BLOCK 2
HEALTH IN RURAL INDIA

BLOCK 2 HEALTH IN RURAL INDIA

Introduction

'Health is wealth' is a common proverb. Health is the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically and emotionally. Health forms an important index of human development which influences the overall development of any society.

We are introducing this block viz. Health in Rural India, as part of Post-Graduate Diploma in Rural Development (PGDRD) Master's Programme in Rural Development (MARD) as we believe that understanding of health in rural India through its infrastructure provides a scope for measuring the health status of the community. Rural Health is one of vital elements of rural life. India being a nation of villages requires an intensive approach towards rural health. Almost seventy per cent of the total population of India lives in rural areas and most of the weaker section of the population is also concentrated in rural areas of India. If the basic health care does not reach to rural areas, where majority of population resides, no matter how much progress is achieved in the urban and semi-urban areas the overall growth of a nation can never be inclusive.

In **Unit 5,** we have attempted to explain the concept, determinants and dimensions of health. Understanding health care structure of rural India brings the significance for achieving Millennium Development Goals (MDGs) and also in improving the health status of people. The understanding of socio-cultural factors in relation to health care provides the challenges of rural health sector in its delivery.

India's health system in terms of state and central health services; public and private and voluntary sectors; allopathic and non-allopathic doctors, qualified and unqualified practitioners and multiple levels has been explained in **Unit 6**. Health financing and manpower are also included in infrastructure of health delivery systems.

Health and nutrition seeking behaviour an important factor that defines a healthy society is explored in **Unit 7**. People in different communities, differentiates regarding consumptions of nutritional food, which in turn helps in understanding the nature and status of health seeking behaviour in rural India.

The health issues related with women, children and vulnerable sections of society are dealt in **Unit 8**. The existing health challenges and government's effort to address healthcare issues of women, children and vulnerable groups in India are addressed in this unit.

Hope this block will help in understanding overview and assessment of the prevailing situations related to healthcare needs of the Elderly and Persons with Disability in India and government initiatives extend to these groups.

UNIT 5 RURAL HEALTH: NEED AND SIGNIFICANCE

Structure

5.0 OBJECTIVES

After reading this unit, you will be able to :

- explore the importance of health for human development;
- explore the significance of rural health for achieving Millennium Development Goals (MDGs);
- understand the impact of poverty and other socio-cultural factors on health indicators of rural India;
- understand the health care structure of rural India;
- know the present health care situation of rural India;
- understand various health policies which aim at improving rural health status; and
- understand present challenges which rural health sector are facing.

5.1 INTRODUCTION

The wisdom of every culture teaches that 'health is wealth'. Health is the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically and emotionally. Health forms an important index of human development which influences the overall development of any society. The human development is a function of three critical dimensions: longevity (the ability to live a long and healthy life); education (ability to read, write and acquire knowledge); and command over resources (the ability to enjoy a decent standard of living and have a meaningful life) (HDI, 2019). According to Oxford dictionary, the meaning of health is the state of being free from illness or injury whereas World Health Organisation (1948) says that health is not merely the absence of disease and infirmity but a state of complete physical, mental and social well-being.

India is home to one-sixth of the world's population and therefore the state of the health of the Indians has a significant bearing on the state of the world's health. Moreover, India as a growing economy is dependent on the health status of its population for its economic growth. Government initiatives in public health have recorded some noteworthy success over a period of time where India has achieved considerable improvements in human development index with an overall global ranking of 129 out of the 189 countries (HDI, 2019). However, as compared to other developed and developing countries (like China, Sri Lanka, Malaysia, Maldives, and Indonesia), India human development index is poor. Further, this rank indicates the overall status of India but does not depict the rural-urban variations and contradictions.

Table 5.1: Human Development Index Ranking (2019)

Countries	Rank	Life Expectancy at Birth (years)
Malaysia	61	76.0
Sri Lanka	71	76.8
China	85	76.7
Maldives	104	78.6
Indonesia	111	71.5
India	129	69.4

Source: Human Development Report 2019 (UNDP)

Check Your Progress I

1) What is the association of heath with human development?

.....

.....

.....

.....

.....

2) What is the current HDI ranking of India and its neighbouring country?

.....

.....

.....

.....

.....

5.2 RURAL HEALTH AND MILLENNIUM DEVELOPMENT GOALS (MDGs)

Rural Health is one of vital elements of rural life. India being a nation of villages requires an intensive approach towards rural health. Almost 68.8% of the total

population of India lives in rural areas and most of the weaker section of the population is also concentrated in rural areas of India (Census, 2011). If the basic health care does not reach to rural areas, where majority of population resides, no matter how much progress is achieved in the urban and semi-urban areas the overall growth of a nation can never be inclusive. India, in order to achieve its Millennium Development Goals (MDGs), has to increase the accessibility of health care facilities to the rural areas. For inclusive economic growth improving access to basic healthcare services to the rural population is of utmost importance.

The MDGs adopted by the United Nations in the year 2000 project the efforts of the international community to "spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty (Government of India, 2017). The MDGs are eight goals to be achieved by 2015 that respond to the world's main development challenges. These goals are further subdivided into 18 numerical targets which are further measured using 40 quantifiable indicators. Health constitutes the prime focus of the MDGs. While three out of eight goals are directly related to health, the other goals are related to factors which have a significant influence on health. Hence the goals and targets are interrelated in many ways. The eight MDGs are to (1) eradicate extreme poverty and hunger; (2) achieve universal basic education; (3) promote gender equality and empower women; (4) reduce child mortality; (5) improve maternal health; (6) combat HIV/AIDS, malaria, and other diseases; (7) ensure environmental sustainability; (8) develop a global partnership for development.

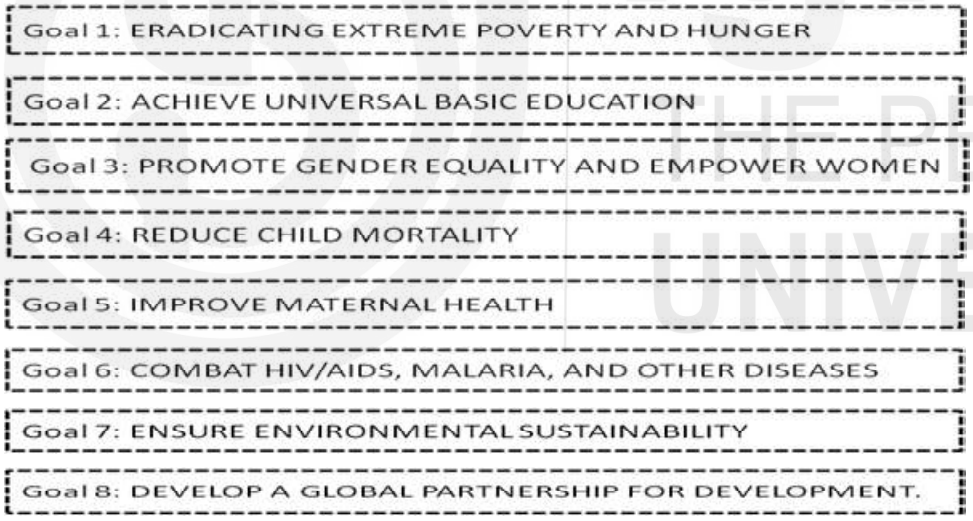


Fig. 5.1: Millennium Development Goals (MDGs)

Check Your Progress II

1) How many MDGs are directly rated to health?

.....

.....

.....

.....

.....

2) Why India needs to increase access to health care services in rural areas?

.....

.....

.....

.....

.....

3) According to the census 2011, what is the percentage of rural population of India?

.....

.....

.....

.....

.....

5.3 RURAL HEALTH AND POVERTY

In the preceding session, we find that majority of the population in India resides in the rural area. Besides this, it is also a harsh reality that majority of disadvantaged section of our society is also concentrated in the rural area. According to the Government of India (2018), total poverty rate in rural India is 25.7% whereas the corresponding percentage for an urban area is 13.7%. Although the overall poverty rate is decreasing both in the rural and urban area the poverty gap between rural and urban areas continue to exist. Further, Indian village is often characterised by ignorance, illiteracy, lack of awareness, orthodox practices, the prevalence of rigid-socio cultural practices, etc. Health is influenced by several genetic, environmental, social and economical factors. The health of a community is intimately related to its economic status, social-cultural practices 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. Thus to improve the health situation of the people of rural area it is essential to make health care facilities available to them as well as provides them with basic health care knowledge and awareness.

Table 5.2: National poverty estimates (% below poverty line) during 1993-94 to 2011-12

Year	Rural (%)	Urban (%)	Total (%)
1993 – 94	50.1	31.8	45.3
2004 – 05	41.8	25.7	37.2
2009 – 10	33.8	20.9	29.8
2011 – 12	25.7	13.7	21.9

Source: Government of India 2018, India in Figures

Check Your Progress III

1) What are the various factors which can impact the health status of an individual?

.....

.....

.....

.....

.....

2) What is the total poverty rate in rural and urban areas of India?

.....

.....

.....

.....

.....

5.4 RURAL HEALTH CARE STRUCTURE

Before discussing the health situation of rural areas it is essential to understanding rural health care structure. The health care services are divided under state list and concurrent list in India. While some items such as public health and hospitals fall in the state list, others such as population control and family welfare, medical education, and quality control of drugs are included in the concurrent list. The Union Ministry of Health and Family Welfare (UMHFW) is the central authority responsible for the implementation of various programmes and schemes in areas of family welfare, prevention and control of disease. The health care under public sector in rural area follows a three-tier system namely Sub-Centre (SC), Primary Health Centre (PHCs), and Community Health Centres (CHCs).

Sub-Centre

Sub-centre is the peripheral unit available at the village level to take care of the health needs of the community. One Lady Health Visitor (LHV) is entrusted with the task of supervision of six sub-centres. A Lady Health Worker (LHW) is in charge of sub-health centres. Each Sub-Centre is required to be manned by at least one Auxiliary Nurse Midwife (ANM) and one male Multi Purpose Worker (MPW). Under the National Rural Health Mission (NRHM), there is a provision for one additional second ANM on a contract basis. Each Sub Centre is required to provide basic drugs for minor ailments and is expected to provide services concerning maternal and child health, family welfare, nutrition, immunization, diarrhoea control, and control of communicable diseases.

Primary Health Centre (PHCs)

In India, PHCs form a basic part of the health care system. The medical officer is appointed to run the PHC and PHC is the first contact point between village community and the medical officer. The PHCs were envisaged to provide an

integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care Primary field staff, who provide outreach services, are called ASHA (Accredited Social Health Activist). The village health nurse (AISA) provides service at the point of care, often in the patient's home. If additional diagnostic testing or clinical intervention is required, the patient is transported to the PHC to be evaluated by the medical officer.

Community Health Centres (CHCs)

CHCs are being established and maintained by the state government under the Minimum Needs Programme (MNP)/Basic Minimum Services (BMS) programme. Four medical specialists including surgeon, physician, gynaecologist and paediatrician support by 21 paramedical and other staff are suppose to staff each CHCs. Norms require a typical CHCs to have 30 indoor beds with operation theatre X-ray, labour room, and laboratory facilities. A CSC is a referral centre for four PHCs within its jurisdiction providing faculties for obstetric care and specialist expertise. There were 5363 CHCs functioning in the country in 2014.

Table 5.3: Health Centre Norms

Year	Population Norm	
	Plain Area	Hilly/Tribal/ Difficult Area
Sub Centre	5,000	3,000
PHCs	30,000	20,000
CHCs	1,20,000	80,000

Source: Government of India 2012, IPHS Guidelines for Sub Centres

Thus, in the field of rural health, the objective was to establish: one Sub-centre for a population 5000 people in the plains and 3000 in tribal and hilly areas, one Primary Health Centre (PHC) for 30000 population in plains and 20000 population in a tribal and hilly area, and one Community Health Centre (CHC/Rural Hospital) for a population of one lakh.

Check Your Progress IV

1) What are the main functions of Sub-Centres?

.....

.....

.....

.....

2) Write down the full form of AISHA, ANM and LHW?

.....

.....

.....

.....

5.5 HEALTH CARE SITUATION OF RURAL INDIA

In 1978, in a landmark global conference organized by World Health Organization (WHO) and UNICEF at Alma Ata (erstwhile USSR), a revolutionary strategy based on primary health care was put forward to reach the goal of Health for All by 2000. After more than three decades, it is the time to critically evaluate where India (particularly rural India) stands in providing healthcare to its people. Since Independence India has made some progress in improving the overall health status of the population. Life expectancy at birth in India was 65.4 years in 2011 as against 55.1 in 1980 (Human Development Report 2011–Sustainability and Equity: A better future for all, United Nations Development Programme (UNDP). Moreover, the same report also says that there is decline in infant mortality, morbidity and maternal deaths. Despite this India continue to face the problem of malnourishment and communicable diseases. Most of the health advancement has occurred in urban areas, policies implemented concentrates largely on growth of economy, not on equity and equality, which have widened the gap between 'urban and rural' and 'haves and have-nots'.

Status of Rural Healthcare facilities and Health Infrastructure

India has made significant progress in improving healthcare, but improving access to basic healthcare services to the rural population is perhaps one of the biggest challenges with which India is dwindling. One of the important causes of poor health status in rural area is the fact that healthcare facilities are remotely available in rural areas. According to the Government of India 2018, only 13 per cent of the rural population has access to primary healthcare and nearly 75 per cent of health infrastructure, medical manpower and other health resources are concentrated in urban areas where 27 per cent of the population lives. When it comes to healthcare, there are two Indias; India, which provides high-quality medical care to middle-class Indians and medical tourists; and India, in which the majority of the rural population lives whose residents have limited or no access to quality health care. India lives in its almost 6.5 Lakhs villages and if basic health care is not to reach the rural areas, then no matter how much progress achieved in the urban and semi-urban areas, as overall growth as a nation will be retarded.

India's healthcare system rests on a primary healthcare system that is grossly inadequate and falls woefully short to ensure that people have access to at least basic healthcare. In 2009-10 only 13 per cent of the rural population has access to a primary healthcare centre with 33 per cent having access to a sub-centre, 9.6 per cent to a hospital and 28.3 per cent to a dispensary or clinic (Government of India, 2018). India has a rudimentary network of public hospitals – there is a shortage of 4,504 primary health centres and 2,135 community health centres in 2009. There is also a shortage of doctors.

Status of Crucial Health Indicators in Rural Area

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 2010 was as high as 50.0; it has fallen to 38.0 by the year 2016. 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 5.4: Estimated Birth Rate, Death Rate and Infant Mortality Rate, 2010- 2016

	Year Birth Rate			Crude Death Rate			Infant Mortality Rate		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
2010	23.7	18.0	22.1	7.7	5.8	7.2	51.0	31.0	47.0
2011	23.3	17.6	21.8	7.6	5.7	7.1	48.0	29.0	44.0
2012	23.1	17.4	21.6	7.6	5.6	7.0	46.0	28.0	42.0
2013	22.9	17.3	21.4	7.5	5.6	7.0	44.0	27.0	40.0
2014	22.7	17.4	21.0	7.3	5.5	6.7	43.0	26.0	39.0
2015	22.4	17.3	20.8	7.1	5.4	6.5	41.0	25.0	37.0
2016	22.1	17.0	20.4	6.9	5.4	6.4	38.0	23.0	34.0

Source:

Status and Spread of Diseases in Rural Area

The majority of rural deaths are caused by communicable, parasitic and respiratory diseases which are somewhere linked with insanitary environment. Huge population in the rural area lives in unhygienic surroundings which in turn, have given rise to water-borne diseases. Many of these can be easily prevented by providing access to clean drinking water and improving sanitation facilities. The World Health Organisation estimates that overall disease burden would fall by 15 per cent with improved access to clean water and sanitation facilities, while the World Bank estimates that 21 per cent of communicable diseases in India are water-related. Nagla (2018) says that three groups of diseases are widespread in rural area; the first disease that is carried in the gastrointestinal tract, such as diarrhoea, typhoid fever, hepatitis, etc; second diseases that are carried in the air through coughing, sneezing or even breathing, such as measles, tuberculosis, etc; and third include infections, which are most difficult to deal with, like malaria, filariasis and kala-azar. Besides, malnutrition remains widely prevalent in rural areas, despite being preventable and curable. Moreover, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/ AIDS, accidents and injuries are also on the rise.

Check Your Progress V

1) What is the present status of health infrastructure of rural India?

.....

.....

.....

.....

2) What kind of diseases is more prevalent in rural India?

.....

.....

.....

5.6 RURAL HEALTH POLICIES

The healthcare in India has undergone tumultuous changes since *Bhore committee in 1946* and each change has only been for better healthcare delivery, encompassing all the sections of the population. The health sector reforms over the 1990s changed the perspective of healthcare from service to commodity. The *Alma Ata declaration of 1978* launched the concept of 'Health for All' by the year 2000. The Declaration affirmed the need for a balanced distribution of health resources and gave an insight into the understanding of primary health care by calling health an integral part of the socio-economic development of a country. The Declaration recommended that primary health care should include at least: education concerning prevailing health problems and methods of identifying, preventing and controlling them; promotion of food supply and proper nutrition, and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health and provision of essential drugs. It called for an integration of preventive, promotive, curative and rehabilitative health services that had to be made accessible and available to the people, and this was to be guided by the principles of universality, comprehensiveness and equity. The responsibility of the state to provide comprehensive primary health care to its people as envisioned by the Alma Ata declaration led to the formulation of India's *First National Health Policy (NHP) in 1983*. The major goal of the policy was to provide universal, comprehensive primary health services. Similarly, *NHP (2002)* sets out a new policy framework to achieve universal access to health care facilities and for achieving that the policy aims at increasing access to the decentralized public health systems by establishing new infrastructure in rural areas and upgrading the existing infrastructure. However, 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. Through the evolution of the health care system in India, several surveys had put forth the importance of community participation in uplifting the health of the people, especially in rural areas. This led to the implementation of the *National Rural Health Mission* as an important component of the eleventh five-year plan. The NHP (2017) shows its concern for specific groups based on varied axes of vulnerability. Despite improvements in health indicators since independence, the gap across social groups remains wide. It is argued that health is largely determined by the social circumstance and social position which individuals possess.

Check Your Progress VI

1) Write a short note on Alma Atta Declaration.

.....

.....

.....

.....

2) What are broader goals of National Health Policy (2002)?

.....

.....

.....

.....

.....

5.7 NATIONAL RURAL HEALTH MISSION

Recognizing the rural-urban gap in terms of health care facilities and to improve rural health infrastructure, the National Rural Health Mission (NRHM) was launched on 12th April 2005 to improve the availability and accessibility of health care facilities in rural areas, especially for the poor, women and children. The mission was made operational with special focus on 18 states having weak demographic indicators and infrastructure. These eighteen states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. Five core strategies formed the foundation of the NRHM; flexible financing down to village level sub-centres; innovative human resource management; strengthening programme management capacity till district/block levels; setting Indian Public Health Standards (IPHS) and measuring health facilities against these norms; 'communitization' or greater Panchayati Raj Institution (PRI) and community involvement in healthcare planning and provision.

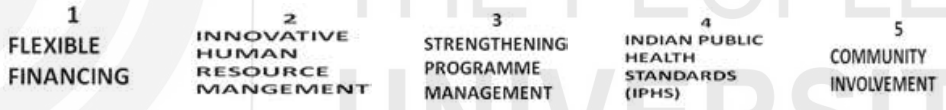


Fig. 5.2: Five Strategies of National Rural Health Mission

NRHM broadly aims at providing quality public health care facilities to the rural population. It also seeks to; reduce Infant Mortality Ratio (IMR), Total Fertility Rate (TFR), Maternal Mortality Ratio (MMR); prevent and control communicable and non-communicable diseases (including locally endemic diseases); revitalize local health traditions and mainstreaming of AYUSH, etc. For achieving these objectives the following initiatives were taken by the Mission.

Improving the availability of critical manpower

The issue of availability of critical manpower in the rural area is proposed to be addressed through initiatives like the introduction of a ASHA (Accredited Social Health Activist) in every village of the 18 high focus states, additional Auxiliary Nurse Midwife (ANM) at each sub-centre, three staff nurses at the Primary Health Centres (PHCs) to make them operational round the clock and additional specialists and paramedical staff at the Community Health Centres (CHCs).

Capacity Building

Given the large army of ASHAs, ANMs, Nurses, and rural medical practitioners the Mission proposed continuous skill development. Strengthening nursing

institutions, linking medical colleges for providing skill development support to rural health workers, involving the voluntary sector in skill development are few key interventions which were taken up.

Decentralisation

For universal health coverage in rural areas, NRMH encourages participation of Panchayat Raj, Zilla Parishad, NGOs and other wide range of community-based organizations (like Self Help Groups, School, Water, Health Nutrition and Sanitation Committees, Mahila Samakhya Groups) and makes them accountable in providing health care opportunities. Initiatives were taken to ensure proper school health check-ups and school health education to be provided to the students. It aims at enhancing the capacity of the Panchayat Raj Institutions (PRIs) to own control and manage public health services.

Normative Framework

The Mission proposed to prepare district health action plans based on a normative framework and health plan for each village through village health Committee of the Panchayat.

Mainstreaming of AYUSH

NRHM also enabled mainstreaming of AYUSH and made provision for providing AYUSH wings in PHCs and CHCs. Efforts are made to integrate AYUSH in primary health delivery.

Reducing IMR/MMR/TFR and the disease burden

Reproductive and child health programme (RCH-II) was launched in 2005 as a part of the Mission as the principal vehicle for reducing IMR, MMR and TFR. Efforts are taken to integrate HIV/AIDS programme with the RCH at the district and sub-district levels.

Financial Plans

Besides increasing the over-all finical budget for health, for improved delivery, the Mission attempts to bring the schemes of the Ministry of Health and Family Welfare within the overarching umbrella of NRHM. It proposed to have a single budget head for the activities under the Mission. The funds under the NRHM budget head would flow through the integrated health society at the state and the district levels. The norms under which the funds would be allocated by the centre to the states and by the states to district based on integrated state/district health activity plans that have been spelt out in the implementation framework.

Achievements of NRHM

All the key health system inputs got a major impetus during the NRHM; including health financing, governance, human resources (HR), health information, drugs and technologies, and service delivery. However, the gradient varied from component to component and state to state, both in terms of quantity and quality of inputs. Unlike many other programmes in the health sector in the past, the NRHM is about crafting a credible public system of health delivery at all level starting from the village and going right up to the district level. One of the key aspects which responsible for the success of NRHM implementation was the decentralization at all levels of health care. All programmes (HIV/AID, cancer and mental health) were brought under the umbrella of NRHM.

The latest census figures reveal that indicators such as literacy, access to clean drinking water, or hygiene and sanitation or food security have shown constant improvement over the last decade (Census, 2011). The major success of NRHM in achieving the maternal and child health indicators and fertility-related indicators could be attributed to the increase in the institutional deliveries, which in turn is attributed to ASHAs. NRHM was launched to provide accessible, affordable, accountable and effective primary healthcare facilities, especially to the poor and vulnerable sections of the population. By reviewing the targets and achievements of the National Rural Health Mission, it can be found that certain targets as envisaged in 2005 at the launch of NRHM have not been achieved. This is because public health is a state subject and there have been issues of lack of capacities and human resource shortage in certain States and general underfunding for the health sector. Although rural health expenditure increased the interstate variations remained.

Check Your Progress VII

1) Write a short note on NRHM.

.....

.....

.....

.....

.....

5.8 PRESENT ISSUES AND CHALLENGES OF RURAL HEALTH SYSTEM

Lower Expenditure on Public Health

India's total healthcare spending at 3.6 per cent of GDP is much lower than that of other countries. Developed nations like the US (16.9%), Germany (11.2%), France (11.2%) and Japan (10.9%) spend even more. India spends the least among BRICS countries: Brazil spends the most (9.2%), followed by South Africa (8.1%), Russia (5.3%), China (5%).

Suboptimal Quality of Care

The focus of most of the programmes including NRHM has been on expansion of infrastructure, human resource, and service coverage, while quality aspects have received inadequate attention. As per government records, 49.7 per cent of sub-centres, 78 per cent of PHCs and 91.5 per cent of CHCs are located in dilapidated government buildings. The government hospitals inherently lack the adequate facilities to deal with the cases of different epidemics and deadly diseases; moreover, at many places, the hospitals are understaffed and lack even the basic healthcare facilities like beds, X-ray machines. Moreover, rural public health facilities are battling with the problems of inadequate manpower. The deficiency of trained doctors and medical professionals has paralysed the rural health facilities. As of March' 2013, the vacancy rates of doctors at PHCs has been 12 per cent while the same at CHCs has been 47 per cent at India level (NRHM, Budget Briefs, 2014-15). Apart from inadequacy, absenteeism is also

adding to the problem. Absenteeism among the primary health providers in India is the highest nearly 40 per cent (Chaudhury, N, et.al, 2006). Primary health care has been a neglected stream for most of the medical practitioners. In 2010, according to the approach paper for the 12th Five Year Plan, 10 per cent of posts for doctors at the PHCs and 63 per cent of the specialist posts at the CHCs and 25 per cent of the nursing posts at PHCs and CHCs combined, remained unfilled (Govt. of India Approach Paper for 12th Five Year Plan, 2012-17). A 2007 World Bank investigation of healthcare in Delhi reported that doctors in primary care centres had less competence and made less effort than staff in the private hospital sector (Rao, Mala and David Mant, n.d). The government-run immunization programmes are also not equity-based. An analysis of district-level data through DLHS data of 2007-08 shows a strong negative correlation between immunization and child mortality rate (India Development Report, 2012/13).

Maternal Mortality Ratio, Neonatal Mortality and Infant Mortality Ratio

The death of infants till age group of 5 years, is still alarming in rural areas. In 2007-08, 30 per cent of rural children died of diarrhoea, dysentery (India Development Report, 2012/13). The share of neonatal deaths in infant mortality nationwide has increased from 66 per cent to 70 per cent between 1990 and 2009 (India Development Report, 2012/13). The in-depth analysis of causes for these deaths is supposed to be premature birth, low weight, birth asphyxia, trauma etc. This problem is substantiated by malnutrition of children and their mothers. In addition to medical factors, socio-cultural factors are also contributing towards child mortality deaths. Child mortality among Scheduled Tribes (STs) is much higher than other social groups. This condition of high infant mortality of India has been compared with some selected Asian countries also. It seems that it outnumbers several countries like Srilanka, Maldives, Nepal, and Bangladesh in this affair.

The comparative rates of decline in IMR and MMR during the pre-and-post-NRHM period though, don't show changes commensurate to the increased coverage and utilization of health services. The annual rate of IMR decline increased from 2.9 per cent in the pre-NRHM period (2000–5) to 3.9 per cent in the post-NRHM period (2005–12), but the annual rate of decline in MMR stayed nearly the same; 5.2 per cent pre-NRHM (2001–3 to 2004–6) and 5 per cent post-NRHM (2004–6 to 2010–12) (Deodhar, 2001). We know that it becomes increasingly difficult to reduce IMR and MMR by purely technological means. It can be argued that health outcomes such as IMR and MMR don't solely depend upon health systems, but also on more proximal social determinants of health.

Health Awareness Issue

Rural people in India in general and tribal populations in particular, have their own beliefs and practices regarding health. Some groups still believe that a disease is always caused by hostile spirits or by the breach of some taboo and seek remedies through magic-religious practices. Moreover, some rural people follow undocumented traditional medicine systems (in addition to the recognised cultural systems of medicine such as Ayurveda, Unani, Siddha and Naturopathy) to maintain positive health and to prevent disease. However, these practices often have endangered the naturally healthy environment e.g. access to healthy and nutritious food, clean air and water, nutritious vegetation, healthy lifestyles, and advantageous value systems and community harmony. The basic nature of rural health problems is also attributed to lack of health education, ignorance and

widespread illiteracy. Developing disease and programme awareness among rural people remains an important objective of all health programs, however, critics claim that these strategies rely heavily on mass media and that the contextual needs of the population are not addressed. National Health Policy – 2002 acknowledges the limited accountability of existing health education programs given the difficulties in evaluating the effectiveness of such interventions.

The Dominance of Unregulated Private Medical Professionals

The expenditure on public health has not only been ignored by the state but by a common man also. The common man terms expenditure on public health as useless. In their view, the quality of treatment and medicines in government-run hospitals has degraded. Their diverted investment in private practitioner and private hospitals has worsened public health system in India. The disillusionment and frustration with the growing ineffectiveness of the government sector is gradually driving poor people to seek the help of the private sector, thus forcing them to spend huge sums of money on credit, or they are left to the mercy of 'quacks'. The apathy of public doctors leads to unregulated private practitioners in health sector. Some of them are quacks. Healthcare costs not only push millions of Indians into poverty but potentially keep the most marginalized sections away from accessing essential health services.

The huge private sector presence cannot be ignored, and its strengths should be utilized more fruitfully. There is need to devise broad principles and guidelines for engagement with the private sector, with certain core tenets being central, such as contracting-in rather than contracting-out, complementary rather than supplementary, transparent and accountable rather than opaque and unaccountable.

Check Your Progress VIII

1) Mention two important challenges which present rural health sector are facing.

.....

.....

.....

.....

.....

5.9 LET US SUM UP

In this unit, we observe that health facilities in rural areas are inadequate and emphasized that equity within the health system is essential for achieving development goals. The 'magical' year of 2000 has come to an end. 'Health for all by 2000' remains as a distant mirage and the slogan has been rephrased as 'Health for all in 21st Century'. Rather than sticking to the conventional models of healthcare provision and health financing arrangements, states and districts should be innovative in approaches. Rural health policies need to be backed with hard evidence rather than ideas and ideology. To improve the prevailing situation, the problem of rural health is to be addressed both at the macro (national

and state) and micro-level (district and regional), in a holistic way, with genuine efforts to bring the poorest of the population to the centre of the fiscal policies. A paradigm shift from the current 'biomedical model' to a 'socio-cultural model' is required, to meet the needs of the rural population.

5.10 KEYWORDS

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

Sex Ratio: The number of females per thousand males in the population

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

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

Neo-Natal Death: A neonatal death is defined as a death during the first 28 days of life (0-27 days).

AYUSH: Ayurvedic, Yoga, Unani, Siddha and Homeopathy

Maternal Mortality Rate: Death which occurs due to due to birth or pregnancy related complications

5.11 REFERENCES AND SUGGESTED READINGS

Deodhar, N.S. (2001). *Health Situation in India.* New Delhi: Voluntary Health Association of India, 2001.

Government of India (2018). National Health Profile (13th issue) Ministry of Health & Family Welfare, Government of India.

Gill, K. (2009). *A Primary Evaluation of Service Delivery under the National Rural Health Mission (NRHM): Findings from a Study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan.* New Delhi: Planning Commission, Government of India.

Government of India. (2018). *India in Figures. Government of India.* Ministry of Statistics and Programme Implementation. New Delhi: Central Statistics Office.

Government of India (2012), *Indian Public Health Standards* (IPHS) Guidelines for Sub Centres.

HDI. (2019). *Beyond Income, Beyond Averages, Beyond Today: Inequalities In Human Development In The 21st Century*. Human Development Report. USA: United Nations Development Programme

Government of India (2017), Millennium Development Goals: Final Country Report of India, Ministry of Statistics and Programme Implementation Government of India

Nagla, M. (2018*) Sociology of Health and Medicine*. Jaipur: Rawat.NRHM (2012) *Meeting People's Health Needs In Rural Areas Framework For Implementation (2005-2012).* National Rural Health Mission, Ministry of Health and Family Welfare. New Delhi: Government of India.

UNIT 6 HEALTH INFRASTRUCTURE AND DELIVERY SYSTEM

Structure

6.0 OBJECTIVES

After reading this unit, you will be able to:

- explain Health Infrastructure;
- model of Health Delivery System; and
- critical evaluation of health delivery system.

6.1 INTRODUCTION

Health is often viewed as an individual attribute, to be enjoyed, attended to and mended at a personal level. This perspective imposes the responsibility of ill health on the individual and also heaps the physical, financial and emotional

burdens of obtaining healthcare on that person. Health status of a population does not remain static. India's health system has many mixes: state and central health services; public and private and voluntary sectors; allopathic and non-allopathic doctors, qualified and unqualified practitioners and multiple levels of health delivery systems. The delivery of healthcare has two important elements i.e., health financing and manpower through health delivery systems. The health systems need to the financed adequately to develop and maintain the required infrastructure, employ an adequate number of skilled health professionals of different categories. The health workforce includes the doctors and other allied health professionals. The shortages of health care forces result in the unsatisfactory of health care to the community.

6.2 HEALTH INFRASTRUCTURE IN INDIA

Health is a fundamental human right and a global social goal. It is pertinent for the realization of basic human needs and for a better quality of life. Health is also considered a causative factor that affects country's aggregate level of economic development. Since development is a consequence of good health, even the poorest developing countries should make it a priority to invest in the health sector. Unfortunately, health has been poorly invested in by countries with low human development and the health sector still remains largely untapped and continues to suffer neglect.

Health infrastructure generally mean to the outbreak of epidemics, improvement of environmental sanitation and provision for some hospitals, health centers and dispensaries scattered in various parts of the country to provide medical relief and promote health conditions. The pattern of health infrastructure promotes future health development programmes in the country. In this context it is also stressed that the health services should be provided for the vast rural population of the country and the health services should be placed as close to the people as possible in order to ensure the maximum benefit to the people of the communities.

The rank of India in the Human Development Index Report 2018 (130 out of 189 countries) issued by UNDP depicts the level of ignorance of the health sector in a country like India. Recently due attention is paid on the various facets of health problems by central and Provincial Health Departments.

6.3 HEALTHCARE INFRASTRUCTURE IN PUBLIC SECTOR

India is one of the fastest growing economy of the world. The very essential components of Primary Health Care is promotion of food supply, proper nutrition, safe water and basic sanitation and provision for quality health information. It is observed that health care services, provision of essential medicines, scarcity of Doctors and other paramedical staffs are bottlenecks in the primary health care scenario.

6.3 HEALTH INFRASTRUCTURE IN PUBLIC SECTOR

Parameter	First Plan (1951-56)	(2015)
Primary Health Centre	725	25,650
Sub Centres	84,376 (1985)	156,231
Community Health Centres	761(1985)	5,624
Total Beds	125,000	914,543
Medical Colleges	42	476 (2017)
Dental Colleges	7	313
Allopathic Doctors	65000	1,041,395 (2017)
Nurses	18500	21,51,850
ANMs	1,27,800	8,92,829
Health Visitor	578	56,644
Health Workers(F)	133194	212,185
Health Workers (M)	-	62,881
Village Health Guides	-	323,000
AYUSH Doctors	NA	773,668

6.3.1 India's Medical Infrastructure at Glance

Number of Community Health Centres (CHC) functioning in government buildings has increased during the period 2005-2017. The percentage of CHCs in Government buildings has increased from 91.6 per cent in 2005 to 96.7 per cent in 2017.

In addition to 4156 Specialists, 14350 General Duty Medical Officers (GDMOs) are also available at CHCs on 31st March, 2017. There was huge shortfall of surgeons (86.5 per cent), obstetricians and gynecologists (74.1 per cent), physicians (84.6 per cent) and pediatricians (81 per cent). Overall, there was a shortfall of 81.6 per cent specialists at the CHCs vis-à-vis the requirement for existing CHCs.

Financial Position

- Total public expenditure on health 5.2 per cent of GDP
- Public Investment 0.9 per cent of GDP
- Budget allocation for health 1.3 per cent of central budget
- Government Expenditure 25 per cent
- Out of pocket expenditure 75 per cent
- Central government contribution to state 15 per cent
- State Budgetary allocations reduced from 7 per cent to 5.5 per cent

- India's health budget has gone up nearly 4000 crore to Rs. 21113.33 crore ($4.35 billion)

Check Your Progress I

1) Mention the Health Infrastructure in India.

.....

.....

.....

.....

.....

.....

.....

.....

.....

6.4 DELIVERY OF PUBLIC HEALTH CARE IN INDIA

Healthcare is one of the India's largest service sector. Under the Indian Constitution, health is a state subject. Each state therefore has its own healthcare delivery system in which both public and private (for profit as well as non-profit actors operate). While states are responsible for the functioning of their respective healthcare systems, certain responsibilities also fall on the federal (central) government, namely aspects of policy-making, planning, guiding, assisting, evaluating and coordinating the work of various provincial health authorities and providing funding to implement national programmes.

6.4.1 Model of Health Care Delivery System in India

India is a union of 28 states and 8 union territories. States are largely independent in matters relating to the delivery of health care to the people. Each state has developed its own system of health care delivery, independent of central government.

The organization at the national level consists of the Union Ministry of Health and Family Welfare. In each state, the organization is under the State Department of Health and Family Welfare that is headed by a State Minister and with a Secretariat under the charge of the Secretary/Commissioner (Health and Family Welfare).

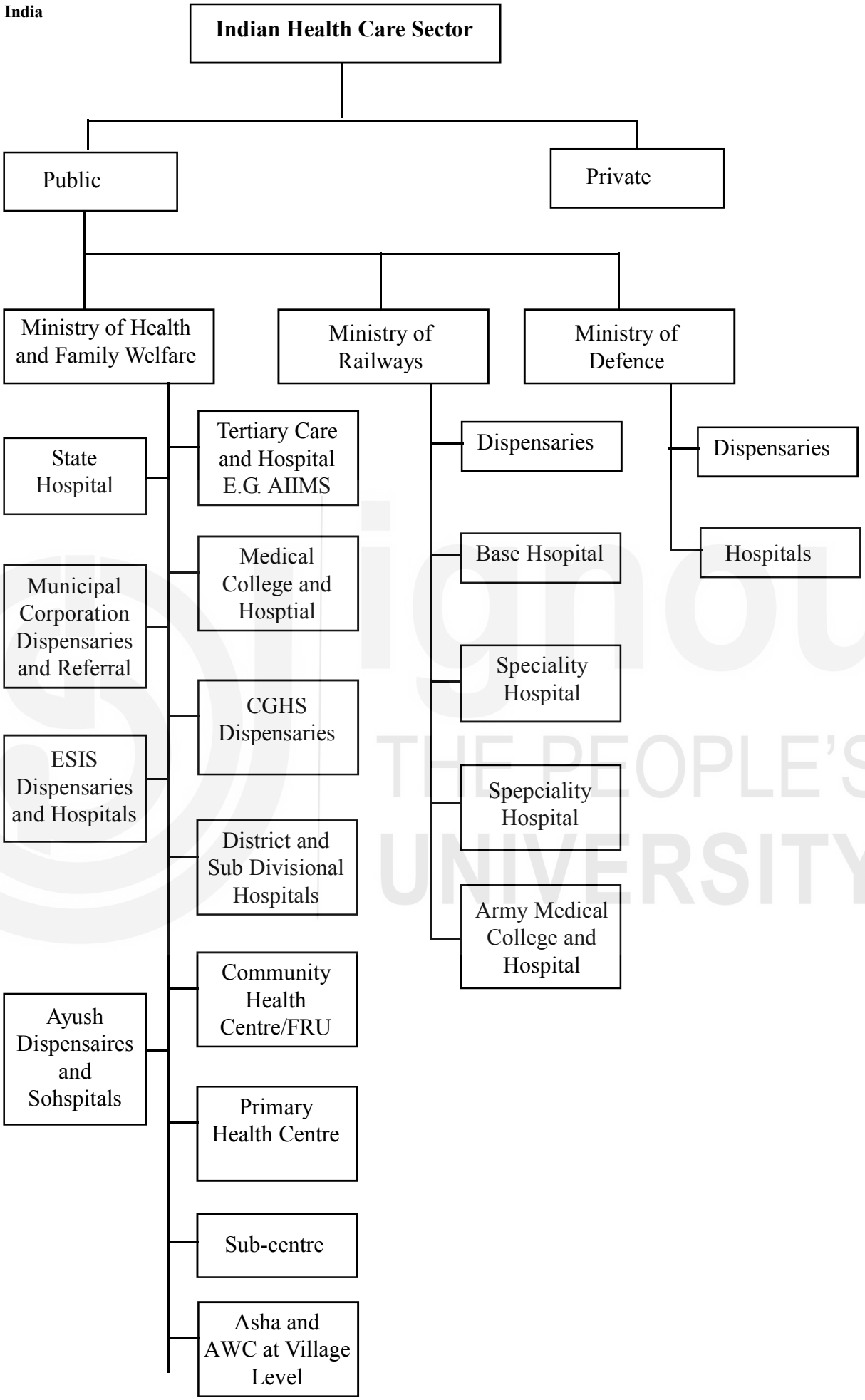


Fig. 6.1 : Health Delivery System in India

Check Your Progress II

1) What is Public Health Care Delivery system?

.....

.....

.....

.....

.....

.....

.....

2) Present the model of Health Care Delivery in India.

.....

.....

.....

.....

.....

.....

.....

6.5 ORGANS OF HEALTH DELIVERY SYSTEMS

The central government responsibility consists mainly of policy making, planning, guiding, assisting, evaluating and coordinating the work of the State Health Ministries. The health system in India has three main links:

1) Central
2) State
3) Local and Peripheral

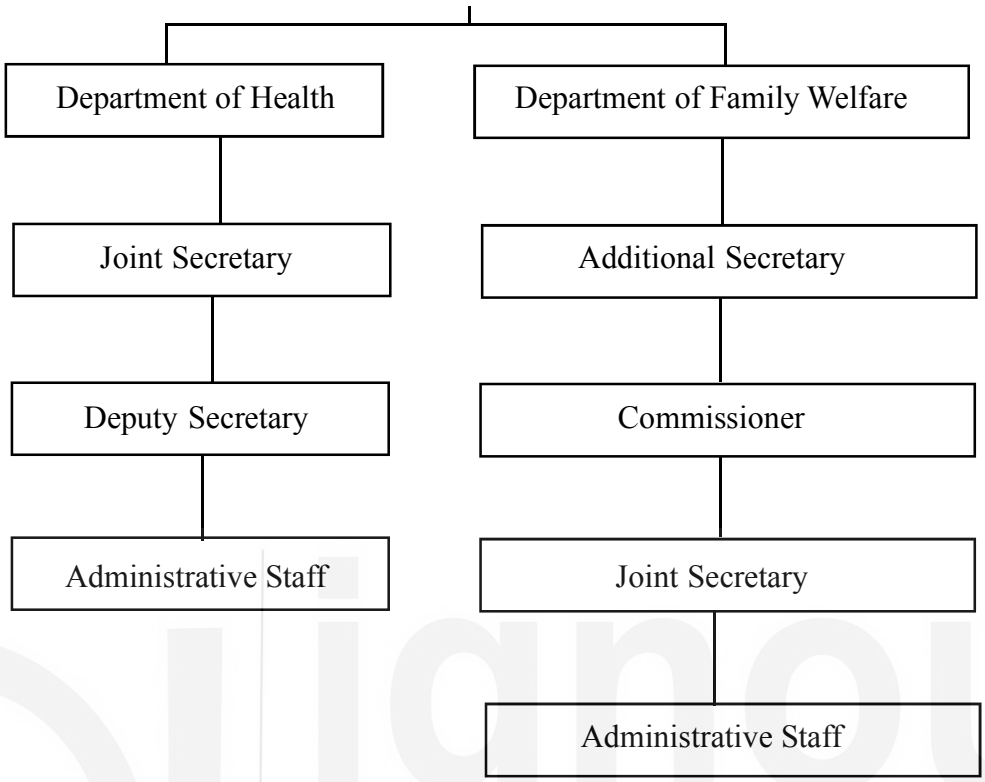
6.5.1 Health Delivery at Central Level

The Official organs of the health system at the national level consist of:

- Ministry of Health and Family Welfare
- The Directorate General of Health Services
- The Central Council of Health and Family Welfare

6.5.1.1 Union Ministry of Health and Family Welfare

Hierarchical Structure of Health Care Administration



Functions of Health Care Administration:

Union List

- International health relations and administration
- Administration of Central Institutes such as All India Institute of Hygiene and Public Health, Kolkata
- Promotion of research through research centres
- Regulation and development of medical, pharmaceutical, dental and nursing profession
- Establishment and maintenance of drug standards
- Census and collection and publication of other statistical data
- Immigration and Emigration
- Regulation of labour in the working of mines and oil fields
- Coordination with states and with other ministries for promotion of health.

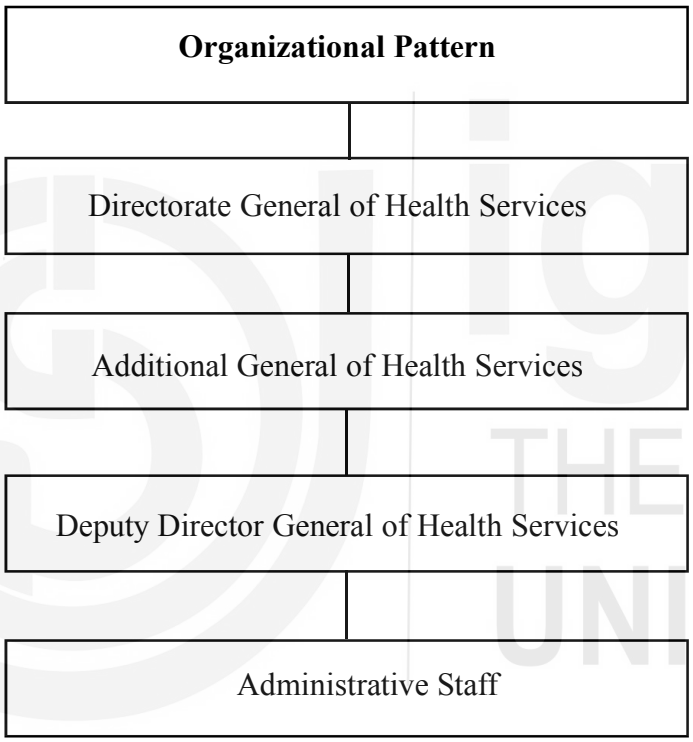
Concurrent List

The functions listed under the concurrent list are the responsibility of both the union and state governments:

- Prevention and extension of communicable diseases
- Prevention of adulteration of food stuffs
- Control of drugs and poison

- Vital statistics
- Labour Welfare
- Ports
- Economic and social Planning
- Population control and Family Planning
- Preparation of health education material for creating health awareness through Central Health Education Bureau
- Collection, compilation analysis, evaluation and dissemination of information through the Central Bureau of Health Intelligence
- National Medical Library.

6.5.1.2 Directorate General of Health Services

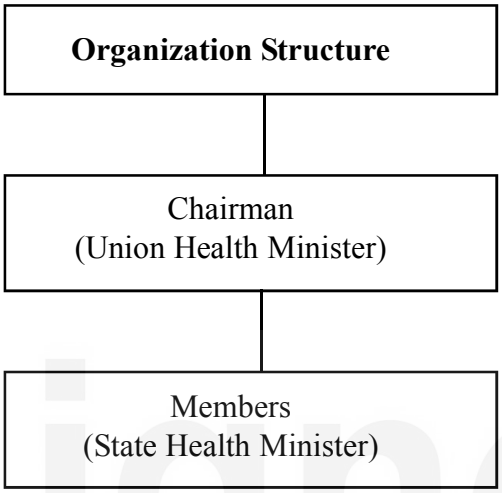


Functions

- International health relations and quarantine of all major ports in country and International airport
- Control of drug standards
- Maintain medical store depots
- Administration of post-graduate training programmes
- Administration of certain medical colleges in India
- Conducting medical research through Indian Council of Medical Research
- Central Government Health Scheme
- Implementation of National Health programmes.

- Preparation of health education for creating health awareness through Central Health Education Bureau
- Collection, compilation, analysis, evaluation and dissemination of information through the Central Bureau of Health Intelligence
- National Medical Library.

6.5.1.3 Central Council of Health



Functions

- To consider the recommended broad outlets of policy regard to matters concerning health like environment hygiene, nutrition and health education
- To make proposals for legislation relating to medical and public health matters
- To make recommendations to the Central Government regarding distribution of Grants-in-aid.

6.5.2 State Level Health Care

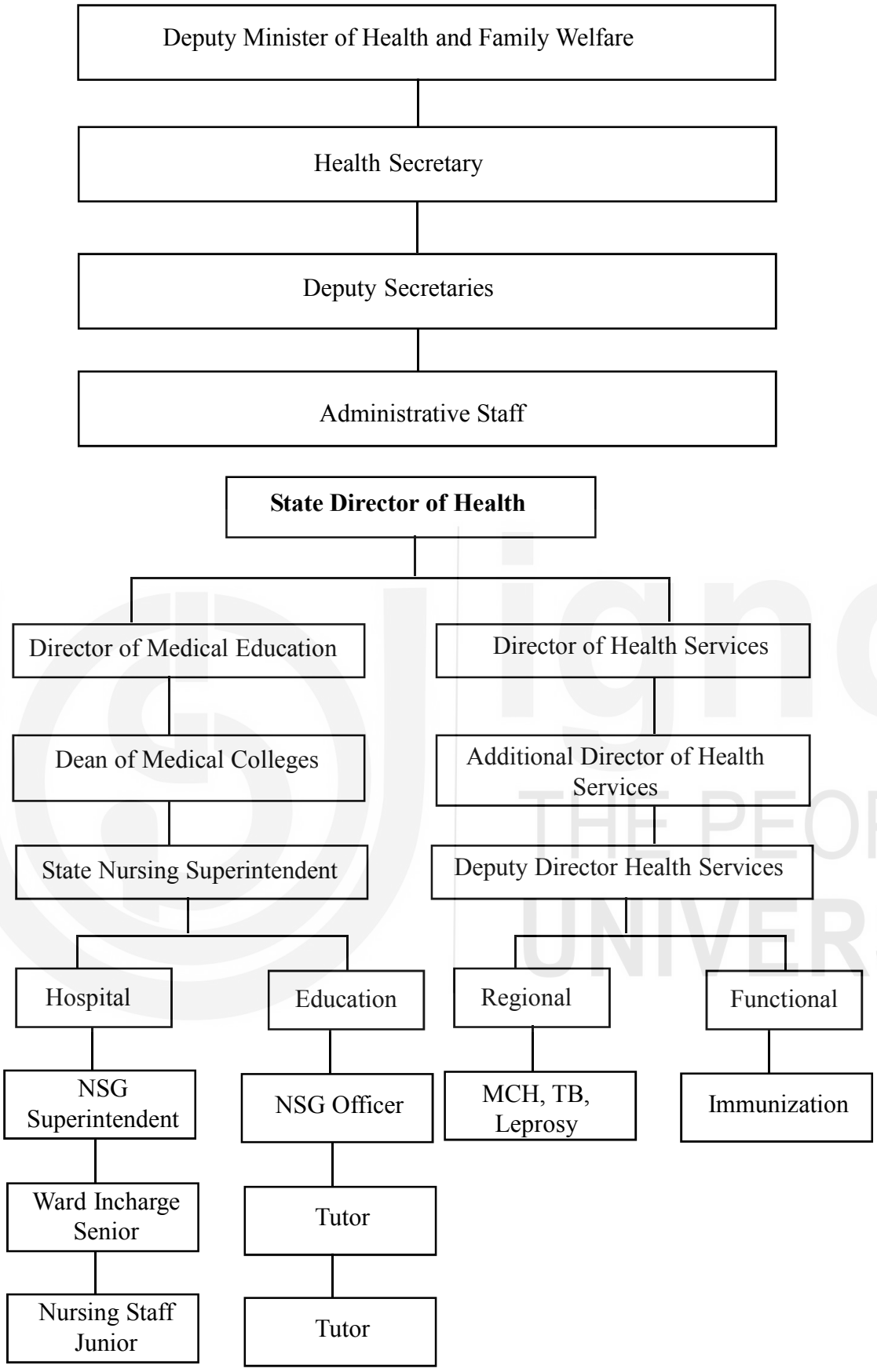
The health subjects are divided into three groups: federal, concurrent and state. The state list is the responsibility of the state, including provision of medical care, preventive health services and pilgrimage within the state.

State Health Administration

At present there are 28 states in India, each state having its own health administration.

Organizational Structure of State Health Administration

State Ministry of Health and Family Welfare



Functions of State Health Director

- Studies in depth and health problem and needs in the state and plans scheme to solve them
- Providing curative and preventive services

- Provision for control of milk and food sanitation
- Prevention of any outbreak of communicable diseases
- Promotion of health education
- Promotion of health programmes such as school health, family planning, occupational health
- Supervision of PHC
- Establishing training outcomes for health personnel
- Co-ordination of all health services with other minister of state such as minister of education, central health minister and voluntary agency.

6.5.3 District Level Health Care

In each district in India, there are six types of administrative areas.

1) Sub-division
2) Tehsils (Taluks)
3) Community Development Blocks
4) Municipalities and Corporations
5) Villages and
6) Panchayats.

The Functions of Municipal Board:

- Construction and maintenance of roads
- Sanitation and drainage
- Street Lighting
- Water supply
- Maintenance of Hospital and Dispensaries
- Education
- Registration of births and deaths etc.
- The corporations are headed by Mayor, elected by councillors who are elected from different wards of the city.

Village Level: Panchayati Raj

The panchayat raj is a three-tier structure of rural local self-government linking the villages to the district includes:

- Panchayat (at the village level)
- Panchayat samiti (at the block level)
- Zila Parishad (at the district level)

6.5.4 Health Care System in Rural Areas

1) At village level
2) At the centre level
3) At Primary Health Centre level

4) At Community Health Centre level.

At the village level, the elementary services are rendered by:

1) **Village Health Guides**: Village health guides is a person with an aptitude for social service and is not gull time government functionary. Village health guide scheme was introduced on 2nd October, 1977. He provides the treatment for common minor ailments; first aid during accidents and emergency; MCH care; family planning; health education.

2) **Local Dais**: Most deliveries in rural areas used to handle by ***untrained dais.*** The training for dais is given for 30 working days. Each ***dai*** is paid stipend of Rs. 300 during the period of training. During her training each ***dai*** is required to conduct at least 2 deliveries under the supervision and guidance of health worker (female), Auxiliary Nurse and Midwife, health assistant (female). ***Dai*** perform the function of MCH care; family planning; immunization; education about health, referral services; safe water and basic sanitation and nutrition.

3) **Aganwadi workers**: Under the Integrated Child Development Scheme (ICDS) there is an aganwadi worker for a population of 1000. There are about 100 such workers in each ICDS project. The aganwadi worker is selected from the community and she under goes training in various aspects of health, nutrition and child development for four months. She is a part time worker and paid an honorarium. She performs Maternal and Child Health (MCH) Care; family planning; immunization, education about health, referral services, safe water and basic sanitation, supplementary nutrition and non-formal education of children.

4) **Accredited Social Health Activist (ASHA):** One of the key components of National Rural Health Mission is to provide every village in the country with a trained female community health activist– ASHA, selected from the village itself and accountable to it. The ASHA is trained to work as interface between the community and the public health system. One ASHA on the population of 1000. ASHA must be primarily a woman from the resident of the village itself. ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygiene practice, healthy living and working conditions, information on existing health services and the need for timely utilization of health and family welfare services. She will counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection, Sexually Transmitted Infections and care of the young child. ASHA will mobilize the community and facilitate them in assessing health and health related services available at the village/ sub-centre/primary health centres, such as immunization, ante-natal checkup (ANC), Post-natal check-up (PNC), ICD, sanitation and other services being provided by the government. She will arrange escort/accompany pregnant women and children requiring treatment/ admission to the nearest pre-identified health facility. ASHA will provide primary medical care or minor ailments such as diarrhea, fever, and first aid for minor injuries. She will also inform about the births and deaths in her and any unusual health problems/disease outbreaks in the community to the sub-centre/primary

health centre. She will also promote construction of household toilets under total sanitation campaigns.

Check Your Progress III

1) What are the Organs of Health Delivery Systems?

.....

.....

.....

.....

.....

2) Mention the hierarchy of Central Council of Health Administration.

.....

.....

.....

.....

.....

3) Give the Model of State Health Administration.

.....

.....

.....

.....

.....

6.6 CRITICAL EVALUATION OF FUNCTIONING OF HEALTH DELIVERY

There is still a short fall of 16 per cent of PHCs and 58 per cent of CHCs; Non availability of staff; Weak referral system; Recurring funding shortfalls; and Lack of accountability for quality of care.

6.6.1 Problems in Public Health Care

Very low use of massive Public health infrastructure; Poor availability and access; and Unsatisfactory work of public health units. Only 20 per cent of OPD and 45 of inpatient care obtained from government health infrastructure while rest is from private sector.

6.6.2 Primary Health Care (PHC)

It is important to emphasize that PHC is not just a descriptive term denoting the first level of health care. It is comprehensive view of health that emerges from

the most critical conceptual advances of twentieth-century public health. Unlike the techno-centric approaches that derive from the bio-medical sciences– such as linear campaigns against small pox and malaria– the PHC approach confronts complex socio-economic, political, and technological relationships. The emphasis of PHC is on:

- Equity in health care;
- Need-based, socially acceptable services with full participation of people;
- State responsibility for incorporating PHC into national development plans through inter-sectoral strategies;
- Affordable technologies ensuring self-sufficiency and effective basic health care with the support of secondary and tertiary care; and
- Collective, not individual efforts.

The repeated failures of technocentric approaches and researches that emphasized the link between socio-economic and demographic factors and health transitions led to the 1978 Alma-Ata Declaration. It stated that mere formal government support would not be sufficient to achieve the desired level of health and that PHC would require a reorientation of national strategies for health planning. It would imply a transfer of health resources to the under-served. The health budget might have to be increased until the total population received essential care and institutions supporting PHC were made effective.

Staff composition for each Primary Health Care (PHC) which includes Family Medical Practitioner (FMP) unit to include four doctors, one PHN, two nurse midwives, eight ANMs (females), four Multi-Purpose Workers (MPWs) (males), one pharmacist, one clerk/assistant, one office assistant, one lab technician, one driver, one sweeper– this adds up to salaries and benefits/capitation of Rs. 6 million (salary structures across states may be different and hence this could vary). Doctors and nurses may either be salaried or contracted. The curative care component should work as a family medical practice with families (500-2000, depending on density) being assigned to each provider. There should be 10 beds per primary health centre. Average rural unit to cover 20,000 population (in the range 10-30 thousand depending on density); average urban unit to cover 50,000 population (in the range 30-70 thousand population depending on density). In rural areas for every 5 PHCs there would be one 50 bedded hospital and this would cost Rs. 400,000 per bed per annum or Rs. 20 million per such hospital. As per this ratio we would need 7500 rural hospitals and this would translate into Rs. 150 billion for the country as a whole. In urban areas for each 10 PHCs one 200 bedded hospital would be needed and this would cost Rs. 500,000 per bed per year or Rs. 100 million per hospital. As per this ratio 700 such hospitals would be needed and this would translate into Rs. 70 billion for the country as a whole.

It is thus evident that the neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The

policy route to comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-political consensus on right to healthcare. There are a lot of small efforts towards this end all over the country, for instance the People's Health Movement or the ***Jan Swasthya Abhiyan (JSA)***. Synergies have to be created for these efforts to multiply so that people of India can enjoy right to healthcare. On the government front the UPA government of Manmohan Singh promises to restructure the public health system via one of its flagship programs, the National Rural Health Mission (NRHM).

The preamble of the NRHM document states, "*Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system.... The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children" (Ministry of Health and Family Welfare: 2005).* This goal will be achieved by strengthening the three levels of rural healthcare – the subcenters, PHC and CHC. At the village/hamlet level a health worker called ASHA (Accredited Social Health Activist) will be appointed who will be the link worker for rest of the public health system in rural areas. Additional resource allocation and up gradation of the facilities at each level has been planned under the Mission.

To conclude, the NRHM should be used as an opportunity to work out a new health financing strategy, which devolves financial resources to local governments and uses a social audit framework to monitor its implementation. Only this will lead to structural changes and improvements in the health of the Indian people. But the government will not do this until healthcare becomes a political agenda and drives elections. Thus, the civil society has to exert pressure from below. The initiatives of the ***Jan Swasthya Abhiyan***, which has set in motion a campaign on Right to Healthcare, is one such move in this direction. The JSA has formulated a Peoples Health Charter, has mobilized groups in 18 states to support the campaign on right to healthcare, has collaborated with the National Human Rights Commission to conduct public hearings on denial of healthcare across the length and breadth of the country and is now actively engaging with the NRHM initiative to not only monitor its progress through community involvement but also use it as an opportunity to restructure health and healthcare in India.

6.6.3 Secondary and Tertiary Care

Secondary Health Care: Secondary health care is at district levels – where most of the conditions are treated there itself. Only the complex ones are referred. Secondary healthcare includes specialists like cardiologists, dermatologists, urologists, and others. Individuals reach bent secondary medical aid providers through the referral of primary healthcare professionals. In a few countries, the individuals cannot consult the specialists without the referral of the medical man at the first care level. The secondary healthcare providers act as a liaison between the patient and therefore the advanced medical aid.The systems that come under this category are referred to as the district health system and county health system.

District health system mainly focuses on child health and maternity care. Healthcare centres receive referrals from various primary healthcare centres and remain open for 24 hours a day. District hospitals include emergency services, neonatal care, comprehensive emergency obstetric.

Tertiary Healthcare

Tertiary healthcare is provided in hospitals with government medical colleges having a specialty and super specialty departments. This ranks on top within the hierarchy. Research centres also fall under tertiary healthcare.This is the care that comes into the image as a referral to patients by the first and healthcare providers.The individuals may require advanced medical procedures like major surgeries, transplants, replacements, and long-term medical aid management for diseases like cancer, or neurological disorders.

Specialised conductive medical aid is the highest sort of healthcare practice and performs all the main medical procedures. Advanced diagnostic centres, specialised medical care units, and modern medical facilities are the key features in tertiary medical aid.The practices that provide tertiary medical aid might be a part of the government or a mixture of both public and personal sectors. The healthcare system in India is an example of the latter.

The health providers who are a part of these three levels of healthcare categories of India, together provide medical services like health issue finding, evaluating, providing treatment, or pertaining to the subsequent level of care supported the health needs.The ever-increasing demand for health needs is pushing the borders of healthcare, forcing it to tread the new paths.Managing a sector with such huge potential might be driven within the success path with the assistance of healthcare consulting firms in India.

Check Your Progress IV

1) Critically evaluate functioning of Health Care delivery system?

.....

.....

.....

.....

.....

.....

.....

2) Describe secondary health care system?

.....

.....

.....

.....

.....

6.7 LET US SUM UP

Healthcare is one of the India's largest service sectors. Under the Indian Constitution, health is a state subject. Each state therefore has its own healthcare delivery system in which both public and private (for profit as well as non-profit actors operate. While states are responsible for the functioning of their respective healthcare systems, certain responsibilities also fall on the federal (central) government, namely aspects of policy-making, planning, guiding, assisting, evaluating and coordinating the work of various provincial health authorities and providing funding to implement national programmes. The health subjects are divided into three groups: federal, concurrent and state. The state list is the responsibility of the state, including provision of medical care, preventive health services and pilgrimage within the state. At present there are 29 states in India, each state having its own health administration. At the village level, the elementary services are rendered by Village health guides, local dais, aganwadi workers, ASHA workers. The initiative to bring healthcare on the political agenda will have to be a multi-pronged one and fought on different levels. The idea here is not to develop a plan of action but to indicate the various steps and involvements that will be needed to build a consensus and struggle for right to healthcare.

6.8 KEY WORDS

Community Health Centres (CHCs): CHCs which constitute the secondary level of health care are designed to provide referral as well as specialist health care to the rural population. In addition to medical services, functions of CHCs also include making provisions for safe drinking water and basic sanitation, prevention and control of endemic diseases, collection of vital **statistics** of the area, health and nutrition, education.

Primary Health Care (PHC): Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their participation.This includes physical, mental and social well-being and it is people-centered rather than disease-centered.

Accredited Social Health Activist (ASHA): An accredited social health activist is a community health worker instituted by the government of India's Ministry of Health and Family Welfare. ASHA create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services.

The National Rural Health Mission (NRHM): The National Rural Health Mission was launched by government of India to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The thrust of the mission is on establishing a fully functional, community-owned, decentralized health delivery system to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

6.9 REFERENCES AND SUGGESTED READINGS

Anstey, V. (1936), *The Economic Development of India*, London: Longmans.

Arnold, D. ((1985), "Medical Priorities and Practice in Nineteenth Century British India", *South Asia Research* 5, 2: 167:186.

Bhore, Joseph (1946), Report *of the Health Survey and Development Committee*, Volume I to IV, Govt. of India, Delhi

CBHI, Various Years:*Health Information of India*, Central Bureau of Health Intelligence, Ministry of Health and Welfare, Government of India, New Delhi

Census of India (1911), Delhi: Government of India.

Duggal, Ravi (2002), "Resource Generation Without Planned Allocation", *Economic and Political Weekly*, Jan 5, 2002

Duggal, Ravi, (2000), The *Private Health Sector in India – Nature, Trends and a Critique,* VHAI, New Delhi

Fendall, R. (1984), *World Health Forum*, 5, 300.

ICMR (1990), *A National Collaborative Study of High Risk Families*, ICMR Task Force, New Delhi

Jeffery, Roger (1988), *The Politics of Health in India*, London: University of California Press.

Meller, H. (1979), "Urbanization and the Introduction of Modern Town Planning Ideas in India 1900-1925", in K.N.Chaudhuri and C.J. Dewey, eds. *Economy and Society*, Oxford: Oxfam.

Ministry of Health and Family Welfare (2005), *National Rural Health Mission*, Ministry of Health and Family Welfare, Government of India, New Delhi

Morley, David et al., (1984), *Practicing Health for All,* Oxford University Press.

National Sample Survey (1987), Morbidity *and Utilization of Medical Services*, 42nd Round, Report No. 384, National Sample Survey Organisation, New Delhi.

Ramasubban, R. (1984), "Public Health and Medical Research in India: Their Origins under the Impact of British Colonial Policy", *Stockholm: SAREC Report* No. 4, Swedish Agency for Research Cooperation with Developing Countries.

Rao, K.N. (1966), *The Nation's Health*, Delhi: The Publication Division.

WHO (1961), *Planning of Public Health Services*, TRS 215, World Health Organisation, Geneva.

WHO, (1988)*, Country Profile - India*, WHO - SEARO, New Delhi

UNIT 7 HEALTH AND NUTRITION: BEHAVIOUR AND PRACTICES

Structure

7.0 OBJECTIVES

After reading this Unit, you will be able to:

- Understand the nature and status of health seeking behaviour in rural India;
- Learn the importance of alternative medicine; and
- Identify the gaps between health service availability, accessibility, use and reasons for the same.

7.1 INTRODUCTION

Health and nutrition have an immense effect on the lives of humans. Good nutrition is an important factor to lead a healthy life. A certain amount of nutrition is needed from an early age for the proper development and growth of the body. Various kinds of foods have different amounts of nutrition and the intake of nutrition depends on the several factors like the age, sex, weight etc.

Better nutrition is related to improved infant, child and maternal health, stronger immune systems, safer pregnancy and childbirth, lower risk of non-communicable diseases (such as diabetes and cardiovascular disease), and longevity. Healthy children can learn better. Also, people with adequate nutrition are more productive and can create opportunities to gradually break the cycles of poverty and hunger.

Malnutrition, in every form, presents significant threats to human health. Malnutrition refers to deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients. Today the world faces a double burden of malnutrition that includes both undernutrition and overweight, especially in low-and middle-income countries. Every country in the world is affected by one or more forms of

malnutrition. Combating malnutrition in all its forms is one of the greatest global health challenges.

Health and nutrition seeking behaviour an important factor that defines a healthy society. People's behaviour differentiates regarding consumptions of nutritional food. The WHO indicates consumers preferences and intra-household decision making as one of the factors related to vegetable consumption in sub-Sahara Africa. Also, it differs from rural to urban, male to females, poor to rich, etc. There are many factors that determines people's behaviour towards health. Inappropriate health seeking behaviour has been linked to worse health outcomes, increased morbidity and mortality and poorer health statistics. Hence, it is important to maintain an appropriate health and nutrition seeking behaviour and practices among the people to improve the health status of a nation and thus its economic development.

7.2 HEALTH SCENARIO IN RURAL INDIA

India is the second most populous country in the world and has changing socio-political demographic and morbidity patterns that have been drawing global attention in recent years. Despite several growth orientated policies adopted by the government, the widening economic, regional and gender disparities are posing challenges for the health sector, especially in rural India. Among 195 nations with more than a billion people, India has been ranked 145th on the Health Access and Quality Index making it one of the biggest underachievers in Asia behind its neighbours like China, Bangladesh, Sri Lanka and Bhutan, according to a Lancetstudy.

India is in the limelight at the global front not only in terms of population burst but also in its health scenario. Even after celebrating its 73years of independence, its population is still brewing under the threat of a degraded health system. There are approximately 85 per cent of the populations who are still fighting for basic healthcare services in their area. This situation has been promoted by worsening living conditions of rural habitats. It is observed that 70 per cent of population has no access to specialist care as 80 per cent of specialists live in urban areas. Only 13 per cent of the rural population have access to primary health centers, 33 per cent to sub-center and 9.6 per cent to a hospital (NFHS-II). The prevalence of underweight children was higher (38%) in rural areas compared to urban cities (29%). Only about 10 per cent children under the age 6-23 months were reported to receive an adequate diet. This inequality in access is accentuated by the stark state level disparity in nutritional status.

The unhygienic and unhealthy conditions of household, unsafe drinking water, open defecation, aggravate expansion of several diseases in these areas. The scenario gets worse through the superstition practiced by rural people. The blind faith of tribals that any disease may be cured by magic has subjugated the minds of the rural population of India. Due to this kind of impression, the rural areas are under the influence of various malpractices which ultimately seal off the procession of modern pathology here. One of the important reasons for the decline of rural health care is inadequate human resources in the health care system. The health institutions like Primary Health Centre (PHC), Sub-Centre (SC), and Community Health Centre (CHC) are facing huge problems because health

professionals are absent. Doctors don't want to work in rural areas either because of infrastructure inadequacy or lack of incentives. In a study conducted by Banerjee, in Rajasthan around 45 per cent of doctors were absent from PHC and 56 per cent from SC. The condition gets intensified with not or little qualified practitioner, minimal amount of expenditure on public healthcare which counts to be 17.9 per cent of total expenditure (Bhat, Ramesh and Nishant Jain, 2004). In comparison to public funding, private funding (private household health expenditure, charity, funds from NGOs, etc.) contribute a great chunk in healthcare.

However, some progress has been made since independence in the health status of the population; this is reflected in the improvement in some health indicators. Under the cumulative impact of various measures and a host of national programs for livelihood, nutrition and shelter which included various steps taken by the government to improve the health scenario in rural areas. Several strategies and missions have been initiated for institutionalizing the prevailing rural health framework to uplift the health standard of common mass. Some of the programmes introduced by the government focusing rural health are:

National Rural Health Mission (NRHM): National Rural Health Mission (NRHM) has been one of the central achievements in the field of rural healthcare. It was first initiated in the year 2005 with an objective to deal with the problems and feebleness across primary healthcare and enhance the status and system of rural areas. It provides effective, accessible, accountable, inexpensive and reliable healthcare to the mass and in particular to those sections who are more poor, vulnerable and prone to health disease.

Pradhan Mantri Matritva Vandana Yojana (PMMVY): PMMVY, previously known as Indira Gandhi Matritva SahyogYojna (IGMSY), introduced in the year 2010, is a maternity program run by the government of India with an objective to encourage women to follow Infant and Young Child Feeding (IYCF) practices including early and exclusive breastfeeding for first six months. It is a conditional cash transfer scheme which is implemented through the State ICDS Cells for pregnant and lactating women of 19 years of age or above for first two live births, from the Ministry of Women and Child Development. It provides partial wage compensation to women for wage-loss during pregnancy, childbirth and childcare.

Janani Suraksha Yojana (JSY): Janani Suraksha Yojana is a flagship program launched in 2005 under the National Rural Health Mission (NRHM) of Government of India modifying the National Maternity Benefit Scheme (NMBS). It is intended to promote institutional delivery to reduce maternal and neonatal mortality. It provides cash incentives to the women for delivering their child in government or other private medical facilities over home-based deliveries.

Health Insurance through Rashtriya Swasthya Bima Yojana (RSBY): Rashtriya Swasthya Bima Yojana (RSBY) is one of the important schemes in the area of rural health. It was launched in the year 2008, which was earlier designed to target only the Below Poverty Line (BPL) households, but has been expanded to cover other defined categories of unorganized workers. Its objective is to provide financial aid for households affected by major health shocks and improve health outcomes (Das, Jishnu and Jessica Leino, 2011).

Swachh Bharat Abhiyan (SBA): Swachh Bharat Abhiyan or Clean India Mission is a campaign in India initiated in the year 2014, whose objective is to eliminate open defecation through the construction of household-owned and community owned toilets. Still in many parts of rural India open defecation is practice which causes the most common life taking diseases like diarrhea, typhoid, hepatitis, intestinal worm infections, cholera, etc.

Even though there were many programmes most of them lacked proper implementation hence, couldn't achieve the desired goal. India being the nation of villages requires an intensive access to rural health care. Rural health is one of the important subject matter to rural life and It's the right of every individual but lack of quality infrastructure, dearth to medical facilities and shortage of primary health care components are denying that right to them. Hence, health care in rural India is a major challenge for the policy makers which should be dealt very effectively and seriously.

Check Your Progress I

1) List the significant programmes by the Government of India to improve the health status in Rural India.

.....

.....

.....

.....

.....

7.3 DETERMINANTS OF HEALTH SEEKING BEHAVIOUR

Healthcare seeking behaviour (HSB) has been defined as, "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy". Health seeking behaviour can also be referred to as illness behaviour or sick-term behaviour. Health seeking behaviour is situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a good state of health.

Studies suggest that several factors influence the HSB of the population and certain segments of the population are more likely to use appropriate HSB than others. Inappropriate HSB and its effects have been found to be skewed among different population segments. For example, in Pakistan, households whose average income was below the minimum wage were less likely to seek formal medical care for their illness than those whose incomes were above the minimum wage. In Kenya, almost 70 per cent of pregnant women within households in the upper socio-economic stratum were found to have their deliveries in health facilities compared with 42 per cent among pregnant women in the middle socio-economic stratum and 38 per cent in the low socio-economic stratum.

In a study in Nigeria, as many as 71 per cent of rural dwellers have reported inappropriate HSB during their last illness episode while only 53 per cent of urban dwellers reported inappropriate HSB during their last illness episode. Similarly, Nigerian women living in areas where the ratio of population to Primary Healthcare Centre (PHC) was high (more than 9,000:1) were less likely to have a skilled birth attendant present during childbirth than areas where the ratio of population to Primary Healthcare Centre (PHC) was lower (less than 6,000:1).

There are numerous variables, such as age, sex, level of education, culture, religion, past experience, that have a serious impact on our actions regarding health problems. In terms of age, people from different age groups take the disease differently, infants and young children have different behaviours than adults. Secondly, several publications in the field of gender and health have demonstrated that there are gender differences with regard to the decision-making process surrounding the proper form of care and treatment. For example, some studies have shown that women in developing countries use formal health care to a lesser degree than men and are more inclined toward traditional healing options instead. Studies investigating gender gaps in the perception and presentation of symptoms show that women not only ask for more social support than men, but also record substantially higher rates of distress. Education has been described as one the most significant variables affecting health indexes. General awareness that individuals get from formal education or literacy such as in schools are more inclined to have a proper and appropriate behaviour towards health issues. As they get aware about particular diseases and take necessary steps for its improvement. Furthermore, the role of culture and religion have a major impact on the ways of treating an illness, specifically in Indian society where culture and religion strongly prevail. However, cultural and religious factors many a time gives rise to difficulty in dealing with the treatment of an illness. Individuals also treat the illness from their past experiences, they tend to use the same treatment which benefited them in the past and avoid the ineffective methods from the past. Nonetheless, marital status has its own effects on taking care of an illness, married women tend to face more issues with their health as compared to married men. This is one stigma that persists to be there in the society towards the diseased patients with certain illnesses that makes them feel aloof and detached due to the negative and unfavorable opinions of the community members and this leaves an impact on minds of the patients regarding their treatment. It includes not only negative opinions but the positive as well. Other than this the availability of medical services and treatment has another major role as the more easily available and accessible medical centers make individuals more encouraged to visit and get proper treatment. Although, the unavailability of inaccessibility of these medical services demotivate and halt the patients to get the treatment, this, on the whole happens in rural areas. Not to mention, the trusted services and health providers promote and reassure the patients to take the treatment properly whenever it is needed instead of neglecting or avoiding. But, even though some patients tend to avoid the symptoms and signs of the illness have to realize the necessity of visiting the medical center once the symptoms start to grow severe, people usually avoid the illness until the signs of it begin to show its severity and once these symptoms start affecting their ordinary life and it becomes difficult to meet the daily basic needs, that is when they start taking care of them and move for the better treatment. They continue to remain under the treatment of their

illness as long as the symptoms persist to exist that not only makes them feel frightened but hopeless if it continues with the no or slow improvement. The longer the symptoms remain the more intolerant such patients become. On the other hand, the knowledge about the illness plays a vital role, if the patient is aware about the symptoms of the illness, he tends to visit sooner or later, often or rarely, gets serious or carefree regarding the treatment. However, if the illness is incurable or fatal, the patient loses hope and tends to show aggressive and detached behaviour. Although, in other cases, some of the patients start viewing the remaining time in an optimistic manner. There have always been differences in opinions and conduct regarding health and its treatment.

Check Your Progress II

2) List the dominant variables that play role in health seeking behaviour.

.....

.....

.....

.....

.....

7.4 IMPACT OF RURAL HEALTH SERVICES

India's National Rural Health Mission (NRHM), one of the largest public health programs in the world launched in 2005, increased the uptake of institutional delivery and antenatal services, particularly among the poorest socio-economic groups, in the less-developed high-focus Indian states. Although the uptake of antenatal services were not improved in the early post-NRHM period 2007–08, there were considerable increase in the uptake of, and decline in its inequity in the late post-NRHM period 2011–12.

Larger equity impacts in the uptake of institutional delivery and antenatal services were found in the late post-NRHM period 2011–12 than in the early post-NRHM period 2007–08, indicating that public health programmes in developing country settings will have larger equity impacts after its almost full implementation and widest outreach. Impact of NRHM was greatest in those states with higher proportion of beneficiaries enrolled under conditional cash-transfer programme of Janani Suraksha Yojana.

Studies found that NRHM's JSY payments were associated with increases in health facility births and decline in neonatal mortality, improvement in immunization rates and breastfeeding practices, decline in economic inequality in institutional delivery in the districts of higher JSY coverage, and decline in maternal mortality in richest districts than in the poorest.

ASHA services have connected marginalised communities with the health care system. Substantial variations in the receipt of ASHA services were reported with 66 per cent of women in northeastern states, 30 per cent in high-focus states, and 16 per cent of women in other states. In areas where active ASHA activity was reported, the poorest women, and women belonging to scheduled castes and other backward castes, had the highest odds of receiving ASHA services.

The role of the AYUSH system in providing health care services in rural India is palpable, with an abysmally inadequate health infrastructure. In rural India, the grossly inadequate health staff are greatly replenished by AYUSH doctors and paramedics. Many of the therapeutics are used in various ways that are safe and efficient for treating community health issues. Many of the concepts mentioned in the classical Ayurveda texts and other medical systems such as Yoga and Naturopathy are being used and many of them are proposed in the implementation and planning of the state programme (PIP).

The aim of rural health services is on improving the health of individuals living in rural India. They are attempting to make health facilities available to this disadvantaged population. It has already had no impressive impact on the improvement of health care services.

7.5 HEALTH SEEKING BEHAVIOUR DUE TO TECHNOLOGY

The number of internet users has increased considerably worldwide. The internet is used forhealth purposes by the general public, and the importance of the internet as a source of health information is growing. Additionally, health-related websites have gained popularity increasingly. Internet-based health information is accessed from a variety of sources, including websites run by organizations, homepages run by individuals, and online support groups where people actively exchange health information and blogs. Online health information has been giving opportunity to consumers and health care professionals for interactive health communication approach. Health care seekers appear to be using the internet to enhance their medical care; they report using the information online to diagnose a problem and feel more comfortable about their health provider's advice given the information found on the internet.

Access to reliable disease information online has been linked to reduced anxiety, increased feelings of self-efficacy, and decreases in utilization of ambulatory care. Therefore health-related websites have the potential to powerfully influence the attitudes and behaviour of consumers. The advantage of the internet is that it is widely available (home, work, libraries), convenient (24 hours a day at home) and anonymous. Health information has permeated the internet. Electronic health information is becoming ubiquitous. Health information is one of the most frequently sought topics on the Internet. The amount of health information available online is astounding. Using the most common method consumers rely on to find healthcare information online a keyword search on ''health'' at a popular search engine recently generated 473,000,000 results.

In the last decade, the percentage of adults who have accessed the Internet to look for health information has rapidly increased. In a national survey in the Netherlands in 2012, 81 per cent of people aged 65-75 years used the Internet and 54 per cent used the Internet for health information. Research shows that online health consumers tend to be more educated, earn more, and have high-speed internet access at home and at work.

Reuters reported that on average 53 per cent of Americans search the internet for health information and, according to the Pew Internet and American Life Project

(2003), of the 63 per cent of Americans who access the Internet (128 million people), 66 per cent of these look for health and medical information. Eysenbach estimated that, on a global level, of the 278 million internet searches that are being conducted each day, approximately 12.5 million searches are health related. Internet users searching for health information will even go to sites aimed at health professionals Understanding who is more likely to use the internet as a health information tool is an important aspect of understanding how the internet is transforming health care.

However, some have drawn attention to the dangers of patients using the internet for health information. For example, some raise the potential for misdiagnosis and exploitation. Others suggest that internet use can erode patients' faith in the authority of health-care practitioners. In response to such concerns, health-care providers have established classificatory systems for evaluating the scientific worth of web information. It is important that health professionals acknowledge patients' search for knowledge, that they discuss the information offered by patients and guide them to reliable and accurate health websites. Therefore, health-care professionals need to improve their own skills in Internet use.

Check Your Progress III

1) Elaborate on the role of technology in shaping rural health seeking behaviour.

.....

.....

.....

.....

.....

.....

7.6 ALTERNATIVE MEDICINE AND RURAL HEALTH

Alternative Medicine as a term used to define a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine (medicine as practiced by holders of MD or DO degrees and by their allied health professionals such as physical therapists, psychologists, and registered nurses). Well-known examples of CAM include aromatherapy, naturopathy, osteopathy, chiropractic, yoga, massage, acupuncture, and herbal and nutritional supplements. While other terms, including "integrative," "alternative," "unconventional," and "holistic" are often used to describe this group of treatments.

Available data on geographical differences in CAM consumption indicate that the prevalence of CAM use in rural regions is higher than in urban areas. A longitudinal study on women's health in Australia found that women who consult alternative health practitioners were more likely to reside in nonurban areas, and

an interview Study of 160 urban and 105 rural residents in Portugal revealed 75 per cent of the rural respondents as using CAM treatments and therapists while only 25 per cent of the urban respondents did so. Lind et al conducted an analysis of 2,37,500 insurance claims from 2 large insurance companies in the United States and found that the proportion of claimants using chiropractors was higher amongst ruralbased residents when compared to those claimants in urban areas (although users of chiropractic in urban areas had more chiropractic visits than users of chiropractic in rural areas). As these findings suggest, there may well be differences between the types of CAM used across geographical location.

AYUSH, an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa and Homeopathy represents the alternative systems of medicine recognized by the Government of India.Traditional medicine is defined as an amalgamation of knowledge, skill, and practices based on theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used for therapeutic, restorative, prevention, diagnosis and maintenance of physical and mental health. These systems are recognised globally for complementing disease prevention, treatment and generic health maintenance. There is widespread use of traditional medicine across developing countries (across Asia, Africa and Latin America) with rapidly emerging markets in North America and Europe. However, despite increasing national and international attention, the formal health systems, particularly in resource-poor settings, are yet to harness its true potential. Recognising such intricacies, the 67th World Health Assembly resolution on traditional medicine has been instrumental in the development of updated WHO Traditional Medicine Strategy (2014–23) with objectives to harness its contribution and promote effective use.

These international developments are of particular significance for India that has a pluralistic medical culture with a well-documented history and practice of alternative medicinal forms namely—Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy–now jointly referred to as AYUSH. As integral part of Indian culture, Indian System of Medicine (ISM) comprising of Ayurveda, Yoga, Unani and Siddha was practiced even before formal health system took shape. Unfortunately, in spite of presenting an effective role for health maintenance (preventive and curative), the ISM has been neglected and marginalized since the pre-independence era (before 1947). Prejudiced approach like curbing the state patronage, abolition of ISM schools and creation of medical bureaucracy further undermined the legitimacy of ISM practice. The potential of ISM was further curbed by the perils of caste-, class-, communal-and language-based politics. Besides, strong epistemological preferences within ISM system undermined its scope and expansion as a formal health care system in the post-independence era. However, time and again, with the realization of strengthening comprehensive primary health care, various Expert Groups and Health Committees in India have recommended integration of ISM with the biomedical/ allopathic system. For instance, Mudaliar Committee was first to recommend utilizing indigenous doctors for delivering vertical healthcare programs. Subsequent national health policies such as National Health Policy (1983), National Education Policy in Health Sciences in 1989 and National Health Policy

(2002) have also pointed out the potential of ISM in improving healthcare access, particularly in the absence of modern healthcare in rural India. But attempts made towards its revival thereafter, only saw bio-medicalization of these systems either for validation through scientific methods or for commercialization and excessive marketization of indigenous therapies. However, the paradigm shift in government's policy post-independence has focused on: creation of schools for ISM to produce licentiates, standardizing curriculum, drug research for patenting and mass production. The institutionalization of ISM in keeping with international interests further led to the creation of the Department of Indian Systems of Medicine and Homeopathy (ISM&H) in 1995 (later renamed as Department of AYUSH in 2003). In pursuance of 'mainstreaming' policy, post-2005, National Rural Health Mission (NRHM) provided an opportunity where strategies like provisioning of AYUSH drugs, co-locating providers at public health facilities and inter-sectoral convergence with ISM functionaries implementing national health programs were devised. Department of AYUSH also launched National AYUSH Mission during 12th plan with an objective of providing affordable, sustainable and accessible care. Subsequently, the elevation of AYUSH Department into an independent Ministry (in November 2014) is a noteworthy policy decision to further upgrade AYUSH educational standards with emphasis on epistemological strengths, quality standardization and stewardship.

Check Your Progress IV

1) What is alternative medicine?

.....

.....

.....

.....

.....

.....

2) What is the role of AYUSH in improving health care in rural India?

.....

.....

.....

.....

.....

.....

7.7 BARRIERS TO HEALTH AND NUTRITION SEEKING BEHAVIOUR

Individual Factors: Lack of personal resources, such as time and social support, and work-related factors such as job pressures, long working hours, and unemployment as barriers to HSB. Physical impediments such as illness and disability and negative personal characteristics such as low motivation, laziness, and lack of self-discipline can also adversely affect the HSB of an individual. A lack of financial resources is also a barrier to HSB.

Cultural factors: Perceived lack of consideration for cultural beliefs, traditions, and practices by health care professionals can cause stress and be a barrier to health service access.

Environmental factors: Aspects of the physical environment can act as a barrier for HSB. Differences in climate and seasonal temperatures can be a barrier for HSB. Sociocultural influences acting as a barrier to HSB included the availability, affordability, and easy access to fast foods.

Economic factor: The financial issue has always been one or another reason as a barrier for HSB. Particularly, in rural areas, the socio-economic conditions hinder towards the positive change in HSB.

Health Service Access: Lack of familiarity with the health care system in new place can act as a barrier to HSB, and the lack of information available in their original language. These barriers can act as impediments to accessing services, particularly for the migrants and the elderly.

Distance and lack of transportation: In many rural areas the medical centers are at a great distance which makes it difficult for the patient to get the treatment at the proper time. Not only the distance, but the lack of transportation adds up to the issue of getting the needed healthcare.

Lack of personnel as a barrier to health seeking behaviour was mainly reported by patients from the rural areas.

7.8 CHALLENGES IN RURAL HEALTH

The six decades of Indian independence have witnessed too many plans, papers and proposals giving top priority to the health issues in India.Unfortunately, amid huge economic growth, health remains the greatest predicament. Even WHO slogans 'Health for All,' 'Millennium Development Goals,' and more recently, 'Free Health Care' have not been converted into concrete action on the ground. Accessibility of healthcare as well as the use of available healthcare facilities, particularly in rural areas, continues to be low in India.

The poor state of health system in rural areas is a result of consolidated outgrowth of degraded system. It explains not only the distance between the existing policy and infrastructure but obstruction in development too. The expenditure on public health system has not only been ignored by the state but also by the common mass. People mostly prefer private practitioners and private hospitals over government run hospitals. The disillusionment and frustration with the growing ineffectiveness of the government sector is gradually driving poor people to seek help of the private sector, thus forcing them to spend huge sums of money on

credit, or they are left to the mercy of 'quacks'. Therefore, it is very essential for us to review primary elements for degradation of Public health system in India.

Some of the challenges in rural health are:

- Inadequate human resources
- Inefficacious infrastructure
- Inclination towards Home Based Deliveries
- Lack of coordination between Medical Research and Health Service delivery Institutions
- High Infant Mortality
- Non-preparedness to fight with Epidemic in rural areas
- Apathetic attitude of medical professionals
- Dominance of unregulated Private medical professionals.

Poor quality services at state-run hospitals force many people to visit private facilities. The overall health care utilization is also low, only half of (52%) of Indian mothers receive three or more antenatal checkups; Only 43.5 per cent of children in India receive all vaccinations {(NHFS-3), 2005-06}. At one side our peripheral health centres are underutilized whereas on other side our tertiary and secondary (District) level facilities are often argued as overloaded with the work that could have been done at lower centres, resulting in compromise of quality. Others continue to argue that even these centres have not successfully exploited the skills of its specialists with only 2–3 OPDs/OTs per week per physician. The underutilization of peripheral centres is attributed to varied factors related to accessibility, quality, affordability, deficient human resource, poor monitoring, lack of community participation and ownership. Vast and diverse geographical locations of India inhibit proper penetration of health care delivery in such areas. Further, health care personnel are reluctant to work at block or below level areas, as they have to face two challenges, first the absence of reasonable living conditions (e.g. proper housing, 24 hour electricity supply, good school for their children, social isolation etc.) and second, the under functioning of majority of health care facilities in such areas and hence no opportunity to translate their technical skills. Absence of stringent transfer policy leads to frustration among staff. Posting of surgeons at under functioning facilities at the beginning of their career erodes their surgical skills and make them non-functional forever. The absence of accessible quality primary care services leads many poor people to either forgo medical care altogether or choose to seek expensive and unregulated care in the private sector. Lack of adequate quality data on burden of disease and trauma for proper planning along with poor public health awareness are a few more issues. MCI and Nursing council of India in their current shape are inert to some extent as their main focus is only on quantitative assessment of staff, infrastructure, material and equipment rather than quality or treatment audit. The qualitative assessment e.g. professional skills of staff, managerial skills of administrators, quality of health care provided, quality of students trained at these institutes are totally missing. Deep rooted corruption is prohibiting the smooth flow of system, especially the prompt purchase of medical equipment and diagnostics. Directorate of Medical and Health, the apex administrative and regulatory body for Medical and Health in India lacks the technical expertise and needs overhauling. The middle level managers of health system e.g. CMHOs,

BMOs are unable to accomplish tasks at their own level. They act as a weak link between higher authority and periphery. System has taken away their self-esteem.

Check Your Progress V

1) What are the barriers and challenges to health seeking behaviour?

.....

.....

.....

.....

.....

7.9 SOLUTIONS TO RURAL HEALTH

The RURBAN initiative of developing villages can be gainfully used for innovative medical manpower management in primary healthcare. Thus, the concept of Model Group Housing at block level/PHC level should be considered where government employees of all the departments e.g. Medical and Health, PWD, School Education, Police, Electricity, Bank, JaldayaVibhag, BDO, Road and Transport, Post and Telegraph etc. could be provided accommodation where required. Facilities like school, playground, community centre, supermarket etc. could be provided in the neighbourhood. This would take care of the "Doctors Deficiency" argument very often put forward as an excuse for non-availability of medical and health facilities. This concept would allow holding, retaining and recruiting fresh talent by facilitating their stay and improvising their quality of life comparable with their counterparts in the city. Thus, the feeling of being deprived and frustrated could be compensated.

The critics might argue that it is a very optimistic project and shall require long time to complete while consuming a lot of resources. While one has waited for solutions including conditional provisions of rural posting, increased allowances or even making the rural services compulsory to doctors or other skilled workers, for more than several decades, the project looks worth serious consideration. The resources under RURBAN model, the funds from Prime Minister exchequer, Member of Parliament, Village Development Project and those under the National Rural Health Mission with low cost housing along with several other projects could be merged to give impetus to the newer solutions.

The model housing township should also harbor the first referral unit (FRU) consisting of a gynecologist, anesthesiologist, pediatrician and surgeon with facility of ICU. Such team effort would provide cohesive and coordinated medical services. The primary health centre physicians could also stay at the model township and may be allowed to run the OPDs and the National health programmes or other specific responsibilities by a 'to and fro' movement every day. The initial phase of populating such hospitals in such model villages (or townships) can happen by way of temporary deployment of skilled manpower from larger govt hospitals or tertiary care centres that feed such rural areas. Emergencies at the PHCs can be either handled through ambulance 108, or the mobile surgical services stationed at the model township which can periodically

conduct camps and handle necessary medical, surgical, emergency and blindness control programme. The sub centres could remain connected to FRU by the ASHA worker or the incharge, who could be from the AYUSH staff. The proposal to effectively mainstream AYUSH in present rural health delivery systems would go a long way and also pave way for looking into the deep rooted indigenous system of medicine well accepted among people. There could be value addition of services by AYUSH staff if they are trained for national health programmes, identifying emergencies in facilitating a decrease in IMR, MMR and IFR. Needless to state, the huge work force of AYUSH is available with majority of the states in India. Further, to reduce the out of pocket expenses, innovative insurance model combining the RSBY with "TOP UP" Scheme created by UNICEF and is proposed by the author as means to bring change under his leadership.

The instant health advice 'electronically' proposed by NIDAN would add to the quality healthcare. Similarly, either outsourcing the diagnostics based on the Rajasthan CT/MR PPP Model could not only add to the quality results and management but would also provide public awareness in the rural areas for early diagnosis and planned preventive strategies. The PPP diagnostic model along with the innovative insurance scheme can generate huge financial resources (the State Government being partner) for the development both at primary and secondary care services. Further, the model townships could be connected through telemedicine to the tertiary care centres for availability of speciality/ superspeciality consultation and also continuing medical education. The health managers could be made administrative incharge for procurement and maintenance of equipment and on a day to day basis could also organize financial planning systems of accountability thereby relieving the medical professionals for delivering their professional services at ease. Paramedic training and orientation could be a periodic phenomena with the Health managers sustaining efficient health delivery system.

Alternatively, measures like pooling of locally available private specialist doctors or sharing specialist from one PHC to another or if there is a lack of manpower at the FRU outsource the overall health services either to the local nursing homes or private cooperative of doctors or the corporate hospitals could be mobilized. The NABH or JCI implementation with regional modifications could improve the quality of services.

To give the impetus to the whole new concept the administrative machinery needs to be integrated and reorganized. The Medical, Health and Education Department need to work in synergy to achieve the objective of overall enhancement of health. It is, therefore, possible for three Departments to be supervised by a singular Principal Secretary. The convergence link for primary, secondary and tertiary level health services should be Director General of Health Services. There could be five Directors under DG namely Director, Infectious Diseases and Epidemiology (including statistics); Director, Non communicable and Life Style Based Diseases (including Nutrition); Director, Mother and Child Health and Family Welfare; Director, Training, continuous Medical Education, School Health and IEC; Director, Mobile Health Unit, Transport, Communication and Information Technology. These could cohesively interact with other supportive departments like PHED and Science and Technology. To give impetus to research on endemic and perennial diseases, the establishment of "Model Rural

Township' concept of ICMR could be very useful. The State Medical Councils (presently inert) could assert their authority in pushing and updating the professional's knowledge by using the human resources at tertiary and secondary care. The tertiary care should be given the task of conducting epidemiological surveys to identify regional rural health issues. All these efforts could create a healthy milieu for rural health practices.

Finally, provision of healthcare for rural areas hinge on the affordability of treatment and diagnostic costs. In order to propel the indigenous production of medical devices, drugs, surgicals and diagnostics, the biomedical scientists in the hospitals, research institutions and elsewhere can come together and translate their knowledge into affordable medical products. By instituting 'innovation clinics', the consulting scientists and doctors could join hands in order to translate their respective knowledge useful for bedside of patient around the Model Rural Research Centre of ICMR. This will be important in fulfilling the concept of 'make in India' thereby saving both the costs of import thereby enabling affordable health care.

7.10 LET US SUM UP

Considering the fact that over 65 per cent of the country's population still lives in rural areas where the health infrastructure, awareness and education levels are very poor, planning for health care is all the more difficult. Since independence, numerous programmes have been initiated, including recent introduction of AYUSH and traditional medicine. However, it is imperative to understand the health seeking behaviour as it dominantly determines the success or failure of policies and programmes at the ground level.

7.11 KEY WORDS

Malnutrition refers to deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients.

Alternative Medicine as a term used to define a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine (medicine as practiced by holders of MD or DO degrees and by their allied health professionals such as physical therapists, psychologists, and registered nurses).

AYUSH, an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa and Homeopathy represents the alternative systems of medicine recognized by the Government of India.

Traditional Medicine is defined as an amalgamation of knowledge, skill, and practices based on theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used for therapeutic, restorative, prevention, diagnosis and maintenance of physical and mental health[43,44].

Healthcare Seeking Behaviour (HSB) has been defined as, "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy". Health seeking behaviour can also be referred to as illness behaviour or sick-term behaviour.

7.12 REFERENCES AND WEB PAGES

https://www.alliedacademies.org/articles/the-importance-of-nutrition-for-health-and-society-13316.html

https://www.who.int/health-topics/nutrition

https://www.who.int/news-room/fact-sheets/detail/malnutrition#:~:text=Malnutrition%20refers%20to%20deficiencies%2C%20excesses,low%20weight%2Dfor%2Dage)%3B

Atuyambe LM. Adolescent motherhood in Uganda: Dilemmas, health seeking behaviour and coping responses. 2008.

Mwase I. Social capital and household healthseeking behaviour for children in the context of urban neighborhoods. The case of Khayelitsha in Western Cape, South Africa: University of Cape Town. 2015

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6143883/

https://www.sas.upenn.edu/~dludden/WaterborneDisease3.pdf

https://www.thehindu.com/sci-tech/health/india-145th-among-195-countries-in-healthcare-access-quality-lancet/article23970214.ece

https://www.researchgate.net/publication/323628689_RURAL_HEALTH_IN_INDIA_PPT_13022018

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4248476/

Olenja J. Editorial Health seeking behaviour in context. 2004.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5417584/

Rehman A, Shaikh BT, Ronis KA. Health care seeking patterns and out of pocket payments for children under five years of age living in KatchiAbadis (slums), in Islamabad, Pakistan. International journal for equity in health. 2014;13(1):30.

Phiri SNa, Kiserud T, Kvale G, et al. Factors associated with health facility childbirth in districts of Kenya, Tanzania and Zambia: a population based survey. BMC pregnancy and childbirth. 2014;14(1):219.

Onwujekwe O, Onoka C, Uzochukwu B, Hanson K. Constraints to universal coverage: inequities in health service use and expenditures for different health conditions and providers. International journal for equity in health. 2011;10(1):50.

Ononokpono DN, Odimegwu CO. Determinants of maternal health care utilization in Nigeria: a multilevel approach. The Pan African medical journal. 2014;17 (Suppl 1)

gender and biomedical/traditional mental health utilization among the Bedouin-Arabs of the Negev. *al-Krenawi A, Graham JR Cult Med Psychiatry. 1999 Jun; 23(2):219-43.*

Gender differences in determinants and consequences of health and illness.*Vlassoff CJ Health PopulNutr. 2007 Mar; 25(1):47-61*

Social ties and mental health.*Kawachi I, Berkman LFJ Urban Health. 2001 Sep; 78(3):458-67.*

https://www2.slideshare.net/amanyhoda/health-behaviour

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5886191/#:~:text=Conclusion%3A%20 In%20high%2Dfocus%20states,full%20implementation%20and%20widest%20outreach.

India's Janani Suraksha Yojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation. *Lim SS, Dandona L, Hoisington JA, James SL, Hogan MC, Gakidou E Lancet. 2010 Jun 5; 375(9730):2009-23.*

Impact of Janani Suraksha Yojana on institutional delivery rate and maternal morbidity and mortality: an observational study in India. *Gupta SK, Pal DK, Tiwari R, Garg R, Shrivastava AK, Sarawagi R, Patil R, Agarwal L, Gupta P, Lahariya C J Health PopulNutr. 2012 Dec; 30(4):464 71.*

Are institutional deliveries promoted by Janani Suraksha Yojana in a district of West Bengal, India? *Panja TK, Mukhopadhyay DK, Sinha N, Saren AB, Sinhababu A, Biswas AB Indian J Public Health. 2012 Jan-Mar; 56(1):69-72.*

India's Conditional Cash Transfer Programme (the JSY) to Promote Institutional Birth: Is There an Association between Institutional Birth Proportion and Maternal Mortality? *Randive B, Diwan V, De Costa A PLoS One. 2013; 8(6):e67452.*

More evidence on the impact of India's conditional cash transfer program, Janani Suraksha Yojana: quasi-experimental evaluation of the effects on childhood immunization and other reproductive and child health outcomes. *Carvalho N, Thacker N, Gupta SS, Salomon JA PLoS One. 2014; 9(10):e109311.*

Inequalities in institutional delivery uptake and maternal mortality reduction in the context of cash incentive program, Janani Suraksha Yojana: results from nine states in India. *Randive B, San Sebastian M, De Costa A, Lindholm L Soc Sci Med. 2014 Dec; 123():1-6.*

Takahashi, Y., Ohura, T., Ishizaki, T., Okamoto, S., Miki, K., Maito, M., Akamatsu, R., Sugimori,H., Yoshiike, N., Miyaki K., ShLPEÕ.Nakavama, T.(2011). Internet use for health-related information via personal computers and cell phones in Japan: a cross-sectional population-based survey. J Med Internet Res.13(4), e110.

Ybarra, M.L.,& Suman, M.(2006). Help seeking behavior and the internet: A national survey. International Journal of Medical Informatics, 75, 29-41.

Williams, P., Huntington, P.,&Nicholas, D.(2003). Health information on the internet: a qualitative study of NHS direct online users. Aslib Proc., 55, 304–312.

McMullan, M.(2006). Patients using the Internet to obtain health information: how this affects the patient-health professional relationship.Patient Educ Couns., 63(1-2), 24-28.

Eysenbach,G.,Diepgen, T.L. (1998). Towards quality management of medical information on the internet: evaluation, labelling, and filtering of information. BMJ. 317(7171),1496-500.

Reuters (2003). Consumer-targeted internet investment: online strategies to improve patient care and product positioning. Reuters Business Insight Report,May.

Heathfield,H., Pitty,D., &Hanka,R.(1998). Evaluating information technology in health care: barriers and challenges. BMJ., 316(7149),1959-1961.

Impicciatore P, Pandolfini C, Casella N, Bonati M. (1997).Reliability of health information for the public on the World Wide Web: systematic survey of advice on managing fever in children at home. BMJ. 314(7098),1875–1879.

Silberg,W.M., Lundberg,G D,&Musacchio R A. (1997).Assessing, controlling, and assuring the quality of medical information on the Internet: Caveant lector et viewor-Let the reader and viewer beware. JAMA.277(15), 1244-1245.

https://www.sciencedirect.com/science/article/pii/S1877042815037271/pdf?md5=c91a83305e8078d509921384bb93545b&pid=1-s2.0-S1877042815037271-main.pdf

https://sci-hub.se/https://doi.org/10.1111/j.1748-0361.2010.00348.x

Adams J, Sibbritt D, Easthope G, Young A. The profile of women who consult alternative health practitioners in Australia. Med J Aust. 2003;179:297-300.

Sibbritt DW, Adams J, Young AF. A longitudinal analysis of mid-age women's use of complementary and alternative medicine (CAM) in Australia, 1996-1998. Women Health. 2004;40(4):41-56.

Nunes B, Esteves MJS. Therapeutic itineraries in rural and urban areas: a Portuguese study. Rural & Remote Health. 2006;6(394).

Lind BK, Diehr PK, Grembowski DE, Lafferty WE. Chiropractic use by urban and rural residents with insurance coverage. J Rural Health. 2009;25(3): 253-258.

World Health Organization. General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine [Internet]. World Health Organization; 2000. http://apps.who.int/iris/bitstream/10665/66783/1/WHO_EDM_TRM_2000.1.pdf

World Health Organization, editor. WHO traditional medicine strategy: 2014–2023. Genève: WHO; 2013.

Bannerman RH, editor. Traditional medicine and health care coverage: a reader for health administrators and practitioners. Geneva: World Health Organisation; 1988.

Debas H T, Laxminarayan R and Straus SE. Complementary and Alternative Medicine In: Jamison DT, Breman JG, Measham AR, et al., editors. Disease control priorities in developing countries. 2nd ed Washington, DC: World Bank; [u.a.]; 2006.

Sunil A. Political Culture of Health in India: A Historical Perspective. Econ Polit Wkly. 2007;42: 114–121.

Mushtaq M. Public health in British India: A brief account of the history of medical services and disease prevention in colonial India. Indian J Community Med. 2009;34: 6 10.4103/0970-0218.45369

Srinivasan P. National Health Policy for Traditional Medicine in India. World Health Forum. 1995;16:190–193.

National Rural Health Mission. National Rural Health Mission (2005–2012)—Mission document. Indian J Public Health. 2005;49: 175–183.

https://www.hindawi.com/journals/bmri/2015/506269/

https://www.hindawi.com/journals/ijhy/2018/8307591/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4248476/

https://www.researchgate.net/publication/323628689_RURAL_HEALTH_IN_INDIA_PPT_13022018

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4248476/

UNIT 8 HEALTH OF WOMEN, CHILDREN AND VULNERABLE GROUPS

Structure

8.0 OBJECTIVES

After reading this Unit, you will be able to:

- understand health and healthcare related issues of women and children in India;
- know the existing health challenges and government's effort to address healthcare issues of women and children in India;
- identify the vulnerable groups and their health related issues, and

- make an overview and assessment of the prevailing situations related to healthcare needs of the Elderly and Persons with Disabilityin India and government initiatives.

8.1 INTRODUCTION

Health is a basic human right of all. The Universal Declaration of Human Rights established a breakthrough in 1948, by stating in Article 25: 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself (herself) and his (her) family….'. The Preamble to the World Health Organisation (WHO) also affirms that it is one of the fundamental rights of every human being to enjoy 'the highest attainable standard of health'. Alma Ata declaration of 1978 set the target of achieving the goal of 'health for all' by 2000.The Millennium Development Goals (MDGs) have incorporated five out of eight goals to health needs of the population. As per Sustainable Development Goals (SDGs), out of the 17 identified goals to be achieved by 2030, many goals are there to achieve health needs of the population especially deprived population. The concern shown by global agencies like United Nations and WHO help us to understand that health is a basic human right of all, irrespective of sex, age, ethnicity, race, national identities and no amount of discrimination, inequality, prejudice or deprivation could stop any section of human population from enjoying the health rights as basic human rights.

Health is a state of wellness. Health is necessary for the biological, mental, psychological, social, cultural, spiritual, economic, and political well-being of all human beings. Health enhances capability and functioning of human beings. Inequalities in the field of health are the most basic form of inequalities and needs to be addressed urgently. Health is an indicator and necessary condition for all paradigms of development (Akram, 2014a). Although several diseases and ailments are common world over, the systems of medicine and therapies are multiple. The physiological, mental, social and cultural needs of people often vary as per their age, gender, socio-economic situations and other macro level realities of life and hence health and healthcare needs of different sections of population also may vary. Situated within thedemographic and social-contextual background, this lesson tries to understand the health and healthcare issues of women, children and other vulnerable groups in India.

8.2 HEALTH OF WOMEN: MAJOR ISSUES

Health of women is one critical area that remained at the core of the Fourth World Conference on Women which was convened by the United Nations during 4-15 September 1995 in Beijing, China. Going beyond this, many health issues of women also found their reflection in the goals and targets of the United Nations' Millennium Development Goals (MDGs) to be achieved by the year 2015. Out of the eight goals, four addressed issues related to women and two specifically addressed health of women. Further, in 2015, the United Nations General Assembly adopted a set of new Sustainable Development Goals (SDGs) to build on MDGs' progress and advance human, economic and sustainable development by 2030. Equality, health and empowerment of all women and girls is a core agenda of these SDGs.

Women are susceptible to many illness or disease and healthcare issues just like men. Most of the communicable and non-communicable or chronic and acute diseases inflict both women and men and the trajectories of treatment and care are followed as per the diagnosis reports for such common or gender neutral ailments. However, some specific ailments or diseases are gender specific and the courses of diagnosis and treatment depend upon the gender specific requirements, for example, the problems of breast cancer and prostate cancer are gender specific. Going beyond these gender neutral or gender specific ailments and disease, there are several life situations and experiences which are witnessed by women only. Maternity experience is one such experience which is applicable in case of women only. Reproductive health is another approach to address some of the common issues related to maternal health but the focus here is on the process of reproduction and sexuality and very often it also includes issues which are beyond the scope of maternal health.

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. Although motherhood is often a positive and fulfilling experience, for many women it is associated with suffering, ill-health and even death (Akram, 2014b). Throughout human history, pregnancy and childbearing have caused death and disability in both women and neonatal. Death of the mother during childbirth or issues related to this is often identified as maternal death or maternal mortality. Pregnancy and childbirth are of course not diseases (WHO, 2009). But, they carry risks because of the varying and embedded complications, practices, processes, beliefs, life conditions and the immediate environment. These risk scan be reduced by health care interventions such as the provision of maternal and public healthcare, antenatal and postnatal care, supplementary nutrition, family planning, safe abortion and improvement in other reproductive conditions.

A much discussed and important aspect of health of women is reproductive health. The term 'reproductive health' was first adopted at the International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994 and heralded a major shift in thinking and approach to population issues – from pure population control through family planning, to a much wider field encompassing not only fertility control but safe sex and pregnancy free from coercion, discrimination and violence. In the ICPD Programme of Action, 'Reproductive health' is defined as: "a state of complete physical, mental and social well-being and...not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of birth control which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."

Check Your Progress I

1) Why do we need to study health of women?

.....

.....

.....

.....

.....

2) What are the main components of reproductive health of women?

.....

.....

.....

.....

.....

8.3 SELECTED INDICATORS OF HEALTH OF WOMEN IN INDIA

8.3.1 Maternal Mortality Ratio (MMR)

The Maternal Mortality Ratio is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births. Such deaths are affected by various factors, including general health status, education and services during pregnancy and childbirth. According to the Annual Report 2018-19, Ministry of Health and Family Welfare (MoHFW), Government of India, "Maternal Mortality Ratio (MMR) in India was exceptionally high in 1990 with 556 women dying during child birth per hundred thousand live births. Approximately, 1.38 lakh women were dying every year on account of complications related to pregnancy and child birth. The global MMR at the time was much lower at 385. There has however, been an accelerated decline in MMR in India. MMR in the country has declined to 130 (SRS 2014-16) against a global MMR of 216 (2015)" (p. 29). Assam continues to be the State with the highest MMR (237) followed by Uttar Pradesh/Uttarakhand (201) and Rajasthan (199).

8.3.2 Institutional Delivery, Proportion of Births Attended by Skilled Health Personnel and Increase in Cesarean Section (CS) Deliveries

In order to reduce maternal mortality and infant mortality, it is extremely important that all births take place in healthcare institutions with proper healthcare facilities for the mother as well as newborn and births be attended by skilled health personnel. The proportion of births attended by skilled health personnel is the percentage of deliveries attended by personnel trained to give the necessary supervision, care and advice to women during pregnancy, labour and the post-

partum period; to conduct deliveries on their own; and to care for newborns. Skilled health personnel include only those who are properly trained and who have appropriate equipment and drugs. Traditional birth attendants, even if they have received a short training course, are not to be included. Institutional deliveries in India have risen sharply from 47 per cent in 2007-08 to over 78.9 per cent in 2015-16 (NFHS-4) while safe delivery has simultaneously climbed from 52.7 per cent to 81.4 per cent in the same period.

The States of Kerala, Lakshadeep and Puducherry have achieved 100 per cent coverage in births attended by skilled health personnel, in 2015-16 as per NFHS-4. A total of 13 States reported that more than 90 per cent of the births were attended by skilled health personnel. The NFHS-4 data also reveal that the growth in institutional delivery is followed by a twofold increase in Cesarean Section (CS) deliveries from 8.5 per cent in 2005-06 to 17.2 per cent in 2015-16. Many States have witnessed high growth in CS deliveries and some of these States are Andhra Pradesh (40.1%), Kerala (35.8%), Tamil Nadu (34.1%), Jammu and Kashmir (Now UT) (33.1%) and Goa (31.4%). Unexpected growth in CS deliveries is also a cause of concern (Muzaffar and Akram, 2019).

8.3.3 Antenatal and Postnatal Care

Antenatal care (ANC) refers to pregnancy-related health care, which is usually provided by a doctor, an auxiliary nurse midwife (ANM) or another health professional. Ideally, ANC should monitor a pregnancy for signs of complications, detect and treat pre-existing and concurrent problems of pregnancy, and provide advice and counselling on preventive care, diet during pregnancy, delivery care, postnatal care and related issues. The main purposes of ANC are to prevent certain complications, such as anaemia, and identify women with established pregnancy complications for treatment or transfer. Postnatal check-ups, healthcare that the mother and the infant receive during the first few weeks after delivery, are particularly important for births that take place in non-institutional settings. Recognizing the importance of postnatal check-ups, three postnatal visits are generally recommended.

8.3.4 Iron and Folic Acid Supplementation to Pregnant and Lactating Women for Prevention and Treatment of Anaemia

After the first trimester of pregnancy, every pregnant woman during ANC is also given iron and folic acid (IFA) tablets for six months, after the first trimester of pregnancy and six months post-partum. Pregnant women, who are found to be clinically anaemic, are given double the dose of IFA. In terms of prevalence of anemia among pregnant women (15-49 years), as per NFHS 4, Jharkhand is the worst performing state having the highest percentage (62.6) of such prevalence followed by Bihar (58.3%), Haryana (55.0%), Madhya Pradesh (54.6%), Tripura (54.4%) and West Bengal (53.6%).

8.3.5 Comprehensive Abortion Care

According to the MoHFW's Annual Report 2018-19, comprehensive abortion care is being provided as it is an important element in the reproductive health component of the RMNCH+A strategy as 8 per cent (2001-03 SRS) of maternal deaths in India are attributed to unsafe abortions. Revised guidelines have been issued for service delivery in India in 2019.

8.3.6 Screening and Care for STIs and RTIs

Screening and care for Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs) are being provided at health facilities as they constitute an important public health problem in India. A policy decision has been taken for universal testing of HIV and syphilis in pregnant women. As per HMIS report for FY 2018-19, over 80 lakh pregnant women are screened for syphilis and approximately 1.86 crore pregnant women have been screened for HIV.

Check Your Progress II

1) Elaborate the situation related to Maternal Mortality Ratio (MMR) in India.

.....

.....

.....

.....

.....

8.4 HEALTHCARE OF WOMEN IN INDIA: SOME IMPORTANT GOVERNMENT PROGRAMMES

8.4.1 Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Health Mission (NHM). It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among pregnant women. JSY is a Centrally Sponsored Scheme, which integrates cash assistance with delivery and post-delivery care. The scheme has identified Accredited Social Health Activists (ASHAs) as an effective link between the Government and pregnant women.

8.4.2 Janani Shishu Suraksha Karyakram (JSSK)

Building on the phenomenal progress of the JSY scheme, Government of India launched Janani Shishu Suraksha Karyakaram (JSSK) in 2011. The initiative entitles all pregnant women delivering in public health institutions to have absolutely free and no expense delivery, including caesarean section. The entitlements include free drugs, consumables, free diet during stay, free diagnostics and free blood transfusion, if required. This initiative also provides free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements were put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. In 2013, the scheme was expanded to cover complications during ante-natal and postnatal period and also sick infants up to 1 year of age.

8.4.3 Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) has been launched by the MoHFW in 2016. Under PMSMA, all pregnant women in the country are provided fixed day, free of cost assured and quality Antenatal Care. As part of the campaign, a minimum package of antenatal care services (including investigations and drugs) is being provided to the beneficiaries on the 9th day of every month. The Abhiyan also involves private sector's health care providers as volunteers to provide specialist care in government facilities.

8.4.4 Scheme for Promotion of Menstrual Hygiene among Adolescent Girls in Rural India

Scheme for Promotion of Menstrual Hygiene was launched by MoHFW, to promote Menstrual Hygiene among adolescent girls in the age group of 10-19 years in rural areas as part of the Adolescent Reproductive Sexual Health (ARSH) in RCH II, with specific reference to ensuring health for adolescent girls. The major objectives of the scheme are: to increase awareness among adolescent girls on Menstrual Hygiene; to increase access to and use of high quality sanitary napkins to adolescent girls in rural areas; and to ensure safe disposal of sanitary napkins in an environmentally friendly manner.

Check Your Progress III

1) Make an assessment of the government initiatives taken to improve the health of women in India.

.....

.....

.....

.....

.....

.....

.....

8.5 HEALTH OF CHILDREN: GLOBAL AND NATIONAL FRAMEWORKS

WHO, in a paper titled as "Early child development – Child health and development" says: The early childhood years are a period of not only great opportunity but also of great vulnerability? The Nurturing Care Framework (WHO, UNICEF & World Bank Group, 2018) was launched at the time of the World Health Assembly in 2018 to provide a roadmap for action. The framework builds on state-of-the-art evidence about how child development outcomes are influenced and how they can be improved by policies and interventions. Nurturing care is characterised by a stable environment that promotes health and optimal nutrition, protects children from threats, and gives them opportunities for early learning, through affectionate interactions and relationships. Main components of Nurturing Care, as per WHO Guidelines, are: good health; adequate nutrition;

responsive care giving; opportunities for early learning; and, security and safety. Goal number 4 of the MDGs talks about reducing child mortality. Further, out of the 17 identified goals of SDGs to be achieved by 2030, first three goals talk about ending poverty, ending hunger and ensuring health for all respectively and focus is definitely on children also.

As per Census of India 2011, the share of children (0-6 years) accounts 13 per cent of the total population in the Country. The child health programme under the National Health Mission (NHM) comprehensively integrates interventions that improve child survival and addresses factors contributing to infant and under-five mortality. It is now well recognised that child survival cannot be addressed in isolation as it is intricately linked to the health of the mother, which is further determined by her health and development as an adolescent. Therefore, the concept of Continuum of Care, that emphasises on care during critical life stages in order to improve child survival, is being followed under the national programme. The newborn and child health are now the two key pillars of the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) Strategic Approach, 2013.The goals for child health in India as envisaged by National Health Policy 2017 and SDG 2030 are presented in Table 8.1.

Table 8.1: Child Health Goals under NHP-2017 and SDG-2030

Child Health Goals under NHP-2017 and SDG-2030			
Child Health Indicator	**Current status**	**NHP 2017**	**SDG 2030**
Neonatal Mortality Rate (NMR)	24	16 by 2025	<12
Infant Mortality Rate (IMR)	34	28 by 2019	—
Under 5 Mortality Rate (U5MR)	39	23 by 2025	d”25

Source: Sample Registration System (SRS) 2016, NHP 2017 & SDG 2030

Check Your Progress IV

1) Why do we need to study the situations related to health of children in India?

.....

.....

.....

.....

.....

.....

.....

.....

8.6 HEALTHCARE OF CHILDREN IN INDIA: MAIN PROBLEMS AND GOVERNMENT PROGRAMMES

8.6.1 Main Problems and Causes of Child Mortality

The MoHFW's Annual Report 2018-19 talks about the main problems and causes of child mortality and newborn health in India. The major causes of child mortality in India as per the SRS reports (2010- 13) are: Prematurity and low birth weight (29.8%); Pneumonia (17.1%); Diarrhoeal diseases (8.6%); other non-communicable diseases (8.3%); Birth Asphyxia and Birth Trauma (8.2%); Injuries (4.6%); Congenital anomalies (4.4%); ill-defined or cause unknown (4.4%); Acute bacterial sepsis and severe infections (3.6%); Fever of unknown origin (2.5%); and, all other remaining Causes (8.4%). Beside these causes, malnutrition is a contributory factor in 45 per cent child deaths.

8.6.2 Nutrition Related Interventions

Malnutrition is considered to be the underlying cause of 45 per ent of child deaths: 35.7 per ent of under-5 children are underweight, 38.4 per ent are stunted and 21.0 per ent are acutely malnourished (wasted). More importantly, 7.5 per ent of children are suffering from severe acute malnutrition, as per the last available national survey (NFHS 4, 2015-16). Further, only 41.6 per ent newborns initiated on breastfeeding within one hour of birth while 54.9 per ent children breastfed exclusively till 6 months of age (NFHS 4, 2015-16).Complementary feeding started for only 42.7% children on time (more than 6 months of age) and 58.4 per ent of children in age group 6 to 59 months are anaemic (NFHS 4, 2015-16).

8.6.3 Rashtriya Bal Swasthya Karyakram (RBSK)

According to the Annual Report 2018-19, MoHFW (p. 436), RBSK provides child health screening and early interventions services by expanding the reach of dedicated mobile health teams at block level. These teams also carry out screening of all the children in the age group 0–6 years enrolled at Anganwadi Centres twice a year and 6-18 years at government school and government aided schools once a year. RBSK covers 30 common health conditions including screening, confirmation and management. Many of these conditions are very critical and if left unaddressed, they could negatively impact the critical period of brain development of the child permanently e.g. treating congenital heart disease, congenital deafness, congenital cataract, developmental delay during infancy. RBSK also provides screening of all newborns at all the delivery points for birth defects. RBSK provides early intervention Centre at all districts to prevent or minimise disability. The strategic interventions to address birth defects, diseases, delays and deficiencies are: screening of children under RBSK; establishment of District Early Intervention Centres (DEICs); and, Birth Defects Surveillance System (BDSS) is being established.

8.6.4 Immunization and Vaccination

The Expanded Program of Immunization (EPI) was introduced globally in 1974. The initial EPI program in India was limited to Bacillus Calmette Guerin (BCG),

diphtheria, tetanus toxoids, whole cell pertussis (DTwP), oral poliomyelitis, and typhoid vaccines, and chiefly covered urban areas. The Universal Immunization Program (UIP), introduced in 1985, improved immunization coverage and extended the focus beyond infancy. Typhoid vaccine was excluded from the schedule, and measles vaccine was added. Vitamin A supplementation was added in 1990, and the Polio National Immunization Days introduced in 1995. Some states introduced hepatitis B vaccine in 2002 and a pentavalent vaccine in 2011. UIP is an essential part of the Child Survival and Safe Motherhood Program since 1992, the Reproductive and Child Health Program (RCH-I) from 1997, and the RCH-II and National Rural Health Mission since 2005(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4928529/).

Under the Universal Immunization Programme, Government of India is providing vaccination to prevent seven vaccine preventable diseases i.e. Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B, Hiaemophilus influenza type b (Hib) and Diarrhea.

Check Your Progress V

1) Explain the importance of nutrition related initiatives to improve the health of children in India.

.....

.....

.....

.....

.....

.....

.....

8.7 HEALTH OF VULNERABLE GROUPS

Vulnerable groups include those sections of population who have limited access to the overall development benefits because of their demographic, physiological, socio-economic, spatial, geographical and other contextually defined limitations. In demographic terms children, old aged people and women are considered vulnerable. In physiological terms, people with any kind of disability are considered vulnerable. Similarly, in socio-economic terms poor and especially those who are living below poverty line are more vulnerable. Rural people are more vulnerable than urban population. Scheduled Caste, Scheduled Tribes and Backward Classes are constitutionally identified deprived people considered as very vulnerable groups. Very often, people working in occupations more exposed to environmental or job related hazards are also defined as vulnerable groups. Some ethnic and minority groups, slum dwellers, unorganized workers are also defined as vulnerable groups in specific contexts.

Health statistics shows that the health outcome of these vulnerable groups are poor because of several interrelated factors related to lack of food and nutrition, unavailability of safe drinking water, unhygienic living conditions, poor access

to healthcare and medical facilities, illiteracy, lack of awareness, and more susceptibility to communicable diseases especial malaria, tuberculosis, diarrhea etc. We have already examined health of women and children in first two section of this Unit. You will read about health of rural people in other lessons. Similarly, one lesson on communicable and non-communicable disease have examined the situations related to affected people at length there. We will try to add some new insights related to health and healthcare of two least discussed vulnerable groups here.

8.7.1 Health of Elderly People in India

The elderly population (aged 60 years or above) in India accounted for 7.4 per cent of total population in 2001 and it increased to 8.6 per cent of total population as per Census 2011. Further composition of elderly population of India is given in Table 2. Both the share and size of elderly population is increasing over time. From 5.6 per cent in 1961 it is projected to rise to 12.4 per cent of population by the year 2026. Most common disability among the aged persons was locomotor disability and visual disability as per Census 2011. Prevalence of heart diseases among elderly population was much higher in urban areas than in rural parts.

Table 8.2: Elderly People in India

Population Aged 60+ (in millions)			
Rural/ Urban	**Male**	**Female**	**Total**
Rural	36.0	37.3	73.3
Urban	15.1	15.5	30.6
Total	51.1	52.8	103.9
Share of Elderly Population in Total Population (%)			
Rural	8.4	9.2	8.8
Urban	7.7	8.5	8.1
Total	8.2	9.0	8.6

Source: Central Statistics Office, Ministry of Statistics and Programme Implementation (MSPI), Government of India (www.mospi.gov.in)

http://mospi.nic.in/sites/default/files/publication_reports/ElderlyinIndia_2016.pdf

The MoHFW launched the National Programme for Health Care of the Elderly (NPHCE) during the year 2010-11, in the 11th plan period, to address various health related problems of elderly people. It covers all elderly people (above 60 Years) in the country. It intends to provide free, specialized health care facilities exclusively for the elderly people through the State health delivery system. The State Government/Union Territory furnish programme Implementation plan in the prescribed format to avail the facility for implementation of the programme as per the guidelines and terms and conditions. Main Strategies of healthcare of elderly people in India:

i) **Preventive and Promotive Care:** The preventive and promotive health care services such as regular physical exercise, balanced diet, vegetarianism, stress management, avoidance of smoking or tobacco products and

prevention of fall, etc. are provided by expanding access to health practices through domiciliary visits by trained health workers. They will impart health education to old persons as well as their family members on care of older persons. Besides, regular monitoring and assessment of old persons are carried out for any infirmity or illness by organizing weekly clinic at PHCs.

ii) **Management of Illness:** Dedicated outdoor and indoor patients services will be developed at PHCs, CHCs, District Hospitals and Regional Geriatric Centres for management of chronic and disabling diseases by providing central assistance to the State Governments.

iii) **Health Man Power Development for Geriatric Services:** To overcome the shortage of trained medical and para-medical professionals in geriatric medicine, in service training will be imparted to the health manpower using standard training modules prepared with the help of medical colleges and regional institutions. The post graduate courses in geriatric medicine will be introduced in Regional Geriatric Centres for which additional teaching and supportive faculties are provided to these institutions.

iv) **Medical Rehabilitation and Therapeutic Intervention:** By arranging therapeutic modalities like therapeutic exercises, training in activities of daily life (ADL) and treatment of pain and inflammation through physiotherapy unit at CHC, district hospital and Regional Geriatric Centre levels for which necessary infrastructure, medicine and equipment are provided to these identified units.

v) **Information, Education and Communication (IEC):** Health education programmes using mass media, folk media and other communication channels are being promoted to reach out to the target community for promoting the concept of healthy ageing, importance of physical exercise, healthy habits, and reduction of stress. Camps for regular medical check-up are being organised at various levels where IEC activities are also specifically promoted.

8.7.2 Health Concerns of Persons with Disabilities in India

Disability poses greater challenges in obtaining the needed range of services. Persons with disabilities face several forms of discrimination and have reduced access to education, good health employment and other socio-economic opportunities. They are victims of physical, sexual, psychological and emotional abuse, neglect, and financial exploitation, while women with disabilities are exposed to several problems including sexual violence. Persons with disabilities face various challenges to the enjoyment of their right to health. For example, persons with physical disabilities often have difficulties accessing health care, especially in rural areas, slums and sub-urban settings; persons with psychosocial disabilities may not have access to affordable treatment through the public health system; women with disabilities may not receive gender-sensitive health services.

As per Census 2011, in India, out of the 121 Cr population, about 2.68 Cr persons are 'disabled' which is 2.21 per cent of the total population. Ministry of Statistics and Programme Implementation (MoSPI), Government of India, has prepared a very comprehensive report on persons with disability with the title "Disabled Persons in India: A Statistical Profile 2016" and the data presented here is taken

from this report. Among the disabled population 56 per cent (1.5 Cr) are males and 44 per cent (1.18 Cr) are females. In the total population, the male and female population are 51 per cent and 49 per cent respectively. In the case of total population, 69 per cent are from rural areas while the remaining 31 per cent resided in urban areas.The Census 2011 revealed that, in India, 20 per cent of the disabled persons are having disability in movement, 19 per cent are with disability in seeing, 19 per cent are with disability in hearing, 6 per cent have disability related to Mental Retardation, 18 per cent have any other disability, 7 per cent are with disability in speech, 3 per cent have mental illness and 8 per cent have multiple disabilities. Further, the Census 2011 also informs that the highest number of disabled persons is from the State of Uttar Pradesh. Nearly 50 per cent of the disabled persons belonged to one of the five States namely Uttar Pradesh (15.5%), Maharashtra (11.05%), Bihar (8.69%), Andhra Pradesh (8.45%), and West Bengal (7.52%).

In an era where 'inclusive development' is being emphasised as the right path towards sustainable development, focussed initiatives for the welfare of disabled persons are essential. The National Policy for Persons with Disabilities (2006) recognizes that Persons with Disabilities are valuable human resource for the country and seeks to create an environment that provides equal opportunities, protection of their rights and full participation in society. A number of International commitments and guidelines came into effect in the recent past targeting the welfare of the disabled persons. India is a signatory to the 'Declaration on the Full Participation and Equality of People with Disabilities in the Asia Pacific Region' (2000). India has ratified the 'UN Convention on the rights of Persons with Disabilities' (2008). India is also a signatory to the 'Biwako Millennium Framework '(2002) for action towards an inclusive, barrier free and rights based society.

There are several Acts and Legislations for taking care of the needs of the persons with disabilities: (i) The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995; (ii)The Rehabilitation Council of India Act, 1992; (iii) The National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999; (iv) Mental Health ACT 1987; and, (v) The Rights of Persons with Disability Act, 2016 (The Rights of PWD Act, 2016 replaced the PWD Act 1995).

In order to ensure rehabilitation, empowerment and overall development of PwDs, government adopted National Policy Statement in the year 2006. The National Policy recognizes that PwDsare valuable human resource for the country and seeks to create an environment that provides them equal opportunities, protection of their rights and full participation in society. The focus of the policy is on the following:

i) **Prevention of Disabilities:** Since disability, in a large number of cases, is preventable, there will be strong emphasis on prevention of disabilities.

ii) **Rehabilitation Measures:** Rehabilitation measures can be classified into three distinct groups:

   a) Physical rehabilitation, which includes early detection and intervention, counselling and medical interventions and provision of aids and appliances. It will also include the development of rehabilitation professionals.

b) Educational rehabilitation including vocational education; and

c) Economic rehabilitation for a dignified life in society.

iii) Women with disabilities require protection against exploitation and abuse. Special programmes has been developed for education, employment and providing of other rehabilitation services to women with disabilities keeping in view their special needs.

iv) **Children with disabilities:** Disabled children are the most vulnerable group and need special attention. The Government would strive to ensure right to care, protection and security for children with disabilities; ensure the right to development with dignity and equality creating an enabling environment where children can exercise their rights, enjoy equal opportunities and full participation in accordance with various statutes; and, ensure inclusion and effective access to education, health, vocational training along with specialized rehabilitation services to children with disabilities. Ensure the right to development as well as recognition of special needs and of care, and protection of children with severe disabilities.

v) **Social Security:** Disabled persons, their families and care givers incur substantial additional expenditure for facilitating activities of daily living, medical care, transportation, assistive devices, etc.

The Department of Empowerment of Persons with Disabilities (DEPwD) implements various schemes to provide benefit to the PwDs. Some of the specific ongoing schemes are: Deen Dayal Disabled Rehabilitation Scheme (DDRS); Assistance to Disabled Persons for Purchase / Fitting of Aids / Appliances (ADIP); District Disability Rehabilitation Centres (DDRCs); National Fellowship for Students with Disabilities (RGMF); Pre Metric scholarship and Post Metric Scholarship for students with Disability; National Overseas Scholarship for students with disabilities; and, Trust Fund for Empowerment of Persons with Disabilities.

Check Your Progress VI

1) Why do we need to talk about the health of the vulnerable groups in India?

.....

.....

.....

.....

.....

2) Explain the health problems of the elderly population in India.

.....

.....

.....

.....

3) What are the initiative taken by government to improve the living conditions of persons with disability in India?

.....

.....

.....

.....

.....

8.8 LET US SUM UP

This lesson has helped us to understand the basic health problems of women, children and some of the vulnerable groups like elderly people and persons living with disability in India. Health is a necessary and basic human right of all sections of human population. Different sections of society witness different types of health issues and hence it is necessary to understand their problems in a contextual way. The health issues of women and children have attracted the attention of global agencies in last few decades. It is very important to understand the specific health problems of different sections of society for initiating appropriate policy intervention. Improvement in the maternal and reproductive health condition of women are necessary not only for ensuring good health to women but also to achieve healthy future generations. The government initiatives are helping the nation to strengthen the health conditions of all segments of the society. The health related and other needs of the elderly population are often ignored. They have to suffer a lot because of such conditions. A proper policy guideline helps us to understand that very often preventive and promotive healthcare is more productive than clinical care especially in the context of elderly population. Disability of any kind creates great hurdles in human life and it is the collective responsibility of the society to take care of the problems of the persons with disabilities. The governmental and civil society cooperation is very necessary to make this world a better place for the living experiences of all vulnerable groups. This lesson has provided you very update information on health and healthcare issues of different categories of people and it will also help you to become a more sensitive person in your practical life.

8.9 KEY WORDS

Maternal health: Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. It intends to improve the health and living experience of the women undergoing pregnancy and minimise the suffering and risks caused during the process.

Reproductive health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. It is also related to safe sex life, capability to reproduce and the freedom to decide if, when and how often to do so.

Maternal Mortality Ratio: It is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental

or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births.

Antenatal care (ANC): It refers to pregnancy-related health care, which is usually provided by a doctor, anauxiliary nurse midwives (ANM) or another health professional. Ideally, ANC should monitor a pregnancy for signs of complications, detect and treat pre-existing and concurrent problems of pregnancy, and provide advice and counselling on preventive care, diet during pregnancy and delivery care.

Vulnerable groups: It generally refers to those sections of population who have limited access to the overall development benefits because of their demographic, physiological, socio-economic, spatial, geographical and other contextually defined limitations.

Elderly population: People aged 60 years or above in India.

8.10 REFERENCES AND SUGGESTED READINGS

Akram, M. (2014a). *Sociology of Health*, Jaipur: Rawat Publications

Akram, M. (2014b): "Maternal Health in India: An Overview," in *Maternal Health in India: Contemporary Issues and Challenges*, Mohammad Akram (ed), Jaipur/ Delhi: Rawat Publication, pp 19–44.

Cockerham, W.C. (2007). *Social Causes of Health and Disease*, Cambridge, UK: Polity Press.

Indian Academy of Pediatrics Committee on Immunization (IAPCOI). Consensus recommendations on immunization and IAP immunization timetable 2012. (2012) *Indian Pediatr.* ;49: 549–64.

McKenzie, J.F., Pinger, R.R. and Kotecki, J.E. (2005). *An Introduction to Community Health*, London: Jones and Bartlett Publishers.

Muzaffar, N. Akram, M. (2019), "Alarming Rise of Caesarean Section Deliveries: A Case Study of Kulgam". *Economic and Political Weekly,* Vol. LIV No. 24, pp. 55-59

Nagla, M. (2018). *Sociology of Health and Medicine,* Jaipur: Rawat Publications

National Family Health Survey India, 1992–93 (NFHS-1),"

National Family Health Survey, 2015– 16 (NFHS-4): (2017). International Institute for Population Sciences, Mumbai.

WHO. (2009). Women and Health: Today's Evidence Tomorrow's Agenda.

WHO report on "NURTURING CARE FOR EARLY CHILDHOOD DEVELOPMENT" https://www.who.int/health-topics/child-health#tab=tab_1 file:///C:/Users/falcon5/Downloads/9789241514064-eng.pdf

WHO Report on "Early child development - Child health and development"https://www.who.int/health-topics/child-health#tab=tab_1

Guidelines for vaccinations of a normal child in Indiahttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC4928529/#ref1

Government of India Reports and Website

- Annual Report 2018-19, Ministry of Health and Family Welfare (MoHFW), Government of India
- Elderly in India 2016, Central Statistics Office, Ministry of Statistics and Programme Implementation (MoSPI), Government of India

  http://mospi.nic.in/sites/default/files/publication_reports/ElderlyinIndia_2016.pdf
- Situation Analysis of The Elderly in India (June 2011), Central Statistics Office, Ministry of Statistics & Programme Implementation, Government of India

  http://mospi.nic.in/sites/default/files/publication_reports/elderly_in_india.pdf
- NATIONAL PROGRAMME FOR HEALTH CARE OF THE ELDERY (NPHCE)

  https://main.mohfw.gov.in/major-programmes/other-national-health-programmes/national-programme-health-care-elderlynphce
- Disabled Persons in India: A Statistical Profile 2016, Ministry of Statistics and Programme Implementation, Government of India

  http://mospi.nic.in/sites/default/files/publication_reports/Disabled_persons_in_India_2016.pdf

ignou
THE PEOPLE'S
UNIVERSITY