(A) HEALTH POLICY IN INDIA:

Despite experiencing growth in the infrastructural facilities by the government health service in rural areas in India, around half the people living in the village use the services of private practitioners for outdoor treatment. However, the reasons for illness, of due to ‘non-availability of medical services’ is 12.86 per cent which is lower as compared to the ‘financial reasons 15.27 per cent or’ reasons related to recognition of severity of sickness by the family which is 74.61 per cent. While a clear class difference exists in all these categories of responses, the reasons offered are more relevant for the poorest than those who are at the top of the socio-economic hierarchy (Goel: 2005). This actually suggests that the infrastructural development of the government health services alone does not necessarily ensure treatment rather it is mostly associated with their ‘recognition of severity’ which is rooted in the material and cultural basis of life.

The lower social status of women in multiple facets life, the harsher impact of poverty on their existence within and outside the household, however, is an accepted reality. Although the large-scale official surveys are yet to highlight the relevant data, it has already been pointed out by social research that, in the families where there is a constant interplay of the constraints of poverty and other social force, processes influencing health in poor households push women to marginalized position. The prevailing health service system in rural areas to the conditions of the poor, also highlights that gender differential determine availability and quality of health care at the family level. The narrative also reveals that the health service system as a whole has kept the poor from exercising their right to health care. Women’s access to quality health care is much poor.
The National Health Policy of 1982 laid stress on the preventive, primitive, public health and rehabilitative aspect of health care services to reach the population in the remotest areas of the country. There is a need to view health and human development as a vital component of overall integrated national socio-economic development, decentralized system of health care delivery with the maximum community and individual self reliance and predication. The policy also laid improved sanitation for all segments of the population (Goel: 2005).

(B) NATIONAL HEALTH POLICY-2002:

The main objective of the policy is to achieve an acceptable standard of good health amongst the general population of the country and increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Salient feature of the policy are as follows:

Increase health sector expenditure to 6 per cent of GDP with 2 per cent of GPD being contributed as public health investment by the year 2000.

1. Increased allocation of 55 per cent of the total public health investment of the primary health sector, the secondary and tertiary health sectors being targeted for 35 per cent and 10 per cent respectively.

2. Apart from the exclusive staff in a vertical would be available for the entire Gamut of public health activities at the decentralized level.

3. Revival of primary health system by providing some essential drugs under central Government funding through the decentralized health system. Provisioning of essential drugs at the public health service centre would create a demand for other professional services also from the local population.

4. More frequent in service training of public health medical personnel at the level of medical officers as well paramedics.
5. Expand the pool of medical practitioners to include a cadre of licentious of medical practice, and also practitioners of Indian systems of medicine and homoeopathy.

6. Implementation of public health programmers through local self government institutions and decentralize the implementation of the programmers to such institutions by 2005.

7. Minimal statutory norms for the development of doctors and nurses in medical institutions.

8. Setting up a Medical Grants Commission for funding new government medical and dental colleges in different parts of the country.

9. Modify the existing curriculum.

10. Enable fresh graduates to contribute effectively to the providing of primary health services as the physician of first contact.

11. Raise the proportion of post graduate seats in public health and family medicine discipline in medical training institutions to 114th of the earmarked seats.

12. Improvement in the ratio of nurse’s vis-à-vis doctors/beds.

13. Improving the skill level of nurses and increasing the ratio of degree holding nurses diploma holding nurses.

14. Need for basing treatment regimens, in both the public and private domain on a limited number of essential drugs of generic nature.

15. Setting up of an organized urban primary health care structure. Funding for the urban primary health system to be jointly borne by the local self government institutions and state and central governments.


17. Inter-personal communication of information and folk and other traditional media to bring about behavioral change.
18. Association of PRIs/NGOs/ trusts in IEC activities.

19. Increase in government funded health research to a level of 1 per cent of the total health spending by 2005, and their after upto 2 per cent by 2010.


21. Encourage setting up of private insurance instrument for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages.

22. Disease control programmers should earmark at least 10 per cent of the budget in respect of identified Programme components to be exclusively implemented through NGO’s (Goel: 2004).

(C) HEALTH PROGRAMMES IN INDIA:

The Indian Government has implemented a number of health programmers to improve the health status of the people. These programmers are:

(1) National Malaria Eradication Programme:

In the year 1953, National Malaria Control Programme was launched in order to reduce malaria which was changed to National Malaria Eradication Programme which meant completely wiping out the diseases of malaria from the country. The main objectives of this Programme were: (I) elimination of deaths from malaria; (ii) reduction in suffering from malaria; (iii) maintaining the gains achieved earlier by reducing whenever possible.

(2) National Filariasis Control Programme:

Filariasis is a term given to include a rage of acute and chronic conditions comprising of fever, elephantiasis of arms, legs and genitals and involvement of lymph channels. The Programme to control this disease was started in 1995. The main objectives in this Programme were:

1. Finding of the extent of the problems in areas where it had not been done so for.
2. Control measure in urban areas by detection and treatment.

3. Control measure in urban areas by killing mosquito larva and treatment of cases.

(3) National Tuberculosis Control Programme:

Tuberculosis is still a major disease in rural area. It is a chronic disease which may affect the lungs and almost all other organs. Classically, it is characterized by loss of weight. In order to fight this disease a National T.B. Control Programme was launched in 1962. The main objectives of the programme were to provide preventive care by BCG vaccination and to detect the active cases at a very early stage so that the diseases may be controlled effectively.

(4) National Leprosy Eradication Programme:

Leprosy is quite common in our country with about 4 million cases estimated. Leprosy is characterized by the presence of light colored patches on the body and thickening of nerves. The national Leprosy Control Programme has been in operation since, 1955 and is redesigned as National Leprosy Eradication Programme in 1983. The Programme is implemented through the establishment of Leprosy Control Units/ Centre, Survey “Education” Treatment (SET) Centers, Urban Leprosy Centers, Temporary Hospitalization Wards, Reconstructive Surgery Units etc.

(5) National Programme for Prevention of Visual Impairment and Control of Blindness:

This Programme was launched in 1976. Before this, it was known as Trachoma Control Program and Vitamin A Prophylaxis Scheme. Since 1982, it has been included in the new 20-point Programme. The Control Strategy of the Programme includes:

1. Health education

2. Establishment of mobile eye clinics
3. Creation of permanent infrastructure for eye care at all levels.

(6) **National Diarrhoeal Disease Control Programme:**

Acute diarrhoea is one of the main causes of death and sickness in our country especially among infants and children below 5 years of age. Under this Programme following strategy is being promoted:

1. Treatment of Acute Diarrhea Therapy (ORT) accompanied by education of mothers on appropriate feeding of children.

2. Encouragement of practices like uninterrupted breast feeding preparations of safe food, well domestic and personal hygiene etc.

(7) **National Goitre Control Programme:**

Iodine deficiency is one of the nutritional problems in our country. It’s most common and visible manifestation is goiter which presents as an enlargement of the thyroid gland in the neck region. It also leads to cretinism which may present with sub-normal intelligence, lack of muscular coordination, deaf mutism, and squint, abnormal and short stature. National Goitre Control Programme of government of India came into existence in 1962 with the following objectives.

1. Survey of areas where goiter is detected.

2. Production and supply after five years to assess the impact of iodized salt on prevalence of endemic goiter. The government has made a commitment to iodize the entire edible salt by 1992. The Programme has been included in the new 20 point Programme.

(8) **Universal Immunization Programme:**

As part of an overall strategy for improving the child survival rate the Expanded Programme on Immunization (EPI) was started in 1978. EPI focused on six childhood diseases coverage of expected mothers with tetanus toxic vaccine. The diseases covered under EPI are:

1. Tuberculosis
2. Diphtheria
3. Pertussis (whooping cough)
4. Tetanus
5. Polio
6. Measles

The Programme is renamed Universal Immunization Programme in 1985 with more inputs.

(9) National Guinea Warm Eradication Programme:

This was initiated in 1983-84. The disease is present in some rural pockets in six States namely Andhra Pradesh, Gujarat, Karnataka, Madhya Pradesh, Maharashtra and Rajasthan. Tamil Nadu which was previously infested is now free from the disease. Following activities are being taken up under this Programme:

1. Active care research twice a year by visiting every village in the endemic districts
2. Chemical treatment of unsafe water sources periodically before and during peak transmission.
3. Personal protection e.g. boiling of water.
4. Health education of the community.
5. Provision of safe water supplies.

(10) National Family Welfare Programme:

India is the first country in the world to have a State sponsored population control Programme which was launched way back in 1952. Even before this the All India Women’s Conference had set up birth control clinics in 1932. In the earlier stages the programme took off slowly with the establishment of a few clinics and distribution of educational material, training and research. In the third five year plan, the objective of stabilizing the growth of population is posited as at the very centre of planned development. The emphasis is shifted
from the purely clinic approach to the more vigorous extension education approach for motivating the people to accept small family norms. In the mid sixties again there was substantial expansion of the Programme with the introduction of Intra-Uterine Devices (IUD). In the IUD Programme the cafeteria approach was adopted. This involved:

1. Offer of monetary incentives to doctors, motivators and acceptors.
2. Mobilization of government functionaries belonging to all departments including revenue collection staff for family planning work.
3. Exerting administrative pressure on field workers.

(11) National Water Supply and Sanitation Programme:

It was initiated in 1954 with the object of providing safe water supply and adequate sanitation arrangements. Environmental Engineering Organization (CPHEEO) is set up in 1954 to provide technical guidance and advice to state governments in preparation and execution of this scheme. According to an assessment made in 1980 by CPHEEO only 30 per cent of rural population had been provided with safe drinking water and 2 percent have basic sanitation facilities. In the urban areas about 82 per cent had safe water supply and 27 per cent sanitation facilities. Out of 5.76 lakh villages about 2.31 lakh villages are identified as problem villages i.e. where drinking water was not available within a distance of 1.6 km. or below the depth of 15 meters or where available source is unhygienic.

(12) Minimum Needs Programme:

This Programme was introduced in the first year of the Fifth five year plan. The objective of this Programme is to establish a network of basic services and facilities by social consumption in the areas that are into nationally accepted norms, within a specified time frame. The Programme is designed to assist in raising living standards, in reducing the rational disparities in development. The Programme is essentially an investment in human resources. The basic needs of the identified for this program are:
1. Elementary Education
2. Adult Education
3. Rural Health
4. Rural Water Supply
5. Rural Roads
6. Rural Electrification
7. Rural Housing
8. Nutrition

(13) Sexually Transmitted Disease Control Programme:

Sexually transmitted diseases are diseases which are spread from person by venereal diseases. The Programme began in 1955; the planning commission recommended the establishment of at least one STD clinic in every district and one headquarter clinic and laboratory in every state. The strategy focused on training, research in various aspects of STD. It was envisaged to establish 5 Regional Training Centers, Regional Laboratories and Regional Survey cum education centers, development of health education with regard to STD and establishment of VDRL testing at district hospital and PHC’s (Goel:2004).

(14) National Rural Health Mission:

The government of India launched a National Rural Health Mission on 12th April 2005. The mission covered the entire country with special focus on 18 states where the challenges of strengthening weak public health system and improving key health indicators was the highest. These states include Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Jammu,& Kashmir and Himachal Pradesh. The mission at provision of integrated comprehensive and effective primary health care to the poor and vulnerable and marginalized section of the society, epically
women and children by improving access, availability, quality and accountability of public health services. The duration of the mission is 7 years from 2005-12 (Singh; 2005).

(15) **Urban Family Welfare Schemes:**

This Scheme is introduced following the recommendation of the Krishnan Committee in 1983. The main focus is to provide services through setting up of health posts mainly in slum areas. The services provided are mainly distribution of contraceptives.

(16) **Sterilization Beds Scheme:**

A scheme for reservation of Sterilization beds in Hospital run by Government, Local Bodies and Voluntary Organization was introduced as early as in the year 1964 in order to provide immediate facilities for tubectomy operations in hospital where such cases could not be admitted due to lack of beds etc. But later with the introduction of the Post Partum Programme some of the beds are transferred to Post Partum Programme and thereafter the beds are only sanctioned to hospitals run local bodies and Voluntary Organization.

(17) **Reproductive and Child Health Programme:**

The Reproductive and Child Health Programme was launched in October 1997 incorporating new approach to Population and Development held at Cairo in 1994. The Programme integrated and strengthened in services/interventions under the Child Survival and Safe Mother Programme and Family Planning Services and added to the basket of services, new areas on Reproductive Tract/Sexually Transmitted Infections (RTI/STI).

The various health programmers introduced by the government for rural health like IMNCI, (Integrated Management of Neonatal and Childhood Illnesses), RCH (Reproductive Child Health- 1997-2004), **Janani Suraksha Yojana** (JSY) – under the Eleventh Five Year Plan (2007-2012) and the National Rural Health Mission (NRHM) (2005-2012) are all focusing on improving the child and women health. Union Budget 2007-08 emphasizes on the mother and
child care and on prevention and treatment of communicable diseases like TB and Malaria. Rural India is infected by communicable diseases which are Water borne, airborne and by sexual transmission.

Along with the government, the private sector is also now taking part in this crusade against health problems. But we have to stride a long distance before we achieve the target of health for all because of many lacunae in the implementation. Involvement of the community is one aspect which would make the journey towards healthy India a comfortable one.

NRHM (National Rural Health Mission) has been envisaged as a focal point of all the programs targeted to improve the health of rural people in India. The approach of involving people or community in administering health measures effectively bringing about transformation in the ideologies of people towards their health is essential to upgrade the quality of rural health. The transition from curative measures to preventive measures plays a vital role in eradication of both communicable and non communicable diseases. People need to be educated at large regarding hygiene and sanitation, preventive measures, procuring safe drinking water etc. and this is possible only when it is done by involving the community. A paradigm shift in the approach from ‘Health for people’ to ‘Health by people’ has to be adopted for the effective implementation of the various health programs.

Women being the focus of all the health programmers, the strategy of the government to include rural women and more precisely the local women in the infrastructure at the root level needs to educate women with health infrastructure and improve their health consciousness. Women have to be active participants in the development process and become agents of change and beneficiaries at the same time. The social, cultural and economic factors continue to inhibit the rural women from gaining adequate access even to the existing public health facilities. This handicap does not merely affect women as individuals but it also has an adverse impact on the health, and the development of the entire family, particularly children. Thus, the rural health as a whole is adversely affected. It is
envisaged that empowered rural women play catalytic role in improving the rural health. Government of India by realizing the importance of women health has come up with various health programmers where the child and women health are focused on.

Since the launch of the community Development Programme in 1951, India has gradually developed a vast health infrastructure. The success of any program requires a system in place where no link is missing. In the hierarchy of rural public health facilities, Community Health Centers (CHC) comes first, Primary Health Centre (PHC) next and finally the Sub Health Centers under whom the Women Health Volunteers (WHVs) work.

**Public Health System**

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+ CHC
 + PHC
 + Sub Centers
 + WHVs/ASHA
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The population coverage norms depend upon whether the centre is in a hilly, tribal, difficult area or in the plains. One volunteer is appointed for every 1000 population and one sub health centre covers a population of 3000-5000. A PHC covers a population of 20000-30000 and a CHC covers 90000-120000 populations.

Local Women at the root level of the hierarchy are a better choice to maintain track of the various health activities in their village. Under the
Integrated Child Development Service (ICDS) Programme, Government has set up Anganwadis’s for every 1000 population in rural India, where one government worker provides immunization, health education, growth monitoring and referral services for children and pregnant women to improve the health status of the rural population. The female Accredited Social Health Activist also called as ASHA (acronym) is appointed for every 1000 population. NRHM aims to increase the availability and accessibility to health care by providing over 400000 ASHAs. A female resident preferably the daughter –in-law of the village between the age group of 25-45 and a minimum of 8th class education is selected as ASHA by village Panchayat Health Committee. She is the key functionary of the NRHM. She will be the first port of call for any health-related demands of the deprived sections of the population, especially women and children, who find it difficult to access health services? She will ensure better access to universal immunization, safe delivery, newborn care, and prevention of waterborne and other communicable diseases, nutrition and sanitation. For this, she will be trained for 3 weeks over a period of 12 months. Her training would be periodic, and will be retrained and will be given on-the-job training. She will be accountable to the Panchayat or the ANM at Sub Health Centre. She would be given performance-based compensation which would be a minimum of Rs. 10000/- per annum. This pattern of compensating the WHVs is expected to motivate her towards serving the public with dedication and ensure her services to the rural population.

The effectiveness of ASHA depends on the training they are imparted with. A Mentoring Group has already been set up at the national level for ASHAs to facilitate the role of NGOs. Grants-in-aid systems for NGOs will be established at the District, State and National levels to ensure their full participation in the Mission.
NUTRITION POLICY OF INDIA:

The major challenge facing rural women of third world today is to overcome the resource constraints that consign them to low levels of productivity and well-being. While women’s role in the food chain is essential to produce that all-important resource, food, it paradoxically does not guarantee women even minimum levels of nutrition. This malnutrition adversely affects women’s participation in the economic system and their productivity. To break this vicious downward spiral, it is important to focus simultaneously on women’s nutrition-related roles and their nutritional status. Diet and nutrition are important factors in the promotion and maintenance of good health throughout the life cycle. Income, prices, individual preferences and beliefs, cultural traditions, as well as geographical, environmental, social and economic factors all interact in a complex manner to shape dietary consumption patterns and affect the morbidity and clinical status of women. A normal balanced diet must include daily food from the various food groups in sufficient amounts to meet the needs of an individual and to maintain good health. Nutritional stress on women is the outcome of low dietary intake on account of economic and social backwardness, and their high energy output for work and child-bearing. That the third-world rural women work more than men when economic and domestic labours are combined seems to be widely accepted. Their reproductive responsibility is inescapable. Among the consequences of this triple burden of market production, home production, and reproduction are the main reasons for high levels of protein-energy malnutrition and anaemia amongst these women. These nutritional problems have received marginal attention in the context of pregnancy and lactation. Maternal depletion on account of high fertility among third-world women has been well recognized, and the consequent high maternal mortality rates of less-developed countries are the subject of great concern. However, less attention has been accorded to these nutritional problems in the context of rural women’s general wellbeing and their participation in economic and social development.
National Nutrition Week is celebrated in September every year to create mass awareness about the nutrition programs. However, the child under-nutrition in India is a major threat to child’s survival, growth and full development potential. According to third National Family Health Survey of 2005-06, in India 20 per cent of children under five-years-old were wasted (too thin for their age) due to acute under-nutrition and 48 per cent were stunted [too short for their age] due to chronic under-nutrition and 70 per cent of children between six months and 59 months were anemic, the percentage of children below five years of age who are underweight.

In this context, since policies and programs on child nutrition and their implementation could not deliver expected results during the 11th Plan which achieved an annual growth rate of 8 per cent, need to be re-looked and new initiatives are called for to tackle them during the 12th Plan when the Prime Minister has agreed to work towards a growth target of 9.0 per cent to 9.5 per cent Children who are under-nourished have substantially lower chances of survival. They are prone to suffer from serious infections and are more likely to die from common childhood illness, such as diarrhea, pneumonia, and measles. Nutritional intervention is a sine qua non when mothers are pregnant and during children’s first two years of life, after which the opportunity for child’s development potential is lost forever. Provision of universal preventive health services and nutritional interventions for children under two and their mothers during pregnancy and lactation can reduce under-nutrition by 25 per cent to 36 per cent. Assured access of poor to pulses and cooking oils at affordable rates can reduce protein and calorie deficiency among the poor.

India, acknowledging that the problem of malnutrition is multi-dimensional, multi-sectoral and inter-generational in nature, and that a single sector scheme cannot address the multifaceted problem, introduced a number of schemes to improve nutrition needs of children and pregnant mothers from time to time under different Ministries, such as
(1) Ministry of Women and Child Development:
   a) Integrated Child Development Services.
   b) Kishori Shakti Yojana
   c) Nutrition Program for Adolescent Girls
   d) Rajiv Gandhi Scheme for Empowerment of Adolescent Girls

(2) Ministry of Human Resource Development
   a) Mid-day Meal Program

(3) Ministry of Health and Family Welfare
   a) Ministry of Human Resource Development
   b) Mid-day Meals Program

(4) Ministry of Health and Family Welfare
   a) National Rural Health Mission
   b) National Urban Health Mission

(5) Ministry of Agriculture
   a) National Food Security Mission
   b) National Horticulture Mission

(6) Ministry of Rural Development
   a) Rajiv Gandhi Drinking Water Mission
   b) Total Sanitation Campaign
   c) Swaranjayanti Gram Swarojgar Yojana
   d) Mahatma Gandhi National Rural Employment Guarantee Program;

(7) Ministry of Food
   a) Targeted Public Distribution System
   b) Antyodaya Anna Yojana
c) Annapoorna. These schemes have had limited success to improve nutritional status, due to fragmented leadership and coordination and reflecting Nutrition is nobody’s responsibility. They need to be re-looked and a more focused and comprehensive effort is called for.

Real per capita GDP in India has grown by nearly 4 per cent per annum over the past 15 years whereas over the same period, the malnourished infants reduced from 52 per cent to 46 per cent (Patel: 2011).

A number of shortcomings in nutrition service delivery system, such as (I) services are not provided where they are badly needed (ii) some really deserving groups of citizens are systematically excluded from services (iii) services are of low quality (iv) accountability for service providers is weak (v) leadership and coordination is fragmented (vi) awareness of the public to demand services is poor (vii) annual nutrition data are not available to enable monitoring of progress. Nutrition is nobody’s responsibility. The Government is expanding funding to the ICDS, the main program tasked with malnutrition reduction among infants but without governance reforms. The World Bank’s study on the working of ICDS (2005) highlighted three important mismatches, namely (I) the gap between design and implementation, (ii) the neglect of the poorest and the most vulnerable, and (iii) the poor quality of services.

Public policy even needs to be reordered to improve nutrition right from the period spanning –9 months to +24 months from conception to the second birthday) as against past policies targeting children under the age of five. Besides, as malnutrition is a consequence of multiple deprivations a comprehensive policy addressing all related issues impacting multiple deprivations is needed to tackle malnutrition effectively. This is evident from a study by the Oxford Poverty and Human Development Initiative, which showed that while 38.9 per cent of the poor in India were under-nourished they were also faced with severe deprivations in other specifically related areas, such as cooking fuel (52.2 per cent) drinking water (12 per cent) and sanitation (49.3 per cent) Efforts to fight creeping nutrition insecurity accompanied by poverty and gender inequality have to be redoubled. Field studies and observations by experts on the current implementation of programs suggest, inter alias, to (i) undertake social audits of the ICDS with reference to
effectiveness of services delivered (ii) monitor the Government’s role & action on nutrition by empowered authority (iii) to simplify implementation of ICDS as there are too many interventions and too many age groups. It is complex to implement, especially in relation to several and different contexts. At present, it tries to do many things for many people and in the process it can satisfy none, (iv) put in place an effective cross-ministry mechanism to deliver food, care and health in combinations that work. Efforts to lift the curse of malnutrition must be unified, (v) involve historically excluded groups in the design, outreach and delivery of nutrition programs, reaching out to women from these groups in particular (vi) devise simpler but more frequent monitoring of nutrition status mechanism so that civil society and the media can hold the Government and other implementers to account for year on year slippage and reward them for good progress (vii) develop new ways of teaching and doing research on how to improve nutrition (Patel : 2011).

**SUMMARY:**

Health Policy of 2002 aims to achieve an acceptable standard of good health amongst the general population of the country and increase access to the decentralized public health system by establishing related new infrastructure in different areas, and upgrading the infrastructure in the existing institutions. To achieve nutrition policy Indian Government has implemented a number of health programmers to improve the health status of the people. It will be instructive to review the development of health planning over the decades in the context of eradication of diseases, improving the medical facilities and development of health planning over the decades in the context of eradication of diseases, improving the medical facilities. Further, special attention is paid for providing potable water supply, improving nutrition, promoting the indigenous system of medicine, the rapid extension of net work of rural health. Network of rural health services with development of a large number of multi-purpose workers has started. For achieving a permanent improvement in the nutritional status of the people, there should be increase in the need of improved nutrition. To control other problem of iron deficiency, National Nutrition Monitoring Bureau suggested programs by improving the iron consumption in habitual diets and by
enhancing their quality. To fortify a suitable food items with iron is also included. The use of iodized salt by the people would be able to reduce the incidences of goiter. Since 1959, UNICEF, WHO, FAO have been focusing on programmes for pre-school age children, pregnant, and lactating women. The mid-day meal programme in schools launched in 1962 was an effort to simultaneously increase school enrolment and improve child nutrition. The Integrated Child Development Service was started in 1975-76. It is expected to provide immunization, supplementary nutrition to child, pregnant and lactating mothers. Since policies and programs on child nutrition and their implementation could not deliver the expected results. The 11th Five Year Plan which achieved an annual growth rate of 8 per cent. These need to be re-looked and new initiatives are called for to tackle them during the 12th Five Year Plan when the Prime Minister has agreed to work towards a growth target of 9.0 per cent to 9.5 per cent. Children who are under-nourished have substantially lower chances of survival. They are prone to suffer from serious infections and more likely to die from common children illness, such as diarrhea, pneumonia, and measles.