Development of Health Services in India (Special Reference to Women)

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Abstract -

Discrimination of women is well Known all over the world ,in communities, society and nation across time and space. They are constituted distinctly unequal categories as compared to men. Women are usually more deprived status in terms of access to resources and enjoyment of rights and freedom that together enhance the quality of human life. There is continuous inequality and vulnerability in all sectors ie. economical, social, political, education, healthcare, nutrition and legal. Women are oppressed in all spheres of life and they need to be empowered in all social contexts.

Key Words: Health care, Nutrition,

Introduction -

History of Health Care in India

Aryans brought with them, their own Gods, agrarian practices, and Vedas. These Vedas were believed to be the guiding principles of life and hence were riddled with shlokas containing hymns and prayers for not just a healthy body but a healthy mind. Indians even had a God of healing known as Dhanvantari.Ayurveda was the science of long life, Charaka, from King Kanishka's court is known for writing down one of the earliest books on medicines sciences, the first detailed healthcare work in India which also described complicated surgical procedures. Charaka's efforts in establishing a healthcare system led to the development of two schools of healthcare i) Surgeons, and ii) Physicians.

In the more recent ancient history notes, it is believed that King Ashoka had

developed the most comprehensive healthcare system under his reign. It is believed that King Ashoka established many hospitals in his empire, these became centers for healthcare and wellness.

It is quite interesting to note that the first modern hospital in India was established by the Portuguese in 1510. It was known as the "Royal Hospital" however, the real revolution in healthcare practices was brought by the French and British colonists

Health Care in Democratic India -

The health policies, plans, and programmes in India mostly evolved during the national movement against colonial rule. The British authorities set up a Health Survey and Development Committee, commonly known as the Bhore Committee (1946) that was also greatly inspired by the aspirations of the national movement. Along with its freedom, India inherited a crippling economy, booming population and a deep healthcare crisis. It should be noted that right before India's independence, a 20 member committee was formed headed by Sir Joseph Bhore. The Bhore committee conducted the first ever and probably the most extensive probe into the healthcare system of India then. The Bhore committee discovered that the availability of hospitals in India was 0.24 per 1000 population, the committee made several suggestions for improving the healthcare system in India, however, within a year of the submission of the said report, British empire, exited India forever.

It also recommended a comprehensive proposal for development of a national programme of health service for the country. Subsequently in 1948, the Sokhey Committee recommended that manpower and services be developed from the bottom upwards. The Committee represented 'a people centred and pluralistic' model of development. However, in the post Independence era, i.e., in the 1950s and 60s, advanced research institutes, medical colleges with tertiary hospitals and primary health centres emerged, while the sub-centres at village level lagged behind. India experienced a crisis in the late 60s, when it went through widespread drought that raised concerns about the 'development model', adopted so far. The international community put the onus of this crisis on the rising population growth, which was seen to be a hindrance to India's growth and development.

Two five years plans, following independence, allocated INR 770 crore to develop healthcare but to no avail. By the third five year plan, the then government decided to conduct another study on understanding the healthcare problem in India. This group, formed in 1966, also studied the Mudaliar and Bhore reports, along with the Healthcare Act of 1935, through its understanding of the acts and reports and their shortcomings, this new group led to the development of the new model of healthcare in India which was a structured strategy involving ground workers, PHCs, Tertiary Care Centres and Urban Hospitals.

Development of Women Healthcare in India -

The empowerment and autonomy of women, and improvements in their political, social, economic and health status, are recognized by the International Conference on Population and Development (ICPD) as highly important ends in themselves. In addition, they are seen as essential for the achievement of sustainable development. Recognizing that discrimination on the basis of gender starts at the earliest stages in life, the document asserts that greater equality for girls with regard to health, nutrition and education is the first step in ensuring that women realize their full potential and become equal partners in development. Many Governments, and Non-Government agencies and Institutions are working on health and nutritional aspect as well as on family welfare since long period. The Bohre Committee Report (1946) laid down the foundation for health in India, gave high priority to provision of maternal and child health services and improving their nutritional and health status. Under the Constitution of India elimination of ill health is one of the important goals.

In 1951 India initiated the first five-year development. The plan planners after analyzing the Census of 1951 realized the threat of population explosion and need to manage and take essential action to overcome for better health of women

After independence antenatal, intrapartum, postnatal and contraceptive care were not readily available. In this period good quality integrated maternal and child health care and family planning services were available to those who were aware and could afford the services of physicians. India is the first country in the world to formulate a National Family planning Programme in 1952, with the objective of "reducing birth rate

to the extent necessary to stabilize the population at a level consistent with requirement of national economy". Right from the independence; women, children and provision of contraceptives, services have been the focus of health services. In sixties government made availability of effective contraceptives. Rapid growth of population in the fifties as found in the 1961 Census, government forms a Department of Family Planning with a sufficient budget..**(Eleventh five year plan).**

In the seventies first time in history, health and nutritional status of women and children were recognized and the priority of all health based programme were focused on women and children. Medical termination of pregnancy act 1971 was enacted with the objective to reduce maternal morbidity and mortality due to unsafe abortions. Food supplementation to pregnant and lactating women and children below five years, were major initiatives. In 1979 Hon'able health minister ShriRajnarayanji renamed the programme as Family Welfare Programme. Family planning programme was dealing with only birth control, Tubectomy and Vasectomy, while Family welfare programme (FWP), included mother and child health welfare and nutrition .The basic objective of Family welfare programme (FWP) is population control as well as good health of the population. In 1983 India formulated the National Health Policy.**(India, 2006).**

During ninth decade., health problems of women and child were well recognized and government attempted to integrate Mother and Child Health (MCH) and family planning as part of the Family Welfare service at all levels. The National Development Committee approved modified GadgilMukharjees formula, which for the first time gave equal weightage to performance of Mother and Child Health (MCH) sector (Infant Mortality Rate reduction) and Family Planning (FP) sector (Crude Birth Rate reduction). International conference on Population and Development (IPCD) was held in Cairo in1994, recommended reproductive health care should be available in the primary health care system. In ninth plan attempts were made to improve the quality and coverage of health care to women, children and adolescents. **(Eleventh five year plan).**

In the new millennium the most threatening crisis is imbalance of sex ratio. In order to foeticides, the Prenatal Diagnostic Techniques Act (1994) was enacted and brought into operation from January 1996. The Act prohibits determination and disclosure

of sex of the fetus. Analysing the 2001 census report the act previously made has been amended (wef.14 February 2003) to ban selection of sex before or after conception and to remove difficulties in the implementation of the Act. **(India, 2006).**

Major Health Policies &Programmes in India -

A brief review of the government policies and programmes over the last 50 years is a reflection of how the healthcare system responds to health and particularly women's health. India has never had an explicit policy for women's health, but a range of policy decisions and measures has directly influenced women's health. This section mentions some of the policies and programmes under the National health Programmes that, to our mind, have been crucial in determining the health situation of women in India. The Ministry of Health and Family Welfare (MOFHW) comprises of the Department of Health, Department of Family Welfare and the Department of Indian System of Medicine and Homeopathy. In addition to general health services provided by MOHFW, specific health and nutritional needs of women are provided through the Integrated Child Development Services (ICDS) Programme under the Ministry of Human Resources Development and newly formed Ministry of Women and Child Development, that was only a department under the MOHFW till 2005. The implementation of the national health programmes carried out through the state government has decentralised public health machinery. The centre will play a coordinating role and provide technical and financial support, wherever it is felt necessary. Below, we discuss some of the policies and programmes briefly to critically examine their effects on the health status of women.

National Health Policy (NHP) -

India committed itself to universal health care in the Bhore Committee report developed way back in 1946. Subsequent to the Alma Ata commitment, the GOI passed the National Health Policy (NHP) in 1983. The NHP talked about comprehensive primary health care services linked to extension and health education; Since then, there have been marked changes in the larger climate and determinant factors relating to the health sector. The NHP 2002 is a continuation of the earlier indicated trends. The new policy deliberates on the need to improve access to health services among all social groups

and in all areas, and proposes to do so by establishing new facilities in deficient areas and improving those existing.

National Population Policy (NPP) 2000 -

In 1951, the draft outlined for the First Five-year Plan, recognised 'Population Policy' as 'essential to planning' and 'family planning' as a step towards access to basic services. The National Population Policy (NPP), adopted in 2000, lays out several objectives and goals to realize the long-term objective of 'stabilizing population by 2045 at a sustainable level.

- The immediate objective is to meet the unmet need for contraception and health infrastructure; The medium term objective is to bring the Total Fertility Rate (TFR) to replacement levels by 2010 through intersectoral action; The long-term objective is to achieve a stable population, consistent with sustainable development by2045.

The policy also states Socio-Demographic Goals to be achieved by 2010, some of which are:

- reducing IMR, MMR; achieving universal immunization, access to information/ counselling; registration of births and deaths, marriages and pregnancy

National Nutrition Policy (NNP), 1993 -

The National Nutrition Policy (1993) advocates a comprehensive inter-sectoral strategy for alleviating all the multi-faceted problems related to nutritional deficiencies, so as to achieve an optimal state of nutrition for all sections of society, but with emphasis on women and children. The strategies adopted include - screening of all pregnant women and lactating mothers for Chronic Energy Deficiency (CED); identifying women with weight below 40 kg and providing adequate ante-natal, intra-partum and neo-natal care under the RCH programme, and ensuring they receive food supplementation through the Integrated Child Development Services (ICDS) Scheme. The ICDS, launched in 1975, provides supplementary feeding to bridge the nutritional gaps that exist in respect of children below 6 years and expectant and nursing mothers. However, the ICDS programme has not been able to reach the nutritional need of children below three years

Reproductive and Child Health (RCH) -

The Mother and Child Health (MCH), nutrition and immunization programmes were brought under the umbrella of the Family Welfare Programme and was finally transformed into the Reproductive Child Health (RCH) programme30. The national RCH programme was launched in 1997 to provide integrated health and family welfare services for women and children. The programme aimed at improving the quality, distribution and accessibility of services and to meet the health care needs of women in the reproductive ages and children more effectively. The components included:

- Prevention and management of unwanted pregnancy; Services to promote safe motherhood and child survival;
- Nutritional services for vulnerable groups;
- Prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs);
- Reproductive health services for adolescents; o Health, sexuality and gender information, education and counselling;

National Rural Health Mission (NRHM) -

The National Rural Health Mission (NRHM 2005) - launched in 18 states that were identified as having poor health indicators - emphasizes on comprehensive primary health care for the rural poor. The main goal of the mission is to provide for effective health care facilities and universal access to rural population. The principle thrust areas as identified in the document are:

- Strengthening the three levels of rural health care- sub-center, PHC and the CHC. It also states that all 'assured services' including routine and emergency care in Surgery, Medicine, Obstetrics and Gynecology and Pediatrics in addition to all the National Health programmers; and all support services to fulfill these should be available and strengthened at the CHC level
- New health financing mechanisms for additional resource allocation and upgradation of facilities.Appointing ASHA (Accredited Social Health Activist) at the village level as the link worker for the rest of the rural public health system

Conclusion and Recommendations -

Healthcare in India has improved substantially since the British period, in fact, India had successfully achieved a polio-free status in its course of development. In fact, despite being in the developmental stage, healthcare facilities in India attract several foreigners who seek holistic healing at cheaper rates. In fact, Kerala has become the capital of ayurvedic treatment which is both exotic as well wholesome in its process. India is emerging as a hub for quality health tourism with individuals from developing and developed nations seeking healthcare here.

As far as women health is concerned with above mentioned studies and discussion, we can conclude that the health of women is being understood in terms of maternal mortality and reproductive health. Maternal deaths indicate one aspect of women's health. It projects the health concern about mother not women. While women's health should be given holistically concern and it is important to consider the morbidities, which are, not only related to reproduction but are social, mental and spiritual. As life expectancy for women is continuing to rise and they are living longer, it is therefore important that women have access to knowledge related to their own health and are able to have control over all aspects of her body along with her reproductive system.

With the emerging need of women, there is a need to have a specific women's health policy based on health of women from birth to elderly geriatric phase of life. Quailitative research required to understand the determinants of health that affect women and develop evidence based social policies for better health of women in India.

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