CHAPTER III

HEALTH PROGRAMMES IN INDIA

Several health initiatives have been taken from time to time to improve the health status of rural as well as urban people of India. This chapter covers public health system prevailed in India under colonial period and the various health committees formed, health policies formulated and the health programmes implemented during the post independence period.

Public Health System in Colonial India

The public health system which was practised in India before the introduction of Western medicines was several centuries’ old Siddha and Ayurveda medicines. Ayurveda is the oldest system of all life sciences, originated in India thousands of years ago. It is not easy to decide the exact period of its origin as this is not the work of a single person and of few years but of thousands of thinkers, philosophers and investigators through ages (Gupta, International Ayurveda Foundation). Ayurveda literally means the Science of life. It is presumed that the fundamental and applied principles of Ayurveda got organized and enunciated around 1500 BC (Ravishankar and Shukla, 2007).

In the second century BC, medical students from different parts of the world used to come to the ancient Takshila University to study Ayurveda. All the specialties of Ayurveda were developed and full-fledged surgery was practised. From second to seventh century A.D, University of Nalanda also attracted foreign medical students.
mainly from Japan and China. This can be called as the revival period of Ayurveda where lots of research works were done in metallic and mineral drugs and their detoxification. By the spread of Buddhism in India, the decline of Ayurveda started. Surgery and Panchakarma practices were banned in the name of Ahimsa. Later with the Mughal invasion, Ayurveda faced a major setback and lots of literature and ancient books were destroyed by the Mughal invaders.

Then with the British regime, the decline was full and the seed was sowed for the growth of the modern medicine in India. Most of the provincial governments did not support the traditional Ayurveda practices and this added to the decline of Ayurveda. By the Eighteenth century, the status of Ayurveda showed some signs of improvements with some provincial rulers showing some interest to promote Ayurveda. In 1827, the first Ayurveda course was started in India in the Government Sanskrit College, Calcutta. The British discontinued this after six years. Later by the beginning of 20th century, many Ayurveda colleges were established in India under the patronage of some provincial Maharajas. The Maharajas of Travancore, Cochin, Jamnagar and Mysore were very keen in promoting the Ayurveda and the colleges established during those days are still considered to be the best. Gulab Kuverba Ayurveda College, Jamnagar; Tilak Ayurveda Mahavidyalaya, Pune; The old Maharaja’s College, Travancore which is the present Government Ayurveda College, Trivandram and Ayurveda College, Kottakkal are examples.

In spite of all these single attempts were made by some British people as back as 1829 for understanding Ayurveda. H.H. Wilson followed by Sir W. Jobes and H.T.Colebrooks did some academic work to bring Ayurveda to the West through their paper on the “Medical and surgical sciences of the Hindus,” in 1823. Another good
work was done by J.R. Royle on the “Antiquity and independent origin of Hindu medicine,” in 1837 and T.A. Wise published the first ever comprehensive treatise of Indian medicine in many foreign languages in 1845, but unfortunately, this went unnoticed by the Western world and nobody took interest to take it further.

The British people’s interest in the Ayurvedic system was very superficial and mostly confined to the commercial potential of the Indian medicinal plants and to a limited extent, the pharmacy dynamics of the valuable plant tradition of India. In 19th Century lot of books were published on this subject namely, Catalogue of Indian Medicinal Plants by John Fleming in 1810, Indigenous Drugs of India by K.L. Dey in 1867, Supplement to Pharmacopoeia of India by Moodeer Sheriff in 1865 and Materia Medica of Hindus by U.C. Dutta in 1877.

In a later stage during the pre-independence era, the Indian National Congress (INC) tried to promote the integrity of this science. In 1907, a professional group of indigenous practitioners established the All India Ayurved Maha Sammelan. In 1916, 11 members of the Imperial Legislative Council, led by Pandit Madan Mohan Malavya, Sir Surendranatha Banerjee and Sir Gangadhar Chithnavis pressed the then Director General of Indian Medical Services to accept the resolution for conducting an investigation into possibility of placing the ancient and indigenous system of medicines on a scientific basis and increasing their usefulness. In 1920, INC passed a resolution demanding the government patronage for Ayurveda. Following this, the provincial Governments started promoting Ayurveda (Patel, 2002).

Siddha system of medicine is practised in some parts of South India especially in the state of Tamil Nadu. This system has come to be closely identified with Tamil civilization. It is a well known fact that before the advent of the Aryans in India, a
well developed civilization flourished in South India especially on the banks of rivers Cauvery, Vaigai and Tamiraparani (Ravishankar and Shukla, 2007).

Unani medicine is another old methodology of treatment of diseases. Unani system of medicine was originated in Greece. The Arabs were instrumental in introducing Unani medicine in India around 1350 AD. The first known Hakim (Physician) was Zia Mohd Masood Rasheed Zangi. Some of the renowned physicians who were instrumental in the development of the system are Akbar Mohd Akbar Arzani (around 1721 AD) the author of the books Qarabadin Qadri and Tibbe Akbar; Hakim M. Shareef Khan (1725-1807) a renowned physician well known for his book Ilaj ul Amraz. Hakim Ajmal Khan (1864-1927) a great name among the twentieth Century Unani physicians in India. He was instrumental in the establishment of Unani and Ayurvedic College at Karol Bagh, Delhi. The first institution of Unani medicine was established in 1872 as Oriental College at Lahore in the undivided India (Ravishankar and Shukla, 2007).

The history of Western medicine in India dates back to 1600, when the first medical officers arrived in India along with the British East India Company’s first fleet of ship’s surgeons. The first hospital in India was the Madras General Hospital in 1679. In 1757, the East India Company established its rule in India, which led to the development of civil and military services. A medical department was established in Bengal as far back as 1764 for rendering medical services to the troops and servants of the Company. At that time, it consisted of four head surgeons, eight assistant surgeons and 28 surgeon’s mates. In 1775, Hospital Boards were formed to administer European hospitals comprising of the Surgeon General and Physician General, who were on the staff of the Commander-in-Chief of the Royal Indian Army.
In 1785, medical departments were set up in the Presidencies of Bengal, Madras and Bombay with 234 surgeons. The medical departments involved both military and civil medical services. In 1796, hospital boards were renamed as medical boards to look after the affairs of the civil part of the medical departments. The Presidency General Hospital, Calcutta was formed in 1796. Four hospitals were formed in Madras between 1800 and 1820. To fulfill the growing need for health professionals, Calcutta Medical College was established by an order in February 1835, which was the first institute of Western medicine in Asia. Medical College Hospital, Calcutta was formed in 1852. In 1854, the British Government agreed to supply medicines and instruments to the growing network of minor hospitals and dispensaries. Government Store Depots were established in Calcutta, Madras, Bombay, Mian Mir and Rangoon (Government of India, 1909 & Mushtaq, 2009).

In 1857, the Indian Rebellion led to the transfer of administration of India to the Crown and different departments of civil services were developed. The British Government appointed Royal Commission to inquire into the health conditions of the army in India in 1859 (Health Survey and Development Committee Report, 1946). The purpose of the appointment of the Royal Commission and other commissions was principal to look into the health conditions of Army (Harrison, 1994).

In 1860, Lahore Medical School (later named King Edward Medical College) was started in Lahore. Afterwards, a network of hospitals was set up throughout India. Reforms were introduced by the sanitary commissioner in 1864. A separate civil medical department was formed in Bengal in the year 1868. In 1869, a Public Health Commissioner and a Statistical Officer were appointed by the British Government. In 1896, with the abolition of the presidential system, all three presidential medical
departments were amalgamated to form the Indian Medical Services (IMS). After the development of IMS, medical duties for the Royal Indian Army were performed by the Army Medical Department, later called the Royal Army Medical Corps (RAMC). In 1904, the Plague Commission was appointed to study the death from the plague in 1896 (Government of India, 1909).

The Lady Reading Health School, Delhi was established in 1918. Medical departments were under the control of the British Government until 1919. The Montague - Chelmsford Constitutional Reforms of 1919 led to the transfer of public health, sanitation and vital statistics to the provinces. This was the first step in the decentralization of health administration in India. In 1920-1921, Municipality and Local Board Acts were passed containing legal provisions for the advancement of public health in provinces. In 1930, the All India Institute of Hygiene and Public Health was established in Calcutta. The Government of India Act, 1935 gave further autonomy to provincial governments. All the health activities were categorized into three parts: federal, federal - cum - provincial and provincial. In 1937, the Central Advisory Board of Health was set up with the Public Health Commissioner as Secretary to coordinate the public health activities in the country. In 1939, the first Rural Health Training Centre was established in Singur near Calcutta and in the same year the Madras Public Health Act was passed, which was the first of its kind in India (Harrison, 1994, Park, K., 2009 & Mushtaq, 2009).

**Health Committees in India**

Over the past decades, various committees and commissions of experts have been appointed by the Government to examine issues and challenges facing the health sector. The purpose of these committees formed from time to time is to review the
current situation regarding health status in the country and suggest further course of action in order to accord the best of healthcare to the people. The committees and commissions have been headed by eminent public health experts, who have studied the issues in an in-depth manner and provided overarching recommendations for various aspects of the health care system in India. The areas covered by them related to organization, integration and development of health care services / delivery system across levels, health policy and planning, national programmes, public health, human resources, indigenous systems of medicine, drugs and pharmaceuticals.

**Bhore Committee, 1946**

The Health Survey and Development Committee was appointed by the Government of India in October, 1943 to make a broad survey of the present position with regard to health conditions and health organization in British India and to recommend for future developments. Sir Joseph Bhore was the Chairman of the Committee, which is also known as the Bhore Committee. The committee submitted its report in 1946. It was the first health report based on a countrywide survey in British India. It is the first organized set of health care data for India. It considered that the health programme in India should be developed on a foundation of preventive health work and proceeds in the closest association with the administration of medical relief. The Committee strongly recommended a health services system based on the needs of the people, the majority of whom were deprived and poor. It felt the need for developing a strong basic health services structure at the primary level with referral linkages. It emphasized the social orientation of the medical practice and high level of public participation (*Report of the Health Survey and Development Committee, 1946*).
The recommendations of the Bhore Committee report are:

1. The integration of preventive and curative services at all administrative levels.

2. Short term Primary Health Centre for 40,000 population.

3. Long term (Three million plan) – Primary Health Centres with 75 beds for each 10,000 -20,000 population.


5. Provision of Social doctor and inter-sectoral approach to health servicers development.

6. Three months training in preventive and social medicine to prepare social physicians for the better health status of the citizens.

**Sokhey Committee, 1948**

The National Planning Committee’s Sub-Committee on National Health was set up by the Indian National Congress in 1948 under the Chairmanship of Colonel S. Sokhey. It states that the maintenance of the health of the people was the responsibility of the State and the integration of preventive and curative functions in a single state agency was emphasized. The Sokhey Committee Report was not as detailed as the Bhore Committee Report, but endorsed the recommendations of the Bhore Committee Report and commented that it was of the utmost significance (*National Planning Committee's Sub-Committee on National Health Reports, 1948*).

**Mudaliar Committee, 1961**

The ‘Health Survey and Planning’ Committee was constituted in 1959 by the Government of India. Dr. A. Lakshmanswamy Mudaliar, Vice Chancellor of Madras University was appointed as the head of this committee. Thus, it was known that Mudaliar Committee, which submitted its report in 1961. The committee studied the progress in the health sector after submission of Bhore Committee Report and also
reviewed the First and Second Five Year Plan health projects. This committee found the conditions in primary health centres (PHCs) to be unsatisfactory and suggested that the PHCs, already established should be strengthened along with the strengthening of sub divisional and district hospital. The major recommendation of this committee report was to limit the population served by primary health centres to 40,000 with the improvement in the quality of health care provided by these centres. Also, provision of one basic health worker (BHW) per 10,000 population was recommended (Report of the Health Survey and Planning Committee, 1961).

Chadha Committee, 1963

The Government of India appointed a committee under the Chairmanship of Dr. M. S. Chadha in 1963. The committee knew as ‘special committee on the preparation of entry of the National Malaria Eradication Programme (NMEP) into maintenance phase’. It studied the arrangements necessary for the maintenance phase of the NMEP. The recommendations are; to ‘Vigilance’ operations in respect of the NMEP should be the responsibility of the general health services, vigilance operations by basic health workers, existing malaria surveillance worker (MSW) may be changed into auxiliary health workers/basic health workers, supervision by one sanitary inspector / health inspector for 20,000 to 25,000 population, creation of the post of laboratory technicians at the PHC and a post of a FPFW and FPHA and basic health workers envisaged as ‘multipurpose’ workers to look after additional duties (Report of the Special Committee on the preparation for entry of the NMEP into the maintenance phase, 1963).
Mukherji Committee, 1966

The committee was appointed by the Government of India during 1965-1966, under the Chairmanship of Union Health Secretary, Shri B. Mukherji. The Committee reviewed the performance and strategy of family planning. The committee observed that the multiple activities of the mass programmes like family planning, smallpox, leprosy, trachoma and National Malaria Eradication Programme (maintenance phase) were making it difficult for the states to undertake these effectively because of the shortage of funds and recommended to delink the malaria activities from family planning so that the latter would receive undivided attention of its staff. It also recommended that separate staff for the family planning programme. The committee, however, does visualize that at a later stage not long from how there can and should be a much greater integration between the Family Planning and Maternity and Child Health Programme and the basic health services. The committee also worked out the composition and organization of basic health services, which should be provided at the Block level. Also, strongly it recommended that importance must be given to the due strengthening of the supervisory levels to correspond to the strengthening of the base organization. This is particularly necessary for the basic health services since the quality of the performance of the functionaries at the base level, who have to be comparatively more numerous but cannot be so well paid nor of very high calibre nor technically so well equipped, will determine greatly the quality of the whole service and the benefits derived therefrom by the rural people. Supervision of their work has, therefore, to be particularly strong and continuous. This supervision must be both administrative and technical and must be adequate both in degree and quality and
must not be confined only to exercise of control but must extend also to providing help and guidance (*Mukerji Committee report on Basic Health Services, 1966*).

**Jungalwalla Committee, 1967**

The Jungalwalla Committee was set up in 1964 under the Chairmanship of Dr. N. Jungalwalla, the then Director of National Institute of Health Administration and Education (currently National Institute of Health and Family Welfare). Thus, it is known ‘Committee on Integration of Health Services’, which submitted its report in 1967. It was asked to look into various problems related to the integration of health services. The committee defined ‘integrated health services’ as “a service with a unified approach to all problems instead of a segmented approach to different problems”. The committee recommended integration from the highest to the lowest level in the services, organization and personnel. That is Medical Care and Public Health Programmes should be put in charge of a single administrator at all levels of hierarchy by adopting the unified cadre, common seniority, recognition of extra qualifications, equal pay for equal work, special pay for special work, abolition of private practice by government doctors and improvement in their service conditions (*Report of the Committee on Integration of Health Services, 1967*).

**Kartar Singh Committee, 1973**

The Government of India constituted a committee in 1972 known as “The Committee on Multipurpose Workers under Health and Family Planning” under the Chairmanship of Kartar Singh, Additional Secretary, Ministry of Health and Family Planning, Government of India. The committee submitted its reports in September 1973 (*Report of the Committee of Multi-purpose Workers under Health and Family Planning Programme, 1973*). Its main recommendations are:
1. The present Auxiliary Nurse Midwives (ANMs) to be replaced by the newly designated “Female Health Workers” and the present day Basic Health Workers, Malaria Surveillance workers, Vaccinators, Health Education Assistants (Trachoma) and the Family Planning Health Assistants to be replaced by “Male Health Workers.”

2. The programme for having multipurpose workers to be first introduced in areas was malaria is in the maintenance phase and smallpox has been controlled, and later to other areas as malaria passes into maintenance phase or smallpox controlled.

3. For proper coverage, there should be one primary health centre for a population of 50,000;

4. Each primary health centre should be divided into 16 sub-centres each having population of about 3,000 to 3,500 depending upon topography and means of communications;

5. Each sub centre to staff by a team of one male and one female health worker.

**Shrivastav Committee, 1974**

The Government of India in the Ministry of Health and Family Planning set up a ‘Group on Medical Education and Support Manpower’ in November 1974 under the Chairmanship of Dr. J.B. Srivastav. The purpose of this committee in accordance with national priorities and needs and to determine what needs to reorient medical education; healthcare assistants to develop a curriculum that was to act as a link between the medical staff multipurpose workers (MPWs). The committee also recommended the creation of bands of paraprofessional and semi-professional health workers from within the community (like school teachers and post masters) itself, the establishment of three cadres of health workers between the community level workers and doctors at PHC, the development of “Referral Service Complex” by establishing linkages between the primary health centre and higher level referral and service centres namely taluk, district, regional and medical college hospitals and
establishment of a Medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of University Grants Commission (UGC) (Report of the Group on Medical Education and Support Manpower, 1974).

**Rural Health Scheme, 1977**

The most important recommendation of the Shriastav Committee was that primary health care should be provided by the community itself through specially trained workers so that the health of the people is placed in the hands of the people themselves. The basic recommendations of the Committee were accepted by the Government of India in 1977, which led to the launching of the Rural Health Scheme. The programme of training of community health workers was initiated during 1977-1978. Steps were also initiated (a) for involvement of medical colleges in the total health care of selected PHCs with the objective of reorienting medical education to the needs of rural people; and (b) reorientation training of multipurpose workers engaged in the control of various communicable disease programmes into uni

**Alma Ata Declaration - Health for All, 2000**

The Alma Ata declaration of 1978 launched the concept of Health for All by the year 2000. It was signed by 134 governments (including India) and 67 other agencies. The Alma Ata Declaration gave an insight into the understanding of primary health care. It viewed health as an integral part of the socioeconomic development of a country. It provided the most holistic understanding to health and the framework that States needed to pursue to achieve the goals of development. The Declaration recommended that primary health care should include at least: education concerning
prevailing health problems and methods of identifying, preventing and controlling them, promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunization against major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, promotion of mental health and provision of essential drugs. It emphasized the need for strong first-level care with strong secondary and tertiary level care linked to it. It is called for an integration of preventive, promotive, curative and rehabilitative health services that had to be made accessible and available to the people and this was to be guided by the principles of universality, comprehensiveness and equity. In one sense, primary health care reasserted the role and responsibilities of the State and recognized that health is influenced by a multitude of factors and not just the health services. At the same time, the Declaration emphasized on complete and organized community participation and ultimate self reliance with individuals, families and communities assuming more responsibility for their own health, facilitated by support from groups such as the local government, agencies, local leaders, voluntary groups, youths and women's groups, consumer groups and other non governmental organizations (NGOs). The Declaration affirmed the need for a balanced distribution of available resources (WHO 1978).

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 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 providing health for all to its citizens after Alma Ata declarations. With a view of
evolving a national strategy for securing the objective of Health For All and to identify specific programmes for the Sixth Five Year Plan, the working group on Health was constituted by the Planning Commission with Shri Kripa Narain, Secretary, Ministry of Health and Family Welfare as its Chairman to review the current health status keeping in view the physical and qualitative implementations of plan programmes, shortfalls and deficiencies and measures for rectifying them. The report of the working Group on “Health for All by 2000 AD” examined the contextual issues in providing health care. The report contains a variety of interrelated recommendations, setting out objectives, strategies and operational goals which are considered feasible. It basically set down the parameters of the problem and set out the specific health tasks and targets to the state in the simplest terms but with full belief, that the goal of Health for All as spelt out here is an achievable one, given the sustained will and the supporting efforts to implement the indicated tasks by 2000 AD.

ICSSR and ICMR Reports on “Health for All - An Alternate Strategy”

The report of Study Group on “Health for All – an alternate Strategy” commissioned by ICSSR and ICMR (1980) under the Chairmanship of Dr. V. Ramalingaswami indicated 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 ICSSR/ICMR report “Health for All - An Alternative Strategy” offered a viable alternative strategy to reach most of the Indians who are in need of such services. The report recommended an alternative health care system that was accessible, culturally acceptable and cost effective for all citizens accountable to the people it served. It advocated: (1) encouraging people to
utilize their age old health culture and practices together with the best of all available systems provided in a simple and effective manner; (2) With the support of the community, this decentralized system could devise a graded training and referral system from the village to community's own hospital and training complex. This would meet almost 95 per cent of all requirements of preliminary health and medical care. Broad based medical and surgical specialty level within a 30,000 population level would be serviced by the government primary health centre. The report was set in the context the failures of the imported, top heavy, centralised, elite oriented model of health care delivery that characterised the first 30 years of Indian independence. It was a move beyond merely reproducing Western social institutions, services and values in the area of health to create a health care delivery system that was more relevant to India. The report also recommended the formulation of a comprehensive national health policy through an intersectoral approach that includes environment, nutrition, education, socio-economic and preventive and curative dimensions.

**Mehta Committee, 1983**

The Ministry of Health and Family Welfare, Government of India, set up a ‘Medical Education Review Committee’ on September 8, 1983. The Chairman of this committee was Dr. Shantilal J. Mehta. The committee submitted its report in 1983. The Mehta committee mainly reviewed the medical education in all its aspects and specifically discussed lack of availability of Health manpower data in India. The committee also recommended establishing Universities of Medical Sciences and Medical and Health Education Commission, a method for updating the manpower data and projections for doctors, nurses and pharmacists (*Report of the Medical Education Review Committee, 1983*).
First National Health Policy, 1983

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 First National Health Policy (NHP) in 1983. The major goal of the policy was to provide universal and comprehensive primary health services. The policy emphasized the role that could be played by private and voluntary organizations working in the country to support the government for integration of health services. It stressed the creation of an infrastructure for primary health care close co-ordination with health related services and activities like nutrition, drinking water supply and sanitation; the active involvement and participation of voluntary organisations, the provision of essential drugs and vaccines, qualitative improvement in health and family planning services, the provision of adequate training and medical research aimed at the common health problems of the people.

Meanwhile, 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 as resource constraints made it “not possible” to achieve 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, GOBI-FFF (Growth monitoring, Oral dehydration, Breastfeeding, Immunization, Female education, Family spacing, Food supplement) 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 (National Health Policy, 1983).

Bajaj Committee, 1987

The expert committee for “Health Manpower Planning, Production and Management” was appointed by the Government of India in 1985. The Chairman of this committee was Dr. J.S. Bajaj, a member of Planning Commission. The committee submitted its report in 1987. The committee examined the problem of health manpower planning, production and management (Report of the Expert Review Committee for Health Manpower Planning, Production and Development, 1987).

Important recommendations of the Bajaj committee are:

1. Recommended for the formulation of National Health Manpower Planning based on realistic survey.

2. Educational Commission for health sciences should be developed on the lines of UGC.

3. Recommended for National and Medical Education Policy in which teachers are trained in health education and science technology.

4. A uniform standard of medical and health science education by establishing universities of health sciences in all states.

5. Establishment of health manpower cells both at the state and central level.

6. Vocational courses in paramedical sciences to get more health manpower.

Bajaj Committee, 1996

The Ministry of Health and Family Welfare, Government of India constituted an ‘Expert Committee on Public Health Systems’ in 1996 under the Chairmanship of Prof. J.S. Bajaj to comprehensively review the public health system in the country and to offer appropriate recommendations. After the detailed deliberations, the committee
exhaustively reviewed the current status of public health system, epidemiological surveillance system, status of control strategies for epidemic diseases, existing health schemes, environmental health and sanitation, role of state and local health authorities in epidemic remedial measures, health manpower planning and health management information system.

The major recommendations of the committees are policy initiatives with respect to review National Health Policy, establishment of health impact assessment cell, surveillance of critically polluted areas, search for alternative strategy/strengthening of health services/system research, uniform adoption of Public Health Act by the local health authorities, establishing National Notification System/National Health Regulations, Joint Council of Health, Family Welfare and ISM and Homeopathy, Establishing an Apex Technical Advisory Body, Constitution of Indian Medical and Health Services, Administrative restructuring of Department of Health and Family Welfare and Directorate General of Health Services (DGHS), strong Health Manpower Planning division under DGHS, opening of Regional Schools of Public Health along with the emphasis on implementation of committee on manpower planning, production and management of 1987 (Report of the Expert Committee on Public Health System, 1996).

**National Population Policy, 2000**

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
the 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 (*National Population Policy, 2000*).

**Second National Health Policy, 2002**

Nearly twenty years after the first health policy, the Second National Health Policy (NHP), 2002 was presented. The NHP 2002 recognized as the noteworthy successes in health since the implementation of the First NHP, 1983. These successes included the eradication of smallpox and guinea worm, the near eradication of polio and the 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 systems 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. The major goals set by this policy are eradication of Polio and Yaws by 2005, elimination of leprosy by 2005, elimination of Kala azar by 2010, elimination of lymphatic filariasis by 2015, achieving zero level growth of HIV/AIDS by 2007 and reduction of mortality by 50 per cent on account of tuberculosis (TB), malaria and other vector and water borne diseases by 2010 (*National Health Policy, 2002*).

**Health Programmes in India**

Several measures have been undertaken by the Government since India’s independence to improve the health of the people. Prominent among these measures are the National Health Programmes, which have been launched by the Government
of India for the control or eradication of the communicable diseases, improvement of environmental sanitation, raising the standard of nutrition, control of population and improving rural health. Various international agencies like World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), United Nations Fund for Population Activities (UNFPA), World Bank as also a number of foreign agencies like Swedish International Development Agency (SIDA), Danish International Development Agency (DANIDA), Norwegian Agency for Development Cooperation (NORAD) and United States Agency for International Development (USAID) have been providing technical and material assistance in the implementation of these programmes. A brief account of these programmes is given below.

**National Family Planning Programme, 1952**

Realising the inevitable high population growth during the initial phases of demographic transition and the need to accelerate the pace of the transition, India became the first country in the world to formulate a National Family Planning Programme (NFPP) in 1952, with the objective of “reducing birth rate to the extent necessary to stabilise the population at a level consistent with requirement of national economy”. The First Five Year Plan stated ‘the main appeal for family planning is based on considerations of health and welfare of the family. Family limitation or spacing of children is necessary and desirable in order to secure better health for the mother and better care and upbringing of children. Measures directed to this end should, therefore, form part of the public health programme’. Thus, the key elements of health care to women and children and provision of contraceptive services have been the focus of India’s health services right from the time of India’s independence. Successive Five Year Plans have been providing the policy framework and funding
for planned development of nationwide health care infrastructure and manpower. The Centrally Sponsored and 100 per cent centrally funded Family Welfare Programme provides the States additional infrastructure, manpower and consumables needed for improving the health status of women and children and to meet all the felt needs for fertility regulation. Since then, the family planning programme has evolved and the programme is currently being repositioned to not only achieve population stabilization but also to promote reproductive health and reduce maternal, infant and child mortality and morbidity (Park, K., 2009, Pandya, 2009 and Five Year Plans).

Community Development Programme, 1952

The Community Development Programme (CDP) inaugurated on October 2, 1952. With the main purpose of developing the rural areas in all dimensions. CDP was envisaged as a multipurpose programme covering health and sanitation (through the establishment of primary health care centres and sub centres) and other related sectors including agriculture, education, transport, social welfare and industries. Each Community Development Block (CDB) consists of 100 villages with an approximate total population of 1,00,000. For one CDB, one PHC was created (Park, K., 2009, Pandya, 2009).

National Malaria Control Programme, 1953

The Government of India launched the National Malaria Control Programme (NMCP) in April 1953. It was based on indoor residual spraying with Dichloro Diphenyl Trichloroethane (DDT) (one kilo per square metre of surface area). The NMCP was in operation for five years (1953-1958). Good results were obtained from India. The number of malaria cases and deaths had decreased significantly. In 1958, NMCP was converted into the ‘National Malaria Eradication Programme (NMEP)
with a view to eradicating malaria from the country. In the beginning, NMEP was highly successful. But very soon, the incidence of malaria cases in India emerged. The urban areas have not received special attention in the Programme that could be one of the reasons for resurgence of malaria in the country. So Urban Malaria Scheme (UMS) launched in 1971.

The strategy was further strengthened and launched a Modified Plan of Operation (MPO) on April 1, 1977. Its main objective was preventing deaths and to reduce morbidity due to malaria. It was integrated with the primary health care delivery system. The MPO was able to control the malaria deaths at a lower level but during 1994, the resurgence of malaria was observed in some states with the epidemics and increase in mortality. As a result ‘Malaria Action Programme’ was launched in 1995, which defined various risk areas programme interventions and strategies such as hardcore areas, epidemic prone areas and triple insecticide resistant areas. But Malaria Action Programme was not able to sustain and an ‘Enhanced Malaria Control Project’ was launched on September 30, 1997, with the help of World Bank in selected areas such as the North-Eastern States and Tribal areas. In 1999, the government decided to drop the term ‘National Malaria Eradication Programme’ and renamed it with ‘National Anti Malaria Programme in 1999. But soon this programme has become the part of National Vector Borne Disease Control Programme (NVBDCP) (Park, K., 2009, Pandya, 2009 and Five Year Plans).

**National Water Supply and Sanitation Programme, 1954**

In 1954, the Government of India introduced a drinking water supply and sanitation programme under its Social Welfare Programme. Later the Government of India supported State Governments to identify villages facing drinking water
problems. Based on its findings in 1972-1973, the Government of India extended its help to State Governments through the Accelerated Rural Water Supply Programme (ARWSP). The Minimum Needs Programme (MNP) later took up this programme. However, in 1977-1978, the Government of India reintroduced this programme, since its performance under the MNP was not satisfactory. In 1986, the Government of India decided to take a mission approach to its effort in providing drinking water and introduced the National Drinking Water Mission (NDWM). In 1991, this was renamed as the Rajiv Gandhi Drinking Water Mission (Park, K., 2009, Pandya, 2009 and Five Year Plans).

**National Leprosy Control Programme, 1955**

Leprosy (Hansen’s disease) probably the oldest disease afflicting the mankind and it is a chronic infection disease. It affects mainly the peripheral nerves. In India, the establishment of the Indian Council of the British Empire Leprosy Relief Association in 1925 (renamed as Hind Kusth Nivaran Sagh in 1947) laid the foundation of organized leprosy work in India. After independence, the Government of India implemented the ‘National Leprosy Control Programme’ (NLCP) in 1955, with the main objective of controlling leprosy through domiciliary treatment with Dapsone. But it was a failure due to the social obstacles and lack of drugs. So the government planned to develop a leprosy eradication strategy and subsequently launched the ‘National Leprosy Eradication Programme’ (NLEP) in 1983, as a 100 per cent centrally sponsored scheme and its aim were to reduce care load to one or less than one per 10,000 population. In 1994, Modified Leprosy Elimination Campaign (MLEC) was launched in all the states and Union Territories (UTs). The programme was extended with World Bank assistance and the first phase of the

Besides regular surveillance activities, the Special Action Project for Elimination of Leprosy (SAPEL) for rural areas and Leprosy Elimination Campaigns (LEC) for urban areas were designed for early detection and prompt Multi Drugs Therapy (MDT) of leprosy cases, along with proper Information, education and communication (IEC) in the difficult and inaccessible rural/tribal areas as well as slums in the urban areas respectively. A total of 1,440 SAPEL/LEC project have been decentralized, which were not generally covered by regular programme activities. Special activities in the form of Focused Leprosy Elimination Plan (FLEP) were carried out in identified districts and blocks in 2005-2006. During the year 2005, Urban Leprosy Control Programme has been implemented. Under which assistance is being provided by the Government of India to urban areas having a population size of more than one lakh. The NLEP is being continued by Government of India from January 2005 onwards. Additional support for the programme is continued to be received from the World Health Organization an International Federation of Leprosy Elimination (ILEP) organization. Now MDT is supplied free of cost by WHO through as NOVARTIS (*Park, K., 2009, Pandya, 2009 and Five Year Plans*).

**National Filaria Control Programme, 1955**

Filaria is a seriously debilitating and incapacitating vector borne disease. It is transmitted by mosquitoes called culex unique fasciatus. It may cause severe deformity and disability. The Government of India launched ‘National Filaria Control
Programme’ (NFCP) in 1955 with the objectives of reduction of the problem in unsurveyed areas and control in urban areas through recurrent anti larval and antiphhrastic measures. In June 1978, the operational component of the NFCP was merged with the Urban Malaria Scheme for maximum utilization of available resources. However, the programme has been extended to rural areas since 1994. The National Health Policy (2002) one of the goals is to eliminate ‘lymphatic filariasis’ by 2015. The NFCP is being implemented through 206 filaria control units, 199 filaria clinics and 27 survey units in endemic urban towns and PHC in rural areas (Park, K., 2009 and Five Year Plans).

**National Tuberculosis Control Programme, 1962**

Tuberculosis is a wide chronic communicable bacterial disease. It is caused by Mycobacterium tuberculosis (Mt) which is commonly known as ‘Koch's bacillus’ or tubercle bacilli or Acid fast Bacillus (AFB). It has got high priority within the health sectors as it is a major public health problem. To control tuberculosis, National Tuberculosis Control Programme (NTCP) has been in operation in the country since 1962. The aim was to detect cases earliest and treat them. In the district, it is implemented through the District Tuberculosis Centre (DTC) and the primary health institutions. But this could not achieve the desired results.

Therefore, it was reviewed by an expert committee in 1992 and based on its recommendation, Revised National TB Control Programme (RNTCP), which is an application to India of WHO recommended a strategy of Directly Observed Treatment Short (DOTS) course, was launched in the country on March 26, 1997. The objective is to achieve and maintain cure rate of at least 85 per cent among newly detected infection TB cases and detection of at least 70 per cent of such cases in the
population. RNTCP was implemented in the country in a phased manner. It is being assisted by the World Bank, Department for International Development (DFID), Global Depositary Receipt (GDR), Global Fund And Tiered Medicines (GFATM), USAID and DANIDA. The Government of India provides 100 per cent grants-in-aid to the implementing agencies i.e. States/UTs, besides free drugs. The states are expected to use the existing infrastructure and also to provide some manpower resources. Phase II of the RNTCP is a step towards achieving the TB related Millennium Development Goal (MDG) targets (Park, K., 2009 and Five Year Plans).

National Goitre Control Programme, 1962

Iodine is an essential micronutrient with an average daily requirement of 100-150 microgram for normal human growth and development. There is an increasing evidence of distribution of environmental iodine deficiency in various parts of the country. The Government of India was implementing the National Iodine Deficiency Disorders Control Programme (NIDDCP) formally known as National Goitre Control Programme (NGCP) since 1962 with a focus on the provision of iodized salt, iodine deficiency disorders survey/ resurvey, laboratory monitoring of iodized salt and urinary iodine excretion, health education and publicity. The government has banned the sale of non-iodized salt in the entire country for direct human consumption under Prevention of Food Alteration Act, 1954 (Park, K., 2009 and Five Year Plans).

Minimum Needs Programme, 1974

The Minimum Needs Programme (MNP) was introduced in 1974. The objective of the programme is to provide certain basic minimum needs and thereby improve the living standard of the people. The programme is designed to assist in raising living standards and in reducing the regional disparities in development. The
programme is essentially an investment in human resources. The basic needs of the people identified for this programme are elementary education, adult education, rural health, rural roads, rural electrification, rural housing, environmental improvement of urban slums and nutrition. In the field of rural health under the MNP were: one PHCs for 30,000 population in plains and 20,000 population in tribal and hilly areas, one sub centre for a population of 5000 people in the plains and for 3000 in tribal and hilly areas and one community health centre (rural hospital) for a population of one lakh or one Community Development Block by the year 2000. In the field of nutrition, the objectives are (a) to extend nutrition support to 11 million eligible persons; (b) to expand “special nutrition programme” to all the Integrated Child Development Services (ICDS) projects and (c) to consolidate the midday meal programme and link it to the health, potable water and sanitation (Sixth Five Year Plan and Park, K., 2009).

National Cancer Control Programme, 1975-1976

The Cancer Control Programme was started in 1975-1976 as a central sector project. In was renamed as the National Cancer Control Programme (NCCP) in 1985 and revised in December 2004. The objective of the programme is the primary prevention of cancers by health education, early detection, strengthening of existing cancer treatment facilities and rehabilitation. Under the revised programme, five schemes are implemented. They are; recognition of new regional cancer centres (RCCs), strengthening of existing regional cancer centres, development of oncology wings in medical colleges, District Cancer Control Programme and decentralized NGO scheme (Jemal, Ahmedin, et al, 2008).
National Programme for Control of Blindness, 1976

The National Programme for Control of Blindness (NPCB) was launched in the year 1976, as a 100 per cent centrally sponsored programme and incorporates the earlier Trachoma Control Programme in 1968. Its main aim to reduce the prevalence of blindness from 1.4 to 0.3 per cent. The activities of NPCB includes the establishment of regional institutes of ophthalmology, upgradation of medical colleges and district hospitals, development of mobile eye units, recruitment of required ophthalmic manpower and ophthalmic services. Cataract surgery for poor people, detection and correction of refractive errors in children and treatment of corneal blindness by corneal transplantation from donated eyes. These services are freely available under it. The NPCB is decentralized and activities are coordinated by State/District Blindness Control Society (DBCS) throughout the country. It has been receiving assistance from DANIDA and supply of equipment, vehicles, improving the management information system, training and development of DBCS (Rathore, A. S., et al, 2008 and Park, K., 2009).

National Mental Health Programme, 1982

The National Mental Health Programme (NMHP) was launched in 1982 with a view to ensuring availability of Mental Health Care services for all. The aim of NMHP are (1) prevention and treatment of medical and neurological disorders and their associated disability; (2) Use of mental health technology to improve general health services; and (3) Application of mental health principles in total national development to improve the quality of life. The objective of the programme are: to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged section of
population, to encourage application of mental health knowledge in general health care and in the social development and to promote community participation in the mental health services development and to stimulate efforts towards self help in the community. The programme strategies are; integration of mental health with primary health care through the NMHP, provision of tertiary care institutions for treatment of mental disorders; and eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority and State Mental Health Authority (Narrow, et al., 1993 and Park, K., 2009).

**National Guinea-Worm Eradication Programme, 1984**

India is the first country in the world to establish the National Guinea Worm Eradication Programme (NGWEP) in 1984 with the objective of eradicating guinea worm disease from the country. The technical assistance provided by World Health Organization (WHO) and National Institute of Communicable Disease (NICD) has worked as the nodal agency. It is centrally sponsored scheme on 50:50 sharing between centre and states. The well defined strategies an efficient information and evaluation system, intersectoral coordination at all levels and close collaboration with WHO and UNICEF, will help to significantly reduce the diseases in affected areas. The country has reported zero cases in August 1996. In the meeting of WHO in February 2000, India has been certified for the elimination of Guinea Worm Disease and on February 15, 2001, declared India as ‘Guinea Worm Disease free’ (National Centre for Disease Control Report).

**Universal Immunisation Programme, 1985**

The Government of India launched Expanded Immunization Programme in 1978 with the objective of reducing the mortality and morbidity resulting from
vaccine preventable diseases of childhood and to achieve self sufficiency in the production of vaccines. In 1985, it was renamed as Universal Immunization Programme (UIP). The immunization services are provided through MCH centres, primary health centres and sub centres, hospitals, dispensaries and ICDS units. Latter, UIP was merged with Child Survival and Safe Motherhood Programme (CSSM) in 1992 and with Reproductive Child Health (RCH) in 1997 (Vashishtha, 2013 and Park, K., 2009).

**National Diabetes Control Programme, 1987**

Diabetes is a chronic disease caused by inherited and /or acquired deficiency in the production of insulin by the pancreas or in its effects. As a result, of this, there is increased concentration of glucose in the blood. In one form, the pancreas fails to produce the insulin that is essential for survival. However, noninsulin-dependent diabetes is much more common. This form of diabetes occurs principally in adults and results from the body’s inability to respond properly to the action of insulin. Malnutrition related diabetes has also been described from some developing countries like India. The Government of India started National Diabetes Control Programme (NDCP) on a pilot basis during Seventh Five Year Plan in 1987 in some districts of Tamil Nadu, Jammu and Kashmir and Karnataka. The main objectives are: (1) Prevention of diabetes through identification of high risk subjects and early intervention in the form of health education, (2) Early diagnosis of disease and appropriate treatment morbidity and mortality with reference to high risk group, (3) Prevention of acute and chronic metabolic, cardiovascular, renal and ocular complication of the disease, (4) Provision of equal opportunity for physical attainment and scholastic achievement for the diabetic patients and (5) Rehabilitation of those
partially or totally handicapped diabetes people (*Park, K., 2009, Pandya, 2009 and Five Year Plans*).

**National AIDS Control Programme, 1987**

The National AIDS Control Programme (NACP) was launched in India in the year 1987. The Ministry of Health and Family Welfare has set up National AIDS Control Organization (NACO) as a separate wing to implement and closely monitor the various component of the programme. The aim is to prevent further transmission of HIV infection and to minimize the socio-economic input resulting from HIV infection. India has now developed the third National Programme Implementation Plan (NACP-III, 2007-2012). Based on the lesson learnt and achievements made in Phase I and II. The primary goal of NACP-III is to halt and reserves the epidemic in India over the next five years by integrating programmes for prevention, care, support and treatment (*Park, K., 2009*).

**Child Survival and Safe Motherhood Programme, 1992**

The Child Survival and Safe Motherhood Programme (CSSM) jointly funded by World Bank and UNICEF were started in 1992-1993 for the implementation up to 1997-1998. The Child Survival and Safe Motherhood Programme were implemented in a phased manner covering all the districts of the country by the year 1996-1997. The objectives of the programmes were to improve the health status of infants, child and maternal morbidity and mortality. The programme seeks to sustain high coverage levels achieved under the Universal Immunisation Programme (UIP) in good performance areas and strengthen the immunisation services of poor performing areas. The programme also provides for augmenting various activities under the Oral Rehydration Therapy (ORT) programme, universalising prophylaxis schemes for
control of anaemia in pregnant women and control of blindness in children and initiating a programme for control of acute respiratory infection (ARI) in children. Under the safe motherhood component, training of traditional birth attendants (TBA), provision of aseptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies were taken up. The approved outlay for the CSSM programme was Rs. 1125.58 crore for the entire IDA credit facility of SDR period. The programme yielded notable success in improving the health status of pregnant women, infants and children and also making a dent in infant mortality rate (IMR), maternal mortality rate (MMR) and incidence of vaccine preventable diseases (Jain, S. K., et al, 2006 and Park, K., 2009).

Reproductive and Child Health Programme, 1996

The Reproductive and Child Health (RCH) programme was launched on October 15, 1997. The programme aimed at improving the health status of young women and young children which have been going on in the country namely family welfare programme, universal immunization programme, oral rehydration therapy, child survival and safe motherhood programme and acute respiratory infection control. The RCH has integrated with Child Survival and Safe Motherhood (CSSM) services and the major interventions are essential obstetric care, 24 hours delivery services at PHCs/CHCs, emergency obstetric care, medical terminations of pregnancy (MTP), prevention of reproductive tract infection (RTI) and sexually transmitted disease (STD), and District Survey. Reproductive and Child Health - Phase II launched on April 1, 2005. The focus of the programme is to reduce maternal and child mortality and morbidity with emphasis on rural healthcare. The major strategies of RCH-II are: (1) Essential Obstetric Care that is (a) institutional delivery; and (b)
skilled attendance at delivery, (2) Emergency Obstetric Care, that is, (a) Operationalising First Referral Units; (b) Operationalising PHCs and CHCs for round the clock delivery services and (3) Strengthening referral system.

Under RCH-II, more flexibility has been given to the states for planning their own interventions for achieving goals. There are some new initiatives taken under this phase. They are: training of MBBS doctors in life saving anaesthetic skill for emergency obstetric care, setting up of blood storage centres, Janani Suraksha Yojana (JSY), Vandemataram scheme and integrated management of neonatal and childhood illness. Now, the RCH-II is under the National Rural Health Mission (Reproductive and Child Health Project Rapid Household Survey, 1998-99 and Park, K., 2009).

Yaws Eradication Programme, 1996-1997

The Yaws Eradication Programme (YEP) was started in 1996-97 in Korapul district of Orrisa then extended to endemic states as a centrally sponsored health scheme. National Institute of Communicable Disease is the nodal agency for planning, guidance, coordination, monitoring and evaluation of the programme. It is implemented by the State Health Directorates of Yaws endemic states utilizing existing healthcare delivery system with the coordination and collaboration of the Department of Tribal Welfare and other related institution. The number of reported cases comes down from 3,500 to zero cases during the period from 1996 to 2004.

National Surveillance Programme for Communicable Disease, 1997

The surveillance is the backbone of any health delivery system because it provides essential data to monitor progress and help in optimizing the allocation of resources. Recognizing the importance of surveillance the Government of India has initiated the planning on ‘Integrated Disease Surveillance Project’ from 1998 with the
objectives of a decentralized state based system of surveillance for communicable and non communicable diseases and to improve the efficiency of the existing surveillance activities of disease control programmes (*Park, K., 2009, Pandya, 2009 and Five Year Plans*).

**National Programme for Control and Treatment of Occupational Disease, 1998 -’99**

Occupational health was one of the components of the National Health Policy 1983 and also included in National Health Policy 2002 but very little attention has been paid to mitigate the effect of occupational disease through the proper programme. Ministry of Health and Family Welfare, Government of India has launched a scheme entitled “National Programme for Control and Treatment of Occupational Diseases” (NPCTOD) in 1998-1999. The National Institute of Occupational Health, Ahmadabad (ICMR) has been identified as the nodal agency. Various research projects have been initiated- prevention, control and treatment of silicoses and silico tuberculosis in Agate Industry, occupational health problems of tobacco harvesters and their prevention, Hazardous process and chemicals database generation, documentation and information dissemination, capacity building to promote research, education and training at National Institute of Occupational Diseases, Health risk assessment and development of intervention programme in cottage industries with high risk of silicosis, preventions and control of occupation health hazards (*Park, K., 2009, Pandya, 2009 and Five Year Plans*).

**Kala-azar Control Programme, 1990-’91**

Kala-azar or Visceral Leishmaniasis (VL) is a chronic disease caused by an intracellular protozoan (Leishmania Species) and transmitted to man by the bite of female phlebotomus sandfly. It is not treated, as lead to death. In India, it has been
known to occur epidemically and endemically in well defined areas in the Eastern sector of the country. The massive insecticide spraying campaign for malaria eradication between 1958 and 1964, Kala-azar declined. But the new cases were seen. The increasing trends of the disease, the government initiated to control measures were planned and the budgetary provision for Kala-azar was the part of NMEP budget unit 1990-1991. An organized centrally sponsored control programme was launched in endemic areas in 1990-1991. The centre provides insecticide, anti-Kala-azar and technical guidance to the affected states. To achieve their goals, Government of India has decided to provide 100 per cent central support from the year 2003-2004. It was merged with NVBDCP in 2003-2004. In May 2005, a Tripartite Memorandum of Understanding has been signed by Health Ministers of India, Bangladesh and Nepal to reduce the annual incidence of Kala-azar to less than one per 1,00,000 populations at the sub-district level by 2015 and to improve the health status of vulnerable groups and at risk population living in Kala-azar endemic areas (Park, K., 2009, Pandya, 2009 and Five Year Plans).

**Dengue and Dengue Hemorrhagic Fever**

One of the important resurgent tropical infectious diseases is dengue caused by virus serotypes (DEN 1, 2, 3 and 4) and transmitted by the infected mosquitoes and Aedes aegypti. In India, dengue has been reported from both urban and rural areas. There is no separate budget for this. However, resources of Directorate of NAMP are utilized for investigation, prevention and control of dengue/ DHF outbreaks and training of paramedical and medical staff. An intensive IEC campaign is launched for preventing and containing all vectors borne disease including dengue (Park, K., 2009, and Five Year Plans).
Japanese Encephalitis Control Programme

Japanese Encephalitis (JE) is a zoonotic disease and caused by an arbovirus group-B (flavivirus) and transmitted by culex mosquitoes. In India, the recognition of J.E, based on serological surveys was first made in 1955. So far all States and UTs have reported JE cases. The Government of India provides need based assistance to the states including support for training programmes and social mobilization. Though Directorate of National Anti-Malaria Programme is monitoring JE situation in the country. There is no separate funds are allocated for JE control. The state should manage the situation / programme and may divert resources of NAMP in the case of outbreaks (Park, K., 2009).

National Rural Health Mission, 2005

The National Rural Health Mission (NRHM) was launched by the Prime Minister of India on April 12, 2005 in an effort to improve public healthcare to the rural population. It covers entire state in India with a special focus on 18 states including eight Empowered Action Groups States. Which have weak public health indicators and/or weak infrastructure. The 18 high focus states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Jharkhand, Jammu and Kashmir, Himachal Pradesh, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh and other remaining States and Union Territories (Andhra Pradesh, Goa, Haryana, Gujarat, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, West Bengal, Daman and Diu, Deidra and Nagar Haveli, Chandigarh, Delhi, Andaman and Nicobar Island, Pondicherry, Lakshadweep) were non-high focus states categories.
The goals of the mission are to improve the availability of and access to quality healthcare for people, especially for those residing in rural areas, the poor, women and children, thereby bridging urban and rural disparities. NRHM will also enable the mainstreaming of Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH) system of health. The mission will be an instrument to integrate multiple vertical programmes along with their funds at the district level. The programmes to be integrated are existing programmes of health and family welfare including RCH-II, National vector borne disease control programmes against malaria, filaria, Kala-azar, Dengue Fever/DHF and Japanese encephalitis, National Leprosy Eradication Programme, Revised National Tuberculosis Control Programme, National Programme for Control of Blindness, Iodine Deficiency Disorder Control Programme, And Integrated Disease Surveillance Project.

NRHM is designed to galvanize the various components of the primary health system, like preventive, promotive and curative care, human resource management, diagnostic services, logistics management, disease management and surveillance and data management system for improved service delivery.

This is envisioned to be achieved by putting in place an enabling institutional mechanism at various levels, community participation, decentralized planning, building capacities and linking health with its wider determinants. It also aims to expedite achievement of policy goals by facilitating enhanced access and utilization of quality health services, with an emphasis on addressing equity and gender dimension (See Appendices) (Park, K., 2009, Pandya, 2009 and NRHM document).
Janani Suraksha Yojana, 2005

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of promoting institutional delivery among the poor pregnant women. The JSY was launched on April 12, 2005, is being implemented in all States and UTs. JSY is a 100 per cent centrally sponsored scheme and it integrates JSY benefits with delivery and post delivery care. Besides the maternal care, the scheme provides cash assistance to all eligible mothers for delivery care. The JSY has identified, the Accredited Social Health Activist (ASHA) as an effective link between the government and the poor pregnant women. Her main role is to facilitate pregnant women to avail services of maternal care and arrange referral transport. The JSY subsidizes the cost of caesarean section or for the management of obstetric complications, up to Rs.1500 per delivery to the government institutions, where government specialists are not in position. All BPL pregnant women aged 19 years and above, preferring to deliver at home is entitled to cash assistance of Rs.500 per delivery up to two live births (Park, K., 2009 and NRHM document).

Janani Shish Suraksha Karakorum, 2011

The Government of India has launched Janani Shish Suraksha Karakorum (JSSK) on June 1, 2011. The scheme is estimated to benefit more than 12 million pregnant women who access government health facilities for their delivery. Moreover, it will motivate those who still choose to deliver at their homes to opt for institutional deliveries. It is an initiative with a hope that states would come forward and ensure that benefits under JSSK would reach every needy pregnant woman coming to
government institutional facility. All the States and UTs have initiated implementation of the scheme. The free entitlements for pregnant women’s are: (1) Free and cashless delivery; (2) free C-Section; (3) free drugs and consumables; (4) free diagnostics; (5) free diet during stay in the health institutions; (6) free provision of blood; (7) exemption from user charges; (8) free transport from home to health institutions; (9) free transport between facilities in case of referral; and (10) free drop back from institutions to home after 48 hours stay.

The free entitlements for sick newborns till 30 days after birth are: (1) free treatment; (2) free drugs and consumables; (3) free diagnostics; (4) free provision of blood; (5) exemption from user charges; (6) free transport from home to health institutions; (7) free transport between facilities in case of referral; and (8) free drop back from institutions to home (Janani Shish Suraksha Karakorum Guidelines Report, 2011).

**National Health Mission, 2013**

The National Health Mission (NHM) with its two Sub Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) was approved by the Cabinet in May, 2013. The framework for Implementation of National Health Mission was approved in December, 2013. The NHM envisages universal access to equitable, affordable & quality healthcare services that are accountable and responsive to people's needs. The main programmatic components include Health System Strengthening in rural and urban areas, Reproductive Maternal New born Child and Adolescent Health (RMNCH+A) and control of Communicable and Non-Communicable Diseases (Annual Report, 2013-14).
National Urban Health Mission, 2013

The National Urban Health Mission (NUHM) as a sub-division of National Health Mission (NHM) has been approved by the Cabinet on May 1, 2013. NUHM envisions to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing and Urban Poverty Alleviation, Human Resource Development and Women and Child Development (Annual Report, 2013-14).

Ashtray Kosher Swarthy Karakorum, 2014

The Ministry of Health and Family Welfare, Government of India has launched a health programme for adolescents, in the age group of 10-19 years, which would target their nutrition, reproductive health and substance abuse, among other issues. The Ashtray Kosher Swarthy Karakorum was launched on January 7, 2014. The key principle of this programme is adolescent participation and leadership, equity and inclusion, Gender equity and strategic partnerships with other sectors and stakeholders. The programme envisions enabling all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and well being and by accessing the services and support they need to do so. To guide the implementation of this programme, Ministry of Health and Family Welfare, Government of India in collaboration with UNFPA has developed a National Adolescent Health Strategy. It realigns the existing clinic based curative approach to
focus on a more holistic model based on a continuum of care for the adolescent health and developmental needs. The Ashtray Kosher Swarthy Karakorum (National Adolescent Health Programme) will comprehensively address the health needs of the 243 million adolescents. It introduced community based interventions through peer educators and is underpinned by collaborations with other ministries and state governments. The objectives are improving nutrition, improve sexually and reproductive health, enhance mental health, prevent injuries and violence and prevent substance misuse (NRHM Components Report).

India Newborn Action Plan, 2014

The India Newborn Action Plan (INAP) is India’s committed response to the Global Every Newborn Action Plan (ENAP), launched in June 2014 at the 67th World Health Assembly, to advance the Global Strategy for Women’s and Children’s Health. The ENAP sets forth a vision of the world that has eliminated preventable newborn deaths and stillbirths. INAP lays out a vision and a plan for India to end preventable newborn deaths, accelerate progress and scale up high impact yet cost effective interventions. INAP has a clear vision supported by goals, strategic intervention packages, priority actions and a monitoring framework. For the first time, INAP also articulates the Government of India’s specific attention to preventing stillbirths. INAP is guided by the principles of integration, equity, gender, quality of care, convergence, accountability and partnerships. It includes six pillars of intervention packages across various stages with specific actions to impact stillbirths and newborn health (NRHM Components Report).

Ashtray Bal Swarthy Karakorum

Ashtray Bal Swarthy Karakorum (RBSK) is a new initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 ‘D’s
viz. Defects at birth, Deficiencies, Diseases and Development delays including disability. The launch of this programme assumes great significance as it corresponds to the release of reproductive, maternal, newborn, child health and adolescent health strategy (RMNCH+A) and also with the Child Survival and Development – A Call to Action Summit held from February 7 - 9, 2013 in Mahabalipuram, Tamil Nadu (NRHM Components Report).

Anyhow, the government of India implemented various health programmes during the periods. Each and every programme or policy should be focusing on particular areas. The main aim of these programmes is improving the health status of the people. But, the NRHM is only the programme is specially focusing on rural health of the people. Many health programmes are merged under it. The NRHM will give more funds to (RCH, NRHM flexi pool, IPPI and NDCP) develop the health care and create infrastructure facilities.