservation and promotion of health (Article 25 of the universal declaration of human rights). Public participation, increasing democratization, the growing awareness of governance and civil society, the breathtaking advances in science and technology and pressures to ensure respect of human rights are important features of a rapidly-changing world scene.

The evaluation of Health is not exactly known but it is related with sufficient indication available through excavations and ancient writings that health care activities, mainly in the form of some sanitary and curative measures. Since health refers to the general condition of an organism resulting from the interaction with the environment. The environment of the individual is continuously changing and he has to undergo a continuous process of adjustment so as to be continuously healthy.

Health is defined as "A continuing property in the sense that is present from the ovum, Until death, it does not disappearing during an illness to return on recovery but the level changes through out the life." as quoted by John Fry, Primary Care.
The Health can be represented in the form of health sickness spectrum as shown below.

The concept of health may be emphasized is to be considered in its dynamic rather than static context. The health determinants, which can be broadly classified in to biological Behaviour, socio-cultural and environmental. Biological and behavioral determinants are directly related to the individuals. These two health's determinants are primarily individuals oriented and hence, they may vary from one individual to another. The socio-cultural or environmental determinants, on the other hand are general in their impact. Of these, the first one is made up of community mores, income, education, and occupation. Religion, nutrition etc and letter concern the nature and quality of the physical, biological and chemical environment within which the individual functions.

Health is clearly not the mere absence of disease. Good Health confers on a person or groups’ freedom from illness - and the ability to realize one's potential. Health is therefore best understood as the indispensable basis for defining a person's sense of well being. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well being, extent of socio-economic disparities, reach of health services and quality and costs of care. And current bio-medical understanding about health and illness.

Health care covers not merely medical care but also all aspects pro preventive care too. Nor can it be limited to care rendered by or financed out of public expenditure- within the
government sector alone but must include incentives and disincentives for self care and care paid for by private citizens to get over ill health. Where, as in India, private out-of-pocket expenditure dominates the cost financing health care, the effects are bound to be regressive. Health care at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore be left to be regulated solely by the invisible hand of the market. Nor can it be established on considerations of utility maximizing conduct alone.

1.1 HEALTH SYSTEM

A health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. It involves the broad range of individuals, institutions, and actions that help to ensure the efficient and effective delivery and use of the spectrum of products and information for prevention, treatment, and care, and support to people in need of these services.

Today, health systems in all countries, rich and poor, play a bigger and more influential role in people’s lives than ever before. Health systems of some sort have existed for as long as people have tried to protect their health and treat diseases. Traditional practices, often integrated with spiritual counseling and providing both preventive and curative care, have existed for thousands of years and often coexist today with modern medicine. But 100 years ago, organized health systems in the modern sense barely existed. Few people alive then would ever visit a hospital. Most were born into large families and faced an infancy and childhood threatened by a host of potentially fatal diseases – measles, smallpox, malaria and poliomyelitis among them. Infant and child mortality rates were very high, as were maternal mortality rates. Life expectancy was short – even half a century ago it was a mere 48 years at birth. Birth itself invariably occurred at home, rarely with a physician present.

Health systems consist of all the people and actions whose primary purpose is to improve health. They may be integrated and centrally directed, but often they are not. After centuries as small-scale, largely private or charitable, mostly ineffectual entities, they have grown explosively in this century as knowledge has been gained and applied. They have contributed enormously to better health, but their contribution could be greater still, especially for the poor. Failure to achieve that potential is due more to systemic failings than to technical
In today’s complex world, it can be difficult to say exactly what a health system is, what it consists of, and where it begins and ends. This report defines a health system to include *all the activities whose primary purpose is to promote, restore or maintain health*. Formal health services, including the professional delivery of personal medical attention, are clearly within these boundaries. So are actions by traditional healers, and all use of medication, whether prescribed by a provider or not. So is home care of the sick, which is how somewhere between 70% and 90% of all sickness is managed. Such traditional public health activities as health promotion and disease prevention, and other health enhancing interventions like road and environmental safety improvement, are also part of the system. Beyond the boundaries of this definition are those activities whose primary purpose is something other than health – education, for example – even if these activities have a secondary, health-enhancing benefit. Hence, the general education system is outside the boundaries, but specifically health-related education is included. So are actions intended chiefly to improve health indirectly by influencing how non-health systems function – for example, actions to increase girls’ school enrolment or change the curriculum to make students better future caregivers and consumers of health care.

**PRIMARY HEALTH CARE**

There are two definitions depending on the structure of the health system:

1. In a system with a gatekeeper, all initial (non-emergency) consultations with doctors, nurses or other health staff are termed primary healthcare, as opposed to secondary healthcare or referral services.

2. In systems with direct access to specialists, the distinction is usually based on facilities, with polyclinics, for example, providing primary care and hospitals providing secondary care.
SECONDARY HEALTH CARE

Specialized ambulatory medical services and commonplace hospital care (outpatient and inpatient services). Access is often via referral from primary healthcare services. It can also include some specialist services provided in the community.

TARITARY HEALTH CARE

Refers to medical and related services of high complexity and usually high cost. Includes patients referred from secondary care for diagnosis and treatment, which is not available in primary and secondary care. Tertiary care is generally only available at national or international referral centers.

1.2 DECLARATION OF ALMA-ATA INTERNATIONAL CONFERENCE ON PRIMARY HEALTH CARE, ALMA-ATA, USSR, 6-12 SEPTEMBER 1978

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

At the Alma Ata (current-day Republic of Kazakhstan) international conference on primary health care, which convened in 1978, the World Health Organization (WHO) and UNICEF proposed a new concept of primary health care (PHC). The Alma Ata conference proved to be a turning point in the history of health-care policy. Backed by the fundamental tenet that
health is a basic human right for which disparities or inequalities should not be allowed, it culminated with a call for citizen-led activities at the regional level in public hygiene, health education, maternal and child health care, and family planning. Accepting that challenge, in 1981 the 34th WHO General Conference drew up a set of global targets aimed at improving health for all by the year 2000. In doing so, they emphasized the importance of primary healthcare to achieving this goal. The Alma-Ata declaration defined primary healthcare as “essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families … and at a cost that the community and country can afford”. It also identified primary healthcare as the first level of contact individuals, families and members of the community have with the national health system. As a result, primary healthcare should be brought as close as possible to where people live and work, and address the main health problems of the community.

Primary healthcare is also defined as: “Essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process.”

The primary health care approach is based on principles of social equity, nation wide coverage, self reliance, intersectoral coordination and people involvement in the planning and implementation of health programmes in pursuit of common health goals. This approach has been described as “Health by people” and “Placing people’s health in people’s hands”. Primary health care was accepted by the members of Countries of WHO as the key to achieving the goal HFA by the year 2000 AD.
The Declaration of Alma Ata stated that primary health care includes at least:

- Education about prevailing health problems and methods of preventing and controlling them.
- Promotion of food supply and proper nutrition;
- An adequate supply of safe water and basic sanitation
- Maternal and child health care including family planning
- Immunization against infectious diseases
- Prevention and control of endemic disease.
- Appropriate treatment of common disease and injuries and
- Provision of essential drugs.

The concept of Primary Health care involves a concerted effort to provide the rural populations of developing countries with at least the bare minimum of health services. The list can be modified to fit local circumstances. The health care approach integrates at the community level the entire factor required for improving the health status of population. As a signatory of Alma Ata declaration, the Government of India has pledged itself to provide primary health care.

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following

**Declaration:**

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.
II
The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III
Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV
The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V
Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI
Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and
community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. Reflects and evolves from the economic conditions and socio cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. Addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. Should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII
All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX
All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X
An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.
In the early 1970’s, the so-called vertical health approach that was used in smallpox and malaria eradication efforts began to face sharp critique. Many public health leaders in U.S. agencies and the World Health Organization were dissatisfied with the failure of the Malaria Eradication Campaign and the ‘vertical’ programs upon which this campaign was founded. Frustrated with the top-down strategies and lack of community participation, more and more people began to adopt an attitude of skepticism regarding western medicine’s tertiary care emphasis in resource-poor areas. This attitude centered on the realization that the delivery of medical care was a limited part of improving health. Disillusioned with vertical programming and the limits of technology-based interventions, people began to recognize that social conditions and non-health sector services were vital to population health and well-being.

Under intense criticism, vertical ideologies gave way to new proposals for health and development. The 1970’s saw a new political will for international development and the re-conceptualization of development activities. This new conception was termed “Human Development” and emphasized building from the bottom up through the provision of basic primary health services. In this formula, primary health care (PHC) required a change in socioeconomic status, distribution of resources, a focus on health system development, and emphasis on basic health services.

Another important impetus for primary health care was the large-scale movement of rural medical services in Communist China, especially due to the ‘barefoot doctors’. These barefoot doctors, who became increasingly popular between the early 1960s and the Cultural Revolution, were a diverse group of village health workers who “lived in the community they worked, emphasized rural rather than urban health care, and preventive rather than curative services”. The large health gains in China as a result of its community-based health programs and similar approaches elsewhere stood in contrast to the poor results of disease-focused programs.

“Primary health care was also favored by a new political context characterized by the emergence of decolonized African nations and the spread of national, anti-imperialist, and leftist movements in many less-developed nations”.

1-13
These changes led to new proposals on development made by some industrialized countries. In 1974, a United Nations resolution on ‘Establishment of a New International Economic Order’ was issued. Modernization was no longer seen as the replication of the model of development followed by the United States or Western Europe. Furthermore, during this time, China began pressing for a conference on Primary Health Care, in order to gain recognition of its own model. As the consensus on primary health care grew, the USSR took a leading role as they, like China, wanted to highlight a successful system of their own.

**Shifts in Global Health Leadership**

New leaders and institutions embodied the academic and political influences of the Primary Health Care movement. Prominent among them was Halfdan Mahler of Denmark. Mahler was elected Director General of WHO in 1973 and was later reelected for two successive five-year terms, remaining at its head until 1988. A respected WHO insider, Mahler worked on Systems Analysis at the World Health Organization and was a strong believer in social justice approaches to global health. His distaste for ‘medical elitism’ and preference for “participatory and bottom-up” initiatives fed into the growing momentum for Primary Health Care.

At the 1976 World Health Assembly, Mahler proposed the goal of "Health for All by the Year 2000." The slogan became an integral part of primary health care. According to Mahler, this target required a radical change. He said that "Many social evolutions and revolutions have taken place because the social structures were crumbling. There are signs that the scientific and technical structures of public health are also crumbling.” This and related ideas would be reiterated at the Conference of Alma Ata that took place in the Soviet Union. Although initially opposed to a Soviet-led Primary Health Care conference as he felt that the USSR model was too top-down, Mahler eventually supported the conference upon recognizing a chance to forward his broader vision.

**Challenges of Primary Health Care Model**

Yet the model of primary health care that emerged from the Alma-Ata conference had several flaws that would plague the PHC movement. First, there was no clear definition of what constituted primary health care. In addition to this vague conception was the need for more
defined and realistic goals. The conference posited no short-term goals besides “Health for All by 2000.” Furthermore, the ascendancy of neo-liberalism began to spoil the political climate for social sector investment.

It is important to recognize that changing foci in international health are as much tied to changing theoretical perceptions of problems as they are to politics. In the case of the radical Primary Health Care movement, the new policies and programs in the 1970s developed in reaction to the perceived failure of postwar disease eradication and infrastructure development programs. Lack of defined goals and strategies meant that primary health care would soon face a backlash in the form of “primary health care” and structural adjustment policies.

Primary health care requires a change in socioeconomic status, distribution of resources, a focus on health system development, and emphasis on basic health services. In the 1940s and 1950s, a first generation of reforms established national health care systems, first in richer and later in poorer countries. These systems came under increasing stress during the 1960s due to escalating costs, mainly because of growing volume and intensity of hospital care. These economic strains were further accentuated in the early 1970s by the oil crisis and economic downturn in most of the developing world. A second generation of reforms promoted primary health care as a strategy to achieve affordable universal coverage, but this did not necessarily satisfy local demand for perceived quality and responsiveness. Furthermore, this new emphasis on primary care often came into direct conflict with established medical systems that emphasized hospital care, making reforms difficult to implement. While the first and second generations of health reforms mainly emphasized the supply side, the third generation pays more attention to the demand side, including attempts to make ‘money follow the patient’, shifting away from central budgetary allocations of resources to providers, and trying harder to assure access for the poor. This conceptual shift took place in the context of major political and economic changes in the world starting in the mid-1980s. Ideologically, this meant greater emphasis on individual choice and responsibility. Politically, this meant limiting promises and expectations about what governments should provide to conform better to their actual financial and organizational capacities (WHO 2000). From a public health perspective, however, a major problem of such a shift toward systems geared to satisfying market demand occurs when true needs are not translated into demand. Poverty can be one reason for such a system failure.
The World Health Report 2000 attempted for the first time to measure how well the world’s health systems are doing. Two major questions were put on the table: What has been achieved in terms of good health, responsiveness, and fair financial contribution (attainment)? How does this compare with the best that could be achieved with the same resources (performance)? The report acknowledges that many of society’s health problems have causes lying outside the health system itself (WHO 2000).

The year-2000 reports from both the UNDP and the World Bank address some of these problems, including the link between poverty and health system organization and performance. The UNDP report addresses poverty in relation to macroeconomic and redistribution policies, accountability, decentralization and local governance, focusing resources on poor and disadvantaged social groups, and the links between poverty and health programmes (UNDP 2000). The World Bank report addresses the nature of poverty and how to measure it. Both reports point out that being poor not only means being hungry, lacking shelter and clothing, being sick and not cared for, illiterate and unschooled; it also means being treated badly by the institutions of state and society and excluded from voice and power in those institutions. Increasing poor people’s voice and participation not only would address their sense of exclusion; it would also lead to health services that better meet their needs (World Bank 2000).

Over the past decade, the number of people living in poverty worldwide has hardly changed, and in some regions the number has raised significantly. While global infant mortality declined from 107 per 1000 live births in 1970 to 59 in 1998, only 10% of this decline occurred between 1990 and 1998 (World Bank 2000). The World Health Report 2000 shows that many countries’ health systems are under-performing. The span in overall performance index between the highest and the lowest performing countries is more than seven-fold.

Why aren’t we doing better? Unequal distribution of resources among and within countries is certainly a major factor, but it is not the only problem. Many unwise policies have been implemented, often because the information necessary to formulate good policy is lacking. Ideally, a sound basis in research should precede and inform the development of health systems. In practice, the motivation for health sector reform more often has been dogmatic than empiric. Even though unsuccessful reforms can have profound and long lasting effects
on society, fundamental changes in health care systems are advocated and undertaken based on less evidence that they will produce the desired results than would be required to license a new antibiotic. Clearly, there is a great need for sound research on which to base reforms and guide their evolution.

1.4 Origin and Evolution of Primary Health Care in India

The art of Health Care in India can be traced back nearly 3500 years. From the early days of Indian history the Ayurvedic tradition of medicine has been practiced. During the rule of Emperor Ashoka Maurya (third century B.C.E.), schools of learning in the healing arts were created. Many valuable herbs and medicinal combinations were created. Even today many of these continue to be used. During his rein there is evidence that Emperor Ashoka was the first leader in world history to attempt to give health care to all of his citizens, thus it was the India of antiquity which was the first state to give it's citizens national health care.

Pre-Alma Ata Declaration Period

Primary Health Care is a vital strategy that remains the backbone of health service delivery. India was one of the first countries to recognize the merits of Primary Health Care Approach (PHC). PHC was conceptualized in 1946, three decades before the Alma Ata declaration, when Sir Joseph Bhore made recommendations that formed the basis for organization of basic health services in India. The Bhore Committee report laid emphasis on social orientation of medical practice and high level of public participation. The salient features of this committee are presented below.

The Bhore Committee: Salient Recommendations

1. Integration of preventive and curative services at all administrative levels.
2. Short Term- Primary Health Centres for 40,000 population.
3. Long Term (Three million Plan)- Primary Health Centres with 75 beds for each 10,000-20000 population.
5. Provision of Social Doctor.
6. Inter-sectoral approach to health services development.
7. Three months’ training in preventive and social medicine to prepare social physicians.

(Source: Reports of Health Survey and Development committee Government of India: New Delhi 1946)

With the beginning of health planning in India and first five-year plan formulation (1951-55), Community Development Programme was launched in 1952 for the all-round development of rural areas, where 80% of the population lived. Community Development was defined as "a process designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance upon the community's initiative". The Community Development Programme was envisaged as a multipurpose programme covering health and sanitation (through the establishment of primary health centers and subcentres) and other related sectors including agriculture, education, transport, social welfare and industries. Each Community Development Block (CDB) comprised approximately 100 villages with a total population of one lakh. For one CDB, one Primary Health Centre was created.

By the close of second five-year plan (1956-61), "Health Survey and Planning Committee", The Mudaliar Committee, was appointed by the Government of India to review the progress made in the health sector after submission of Bhore committee report. The major recommendation of this committee report was to limit the population served by primary health centers to 40,000 with the improvement in the quality of health care provided by these centers. Also, Provision of one basic health worker per 10,000 populations was recommended.

The Jungalwalla Committee in 1967 gave importance to integration of health services. Integrated health services were defined as "a service with a unified approach for all problems instead of a segmented approach for all different problems". The committee recommended integration from the highest to lowest level in the services, organization and personnel.
The Kartar Singh Committee on Multipurpose workers in 1973 laid down the norms about health workers. For ensuring proper coverage the committee recommended, one primary health centre to be established for every 50,000 population. Each primary health centre to be divided into 16 sub-centers each for a population of 3,000 to 3,500. Each sub-centre to be staffed by a team of one male and one female health worker. The work of 3-4 health workers to be supervised by one health assistant.

The Shrivastav Committee on Medical Education and Support Manpower in 1975 suggested creation of bands of Para-professional and semi professional health workers from within the community (e.g. school teachers, post masters etc.). It also recommended the development of a "Referral Service Complex" by establishing linkages between the primary health centre and higher level referral and service centers, viz taluka/ tehsil, district, regional and medical college hospitals.

Following the suggestions of the Shrivastav committee report, Rural Health Scheme was launched in 1977, wherein training of community health workers, reorientation training of multipurpose workers, and linking medical colleges to rural health was initiated. Also to initiate community participation, the Community Health Volunteer-Village Health Guide (VHG) Scheme was launched. The VHG was to be a person from the village, mostly women, who was imparted short-term training and small incentive for the work. An Illustration of rural health care system in India is presented in Box 1.2 photos from NRHM photo gallery.

Alma Ata Declaration and Beyond

The Alma Ata declaration of 1978 launched the concept of Health for all by year 2000. It was signed by 134 governments (including India) and 67 other agencies. The declaration advocated the provision of first contact services and basic medical care within the framework of an integrated health services.

Rural Health Care System – the structure and current scenario the health care infrastructure in rural areas has been developed as a three tier system and is based on the following population norms:
Sub-Centres (SCs)

The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is manned by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker/ MPW (M). One Lady Health Worker (LHV) is entrusted with the task of supervision of six Sub-Centres. Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children.

Primary Health Centres (PHCs)

PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme (BMS). At present, a PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, primitive and Family Welfare Services.

<table>
<thead>
<tr>
<th>Centre</th>
<th>Population Norms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plain Area</td>
</tr>
<tr>
<td>Sub-Centre</td>
<td>5000</td>
</tr>
<tr>
<td>Primary Health Centre</td>
<td>30,000</td>
</tr>
<tr>
<td>Community Health Centre</td>
<td>1,20,000</td>
</tr>
</tbody>
</table>
Community Health Centres (CHCs)

Each community health center covering a population of 80,000 to 1.20 lakh with 30 beds and specialist in surgery, medicine, obstetrics and gynecology and pediatrics with X-ray and laboratory facilities. The specialist at the community health center may refer a patient directly to the state level hospital or the nearest medical college hospital as may be necessary without the patient having to go first to the sub divisional or District hospital.

Box 1.2: Rural Health Care System in India

Community Health Centre (CHC)
A 30 beded Hospital/Referral Unit for 4 PHCs with Specialised services

Primary Health Centre (PHC)
A Referral Unit for 6 Sub Centres 4-6 beded manned with a Medical Officer incharge and 14 subordinate paramedical staff

Sub Centre (SC)
Most peripheral contact point between Primary Health Care System & Community manned with one MPW(F)/ANM & one MPW(M)

The declaration asserted "PHC is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."
Several critical efforts outlined Government of India's commitment to provide health for all of its citizens after Alma Ata Declaration. The Report of the Study Group on "Health for All - An Alternate Strategy" commissioned by ICSSR and ICMR (1980) argued that most of the health problems of a majority of India's population were amenable to being solved at the primary health care level through community participation and ownership. The report recommended the formulation of a comprehensive national health policy through an inter-sectoral approach that includes environment, nutrition, education, socio-economic, preventive, and curative dimensions. The Report of the Working Group on "Health for All by 2000 AD", also examined the contextual issues in providing health care. The report set out health targets to be achieved by 2000 AD for which existing health services and manpower had to be increased substantially.

The responsibility of the state to provide comprehensive primary health care to its people as envisioned by the Alma Ata Declaration led to the formulation of India's National Health Policy (NHP) in 1983. The major goal of policy was to provide of universal, comprehensive primary health services. The policy emphasized the role that could be played by private and voluntary organizations working in the country to support government for integration of health services.

A selective approach as an "interim" measure to the long-term process of comprehensive primary health care implementation was introduced in many countries, including India. Led by Walsh and Waren (1979), it was argued that resource constraints made it "not possible" to achieve the Alma Ata goals within the committed time limit. Thus, the focus shifted from the development of health systems and infrastructure for primary health care and ensuring health equity to several vertical interventions based on technical justifications and cost-effectiveness analysis. UNICEF also suggested its selective approach of GOBI-FFF (Growth monitoring, oral rehydration therapy, breast feeding, immunization, female literacy, family planning, food supplements for pregnant women) for improving child survival.

By the turn of the millennium, despite some gains in health outcomes and vast improvements in the availability of health infrastructure through a three-tier network, India had yet to achieve most of the goals enshrined in its first national health policy.
The National Population Policy (NPP) was announced in the year 2000, the overarching policy framework for family planning and maternal and child health goals, objectives and strategies. The immediate Objective of NPP was to address the unmet needs of contraception, health care infrastructure, and health personnel, and to provide integrated delivery for basic reproductive and child care services. It envisaged development of one-stop integrated and coordinated service delivery at the village level for basic reproductive and child health services through a partnership of the government with voluntary and non-governmental organizations.

Nearly twenty years after the first health policy, the IIInd National Health Policy (2002) was presented. The NHP 2002 recognized the noteworthy successes in health since the enunciation of the first NHP in 1983. These successes included the eradication of small pox and guinea worm, the near eradication of polio, and progress towards the elimination of leprosy and neonatal tetanus. The NHP sets out a new policy framework to achieve public health goals in the socio-economic circumstances currently prevailing in the country. The approach aims at increasing access to the decentralized public health system by establishing new infrastructure in deficient areas and upgrading the infrastructure of existing institutions. It sets out an increased sectoral share of allocation out of total health spending to primary health care.

More recently (2005), the Government of India has launched the National Rural Health Mission (NRHM), with the goal of improving the availability of and access to quality health care by people, particularly in rural areas. The Mission envisages a synergistic primary health care approach for decentralized health planning and implementation at the village and district level. The mission was made operational from April 2005 throughout the country with special focus on 18 states having weak demographic indicators and infrastructure. The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care, especially to the poor and vulnerable sections of the community. It reaffirms the political will to increase public health fund allocation to 2-3% of GDP from existing allocation of 0.9% of GDP.
NRHM is visualized as an architectural correction of the Indian public health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country. It envisages appropriate health personnel to be placed at different levels starting from village level in fully functioning health centers with adequate linkages amongst different levels. An Illustrative Structure model is depicted in Figure 1.1 showing health structures functioning at different levels with a set of key health personnel performing adequate functioning in coordination with others sectors.

NRHM has as its key components as provision of a female health activist in each village; a village health plan formulation through a local team headed by the health and sanitation committee of the Panchayat; strengthening of rural hospitals for effective curative care and
making them measurable and accountable to the community through Indian Public Health Standards (IPHS); integration of vertical health and family welfare programmes; strengthening of primary health care through optimal utilization of funds, infrastructure and available manpower. NRHM works on five key approaches- communization emphasizing community involvement, flexible financing for increased monetary autonomy at different levels, capacity building to empower multiple stakeholders for efficient health delivery and human resource management to generate more manpower and equiping health personnel with adequate multiple skills. (Figure1.2). The strategies proposed in NRHM are show bellows.
Strategies under National Rural Health Mission Core Strategies under Mission:

❖ Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.

❖ Promote access to improved healthcare at household level through the village level worker (Accredited Social Health activist- ASHA)

❖ Health plan for each village through Village Health Committee of the Panchayat.

❖ Strengthening sub-centre through better human resource development, clear quality standards, better community standards, better community support and an untied fund to enable local planning and action and more Multipurpose workers.

❖ Strengthening existing Primary Health Centres through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.

❖ Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard. (Indian Public Health Standards defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels)

❖ Preparation and implementation of an inter-sector district health plan prepared by district health mission, including drinking water supply, sanitation, hygiene and nutrition.

❖ Integrating vertical health and family welfare programmes at national, state, district and block levels.

❖ Technical support to national, state and district health mission, for public health management.

❖ Strengthening capacities for data collection, assessment and review for evidence base planning, monitoring and supervision.
Formulation of transparent policies for deployment of human resource for health.

Developing capacities for preventive health care at all levels for promoting healthy life style, reduction in consumption of tobacco and alcohol etc.

Promoting non-profit sector particularly in underserved areas.

**Supplementary Strategies under Mission:**

- Regulation for Private sector including the informal Rural Medical Practitioners (RMPs) to ensure availability of quality service to citizens at reasonable cost.

- Promotion of public private partnerships for achieving public health goals.

- Mainstreaming Indian system of medicine (AYUSH) revitalizing local health traditions.

- Reorienting medical education to support rural health issues including regulation of medical care to medical ethics.

- Effective and visible risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.
1.5 HEALTH POLICIES & PROGRAMMES IN INDIA – A CRITICAL ANALYSIS

This section mentions some of the policies and programmes under the National health Programmes that, to our mind, have been crucial in determining the health situation of women in India. Since independence, several policies and programmatic interventions have been formulated to meet the health needs of people in the country. Besides, the specific policies that were initiated, the five-year plans, are a statement of the sectoral policies and programmes introduced by the Government of India. The progress of the five year plans, from the first introduced in 1951-56 to the tenth five year plan (2002-07), are indicative of the shifts in the government’s priorities and commitment vis-à-vis specific health issues.

The Ministry of Health and Family Welfare (MOFHW) comprises of the Department of Health, Department of Family Welfare and the Department of Indian System of Medicine and Homeopathy. Under the provision of the Constitution of India, Public health is primarily a state subject. National health programmes have been designed with flexibility to permit the state public health administration to create their own programmes according to their needs and depending on the epidemiological profile of the population. The implementation of the national health programmes carried out through the state government has decentralized public health machinery. The centre will play a coordinating role and provide technical and financial support, wherever it is felt necessary. Below, we discuss some of the policies and programme briefly to critically examine their effects on the health status of women.

National Health Policy (NHP)

India committed itself to universal health care in the Bhore Committee report developed way back in 1946. Subsequent to the Alma Ata commitment, the GOI passed the National Health Policy (NHP) in 1983. The NHP talked about comprehensive primary health care services linked to extension and health education; large scale transfer of knowledge, skills and requisite technologies to ‘health volunteers’; intersectoral cooperation and better utilization and strengthening of traditional systems of medicine. Since then, there have been marked changes in the larger climate and determinant factors relating to the health sector. The NHP 2002 is a continuation of the earlier indicated trends. The new policy deliberates on the need
to improve access to health services among all social groups and in all areas, and proposes to do so by establishing new facilities in deficient areas and improving those existing. The policy sets forth several time bound objectives including reduction of MMR, IMR, mortality due to TB and malaria by 2010, and zero growth of HIV/AIDS by 2007.

The new policy identifies many of the deficiencies plaguing the health care system and proposes a substantial increment in government expenditure on health care. However, in terms of its prescriptions, it represents a retreat from the fundamental concept of the NHP 1983 that was committed to the ‘Health for All by 2000’ through the universal provision of comprehensive primary health care services. In contrast, NHP 2002 conveniently omits the concept of comprehensive and universal health care, thus reducing primary health care to primary level care. The silence maintained on village health worker (first contact in the primary health care) and strengthening public referral services exemplify the trend.

The policy, while on one hand is totally silent and ambiguous on the need for essential drugs, price control and standardized regimens of treatment, regulation of private medical colleges/institutions and medical research, on the other, many of its formulations pave way for greater privatization of the system. Employing user fee in public hospitals, promoting ‘health tourism’ by making provisions for patients from other countries to avail domestic facilities for treatment in India, encouraging ‘setting up of private insurance for expanding the scope of covering secondary and tertiary sector under private health insurance packages’, etc. mark the government’s intention of legitimizing further privatization and departing from providing comprehensive, secondary and tertiary care. Last but not the least, health issues of women and children have been reduced to a section of rhetoric and passing references without specific prescriptions. Neither does it consider the steady decline of the female-male sex ratio over the few decades as a cause of concern, nor does it highlight any measures to prohibit sex selective abortions such as licensing and regulation of prenatal diagnostic centers. It also fails to acknowledge the problem of malnutrition, or suggest strategies and interventions to tackle the issue.
National Mental Health Programme (NMHP)

A National Mental Health Programme (NMHP) was launched in 1982, keeping in view the heavy burden of mental illness in the country and the inadequacy of the health system to meet the specific mental health needs. This programme aimed to shift the basis of practice from the traditional (psychiatric) services to community care. However, in reality, the NHMP is only a footnote to the national health policy, and does not offer any (fiscal or technical) support for building community initiatives. In practice, the treatment of mental health problems is still heavily relying on the bio-medical model and is limited to the dispensing of drugs.

Mental health care services are limited to those diagnosed with severe illness, where the patient is treated as a ‘societal burden’. The pattern of institutional care, especially for women, reeks of neglect and paternalism and requires gender sensitive cross-referral systems.

The GOI also launched the District Mental Health Programme (DMHP) in 1996-1997 under the recommendation of the Central Council of Health and Family Welfare. The programme, initially launched in 4 states, was extended to 22 districts in 20 states by the year 2000 with a grant assistance of Rs. 22.5 lakhs each. The goal was to develop a community-based approach that has been neglected despite the programme commitment towards it. The other objectives were to impart public education in mental health to increase awareness and reduce stigma, early detection and treatment through both OPD and indoor services, and providing data from the community to the state and central levels for future planning of mental health programmes.

The programme has been criticized as giving more importance to curative services rather than preventive measures. There is also a shortage of professional manpower, and the training programmes are not adequate. Moreover, the medical care provided is still custodial in nature and requires a therapeutic approach.
Reproductive and Child Health (RCH)

The Mother and Child Health (MCH), nutrition and immunization programmes were brought under the umbrella of the Family Welfare Programme and was finally transformed into the Reproductive Child Health (RCH) programme. The national RCH programme was launched in 1997 to provide integrated health and family welfare services for women and children. The programme aimed at improving the quality, distribution and accessibility of services and to meet the health care needs of women in the reproductive ages and children more effectively.

The components included:

- Prevention and management of unwanted pregnancy;
- Services to promote safe motherhood and child survival;
- Nutritional services for vulnerable groups;
- Prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs);
- Reproductive health services for adolescents;
- Health, sexuality and gender information, education and counseling;
- Establishment of effective referral systems;

The second phase of the programme, RCH II sought to address the inaccessibility problem of the population by re-looking at the location of sub-centers, PHCs and CHCs, working in convergence with other departments such as ICDS, Water and Sanitation, etc. It also aims at upgrading the RCH facilities at the PHC by providing for obstetric care, MTP and IUD insertion. Hiring of private anesthetics, where none exist and referral transport facilities for poor families are some of the components of the programme. While the RCH programme entered its second phase, a five-state social assessment of RCH I (1997-2002) revealed:

- Health services were not available at suitable timings for women;
- Unresponsiveness of the health system to problems concerning mobile population;
- Complete neglect of adolescent health needs;
• Low priority accorded to treatment of gynecological morbidities among women, even as the untreated side effects of contraceptives and post delivery complications continued to burden women;
• Failure to involve men in the programme, thus rendering the RCH programme as ‘women centric’.

Despite the guidelines of the RCH programme and the existing reproductive health care services, there are certain issues that have been completely neglected and ignored by the experts. Women are unable to seek care for problems, which are not related to pregnancy and other gynecological complications. For instance, there are no services for occupational health problems, domestic violence or abuse and mental health problems. In addition to this, the programmes deny a commitment to respond to women’s health needs throughout the life cycle and to go beyond the constricted conceptualization of their reproductive roles as concerned only with child bearing.

**National Rural Health Mission (NRHM)**
The National Rural Health Mission (NRHM 2005) – launched in 18 states that were identified as having poor health indicators – emphasizes on comprehensive primary health care for the rural poor. The main goal of the mission is to provide for effective health care facilities and universal access to rural population.

• Strengthening the three levels of rural health care- sub-centre, PHC and the CHC. It also states that all ‘assured services’ including routine and emergency care in Surgery, Medicine, Obstetrics and Gynecology and Pediatrics in addition to all the National Health programmes; and all support services to fulfill these should be available and strengthened at the CHC level.
• New health financing mechanisms for additional resource allocation and up gradation of facilities.
• Appointing ASHA (Accredited Social Health Activist) at the village level as the link worker for the rest of the rural public health system.
• Private public partnerships and regulation of private sector.
The programme document identifies all these as attempts to establish the horizontal linkages of various health programmes and provide comprehensive primary health care rather than promoting the vertical programmes, which has till now failed to provide health for all.

However, NRHM 2005 has been criticized by health activists and women’s groups alike as being ‘old wine in a new bottle’. Only a marginal proportion of the increased health budget has gone into the rural health system improvements under NRHM and in reality the budgets for all Family Welfare activities including the RCH II package has been clubbed together as the budget for NRHM. A consequence of such reallocation is the danger of NRHM activities being usurped by RCH programme.

The performance indicators of the ASHA and her compensation are related to RCH and there is a high possibility that this disproportionate emphasis on family planning and RCH will undermine the effectiveness of other primary health care components. Hence, though the NRHM document reflects the renewed commitment of the government to provide comprehensive health care, it has inbuilt problems of becoming selective and abdicating the government’s responsibility for healthcare provisioning.

**National Malaria Eradication Program**

India’s commitment to the goal of health for all by 2000 AD necessitated the integration of anti-malaria activities with primary health care. Primary health centers are involved in the collection and examination of blood smears from fever cases through multi purpose workers. The program in the rural and remote areas relies considerably on community participation. The drug distribution centers are manned by panchayat members, forst officials, village health guides and other community workers. Fever treatment reports are manned by teachers, forest and revenue officials. However insecticides spraying operations in areas with API and above, being a specialized task, have been retained as a vertical program, under supervision of district malaria officers.

The recent resurgence of malaria in many parts of the country necessitated the need to strengthen the health promotion component of the program. Therefore, it has been decided to
observe “Malaria Week” before the onset of monsoon i.e. 1st May to 7th May every year. The main objective is to create awareness among the masses about malaria and its prevention.

**National Filaria Control Program**

The National Filaria Control Program (NFCP) has been in operation since 1955. According to recent estimates about 420 million people are exposed to the risk of infection; 19 million manifest the disease, and 25 million have filarial parasites in their bloods.

In June 1978, the operational component of the NFCP was merged with the urban malaria scheme for maximum utilization of available resources. The training and research components however continue to be with the director, National Institute of Communicable Diseases, Delhi.

**National Leprosy Control Program**

The National Leprosy Control Program (NLCP) has been in operation since 1955 as a centrally aided program to achieve control of leprosy through early detection of cases and DDS (dapsone) monotherapy on an ambulatory basis. The NLCP moved ahead initially at a slow pace, presumably for want of clear cut policies or operational objectives for nearly two decades (10). The program gained momentum during the 4th five – year plan after it was made a centrally – sponsored program. In 1980 the government of India declared its resolve to “Eradicate” leprosy by the year 2000 and constituted a working group to advice accordingly. The working group submitted its report in 1982 and recommended a revised strategy based on multi – drug chemotherapy aimed at leprosy “eradication” through deduction in quantum of infection in the population, reduction in the sources of infection and breaking the chain of transmission of disease. In 1983 the control program was redesignated national leprosy “Eradication” program with the goal of eradicating the disease by the turn of the century.

National Tuberculosis Program (NTP) has been in operation since 1962. Its objectives are;
1. **Long term objectives** –

To reduce tuberculosis in the community to that level when it cease to a public health program i.e.

   a. One case in facts less than one new person annually;
   
   b. The prevalence of infection in age group below 14 years is brought to less than 1%, against about 30% at present.

2. **Operational or short term objectives** –

   a. To detect maximum number of TB cases among the outpatients attending any health institutions with symptoms suggestive of tuberculosis and treat them effectively.
   
   b. To vaccinate new borne and infants with BCG.
   
   c. To undertake the above objective in an integrated manner through all the existing health institutions in the country.

**National Tuberculosis Control Program**

The National Tuberculosis Control Program has been accorded high priority by the government. With the inclusion of MTP in the 20-point program, there is expansion of essential activities under the program. There has been considerable increase in budget allotment. The international agency like WHO, ISDA, DANIDA, World Bank etc are providing the assistance to NTP.

**National Diarrhoeal Disease Control Program**

National Diarrhoeal Disease Control Program was started during the 6th to bring down diarrhoea – related mortality 9 this includes cholera) through promotion of oral dehydration therapy. The program was intensifi ed during 7th plan to reduce diarrhoea mortality by 50% by the year 1990. This program is integrated with primary health care at the village/subcentre/PHC levels, and at District Hospital level. Private practitioners are also involved in the program. Every village health guide is supplied 100 packets of oral dehydration salts per year. In addition, 200 such packets are supplied to subcentres
functioning under the Family Welfare Program is health education. Health education materials like Home treatment of diarrhoea in regional languages is supplied to all PHC’s for three distribution.

**Iodine Deficiency Disorders (IDD) Program**

India commenced a goiter control – program in 1962; based on iodized salt. At the end of three decades, the prevalence of the disease still remains high. In retrospect, it becomes clear that the failure was mostly due to the operational and logistic difficulties. That is the production of iodized salt did not keep pace with requirement.

The IDD Control Program has been initiated in which nation – wide, rather than area specific use of iodized salt is being promoted. It was decided as a national policy to fortify all edible salt in a phased manner by end of Eight plan. The essential component of a national IDD program are use of iodized salt in place of common salt, monetary and surveillance, manpower training and mass communication. 26 states and UT’s have completely banned the use of salt other than iodized salt and have set up iodized deficiency disorder control cells to ensure effective implementation of program.

**National Program For Control of Blindness**

The National Program For Control of Blindness was launched in 1976 and incorporates the earlier trachoma control program started in 1968. The ultimate goal of program is to reduce blindness in the country from 1.4% to 0.3% by 2000 AD and to provide comprehensive eye care through primary health care. To strengthen the program it was decided to establish district blindness control societies (DBCS) under the chairmanship of the district controller.

**National Cancer Control Program**

In India it is estimated that there are 1.5 to 2 Million cancer cases at any given point of time with above 0.6 Million new cases coming every year. The Government of India started the
National Cancer Control Program in a limited form during the year 1975 – 76. This scheme continues during the 6th and 7th Plan period.

**National Diabetes Control Program**

The main objectives of the programs are

1. Identification of high-risk subjects at an early stage and imparting appropriate health education.
2. Early diagnosis and management of cases
3. Prevention, arrest or slowing of acute metabolic as well as chronic cardiovascular – renal complication of the disease.

The central focus of The National Diabetes Control Program would be on a district diabetes control program. The program will function at 3 levels – the Sub center, Primary health center and district Hospital Level. It was stipulated that the program during the 7th Plan be undertaking in 5 districts in different states.

**Child Survival and Safe Motherhood Program**

Care for “Mother and Child” occupies a paramount place in our health services delivery system. This is reflected from the fact that 9 out of 17 goals listed in the National Health Policy relate to maternal and Child Health. The program is introduced as part of overall reduction of infant mortality child mortality and maternal mortality rate. Implementation of universal immunization program have provided an opportunity of reaching infants and pregnant women for provision of other health intervention necessary for achieving the goal with effect from August 1992 the programmed named Child Survival and Safe Motherhood Program is being implemented with financial assistance with world bank and UNICEF.

**Universal Immunization Program**

Experience with small pox eradication program showed the world that immunization was the most powerful and cost effective weapon against vaccine preventable diseases. In 1974, the WHO launched its “Expanded Program on Immunization” (EPI) against 6, most common, preventable childhood diseases, viz. diphtheria, pertussis (whooping cough) tetanus, polio,
tuberculosis and measles. From the beginning of the program UNICEF has been providing significant support to EPI.

The primary health care concept as enunciated in 1978 Alma–Ata Declaration included immunization as one of the strategies for reaching the goal of health for all by year 2000. While the WHO’s program is called EPI, the UNICEF in 1985 renamed it as “Universal Child Immunization” (UCI).

The government of India launched its EPI in 1978 with the objective of reducing the mortality and morbidity resulting from vaccine preventable disease of childhood, and to achieve self-sufficiency in the production of vaccines. Universal Immunization Program was started in India in 1985. It was to vital components: immunization of pregnant women against tetanus, and immunization of children in their 1st year of life against the 6 EPI target diseases.

1.6 FROM BHORE COMMITTEE TO NATIONAL RURAL HEALTH MISSION: A CRITICAL REVIEW.

Sir Joseph Bhore Committee or Health Survey and Development Committee was constituted in 1946. It was guided by lofty principals as 'nobody should be denied access to health services for his inability to pay' and that the focus should be on rural areas. Following the acceptance of report of Bhore Committee by rulers of newly independent country, a start was made in 1952 to setup primary health centers to provide integrated promotive, preventive, curative and rehabilitative services to entire rural population, as an integral component of wider Community Development Programme. In 1952, India was the first country to launch a national programme emphasizing family planning to stabilize the population at a level consistent with the requirement of national economy. The convulsive political changes that took place in the 1970s impelled the Central Government to implement the vision of Sokhey Committee of having one Community Health Worker for every 1000 people to entrust 'people health on people's hand'. India has come quite close to Alma Ata Declaration on Primary Health Care made by all countries of the world in 1978. The Declaration included commitment of governments to consider health as fundamental right; giving primacy to expressed health needs of people; community health reliance and community involvement;
Intersectoral action in health; integration of health services; coverage of entire population; choice of appropriate technology; effective use of traditional system of medicine; and use of only essential drugs. In 1982, Government made a major move in health politics by coming up very sharply against the health work done in the country in last 35 years. National Health Policy was thus formed in 1982 to make architectural corrections in health care system. National Health Policy gave a general exposition of the policies, which require recommendation in the circumstances then prevailing in health sector. The Universal Immunization Programme (UIP) was launched in 1985 to provide universal coverage of infants and pregnant women with immunization against identified vaccine preventable diseases. From the year 1992-93, the UIP has been strengthened and expanded into the Child Survival and Safe Motherhood (CSSM) Project. It involves sustaining the high immunization coverage level under UIP, and augmenting activities under Oral Rehydration Therapy, prophylaxis for control of blindness in children and control of acute respiratory infections. Under the Safe Motherhood component, training of traditional birth attendants, provision of aseptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies are being taken up. In 1997, Reproductive and Child Health (RCH-Phase1) programme was launched which incorporated child health, maternal health, family planning, treatment and control of reproductive tract infections and adolescent health. RCH Phase-2 (2005-2010) aims at sector wide, outcome oriented program-based approach with emphasis on decentralization, monitoring and supervision, which brings about a comprehensive integration of family planning into safe motherhood and child health. There is a differential approach for Empowered Action Group (EAG) and non-EAG states with improved ownership among states with dedicated structural arrangements to improve program management.

The National Rural Health Mission (2005-2012) is a major undertaking by United Progressive Alliance Government to honor its commitments under common minimal programme. The political commitment to rural health and access to primary health care that the CMP articulated was itself a matter of considerable cheer. NRHM is also strategic framework to implement the National Health Policy 2002. It has adopted key guidelines given in National Health Policy 2002, e.g. equity, decentralization, involving Panchayati Raj Institutions (PRIs) and local bodies in owning primary health care management, strengthening primary health care institutions and suggestions for generating alternate source of financing. The NRHM subsumes key national programmes, namely, Reproductive and
Child Health-2 (RCH-2), National Disease Control Programmes and Integrated Disease Surveillance Project. The mission covers the entire country, with special focus on 18 states, which have relatively poor infrastructure. These include all 8 Empowered Action Group (EAG) states viz. Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa, Uttrakhand, Chattisgarh and Jharkhand; 8 North East States besides Jammu and Kashmir and Himachal Pradesh.

NRHM lists a set of core and supplementary strategies to meet its goals of reduction in IMR and MMR; universal access of public health services such as women health, child health, water, sanitation and hygiene, immunization and nutrition; prevention and control of communicable and non-communicable diseases; access to integrated comprehensive primary health care; population stabilization; revitalization of local health tradition and mainstreaming AYUSH; and promotion of healthy lifestyles. Health services are available and functional, they are definitely accessed and used by people, especially the poor. The problem generally is non-availability and poor quality of services. Patients are frequently dissatisfied with the quality of government services they receive, for reasons that include inconvenient OPD hours, high cost of services, drugs and tests, staff shortages, and lack of supplies and diagnostic techniques. Modern diagnostic techniques, such as blood sugar estimation by glucometer, pregnancy test by urinary HCG, use of nebuliser to administer a bronchodilator in acute bronchial, etc. need to be made available at the PHC level, even if it means higher costs.

Problem of accessibility is further accentuated by the lack of gender perspective in planning. The government looks at woman primarily as a child-producing machine, and the existing, inadequate health services are circumscribed within this concern.

The health programme is based on the premise that maternal mortality is the cause of low sex ratio, low life expectancy and high death rates for the female population. It believes that specific inputs to reduce deaths would make a positive impact on women’s health. However, many of the causes of maternal mortality are rooted in the low social and health status of women long before they become mothers and it is this factor that is usually overlooked.

The general health problems faced by women rarely get the attention they deserve. Even within this limited concern, government programmes are badly designed and implemented.
Women, especially poor women, it is believed, ‘produce irresponsibly’. The medical profession’s preoccupation with the reproductive function has also led to the inclusion of the family planning programmes as part of Mother and Child Health services. Yet, most women do not receive adequate ante-natal care. Though the government may claim that its focus on the reproductive age is important, some of the most common reproductive health problems of women, such as pain during menstruation, backache, infertility and reproductive tract infections, remain neglected. There is a widespread notion that reproductive tract infections are ‘natural or mere baseless complaints of neurotic women’. Few women have access to gynecological examination. The ANM or MPW are untrained to detect and treat reproductive tract infections. The dearth of women doctors in rural areas results in women continuing to suffer in silence from these ailments.

The health care systems of many developing countries emerged from colonial medical services that emphasized costly high technology, urban based, curative care. When these countries became independent in the 1950s and 1960s, they inherited health care systems modeled after the systems in industrialized nations. Public health programs of international development agencies during this period were also largely targeted at eradicating specific diseases such as smallpox, yaws, and malaria. Each disease eradication program operated autonomously, with its own administration and budget and very little integration into the larger health system. There were some successes during this period (for example, eradication of smallpox and a decrease in tuberculosis). However, these short-term interventions were not addressing poor populations’ overall disease burden. Analysts realized that although one disease might be controlled or eliminated, recipients of that intervention might die of another disease or its complications. The situation worsened into the early 1970s, as populations continued to experience failing health outcomes with rising spending.

Recognizing that narrow targets were not the only option, countries attempted to implement comprehensive approaches to the provision of basic health services. Examples included the creation of the rural health center, staffed by medical and health assistants and supported by the Bhore Commission in India; the implementation of “community-based health programs” in Nicaragua, Costa Rica, Guatemala, Honduras, Mexico, Bangladesh, and the Philippines; and the barefoot doctor program in China. As part of the overall efforts to improve population health, these countries brought a new theme to international health discourse: commitment to social equity in health services. Social equity means that although different
socio economic levels exist, the gaps between those levels are not insurmountable. Examples from these countries contributed to the optimism that inequity could be tackled to improve global health.

Introduction of “health for all.” By the mid-1970s international health agencies and experts began to examine alternative approaches to health improvement in developing countries. The impressive health gains in China as a result of its community-based health programs and similar approaches elsewhere stood in contrast to the poor results of disease-focused programs. Soon this bottom-up approach that emphasized prevention and managed health problems in their social contexts emerged as an attractive alternative to the top-down, high-tech approach and raised optimism about the feasibility of tackling inequity to improve global health. Thus, “health for all” was introduced to global health planners and practitioners by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) at the International Conference on Primary Health Care in Alma Ata, Kazakhstan, in 1978. The declaration was intended to revolutionize and reform previous health policies and plans used in developing countries, and it reaffirmed WHO’s definition of health in 1946: “a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity.”

The conference declared that health is a fundamental human right and that attainment of the highest possible level of health was an important worldwide social goal. To achieve the goal of health for all, global health agencies pledged to work toward meeting people’s basic health needs through a comprehensive approach called primary health care. Primary health care as envisioned at Alma Ata had strong sociopolitical implications. It explicitly outlined a strategy that would respond more equitably, appropriately, and effectively to basic health needs and also address the underlying social, economic, and political causes of poor health. It was to be underpinned by universal accessibility and coverage on the basis of need, with emphasis on disease prevention and health promotion, community participation, self-reliance, and intersectoral collaboration. It acknowledged that poverty, social unrest and instability, the environment, and lack of basic resources contribute to poor health status. It outlined eight elements that future interventions would use to fulfill the goal of health improvement: education concerning prevailing health problems and methods of preventing and controlling...
National Rural Health Mission (NRHM) is not a first program on rural health in independent India, even then, the enthusiasm and attention of the health personnel and people toward the program is phenomenal. This may partially be attributed to the apparent commitment and sincerity of the government, which was rightly reflected in the confessional speech of the prime minister of India, on April 12, 2005, on the launch of this program, when he said "We have grievously erred in the design of many of our health programs. We have created a delivery model that fragments resources and dissipate energies. Most importantly, we have paid inadequate attention to the public health issues."

National Rural Health Mission (NRHM) has been envisaged as a focal point of all the programs targeted to improve the health of people in rural India. It has been widely debated both, before and after the implementation. Ongoing corrective measures and performance appraisal are integrated with this program. Deliberations by experts from various fields, adaptation of the successful best practices, and learning from the failures make NRHM a different program. No government program was as meticulously prepared or planned as NRHM since Independence. The key functionary of this program, Accredited Social Health Activist (ASHA), a voluntary worker, incorporates all the good qualities of previous similar functionaries in various programs. The active involvement of Panchayati Raj Institutions (These Panchayati Raj Institutions or PRIs, as they are known here, are the institutions for local self government where locally elected representatives make decision for the people in the area. The PRIs have been formed at every village level throughout the country.), community (The involvement of community ensure that people decide for themselves to increase their participation in the programs), (Non Government Organizations (NGO), and Private Practitioners are welcome steps. Although, this also does not mean that everything is good in NRHM. The issues of attrition of ASHA, over dependency of it on Anganwadi (Anganwadi literally means courtyards, The government of India has setup an Anganwadi for every 1000 population in rural India, where one government worker provide immunization, health check ups, supplementary nutrition, non formal preschool education, health education, growth monitoring and referral services for children and pregnant women to improve the health status of the rural population specifically women and child.) worker etc need to be addressed. This review analyze NRHM in the light of past health experiences, specially
focusing on ASHA. At present, it can be said that this program has all the necessary components to make improved health scenario, in rural India, a reality.

This NRHM aims to improve rural health by targeting phased increase in the funding for the health up to 2 - 3% of the Gross Domestic Product (GDP). The mission also tries to correct the most of the shortcomings of previous programs i.e. inappropriate training, lack of technical guidance, supervision and co-ordination and, poor community participation. Besides, this plans to cover capacity building, public private partnership and induction of management and public health and financial personnel.

In NRHM, the commitment of the government is palpable and categorical as the program is time bound, with clear objectives and achievable goals it all these factors make NRHM a different program then previous ones. The desire for achievable targets reflected in acceptance of Indian Public Health standards (IPHS) for Community Health Centers (CHC) accepting that BIS standards are very much resource oriented and difficult to achieve in present conditions of the health system in India.

1.8 EVALUATING THE ROLE OF PRIMARY HEALTH CENTER

Globally, governments are searching for ways to improve equity, efficiency, effectiveness and responsiveness of their health systems. At present, there is no agreement on optimum structures, content, and ways to deliver cost-effective services to achieve health gains for the population. However, in recent years there has been an acceptance of the important role of primary healthcare in helping to achieve these aims; providing cost-effective healthcare to the general population. Primary healthcare is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

International studies show that the strength of a country’s primary care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases. This relationship is significant after controlling for determinants of population
health at the macro-level (GDP per capita, total physicians per one thousand population, percentage of elderly) and micro-level (average number of ambulatory care visits, per capita income, alcohol and tobacco consumption).

Healthcare in India is the responsibility of constituent states and territories of India. The Constitution charges every state with "raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002.

In India, fertility, mortality and morbidity remain unacceptably high, both compared to countries in the region and those at similar income levels. Although poverty and low levels of education are the root causes, poor stewardship over the health system bears some responsibility. India’s primary healthcare system is based on the Primary Health Centre (PHC) which is not spared from issues such as the inability to detect diseases early due to lack of multi-disciplinary medical expertise and laboratory facilities and insufficient quantities of general medicines. At the same time, patients usually do not visit PHCs in the early stages of their diseases, while healthcare providers (if at all present) are forced to focus only on seriously ill patients due to the volume of cases.

What prompted me to write this article was a component of the speech given by Bill Gates at the 2005 World Health Assembly in Geneva. After an introduction based on the tragic health inequality between the developing and developed countries, the report addressed the importance of a fully-functioning healthcare delivery system; how millions of people could get the benefits of new discoveries if healthcare delivery was a priority and if delivery shaped design. Universal access to healthcare is a norm in most developed countries and some developing countries. Unfortunately, in India, not only is there pre-existing inequality in healthcare provisions, but this is further enhanced by difficulties in accessing it, which is due to geographical, socio-economic or gender distance.

Studies from developed countries demonstrate that an orientation towards a specialist-based system enforces inequity in access. Health systems in low income countries with a strong primary care orientation tend to be more pro-poor, equitable and accessible. At the operational level, the majority of studies comparing services that could be delivered as either primary health care or specialist services show that using primary care physicians reduces
costs, and increases patient satisfaction with no adverse effects on quality of care or patient outcomes.

In India, Primary Health Centres (PHCs) are the cornerstone of rural healthcare; a first port of call for the sick and an effective referral system; in addition to being the main focus of social and economic development of the community. It forms the first level of contact and a link between individuals and the national health system; bringing healthcare delivery as close as possible to where people live and work.

Each PHC is targeted to cover a population of approximately 25,000 and is charged with providing promotive, preventive, curative and rehabilitative care. This implies offering a wide range of services such as health education, promotion of nutrition, basic sanitation, the provision of mother and child family welfare services, immunization, disease control and appropriate treatment for illness and injury. The PHCs are hubs for 5-6 sub-centers that cover 3-4 villages and are operated by an Auxiliary Nurse Midwife (ANM). These facilities are a part of the three tier healthcare system; the PHCs act as referral centers for the Community Health Centres (CHCs), 30-bed hospitals and higher order public hospitals at the taluka and district levels.

Primary healthcare services substantially affects the general health of a population, however many factors undermine the quality and efficiency of primary healthcare services in developing countries. In India, although there are many reasons for poor PHC performance, almost all of them stem from weak stewardship of the sector, which produces a poor incentive framework. The World Health Organization (WHO) specifically points out that to some extent, the deterioration in health status is attributed to inadequacies in PHC implementation, neglecting the wider factors that have been responsible for this deterioration such as lack of political commitment, inadequate allocation of financial resources to PHCs and stagnation of inter-sectoral strategies and community participation. The main ones being bureaucratic approach to healthcare provision lack of accountability and responsiveness to the general public and incongruence between available funding and commitments.

The current PHC structure is extremely rigid, making it unable to respond effectively to local realities and needs. For instance, the number of ANMs per PHC is the same throughout the country despite the fact that some states have twice the fertility level of others. Moreover, political interference in the location of health facilities often results in an irrational
distribution of PHCs and sub-centres. Government health departments are focused on implementing government norms, paying salaries, ensuring the minimum facilities are available rather than measuring health system performance or health outcomes. Further, the public health system is managed and overseen by District Health Officers. Although they are qualified doctors, they have barely any training in public health management; strengthening the capacity for public health management at the district and taluka level is crucial to improving public sector performance.

The lack of accountability stems from the fact that there is no formal feedback mechanism and incentive to treat citizens as clients. Patients often complain of rude and abrupt health workers that discriminate against women and minorities from scheduled castes or tribes. The lack of accountability leads to absentee doctors; as it is difficult to attract qualified doctors to rural areas, unresponsive ANMs, inconvenient opening times and little or no community participation.

The lack of resources, which is acute in some states, is certainly a contributing factor to the poor performance of the primary healthcare system. In poor states, spending levels are low while expectations for coverage remain high. The incongruence between resources and targets result in lack of medicines; the current budget for essential drugs being Rs 75,000 per annum which is insufficient to cater to large number of patients, limited doctor salaries. In order to improve primary care services, a number of approaches are used in developing countries. Capacity building and encouraging community involvement are some of the main factors. Capacity building aims to improve the knowledge and skills of primary care professionals and community involvement improves governance and accountability of public primary health clinics, which lead to increase in drug supply and improved provider skills. A widely used mechanism to improve primary health services is contracting.

Contracting improves public services by utilizing the private sector’s greater flexibility to improve services and responsiveness to consumers, increases managerial autonomy, decentralizes decision making to managers on ground. It allows the government to focus less on service delivery and more on comparative advantage roles. Contracting can also improve the level of national equity as a government can create contracts that focus on delivering primary care services to vulnerable populations.
Improved access to primary healthcare and its gate-keeping function lead to less hospitalization, less utilization of specialist and emergency centers and less chance of patients being subjected to inappropriate health interventions. In low-income settings, the cost effectiveness of PHC compared to other health programmes has been reinforced by World Bank findings; selected primary healthcare activities such as infant and child health, nutrition programmes and immunization appeared as ‘good buys’ compared to hospital care and such interventions could avert a large population of deaths. The Bamako Initiative in Benin and Guinea demonstrate that even in resource-poor settings, it is possible to implement and sustain basic PHC services.

Thus, it is evident that the success of health systems exists in tapping the existing potential and making appropriate structural changes. The role of primary care should not be defined in isolation but in relation to the constituents of the health system.

Primary, secondary, generalist and specialist care, all have important and inclusive roles in the healthcare system and should be used to create a comprehensive and integrated model; one that combines universalism and economic realism with the objective of providing coverage for all.

**1.9 PRIMARY HEALTH CENTRE IN GUJARAT**

The state of Gujarat came into existence on 1st May 1960 and is the seventh largest state in India with an area of around 196,024 sq. km. located on the Western coast of India; it has the longest coastline in the country of about 1600 km. The geographical areas in Gujarat comprise desert areas of Kutch, arid /semi arid regions of North Gujarat, Saurashtra and Kutch, tribal/nutrition hilly and forested areas of South Gujarat, plain and irrigated areas of Central Gujarat and coastal areas right from South Gujarat to North western part. Administratively, it is made up of 25 districts subdivided into 225 talukas. Gujarat has been in the forefront of industrial and economic activity in the country and has made rapid progress on all fronts be it economic growth, human resource development, or diversifying its industrial base.

At the time of its creation, it was largely an agrarian economy with little industrial base. Animal Husbandry and Dairying have played a vital role in the rural economy of Gujarat.
Today Gujarat accounts for nearly 19% of the total industrial investments in India and has emerged as a leading industrial State in the country. It is also one of the most urbanized States in India with 37% of the population living in urban areas. Most urban and rural settlements contain a mix of communities, with varying socio-economic levels. Growing industrialization of the State, increasing needs of the people for better quality of life and the need to cater to the burgeoning trade has put tremendous pressure on the existing infrastructure in the State.

**Organization of Health Services & Programmes**

Gujarat has a well-networked health infrastructure. As in other states, Gujarat implements the various national programmes. The UNFPA funded IPD project is being implemented in the five districts of Surendranagar, Kachchh, Dahod, Sabarkantha and Banaskantha. The European Commission and GOI supported, Sector Investment Programme (SIP) is also being implemented in the state. The Department of Health & Family Welfare, (DoHFW) consists of two main divisions, viz. health and family welfare. It is headed by a Minister of Cabinet rank, while the administrative set up consists of one Principal Secretary. From an administrative perspective, the DoHFW is divided into Directorates / Commissionerate, which include inter-alia, the State AIDS Society, Commissionerate of Health, Directorate of Indian System of Medicine and Directorate of Central Medical Store Office (CMSO). Gujarat also has a number of non-governmental organizations (NGOs) working on health and development activities.
The public health care system of Gujarat consists of primary, secondary and tertiary institutions. Gujarat has a well-networked infrastructure comprised of 7274 sub-centers, 1072 Primary Health Centers and 270 Community Health Centers. The secondary level consists of taluka and district hospitals; the tertiary level covers teaching hospitals in medical colleges and specialized hospitals. The state has over 24,000 allopathic doctors, less than four thousand of who work in government agencies. Of the 2528 allopathic hospitals in Gujarat, only 503 are within government, which indicates a well-developed private health sector in the state. There are eight allopathic medical colleges (five self-financed) and 28 training schools for auxiliary nurse midwives. Gujarat implements national programmes for TB, malaria, leprosy, blindness, epidemic control, AIDS and family welfare (including reproductive and child health). A UNFPA-funded project is being implemented in five districts (Surendranagar, Kachchh, Dahod, Sabarkantha, Banaskantha). The Department of Health and Family Welfare has two divisions: health and family welfare. Headed by a Minister of Cabinet rank, DoHFW has one Principle Secretary. Its Directorates and Commissions include the State AIDS Society, the Commissionerate of Health, the Directorate of Indian System of Medicine and the Directorate of Central Medical Store Office (CMSO).
1.10 INTRODUCTION OF SAURASHTRA REGION

Saurashtra (also known as Soruth and Sorath) is a region of western India, located on the Arabian Sea coast of Gujarat state. It is a peninsula also called Kathiawar after the Kathi Darbar rulers who ruled part of the region once. The Peninsula is shared with the Kachchh region which occupies the north, Saurashtra or Sorath forming the southern portion.

Sorath was the former name of the Muslim-ruled Princely State of Junagadh ("Junaghar" or the "Old City"). During British rule, Junagadh and its neighboring princely states were supervised by the Western India States Agency (WISA). In 1947, Junagadh's Muslim ruler desired to accede his territory to Pakistan, but the predominantly Hindu population rebelled, and while he fled to Pakistan, a plebiscite was conducted as a result of which the kingdom was merged into the Indian Union.

After India’s independence in 1947, 217 princely states of Kathiawar and Saurashtra, including the former kingdom of Junagadh, were grouped together to form the state of Saurashtra in 1948. The capital of Saurashtra was Rajkot On November 1, 1956; Saurashtra was merged into Bombay state. In 1960 Bombay state was divided along linguistic lines into the new states of Gujarat and Maharashtra. The territory of Saurashtra, including that of the former kingdom of Sorath or Junagadh is now part of the state of Gujarat. Saurashtra region includes Junagadh, Rajkot, Jamnagar, Bhavnagar, Surendranagar and Porbandar.

Junagadh is a city and a municipal corporation, the headquarters of Junagadh district in the Indian state of Gujarat. The city is located at the foot of the Girnar hills. Literally translated, Junagadh means "Old Fort". It is also known as "Sorath", the name of the earlier Princely State of Junagadh.

Rajkot is the 4th largest city in the state of Gujarat, India. Rajkot is the 28th urban agglomeration in India, with a population more than 1.43 million as on 2008.[5][6] Rajkot is ranked 22nd in The world’s fastest growing cities and urban areas from 2006 to 2020.

Rajkot is a city of Gujarat state in India and administrative headquarters of the Rajkot District, located on the banks of the Aji River and Niari River. Rajkot was the capital of the then Saurashtra state from 15 April 1948 to 31 October 1956 before merging in bilingual
Bombay State on 1 November 1956. Rajkot was merged into Gujarat State from bilingual Bombay state on May 1, 1960.

After independence Rajkot became capital of the State of Saurashtra. Rajkot was merged into the newly-created Gujarat State when it was separated from the bilingual Bombay State on May 1, 1960.

Amreli is a city and a municipality in Amreli district of the Saurashtra region in the state of Gujarat, India.

It is believed that during the year 534 AD, Amreli existed as a city place with name Anumanji. After that the name was Amlik and then Amravati. The ancient Sanskrit name of Amreli was Amarvalli. Initially Amreli was the part of Former Gaekwad of Baroda. During Gaekwad regime in 1886, the compulsory and free education policy was adopted in Amreli for the first time. After independence the district became the part of Bombay State and a separate district in Gujarat State after the bifurcation of Bombay State.

Porbandar is a coastal city in the Indian state of Gujarat, perhaps best known for being the birthplace of Mahatma Gandhi and Sudama (Friend of Lord Krishna). It is the administrative center of Porbandar District.

Porbandar was formerly the seat of the eponymous princely state in British India. The ruling family of the state belonged to the Jethwa clan of rajputs and had been established in the area since at least the mid 16th century. The state was subordinate to the Mughal governor of Gujarat until being overrun by the marathas in the latter half of the 18th century, whereafter they came under the authority of the Gaekwad court at Baroda, and eventually of the Peshwa. In common with the other states of Kathiawar, the state first came into the ambit of British influence in 1807, when the HEIC guaranteed security in the area in lieu of a fixed annual tribute to be paid to the Peshwa and the Gaekwad. In 1817, the Peshwa ceded his share to the HEIC; in 1820, the Gaekwad agreed to have the HIEC collect his due tributes in Kathiawar and remit the same to his treasury.

Upon the Independence of India in 1947, the state acceded unto the dominion of India. It was merged with the 'United state of Kathiawar' with effect from February 15, 1948 and eventually came to form part of the present-day state of Gujarat.
**Jamnagar** is a city and a municipal corporation in Jamnagar district in the Indian state of Gujarat. The city was built up substantially by Maharaja Kumar Shri Ranjitsinhji in the 1920s, when the district was known as Nawanagar. The district lies just to the south of the Gulf of Kutch. Jamnagar has shot to prominence as Reliance Industries, India's largest private company, established the world’s largest refinery near Moti Khavdi village.[1] It is also home to Essar Oil, another important oil refinery of India, Essar Oil Refinery, Vadinar.[2] The city is also known for featuring India’s only Ayurvedic university.

**Bhavnagar** is a city in the Indian state of Gujarat. It was founded in 1723 AD by Bhavsinhji Gohil (1703-64 AD) and was named after its founder and ruler. It was capital of Bhavnagar State which was the first princely state to merge with the democratic Indian Union in 1948.

It is currently the administrative headquarters of the Bhavnagar District. It is the sixth-largest city of Gujarat, and the third-largest city in the Saurashtra region. Bhavnagar is also known as the cultural capital of Saurashtra.

The Gohil Rajputs of the Suryavanshi clan, facing severe competition in Marwar, moved down to the Gujarat coast around AD 1260 and established three capitals - Sejakpur, Umrala and Sihor (then known as Sirohi). [1] In 1822-1823, Sihor were raided by Khanthaji Kadani and Pilaji Gaekwad, but they were repulse by Bhavsinhji Gohil. After great losses in the battle, he realized the weakness in location of Sihor. In 1823, he established a new capital near Vadva village, 20 km away from Sihor, and named it Bhavnagar. It was a carefully chosen strategic location having potential of maritime trade. Naturally, Bhavnagar became the capital of Bhavnagar State. [2]

The old town of Bhavnagar was a fortified town with gates leading to other important towns of the region. Bhavnagar remained a major port, for almost two centuries, trading commodities with Africa, Mozambique, Zanzibar, Singapore and the Persian Gulf.

**Surendranagar** is an administrative district in the state of Gujarat in India, situated around 22° 43’ N latitude and 71° 43’ E longitude containing the district headquarters. The population is approximately 1,515,148. Surendranagar is also known as Zalawad, as the city of Surendranagar was ruled by Zala Rajputs. Surendranagar City (including Wadhwan City) has about 400,000 inhabitants, and is known as the city of Hi-Tech Bungalows.
1.11 CURRENT SCENARIO OF PHC IN SAURASHTRA

Health infrastructure do experience shortfall of paramedics in sub-centers as well as medical doctors in PHCs in Saurashtra region. Lack of attention to the patients in the PHCs/CHCs is found to be the most common reason for not utilizing the services.

The tough geographical conditions of Saurashtra with inaccessible, remote and tribal areas having weak communication infrastructure and the economic status of many families in villages are also very low.

There is a significant shortage at the level of specialists, doctors in rural areas, staff nurses and ANMs. The staff nurse position has to be urgently improved for attaining IPHS standards so that PHCs become functional 24x7. Some of the common problems related to unavailability of local service providers especially staff nurses, difficult duty stations with no place to stay for MOs, deputation to other areas, etc. Similarly in hiring consultants for Gynecologist and Anesthetist at FRU did not give much result due to lack of publicity, unawareness about the scheme among the service providers, absences of identification of fixed place, days for which specialist’s service is required. Co-ordination between the facilities and district authorities was not adequate as a result to a large extent funds were under-utilized.

In many PHC availability of only diagnostic facilities, but there is absences of any follow up services and mechanism to provide surgical interventions.

Funds for both major and minor civil work were available. However, due to various reasons like lack of communication between RCH societies and the facilities, poor response from the concerned district authorities, delay in the transfer

At the village level both ASHA (and State's Arogymitr) are getting to be in position so that all areas are covered Chiranjivi Scheme has yielded visible results in increasing institutional delivery capacity and has found public acceptance private providers have joined enthusiastically but in underserved areas there would be no escape from increasing public
provision. To be fully effective Rogi Kalyan Samitis need sustained nurture and reinforcement through instruction guidance and training so that societies become truly autonomous take decisions without fear and are responsible to local needs.

HEALTH STATUS IN SAURASHTRA

<table>
<thead>
<tr>
<th>City</th>
<th>No. of CHC</th>
<th>No. of PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhavnagar</td>
<td>12</td>
<td>41</td>
</tr>
<tr>
<td>Amreli</td>
<td>11</td>
<td>35</td>
</tr>
<tr>
<td>Junagadh</td>
<td>15</td>
<td>51</td>
</tr>
<tr>
<td>Jamnagar</td>
<td>10</td>
<td>36</td>
</tr>
<tr>
<td>Rajkot</td>
<td>14</td>
<td>42</td>
</tr>
<tr>
<td>Surendranagar</td>
<td>9</td>
<td>31</td>
</tr>
<tr>
<td>Porbandar</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>