CHAPTER – IV : EXTENSION IN HEALTH AND FAMILY WELFARE

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IV.I HEALTH IN RURAL DEVELOPMENT

With the changing concept of development, two allied concept,'human development' and sustainable development', find frequent mention in the literature on development. The ultimate objective of human development is to improve human well-being and the quality of people's lives. The UNDP Human Development Index (HDI) comprises of three components, i.e. health, education, employment. Health is a pre-requisite for human development and is essentially concerned with the well-being of the common man. The concept of sustainable development also lays emphasis on the development of social capital. It is directly concerned with increasing the material standard of living of the poor at the grassroots level which can be quantitative measured in terms of increased food, real income, educational service, health care, sanitation and water supply etc. Health is at the very centre of the concerns of an individual. Unless the people have healthy living, they can not enjoy the other benefits of life. It is now universally regarded as an important index of social development. Health is fundamental to national progress in any sphere. It is the measure of energy and productive capacity in every country.

The concept of health is a broad one. The popular interpretation considers a person healthy if his body is performing all its physiological function normally. This is, however, only one aspect of being healthy. But apart from physiological fitness there are several other factors determining the state of health of a man. These include environmental, social and psychological factors, and list continues even beyond these parameters for several modern definitions of health. The Health Survey and Development Committee rightly observes, "The term health implies more than absence of sickness in the individuals and indicates a state of harmonious functioning of the body and mind in relation to his physical and social environment so as to enable him to enjoy life to the fullest possible extent and to reach his maximum level of productive capacity,"[1] The most widely used modern definition of health was developed by the WHO- "a complete state of physical, mental and social well being, not merely free from sickness or infirmity".[2] The WHO also radically expanded the scope of health by explicitly including the mental and social dimensions of human prosperity and by extending the roles and responsibilities of health professionals and their relationship to the larger society. The Indian Council For Medical Research (ICMR) and the Indian Council For Social Science Research (ICSSR)

in its report of health for all by 2000 AD acknowledged, "health is a function, not only of medical care, but of the overall integrated development of society - cultural, economic, social, and political".[3] It is accordingly, a function that covers host of area including nutrition, personal hygiene, family life, environmental conditions and access to social services including medical care. The multiplicity of factors involved in the promotion of sound health care system renders it more a social rather than a medical problem.

Role of Health in Development

Improvement in health status is viewed primarily is a product of socio economic development. Countries that enjoy higher per capita income also experience higher health status. Development implies improved nutrition, hygienic living and working conditions, greater awareness of health problems and wider accessibility to health care services. Alfred Marshall wrote that "health and strength - physical, mental and moral.....are the basic of industrial wealth; while conversely the chief importance of material wealth lies in the fact that when wisely used, it increases the health and strength physical, mental and moral of the human race".[4]

Better health is desirable as an end in itself. It brings substantial economic benefits releasing resources that can then be used to achieve other developmental goals. Better health and nutrition raise worker's productivity, decrease the number of days they are ill, and prolong their potential working lives. Health and nutrition also have long run effect on productivity and output. Workers who have had a healthy childhood have well developed physiological and cognitive processes. Episodes of illness during childhood have a lasting impact on an individual's physical and mental abilities.

Better diets, housing and control of communicable diseases have raised the quality of life in all spheres. Even the benefits of good health flow well into the future. For instance, a mother's good health strongly influences the early physical and mental development of her children. In an increasingly integrated world, trade and tourism are perhaps the two most important sectors influenced by the status of health in a country. Communicable diseases such as HIV/AIDS, Malaria, Tuberculosis etc. in a country reduce its attractiveness for trade (especially of agricultural and food products) and tourism.

Thus, health is the most precious component for the happiness and all round development of man in society. An individual's health and the health of a society are

considered complementary to each other. It is a fact that the individual's health contributes to higher productivity and economic development which, in turn, provides them with higher wages and better prospects for good health. Thus, societal development largely depends on the health of the people. It has been rightly pointed out in the report on the Census of India (1971) that, "the expenditure on improving the health of a nation is regarded as a good investment yielding indirect return in increased efficiency and productivity".[5]

IV.II CONCEPT OF PRIMARY HEALTH CARE

Public health emphasizes on the health of population. Public health can be defined as "What we as a society do collectively to ensure the conditions in which people can be healthy". The main concern here is the various aspects of public health. There are many social problems that increase an individual susceptibility to disease. Public health is also concerned with collective action to over come these social problems. Such measures include community action to ensure environmental hygiene, uncontaminated food and drinking water, proper sanitary conditions and the prevention of infectious diseases. To prevent diseases and promote better health, public health can work at three different levels: Primary, Secondary and Tertiary. The term of primary health care was first used to mean the care given to the patient by the health worker who saw him first. It was also called 'first contact care'. If the patient was referred to hospital, it was called secondary care'. More recently, the Alma Ata conference in 1978 gave primary health care a wider meaning. Primary health care is defined as "essential health care and universally accessible to all citizens and acceptable to them through their full participation and at a cost that the community and country can afford" (WHO, 1978). It addresses the main health problems in the community through preventive, curative, promotive and rehabilitative medical and health services. The primary health care strategy as outlined in the Alma Ata declaration of 1978 envisaged a revolutionary strategy which recognized that health for the majority of the people could not be achieved through the conventional hospital based health system. The Alma Ata strategy of primary health care upholds that health care would not only be available but it should be accessible, affordable, acceptable and appropriate to the needs of the people. It is now admitted that instead of concentrating on development of health care alone, it may be more worth while to device

a concrete strategy of integrated development simultaneously in the fields of health and social welfare.

The concept of primary health care has been accepted by all countries as the key to the attainment of health for all by 2000 A.D. It has been accepted as an integral part of the country's health system. It includes the following elements:

[a] Promotion of food supplies and proper nutrition.

[b] Education about health problems and their control.

[c] Safe water supply and basic sanitation.

[d] Mother and child health and family planning.

[e] Immunization against infectious, diseases and injuries.

[f] Prevention and control of locally endemic diseases.

[g] Treatment of common diseases and injuries,

It calls for a continuing process of dialogue, popular consultation, organizational adaption and possible change in social, political, economic and cultural environments. Primary Health Care is based on four basic principles[6]:-

Equitable Distribution:- Health services should be available to all sections of society with special attention to the needy and vulnerable groups. Primary health care aims at correcting urban-rural imbalances and bringing health services to the door-step of every citizen.

Community Participation:- It requires the involvement of individuals, families and communities in promotion of their own health and welfare, including self care. The community should participate in the planning, implementation and maintenance of health services.

Multisectoral Approach:- One of the basic tenets of primary health care is that full health cannot be provided by the health sector alone. It requires the joint efforts of the health sector and other health-related sectors viz. education, food, agriculture, social welfare, housing and public works, rural reconstruction etc.

Appropriate Technology:- It calls for scientifically sound materials and methods that are socially acceptable, directed against relevant health problems. The examples are domiciliary treatment as against sanatorium treatment for TB Patients, Oral rehydration therapy in cholera and other diarrheal diseases etc.

The International conference on primary health care calls for urgent and effective national and international action to develop and implement

primary health care through out the world and particularly in developing countries in a spirit of technical co-operation and in keeping with the New International Economic Order. It urges governments, WHO and UNICEF and other international organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care. The government of India became one of the signatories to the Alma Ata declaration of the World Health Organization in 1978.

IV.III HEALTH AND FAMILY WELFARE PROGRAMMES IN INDIA

Ever since the government of free India has come into being it has taken up health as one of the important component of social and economic development in the country. In order to provide good health care services, the Government of India planned for people-oriented health policy programmes. In the British India, by and large, the health system was elite biased, urban based and curative-oriented, and was not geared even to providing minimum health care services to the mass of the rural people. The system suffered largely in terms of both inadequacies of health institutions and facilities as well as manpower.[7] Consequently, the majority of people in both the urban and rural area were subject to critical health and environmental sanitation problems: widespread incidence of infections and communicable diseases; severe malnutrition; inadequate supply of safe drinking water and poor sewage disposal; high levels of mortality particularly among infants, children and mothers; and low expectation of life. Broadly speaking, there were four major problems associated with health status of population: over population, wide spread incidence of communicable diseases, malnutrition and inadequacy of health care infrastructure.

The present health care system in India has its origin in the recommendations of the Health Survey Development Committee appointed in 1943 under the chairmanship of Sri Joseph Bhore whose report was published in 1948. The committee insisted that "medical relief and preventive health care must be urgently provided as soon as possible to the vast rural population of the country". The main thrusts of the Report was on preventive work rather than curative; the health service should be placed as close to the

vast rural population of the country and to secure the active cooperation of the people in the development of the health programme.[8]

From 1951, the successive Five Year plans have reflected the Government's public health policy. During the planning period, there was obviously a progressive increase in the involvement of government in matter of public health. From the beginning, the emphasis in health sector planning has, accordingly, been on the need for the creation of an infrastructure for the delivery of health services through out the country. This was clearly reflected in the priorities enunciated by the first plan and specific objectives defined by the second.

The First plan (1951-56) priorities were to provide preventive health care to the rural people through health units (PHC) and mobile units; control of malaria; ensure health services for mothers and children; expand education; training and health education and give priorities to family planning and population control. With the launching of the Community Development Programme in October, 1952, a modest beginning was made to implement a programme of setting up Primary Health Centers (PHCs) as an integral component for all-round development of rural areas. A PHC with three sub-centers for every Community Development Block covering approximately 60,000 people was designed to provide integrated curative, preventive and promotive health services to the rural population. The PHCs were envisaged as the focal point from which primary health care services would radiate through Sub-centres in the rural areas. These were also expected to be responsible for medical care, control of communicable diseases and maternal and child health.

The Third (1961-66) and Fourth Plans (1969-74) highlighted the shortfalls in the implementation of the programmes and sought to improve the performance in the health sector. The Third plan, launched in 1961, directed attention to the shortage of health personnel, and inadequate training facilities for the different categories of staff required in rural areas. The Fourth Plan, which began in 1969, after a three year plan holiday, reiterated these difficulties and pleaded for the establishment of effective machinery for speedy construction of buildings and improvement of the performance of Primary Health Cares by providing staff, drugs and equipment.

Meanwhile, the report of the Mudaliar Committee on Health Survey and Planning was published in 1962. Briefly the committee reviewed the progress on public health since the submission of the Bhore Committee Report. The main recommendations of the

report were regarding steps to enhance the health delivery system; to stream line its organization; to develop training facilities for para-medical personnel; and to advocate the creation of 'auxiliary health workers' specially trained to help public health officers. However the Mudaliar Committee report did not do much to reverse the trend towards urban oriented public health services with emphasis on the curative side. During the Fourth Five year plan, the Committee on Multi Purpose Workers under Health and Family Planning Programme, also known as Katar Singh Committee (1972-73) was constituted. The Multi Purpose Workers Scheme (MPS) aims at providing package of health services to the rural population at their door step to meet the growing needs of the people regarding health and family planning services. It intends to make to people aware of the services and at the same time educate them about the contribution they could make. Each sub-centre would be manned by a trained Female Health Worker (Auxiliary Nurse Mid-Wife) and a trained Male Health Worker known as Multipurpose Worker to provide health services in the form of an entire package.[9]

The Fifth Plan (1974-79) reformulated the health programme in order to "consolidate past gains in various fields of health such as communicable diseases, medical education and provision of infrastructure in rural areas."[10] This consolidation of the past gains was envisaged in the context of the new National Minimum Needs Programme (MNP) introduced by the plan. The health related components of MNP were ensuring in all areas a minimum uniform availability of public health facilities. It included preventive medicine, family planning and the detection of early morbidity. It stressed on supplying drinking water to villages and carrying out environmental improvement of slums. The Plan further envisaged that "the delivery of the integrated health care programmes will be through multi-purpose health auxiliaries- a new category of paramedical personnel to be specially trained for the purpose."[11] This was a step forward in the direction of rural orientation to the medical and para-medical personnel. As a result, one PHC for 30,000 persons and one sub-centre for 5,000 persons were to be established.

In 1975 a report was submitted by a group, under the chairmanship of Dr. J.B. Srivastava. The group was asked to devise a suitable curriculum for training a cadre of Health Assistants. The group recommended an alternative strategy for development which is suited to our conditions, limitations and potentialities. It includes the criteria of development of an integrated service covering promotive, preventive and curative aspects

of health services and family planning ; universal coverage and equal accessibility to all citizens; full utilization of paramedical resources available in the community. The group emphasized on the community approach that represents a step forward towards the development of primary health care. Accordingly, the group maintained that it is the duty of the community to provide a proper environment for helping each individual to be healthy. This report led to the Community Health Worker Scheme which was launched in October, 1977 as a centrally sponsored and funded scheme. According to this scheme, a Community Health Worker (CHW) is given training for a period of 3months to teach the fundamentals of health sciences, measures for maintaining health, hygiene, treatment of common infectious diseases, first aid etc. He is expected to provide basic health care facilities to a village or community with a population of 1000. Another decision taken by the Government of India pertained to implement the Village Health Guide Scheme from October 2, 1977 by having a worker from within the community trained in some basic work to render assistance in maternal care and educate mothers about family welfare schemes. [12]

An important milestone in India's health services development was reached with the signing of the Alma Ata Declaration (WHO – UNICEF sponsored International Conference on Primary Health Care) on September 12, 1978 recommending "Health for All by 2000 AD" through Primary Health Care approach. Responding to this declaration, a study group of the Indian Council of Social Science Research and the Indian Council of Medical Research (1981) drew up a wide range of recommendations in these lines. The Report recommends that the existing "exotic, top-down, elite-oriented, urban based centralized bureaucratic system, which over-emphasizes the curative aspects, large urban hospitals and drugs." Should be replaced by an alternative model of health care services which is strongly rooted in the community and which integrates preventive, promotive and curative aspects. The report also endorses the Community Health Workers Scheme. It has laid stress on maternal and child health; nutrition, environmental improvement, health education and family planning.[13]

The ICSSR – ICMR report has had some impact on the strategy adopted for the Sixth Five Year plan (1980 – 85). In this Plan, health was viewed in its totality as a part of the strategy of human resource development. Under the Plan, the Minimum Needs Programme (MNP) had been allowed to continue as the main instrument for the development of the rural health care delivery system. The adoption of National Health

Policy (1983) during this period was taken as a high watermark in the national health scenario.

The document of NHP points out that the demographic and health picture of the country still constitutes a cause for serious and urgent concern. The high rate of population growth continues to have an adverse effect on health of the people and the quality of their lives. The mortality rates for women and children are still distressingly high; almost one-third of the total deaths occur among children below the age of five years; infant mortality is around 129 per thousand live births. The NHP has enunciated the long-term demographic goal of the country to be attained by the year 2000.

TABLE - 4.1 TARGETS OF HEALTH FOR ALL BY 2000 AD

SL NO.	INDICATOR	GOALS BY 2000 AD
1.	Infant Mortality Rate (IMR)	Below 60 per thousand live births.
2.	Crude Death Rate (CDR)	9.0 per thousand
3.	Maternal Mortality Rate (MMR)	Below 2 per thousand live births.
4.	Life Expectancy at Birth (Yrs.)	64
5.	Crude Birth Rate (CBR)	21 per thousand
6.	Growth Rate of Population (Annual)	1.20 percent
7.	Total Fertility Rate (TFR)	2.3 children per women

Source: India, Health Information on India, New Delhi, Directorate - General of Health Services, 1983.

As the nation was committed to achieve the goal of 'health for all' by the year A.D. 2000, therefore, the Seventh Five Year Plan (1985-90) had envisaged developing the country's vast human resources for the acceleration and speeding up of the total socio-economic development and attaining an improved quality of life. The main thrust was on the MNP to provide necessary health care services to the rural masses.

The Eighth Five Year Plan (1992-97) had the aim of enforcing a balanced development of primary, secondary and tertiary health care services in the country with priority on primary health care services. The main programmes pertaining to control of diseases include control of communicable diseases, malaria eradication, control of Kala azar, leprosy eradication, tuberculosis control, guinea-worm eradication, control of AIDS and diarrhea diseases and such non-communicable diseases as cancer control, diabetes control, mental health etc. The plan stressed on the needs of the tribal population and

communities living in difficult and inaccessible areas; and making the rural health services responsive to the needs of the rural masses and accountable to the community. The plan also emphasized on ensuring the urban basic services for the comprehensive development of health and welfare services.

India's Ninth Plan (1997-2002) identifies health as one of the priority areas and emphasizes on control of communicable and non-communicable diseases; improved health management information systems; and facilitation on Panchayati Raj institutions' involvement in programmes on health care. The plan gave stress on enable people to be better providers of their own health care; rejuvenating the public sector to better deliver its core services and engaging the private sector to meet societal health goals. The Ninth Plan envisaged reorganization and restructuring of all the elements of health care so that they function as integral components of a multi professional health system.

Thus, at the beginning of 21st century, it has become clear that public health initiatives indeed have contributed significantly to the improvement of health indicators. There has been impressive progress in certain areas concerning health care.

TABLE - 4.2 ACHIEVEMENTS OF INDIA FROM THE YEARS 1951-2000

INDICATORS	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6 (RGI)
Crude Birth Rate(per 1000 population)	40.8	33.9 (SRS)	26.1 (SRS)
Crude Death Rate (per 1000 population)	25	12.5(SRS)	8.7 (SRS)
IMR (per 1000 live births)	146	110	70(SRS-99)
U5MR (per 1000 live births)	-	173	101
Epidemiological Shifts			
Malaria (cases in Million)	75	2.7	2.2
Leprosy (per 10,000)	38.1	57.3	3.74
Small Pox (No of cases)	>44887	Eradicated	
Guinea worm	NA	>39792	Eradicated
Polio	29709	265	Near Eradication
TB (100000)	NA	NA	136.9
SC/ PHC / CHC	725	57,363	1,63,181(99-RHS)

INDICATORS	1951	1981	2000
Dispensaries & Hospitals (all)	9209	23,555	43,322(95-96CBHI)
Beds (Pvt. & Public)	117,198	569,495	8,70,161(95-96-CBHI)
Doctors (Allopath)	61,800	2,68,700	5,03,900(98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000

Source: GOI 2001a; IIPS 1995 and ORGI, various issues, Sample Registration System Bulletin. and Various issues, Health Information of India

There has been marked expansion in hospitals, dispensaries and medical institutions. For example, the number of medical colleges has gone up from 28 in 1951 to 175 in 1996 and that of hospitals from 2,694 in 1951 to 13,692 in 1992. There has been a colossal increase in the number of health institutions particularly in the rural sector. In 1996, the country had 2,424 community Health centres, 21,853 PHCs and 1, 32,727 Sub-centres. Availability of trained manpower is one of the important indicators of health development. On this count, the number of registered medical practitioners has increased from 61,840 in 1951 to 4,10, 875 in 1992 and 4,50,000 in 1996.[14] Further significant achievement has been made in extending drinking water facilities in rural as well as urban areas covering 56.3 percent of rural population in 1985 to 82 percent in 1996 and 72.9 percent of urban population in 1985 to 85 percent in 1996.

While the country has registered some remarkable progress in certain areas in the field of health care, it is lagging behind with negative consequences in other areas. In several areas in health sector, the country has done poorly in comparison to other countries of the world.

TABLE - 4.3 : LIFE EXPECTANCY AT BIRTH AND IMR IN SELECTED DEVELOPING COUNTRIES

Sl.No.	Country	Life Expectancy at Birth	IMR(per1000)
1.	China	68.8	44
2.	Indonesia	63.0	58
3.	India	60.8	74
4.	Malaysia	70.9	13
5.	Pakistan	61.8	89

6.	Korea	71.3	11
7.	Singapore	74.9	6
8.	Srilanka	72.0	17

Source: UNDP, Human Development Report, 1996

Besides, there are differences in the morbidity and mortality rates among the states and between rural and urban areas. The indicators of human development vary from state to state. The statistics bring out the wide differences regarding the attainments of goals between the better-performing states and the low-performing states. It is clear that national averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country. Despite a thrust in the NHP-1983 on narrowing down the gulf by way of establishing more public health institutions at the lower levels, a large gap in facilities still persists.

TABLE - 4.4 : DIFFERENTIALS IN HEALTH STATUS AMONG STATES

SECTOR	POPULATION BPL (%)	IMR/1000 LIVE BIRTHS (1999-SRS)	<5 MORTALITY/ 1000(NFHSII)	MMR/LAKH	LEPROSY/ 1000	MALARIA CASES IN 2000 (Thousands)
INDIA	26.1	70	94.9	408	3.7	2200
Better performing states						
Kerala	12.72	14	18.8	87	0.9	5.1
Maharashtra	25.02	48	58.1	135	3.1	138
TN	21.12	52	63.3	79	4.1	56
Low Performing States						
Orissa	47.15	97	104.4	498	7.05	483
Bihar	42.60	63	105.1	707	11.83	132
Rajasthan	15.28	81	114.9	607	0.8	53
UP	31.15	84	122.5	707	4.3	99
MP	37.43	90	137.6	498	3.83	528

Source: Government of India, Economic Survey 1996-97, New Delhi, MOF, 1997

Again, the dominant diseases in India are water-borne which account for 75 percent of ailments and deaths. About two lakhs villages do not have adequate drinking water facilities. Lack of sanitation and drinking water facilities add considerably poor health and diseases. Diarrhea diseases continue to account for more than half-a-million infant deaths annually. Out of six million cases of leprosy in the world, two million are estimated to be found in India of which 15 percent are children. The annual incidence of malaria of India, after falling sharply from 75 million in 1950 to less than one million by 1970, has gone up since then and is estimated at about two million. During 1996, the country witnessed a sudden out break of infectious diseases like plague, dengue fever, kalaazar etc., in various parts. Tuberculosis is another infectious disease which accounts for 1.5 percent of total population in India of which about one-fourth or 0.4 percent are sputum positive or infectious. In the case of blindness, there is an estimated 12 million blind persons, who cannot see from a six meter distance and another 45 million people are suffering from visual impairment. In the case of AIDS, it is estimated that out of an estimated 10 million people infected with HIV in 1995, two million are in India. According to the World Bank, "the rate of new infectious in Africa will slow somewhat and that new transmission will be concentrated in India and other Asian and Island region." [15]

Besides, these diseases there are an increase in mortality through 'life-style' diseases like diabetes, cancer and cardiovascular diseases. The increase in life expectancy has increased the heath care requirement for older people. Similarly, the increasing burden of injury and violence cases and mental disorder are also a significant public health problem.

Moreover, this continuous trend of increasing health problems is accompanied by a simultaneous decrease in plan outlays on health in successive five year plans. The plan outlay demonstrates a significant increase in the total budgetary allocation for health in successive five year plans. But in terms of percentage it shows a steady decline from 4.7 percent in First Plan to 0.6 percent during the Ninth Plan. It seems to be an unhealthy trend as government wants to achieve a target of "Health for All by 2000 AD".

TABLE - 4.5 : TRENDS IN EXPENDITURE ON HEALTH AND FAMILY WELFARE, 1951-2002

PLAN	PERIOD	TOTAL PLAN INVESTMENT	HEALTH (WITH %) (Figures in Rs. Crore)
First	1951-56	1,960	652 (3.33%)
Second	1956-61	4,672	1,408 (3.01%)
Third	1961-66	8,576.5	2,259 (2.63%)
Annual	1966-69	6,625.4	1,402 (2.12%)
Fourth	1969-74	15,778.8	3,355 (2.13%)
Fifth	1974-79	39,426.2	7,608 (1.93%)
Annual	1979-80	12,176.5	2,231 (1.83%)
Sixth	1980-85	109,291.7	20,252 (1.85%)
Seventh	1985-90	218,729	36,886 (1.69%)
Annual	1990-91	61,518	9,609 (1.56%)
Annual	1991-92	65,855	10,422 (1.58%)
Eighth	1992-97	434,100	75,822 (1.75%)
Ninth	1997-2002	859,200	51,181 (0.6%)

Source: India, Five Year Plans, GOI, Planning Commission & Economic Survey, GOI, Ministry of Finance, 1997.

Thus with the beginning of the 21st Century, it is self – evident that in a country like India, which has a wide variety of socio-economic settings, national health programmes have to be designed with enough flexibility to permit the State public health administrations to craft their own programme package according to their needs. Overriding importance would be given to ensuring a more equitable access to health services across the social and geographical expanse of the country. Emphasis will be given to increasing the aggregate public investment through a substantially increased contribution by the Central Government. It is expected that this initiative will strengthen the capacity of the public health administration at the state level to render effective service delivery. The contribution of private sector in providing health services would be much enhanced, particularly for the population group which can afford to pay for services. Primacy will be given to preventive and first-line curatives at the primary health level through increased sectoral share of allocation. Emphasis will be laid on rational use of drugs within the allopathic system. Increased access to tried and tested systems of traditional medicine will be ensured. With these broad and extended efforts it can certainly be expected to achieve the time – bound goals outline in NHP-2002.

TABLE - 4.6 : GOALS TO BE ACHIEVED BY 2000 – 2015

Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kalaazar	2010
Eliminate Lymphatic Filariasis	2015
Achieve Zero Level Growth of HIV/AIDS	2007
Reduce Mortality by 50% on account of TB, Malaria, and other vector and water borne diseases	2010
Reduce prevalence of Blindness to 0.5%	2010
Reduce IMR to 30/1000 and MMR to 100/lakh	2010
Establish an integrated system of Surveillance, National Health Accounts and Health Statistics	2005
Increased health expenditure by Govt. as a % of GDP from the existing 0.9% to 2.0%	2010
Increase share of Central grants to constitute at least 25% of total health spending	2010
Increase State Sector Health spending from 5.5% to 8%	2010

The main objective of the policy is to achieve an acceptable standard of good health amongst the general population of the country. The NHP – 2002 sets out an increased allocation of 55% of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targeted for 35% and 10% respectively. The Policy envisages the gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, Malaria, HIV/AIDS, and Universal Immunization programmes, would need to be continued till moderate levels of prevalence are reached. Powers are given to the Head of the District health administration to allocate the time of the rural health staff for managing different programmes at the field level, depending on local needs. NHP – 2002 lays great emphasis upon the implementation of public health programmes through local self government institutions. The policy envisages that priority should be given to school health programmes, which aim at preventive health education, providing regular health check-ups and promotion of health seeking behavior among children. The policy welcomes the participation of the private sector including private insurance in all areas of health activities – primary, secondary or tertiary. The policy commits the highest priority of the central government to the funding of the identified programmes relating to

women's health. Also, the policy recognizes the need to review the staffing norms of the public health administration to meet the specific requirements of women in a more comprehensive manner. Possible threat to health security in the post – TRIPS era, as a result of a sharp increase in the prices of drugs and vaccines has been acknowledged. This policy envisages a national patent regime which ensures the affordable access to the latest medical and other therapeutic discoveries.

The Government of India has launched a National Rural Health Mission (NRHM) on 12th April, 2005; with objectives to provide integrated comprehensive and effective primary health care to the unprivileged and vulnerable sections of the society, especially women and children by improving access, availability and quality of public health services. The NRHM objectives indicate the motivation on the part of Government to correct the rural-urban, inter-state and gender inequalities in health.

The Mission aims for empowering local communities for public health by devising specific health plans for each village through village health committees of panchayat. The NRHM strategy integrates health with sanitation and hygiene, nutrition and safe drinking water. The objectives of Mission is to achieve acceptable health and nutrition status of women, girls and children by ensuring appropriate access of state sponsored health and nutrition services. In Rural Health Mission strategy the Community Health Volunteers (CHVs), Auxiliary Nurse Midwives (ANMs) and Anganwadi Workers (AWWs) have a focal role to play as the frontline team.

The importance of community participation forms the cornerstone of the concept of primary health care to achieve the goal of 'Health for All'. For the success of the programmes it is essential to encourage and ensure full community participation through the effective propagation of relevant information through which individuals, families and community can assume responsibility for their health and well-being. Regular interactive sessions with mothers, parents group, old age persons added by audiovisual demonstration along with household contact and monitoring, development of local resources groups etc. should be incorporated

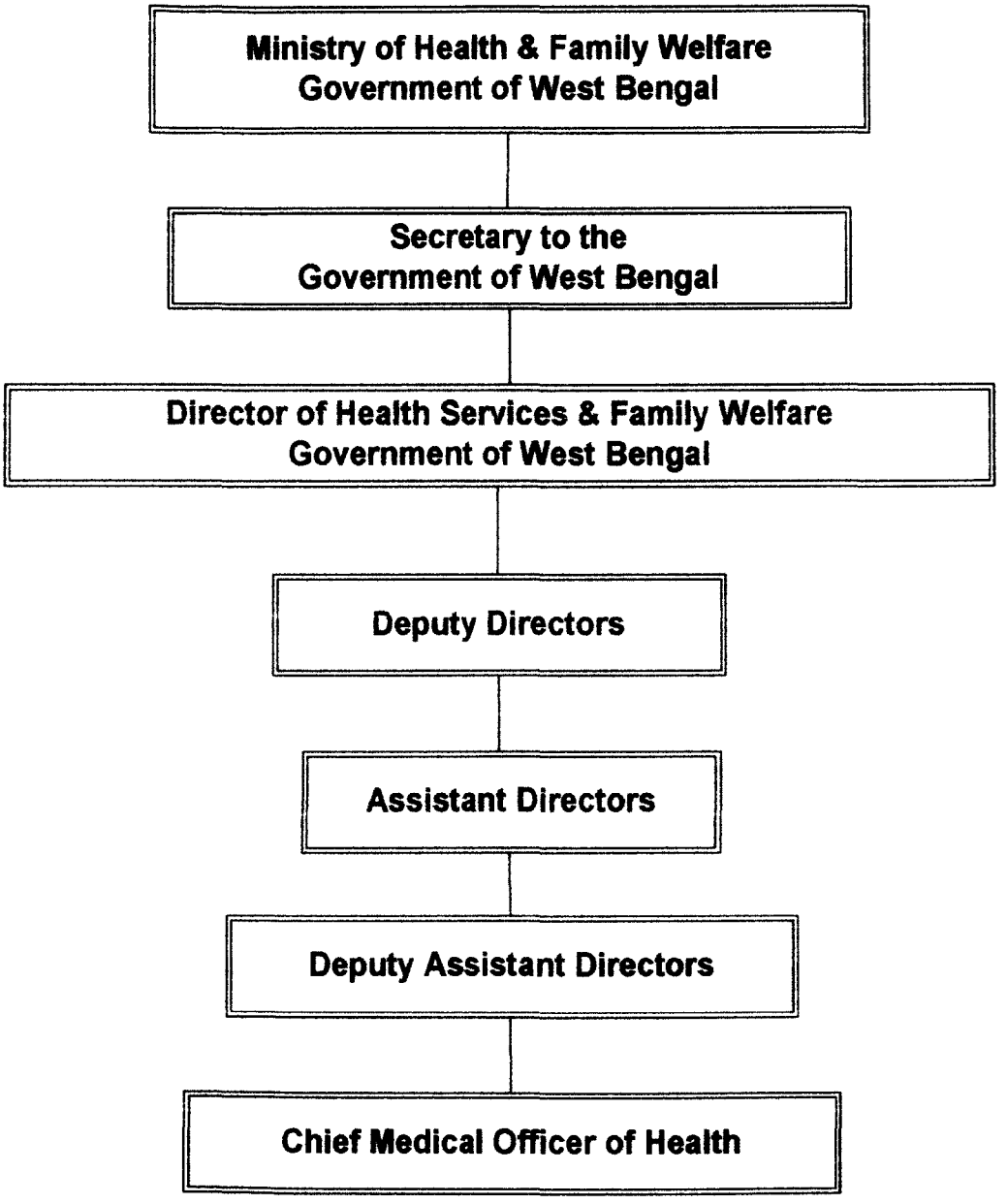
IV.IV ORGANISATIONAL MANAGEMENT OF HEALTH IN WEST BENGAL

Provision of basic health care services to the rural community is the primary objective of the government of West Bengal. Rural health services, water supply, environmental sanitation, nutrition, health education are all brought together in the form of an integrated package to improve the social, economic and health conditions of the people of the state. The health package of primary health care provides such inputs which promote the well being and good health of the people.

The administration of Health Department in West Bengal has a three-tier system. At the top is the Directorate of Health and Family Welfare followed by the office of Chief Medical Officer of Health (CMOH) at the district level and at the peripheral level is the Block Medical Officer (BMO) of the PHC. The Directorate of Health and Family Welfare is headed by the Director and is assisted by a team of Joint Directors, Deputy Directors and Assistant Directors to provide leadership to the team. The Directorate oversees the implementation of the various health programmes including rural health services.

The district offices of the Chief Medical Officer of Health (CMOH) in West Bengal is the nerve centre for the integration of all state financed health activities in the rural areas. With the introduction of the MPW scheme, the MPWs are assigned the responsibility of undertaking comprehensive health activities for a population of 5,000 persons at the sub-centre level. CMOH is responsible for planning, execution, monitoring and evaluation of all health and family welfare programmes in the district. His functions include: issuing of posting orders of supervisors of different tiers in the district, sub-division and block levels as well as posting one male multipurpose health assistant and one female multipurpose health assistant. The CMOH is assisted by district level line and staff personnel to provide supervision of various health institutions in the district and the specialists in the fields like malaria, leprosy, tuberculosis, school health, nursing, drugs control and health intelligence to give staff support. At the district level, management of MPW scheme is done through the district health supervisors, the district nursing supervisor and the district health education officer assisted by a deputy health officer. The district health supervisors provide technical supervision and guidance to the PHC

CHART – 4.1 : ORGANISATIONAL SETUP OF HEALTH & FAMILY WELFARE



supervisory staff and also to the junior health assistant (male) in all health programmes, like malaria, tuberculosis, leprosy and family welfare. The district nursing supervisor gives technical guidance and supervises the senior health assistant (female) at the PHC.

Senior health assistant (female) visit the sub-centres for supervision and give guidance to the junior health assistant (F) in maternal and child health, family welfare, nutrition and immunizations. The District Health Education Officer guides the Block Social Welfare Officers of the PHC in educational activities such as orientation training camps, mass educational media activities, film shows etc.

The district immunization officer monitors the immunization programme. The district tuberculosis officer monitors the T.B. programme in the district. He organizes BCG campaigns with the help of PHC staff. The district malaria officer gives guidance and supervision of various categories of staff such as the MPWs, sanitary inspector at the PHC and SCs assists in detection and treatment of leprosy cases at the SCs.

The monthly review meetings of the PHCs are held at the office of CMOH once in a month. All the BMOHs / MOHs of the PHCs in the district attend this meeting which is presided over by CMOH. The monthly performance of each PHC in the district is discussed in detail and the targets achieved under various health programmes and shortfalls in the achievements of the programmes are discussed item wise so that suitable actions can be taken to improve the performance of each PHC.

The Primary Health Centre (PHC) at the block level is a key institution in primary health care approach to delivery of rural health care services. In the state of West Bengal, there are 1993 PHCs and 12,101 sub-centres.[16] The Primary Health Centre is provided with 2 or 3 Medical Officers assisted by a number of paramedical staff. One of the senior Medical Officers is designated as Block Medical Officer of Health (BMOH) in charge of the PHC. Besides the medical officers, the PHC team consists of Block Sanitary Inspector, Social Welfare Officers, Laboratory Assistant, Block Public Health Nurse, Health Assistants (Male and Female) to provide line and staff support to the multipurpose health workers. The sub-centre acts as a link between the PHC and the villages. It provides clinic-based services to the villages. The sub-centre of the PHC forms the base of activities of two multi-purpose health workers (male and female) who cater to the need of about 5,000 to 8,000 population.

At the sub-centre level, there are two main functionaries, the MPWs (Male and Female), who cater to the needs of about 5000 population in about 5 villages. The MPW (female) has an additional responsibility of providing maternal and child health care and attending to deliveries. In addition to them there is one Auxiliary Nurse Midwife (rural) in each sub-centre who will be available to the rural people at any time.

TABLE - 4.7 : DEMOGRAPHIC, SOCIO-ECONOMIC & HEALTH PROFILE OF WEST BENGAL

S.NO.	ITEM	WEST BENGAL	INDIA
1.	Total population (census 2001) (in million)	80.18	1028.61
2.	Crude Birth Rate (SRS 2005)	18.8	23.8
3.	Crude Death Rate	6.4	7.6
4.	Total Fertility Rate (SRS 2004)	2.2	2.9
5.	Infant Mortality Rate (SRS 2005)	38/1000	58/1000
6.	Maternal Mortality Ratio(SRS2003)	194/1000	301/1000

Source: RHS Bulletin, March 2006, M/O Health & Family Welfare, GOI

The position of West Bengal in the field of health and family welfare in terms of states average as is shown by the health indicators is higher than the national average but compared with other states in the Indian Union, West Bengal is disgracefully lagging behind and ranks only eight among the sixteen major states. Infant mortality has decreased in line with all-India performance and is the fourth lowest in the country, and life expectancy is slightly above the Indian average. But treatment of acute respiratory infections and diarrhea has declined, and malnutrition remains unacceptably high. Incidence of malaria in duars area is increasing. The state is still far behind the better performing states like Kerala. In addition, there are large intra-state variations in health outcomes between districts.

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