UNIT 3 RURAL HEALTH CARE

Structure

3.0 OBJECTIVES

After studying this unit, you should be able to:

- appreciate that *health* is an important parameter of development;
- outline the health care services available in our country and their evolution;
- identify the relationship between socio-economic factors and health;
- describe the organisational structure for the delivery of health care services;
- critically analyze the various health programmes and schemes; and
- explain the impact of various programmes and health care services on morbidity and mortality.

3.1 INTRODUCTION

After studying the relationship between health and socio-economic development for decades, economists and social scientists have now come to a consensus that *health* forms an important index of human development and in turn that of the development of any society. ***Health, defined as the state of complete physical, mental, social and spiritual well-being and not merely absence of disease and infirmity***, proves to be a major contributor to the level of quality of life. We all agree that the basic objective of human development is to improve the quality of life. Healthy population plays a key role in achieving the developmental activities as health helps to improve the productivity of mankind both directly and indirectly.

The health picture of our country is far from satisfactory. The vision of "Health for all by 2000" has not materialized. The situation in rural areas of India, where over two thirds of our population lives, is worse, with only rudimentary health care services being available to the masses. All the recent advances in medical science and technology have not reached the majority of the disadvantaged people living in rural India. Poor socio-economic status (poverty) and poor health status together make a vicious cycle wherein poverty brings in inadequate nutrition, unhealthy environment, sickness causing low productivity and hence poverty. India with a wide range of topographic and climatic conditions has witnessed various types of natural disasters. During 2001 eleven states were affected by heavy rains and floods, one with a cyclone and three with landslides. In most of these calamities, the worst affected is the population of rural areas.

In this unit we shall detail the present scenario of health care services and the different health programs under the revised National Health Policy relevant to rural areas of India.

3.2 POVERTY AND HEALTH

Health does not exist in isolation. It is influenced by a host of genetic, environmental, social and economical factors, related to each other. The health of a community is intimately related to its economic status and its social and political organization. There is little doubt that in most of the developed countries it is the economic progress that has been the major factor in reducing morbidity, increasing life expectancy and improving the quality of health.

Poverty though difficult to define, is much more than just *the lack of money*. It is a state that involves the total life of a person, his/her food, clothing, housing, education, health, family life, and aspirations.

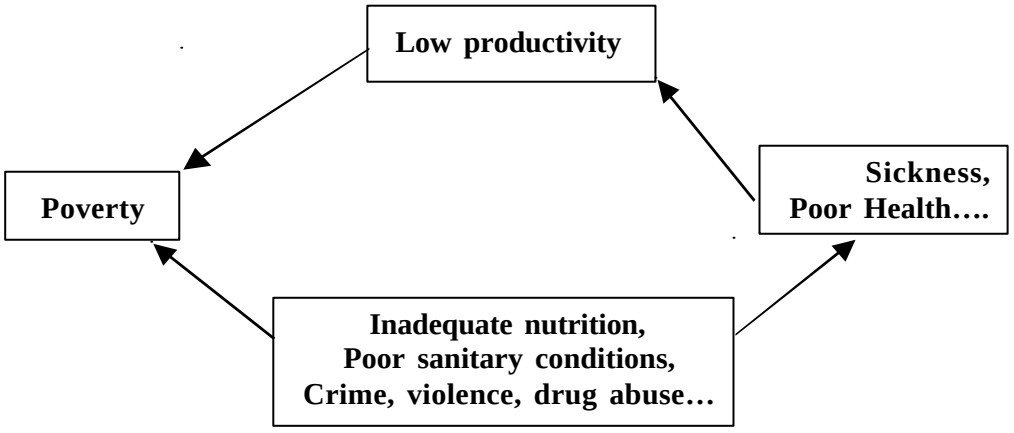

Fig. 1

Poverty leads to sickness by depriving individuals of their needs of adequate nutrition and shelter and by exposing them to hazards of poor sanitary conditions. It is an established epidemiological fact that the prevalence and distribution of disease is strongly influenced by socio-economic factors. Poverty also predisposes one to crime, violence, drug abuse and many other forms of deviant behavior. All these are responsible for low productivity, which in turn leads to poverty. (See Fig. 1 above.)

It is estimated that 70-75 % of all the deaths of children below 5 years of age in the developing countries is because of three categories of diseases— infections spread through human excreta, airborne infections and malnutrition— and all of these can very easily be associated with poor socio-economic status of the poor.

Check Your Progress I

Note: a) Use the space provided for your answers.

b) Check your answers with the possible answers provided at the end of this unit.

1) Why do we need to focus on rural areas for the provision of health care services?

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2) Why do you think "health" is important for overall development?

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3) How is poverty related to health?

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3.3 HEALTH SITUATION IN RURAL INDIA

To know about the health standard of a society, we need to understand some of the indicators of health. The commonly used health indicators are: Crude Death Rate, Infant Mortality Rate, Birth Rate, Sex Ratio, Life Expectancy at Birth and Access to Health Care Services. (S*ee the keywords for the meanings of these terms*.)

Looking at the following data on a few of the health indicators, it is clear that the rural areas have far poorer health standards in comparison to the urban areas.

Table 3.1: Birth Rate, Death Rate and Infant Mortality Rate – Rural Urban Break-up

	Birth Rate			Death Rate			Infant Mortality Rate		
Year	**Total**	**Rural**	**Urban**	**Total**	**Rural**	**Urban**	**Total**	**Rural**	**Urban**
1987	32.2	33.7	22.7	10.9	12.0	7.4	102	104	61
1995	28.3	30.0	22.7	9.0	9.8	6.6	74	80	49
1996	27.5	29.3	21.6	9.0	9.7	6.5	72	77	46
1997	27.2	28.9	21.5	8.9	9.6	6.5	71	77	45
2001	27.5	27.1	20.2	8.4	9.0	6.3	66	72	42

Source: Office of the Registrar General of India & SRS Bulletin, 2001, and Sample Registration System Vol. 36, No.1, April 2002.

Though the overall picture is far from satisfactory, we notice improvement over the years, but this improvement is more marked in the urban areas. The rural IMR in 1987 was as high as 104; it has fallen to 72 by the year 2001, though the overall IMR has fallen from 102 to 66. The urban IMR for the same year is only 42. The life expectancy at birth also shows a rural urban differentiation. It has gone up from 50.5 years in 1971-81 to 63 for 1996-2001. There is significant difference of about 8 years being less in rural areas than that in urban areas. Similarly, incidence of low birth rate, a major cause of high infant mortality, is quite high in rural areas. The prevalence of communicable diseases is also relatively high in rural areas.

Table 3.2: Birth Rate, Death Rate and Infant Mortality Rate, 2001

India/State/ Union Territory	Birth Rate			Death Rate			Infant Mortality Rate		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
INDIA	27.5	27.1	20.2	8.4	9.0	6.3	66	72	42
Andhra Pradesh	20.8	21.3	19.6	8.1	8.9	5.6	66	74	39
Assam	26.8	27.8	18.5	9.5	9.8	6.6	73	76	33
Bihar	31.2	32.3	23.4	8.2	8.5	6.3	62	63	52
Gujarat	24.9	26.6	21.5	7.8	8.8	5.6	60	67	42
Haryana	26.7	27.8	22.8	7.6	7.6	7.4	65	68	54
Karnataka	22.2	23.6	19.0	7.6	8.2	6.4	58	69	27
Kerala	17.2	17.4	16.6	6.6	6.8	6.1	11	12	9
Madhya Pradesh	30.8	32.8	23.0	10.0	10.8	7.2	86	92	53
Maharashtra	20.6	21.0	20.1	7.5	8.5	5.9	45	55	27
Orissa	23.4	23.9	19.6	10.2	10.7	6.8	90	94	60
Punjab	21.2	22.1	18.7	7.0	7.2	6.4	51	55	37
Rajasthan	31.0	32.3	24.7	7.9	8.3	6.2	79	83	57
Tamil Nadu	19.0	19.6	17.8	7.6	8.4	6.0	49	54	35
Uttar Pradesh	32.1	33.2	27.0	10.1	10.6	7.8	82	86	62
West Bengal	20.5	22.8	13.8	6.8	7.0	6.4	51	53	38
Arunachal Pradesh	22.0	22.9	12.8	5.5	5.9	2.3	39	41	11
Chhattisgarh	26.3	29.0	22.4	8.8	10.1	7.0	76	88	56
Goa	13.9	14.0	13.9	7.5	8.1	6.5	19	21	16
Jharkhand	26.3	28.3	19.5	8.8	9.7	6.0	62	67	40
Himachal Pradesh	21.0	21.3	16.8	7.0	7.1	5.3	54	55	32
J & K	20.1	21.1	16.3	6.1	6.1	6.0	48	50	39
Manipur	18.2	19.0	15.9	5.1	4.8	6.1	20	19	23
Meghalaya	28.3	30.7	15.0	9.0	9.9	3.9	56	57	41
Mizoram	15.7	17.7	13.2	4.4	5.2	3.4	19	23	12
Nagaland	NA	NA	12.4	NA	NA	2.6	NA	NA	13
Sikkim	21.6	21.8	16.7	5.1	5.2	3.2	42	43	31
Tripura	16.1	16.6	13.5	5.6	5.6	5.2	39	40	30
Uttaranchal	18.5	21.1	16.6	7.8	10.0	6.1	48	69	26
Andaman & Nicobar islands	16.8	17.8	14.2	4.7	5.0	4.1	18	21	8
Chandigarh	16.1	20.6	15.6	3.5	2.2	3.7	24	28	23
Dadra & Nagar Haveli	29.3	30.1	20.0	6.5	6.8	2.9	58	62	9
Daman & Diu	22.3	22.6	22.0	6.7	7.6	5.9	40	42	35
Delhi	18.7	23.2	18.1	5.0	5.4	5.0	29	34	28
Lakshadweep	20.4	22.1	18.7	5.0	4.7	5.2	33	34	33
Pondicherry	17.9	18.7	17.3	7.0	7.7	6.6	22	31	15

Source: Sample Registration System Vol. 36, No. 1, April 2002.

There is considerable interstate variation in the health indicators as may be seen in Table 3.2. These differences are mainly due to the interstate variations in topographic conditions, literacy and socio-economic factors. Notice that the death rate in rural Kerala is 6.8 while in rural Madhya Pradesh it is 10.8. The death rate in rural Uttar Pradesh is 10.6 in comparison with 7.8 in urban Uttar Pradesh. Even the infant mortality rate shows a considerable interstate variation, being the lowest at 11 in the state of Kerala, while it is the highest at 90 in Orissa. It may be noted that the overall infant mortality rate for our country is 66.

About 73% of our population lives in rural areas of the country, where the basic amenities and health care services are dismal. India has a dubious distinction of being self-sufficient in food production while having the largest number (75 million) of 'under five' malnourished children in the world.

Despite all the developmental programmes we have some shocking facts to consider:

Table 3.3: Safe drinking water and adequate excreta disposal facilities

	Urban	Rural	Total
Population with safe drinking water available in the house or within reasonable access.	92.6%	72.3%	77.9%
Population with adequate excreta disposal facilities available (Toilet/latrines).	80.7%	18.9%	36.0%

Source: National Family Health Survey – 2, Oct. 2000

It is important to note that in rural areas:

- Infectious diseases continue to be a major cause of death and disease.
- Many of such infectious diseases are preventable.
- Malnutrition still continues to be a major cause of disease and death.
- Deaths from famines, floods and other natural calamities have decreased.
- Small pox has been eradicated.
- The incidence of diseases like cholera and malaria have shown decline.
- Vaccination programmes have provided some protection bringing down the prevalence of certain vaccine preventable diseases.
- Morbidity and mortality among women continues to be higher than among men.
- Neglect of the girl child, its poor health and poor nutritional status are prevalent.
- Adverse sex ratio, 933 females per 1000 males (2001 census), is alarming.
- Prevalence of under-weight children below the age of 3 years is 24% in rural areas against 21% in urban areas is equally alarming.
- Only 33.5% of deliveries are attended by trained personnel in rural areas in comparison to 73.5% in urban areas.

It is more than evident that the health situation in rural areas continues to be far from satisfactory, and it results in major drawback in developmental work. In the revised National Health Policy of the Government of India there is a lot of emphasis given to comprehensive rural health care services.

Check Your Progress II

Note: i) Use the space provided for your answers.

ii) Check your answers with the possible answers provided at the end of this unit.

1) Fill in the blanks with suitable words/figures:

a) Death Rate in rural India was ..... and in urban India ..... in the year 2001.

b) The lowest IMR was recorded by the state of ..... and it was ..... per 1000 live births (2001).

c) The highest overall IMR was recorded by the state of .... (2001).

d) In 2001, there were about ..... *below five* malnourished children in India.

e) As per the 2001 census, the sex ratio is ..... females per thousand males.

f) The population having adequate excreta disposal facilities in rural India was ..... % in 2001.

3.4 HEALTH CARE SERVICES

Having understood the health situation of rural India, let us study the present health care services available and their evolution from the time India became independent in 1947. The health status of the people at that time was one of the poorest in the world. Expectation of life at birth was 26.9 years for males and 26.5 for females; 50% of the deaths were among children under the age of ten and in this group half of the mortality took place during the first year of life.

The important report on public health, which had appeared around 1947, was that of Health Survey and Development Committee (**Bhore Committee**). Set up in 1943, it gave its report in 1946, which is supposed to be the blueprint for the system of health services in India. The basic principles of the report are that no individual should be denied adequate medical care on grounds of inability to pay, special emphasis should be given to preventive work, focus on rural population and active co-operation of people must be secured in the development of health programmes. The committee recommended that a living wage for all workers, improvement in agriculture and industrial production, elimination of unemployment; suitable housing and clean environment are essential for healthy living.

The smallest health unit was designated a Primary Health Unit serving a population of 10,000-30,000 people. Each PHU was to have 70 beds and 6 medical officers in addition to other staff. 15-25 PHUs would constitute a Secondary Health Unit and three to five of the latter were to form the District Health Organisation (having a bed strength of 2,500) to serve a population of about 30,00,000. In view of the paucity of funds and manpower the planning was phased into short- and long-term planning. In the short-term a PHU was to cover a population of 40,000 instead of 10,000-30,000 and emphasis was placed on 30-bedded hospitals, one for every two PHUs.

Rest of the activities including setting up of District Health Care Centres were to be taken up only after the short-term targets were achieved. It also recommended that medical practice must be socially oriented to meet the needs of the people and must involve free participation of the community in the development of health care services. Bhore Committee recommendations continue to shape the health care services in India even today.

The **First Five Year Plan** accepted the suggestions of Health Survey Committee and First Primary Health Centre was established in October '52 as a part of the Community Development Programme based on the objective of bringing about multi-faceted development of rural areas. The major function of PHC under the integrated—curative, preventative and promotional—approach to the development of health services was:

i) Medical Care

ii) Control of Communicable Diseases

iii) Maternal and Child Health

iv) Collection of Vital Statistics

v) Protection of Water Supply and Environmental Sanitation

vi) Conduct of School Health Programme

vii) Family Planning Services which were added on later.

A PHC was envisaged as a nucleus for all health activities in the area. Soon a network of PHCs was set up throughout the country, but with only a skeleton staff comprising one medical officer, one sanitary inspector, a health visitor, one compounder and four auxiliary nurse midwives covering a population of 60,000 people.

Infectious and communicable diseases were the major killers at that time. So, in the First Plan period, the Government started several National Programmes (such as the National Malaria Control Programme, the National Leprosy Control Programme, etc.) for controlling communicable diseases. These were called vertical programmes as each of them was implemented through a single purpose nation wide organization. Even the Family Planning Programme was a vertical programme launched during the First Plan period. In the Second Five Year Plan (1956-61), the thrust was to expand the then existing health services and to bring them within the reach of all the people. Soon it was realized that there was shortage of skilled manpower. Accordingly, it was planned to have training programmes to develop technical manpower; develop institutions to control communicable diseases and establish institutional facilities for delivering health care throughout the country.

The Health Survey and Planning Committee (**The Mudaliar Committee**) was appointed to assist and review the development of health care services in independent India. Its report submitted in 1961 observed that the primary health care as developed bore no resemblance to the one visualized by the Bhore Committee. Mudaliar Committee recommended:

- consolidation of the then existing services before taking up any expansion.
- strengthening staffing in the then existing PHCs.
- that each PHC should serve a population of 40,000 instead of 60,000.
- not to open any new PHC without ensuring the full staff component.
- strengthening of the district hospitals with mobile clinics to cover non-PHC populations.

Despite the recommendations of the committee, there was considerable expansion of PHC network in the 1960s, mainly because of the burden of vertical programmes.

In the early 1970s, several multi-disciplinary epidemiological and sociological studies were conducted before launching the various specific programmes. In 1973, a Government of India's Committee recommended the provision of integrated health and family planning services through multi-purpose workers. The committee on multi-purpose workers (**Kartar Singh Committee, 1973**) reviewed the functions of PHCs and observed that there was little co-ordination among the various health workers. It recommended:

- one male multi-purpose worker for a population of six to seven thousand initially;
- one female health worker (ANM) for a population of ten to twelve thousand;
- integrated training for all workers and
- co-ordination of programmes and personnel.

The new Government at the centre launched a Community Health Worker Scheme in 1977. The objective was to provide health services to rural population through village level Community Workers, who were to act as links between the health services and the people. This programme also collapsed because of several reasons.

The Fifth Five Year Plan (1974-79) acknowledged that the health care services in the urban areas had expanded at the cost of the rural services. It intended to provide integrated health services, family-planning services and nutritional packages through the Minimum Needs Programme (MNP).

Primary Health Care

It was felt more and more that an integrated approach to health care had to be developed. This led to the emergence of the concept of Primary Health Care wherein basic health needs of rural India could be taken care of. In 1978, India signed the Alma-Ata Declaration on 'HEALTH FOR ALL BY 2000 A.D.'. Here also primary health care was visualized as the nucleus of the health care system. According to the declaration, *primary health care is the essential health care based on practical, scientifically sound and socially acceptable methods made available to one and all the members of the community with their full participation and at a cost that the community and the country can afford.* This view forms an integral part of the country's health system, which is understood to contribute to the overall socio-economic development.

Primary health care covers:

- promotive, preventive, curative and rehabilitative services;
- prevention and control of endemic diseases;
- adequate supply of safe water and basic sanitation;
- promotion of food supply and nutritional services;
- maternal and child health care;
- family planning services;
- provision of essential drugs;
- immunization against vaccine preventable diseases and
- health education regarding prevailing health problems and their solutions.

National Health Policy

Adopted during the Sixth Plan (1980-85) by the Parliament in 1983, the National Health Policy underlined the need to provide universal, comprehensive primary health care relevant to the actual needs of the community at a cost that people can afford. The policy emphasized the need to re-structure the health services with the following broad aims:

- Provision of a network of primary health care services with organized support of volunteers, auxiliaries, paramedics and adequately trained multi-purpose workers.
- Location of curative centres according to the size of the population they serve.
- Large-scale transfer of knowledge, skills and techniques to health volunteers selected by community.
- Efforts to build up individual self-reliance and community participation.
- A well functioning referral system to provide support to family health care.
- Establishing a nationwide chain of sanitary-cum-epidemiological stations to provide integrated service to eradicate/control diseases.
- Support of voluntary agencies in health services.
- Establishing centres for specialized treatment wherever required.
- Make special efforts in the areas of mental health and rehabilitation work.
- Priority to the provision of services to people living in tribal, hills, backward and disease prone areas.

Special emphasis was given to Rural Health Care in the Seventh Plan (1985-90). It stipulated the establishment of the following:

— One sub-centre for a population of 5,000 in planes and 3,000 in tribal and hilly areas.

— One primary health centre for a population of 30,000 in planes and 20,000 in tribal and hilly areas.

— One community health centre for a population of 1,00,000 (one block).

It was envisaged to cover the entire population by setting up 54,883 sub-centres and 12,390 PHCs. But the targeted 1,553 Community Health Centres were not sufficient to cover even 50% of the population. The policy also contained an analysis of the poor state of health status and health services. It admitted that such an approach had been at the cost of comprehensive primary health care. In view of the significant epidemiological and demographic changes in the country, an exercise was undertaken by the Ministry of Health and Family Welfare to revise the National Health Policy. The revised draft National Health Policy has since been formulated. The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. Overriding importance has been given to ensuring a more equitable access to health services across the social and geographical expanse of the country to tackle the dual menace of communicable and non-communicable diseases. The Department of Health is implementing disease control programmes for controlling communicable diseases, such as malaria, TB, leprosy and AIDS, as well as non-communicable diseases like blindness, cancer, mental disorders, etc. Disease surveillance programme is also under implementation in 100 districts with a proposal to be extended to cover the entire country during the Tenth Plan Period. The plan outlay for the central health sector scheme during the year 2001-02 was Rs. 1,450 crores, which is an increase of 11.5 % over the outlay of the then previous year.

3.5 ORGANISATIONAL STRUCTURE

Starting from the periphery at every village or a population of 1,000 there is one community health worker/health guide who acts as a link between health services and the people.

For a population of 3000-5000 there is one sub-centre, which is staffed with one male and one female multipurpose worker (MPW). These grass roots level workers provide comprehensive promotive, preventive and basic curative services. They also help in

implementing programmes for controlling communicable diseases, family welfare services and maternal and child health services.

For 3-4 sub-centres there are two (one male and one female) health assistants, who provide supervisory support and act as links between the sub-centres and PHCs.

For a population of 20,000-30,000, a Primary Health Centres (PHC), which is the main centre of health services, provides composite health services. It is staffed with one male and one female medical officer, one male and one female health assistant, a block extension educator, a lab technician, a pharmacist, a statistical assistant, two persons for secretarial work and a few multi-purpose workers.

A Community Health Centre (CHC) is there for a population of 1,00,000. It is a thirty-bedded hospital, with X-ray and laboratory services, specialized services and surgical services. As for its staff, it normally has four specialists (surgery, medicine, obstetrics & gynecology and pediatrics), three medical officers, eight nurses, two pharmacists, one X-ray technician, ophthalmic assistant and other ward and support staff. The CHC is responsible for providing specialized services including surgical services and referral services to all the PHCs.

There is a proposal to have a sub-divisional health centre for a population of approximately 5,00,000 people. It is also proposed that every district with a population of over 10,00,000 people would have an apex medical organization from where all health services pertaining to that district would radiate. It will also support, co-ordinate, supervise and control the entire network of health care services for that district.

At the Centre, the Department of Health in the Ministry of Health and Family Welfare is responsible for formulating different plans and policies pertaining to health care of the country. They are also responsible for launching and implementing various programmes of health care nation wide. The organisational structure of the rural health care mentioned above is broadly as per the plan spelt out by the Ministry, though there may be some variations in the states depending upon various factors.

Check Your Progress III

Note: a) Use the space provided for your answers.

b) Check your answers with the possible answers provided at the end of this unit.

1) Describe the Primary Health Centre (PHCs) network in brief.

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2) What is the concept of Primary Health Care and what does it cover?

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3) List the five main features of the National Health Policy 1983.

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3.6 HEALTH CARE PROGRAMMES

The Government takes concerted measures to combat communicable and non-communicable diseases at the national level. For this purpose, the Centre organises various National Health Programmes, which have a bearing on morbidity and mortality and hence improve the quality of common man's life. These programmes also reinforce the delivery of primary health care throughout the country. We shall dwell upon a few of the major ones relevant to rural health.

3.6.1 National TB Control Programme

TB is an infectious disease caused by a bacterium. It is spread through air originating from a person suffering from TB. A single patient can infect ten or more people in a year. Generally, it affects people in their most productive years of life and is commonly associated with poverty, over-crowding and malnutrition. National Tuberculosis Control Programme (NTCP) has been under implementation since 1962 with the objective of detecting as many cases as possible and effectively treating them. Since its inception, the programme has been integrated with the primary health care infrastructure in the states. In 1992, an expert committee evolved a Revised National Tuberculosis Control Programme (RNTCP) based on the Directly Observed Treatment Shortcourse (DOTS) strategy, under which the patients swallow the drugs under the direct observation of a health worker (DOT provider). RNTCP has been expanding rapidly and the present coverage is over 252 million. It is anticipated that the entire country would be covered by 2005.

3.6.2 National Programme for the Control of Blindness

The National Programme for the Control of Blindness was launched in 1976 with the goal to reduce the prevalence of blindness from 1.4% to 0.3% by the year 2000. The programme objectives were to develop eye-care infrastructure throughout the country, expand coverage to under served areas, secure participation of the non-government and the private sectors. Since the major cause of visual impairment and blindness in more than half the cases is cataract, a target-oriented cataract operation programme was also initiated. There was a shift from eye-camp approach to a fixed facility surgical approach, and also from conventional surgery to lens implant surgery for a better quality of post-operative vision. There is a provision for financial assistance to Non-Government Organisations for performing free cataract operations and also for grants in aid to NGOs for organising eye-camps. There is also non-recurring grant-in-aid to NGOs for expansion/upgrading of eye-care units in backward rural areas.

3.6.3 National Leprosy Control Programme

The National Leprosy Control Programme has been in operation since 1955. With the availability of highly effective treatment of leprosy, the programme was re-designated as *National Leprosy Eradication Programme* in 1983. Free multi-dose therapy services are now available in all the districts of the country. Any person having

suspected signs of leprosy can consult the nearest health worker or PHC or leprosy clinic for free advice and treatment.

3.6.4 National Malaria Eradication Programme

The National Malaria Eradication Programme is the world's biggest programme against a single communicable disease. An organized programme for controlling malaria in the country has been in operation since 1953. In 1979, it was renamed the National Anti-Malaria Programme (NAMP). Implementation of this programme recorded dramatic successes, but an era of resurgence followed with a peak in1976. The challenge was met with a change in the malaria control strategy in 1995, with emphasis on (i) early case detection and prompt treatment, (ii) selective vector control, (iii) promotion of personal protection methods, (iv) early detection and containment of epidemics, (v) information, education and communication and (vi) management capacity building.

3.6.5 National Filaria Control Programme

The National Filaria Control Programme comprises anti-larval measures, environmental methods of controlling mosquito breeding, biological control through larvivorous fish and anti-parasite measures. Since 1997, 13 districts in 7 states have been brought under the ambit of single-dose mass administration of DEC(an anti Filaria drug).

3.6.6 National Iodine Deficiency Disorders Control Programme

The National Iodine Deficiency Disorders Control Programme launched in 1962 aims at bringing down the prevalence of Iodine Deficiency Disorders (IDD) to below 10% in all districts of the country. Sample surveys conducted in 25 states and 5 union territories have revealed that IDD is a major health problem in 241 districts where the prevalence is more than 10%. The aim of the programme is to identify areas suffering from this problem and supply iodized salt in place of common salt in order to reduce the deficiency of iodine content in the food taken at those places.

3.6.7 Medical Care for Remote and Marginalized Tribal and Nomadic Communities

Medical Care for Remote and Marginalized Tribal and Nomadic Communities is a new scheme that was launched during the Ninth Five Year Plan with an outlay of rupees ten crores. Under this scheme, various projects have been taken up by ICMR, viz the prevention and control of hepatitis B among the primitive tribes of Andaman and Nicobar Islands; the programme for cholera, gastroenteritis and vitamin A deficiency among the tribes of Orissa and the intervention programmes for nutritional anaemia among the primitive tribal population of India.

3.6.8 National Mental Health Programme

National Mental Health Programme: This programme envisages a community based approach to the problem which includes training of mental health teams at the identified nodal institutes, increase awareness about mental health problems and provide services for early detection and treatment of mental illnesses. The Government of India provides funds to the State Governments and the nodal institutes to meet the expenditure on staff, equipment, medicines, training activities, etc. This programme is under implementation in 22 districts in 20 states with a budgetary allocation of rupees 28 crores in the Ninth Five Year Plan.

3.7 FAMILY WELFARE SERVICES

Population explosion has been the most crucial problem our country is facing. We were 361 million in 1951; the number doubled by 1981 and rose to 837 million in 1991 (an increase of about 15 million every year) and in 2001 our population reached 1027 million.

India has been the first country to officially adopt a National Family Planning Programme. The objectives laid down in the First Five Year Plan (1951-56) were to obtain an accurate picture of the factors contributing to the rapid growth of our population, to discover suitable techniques of family planning and make advice on family planning an integral part of the health services. Since then, policies have been revised from time to time and their implementation has shown significant increase in expenditure on family welfare services over the years. More than two-thirds of the plan outlay of the family welfare programmes is allocated to services and supplies and maternal and child care facilities. Family welfare is a Centrally sponsored programme. Although the schemes are implemented through the State Governments, the cost is borne entirely by the Centre.

Reproductive and Child Health Programme

On the recommendations of the International Conference on Population and Development, held in 1994 at Cairo, Egypt, the Government of India launched the Reproductive and Child Health (RCH) Programme on 15th August 1997. The concept of RCH Programme is to provide need based, client centered, demand driven, high quality and integrated RCH services to the beneficiaries.

The main highlights of the RCH programme are as follows:

a) The programme integrates all interventions of fertility regulations, maternal and child health with reproductive health of both men and women.

b) The services provided are client centered, demand driven, high quality and need based.

c) The programme envisages upgrading the level of facilities for providing various interventions.

d) Attempts are on for improving the facilities for obstetric care, MTP and IUD insertion in PHCs and sub-centres.

e) The programme aims at improving the outreach of services primarily for the vulnerable sections of the population.

f) Involvement of NGOs and voluntary organisations encouraged and welcome.

Maternal Health

The major causes of high maternal mortality have been identified as anaemia, hemorrhage, toxemia, obstructed labour, and infections after delivery and unsafe abortions. To tackle these problems, the new initiatives taken are as follows:

a) Contractual appointment of staff.

b) 24-hour delivery services at PHCs/CHCs.

c) Referral transport to indigent (very poor) families.

d) Safe motherhood consultants (doctors trained in MTP).

e) Training of *dais*.

Child Health

Improvement in child health and survival are important aspects of family welfare programmes. Low birth weight, diarrhoeal diseases, respiratory infections, vaccine preventable diseases, inadequate maternal care and that for the new born have been identified as the major causes of high infant and child mortality in our country. Under the RCH programme, interventions like anti-natal care, increasing safe deliveries, essential care for the new born, immunization against six vaccine preventable diseases and control of diarrhoea deaths are being implemented. As a result of these interventions deaths due to vaccine preventable diseases have come down significantly. Similarly with the implementation of the Oral Re-Hydration Programme, the deaths due to diarrhoea have come down from an estimated 10-15 lakhs in 1985 to 6 lakhs in 1997.

Involvement of NGOs in the Family Welfare Programmes

the NGO division of the Department of Family Welfare is looking after the Mother NGO proposals (received from all over the country) and the innovative projects undertaken by the National NGOs.

3.8 PRESENT STATUS AND ITS REVIEW

The Government of India, through the Ministry of Health and Family Welfare, has been providing infrastructure for delivering health care services to rural masses over the years. We have studied the evolution of such services, the organisational structure and various vertical programmes involved in the delivery of such services. As per the population norms, the existing infrastructure of PHCs is inadequate in many states. The Department of Family Welfare does not provide funds for setting up new ones. The State Government is responsible for opening and maintaining these centres under the MNP/Basic Minimum Service programmes. **Pradhan Mantri Gramodaya Yojana for Primary Health Sector** is an initiative to strengthen and revitalize the primary health infrastructure for improved provisioning of the basic minimum services in rural areas, so as to improve the quality of life. The Planning Commission of India allocated an additional Central Assistance of Rs. 2800 crores in 2001-2002 for six sectors viz. Rural Electrification, Primary Health, Primary Education, Shelter, Drinking Water and Nutrition. Further improvements are being planned and implemented in the current plan period.

The present status of health services may be visualized in Table-4 below.

Table 3.4: Health Status at a Glance

Item	Year	Status
The Number of PHCs functioning in rural India:		
— Sub-centres		1,37,292
— PHCs	2001 – 02	22,807
— CHCs		3,027
The number of hospital beds		
— For the whole of India	Jan. 1988	5,85,889
— Urban		4,92,820
— Rural		93,069
The number of hospital beds		
— For whole the of India	Jan. 1998	6,65,639
Population per hospital bed	1998	1,451
Hospital beds per 10,000 population	1998	6.9

Life Expectancy	2000	64.6 yrs
Crude Birth Rate	2001	27.5
Crude Death Rate	2001	8.4
Infant Mortality Rate	2001	66
Maternal Mortality Ratio	1998	407
Deliveries attended by trained personnel		
—Total	1995-96	42.3%
—Urban		73.5%
—Rural		33.5%
Women of childbearing age using family planning services	1998-99	48.2%
Eligible infants up to 1 year who have been fully immunized according to National Immunization Policy	1998-99 2001	34.5% 49.0%
Prevalence of low-weight birth rate		
(Weight < 2500 gms at birth)	1995-96	
—Total		23.0%
—Urban		21.0%
—Rural		24.0%

Source: National Family Health Survey, 1998-99, Oct. 2000, Health Information of India, 1997,98, July 2000, SRS Bulletin 2001, SRS Vol. 36 No.1,April 2002

Looking at the above figures, it is apparent that the health situation in India, especially in the rural areas, is far from satisfactory, though there has been an improvement in the health status of the rural population since independence. The ICSSR and ICMR study group in its report *'Health for All: An Alternative Strategy (1981)'* commented that the overall picture was a mixture of light and shade. There are some areas of outstanding achievements, like the eradication of smallpox, but there are many areas of grave failures. The report also observed that there was not much change in the overall picture of mortality. The diseases like malaria, leprosy, cholera, filaria, measles, TB, gastroenteritis, whooping cough, bronchitis, pneumonia, etc. are still the commonest causes of morbidity and mortality. They all can be attributed to poverty, ignorance, bad nutrition, bad sanitation and lack of safe potable water and low levels of immunity. The report also observes that though there is reasonable growth in the health care services, they are unrelated to the needs of the poor and rural people. The delivery system appears to be based more on western models having no roots in the culture and traditions of our people. The major drawbacks are that it is more of a curative approach and comprises more of urban secondary and tertiary care through hospitals. Despite setting up a huge PHC network, there are difficulties because of its urban bias.

There is also a mention of services being highly centralized and bureaucratized rendering it unable to cope with the problems of distance and those of referral services for PHCs.

Too much dependence on doctors has also been a shortcoming, as they do not have the right kind of training in preventive and community health. There is no system to motivate qualified doctors to go to rural areas.

The National Health Policy too attributed the unsatisfactory health situation in the country to the adoption of hospital based curative approach to health services at the cost of comprehensive health care to all. Some experts feel that the preventive programmes were not designed on the basis of proper field surveys.

Various expert committees have been reviewing the status of health services from time to time. According to some, the health care delivery system in the rural areas of our country is said to fail at the periphery, i.e. the services do not reach the poor or the bulk of the rural people. Lately the policy has been concentrating on curative institutions in cities equipping them at par with international standards of medical care, while the peripheral institutions are deprived of the most basic facilities.

The report of an Indian Council of Medical Research Study (1989) on PHCs reflects the unsatisfactory picture of health services at the grass roots level with reasons as follows:

1) Most of the PHCs were not equipped with proper staff.
2) Most of the PHCs did not have adequate supply of medicines.
3) Labour room and operation room facilities were inadequate.
4) Majority of sub-centres had no facilities for the routine check-up of pregnant women.
5) The pre-natal, anti-natal and family planning services were found to be unsatisfactory.
6) The neo-natal, child-care and immunization facilities were found to be unsatisfactory.

A national review of the Immunization Programme in India (1989) covering 35 districts and 8 urban units states that despite the extensive efforts under the universal immunization programme, morbidity and mortality due to vaccine preventable diseases continue to be high. During the survey it was found that often there was a short supply of vaccine or the equipment required for cold chain. Poor monitoring of the quality of vaccines, no power supply and poor supervision were the other areas responsible for unsatisfactory results. The universal immunization programme was given the status of National Technology Mission in 1986 and became operational in all districts of the country during 1989-90. It became a part of Reproductive and Child Health Programme (RCH) in 1997. The results in the last thirteen years (1987-2000) have been encouraging as shown by the significant decline in the reported incidents of these diseases as compared to the incidents in 1987. By the end of March 2001, coverage levels had improved significantly.

Table 3.5: Immunization

Immunization Status (% coverage)	**(2000 – 2001)**
TT for pregnant mothers	83.4
B.C.G.	102.7
Measles	92.1
D.P.T.	100.3
Polio	98.2

Source: Office of Registrar General India & Ministry of Health and Family Welfare

Table 3.6:Decline in the Incidence of Diseases

Diseases	**1987**	**2000**	**% decline**
Polio	28,257	265	99.06 %
Diphtheria	12,952	4,352	66.40 %
Whooping Cough	1,63,786	26,752	83.70 %
NNT	31,844	2,197	93.10 %
Measles	2,47,519	25,259	89.80 %

Source: Annual Report Ministry of Health and Family Welfare, 2001–02

Pulse polio immunization for polio eradication was launched in the country in 1995, as a result of which the number of polio cases has shown a rapid decline from 1,934 in 1998 to 161 in 2001.

The success story of the National Health Programmes also is a mixed one. Malaria showed resurgence (peak incidence 6.47 million cases in 1976), but has been controlled with modified plans of operation. There is decline every year, e.g. 12.37 % of the total malaria cases during 2000 and 3.42 % during 2001. In the case of Tuberculosis, the programme has been expanded with considerable increase in budget allocation, but the incidence of the disease is not showing any let up. The Government of India and WHO joint review of the programme was undertaken in February 2000, and it was found that the implementation of RNTCP was successful and there has been a striking increase in the proportion of patients cured. The prevalence rate of Leprosy is 3.74 cases per 10,000 persons, reduced from 57 per 10,000 in 1981.Thirteen states have reached elimination level (prevalence rate of less than 1 per 10,000). Thanks to the widespread availability of MDT, almost every "leprosy beggar" at traffic lights in fact is a fully treated and non-infectious leprosy patient.

Check Your Progress IV

Note: a) Use the space provided for your answers.

b) Check your answers with the possible answers provided at the end of this unit.

1) Fill in the blanks:

a) As per 2001-02 data, the number of PHCs functioning in rural India is .....

b) National Tuberculosis Control Programme was launched in .....

c) The objective of the National Programme for Control of Blindness was to reduce the prevalence of blindness from ..... to .....%.

d) Present (2001 data), Crude Death Rate is .....

e) Resurgence of malaria was seen in (year) .....

f) The % decline in the case of measles is ..... % from 1987 to 2000.

g) In the administrative structure of rural health care in India, the community health centre caters to a population of ..... persons.

2) List four reasons given in the report of ICMR study (1989) for unsatisfactory rural health care.

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3) Mention the main reasons due to which the health care services have not been significantly satisfactory in rural India.

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3.9 LET US SUM UP

In this unit we have emphasized that health is an important parameter of development. The Government is committed to the objective of providing health for all. At present the health scenario as depicted by the various health indicators is unsatisfactory, more so in the rural areas. The health situation of the country has undergone significant changes during the past few years but the communicable diseases continue to be the leading cause of morbidity in rural areas. There is a definite need for improving the system for an adequate and comprehensive health care services in rural India.

We also presented an overview of the health care services available in our country. There is an extensive infrastructure for providing primary health care services at the grass root level and this is being continuously monitored, upgraded and reviewed by the Ministry of Health and Family Welfare. We learnt that the health status of the rural masses continues to be far from satisfactory, mainly because of the urban *hospital bias*, thrust on curative approach, non-involvement of communities in policy making, low priority to public health programmes and lack of medical human resource for rural areas.

We also analyzed the impact of various programmes and health care services. There has been a marked improvement in certain segments of health status spelling the success of certain National Programmes like Pulse Polio Programme, RCH Programme, etc. There is still a vast scope for improvements.

3.10 KEY WORDS

Birth Rate : Number of births in a year per thousand mid-year population.

Cold Chain : A process required to maintain, store and transport the vaccines at required cold temperature.

Crude Death Rate : Number of deaths in a year per thousand persons.

0-4 Age Specific Mortality : Number of deaths in the age group 0-4 years per thousand children in the same age group in a given year.

Infant Mortality Rate : Number of the deaths of infants (within one year of birth) per thousand live births in a year.

Life Expectancy at Birth : The number of years a new born child is expected to live subject to the mortality risks prevailing for the population at the time of its birth.

Low Birth Weight	**:**	Less than 2,500 Gms.
Per capita Income	**:**	The national income divided by the population of the country or the average income per head.
Sex Ratio	**:**	The number of females per thousand males in the population.
Epidemiology	**:**	The study of the distribution and the determinants of disease prevalence in a population.

3.11 REFERENCES AND SUGGESTED READINGS

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3.12 CHECK YOUR PROGRESS – POSSIBLE ANSWERS

Check Your Progress I

1) Two thirds of our population lives in rural areas where health services are far from satisfactory. The ill effects of natural disasters like heavy rains, floods and cyclones are maximum on rural population. Poverty plays an important role in non-availability of quality health care. Infections (which are preventable) are still a major cause of mortality and morbidity leading to poor health and development in rural areas.

2) Health of a community is directly related to productivity as sickness and poor health leads to poor quality of life and low productivity.

3) Poverty exposes a person to inadequate nutrition, clothing, shelter and poor sanitary condition leading to high incidence and prevalence of disease. Poverty also predisposes to crime, violence and drug abuse responsible for low productivity. Inability to pay for promotive and curative medical services also leads to poor health.

Check Your Progress II

1) a) 9.0, 6.3
   b) Kerala, 11
   c) Orissa
   d) 75 million
   e) 933
   f) 18.9

Check Your Progress III

1) One community health worker for every village or a population of 1000

   A sub-centre for a population of 3000-5000 for comprehensive primary care

   A male and a female health assistant for 3-4 sub-centres

   A primary health centre for a population of 20000-30000

   A community health centre (30 bedded hospital) for a population of 1,00,000

2) Primary health care is a nucleus of health care system based on practical and socially accepted methods being made available to all the members of the community with their participation at a cost that community can bear.

   It covers promotive and preventive like immunizations and sanitary services, curative medical services, maternal and child health, family planning services. It also covers rehabilitative services and health education.

3) Providing a network of primary health services

   Developing individual self reliance and community participation

   Efficient referral system to provide support to family health care

   Priority of people living in tribal and backward areas

   Support of voluntary agencies in health

Check Your Progress IV

1) a) 22,807

   b) 1962

   c) 1.4, 0.3

   d) 8.4

   e) 1976

   f) 89.8

   g) 1,00,000

2) Inadequate staffing and inadequate supply of medicines at PHCs in the rural area has been the major reason for unsatisfactory rural health care. At sub-center's level there were no facilities for anti-natal check ups of pregnant woman and family planning services. The child care and immunization facilities were also found to be unsatisfactory.

3) Though overall picture of mortality and morbidity shows an improvement since independence, diseases like small pox, polio, whooping cough show a definite decline but malaria, measles, TB and some other infectious diseases are still the common cause of mortality and morbidity in rural areas. The major cause appears to be poverty, ignorance, bad nutrition, insanitation and lack of potable water. The health care services seem to be unrelated to the needs of the poor and rural people having no roots in the culture and tradition of the village people. The urban bias in secondary and tertiary care is also responsible for unsatisfactory rural health care.