CHAPTER - 5

PROMOTION AND PROTECTION OF RIGHT TO HEALTH THROUGH HEALTH PLANS

I. INTRODUCTION

The evolution and development of health policies and law in India centres during the endemic diseases and reprisal of remedial strategies.¹ Now the definition of health is not merely concentrated on the absence of disease but extend to the complete physical, mental and social well being.² It has until recently tended to focus on infective microorganisms, which were seen as the major source of human morbidity and mortality in India, as in most countries at the commencement of the epidemiological transition. Water and food-borne diseases in particular have been the target of a long sustained, widespread and still ongoing sanitary campaign.³ In the British India, general death rate was 22.4, infant mortality rate was 162 per thousand, expectation of the life at birth was 26.91 for males and 26.56 for females. Nearly half of the total number of death were among children under 10 years.⁴

Endemic diseases like leprosy, tuberculosis etc. caused considerable morbidity. There was a wide prevalence of unsanitary conditions in rural and urban areas. Provision for protected water supply and drainage was totally inadequate. Food consumed was both insufficient and ill balanced.⁵ But, today 'The Report on Health'⁶ examines the

¹ J. Bhore, Govt. of India, Report of the Health Survey and Development Committee, (1946).
³ Ibid., also see Sumit Guha, Health and Environmental Sanitation in Twentieth Century India, Monica Das Gupta, Health, Poverty and Development in India, (1996).
⁴ Ibid. Also sec. Report of the Public Health Commissioner, Govt. of India (1934).
⁶ Annual Report to the People on Health, Government of India, Ministry of Health and Family
progress made in the health sector, identifies the constraints in providing universal access and provides options and future strategies. In terms of life expectancy, child survival and maternal mortality, India's performance has improved steadily. Life expectancy is now 63.5, infant mortality rate is now 53 per 1000 live births, maternal mortality ratio is down to 254 per lakh live births and total fertility rate has declined to 216. However, there are wide divergences in the achievements across states. There are also in equities based on rural urban divides, gender imbalances and cast patterns.

II. NATIONAL FIVE YEAR PLANS

Since "health" is an important contributory factor in the utilization of manpower, the Planning Commission gave considerable importance to health programmes in the five year plans. For purpose of planning, the health sector has been divided into the following sub-sectors:  

(a) Water supply and sanitation  
(b) Control of Communicable diseases  
(c) Medical education, training and research  
(d) Medical care including hospitals, dispensaries and primary health centres  
(e) Public health services  
(f) Family planning; and  
(g) Indigenous system of medicine

All the above sub-sectors have received due consideration in the five year plans. However, the emphasis has changed from plan to plan depending upon the felt needs of the people and technical considerations. To give effect to a better coordination between the

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Centre and the State Governments, a Bureau of Planning was constituted in 1965 in the Ministry of Health, Government of India. The main function of this Bureau is compilation of National Health Five Year Plans. The Health Plan is implemented at various levels, e.g. Centre, State, District, Block and Village.8

The five year plans were conceived to rebuild rural India, to lay the foundations of industrial progress and to secure the balanced development of all parts of the country. Recognizing 'health' as an important contributory factor in the economic condition of the country, the Planning Commission gave considerable importance to health programmes in the five year plans.9 The broad objectives of the health programmes during the five year plans have been:

(a) control or eradication of major communicable diseases;
(b) strengthening of the basic services through the establishment of primary health centres and sub-centres;
(c) population control; and
(d) development of health manpower resources.10

Today, India has a vast network of governmental voluntary and private health infrastructure manned by large number of medical and paramedical persons. During the Tenth Plan, efforts were intensified to improve the health status of the population by optimizing coverage and quality of care by identifying and rectifying the critical gaps infrastructure, manpower, equipment, essential diagnostic reagents and drugs.11 The approach during the Tenth Plan was to improve

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access to, and enhance the quality of primary health care in urban and rural areas by providing an optimally functioning primary health care system as a part of Basic Minimum Services and to improve the efficiency of existing health care infrastructure at primary, secondary and tertiary care setting through appropriate institutional strengthening, and improvement of referral linkages. The monitorable targets for the Tenth Five Year Plan and beyond were as follows:

(a) Reduction of poverty ratio by 5 per cent points by 2007, and by 15 per cent points by 2012;
(b) All children in school by 2003; all children to complete 5 years of schooling by 2007;
(c) Reduction in gender gaps in literacy and wage rates by at least 50 per cent by 2007;
(d) Reduction in the decadal rate of population growth between 2001 and 2011 to 16.2 percent;
(e) Increase in literacy rate to 75 per cent within the plan period;
(f) Reduction of maternal mortality ratio to 2 per 1000 live births by 2007 and to 1 by 2012; and
(g) All villages to have sustained access to potable drinking water within the plan period.

These targets reflect the concern that economic growth alone may not lead to the attainment of long-term sustainability and of adequate improvement in social justice. Earlier plans have had many of these issues as objectives, but in no case specific targets were set. As a result, these were viewed in terms of being desirable but not essential. However, in the Tenth Plan, these targets are considered to be as central to the planning framework as the growth objective.
III. NATIONAL HEALTH PROGRAMMES

Technological improvements and increased access to health care have resulted in a steep fall in mortality, but the disease burden due to communicable diseases and non-communicable diseases, environment pollution and nutritional problems continue to be high inspite of the fact that norms for creation of infrastructure and manpower are similar throughout the country, there remains substantial variation between states and districts within the states, in availability and utilization of health care services and health indices of the population. During Tenth Plan there is continued commitment to provide essential primary care, emergency life saving services, services under national disease control programme free of cost to individuals, based on their needs, and not on their ability to pay.

Government has set targets in the Tenth Five Year Plan to control certain diseases like HIV/AIDS, tuberculosis, leprosy, malaria, and blindness etc. through various National Health Progammes. Among this various international agencies like WHO, UNICEF, UNFPA, World Bank as also a number of foreign agencies like SIDA, DANIDA, NORAD, and USAID have been providing technical and material assistance in the implementation of these programmes. A brief account of these programmes which are currently in operation is given below:

(i) Vector Borne Disease Control Programme

Directorate of National Anti Malaria Programme (NAMP) is the national nodal agency for prevention and control of major vector borne diseases of public health importance namely malaria, filaria, Japanese encephalitis, kala-azar and dengue/dengue haemohagic fever. Till 2002-2003, the centrally sponsored schemes viz. National Anti-Malaria
Programme, national filaria control programme and kala-azar control programme, had been operative in the country on the cost sharing basis between Centre and States. There was no specific centrally sponsored programme for J.E. and dengue/DHF, and the states were managing these diseases out of their own resources and with limited need based support and technical guidance from the Directorate of NAMP. However, in pursuance of the concept of convergence, the Government of India has approved a National Vector Borne Disease Control Programme (NVBDCP) from the year 2003-2004 by inclusion of Japanese Encephalitis (JE) and dengue/Dengue Hemorrhagic Fever (DHF) with other three ongoing programmes.\textsuperscript{12}

National Malaria Control Programme (NMCP) was launched in India in April 1953. It was based on indoor residual spraying with DDT (1 gm per sq. metre of surface area) twice a year in endemic area where spleen rates were over 10 percent. The National Malaria Control Programme (NMCP) was in operation for 5 years (1953-58). The results of the programme were highly successful in that the incidence of malaria had declined sharply from 75 million cases in 1953 to 2 million cases in 1958, an estimated 80 percent reduction of the malaria problem. It also paid rich dividends to the country in different fields like agriculture, lane projects and industry. Encouraged by these spectacular results Government of India in the Ministry of Health changed the strategy from malaria control to eradication, and launched the more ambitious National Malaria Eradication Programme (NMEP) in 1958.\textsuperscript{13} According to international standards, the programme was divided into preparatory, consolidation and maintenance phases. In the beginning, malaria eradication programme was highly successful. But very soon setbacks appeared in the form of focal outbreaks. The


annual incidence of malaria cases in India escalated from 50,000 in 1961 to a peak of 6.4 million cases in 1976.\textsuperscript{14}

(ii) National Filaria Control Programmes

The National Filaria Control Programme (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 blood. The strategy follows the World Health Organization (WHO)\textsuperscript{15} recommendation of annual single dose mass drug therapy with DEC/DEC with albendazole as a supplement of existing National Filaria Control Programme (NFCP) strategy 13-30 highly endemic districts to reduce transmission of filaria to a very significant low level. During 2003-04, central assistance of Rs. 19.5 crores was provided to the endemic States for supporting lymphatic filariasis elimination operations in the endemic districts.\textsuperscript{16}

(iii) Kala Azar Control Programme

Kala-Azar Control Programme was launched in 1990-1991. This has brought down the incidence and death rate of the disease by 75 percent by the year 2002.\textsuperscript{17}

The strategy for Kala-Azar Control includes three activities: interruption of transmission for reducing vector population by undertaking indoor residual insecticidal spray twice annually; early

\textsuperscript{14} K. Park Preventive and Social Medicine, 227, (2005).
\textsuperscript{15} WHO – World Health Organization, also see Swasth Hind National Health Programmes (1996), Vol.XI (8-9), pp.139.
diagnosis and complete treatment of Kala-Azar cases; and health education for community awareness.\(^{18}\)

In view of the success achieved so far, National Health Policy envisages Kala-azar elimination by the year 2010. The Tenth Five Year Plan targets are: Prevention of death due to Kala-azar by 2004 with annual reduction of at least 25 percent; zero level incidence by 2007 with at least 20 percent annual reduction using 2001 as the base year, and elimination of Kala-azar by year 2010. To achieve these goals, Government of India has decided to provide 100 percent central support from the year 2003-04.\(^{19}\) An estimated population of 130 million is exposed to the risk of Kala-Azar in the endemic areas. The annual incidence of disease has come down from 77099 cases in 1992 to 31217 cases in 2005 and deaths from 1419 to 157, respectively.

(iv) **Japanese Encephalitis Control Programme**

Japanese Encephalitis is a disease with high mortality rate and those who survive do so with various degrees of neurological complications. During the last few years it has become a major public heath problem. States of Andhra Pradesh, West Bengal, Assam, Tamil Nadu, Karnataka, Bihar, Haryana, Kerala and Uttar Pradesh are reporting maximum number of cases.\(^{20}\)

The strategies for control of Japanese include: (a) care of the patient; (b) development of a safe and standard indigenous vaccine; (c) sentinel surveillance including clinical surveillance of suspected cases; (d) studies to identify the high risk groups by measuring the blood level

\(^{18}\) Ibid.
\(^{19}\) Ibid.
of antibodies; and (e) epidemiological monitoring of the disease for effective implementation of preventive and control measures.21

Technical support is provided, on request by the State health authorities for the outbreak investigations and control. Insecticides used under the National Anti-Malaria Programme are used for the control of Japanese Encephalitis (JE) outbreaks where required.22

(v) Dengue Fever Control Programme

During 1996, an outbreak of dengue was reported in Delhi. Since then dengue has been reported from other states also. In view of this major outbreak of the disease a “Guideline of Preparation of Contingency Plan in case of outbreak/epidemic of Dengue/Dengue Hemorrhagic fever” was prepared and sent to all the states. It includes all the important aspects of control measures like identification of outbreak, delineation of affected area, containment of outbreak, case management vector control, Information-Education-Communication (IEC)23 activities about Do’s and Don’ts for prevention of dengue, monitoring and reporting etc. Technical assistance for investigation, prevention and control of Dengue/Dengue Hemorrhage Fever (DHF) outbreak is provided to the State through Directorate of National Anti Malaria Programme.24

22 Park, op. cit., at 332. Also see NICD (1997), Investigation & Control of Outbreak, Japanese Encephalitis.
23 IEC-Information Education Communication.
National Leprosy "Eradication Programme"

The National Leprosy Control Programme (NLCP) has been in operation since 1955 as a centrally aided programme to achieve control of leprosy through early detection of cases.\(^\text{25}\)

The (NLCP) National Leprosy Control Programme moved ahead initially a slow pace, presumably for want of clear-cut policies on operational objectives for nearly two decades.\(^\text{26}\)

The availability of Dapsone monotherapy for Leprosy laid the foundation of National Leprosy Control Programme in 1955 with the main objective of controlling leprosy through domiciliary treatment with Dapsone. Social obstacles, non-availability of drugs, lack of primary prevention (vaccination) and lepral resistance to Dapsone caused programme failure. In 1981, Government of India asked the Indian scientists to develop a leprosy eradication strategy and subsequently launched the National Leprosy Eradication Programme (NLEP) in the year 1983 with health problem by the year 2000 A.D.\(^\text{27}\) Later World Health Organization (WHO) in 1991 adopted a reduction calling for elimination of leprosy as a public health problem by the year 2000 A.D. (reducing prevalence to less than one case per 10,000 population).\(^\text{28}\)

The goal of leprosy elimination at national level (<1 case/10000 population) as set by National Health Policy (2002) was achieved in the month of December 2005. Even though the disease came down to a level of elimination, still it is prevalent with moderate endemicity in


about 20 percent of the district. During 2005-06 a total of 1.61 lakh new leprosy cases were detected.

(vii) National Tuberculosis Programme

National Tuberculosis Programme (NTP) has been in operation since 1962. India accounts for nearly one third of global burden of tuberculosis. Every year, approximately 1.8 million persons develop tuberculosis of which about 0.8 million are new smear positive highly infectious cases and about 4.17 lakh people die of Tuberculosis (TB) every year, one person die every minute, and about 1006 people die every day.29

Since 1993, India has successfully implemented Revised National Tuberculosis Control Programme (RNTCP) using directly observed treatments (DOTS) strategy. As of March 2004, this programme covered about 76 per cent of Country’s population (more than 851 million persons) in 466 districts and belongs to category 3 of Directly observed Treatment (DOT) strategy. Tuberculosis remains a public health problem, with India according for one-fifth of the world incidence. Every year 1.8 million people in India develop tuberculosis, of which 0.8 million are infectious smear positive cases the emergence of (HIV-TB).

Co infection and multi drug resistant tuberculosis has increased the severity and magnitude of the problem. RNTCP has achieved nation wide coverage in March 2006. Since the inception of the programme, over 6.3 million patients have been initiated on treatment and the programme has achieved all the proposed goals in terms of

expansion of directly observed treatment, short course (DOTS) services, case finding, and treatment success during the Tenth Plan.

Table 2
The Tuberculosis Estimates for India (2002)

<table>
<thead>
<tr>
<th>Population</th>
<th>049 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Rank (by estimated number of cases)</td>
<td>1</td>
</tr>
<tr>
<td>Incidence (all cases/100000 population)</td>
<td>168</td>
</tr>
<tr>
<td>Incidence (New Smear +ve cases/100000 population)</td>
<td>75</td>
</tr>
<tr>
<td>Prevalence (Smear +ve/100000 population)</td>
<td>156</td>
</tr>
<tr>
<td>TB Mortality per 100000 population</td>
<td>37</td>
</tr>
<tr>
<td>Percentage of adults (15-49 years) TB Cases HIV Positive</td>
<td>4.6</td>
</tr>
<tr>
<td>Percentage of New cases multi-drug resistant</td>
<td>3.4</td>
</tr>
</tbody>
</table>


The 4.4 per cent death rate in Revised National Tuberculosis Programme (RNTCP) area is substantially lower than the 29 percent mortality document among treated smear positive tuberculosis patients in non-RNTCP areas.30

(viii) National AIDS Control Programme

The first (AIDS) case in India was recorded in May 1986. Since then, many hundred of cases of AIDS have been reported from every State of the country.31 Realizing the gravity of epidemiological situation of (AIDS) prevailing in the country, the Government of India has

30 Ibid.
launched a comprehensive plan of action the National (AIDS) Control Programme since 1987.\textsuperscript{32} The programme is assisted financially by the World Bank and the World Health Organization in eighth five year plan. The World Bank loan became effective from 1992 onward.\textsuperscript{33}

The Government of India launched a 5 year HIV/AIDS Control Project from September 1992 to September 1997 as 100 per cent centrally sponsored project for all States/Union territories. The project was later on extended time to time with new plans.\textsuperscript{34} According to statistics released on 6 July, 2007, by National AIDS Control Organization (NACO) supported by UN AIDS and WHO, indicated that national adult HIV prevalence in India is 0.36 per cent, which corresponds to an estimated 2 million to 3.1 million people living with HIV/AIDS in India. The overall HIV/AIDS budget for NACO for the year 2005-2006 was US$ 103 million and for the year 2006-2007, it was US $ 138 million. To ensure sustainability, NACO is instrumental in promoting HIV/AIDS prevention and care activities into the ongoing governmental programmes of the government.

(ix) National Programme for Control of Blindness

The National Programme for control of blindness was launched in the year 1976 as a 100 percent centrally sponsored programme and incorporates the earlier trachoma control programme started in the year 1968. The National Survey on Blindness (2001-2003) shows an estimated 1.1 per cent prevalence of blindness in general population with 62.6 per cent share, cataract continues to be the main cause of blindness. Uncorrected refractive errors were responsible for 19.7 per

\textsuperscript{33} J. Kishore, \textit{op. cit.}, p.12.
cent, glaucoma 5.8 per cent, posterior segment pathology for 4.7 per cent, corneal opacity for 0.9 per cent of blindness. Other causes were responsible for 6.2 per cent of blindness.\(^{35}\)

The findings of the survey conducted during 2001-2002, in randomly selected districts of the States covered by World Bank Project shows that dependence on eye campus has now reduced, except in remote and tribal areas; involvement of Primary Health Centres/Community Health Centre's doctor in the programme has increased; higher percentage of cataract operated persons consult the doctor at an early stage; there is increase in demand for modern techniques like intra ocular lenses and suture-less surgeries; and about 84 per cent of cataract operated persons receive free spectacles from the health facilities.\(^{36}\)

It is global initiative to reduce avoidable (Preventable and Curable) blindness by the year 2020. India is also committed to this initiative. The plan of action for the country has been developed with following main features:

(a) Target diseases are cataract, refractive errors, childhood blindness, corneal blindness, glaucoma, diabetic retinopathy.

(b) Human resource development as well as infrastructure and technology development at various levels of health system. The proposed four tier structure includes Centres of Excellence Training Centres (200), Service Centres (2000), and Vision Centres (20,000).

\(^{35}\) Government of India, National Programme for Control of Blindness Course Material for Training in District Programme Management (Revised 1996). Ophthalmic Section, Ministry of Health and Family Welfare, Nirman Bhavan, New Delhi.

Fig. 1: Shows the proposed structure for primary, secondary and tertiary eye care.

(x) Iodine Deficiency Disorders (IDD) Programme

India commenced a goitre control programme in 1962, based on iodized salt. At the end of three decades, the prevalence of the disease
still remains high. It became clear that the failure was mostly due to operational and logistic difficulties. It is estimated that nearly 167 million persons are exposed to the risk of Iodine Deficiency Disorder (IDD), of which 71 million are having goitre, cretins and mild neurological disorders. As a result, a major national programme – the Iodine Deficiency Disorders (IDD) Control Programme has been initiated in which nationwide, 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 Eighth Plan. The essential components of a National Iodine Deficiency Disorders (IDD) Programme are use of iodized salt in place of common salt, monitoring and surveillance, manpower training and mass communication. The aim of the national programme was to bring down the incidence of Iodine Deficiency Disorders (IDD) to below 10 per cent by the year 2012.

(xi) Universal Immunization Programme

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

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41 Park, op.cit., p.342.
EPI 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.\textsuperscript{43}

Significant achievements have been made in India under this programme. At the beginning of the programme in 1985-86, Vaccine coverage ranged between 29 per cent for BGC and 41 per cent for DPT. By the end of 2002, coverage levels had gone up significantly to about 82.9 per cent for Tetanus Toxoid for pregnant women, about 81 per cent for BGC, 70 per cent for DPT and 70 per cent for OPV. Since then, there is a significant decline in the reported incidence of the vaccine preventable diseases as compared to their incidence in 1987, as shown in Table 3.

**Table 3**

**Percentage Decline in Vaccine Preventable Diseases from year 1987 to 2001**

<table>
<thead>
<tr>
<th>Disease</th>
<th>1987</th>
<th>2001</th>
<th>%age Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poliomyelitis</td>
<td>28257</td>
<td>286</td>
<td>99.05</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>12952</td>
<td>4954</td>
<td>61.75</td>
</tr>
<tr>
<td>Pertussis</td>
<td>163786</td>
<td>28900</td>
<td>82.36</td>
</tr>
<tr>
<td>NNT</td>
<td>11849</td>
<td>1354</td>
<td>95.75</td>
</tr>
<tr>
<td>Measles</td>
<td>247519</td>
<td>45301</td>
<td>81.70</td>
</tr>
</tbody>
</table>


Pulse Polio Immunization Programme was launched in the country in the year 1995. Under this programme children under five years of age given additional oral polio drops in December and January every year on fixed days. Since then there is a significant decline in the incidence of poliomyelitis following the success of the polio eradication


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programme, the next likely diseases for elimination are measles and neonatal tetanus.\textsuperscript{44} India has the target number of Infants who reach their first birthday not fully immunized the (UIP) Universal Immunization Programme has also developed a multi year plan for 2005 to 2010 to reduce infant mortality rate to below 30 per 1000 live births and secondly to achieve universal immunization of children against all vaccine preventable diseases.

**(xii) National Guinea – Worm Eradication Programme**

India launched its National Guinea – worm eradication programme in 1984. From the very beginning the programme was integrated into the national health system at village level. With well defined strategies, an efficient information and evaluation system, intersectional coordination at all levels and close collaboration with World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), India was able to significantly reduce the disease in affected areas. The country has reported zero cases since August 1996. In February, 2000, the International Commission for the certification of Dracunculiasis Eradication recommended that India be certified free of dracunculiasis transmission.\textsuperscript{45} globally the Guinea Worm Eradication Program has attracted much less political support than polio eradication. The lack of comparable urgency to publicize and complete this campaign is regrettable.

As 40,000 Guiniawarm cases were occurring annually in 12840 endemic villages across 89 districts of the then endemic states, viz. Andhra Pradesh, Gujarat, Karnataka, Madhya Pradesh, Maharashtra and Rajasthan. The State of Tamil Nadu remained free

\textsuperscript{45} WHO, Weekly Epidemiological Record, No. 22 & 2nd June, 2000.
from Guniawarm (GW) since 1982. The last case was reported in July 1996 in Jodhpur in Rajasthan. The country was certified by “International Commission for Certification of Disease Eradication (ICCDE) World Health Organization as disease free on February 15, 2000. Routine Surveillance and IEC in all former endemic states was recommended to be continued till global eradication of disease is achieved, is being carried out.46

(xiii) National Cancer Control Programme

In India, it is estimated that there are about 2 million cancer cases at any given point of time with about 0.7 million new cases coming every year. The Government of India started the National Cancer Control Programme in a limited form during the year 1975-76 when central assistance of Rs.2.5 lakh was provided to institutions for purchase of Cobalt Therapy units for treatment of cancer patients. This scheme continued during the sixth and seventh plan period. During the Eighth Five Year Plan emphasis was on prevention, early detection of cancer and augmentation of treatment facilities in the country.47 Cancer has become an important public health problem in India with an estimated 7 to 9 lakh cases occurring every year. At any time of point, it is estimated hat there are nearly 25 lakh case in the country. The strategy under the National Cancer Control Programme (NCCP) was revised in 1984-85 and further in 2004 with stress on primary prevention and early detection of cancer cases. In India tobacco related cancers account for about for half the total cancers among men and 20 percent among women. About one million tobacco related deaths occur each year, making tobacco related health issues major public health concern.

46 http://www.nicd.nic.in (accessed on 12 Oct., 2010).
(xiv) National Mental Health Programme

The National Mental Health Programme was launched during seventh Five Year Plan with a view to ensure availability of Mental Health Care services for all, especially the community at risk and underprivileged section of the population, to encourage application of mental health knowledge in general health care and social development. A National Advisory Group of mental health was constituted under the chairmanship of the secretary, Ministry of Health and Family Welfare for the effective implementation of the National Health Programme. 48

(xv) National Programme for Prevention and Control of Diabities, CVDs and Stroke

The National Diabetes Control Programme was started on a pilot basis during Seventh Five Year Plan in some districts of Tamil Nadu, Karnataka and Jammu and Kashmir, but due to paucity of funds subsequent years this programme could not be expanded further. The main objectives of the programme are (i) identification of high risk subject at an early stage and imparting appropriate health education (ii) early diagnosis and management of cases (iii) Prevention, arrest or slowing of acute metabolic as well as Chronic Cardiovascular – renal complications of the diseases. 49

Common risk factors for both CVD and diabetes are unhealthy diet, physical inactivity and obesity. There is evidence-based information that NCDs (Non-Communicable Diseases) are preventable through integrated and comprehensive interventions. Cost-effective interventions exist and have worked in many countries. The most

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48 Park, op.cit., p.347.
49 Ibid.
successful one have employed a range of population wide approaches combined with interventions for the individuals. Thus, the programme will aim to prevent and control common national communicable diseases (NCDs) risk factors through an integrated approach and to reduce premature morbidity and mortality from diabetes, CVD, and stroke. Up scaling based on pilot results will be done during the Eleventh Five Year Plan.

(xvi) Controlling the H1N1 Pandemic

In recent times, Influenza a H1N1 virus created a scare by affecting birds/poultry in more than 60 countries including India. The speed and virulence with which the novel H1N1 virus spread in 2009 in over 200 countries, including India took the public health system by surprise and created a public health crisis. Containment of epidemics and rapid response to disease out breaks through a nation wide networking of public health resources including public health laboratories is one of the major problems today. In an important policy shift during 2008-09, the Government of India decided to provide the services of epidemiologists in all district headquarters and state headquarters and entomologists and microbiologists and 23 entomologists have joined. However, integrated disease surveillance is still faced with inadequately trained professionals, ill-equipped public health labs and inadequate capacity for rapid response to disease outbreaks in many states. The ongoing initiative of upgrading the National Institute of Communicable Diseases into National Centre of Disease Control with responsibility of enhanced capabilities for lab based surveillance of communicable diseases and rapid response for minimizing the effects of disease outbreaks is a major development in this field.50

National Water Supply and Sanitation Programme

The National Water Supply and Sanitation Programme was initiated in 1954 with the object of providing safe water supply and adequate drainage facilities for the entire urban and rural population of the country.

The Government of India launched the International Drinking Water Supply and Sanitation Decade Programme in 1981. Targets were set on rural, 80 per cent for urban sanitation and 25 per cent for rural sanitation.

The latest assessment indicates that population and 16 per cent population has access to adequate sanitation facilities (out of which 2 per cent are in rural areas). Water supply and sanitation in India continued to be inadequate, despite longstanding efforts by the various level of Government and countries at improving coverage. The level of investment in water and sanitation, albeit low by international standards, has increased during the 2000's. Access has also increased significantly. For example, in 1980 rural sanitation coverage was estimated at 1 percent and reached 21 percent in 2008. Also, the share of Indians with access to improved sources of water has increased significantly from 72 per cent in 1980 to 88 per cent in 2008. At the same time, local government institution in charge of operating and maintaining the infrastructure are seen as week and lack the financial resources to carry out their functions. In addition no major city in India is known to have continues water supply and an estimated 72 per cent of Indians still lack access to improve sanitation facilities.

The number of innovative approaches to improve water supply and sanitation have been tested in India, in particular in the year
2000's. These include demand-driven approaches in rural water supply since 1999, community and lack total sanitation, a public-private partnerships to improve the continuity of urban water supply in Karnataka and the use of micro-credit to women in order to improve access to an improved water source, but only 31 percent had accessed to improve sanitation.\(^51\)

(xviii) National Family Welfare Programme

One of the important indices of population concentration is the density of population. In the Indian census, density is defined as the number of persons, living per square kilometer. The trends of the density in the country from 1901 onwards are as shown in Table 4.

<table>
<thead>
<tr>
<th>Year</th>
<th>Per Sq. Km</th>
</tr>
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<tbody>
<tr>
<td>1901</td>
<td>77</td>
</tr>
<tr>
<td>1911</td>
<td>82</td>
</tr>
<tr>
<td>1921</td>
<td>81</td>
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<td>216</td>
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</tbody>
</table>


While in common parlance, family size refers to the total number of persons in a family, in demography, family size means the total number of children a woman has borne at a point in the time.\(^52\) The

completed family size indicates the total number of children borne by a woman during her child bearing age, which is generally assumed to be between 15 and 45 years. The total fertility rate gives the appropriate magnitude of completed family size.\(^{53}\)

The question of family size is important from the demographic point of view. The family planning programme’s campaign is currently based on the theme of a “two child” family norm, with a view to reach the long-term demographic goal of (NRR = 1). Family planning involves both decision regarding the “desired family size” and the effective limitation of fertility once that size has been reached. Table 5 shows the total fertility rates (completed family size) in India and selected countries. The decrease in family size does not appear to be due to any reduction in fertility; rather it appears to be due to the result of deliberate family planning.

Table 5

Total Fertility Rates in Selected Developed and Developing Countries 1990 and 2002

<table>
<thead>
<tr>
<th>Country</th>
<th>1990</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>3.9</td>
<td>3.1</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>4.6</td>
<td>3.5</td>
</tr>
<tr>
<td>Nepal</td>
<td>5.2</td>
<td>4.3</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Myanmar</td>
<td>4.0</td>
<td>2.9</td>
</tr>
<tr>
<td>China</td>
<td>2.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Pakistan</td>
<td>6.0</td>
<td>5.1</td>
</tr>
<tr>
<td>UK</td>
<td>1.8</td>
<td>1.6</td>
</tr>
<tr>
<td>USA</td>
<td>2.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Japan</td>
<td>1.6</td>
<td>1.3</td>
</tr>
<tr>
<td>Switzerland</td>
<td>1.5</td>
<td>1.4</td>
</tr>
</tbody>
</table>


\(^{53}\) Ibid.
India launched a nation-wide family planning programme in 1952. During the Third Five Year Plan (1961-66) family planning was declared as "the very centre of planned development". During the Fourth Five Year Plan (1969-74) the Government of India gave "top priority" to the programme. During the fifth five year plan (1975-80) there have been major changes. In April 1976, the country framed its first "National Population Policy".

Although the performance of the programme was low during 1977-78, it was a good year in as much as the programme moved into new healthier direction. The 42nd Amendment of the Constitution has made "population control and family planning" a concurrent subject, and this provision has been made effective from January 1977. The sixth and seventh five year plans were set to achieve these goals. During 1992 these programmes were integrated under Child Survival and Safe Motherhood (CSSM) Programme.54

The Government of India have evolved a more detailed and comprehensive National Population Policy 2000 to promote family welfare.55

The investment on family welfare programme during successive plan-periods is tabulated below. It can be seen that from a modest sum of 0.65 crores during the First Plan, the investment has reached a colossal amount of Rs. 27125 crores during the tenth plan period.

## Table 6

### Expenditure under the Programme from the First to Tenth Five Year Plan

(Rs. in Crore)

<table>
<thead>
<tr>
<th>Period</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Plan (1951-56)</td>
<td>0.65</td>
</tr>
<tr>
<td>Second Plan (1956-61)</td>
<td>5.00</td>
</tr>
<tr>
<td>Third Plan (1961-66)</td>
<td>27.00</td>
</tr>
<tr>
<td>Annual Plan (Inter Plan 1966-69)</td>
<td>82.90</td>
</tr>
<tr>
<td>Fourth Plan (1969-74)</td>
<td>285.8</td>
</tr>
<tr>
<td>Fifth Plan (1974-79)</td>
<td>285.6</td>
</tr>
<tr>
<td>Annual Plan (1978-79)</td>
<td>101.8</td>
</tr>
<tr>
<td>Annual Plan (1979-80)</td>
<td>116.2</td>
</tr>
<tr>
<td>Sixth Plan (1980-85)</td>
<td>1309.00</td>
</tr>
<tr>
<td>Seventh Plan (1985-90)</td>
<td>2868.00</td>
</tr>
<tr>
<td>Annual Plan (1990-91)</td>
<td>675.00</td>
</tr>
<tr>
<td>Annual Plan (1991-92)</td>
<td>749.00</td>
</tr>
<tr>
<td>Eighth Plan (1992-97)</td>
<td>6195.00</td>
</tr>
<tr>
<td>Ninth Plan (1997-2002)</td>
<td>14170.00</td>
</tr>
<tr>
<td>Tenth Plan (2002-2007)</td>
<td>27125.00</td>
</tr>
</tbody>
</table>


The Family Welfare Programme in India has come a long way and holds forth the promise that in the not very distant future it may be accepted as a way of life by most people. Although birth control continues to occupy the same important position in the programme as it used to be in the earlier days the programme now aims at achieving a higher end- and that is, to improve, in conjunction with other development programmes, the quality of life of the people.  

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(xix) Minimum Needs Programme

The Minimum Needs Programme (MNP) was introduced in the First Year of the Fifth Five Year Plan (1974-78). The objective of the programme is to provide certain basic minimum needs and thereby improve the living standards of the people. It is the expression and economic development of the government of the "social and economic development of the community particularly the underprivileged and under served population." 57

(xx) 20 Points Programme

In addition to the Five Year Plans and Programmes, in 1975, the Government of India initiated a special activity. This was the 20-point programme – described as an agenda for national action to promote social justice and economic growth.

On August 20, 1986, the existing 20-point programme was restructured. Its objectives are spelt out by the Government as "eradication of poverty, raising productivity, reducing inequalities, removing social and economic disparities and improving quality of life." At least 8 of the 20 points are related, directly or indirectly, to health. These are: 58

<table>
<thead>
<tr>
<th>Point</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point 1</td>
<td>Attack on rural poverty</td>
</tr>
<tr>
<td>Point 7</td>
<td>Clean drinking water</td>
</tr>
<tr>
<td>Point 8</td>
<td>Health for all</td>
</tr>
<tr>
<td>Point 9</td>
<td>Two child norm</td>
</tr>
<tr>
<td>Point 10</td>
<td>Expansion of education</td>
</tr>
</tbody>
</table>

57 Ibid
The restructured 20 point programme constitutes the charter of the country’s socio-economic development. The vision, goals and objectives as well as broad strategies as articulated in the XIth Five Year Plan for the years 2007-12 and the Framework of Implementation of its flagship programme the National Rural Health Mission currently provide the guiding principles for the health sector. These are as briefly summarized below.\(^5^9\)

- Health as a right for all citizens is the goal that the plan will strive towards.
- A comprehensive approach that encompasses individual health care, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene, and feeding practices.
- To transform public health care into an accountable, accessible, and affordable system of quality services.
- Convergence and development of public health systems and services that are responsive to the health needs and aspirations of the people.
- Public provisioning of quality health care to enable access to affordable and reliable health services, especially in the context of preventing the non-poor from entering into poverty or in terms of reducing the suffering of those who are already below the poverty line.
- Reducing disparities in health across regions and communities by ensuring access to affordable health care.

• Good governance, transparency, and accountability in the delivery of health services that is ensured through involvement of Panchayati Raj Institutions (PRI)s, community, and civil society groups.

• To raise public spending on health from 0.9 per cent of GDP to 2-3 per cent of GDP, with improved arrangement for community financing and risk pooling.

• To undertake architectural correction of health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.

• Reduction in child and maternal mortality.

• Universal access to public services for food and nutrition, sanitation and hygiene.

• Universal access to public health care services, integrated comprehensive primary health care, with emphasis on services addressing women’s and children’s health and universal immunization.

• Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.

• Population stabilization, gender and demographic balance.

• Revitalize local health traditions and mainstream AYUSH.

• Promotion of healthy lifestyles.

The time bound objectives set out for the XIth Eleventh Five Year Plan for achievement by the year 2012 are:

• Reducing Maternal Mortality Ratio (MMR) to 1 per 1,000 live births.

• Reducing Infant Mortality Rate (IMR) to 28 per 1,000 live births.

• Reducing Total Fertility Rate (TFR) to 2.1.
• Providing clean drinking water for all by 2009 and ensuring no slip-backs.
• Reducing malnutrition among children in the age group 0-3 year to half its present level.
• Reducing anaemia among women and girls by 50 percent.
• Raising the sex ratio in the age group 0-6 years to 935 by 2011-12, and to 950 by 2016-17.
• Malaria Mortality Reduction Rate : 50 per cent up to 2010, additional 10 per cent by 2012.
• Kala Azar Mortality Reduction Rate : 100 per cent by 2010 and sustaining elimination until 2012.
• Filaria/Microfilaria Reduction Rate : 70 per cent by 2010, 80 per cent by 2012 and elimination by 2015.
• Dengue Mortality Reduction Rate : 50 per cent by 2010 and sustaining at the level until 2012.
• Contract operations : Increase to 46 lakhs by 2012.
• Leprosy Prevalence Rate : Reduce from 1.8 per 10,000 in 2005 to less than 1 per 10,000 thereafter.
• Tuberculosis DOTS series : Maintain 85 per cent cure rate through entire mission period and also sustain planned case detection rate.

In terms of systems improvements the NRHM targets were:

• Upgrade all PHCs into 24x7 PHCs by the year 2010.
• Upgrading all Community Health Centres to Indian Public Health Standards.
• Increase Utilization of first referral units from bed occupancy by referred cases of less than 20 per cent to over 75 per cent.
• Engaging 4,00,000 female Accredited Social Health Activities (ASHAs).
IV. NATIONAL HEALTH POLICIES

The evolution and development of health policies culminated into a comprehensive National Health Policy in 1983. The policy laced with ancient and modern heritage of health care and constitutional objective of health and well being of the citizens of the country. The policy admitted that the existing situation has come about because of the almost wholesale adoption of public health policies and establishment of curative centres based on the western models which are really not suitable for our conditions. The present system is largely curative, benefiting the upper crust of society especially those residing in the urban areas. The preventive promotive and rehabilitative aspects of health care have been neglected.\(^{60}\) The community has not been involved in the identification of their health needs and priorities as well as in the implementation and management of the various health related programmes. The policy targeted 'Health for All' by 2000 A.D. through the universal provision of comprehensive primary health care services. The policy stated small family norms voluntary for population stabilization and thrashing of a National population policy, and National Medical and Health Education Policy.\(^{61}\) For restructuring the health services the policy health services for provision of a well dispersed network of comprehensive primary health care services, integrally linked with the extension and health education approach.\(^{62}\) The major focus of attention would be on comprehensive primary health care, attention would also have to be given to establishment of centres to provide services. To reduce governmental expenditure, efforts should be made to encourage private investments in such fields to that the majority of such centres within the government setup can provide

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\(^{61}\) *ld* at p.235.

\(^{62}\) *ld* at pp.235-236.
treatment to those entitled to free care, the affluent sector being looked after by the paying clinics.  

The policy feels that the country has a large number of private practitioners in various systems like Ayurveda, Unani, Sidha, Homeopathy, Yoga, Naturopathy etc. and regards that these resources have not so far been adequately utilized. It calls upon the necessity to initiate organized measures to enable each of these various systems of medicine and health care to develop and integrate their services in the overall health care delivery system by a meaningful phased integration of the indigenous and the modern systems. The policy identified nutrition prevention of food adulteration, maintenance of the quality of drugs; water supply and sanitation; environmental protection; immunization programme; maternal and child health services; school health programme; and occupational health services as special areas of attention. The policy stress health education, child family education information system management and health insurance scheme. The National Health Policy is progressive and comprehensive document. For implementation of the goals set out in the policy, the need for urgent action and implementation deserves serious attention. The progress of National Health Policy leaves a lot to be desired and National Medical and Health Education Policy as well as the National Population Policy are to formulation in the high of pollution policy.

Since then there has been significant changes in the determinant factors relating to the health sector, necessitating revision of the policy, and a new National Health Policy, 2002 was evolved. The main

\[\text{\textsuperscript{63}} \text{ Ibid.}\]
\[\text{\textsuperscript{64}} \text{ Id. at pp.236-237.}\]
\[\text{\textsuperscript{65}} \text{ Id. at p.237-238.}\]
\[\text{\textsuperscript{66}} \text{ Ibid.}\]
\[\text{\textsuperscript{67}} \text{ Id. at 267-268.}\]
The objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to decentralized public health system by establishing new infrastructure in the existing institutions over riding importance would be given to ensure a more equitable access to health services across the social and geographical expense of the country. Primacy will be given to preventive and first line curative initiatives at the primary health level.\textsuperscript{68}

The policy is focused on those diseases which are principally contributing to disease burden such as tuberculosis, malaria, blindness and HIV/AIDS.\textsuperscript{69} Emphasis will be laid on rational use of drugs within the allopathic system. To translate the above objectives into reality, the health policy has laid down specific goals to be achieved by year 2005, 2007, 2010 and 2015.\textsuperscript{70} These are as given in Table-7. Steps are already under way to implement the policy.

| Table 7 |
| National Health Policy – 2002 |
| Goals to be Achieved by 2015 |
| Eradicate Polio and Yaws | 2005 |
| Eliminate Leprosy | 2005 |
| Eliminate Lymphatic Filariasis | 2010 |
| Achieve Zero Level Growth of HIV/AIDS | 2015 |
| Reduce Mortality by 50% on account of TB, Malaria and other vector and water borne diseases | 2007 |
| Reduce Prevalence of blindness to 0.5% | 2010 |


\textsuperscript{69} HIV/AIDS -

<table>
<thead>
<tr>
<th>Goal</th>
<th>By Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce IMR to 30/1000 and MMR to 100/Lakh</td>
<td>2010</td>
</tr>
<tr>
<td>Increase Utilization of public health facilities from current level of $&lt;20%$ to $75%$</td>
<td>2010</td>
</tr>
<tr>
<td>Establish and integrated system of surveillance, national health accounts and health statistics</td>
<td>2005</td>
</tr>
<tr>
<td>Increase health expenditure by government as a $%$ of GDP from the existing $0.9%$ to $2.0%$</td>
<td>2010</td>
</tr>
<tr>
<td>Increase share of central grants to constitute at least $20%$ of total health spending</td>
<td>2010</td>
</tr>
<tr>
<td>Increase state sector health spending from $5.5%$ to $7%$ of budget</td>
<td>2005</td>
</tr>
<tr>
<td>Further increase to $8%$ of the budget</td>
<td>2010</td>
</tr>
</tbody>
</table>


V. NATIONAL HEALTH COMMITTEES

(i) Bhore Committee, 1946

The Government of India in 1943 appointed the Health Survey and Development Committee with Sir Joseph Bhore as Chairman, to survey the then existing position regarding the health conditions and health organization in the country, and to make recommendations for the future development. The committee which had among its members some of the pioneers of public health, met regularly for 2 years and submitted in 1946 its famous report which runs into 4 volumes. The committee put forward, for the first time, comprehensive proposals for the development of national programme of health services for the country. The committee observed: "if the nation’s health work and that such activities should proceed side by side with those concerned with
the treatment of patients" some of the important recommendations of
the Bhore Committee were:

(a) Integration of preventive and curative services at all
administrative levels;

(b) The Committee visualized the development of primary health
centres in 2 stages:

* as a short-term measure, it was proposed that each primary
health centre in the rural areas should cater to a population of
40,000 with a secondary health centre to serve as a supervisory,
coordinating and referral institution. For each Primary Health
Centre (PHC), two medical officers, 4 public health nurse, one
nurse, 4 midwives, 4 trained dais, 2 Sanitary Inspectors, 2 health
assistants, one pharmacist, and 15 other class IV employees
were recommended.

* a long term programme (also called the 3 million plan) of setting
up primary health units with 75 bedded hospitals for each 10,000
to 20,000 population and secondary units with 650-bedded
hospital again regionalized around district hospitals with 2500
beds; and

* major changes in medical education which includes 3 month's
medicine to prepare "social physicians".

Although the Bhore Committee's recommendations did not form
part of a comprehensive plan for national socio-economic
development, the committee's report continues to be a major
national document and has to provided guidelines for national
health planning in India.
(ii) Mudaliar Committee, 1962

By the close of the Second Five Year Plan (1956-61), a fresh look at the health needs and resources was called for to provide guidelines for national health planning in the context of the Five Year Plans. In 1959, the Government of India appointed another committee known as "Health Survey and Planning Committee", popularly known as the Mudaliar Committee (after the name of its Chairman, Dr. A.L. Mudaliar) to survey the progress made in the field of health since submission of the Bhore Committee's Report and to make recommendations for future development and expansion of health services.

The Mudaliar Committee found the quality of services provided by the primary health centres inadequate, and advised strengthening of the existing primary health centres before new centres were established. It also advised strengthening of sub-divisional and district hospitals so that they may effectively function as referral centres.

The main recommendations of the Mudaliar Committee were: (a) consolidation of advances made in the first two five year plans; (b) strengthening of sub-divisional and district hospitals with specialist services to serve as central base of regional services; (c) regional organizations in each state between the headquarters organization and the district in charge of a Regional Deputy or Assistant Directors – each to supervise 2 or 3 district medical and health officers; (d) each primary health centre not to serve more than 40,000 population; (e) to improve the quality of health care provided by the primary health centres; (f) integration of medical and health services as recommended
by the Bhore Committee; and (7) Constitution of an All India Health Service on the pattern of Indian Administrative Service.

(iii) Chadah Committee, 1963

In 1963, a committee was appointed by the Government of India, under the Chairmanship of Dr. M.S. Chadah, the then Director General of Health Services to study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme.

The Committee recommended that the “Vigilance” operations in respect of the National Malaria Eradication Programme should be the responsibility of the general health services, i.e. primary health centres at the block level.

The committee also recommended that the vigilance operations through monthly home visits should be implemented through basic health workers, one basic health worker per 10,000 population was recommended. These workers were envisaged as “multipurpose” workers to look after additional duties of collection of vital statistics and family planning, in addition to malaria vigilance. The Family Planning Health Assistants were to supervise 3 or 4 of these basic health workers. At the district level, the general health services were to take the responsibility for the maintenance phase.

(iv) Mukherji Committee, 1965

Within a couple of years of implementation of the Chadah Committee’s recommendations by some states, it was realized that the basic health workers could not function effectively as multipurpose workers. As a result the malaria vigilance operations had suffered and
also the work of the family planning programme could not be carried out satisfactorily. This subject came up for discussion at a meeting of the Central Health Council in 1965. A committee known as “Mukerji Committee, 1965” under the Chairmanship of Shri Mukerji, the then Secretary of Health to the Government of India, was appointed to review the strategy for the family planning programme. The committee recommended separate staff for the family planning programme. The family planning assistants were to undertake family planning duties only. The basic health workers were to be utilized for purpose other than family planning. The committee also recommended to delink the malaria activities from family planning so that the latter would receive undivided attention of its staff. The recommendations were accepted by the Government of India.

(v) Mukerji Committee, 1966

As the states were finding it difficult to take over the whole burden of the maintenance phase of malaria and other mass programmes like family planning, small pox, leprosy, trachoma etc. due to paucity of funds, the matter came up for discussion at a meeting of the Central Council of Health held in Bangalore in 1966. The Council recommended that these and related questions may be examined by a committee of Health Secretaries, under the chairmanship of the Union Health Secretary, Shri Mukerji. The committee worked out the details of the BASIC HEALTH SERVICE which should be provided at the block level, and some consequential strengthening required at higher levels of administration.

(vi) Jungal Walla Committee, 1967

The Central Council of Health at its meeting held in Srinagar in 1964, taking note of the importance and urgency of integration of
health services, and elimination of private practice by government doctors, appointed a committee known as the “Committee on Integration of Health Services” under the chairmanship of Dr. N. Jungalwalla, Director, National Institute of Health Administrator and Education, New Delhi to examine the various problems including those of service conditions and submit a report to the Central Government in the light of these considerations. The report was submitted in 1967.

The committee defined, “integrated health services” as: (a) a service with a unified approach for all problems instead of a segmented approach for different problems; and (b) medical care of the sick and conventional public health programmes functioning under a single administrator and operating in unified manner at all levels of hierarchy with due priority for each programme obtaining at a point of time.

(vii) 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 terms of reference of the committee were to study and make recommendation on: (a) the structure for integrated services at the peripheral and supervisory levels; (b) the feasibility of having multipurpose, bipurpose workers in the field; (c) the training requirements for such workers; and (d) the utilization of mobile service units set up under family planning programme for integrated medical, public health and family planning services operating in the field. The Committee submitted its report in September 1973. Its main recommendations were: (a) that the present Auxiliary Nurse Midwives to be replaced by the newly designated “Female health Workers”, and
the present-day Basic Health Workers, Malaria Surveillance Workers, Vaccinators, Health Education Assistants and the Family Planning Health Assistants to be replaced by "Male Health Workers". (b) The programme for having multipurpose workers to be first introduced in areas where malaria is in maintenance phase and small pox has been controlled, and later to other areas as malaria passes into maintenance phase or small pox controlled. (c) For proper coverage, there should be one primary health centre for a population of 50,000; (d) Each primary health centre should be divided into 16 sub-centres each having a population of about 3,000 to 3,500 depending upon topography and means of communications; (e) Each sub-centre to be staffed by a team of one male and one female health worker (f) There should be a male health supervisor to supervise the work of 3 to 4 male health workers; and a female health supervisor to supervise the work of 4 female health workers (g) The present-day lady health visitors to be designated as female health supervisors and (h) The doctor in charge of a primary health centre should have the overall charge of all the supervisors and health workers in his area. The recommendations of the Kartar Singh Committee were accepted by the Government of India to be implemented in a phased manner during the fifth Five Year Plan.

(viii) Shrivastav Committee, 1975

The Government of India in the Ministry of Health and Family Planning had in November 1974 set up a 'Group on Medical Education and support manpower' popular known as the Shrivastav Committee:* to devise a suitable curriculum for training a cadre of health assistants so that they can serve as a link between the qualified medical practitioners and the multipurpose workers, thus forming an effective team to deliver health care, family welfare and nutritional services to the people; (b) to suggest steps for improving the existing medical
educational process as to provide due emphasis on the problems particularly relevant to national requirements, and (c) to make any other suggestions to realize the above objectives and matters incidental thereto.

The group submitted its report in April 1975. It recommended immediate action for: (a) creation of bands of para-professional and semi-professional health workers from within the community itself (e.g., school teachers, postmasters, gram sevaks) to provide simple, primitive, preventive and curative health services needed by the community, (b) establishment of 2 cadres of health workers, namely multipurpose health workers and health assistants between the community level workers and doctors at the Primary Health Centres (PHC); (c) development of a ‘Referral Services Complex’ by establishing proper linkages between the Primary Health Centre (PHC) and higher level referral and service centres, viz. taluka/tehsil, district, regional and medical college hospitals, and (d) establishment of a Medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of the University Grants Commission.

The committee felt that by the end of the sixth plan, one male and one females health worker should be available for every 5,000 population. Also there should be one male and female health assistant for 2 male and 2 female health workers respectively. The health assistants should be located at the sub-centre, and not at the Primary Health Centre (PHC).

VI. RURAL HEALTH SCHEME, 1977

The most important recommendation of the Shrivastava Committee was that primary health care should be provided within 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 in 1977, which led to the launching of the Rural Health Scheme. The programme of training of community health workers was initiated during 1977-78, steps were also initiated (a) for involvement of medical colleges in the total health care of Selected Primary Health Centres with the objective of reorienting medical education to the needs of rural people; and (b) reorientation training of multipurpose workers engaged into uni-purpose workers. This “Plan of Action” was adopted by the joint meeting of the Central Council of Health and Central Family Planning Council held in New Delhi in April 1976.

VII HEALTH FOR ALL

In 1977, it was decided in the World Health Assembly to launch a movement known as “Health for All by the year 2000” – The fundamental principle of (HFA) Health for all strategy is equity, that is an equal health status for people and countries, ensured by an equitable distribution of health resources. The Member Countries of WHO at the 30th World Health Assembly defined Health for All as:

“Attainment of a level of health that will enable every individual to lead a socially and economically productive life”.

In 1978, the Alma-Ata International Conference on Primary Health Care reaffirmed health for all as the major social goal of governments, and stated that the best approach to achieve the goal of Health for All (HFA) is by providing primary health care, especially to the vast majority underserved rural people and urban poor. It was
envisioned that by the year 2000, at least essential health care should be accessible to all individuals and families in an acceptable and affordable way, with their full participation.\(^{71}\)

The *Alma-Ata* Conference caused all governments to formulate national policies. Strategies and plans of action to launch and sustain primary health care as part of a national health system. It is left to each country to develop its norms and indicators for providing primary health care according to its own circumstances. In 1981, a global strategy for health for all (HFA) was evolved by World Health Organization. The global strategy provides a global framework that is broad enough to apply to all Members States and flexible enough to be adapted in national and regional variations of conditions and requirements. This was followed by individual countries developing their own strategies for achieving Health for All (HFA) and synthesis of national strategies for developing regional strategies.\(^{72}\)

**VIII. NATIONAL STRATEGY FOR HEALTH FOR ALL/2000**

As a signatory to the *Alma-Ata* Declaration in 1978, the Government of India was committed to taking steps to provide Health for All (HFA) to its citizen by 2000 A.D. In pursuance of this objective various attempts were made to evolve suitable strategies and approaches. In this connection two important reports appeared:

(i) Report of the Study Group on "health for All – an Alternative Strategy", sponsored by ICSSR and ICMR.\(^{73}\)

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\(^{71}\) WHO (1981) Global Strategy for Health for All by the Year 200 HFA Ser. No. 3.

\(^{72}\) *Ibid.*

\(^{73}\) *Ibid.*
Both the groups considered in great detail the various issues involved in providing primary health care in the Indian Context. These reports formed the basis of the National Health Policy formulated by the Ministry of Health and Family Welfare, Government of India in 1983 which committed the government and people of India to the achievement of Health for All (HFA).

The National Health Policy echoes the World Health Organization (WHO) call for Health for All (HFA) and the Alma-Ata Declaration. It had laid down specific goals in respect of the various health indicators by different dates such as 1990 and 2000 A.D. Foremost among the goals to be achieved by 2000 A.D. were:

(i) Reduction of Infant Mortality from the level of 125 (1978) to below 60.
(ii) To raise the expectation of life at birth from the level of 52 years to 64.
(iii) To reduce the crude death rate from the level of 14 per 1000 population to 9 per 1000.
(iv) To reduce the crude birth rate from the level of 33 per 1000 population to 21.
(v) To achieve a Net Reproduction Rate of one.
(vi) To provide potable water to the entire rural population.

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76 Government of India (1983), Statement on National Health Policy,
IX. THE MILLENNIUM DEVELOPMENT GOALS

In September 2000, representatives from 189 countries met at the Millennium Summit in New York, to adopt the United Nations Millennium Declaration. The goals in the area of development and poverty eradication are now widely referred to as "Millennium Development Goals" (MDGs). The MDGs place health at the heart of development and represent commitments by governments throughout the world to do more to reduce poverty and hunger and to tackle ill-health; gender inequality; lack of education; access to clean water; and environmental degradation. They were an integral part of the road map towards the implementation of the UN Millennium Declaration. Three of the 8 goals, 8 of the 18 targets required to achieve them, and 18 of the 48 indicators of progress, were health related. They assist in the development of national policies focusing on poor and help track the performance of health programmes and systems. Although, the Millennium Development Goals (MDGs) do not cover the whole range of public health domains, a broad interpretation of the goals provides an opportunity to tackle important crosscutting issues and key constraints to health and development. Governments have set a date of 2015 by which they would meet the Millennium Development Goals i.e. eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality; improve material health; combat HIV/AIDS, malaria and other communicable diseases; ensure environmental sustainability; and develop a global partnership for development. Table 8 shows the detailed information regarding the indicators of health related (MDGs) Millennium Development Goals in India i.e. the base line (1990) and current level data.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1: Eradicate Extreme Poverty and Hunger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 2: Halve, between 1990 and 2015, the proportion of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>people who suffer from Hunger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal 1. Target 2. 14 – Prevalence of under weight children</td>
<td>1990</td>
<td>53.4</td>
</tr>
<tr>
<td>(under - five years of age)</td>
<td>2001</td>
<td>47.0</td>
</tr>
<tr>
<td>Goal 1. Target 2 15 – Proportion (%) of population below</td>
<td>1991</td>
<td>25</td>
</tr>
<tr>
<td>minimum level of dietary energy consumption</td>
<td>1999</td>
<td>24</td>
</tr>
<tr>
<td>Goal 4: Reduce Child Mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 5 : Reduce by two-thirds, between 1990 and 2015, the</td>
<td>1990</td>
<td>112.0</td>
</tr>
<tr>
<td>under-five mortality rate</td>
<td>2002</td>
<td>90.9</td>
</tr>
<tr>
<td>Goal 4. Target 5. 113 – Under five mortality rate (Probability of dying between birth and age 5)</td>
<td>1990</td>
<td>80.0</td>
</tr>
<tr>
<td>Goal 4. Target 5. 114 – Infant Mortality Rate</td>
<td>2000</td>
<td>68.0</td>
</tr>
<tr>
<td>Goal 4. Target 5.115 – Proportion (%) of 1 year old children immunized for measles</td>
<td>1990</td>
<td>32.7</td>
</tr>
<tr>
<td>Goal 5: Improve Maternal Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 6: Reduce by three-quarters, between 1990 and 2015,</td>
<td>1990</td>
<td>42.0</td>
</tr>
<tr>
<td>the maternal mortality ratio</td>
<td>2001</td>
<td>4.07</td>
</tr>
<tr>
<td>Goal 5. Target 6 116 – Maternal Mortality Ratio</td>
<td>1990</td>
<td>89/36</td>
</tr>
<tr>
<td>Goal 5. Target 6 117 – Proportion (%) of births attended by skilled health personnel</td>
<td>2001</td>
<td>42.3</td>
</tr>
<tr>
<td>Goal 6: Combat HIV/AIDS, Malaria and Other Diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 7: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td>Goal 6. Target 7. 118 – HIV Prevalence Among Young People 15-24 years age group</td>
<td>2001(M)</td>
<td>0.22</td>
</tr>
<tr>
<td>15-49 years age group</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td>Goal 6. Target 7. 119 – Condom Use in High Risk population</td>
<td>2001 (F)</td>
<td>39.8</td>
</tr>
<tr>
<td>Goal 6. Target 7. 120 – Radio of Children Orphaned/Non-Orphaned in Schools</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td>Target 8: Halve halted by 2015, and begun to reverse the incidence of malaria and other major diseases</td>
<td>2001</td>
<td>NA</td>
</tr>
<tr>
<td>Goal 6. Target 8. 121 – Malaria death rate per 100,000 in Children (0.4 years of age)</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td>2000</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Goal 6. Target 8. 121 – Malaria death rate per 100,000 (all ages)</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td>2002</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Goal 6. Target 8. 121 – Malaria death rate per 100,000</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td>2002</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Goal 6. Target 8. 121 – Malaria prévalence rate 100,000</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td>2002</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Goal 6. Target 8. 122 – Proportion (%) of 5 population under age in malaria risk areas using insecticide – treated bed nets</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td>2000</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Goal 6. Target 8. 122 – Proportion (%) of population under age 5 with fever being</td>
<td>1990</td>
<td>NA</td>
</tr>
</tbody>
</table>
treated with antimalarial drugs.

| Goal 6. Target 8. 123 – Tuberculosis Death Rate per 100,000. | 1990 | NA |
| 2002 | 426 |
| Goal 6. Target 8. 123 – Tuberculosis prevalence rate per 100,000 | 1990 | NA |
| 2002 | 40.4 |

Goal 6. Target 8.124 – Proportion (%) of Smear-positive pulmonary tuberculosis cases detected and put under directly observed treatment short course (DOTS).

| 2001 | 22.7 |
| 1990 | NA |
| 2000 | 84 |

Goal 7: Ensure Environmental Sustainability

Target 9: Integrate the principles of sustainable development into country polices and programmes and reverse the loss of environmental resources

| Goal 7. Target 9. 129 – Proportion (%) of population using biomass fuels | 1990 | NA |
| 2000 | 81 |

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water.

| Goal 7. Target 10 130 – Proportion (%) of | 1990 | 61 |
| Goal 7 Target 10.130 – Proportion (%) of population with sustainable access to an improved water source, rural | 2000 | 79 |
| Goal 7 Target 10.130 – Proportion (%) of population with sustainable access to an improved water source, urban | 1990 | 88 |
| Target 11: By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers | 2000 | 95 |
| Goal 7. Target 11. 131 – Proportion (%) of Urban population with access to improved sanitation | 1990 | 44 |
| | 2000 | 61 |

| Goal 8: Develop global partnership for development | |
| Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries. | |
| Goal 8. Target 17. 146 – Proportion (%) of affordable essential drugs on a sustainable basis | 1990 | NA |
| | 1997 | 80 |


The concepts and definitions of Millennium Development Goals (MDGs) are as follows. Here G denotes goal number, T-target number and l-indicators number prevalence of underweight children (under five years of age (Goal 1. Target 2.14): Proportion of children of under five years with low weight for age, as measured by percentage of children in moderate and severe malnutrition – those falling below 80 per cent of the median weight for reference value or below 2 standard deviations.
deviations of national or international reference population, such as growth charts of the US National Center for Health Statistics.

Proportion (%) of population below minimum level of dietary energy consumption (Goal 1. Target 2.15): since there is no specific data available, proxy indicator proportion of population under nourished” is used. It is the proportion in percentage of persons whose food intake falls below the minimum requirement of food intake that is insufficient to meet dietary energy requirements continuously.

Under five mortality rate (Goal 4. Target 5.113): probability of dying between birth and exactly five years of age, infant mortality rate (Goal 4. Target 5.114): Probability of dying between birth and exactly one year of age, expressed per 1,000 live births.

Infant mortality rate (Goal 4. Target 5.114): Probability of dying between birth and exactly one year of age expressed per 1,000 live births.

Proportion (%) of 1 year old children immunized for measles (Goal 4. Target 5.115): The percentage of infants reaching their first birth day fully immunized against measles (1 dose).

Maternal Mortality Ratio (Goal 5. Target 6.116): Annual number of maternal death per 100,000 live-births. A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Proportion (%) of births attended by skilled health persons (Goal 5. Target 6.117): The proportion in percentage of births attended by skilled personnel per 1000 live births. Skilled health personnel refer
exclusively to those health personnel (for example, doctors, nurses, midwives) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications. Traditional birth attendants trained or untrained, are not included in this category.

HIV prevalence among young people (Goal 6.Target 7.118): Since the relevant data is not available, the proxy indicator as proposed by UNAIDS/WHO is used. The proxy indicator is "HIV prevalence among 15-24 years old by sex" which is the estimated number of young people (15-24 years old) living with HIV/AIDS as per proportion of the same population and sex.

These country-specific estimates are expressed as a range generated by regional modeling. The other proxy indicator is "HIV prevalence rate among population 15-49 years of age".

Condom use in High-Risk Population (Goal 6.Target 7.119)

Since the data is not available, it has been proposed to use, "condom use among 15-24 years old by sex". This is the percentage of young men and women of age 15-24 years, who said that they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months.

Ratio of children orphaned/non-orphaned in schools (Goal 6.Target 7.120)

Since the data is not available, the proxy indicator is used as "AIDS Orphans currently living" which is the estimated number of
children (0-14) in a given year, having lost their mother or both parents to AIDS.

**Malaria Death Rate per 100,000 in Children (0-4 years of age) (Goal 6 Target 8.121)**

Proportion of children (0-4 years of age) died due to malaria in a given year. Malaria death rate per 100,000 in all age groups (G6.T8.121) : Proportion of people of all age group died due to malaria in a given year. It is malaria crude death rate.

**Malaria Prevalence Rate per 100,000 Population (Goal 6. Target 8.121)**

Proportion of notified or reported cases of malaria per 100,000 population in a given area. It is malaria crude prevalence rate.

**Proportion (%) of population under age 5 in malaria risk areas using insecticide treated bet nets (G6. T8. 122):** The percentage of children under-give years of age who are using insecticide treated bet nets among the same population living in malaria risk area, in a given year.

**Proportion (%) of population under age 5 with fever being treated with anti-malarial drugs (Goal 6. Target 8.122):**

The percentage of children under five years of age who are with fever being treated with anti-malarial drugs among the same population living in malaria risk area in a given year.

**X. SUM UP**

Health is a positive state of well being in which the harmonious development of physical and mental capacities of the individual lead to
the enjoyment of a rich and full life. It is not a negative state of mere absence of disease. Health further implies complete adjustment of the individual to his total environment, physical and social. Health involves primarily the application of medical science for the benefit of the individual and of society. But many other factors, social, economic and educational have an intimate bearing on the health of the community. Health is thus, a vital part of a concurrent and integrated programme of development of all aspects of community life.\textsuperscript{80}