Chapter 5:
Health Care Delivery System in India and West Bengal
5.1: The Organizational Set-Up

The pattern of health care delivery services in West Bengal lying in a quasi-federal state like India can not generally be insulated from the national trends. There are two aspects of the health programme in West Bengal. The former effort comprises different methods of population control and family welfare, while the latter relates to measures of health care. Along with this, emphasis has been placed on improved arrangements for medical education and training and creation of increased hospital facilities and health manpower development throughout the state since the inception of First Five Year Plan in 1951.

Promotion of health of the mother and child with emphasis on reproductive and child health programme has been one of the most important objectives of the Family Welfare Programme in India. The Government of India took steps to strengthen maternal and child health service as early as the First and Second five year plans (1951-56 and 1956 - 61). As part of the Minimum Needs Programme initiated during Fifth Five Year plan (1974-79), maternal health, child health, and nutrition services were integrated with family planning services. The primary aim at that time was to provide at least a minimum level of public health services to pregnant women, lactating mothers, and preschool children.

In 1992-93, the Child Survival and Safe Motherhood programme continued in the process of integration by bringing together several key child survival intervention with safe
motherhood and family planning activities. In 1996, safe motherhood and child health services were incorporated into the child health programme.

On 11 May 2000, the Indian population crossed the 1 billion mark, having increased five fold over the past 100 years. The world’s population during the same period only tripled. For almost half of these 100 years India has had a national family planning programme aiming at stabilizing the population at levels consistent with national development needs. But the programme has had limited success in helping to reduce fertility and mortality.

The National population policy of Govt. of India in 2000 also emphasizes the government’s commitment to the safe motherhood programmes within the wider context of reproductive health by the policy, several goals pertains to safe motherhood namely that 80 percent of all deliveries should be attended by trained personnel, and the maternal mortality ratio should be reduced to a level below 100 per 100000 live births. Empowering women for improved health and nutrition is one of the twelve strategy themes identified in the policy to be pursued in stand alone or intersectoral programmes.

In the context of great socio-economic changes taking place in and around national spheres, it would be fruitful to examine the organizational set-up prevailing in India.

India is a quasi - federal state divided into twenty-eight states and seven union territories. These are again divided into districts. They are again demarcated into smaller sub-districts or taluks under which there are the community development blocks in the
country. During the planning era, health services infrastructure and health care facilities have expanded considerably. Broadly, the health services in India has the following organization - national, state, district, block and village which extends from the national level to the sub-centre level in the remote rural areas.

5.1.1: National Level:

The official organs of the health system at the national level consists (1) the Union Ministry of Health and Family Welfare, (2) The Directorate General of Health Services and (3) the central Council of Health and Family Welfare. The nature and functions of these organs may be enumerated as follows.

(1) The Union Ministry of Health and Family Welfare:

The responsibility of the Union Health Ministry consists mainly of policy making, planning, guidance, coordination and evaluation. The functions have been set out in the seventh Schedule of Article 246 of the Constitution of India under two heads - the Union list and the Concurrent list. The functions specified in the Union list are: administration of international health, administration of central institutes, promotion of research, drugs control, census operations, regulation of labour and coordination with the states. The functions specified in the Concurrent list are the responsibility of both the Union and State Governments. These are prevention of spread of communicable diseases, prevention of food adulteration, control of drugs and poisons, vital statistics, labour welfare and economic and social planning.
The Ministry of Health is headed by a Cabinet Minister, a Minister of State and a Deputy Health Minister. The Ministry is bifurcated into department of Family Welfare. The department is headed by a Secretary, who is a general administrator, usually belonging to the Indian Administrative Service. He is assisted by joint Secretaries, deputy secretaries and other administrative staff.

(2) The Directorate of Health Services:

The Directorate is the principal technical adviser to the Union Government in all medical and public health matters. The Directorate is required to provide leadership to a very elaborate team. Consisting of health specialists, he has the responsibility of advising the Ministry on a wide range of technical matters with a view to pursue the state governments to fall in line with the plans and programmes formulated by the central government.

The Directorate is assisted by two Additional Director Generals and a number of Deputy Director Generals. All Major health programmes, medical education, medical care services, rural health services, the Central Government Health Schemes are headed by Deputy Director General.

There are three bureaus - namely, the Bureau of Health Planning, the Central Bureau of Health Intelligence and the Central Health education Bureau.

There are also officers like Assistant Director General for tuberculosis, leprosy, and
programme on immunization, control of blindness, filariasis, sexually transmitted diseases, goiter, nutrition, blood transfusion, disaster relief, drug control and medical stores.

(3) **The Central Council of Health:**

The Central Council of Health was set up by a Presidential Order in 1952 to promote greater coordination between the central and the states in the implementation of health programmes and the measures pertaining to health. A similar council also exists for family welfare. In recent years, these two councils have been meeting jointly to take coordinated decisions. The Central Council of Health and Family Welfare also make distribution of grants-in-aid and review the work done through the utilization of these grants.

5.1.2: **State Health Administration**

The states are independent in matter pertaining to the provision of health services to people living within their jurisdiction. Consequently, each state has evolved its own pattern of health administration. But in each state there is a Minister of Health and Family Welfare elected by the people and Directorate of Health Services (known in some states as the Directorate of Health and Family Welfare).

The State Health Ministry is headed by a Minister of Health and Family Welfare and a Deputy Minister of Health and Family Welfare. In some states, the Health Minister is also in charge of other portfolios. The Health Secretary is usually a senior officer of the Indian Administrative Service.
The Health Directorate is headed by the Director of Health Services (or Director of Medical and Health Services as it is known in some states) who is assisted by a team of joint directors, deputy directors and assistant directors. The deputy and assistant directors may be of two types - regional and functional. The regional directors inspect all the branches of public health within their jurisdiction irrespective of their speciality. The functional directors are usually specialists in a particular branch of public health such as nursing, family planning, blindness control, programme on immunization, tuberculosis, leprosy, malaria, health education, maternity and child welfare. A recent development in many states is the appointment of a Director of Medical Education. The State Health Directorate is responsible for formulating and evaluating plans, directing the execution of approved plans and programmes.

5.1.3: The District Pattern of Health Administration

The district health organization is headed by a single chief, the Chief Medical Officer of Health who is responsible for all community services in the district. The office of the Chief Medical Officer of a district serves as the nerve centre to integrate all state financed health activities in the rural areas. The CMOH is assisted by a superintendent for the District Hospital, a District Health Officer, a District Family planning Officer and others in the field of malaria, T.B., Leprosy, school health etc. However, there is no uniform pattern and this varies from state to state.

In the urban areas, the health departments of municipalities provide preventive and curative health services. In most of the municipalities, the health officer belongs to the
state cadre of health services. Besides, there are also rural states financed hospitals and health institutions, which supplement the work of municipalities.

5.1.4: **Rural Health Services**

The Government of India in 1977 launched a scheme known as "Rural Health Service". It is based on the recommendations of the Shrivastav Committee in 1975, which recommended to create a band on voluntary workers (e.g. community health workers) who would function as an interface between the local community and the national health scheme was subsequently modified in the light of the National Health policy which was approved by the Parliament in 1983 to achieve the goal of Health for All by the year 2000. The rural health infrastructure to deliver the rural health care, as it exists today, may be enumerated as follows:

(1) **Block Level:**

The unit of health care delivery at the block level is a Primary Health Centre. The functions of a Primary Health Centre comprise medical care, child and maternal health, family planning, school health, environmental sanitation, control of communicable and non-communicable diseases, collection of vital statistics, health education, training of auxiliary health personnel, referral services. Primary Health Centre is the first contact point between village community and medical officer. These centres are established and maintained by state governments under the Minimum Needs Programme. A PHC is moved by a medical officer supported by fourteen paramedical and other staff. It acts as the referral unit for six sub-centres. It has 4 to 6 beds for patients. As on 31. 12. 1996.
21889 PHCs were functioning in the country. For a PHC the population norms are 30,000 in areas and 20,000 in hilly/tribal areas.

(2) **Sub-Centre:**

Each sub-centre caters to a population of about five thousand and three thousand (in hilly and remote areas). The staff at each sub-centre consists of one health worker (male) and health worker (female).

The male and female health workers are "multipurpose" workers trained for definite tasks and functions which comprise the treatment of minor illness, maternal and child health, family planning control of communicable diseases, immunization training of dais, nutrition, distribution of iron and folic acid tablets, maintains contact between primary health care system and the community. Nearly, 97,757 sub-centres established after 1\textsuperscript{st} April, 1981 are funded by Ministry of Health and Family Welfare out of a total number of 1,33,498 sub-centres in the country. Rests are being funded by the state Governments under the MNP programmes. However, there were 163181 sub-centres in the country in 2000.

(3) **Village Level:**

There are three health functionaries at the village level, namely, the Health Guides, Trained Dais and Anganwadi workers.
i) **Health Guides**

In India, majority people live in rural areas and they are hardly covered by health services. It is now realized that a wide range of illness can be treated at the village level by a simple training. He has been called a village Health Guide (formerly known as community health worker or community health volunteer).

The scheme was initiated in the country in 1977. The Health Guides are voluntary Health workers selected by the local community and trained locally for three months at the primary health centre and sub-centre. After training, they are given a Manual which gives them detailed instructions to be followed by them and a medical kit containing medicines about worth Rupees 600 - a year. The Health Guides (mostly women) provides the first contact and the official health system. It was proposed to train one health guide for every one thousand population during the seventh plan period.

The Health Guides refer cases to the nearest primary health centre when necessary. Their work is supervised by the community Health Nurses and Health Assistants.

ii) **Trained Dais:**

Dais have a vital role in providing domiciliary midwifery services in rural areas. They are trained for one month at the primary health centre or sub-centre. She serves as a link between the families in her village and the health worker / ANM. She functions like the Health Guides, with greater emphasis to improve maternal and child health in her village. They are being involved in the propagation of small family norms as on 01.04.1996.

There was 660996-trained dais in the country. At present there training programmes is
being implemented by MCH Division.

iii) **Anganwadi Worker:**

Under the Integrated Child Development Services (ICDS) there is one Anganwadi worker for one thousand populations. The services rendered by her comprise health check up, immunization, nutrition, and referral services etc. The beneficiaries are especially nursing and pregnant women and children below the age of six years.

iv) **Community Health Centres:**

In order to provide adequate treatment and referral services, the Government has established one community health centre (CHC) for every 100,000 population by upgrading some primary health centres and sub-district hospitals.

Each community health centre has thirty beds and four specialists in surgery, medicine, obstetrics and gynecology and pediatrics with one-operation theatre. X-ray and laboratory facilities supported by 21 paramedical and other staff. It provides all the specialists and referral services to four Primary Health Centres in its jurisdiction. At each community health centre, services are provided for strengthening preventive and promotive aspects of medical care. As on 31.12.1996, 2433 CHCs are functioning in the country. The respective population norms are 1, 20,000 and 80,000 in plain areas and hilly / tribal areas. Other Personnel - like The Health and Family Welfare Ministry under the Govt. of India has been conducting various training programmes for the orientation and training of medical and para-medical personnel working at the primary health centres and
community health centres. There are varieties of health assistants (male), health assistant (female), health worker (male), male health workers, female health workers etc. The functionaries of each category along with physicians are imparted training in the health and family welfare training institution from time to time.

**Other Agencies:** There are various other agencies providing medical services like Armed Forces Medical Services' providing medical care to defence personnel. Health care for Railway Employees, Health Insurance for the Central Govt. employees, the Employee State Insurance Scheme etc. in the Country.

5.1.5: **Non-Governmental Organizations:**

Non-Governmental Organizations are playing very important role in the health sector in recent years. These organizations look for their own resources and funding. They are closer to people. Whenever, the government institutions are not able to do their work, the non-governmental organizations are leading a helping hand to them. They may have experiments on new things. They are creating health awareness among various health issues among the public. Indian Red Cross Society, Indian Council for Child Welfare, the All India Blind Relief Society, Tuberculosis Association of India, All India Women's Conference are notable among them.

i) **Private Practitioners:**

There are thousands of private practitioners in the country. Besides there are private clinics, nursing homes and hospitals mushrooming all over the country.
ii) **International Agencies:**

The Rockefeller Foundation, Ford Foundation and CARE (Co-operative for American Relief Everywhere) are examples of voluntary international health agencies. Various other international agencies like WHO, UNICEF, World Bank, US AID, and DANIDA etc. have been providing material assistance in the implementation of health programmes in India.

iii) **Indigenous System of Medicine:**

Traditional medicine is the sum-total of all this knowledge and practice used in prevention of physical, mental and social imbalance handed down from generation to generation. This may be considered as a solid amalgamation of ancestral experience and dynamic medical knowledge.

Traditional systems of medicine and practice that are recognized by the Government of India are Ayurveda, Siddha, Unani, Yoga and Homeopathy. The practices are acupuncture, naturopathy, folk medicine and tribal medicine, herbal medicine etc. These systems have become an integral part of the social culture in India, China and Vietnam.

Promotion of traditional medicine is the need of the day because of the increasing cost of modern medical care and growing adverse effects (toxic effects) of synthetic drugs, non-availability to the masses in remote areas. Besides, as compared to modern drugs, they
have least or no side effects. The Government of India obviously puts stress on the development of this type of medicine in recent years particularly since the Sixth plan.

In order to accomplish its responsibility to the people, the Governments of India has formulated its health and health related policies. But in the near future, there is very little hope for any positive change on hundred percent basis. Our doctors leaving aside a few are not motivated to work in the rural areas. Their training is not appropriate or befitting in rural areas. It is also true that a basic amenity for running medical centres is non-existent in our villages. Till date we have not been able to bridge the gap between rural and urban areas. Our education system has certain flaws and it does not prepare the doctors mentally or practically to cater to the needs of the rural masses. Despite lot of talks for changing the present health care delivery system, we have not succeeded in moving further, although a heavy amount spent from the Govt. exchequer to provide medical graduates and other health personnel. The net result is that it is impossible for the poor to get health and medical services when they are sick. They are forced to continue to live under sub-human health conditions, although a vast network of organizational setup has been established to function as the administrative machinery.

5.2: Health and Family Welfare Measures: A. Govt. Policies and Performance at National level

"The ultimate objective of the planned development is to ensure well-being through sustained development in the quality of life of the people, particularly the poor and the vulnerable segments of the population. In terms of policy measures, it requires emphasis
on social sector development and programmes. The development of human resource contributes to sustained growth and productive employment. A healthy, educated and skilled workforce can contribute more significantly and effectively to economic development" (Government of India, Economic Survey, 2007-2008). For improvement in health of the people, there is a need for expanding medical facilities in both rural and urban areas of the country. This implies the development of physical and human infrastructure. At the time of independence, India had very poor social infrastructure and the planning process during the last six decades has made efforts strengthen it at various levels. It would be of interest to make an assessment of achievements, shortcomings and failures in this regard. Health Planning in India is an integral part of national socio-economic planning. The guidelines for national health planning were provided by a number of committees dating back to the Bhore Committee in 1946 and the Mudaliar committee, 1962. These committees were appointed by the Govt. of India from time to time to review the existing health situation and recommend measures for further action.

Economic planning in an overpopulated country like India would be meaningless if it is not well coordinated with population planning. The importance of health planning, population planning and family planning need not be over emphasized as instruments of economic planning aiming at sustainable development.

India’s First Five Year Plan incorporated the general policy for development of health with emphasis on control of communicable diseases, improvement of environmental sanitation including rural and urban water supply, provision of maternal and child health
services, training programmes, health education and nutrition. Community Development Programme was launched in 1952. Provision of medical relief and preventive health services with co-ordination of health policies between central and state governments were part of the programme. During 1954-55 India was concentrating on Malaria and Filaria control. Family Planning was started in the same year. As such during the First and second five year Plans due emphasis was laid on the control of communicable diseases, improvement of environmental sanitation, rural and urban water supply training of medical and health personnel and establishment of institutional facilities for providing health services.

The Second Five Year Plan clearly stressed on curbing population growth as an important condition for improvement in the level of living. Nutritional demands of the people were posing problems and accounted for the malnutrition in the country. The major problem in the 1960's was that of population explosion. Most of the efforts were directed towards reducing the fertility rate by giving incentives to those accepting the small family norm.

The broad objectives of the Third Five Year Plan were to expand the health services and increased emphasis was laid on preventive and public health services. The Third Five Year Plan laid the foundation for health serious delivery system through the establishment of Primary Health Centres (PHCs) alongside important programmes included in the earlier two plans. In the Third Plan, the clinic based approach was sought to be replaced by an extension-education approach in which health workers were to visit
women of child-bearing ages to motivate to limit their family size. During the Third Plan period, the Family Planning Programme (FPP) was made an integral part of the public health department of all states.

The aim of the *Fourth Five Year Plan* sought to overcome the shortage of qualified health personnel and to improve the existing medical and public health services. The other objectives set fourth in the earlier Five Year Plans continued to receive due attention. The Fourth Plan programmes for expansion of medical and public health facilities were set within the targets suggested by the Health Survey and Planning Committee (Mudaliar Committee) and efforts were made to provide effective base for health services in rural areas. In the Fourth Plan the FPP was treated on the highest priority basis.

Although the Government of India took steps to strengthen maternal and child health services since the First Five Year Plan (1951-56), it gathered momentum during the *Fifth Five Year Plan* (1974-79). The National Programme of Minimum Needs was incorporated with a provision of Rs. 2803 crores which covered elementary education, rural health, rural roads and water supply, slum improvement and rural electrification. These provide the environment for healthy living and assist in raising living standards of people. As part of the Minimum Needs Programme initiated during this plan, maternal health child health and nutrition services were integrated with family planning services. The primary aim at that time was to provide at least a minimum level of public health services to pregnant women, lactating mothers and preschool children.
The Sixth five Year Plan assigned a high priority to programmes of promotion of gainful employment, eradication of poverty, population control and meeting this basic human need as integral component of Human resources Development Programme. An integrated approach to the problems of public health and proper coordination of activities of different Government departments and ministries and the Panchayet and Non-government Organizations having a bearing on family planning and maternal and child care had been duly emphasized.

Keeping in view, the importance of rural health infrastructure for the Family Planning, concerted efforts were made to build up Sub-Centres. Primary Health Centres and the Community Health Centres and the Minimum Needs Programme. High morbidity and mortality rates among infants and mothers were believed to be responsible for the desire for more children. The plan aimed at bringing down these rates through improvement of health and nutrition status and through various extension programmes of immunization, supplementary nutrition and health care services. The school health programme was also to be strengthened. The expanded programme of immunization against Polio, T.B, Typhoid and Measles were to be continued and further strengthened. Programmes for immunization for mothers and children were also to be continued. All these measures aimed at the specific goal of sound health as well ensuring maternal and child health care for the period 1980 – 2000 A.D., as the country adopted the policy of Health For All by 2000 A.D. Again during the Sixth Five Year Plan, health care programmes were restructured and reoriented according to the National Health Policy. 1983.
During the *Seventh Five Year Plan* all the health care measures introduced and initiated during the Sixth Plan were to be reviewed, improved and consolidated with more emphasis on the care of pregnant and nursing mothers, care of the new born and young child.

In order to bring more woman and children within the easy reach of MCH (Maternal and Child Health) services, the primary health infrastructures was to be strengthened and efforts were made to maximize the use of ICDS infrastructure for the enhancement of MCH programmes. Special campaigns were organized for improved services utilization and to educate women on the advantages of prolonged breast feeding.

During the two annual plans, before the commencement of the 8th Five Year plan, the health sector and the family welfare sector laid emphasis on the programmes already introduced in the earlier plans. One notable development since the early 1990s has been the intensification of the women’s movements within the country and outside. This had its critical impact on FWP policies. The process of democratic decentralization had been set in motion with the passing of constitutional amendments 72 and 73 and the enactment of Panchayet Raj and Nagar Palika Acts in 1992. The reservation of one third of the seats in Panchayats for women members was also enacted to boost the process of women's empowerment. The process of imposing coercive measures by the state governments through primary health centers on women had also been sought to be curtailed. The
pressure on women sterilization by health officials had often viewed as a serious infringement on women’s fundamental rights.

In the context of the above, the *Eighth Five Year Plan* remarked emphatically. “Health facilities must reach the entire population by the end of the Eighth plan. It was towards human development that health and population control were listed as major two objectives of the plan. The “Health for All” strategy was to take into account not only high-risk vulnerable groups (i.e. Mothers and Children), but must focus sharply on the underprivileged segments within the vulnerable groups within the “Health for All” strategy.

The recommendations of the came up with a Programme of Action, which viewed population policies as an integral part of programmes for women’s development and rights, women’s reproductive health, poverty alleviation and sustainable development. It was strongly felt at the Cairo Conference that population policies, which are dominated by macro demographic considerations, are unnecessarily burdening women with the task of regulating reproduction and fertility regulation to meet the macro-goals. Following International Conference on Population and Development (ICPD), held in Cairo in 1994, organized by the United Nations, the Government of India adopted the so-called Reproductive and Child Health (RCH) approach to family planning and population stabilization with its emphasis on the health and welfare of mothers and children or on the broadly defined reproductive health of the entire population along with stress on reproductive rights and gender equity. In the above context, the new National Population
Policy, 2000 and National Health Policy, 2002 were finally announced. However the allocation of fund has never reached a bare 2 per cent of the total development budget, in spite of expressions of priority.

As already noted the Child Survival and Safe Motherhood programme duly incorporated into the RCH programme seeks to integrate maternal health, child health and fertility regulation interventions with reproductive health programmes for both women and men. With regard to maternal and reproductive health, the important elements of the programme include:

The National Population Policy adopted by the Government of India in 2000 (Ministry of Health and Family Welfare 2000) reiterates the Government's commitment to the safe motherhood programmes within the wider content of reproductive health. Among the national socio demographic goals for 2010 specified by the policy, several goals pertain to safe motherhood, namely that 80 percent of all deliveries should take place in institutions by 2010, 100 percent of deliveries would be attended by trained personnel, and the maternal mortality ratio should be reduced to a level below 100 per 100,000 live births. Empowering women for improved health and nutrition is one of the 12 strategic themes identified in the policy to be pursued in stand alone or intersectoral programmes.

The Ninth Five Year Plan accordingly attempted to integrate all the related programmes of the 8th plan. The concept of RCH is to provide to the beneficiaries need based, client centered, demand driven, high quality integrated RCH services. The RCH programme is
a composite programme incorporating, inter alia, the inputs of the Government of India as well as funding support from external donor agencies including World Bank and the European Commission. It has been taken up in recognition of the legitimate right of the citizens to be provided with all the facilities for Reproductive and Child Health. Therefore, the RCH programme seeks to ensure relevant services for assuring reliable Reproductive and Child Health to all citizens. The strategy of the government of India is to provide reproductive and child health assignment for the country's population by adopting different steps simultaneously.

During the 9th Plan period steps were initiated to develop a well-structured organization of primary health care to ensure basic health and family welfare services to all citizens of the country and also and appropriate referral linkages between primary, secondary and tertiary care facilities in defined geographical area to promote optimal utilization of the available facilities. Along with urban health care facilities, rural health care for all through optimally functioning network of PHCs and sub-centres as part of basic minimum services were being carried on.

The on-going programme of STEP (Support of to Training and Employment Programme) by January 1997. A budget provision of Rs.16 crore has been made for STEP during 1997-98.

"Rashtriya Mahila Kosh" set up in March 1993 as a instrument for extending credit needs of poor women in the informal sector, has sanctioned credit worth Rs 40 crore out of
which an amount of Rs. 28 crore has been released unto September 1997 to benefit 217846 women.

The “Mahila Samridhi Yojana” launched in October 1993, aims to promote thrift among rural household as such. Up to March 1997, a total of about 246 lakh women have been opened accounts with a total deposit of Rs 265 crore. It is proposed to revamp the scheme during 1997-98. A sum of Rs. 39 crore has been provided in 1997-98.

A new scheme “Balika Samridhi Yojana” has been launched on October 2, 1997. Under this scheme, the mother of a girl child born on or after August 15, 1997 in a family below the poverty line in rural and urban areas will be given a grant of Rs. 500/. Further a scholarship will be given for education of the girl child when she attends school.

For holistic development, Integrated Child Development Services Scheme (ICDS), the widely acclaimed and unique programme provides an integrated package of services comprising supplementary nutrition immunization, health check-up and referral services, pre-school non-formal education and ensuring health to children below six years. Apart from ICDS the other programmes for child development includes Early Childhood Education, Balwadi Nutrition programme, Day Care Centre for children below 5 years and belonging to the weaker sections of society.
The Tenth Five Year Plan has outlined specific targets for human development and health development. Among them notable in this regard are:

Reduction of gender gaps, illiteracy and wage rates by at least 50 percent by 2007.

Reduction in the decadal rate of population growth between 2001 & 2011 to 16.2%.

* Reduction of Infant mortality rate (IMR) to 45 per 1000 live births by 2007 and to 28 by 2012.

* Reduction of Maternal mortality ration (MMR) to 2 per 1000 live births by 2007 and to 1 by 2012.

All villages to have sustained access to potable drinking water within the Plan period.

Along with these priorities other programme set in the carrier plans will be continued and consolidated in improving access of all people and especially of mothers and children to health care.

India’s Family Planning Programme (renamed as Family Welfare Programme in late 1970s ) has had a single objective for nearly 30 years, to reduce fertility as quickly as possible. The programme had sought to achieve this goal through a strategy based on contraceptive targets and cash incentives to accepters and providers. This was termed as Target- oriented Approach. Since past few years, the government of India reorganized that contractive target and cash incentive have resulted in the inflation of preference static and the neglect of quality of services. As a result, cash incentive was with drawn from 1\textsuperscript{st} 1996 the FWP was implemented all over India on the basic of Target Free Approach.
To sum up, the base and basis of health care services of the Govt. of India has been decentralized, area specific micro planning, within the general directional framework of a national policy, linking population control with the programme of female literacy, women’s employment and empowerment, social security, access to health services of all and special care of mother and child.

The Approach Paper to the *Eleventh Five Year Plan* stresses upon a comprehensive strategy for better health encompassing individual health care, public health, sanitation, clean drinking water, access to food and knowledge about hygiene and feeding practice. With converted action including enabling pregnant women to have institutional deliveries and nutritional supplements, providing home-based neo-natal care including emergency life serving measures etc.

The development goals set for the 11th Plan for 2011-12 are to (i) to reduce Maternal Mortality Rate to 100 per 1,00,000 live births, (ii) to reduce Infant Mortality Rate to 28 per 1000 live births, (iii) to reduce total fertility rate to 2.1, (iv) to provide clean drinking water to all by 2009, (v) to reduce malnutrition among children of age group 0-3 to half its present level, (vi) to reduce anaemia among women and girls by 50% and (vii) to raise sex ratio for age group 0-6 to 935 by 2011-12 and 950 by 2016-17.
5.3: Some Recent Important Plans for Women and Child Health Care by Central Government

Six decades of hard work has resulted in considerable achievements in improving health standards in terms of life expectancy, infant and maternal mortality rates. Small pox and plague have been eliminated and several other diseases like malaria, tuberculosis and diarrhoea have been contained to a large extent.

The strong link between poverty and health needs to be recognized. Long term illness and expensive illness can drive non-poor into poverty. To improve health care, a comprehensive approach is needed which comprises individual health care, public health, sanitation, clean drinking water and knowledge of hygiene and bringing up children. Whereas the rich can afford to pay for treatment, the poor and marginal groups find it difficult to pay the cost of expensive medical treatment, more especially long term and chronic illness. On account of this, the state owes a responsibility to provide for health of deprived and marginal groups which include women and children especially. Some recent important health policies are discussed below.

5.3.1: National Rural Health Mission:

National Rural Health Mission (NRHM) is the main vehicle for giving effect to the mandate of the NCMP. Operationalized throughout the country, its special focus is on 18 States with weaker health infrastructure and health status indicators. Provision of accessible, affordable, accountable, effective and reliable primary health care facilities especially to the poor and vulnerable sections of the population, bridging the gap in rural
health care services through creation of a cadre of Accredited Social Health Activists (ASHA), improved hospital care, decentralized planning, ensuring population stabilization, intersectoral convergence and maintaining gender balance constitute the basic features of the NRHM.

The Mission envisaged selection of a trained female community health worker called Accredited Social Health Activities (ASHA) in each village in the ratio of one per 1000 population in all 18 high-focus States and in tribal and under-served areas of other States. ASHA would reinforce community action for universal immunization, safe delivery, newborn care, prevention of water-borne and other communicable diseases, nutrition and sanitation. ASHAs would work in close coordination with the Anganwadi Workers (AWW). ASHAs would also provide immediate and easy access for the rural population to essential health supplies like Oral Rehydration Solution (ORS), contraceptives, a set of ten basic drugs, and a health communication kit developed for villages.

**Strengthening of Primary Health Infrastructure & Improving Service Delivery**

Through there has been a steady increase in health care infrastructure available over the plan period as per the Rural Health Infrastructure Bulletin 2006, there is a shortage of 19,269 Sub-Centres (SCs), 4,337 Primary Health Centres (PHCs) and 3,206 Community Health Centres (CHCs) as per 2001 population norm. Further, almost 50 per cent of the existing health infrastructure is in rented buildings. Last but not the least, poor upkeep and maintenance, and high absenteeism of manpower in rural areas, have eroded the credibility of the health delivery system in the public sector. NRHM seeks to strengthen
the public health delivery system at all levels. All the facilities are also being provided untied funds to enable the local management committee to carry out locally relevant initiatives for better service delivery. Flexible, decentralized planning is the pivot on which the entire concept of the Mission revolves.

The NRHM seeks to strengthen service delivery by ensuring community ownership of the health facilities. The success of decentralized planning process under NRHM hinges on the capacity of the districts and the States. The management capacity at the States, districts and blocks is being strengthened with the constitution of the Programme Management Units (PMUs) with professionals including MBAs, Chartered Accountants, and computer experts etc. These professionals have been assigned specific roles and a training component has been built in to make management effective.

The UNICEF evaluation conducted over 2006 has indicated that the coverage of immunization has improved from 52.8 per cent for full immunization in 2000-01 to 54.5 per cent during 2004-05. Janani Suraksha Yojana (JSY) has been launched all over the country to promote safe delivery, and incentives are being provided to BPL families for institutional delivery. During 2005-06, over 6 lakh beneficiaries of JSY were reported by the States and during 2006-07, till December 2006, 12 lakh beneficiaries have been reported under JSY by the States. Outlay on NRHM has gone up by 23 per cent from Rs 6,731 crore in 2005-06 to Rs. 11,505 crore in 2006-07.
Reproductive and Child Health (RCH-II) Programme

The Second phase of Reproductive and Child Health (RCH-II) Programme, launched on April 1, 2005 for a period of 5 years, intends to improve the performance of family welfare in reducing maternal and infant morbidity and mortality, and unwanted pregnancies, and thus lead to population stabilization. Reoriented and revitalized to give a pro-poor focus, the programme is envisaged as an umbrella programme by integrating all the related and inter-linked stand alone schemes into a single composite programme. With a sector-wide approach to family welfare, it adopts a decentralized process by inviting each State/UT to prepare its own implementation plan on the basis of a situational analysis of ground realities and requirements. Funds approved for RCH II went up from Rs. 1,523.75 crore to Rs. 1,871.67 crore between 2005-06 and 2006-07.

Universal Immunization Programme

Under this programme, vaccines are given to infants and pregnant women for controlling vaccine-preventable diseases, namely childhood Tuberculosis (BCG), Diphtheria, Pertussis and Tetanus (DPT), Measles, Poliomyelitis (OPV) and Neonatal Tetanus (NNT). The programme was first launched in the urban areas in 1985. The coverage was progressively extended to cover the entire country by 1990. Between 1988 and 2005, there has been a decline of 40 per cent in Diphtheria, 69 per cent in Pertussis, 66 per cent in Measles, 92 per cent in NNT and 99 per cent in polio cases.
**Pulse Polio Programme**

An outbreak of Polio has been witnessed in the recent past with the spread of polio virus. During 2006, 666 cases have been reported. To respond to this, supplementary immunization activities have been intensified in the high risk areas.

**National Tuberculosis Control Programme**

The Revised National TB Control Programme (RNTCP) using Directly Observed Treatment Short-course (DOTS) strategy is being implemented with the objective of covering at least 85 per cent of new sputum positive patients to be put on treatment and detection of at least 70 per cent of such patients. Under implementation since 1997, the entire country has been covered by March 2006. Till date, the RNTCP has placed more than 65 lakh patients on DOTS treatment, averting more than 11.78 lakh deaths. Overall performance of RNTCP is as per expectation with cure/ treatment completion rate consistently above 85 per cent and death rate reduced to less than 5 per cent among registered TB patients.

**Janani Suraksha Yojana (Maternity Protection Scheme)**

Janani Suraksha Yojana (JSY) under the overall umbrella of National Rural Health Mission (NRHM) is being proposed by way of modifying the existing National Maternity Benefit Scheme (NMBS). While NMBS is linked to provision of better diet for pregnant women from BPL families, JSY integrates the cash assistance with antenatal care during the pregnancy period, institutional care during delivery and immediate post-partum
period in a health centre by establishing a system of coordinated care by field level health worker. The JSY would be a 100% centrally sponsored scheme.

The scheme has the dual objectives of reducing maternal and infant mortality by promoting institutional deliveries. The scheme is 100% centrally sponsored and integrates cash assistance with medical care. Under NRHM out of 184.25 lakh institutional deliveries conducted in the country, (as on 1st April, 2007) JSY beneficiaries were 28.74 lakhs.

Two crucial factors have to be taken into account, one being that India does not have the institutional capacity to receive 26 million women giving birth every year, and the other that half of maternal deaths occur outside the delivery, during pregnancy, abortions and post-partum complications. A gradual approach of increasing institutional capacity and encouraging institutional deliveries would ensure success of the scheme. Secondly, JSY money sometimes does not reach hospitals on time and thus, poor women and their families do not receive the promised amounts. This problem should also be redressed.

5.3.2: National Urban Health Mission:

National Urban Health Mission (NUHM) is intended to meet health needs of urban poor, particularly the sum dwellers, making available to them their essential primary health care services. NUHM will cover all cities with a population of 1, 00,000. It would cover slum dwellers, other marginalized urban dwellers like rickshaw pullers, street vendors.
railway and bus station coolies, homeless people, street children, construction site workers, who may be in slums or on sites.

5.4: Conclusion

Over the years of development efforts, India has achieved remarkable progress in achieving basic health indicators, namely, reduction in death rate, infant mortality rate and increase in life expectancy. As early as 1952, India adopted family planning as an official policy. Initially, the approach was a narrow, clinical one. But subsequently it involved intensive as well as intensive community orientation. In spite of achieving a large infrastructure and community participation, improvement in the well being of the people of the society raises skepticism about the matter. In the planning process in India today investment in health is regarded not as a philanthropic welfare measure but as an investment in development. But the desired goal has not yet been achieved. The problem of ecological degradation, industrial waste management and unsustainable agricultural practices needs to be viewed as inter related issues in health care management.

To sum up unless the minimum basic needs: food, safe drinking water, energy and proper nutrition are provided to the poor people living in rural and urban areas the dreams of achieving minimum health for everybody will never be fulfilled. It is a fact that so use of these linkages and interrelationships are increasingly been recognized by policy planners and attempts are being taken to fulfill them over the five years. However, given the decreasing expenditure and concern for the rural sector and withdrawal of state support
from social security measures under the impact of liberated policy regime, health status of a
majority of Indians and that of women and children may be adversely affected in the
coming years.

In this context, it is worthwhile mentioning that for globalization to succeed, it must be
公平 and benefit the whole of humanity especially that of the developing world. As
prerequisites of this, development at the national level has to be democratically inclusive
and economically sustainable putting stress on millennium development goals as well as
Facing major challenges likes fluctuations in international financial market, energy and
climate change ensuring food security, national and global efforts to create job
opportunities. As a corollary of this a lot of sincere work is needed in the health sector to
protect the children and women from all ills and all concerned should aim at an
operational strategy for development.