UNIT I - INTRODUCTION

INTRODUCTION

Administration is the activities of group cooperating to accomplish common goals it is the organisation and use of men and materials to accomplish a purpose. It is the specialised vocation of managers who have skills of organising and directing men and materials.

Meaning of Administration

The word "administer" is derived from the Latin word "ad+ ministraire", means 'to care for' or 'to look after people-to manage affairs'.

Administer means "serve"- the meaning is sluggish enough, as it insists on the administrator to regard himself as servant, not that the master to look after, perform all functions.

Definition of Administration

"Administration is the direction, coordination and control of many people to achieve some purposes or objectives**."** **- Pfiffner and Prethus.**

"Administration has to do with getting things done; with the accomplishment of defined objectives".

- **Luther Gullick.**

"Administration is the activities of the groups cooperating to accomplish common goals"

- **Herbert A Simon**

Management and Administration

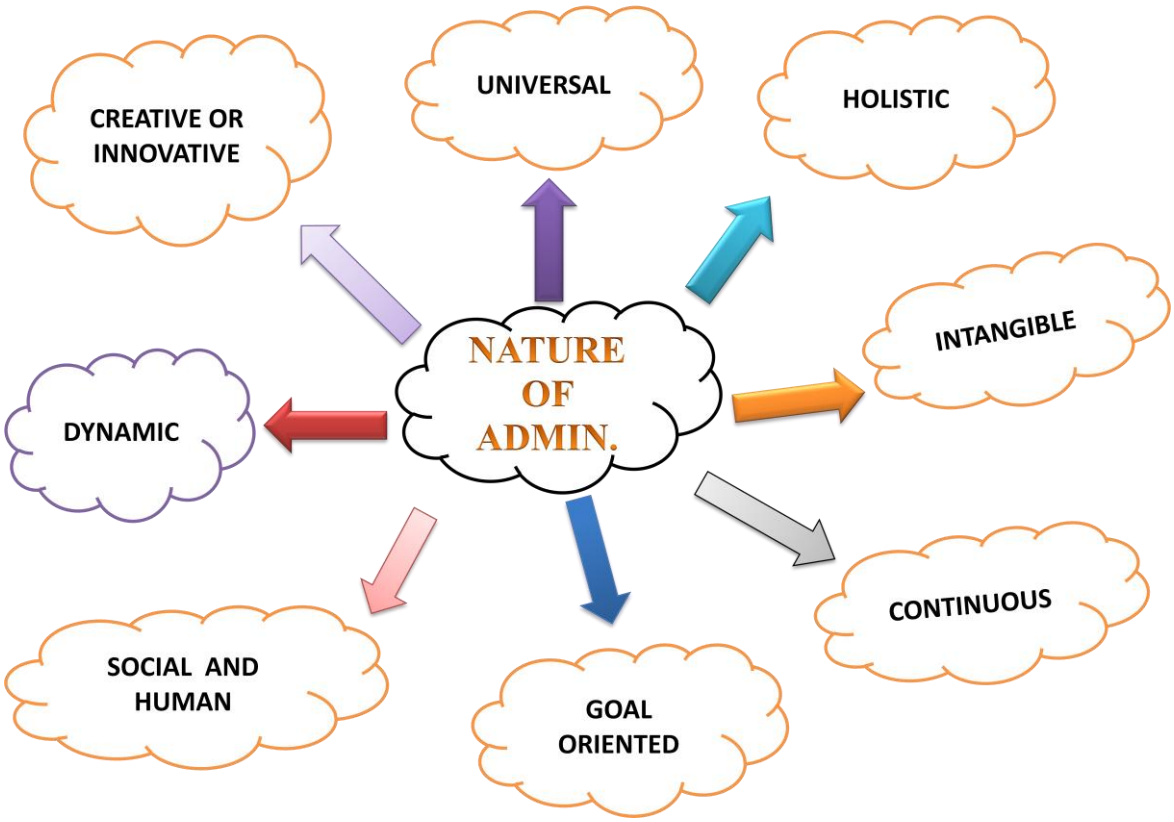
"These two words are slightly similar and can employ interchangable. Although, this 2 words are different in terms of practice. 'Management' refers to private sector. Whereas administration refers to public sector" (Sukotai Dhammatirat). To support this idea, Derek French and Heather Saward also define these 2 wards as "Management or Administration is the process for exceeding the goal expected." However, Michel A Hitt defines these 2 words in different meaning. He perceives meaning of management in wider range comparing to Administration. "Management is the integration of resources for exceeding the company goal by employing 4 principles:

1. Objectives
2. Effectiveness
3. Resources
4. Integration and Coordination

And Administration refers to executive level of management. On the other hand, the Management refer to middle management level. (Oliver Sheldon). In addition, "Management" provided clear process for exceeding goal, which are the 4 Functions of

Management: Planing, Organizing, Leading and Controlling (Bovee et al. 1993). While, it did not define clearly in "Administration's literatures."

Nature of Administration



Administrative process is intellectual, social dynamic and creative as well as continuous. The features or nature of administration is as follows:

1. It is universal: because irrespective of nature and objectives of organization, all basic elements of administration such as planning, organizing, staffing, directing, coordinating, reporting, budgeting can apply its effective achievement of goals.
2. It is holistic: the whole process of administration embrace the organization and its function in entirely, ie, involve total activities of the organization.
3. It is intangible: since administration is visualized as abstract. It cannot be transferable to anywhere. So every organization has to develop its own administrative style within the content of functional elements of administration.
4. It is continuous and ongoing process: the cycle f administration goes on continuously.
5. It is goal oriented: administration is always struggling to achieve the laid down goals and objectives of the organization.
6. It is social and human: usually administration, there will be group of people are there to achieve the objective; it needs goal social and interpersonal contact or relationship to achieve the goal.

7. It is dynamic: Administration has the elements of flexibility and adaptability and adjustability rising to the needs and demands of different situations
8. It is creative or innovative: to have an effective administration existed administration provides innovation, offers and invites creative ideas it its organizational teams.

Philosophy of Administration

What a Philosophy need to do?

- Sharp focus- integrated elements, system of proper and unified relationship
- Principles are developed- valid guidelines for future.
- Both ends and means
- Provide reliable tool to the executives.
- Communicate spirit and rounded feelings and satisfaction

Administration is a moral act and also a moral agent. A philosophy of administration should be conceived in such a way that if not described relatively and provides reliable tool to the executive, it constitutes a grand total which exceeds the sum of its parts.

- Administration believes in **cost-effectiveness**: in the management or administration of any enterprises for organization, the quantity, the quality, timing and cost of the work necessary to reach the objectives of the enterprises are interrelated factors which must be given constant attention. If the resources of health work, in trained persons and in finances were unlimited, the need for constant attention to these factors would not be so great. But the limitation in the number of trained personnel and the lack of adequate financial resources are major obstacles to greatly improved health in the world today.
- Administration believes in **execution and control of work plans**: One of the greatest possible contributors to wastage of our precious resources, whether at the local or national level, is the failure of those at any level of administration, and at all stages in the management of the activity, to base all decision on verifiable facts.
- Administration believes in **delegation of responsibility and authority**: The delegation of responsibility and authority is an important aspect of successful administration, to place the responsibility for decision at the lowest possible organizational level in order to attain decision as speedily as possible. No administration can do in detail all the work he is administering for; by definition of an administration managers the work of others. The responsibility and authority placed in each position must correspond to the responsibility which the position carries.
- Administration believes in **human relations and good morale:** The function of administration is to attain an established objective through the management of people, administration if deeply concerned with human relations. Good morale of the staff is essential to the success of any understanding and the morale is affected by both financial and non financial factors.

- Administration believes **in effective communication**: Effective communications are essential for all aspects of effective administration. Staff must be adequately and correctly informed about plan, methods, schedules, problems events and progress. It is necessary instructions, knowledge and informations should clearly present as to rule out any misinterpretations or misunderstanding. Proper and adequate communication is not just in one direction, it requires two way passages. Communication must follow from the bottom upwards as well as top to bottom.

Purpose of administration

- Accomplishing the goals of the organizations.
- Maintaining the quality of service/ care within the financial limitations of the organization.
- Encouraging the motivation of the employees and the clients in the area.
- Increasing the ability of subordinates and peers to accept change
- Developing a team spirit and increased morale.
- Furthering the professional development of the personnel**.**

Elements/ functions/ components of Administration

Administration may be defined as all the actions rationally performed by one person or a number of people in concert to fulfil a common purpose set by someone else of their accomplishment.

Professor **Luther Gullick** (1937) summed up certain principles or elements in the word **"POSDCORB".** It is a word made up word designed to call attention to the various functional elements of the work of a chief executive because "Administration" and "Management" have lost all specific content.

"P". Stands for **Planning**: that is working out a broad outline, the things that need to be done and the methods for doing them to accomplish to purpose set for the enterprises or of the purpose in hand.

"O". Stands for **Organizing**: That is the establishment of the formal structure of authority through which work of sub divisions are arranged, defined and coordinated for the defined objectives.

"S". Stands for **Staffing**: That is the whole personnel function of bringing in and training the staffing and maintaining favourable conditions of work.

"D". Stands for **Directing:** That is the continuous tasks of making decision and embodying them, in specific and general orders and instructions and serving as leader of the enterprise.

"CO". Stands for **Co-ordinating**. That is all important duty of inter relating the various parts of the work and eliminating of overlapping and conflict.

"R" Stands for **Reporting:** That is keeping those to whom the executive is responsible informed as to what is going on, which thus includes keeping himself and his subordinates informed through records, research and inspection.

"B". Stands for **Budgeting:** With all that goes with budgeting in the form of fiscal planning, accounting and control.

Scope of Administration

The scope of administration must then recognise administration. The main form of applied administration based on its major functions is as follows:

1. Political Function: of the administration includes the executive- legislative relationship, political-administrative activities of the cabinet o ministry, the minister permanent official relationship on short, the study of the twilight zone between politics and administration proper.
2. Legislative function includes not merely delegated legislation, bur the preparatory work done by the administrative officials and departments in connection with the drawing up of the bill to be introduced in the legislature and its passage through that body.
3. Financial function includes the whole of financial administration from the preparation of the budget to its execution, accounting, audit, treasury, management.
4. Defensive function covers the military administration.
5. Educational function relates to educational administration in its broadest sense.
6. Social administration includes the activities of the departments concerned with food, housing, health, social security, employment.
7. Economic administration concerned with the vast field of administration activities relating to protection and encouragement industries and agriculture, securing a prosperous and stable economy, encouragement and promotion of foreign trade and commerce, running of public utilities and enterprises by government, regulation of industries in the interest of consumer and so on.
8. Foreign administration includes the conduct of foreign affairs diplomacy, international cooperation, administration of the international agencies of various kinds etc.
9. Imperial administration covers the problems and techniques arising from the rules of one person or nation over another.
10. Local administration is concerned with the activities of the bodies.

Principles of Administration

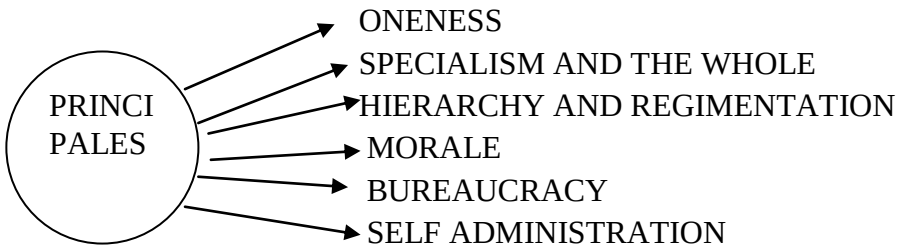
Henri Fayol Principles of Administration

1) **Division of labour:** In any administration or manager cannot perform all the activities to achieve its objectives. So there should be division of work according to job which grouped according job which grouped according to departments.
2) **Authority, responsibility, and accountability**: If the person has to perform job assignment effectively according to their own qualification and experience, there should be delegation of authority and responsibility needed, which in turn helps to get accountability.
3) **Discipline:** For smooth running of administration to achieve the objectives there should be proper observation of the rules, regulations, norms, decorum, manners,

code of ethics and respect; this requires to be enforced within with in the organization by the manager.

4) **Unity of command:** In any organization the subordinates should be supervised by a single supervisor to whom he/she should be accountable.
5) **Unity of direction**: In any organization, there should be one supervisor to give direction to his/her subordinates.
6) **Subordination of individual interest interest to organizational interest.** This implies that narrow selfish interest should be overcome or should turn to common and board interest of the organization welfare. eg. collective bargaining
7) **Remuneration of personnel:** There should be to fair policy for payment to the personnel justifying the work load, job hazards, efficiency and quality of performance.
8) **Centralization:** There should be some amount of greater and larger authority resting with top level managers.
9) **Scalar chain of command**: which implies that there is chain or link of directional instruction from the top level to the lowest rank of organizational members in the hierarchy
10) **Order:** In an administration there should be proper, systematic arrangement of staff, materials, supplies and equipments according to the requirement of specific job departments.
11) **Equity:** In administration, there should be a fair and impartial treatment to all workers irrespective of their job.
12) **Stability of texture of personnel**: organizations should make proper efforts stability and continuity in the texture of personnel, which gives security and promotes productions.
13) **Initiative:** Administration should always be encouraging initiative from each employee by allowing him freedom to do his/her best.
14) **Esprit de corps:** It refers to sense of belonging. This fosters the team spirit. ie. the spirit of working together to achieve objective effectively.

According to Finer:



Five Elements: management roles and actions

- **Prevoyance**. (Forecast & Plan)- Examining the future and drawing up a plan of action. The elements of strategy.
- **To organize -** Build up the structure, both material and human, of the undertaking.
- **To command -** Maintain the activity among the personnel.
- **To coordinate -** Binding together, unifying and harmonizing all activity and effort.
- **To control -**Seeing that everything occurs in conformity with established rule and expressed command.

2. HEALTH ADMINISTRATION

Publication health administration is an area of activity which calls for specialized knowledge and the techniques which can help the people to achieve the healthy people. Health administration is an art as it can help to direct and guide the efforts of those involved in such an organization towards some specific ends or objectives efficiently.

Principles of Health Administration

a) There should be sound National Health Policy
b) Sound Health Administrative structure may be designed for the implementation of the health policy
c) Sound and systematic planning of health programme is necessary for the benefit of the whole community
d) There should be integration of preventive and curative services at all administrative levels.
e) There should not be considered in isolation from other socioeconomic factors.
f) There should be centralised directions and decentralized actions.
g) Health opportunities need not to be related to purchasing power of the people.
h) Planned health programmes should be based on priority and must meet health need of people.
i) Ensure basic health services available, accessible and acceptable to the people as close to their home as possible.
j) Health consciousness should be fostered through health education and by providing opportunities for participation of people in the health programmes.
k) Doctors should be trained to act as social physicians as well as to promote healthy and happier life.
l) Nursing personnel and other allied health personnel should be given community oriented education in their curriculum.
m) New categories of health personnel should be given suitable training to provide proper services to people at their level.

n) Medical education can be reoriented and medical services reorganised with the involvement and cooperation of political and social scientists
o) All the systems of medicine must be encouraged to provide decent health to people in the coordinated fashion.
p) Utilize community resources and encourage local participation to self help programs at the village level.
q) There should be provision for staff development programs.

Objectives of Health Administration

1. Increasing the average length of the human life.
2. Decreasing the rates of mortality and morbidity. Eg. IMR, MMR, etc.
3. Increasing the physical, mental, social well-being of the individual.
4. Increasing the pace of adjustment of individual to his environment.
5. Providing total health care to enrich quality of life.
6. Make provision of primary health care services to every one irrespective of the areas.
7. Development of health man power is required to provide proper services to the community.
8. Implementation of effective measures for the surveillance, promotion and control of major diseases.
9. Promotion of nutritional standard and formulation of nutrition policies
10. formulation of health policies and their periodic revisions to time

3. INDIAN CONSTITUTION

INTRODUCTION

The majority of the Indian subcontinent was under British colonial rule from 1858 to 1947. This period saw the gradual rise of the Indian nationalist movement to gain independence from the foreign rule. The movement culminated in the formation of the on 15 August 1947, along with the Dominion of Pakistan. The constitution of India was adopted on 26 January 1950, which proclaimed India to be a sovereigndemocraticrepublic**.** Constitution of India is the supreme law of India. It lays down the framework defining fundamental political principles, establishing the structure, procedures, powers and duties, of the government and spells out the fundamental rights, directive principles and duties of citizens. Passed by the Constituent Assembly on 26 November 1949, it came into effect on 26 January 1950.

Evolution of the Constitution

Acts of British Parliament before 1935

After the Indian Rebellion of 1857, the British Parliament took over the reign of India from the British East India Company, and British India came under the direct rule of the Crown. The British Parliament passed the Government of India Act of 1858 to this

effect, which set up the structure of British government in India. It established in England the office of the Secretary of State for India through whom the Parliament would exercise its rule, along with a Council of India to aid him. It also established the office of the Governor-General of India along with an Executive Council in India, which consisted of high officials of the British Government.

Government of India Act 1935

The provisions of the Government of India Act of 1935, though never implemented fully, had a great impact on the constitution of India. Many key features of the constitution are directly taken from this Act. The federal structure of government, provincial autonomy, bicameral legislature consisting of a federal assembly and a Council of States, separation of legislative powers between center and provinces are some of the provisions of the Act which are present in the Indian constitution.

The Cabinet Mission Plan

In 1946, at the initiative of British Prime Minister Clement Attlee, a cabinet mission to India was formulated to discuss and finalize plans for the transfer of power from the British Raj to Indian leadership and providing India with independence under Dominion status in the Commonwealth of Nations.[6][7] The Mission discussed the framework of the constitution and laid down in some detail the procedure to be followed by the constitution drafting body. Elections for the 296 seats assigned to the British Indian provinces were completed by August 1946. The Constituent Assembly first met and began work on 9 December 1946.

Indian Independence Act 1947

The Indian Independence Act, which came into force on 18 July 1947, divided the British Indian territory into two new states of India and Pakistan, which were to be dominions under the Commonwealth of Nations until their constitutions were in effect. The Constituent Assembly was divided into two for the separate states. The Act relieved the British Parliament of any further rights or obligations towards India or Pakistan, and granted sovereignty over the lands to the respective Constituent Assemblies. When the Constitution of India came into force on 26 January 1950, it overturned the Indian Independence Act. India ceased to be a dominion of the British Crown and became a sovereign democratic republic. 26 November 1949 is also known as national law day.

Constituent Assembly

The Constitution was drafted by the Constituent Assembly, which was elected by the elected members of the provincial assemblies.[8]Jawaharlal Nehru, C. Rajagopalachari, Rajendra Prasad, SardarVallabhbhai Patel, MaulanaAbulKalam Azad, Shyama Prasad Mukherjee and NaliniRanjanGhosh were some important figures in the Assembly. There were more than 30 members of the scheduled classes. Frank Anthony represented the Anglo-Indian community, and the Parsis were represented by H. P. Modi and R. K. Sidhwa. The Chairman of the Minorities Committee was HarendraCoomarMookerjee, a

distinguished Christian who represented all Christians other than Anglo-Indians. Ari BahadurGururng represented the Gorkha Community. Prominent jurists like AlladiKrishnaswamyIyer, B. R. Ambedkar, BenegalNarsing Rau and K. M. Munshi, Ganesh Mavlankar were also members of the Assembly. Sarojini Naidu, Hansa Mehta, DurgabaiDeshmukh and RajkumariAmritKaur were important women members. The first president of the Constituent Assembly was SachidanandSinhalater,Rajendra Prasad was elected president of the Constituent Assembly.[8] The members of the Constituent Assembly met for the first time in the year 1946 on 9 December.[8]
In the 14 August 1947 meeting of the Assembly, a proposal for forming various committees was presented. Such committees included a Committee on Fundamental Rights, the Union Powers Committee and Union Constitution Committee. On 29 August 1947, the Drafting Committee was appointed, with DrAmbedkar as the Chairman along with six other members. A Draft Constitution was prepared by the committee and submitted to the Assembly on 4 November 1947.

Parts
Parts are the individual chapters in the Constitution, focused in single broad field of laws, containing articles that addresses the issues in question.

- **Preamble**
- **Part I**[9] - Union and its Territory
- **Part II**[10] - Citizenship.
- **Part III** - Fundamental Rights
- **Part IV**[11] - Directive Principles and Fundamental Duties.
- **Part V**[12] - The Union.
- **Part VI**[13] - The States.
- **Part VII**[14] - States in the B part of the First schedule *(Repealed)*.
- **Part VIII**[15] - The Union Territories
- **Part IX**[16] - Panchayat system and Municipalities.
- **Part X** - The scheduled and Tribal Areas
- **Part XII** - Finance, Property, Contracts and Suits
- **Part XIII** - Trade and Commerce within the territory of India
- **Part XIV** - Services Under the Union, the States and Tribunals
- **Part XV** - Elections
- **Part XVI** - Special Provisions Relating to certain Classes.
- **Part XVII** - Languages
- **Part XVIII** - Emergency Provisions
- **Part XIX** - Miscellaneous
- **Part XX** - Amendment of the Constitution
- **Part XXI** - Temporary, Transitional and Special Provisions

- **Part XI** - Relations between the Union and the States.
- **Part XXII** - Short title, date of commencement, Authoritative text in Hindi and Repeals

Federal Structure

The constitution provides for distribution of powers between the Union and the States.

It enumerates the powers of the Parliament and State Legislatures in three lists, namely Union list, State list and Concurrent list. Subjects like national defense, foreign policy, issuance of currency are reserved to the Union list. Public order, local governments, certain taxes are examples of subjects of the State List, on which the Parliament has no power to enact laws in those regards, barring exceptional conditions. Education, transportation, criminal law are a few subjects of the Concurrent list, where both the State Legislature as well as the Parliament have powers to enact laws.

Changing the constitution

Amendments to the constitution are made by Parliament. However they must be approved by a super-majority in each house, and certain amendments must also be ratified by the states. The procedure is laid out in Article 368. Despite these rules there have been over ninety amendments to the constitution since it was enacted in 1950. The Supreme Court has ruled, controversially, that not every constitutional amendment is permissible. An amendment must respect the "basic structure" of the constitution, which is immutable.....

In 2000 the National Commission to Review the Working of the Constitution (NCRWC)[19] was setup to look into updating the constitution of India.

Judicial review of laws

This section requires expansion.

Judicial review is actually adopted in the Indian constitution from the constitution of the United States of America. In the Indian constitution, Judicial Review is dealt under Article 13. Judicial Review actually refers that the Constitution is the supreme power of the nation and all laws are under its supremacy. Article 13 deals that

1. All pre-constitutional laws, after the coming into force of constitution, if in conflict with it in all or some of its provisions then the provisions of constitution will prevail. if it is compatible with the constitution as amended. This is called the Theory of Eclipse.
2. In a similar manner, laws made after adoption of the Constitution by the Constituent Assembly must be compatible with the constitution, otherwise the laws and amendments will be deemed to be void-ab-initio.

In such situations, the Supreme Court or High Court interprets the laws as if they are in conformity with the constitution.

4. HEALTH ADMINISTRATION AT THE CENTRE AND STATE LEVEL

Introduction

Constitutionally, every individual in India has the right of availing health services to protect his/her basic right of being healthy. To this effect, the Government of India has developed health administration machinery and mechanism to plan, organise, and deliver healthcare services to the people in rural and urban areas.

For the purpose of achieving health goals and dealing with health subjects, the Government of India has evolved healthcare organisation at the centre, state, district, and local level.

Meaning and definition

Health administration is a branch of public administration which deals with matters relating to the promotion of health, preventive services, medical care, rehabilitation, the delivery of health services, the development of health manpower, medical education, and training.

Public health administration is the science and art of organising and coordinating government agencies whose purpose is to improve the physical, mental, and social wellbeing of people. It aims at the prevention of disease, preservation, and promotion of health.

History of health administration in India

Health administration is a part of public administration of the country and is one of the aspects of social welfare activities of the government. Modern public health organisation and administration is designed to prevent disease, prolong life, and to promote physical and mental efficiency through organised community efforts.

During the independence period the medical and public health service at the centre were administered by two separate department heads – Director General of Indian Medical Services and Commission of Public Health Service respectively, but after independence these two offices were amalgamated into Directorate General of Health Services which was headed by the Director of Health Services.

Post-independence era

For public health in post-independence year in 1947 after independence a democratic regime was set up in India with new concept aimed towards the establishment of a welfare state. The Bhore Committee report and recommendations became the basis for most of the planning and measures adopted by the National Government.

1947: Ministries of health were established at the centre and states.

1948: India became the member of WHO.

1949: The post of Registrar General of India was created in the Ministry of Home Affairs.

1950: The Government of India set up a planning commission to make an assessment of material, capital, human resources of the country and to draft developmental plans for the most effective utilisation of these resources.

Five year plan: Planning commission has formulated successive five-year plans to rebuild rural India to lay foundation of industrial progress and to secure the balanced development of all parts of the country.

National health policy: The Ministry of Health and Family Welfare, Government of India, evolved a national health policy in 1983 keeping in view the national commitment to attain the goal of health for all by the year 2000. The main objective of this policy was to achieve an acceptable standard of good health amongst the general population of the country.

Objectives of health administration

1. To increase the average length of human life.
2. To decrease the mortality and morbidity rates.
3. To increase the physical, mental, and social wellbeing of the individual.
4. To provide total healthcare to enrich quality of life.
5. To increase the pace of adjustment of the individual to his environment.
6. To make provision of primary healthcare services to everyone.
7. To develop healthy manpower to provide proper services to the community.
8. To formulate health policies and their periodic revision from time to time.

Principles of health administration

1) Centralised director and decentralised activity.
2) When a special function is to be undertaken, it should be undertaken by or in cooperation with the official body.
3) There should not be duplication and overlapping in rendering combined ____.

4) Treatment and prevention of diseases should be administratively combined.

5) Administration must be based on a sound economic consideration and practicable financial budgeting.

6) A clear picture of the complete plan must be made before starting a programme.

7) A programme of continuing staff education is essential.

8) Programme should be planned on a scientific priority basis.

9) Periodic appraisal of services rendered, effectiveness of the programme, and evaluation of the results is the major responsibility of the health administration.

10) Provision must be made for desirable working conditions for all members of the staff.

11) There should be sound national health policy.

12) Sound healthy administrative structures may be designed for the implementation of various health policies.

13) There should be integration of preventive and curative services at all administrative levels.

14) Health should not be considered in isolation from other socioeconomic factors.

15) Health opportunities need not be related to the purchasing power of the people.

16) Health consciousness should be fostered through education and by providing opportunities for participation of people in the health programmes.

17) All the systems of medicine must be encouraged to provide decent health to people in a coordinated fashion.

18) Health services should be organised form the bottom up and not from the top down.

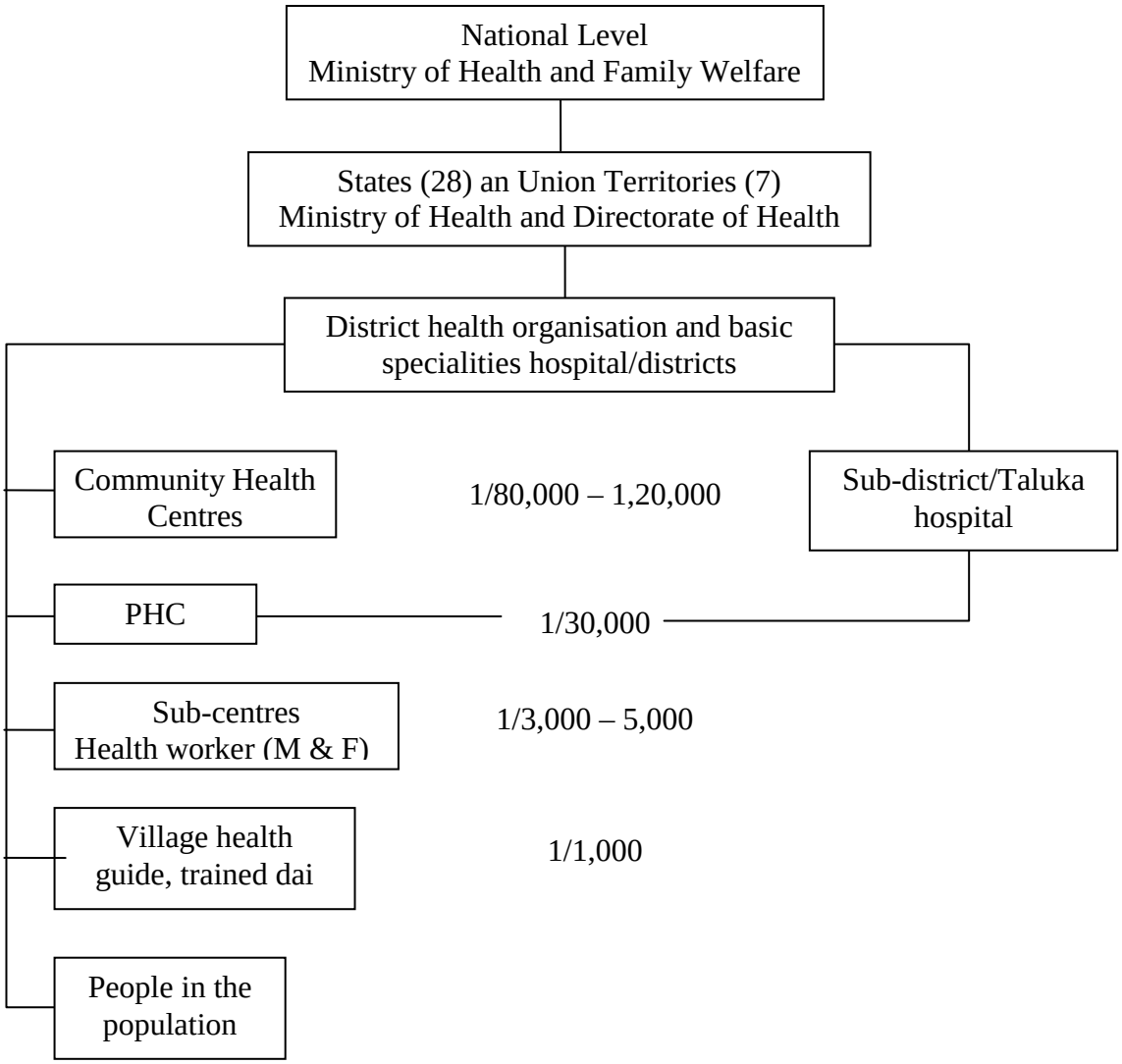
19) There should be a provision for staff development programmes.

Health system in India

India is a union of 28 states and 7 union territories. Under the constitution of India, the states are largely independent in matters relating to the delivery of health care to the people. Each state, therefore, has developed its own system of healthcare delivery independent of the central government. The central responsibility consists mainly of policy making, planning, guiding, assisting, evaluating, and coordinating the work of the state health ministries so that health services cover every part of the country and no state lags behind for want of these services.

The health system in India has 3 main links: central, state, and local or peripheral.

Synoptic view of the health system in India



Health administration at the central level

The official organs of the health system at the national level consist of 3 units:

1. Union Ministry of Health and Family Welfare.
2. The Directorate General of Health Services.
3. The Central Council of Health and Family Welfare.

I. Union Ministry of Health and Family Welfare

Organisation

The Union Ministry of Health and Family Welfare is headed by a Cabinet Minister, a Minister of State, and a Deputy Health Minister. These are political appointment and have dual role to serve political as well as administrative responsibilities for health.

Currently the union health ministry has the following departments:

1. Department of Health
2. Department of Family Welfare
3. Department of Indian System of Medicine and Homoeopathy

a. Department of Health

It is headed by a secretary to the Government of India as its executive head, assisted by joint secretaries, deputy secretaries, and a large administrative staff.

The Department of Health deals with planning, coordination, programming, evaluation of medical and public health maters, including drug control and prevention of food adulteration.

Functions

The functions of the Union Health Ministry are set out in the seventh schedule of the Article 246 of the Constitution of India under union list and concurrent list.

Union list

1. International health relations and administration of port-quarantine

   All the matters related to the international agencies, and coordination of their activities in the country are undertaken by the DGHS. All the major ports in the country such as Calcutta, Vishakapattanam, Chennai, Mumbai, Kandla and

international airports like Mumbai, Santa Cruz, Dum Dum, Meenambakkam, Trissur, and Palam are directly controlled by DGHS.

2. Administration of central health institutes such as All India Institute of Hygiene and Public Health, Kolkata; National Institute for Control of Communicable Diseases, Delhi, etc.

3. Promotion of research through research centres and other bodies.

4. Regulation and development of medical, nursing and other allied health professions.

5. Establishment and maintenance of drug standards.

6. Census, and collection and publication of other statistical data.

7. Immigration and emigration.

8. Regulation of labour in the working of mines and oil fields and

9. Coordination with states and 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. The centre and states have simultaneous powers of legislation. They are as follows:

a. Prevention of extension of communicable diseases from one unit to another.

b. Prevention of adulteration of food stuffs.

c. Control of drugs and poisons.

d. Vital statistics.

e. Labour welfare.

f. Ports other than major.

g. Economic and social health planning

h. Population control and family planning.

Department of Family Welfare

It was created in 1966 within the Ministry of Health and Family Welfare. The secretary to the Government of India in the Ministry of Health and Family Welfare is in overall charge of the Department of Family Welfare. He is assisted by an additional secretary and commissioner, and one joint secretary.

The following divisions are functioning in the department of family welfare.

(a) Programme appraisal and special scheme

(b) Technical operations: looks after all components of the technical programme viz. Sterilization/IUD/nirodh, post partum, maternal and child health,UPI, etc.

(c) Maternal and child health

(d) Evaluation and intelligence: helps in planning, monitoring and evaluating the programme performance and coordinates demographic research.

(e) Nirodh marketing supply/ distribution

(f) Transport

(g) Universal immunization programme

(h) Area project

(i) Mass education and media: responsible for providing educational publicity and extent support to education.

Functions

a.To organise family welfare programme through family welfare centres.

b. To create an atmosphere of social acceptance of the programme and to support all voluntary organizations interested in the programme.

c. To educate every individual to develop a conviction that a small family size is valuable and to popularise appropriate and acceptable method of family planning

d.To disseminate the knowledge on the practice of family planning as widely as possible and to provide service agencies nearest to the community.

e. To organise basic research of human fertility, genetics and population dynamics and to on the evolution of easy and reliable method of contraception.

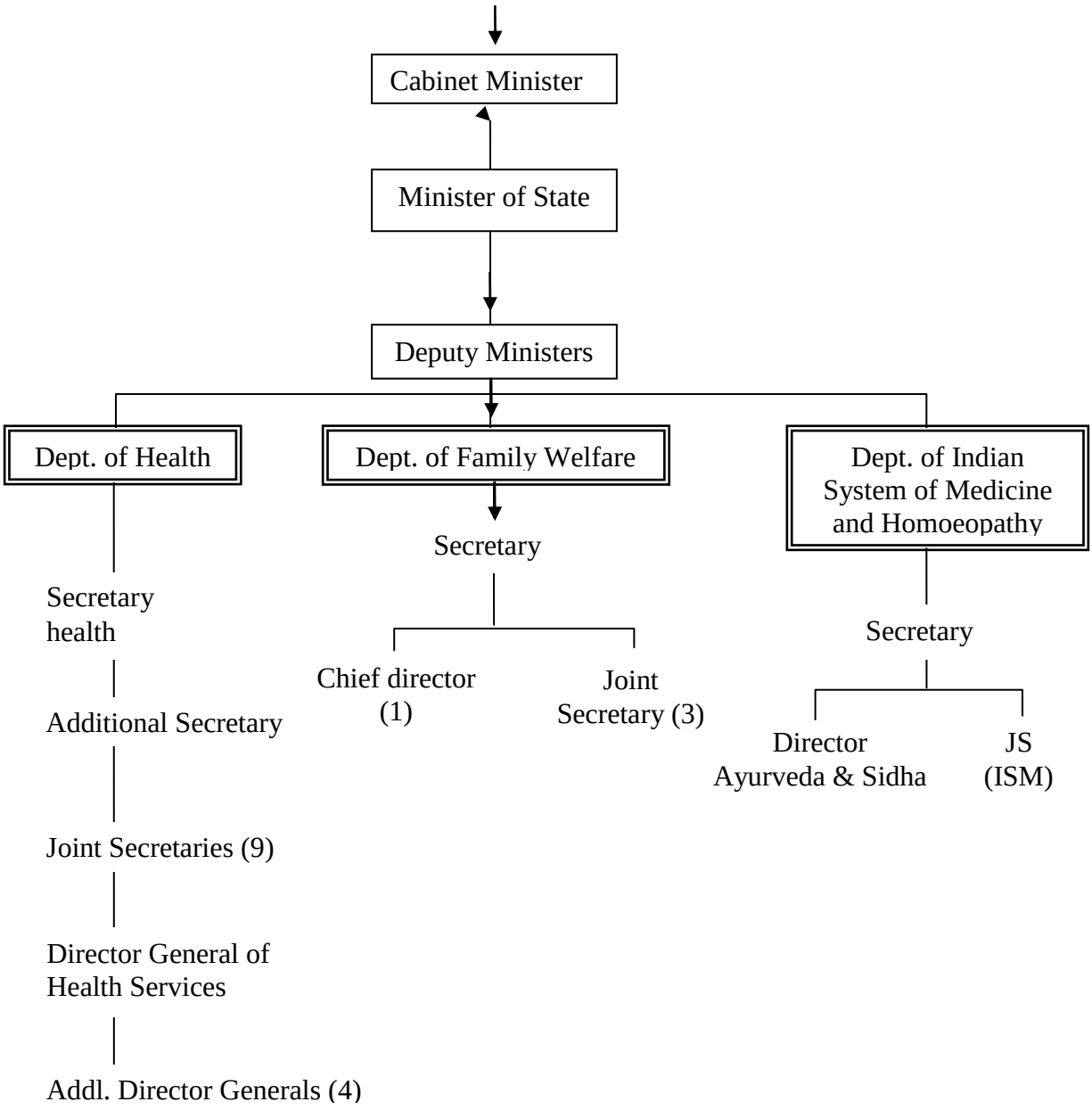
f. To study the social factors that affect fertility and to take such steps as will reduce the number of children in a family.

g.To coordinate the family planning programme with the child welfare and maternal health services throughout the country.

h.To organise production of contraceptive device in adequate quantities to maintain the supply at all levels at a minimum cost.

i. Indian system of medicine and homeopathy helps to promote/ISM in the country through training, research and use.

Ministry of Health and Family Welfare



3. The department of Indian system of medicine and homeopathy

It was established in march 1995 and had continued to make steady progress. Emphasis was on implementation of the various schemes introduced such as education, standardisation of drugs, enhancement of availability of raw materials, research and development, information, education and communication and involvement of ISM and Homeopathy in national health care.

Most of the functions of this ministry are implemented through an autonomous organisation called DGHS.

II. Directorate General of Health Services

Organisation

The DGHS is the principal adviser to the Union Government in both medical and public health matters. He is assisted by a team of deputies and a large administrative staff. The Directorate comprises of three main units:

i. Medical care and hospitals

ii. Public health

iii. General administration

Functions

1. **General functions:** The general functions are surveys, planning, coordination, programming and appraisal of all health matters in the country.

2. **Specific functions**

   a. **International health relations and quarantine:** All the major ports in the country and international airports are directly controlled by the Director General of Health Services. All matters relating to the obtaining of assistance from international agencies and the coordination of their activities in the country are undertaken by the Director General of Health Services.

   b. **Control of drug standards:** The drugs control organisation is part of the DGHS and is headed by the Drugs Controller. Its primary function is to lay down and enforce standards and control the manufacture and distribution of drugs through both Central and State Government offices. The Drugs Act (1940) vests the central Government with the powers to test quality of imported drugs.

c. **Postgraduate training:** The DGHS is responsible for the administration of national institutions, which also provide postgraduate training to different categories of health personnel.

- All India Institute of Hygiene and Public Health, Kolkata.
- All India Institute of Mental Health, Bangalore.
- National Institute of Communicable Diseases, Delhi, etc.

d. **Medical education:** The DGHS is directly in charge of the following medical colleges in India:

- Lady Hardinge
- Maulana Azad
- Medical colleges at Pondicherry and Goa.

Besides these, there are many medical colleges in the country which are guided and supported by the Centre.

e. **Medical research:** Medical research in the country is organised largely through the ICMR, founded in 1911 in New Delhi. The council plays a significant role in aiding, promoting and coordinating scientific research on human diseases, their causation, prevention and cure. The research work is done through the councils, and several permanent research institutes, e.g., Cancer Research Centre, TB Chemotherapy Centre at Chennai. The funds of the council are wholly derived from the budget of the Union Ministry of Health.

f. **National Health Programmes:** The various national health programmes for the eradication of malaria and for the control of tuberculosis, filarial, leprosy, AIDS and other communicable diseases involve expenditure of crores of rupees. The central directorate plays a very important part in planning, guiding and coordinating all the national health programmes in the country.

g. **Central Health Education Bureau:** An outstanding activity of this Bureau is the preparation of education material for creating health awareness among the people. The bureau offers training courses in health education in different categories of health workers.

h. **Health intelligence:** The Central Bureau of Health Intelligence was established in 1961 to centralise collection, compilation, analysis, evaluation, and dissemination of all information on health statistics for the

nation as a whole. It disseminates epidemic intelligence to states and international bodies.

i. **National Medical Library:** The Central Medical Library of DGHS was declared the National Medical Library in 1966. The aim is to help in the advancement of medical, health and related sciences by collection, dissemination and exchange of information.

III. Central Council of Health

The Central Council of Health was set up by a Presidential Order on August 9, 1952, under Article 263 of the Constitution of India for promoting coordinated and concerted action between the centre and the states in the implementation of all the programmes and measures pertaining to the health of the nation. The Union Health Minister is the chairman and the state health ministers are the members.

Functions

1. To consider and recommend broad outlines of policy in regard to matters concerning health in all its aspects such as the provision of remedial and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research.

2. To make proposals for legislation in fields of activity related to medical and public health matters and to lay down the pattern of development for the country as a whole.

3. To make recommendations to the Central Government regarding distribution of available grants-in-aid for health purposes to the states and to review periodically the work accomplished in different areas through the utilisation of these grants-in-aid.

4. To establish any organisation or organisations invested with appropriate functions for promoting and maintaining cooperation between the Central and State Health administrations.

AT THE STATE LEVEL

Historically, the first milestone in the state health administration was the year 1919, when the states (provinces) obtained autonomy, under the Montague-Chelmsford reforms, from the central Government in matters of public health. By 1921-22, all the states had created some form of public health organisation. The Government of India Act, 1935 gave further autonomy to the states. The state is the ultimate authority responsible for health services operating within its jurisdiction.

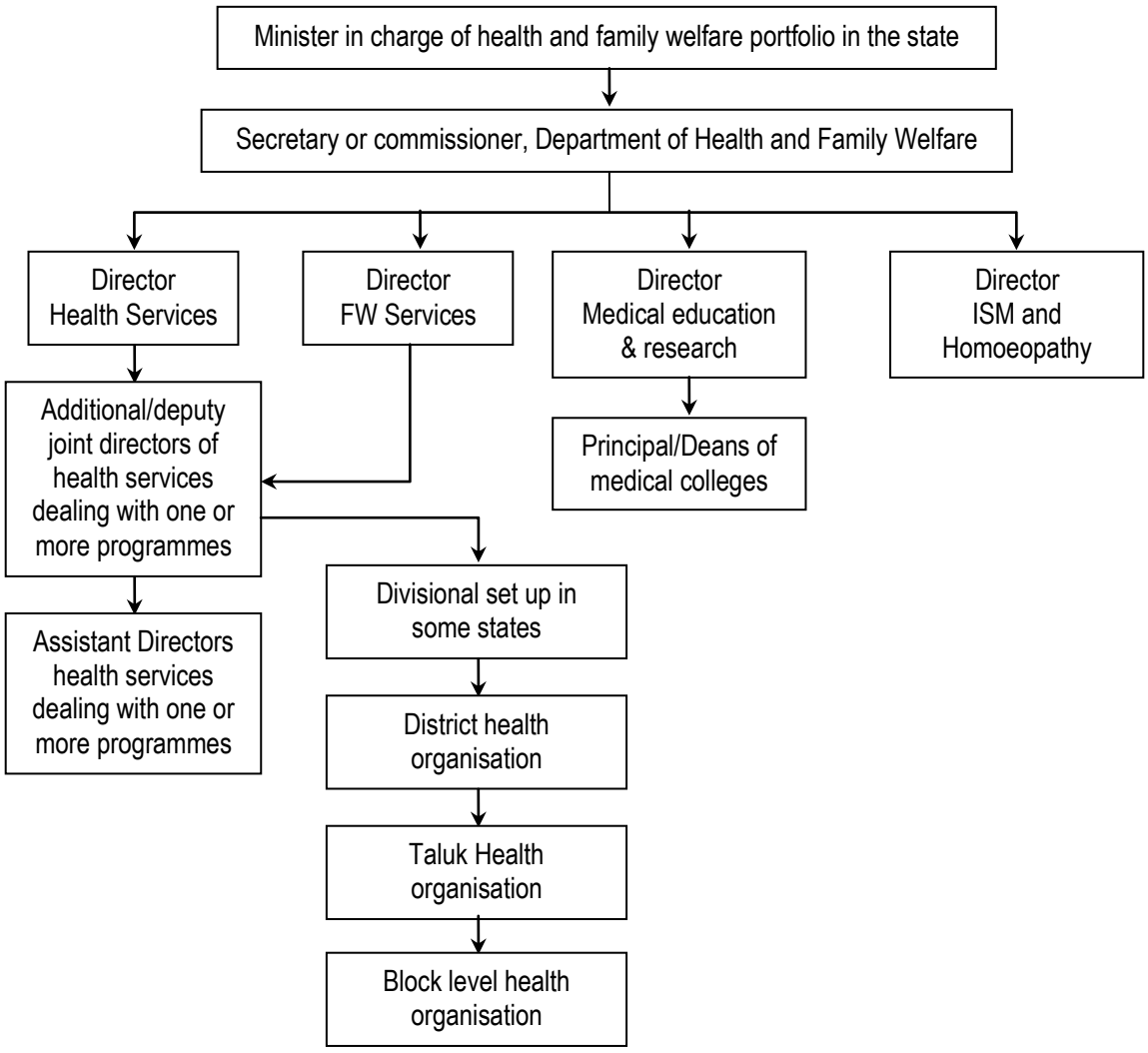
State health administration

At present there are 31 states in India, with each state having its own health administration. In all the states, the management sector comprises the state ministry of Health and a Directorate of Health.

1. State Ministry of Health

The State Ministry of Health is headed by a Minister of Health and FW and a Deputy Minister of Health and FW. In some states, the Health Minister is also in charge of other portfolios. The Health secretariat is the official organ of the State Ministry of Health and is headed by a Secretary who is assisted by Deputy Secretaries, and a large administrative staff.

Organisational structure of the health and family welfare services at state level



Functions : health services provided at the state level

- Rural health services through minimum needs programme
- Medical development programme
- M.C.H.,family welfare & immunization programme
- NMIP(malaria) & NFCP(filaria)
- NLEP, NTCP, NPCB, prevention and control of communicable diseases like diarrhoeal disease, KFD, JE,
- School health programme, nutrition programme ,national goitre control programme
- Laboratory services and vaccine production units
- Health education and training programme, curative services, national Aids control programme

2. State Health Directorate

The Director of Health Services is the chief technical adviser to the state Government on all matters relating to medicine and public health. He is also responsible for the organization and direction of all health activities. With the advent of family planning as an important programme, the designation of DHS has been changed in some states and is now known as Director of Health and Family Welfare. The Director of Health and Family Welfare is assisted by a suitable number of deputies and assistants. The Deputy and Assistant Directors of Health may be of two types –

Regional

Functional.

The **regional directors** inspect all the branches of public health within their jurisdiction, irrespective of their speciality.

The **functional directors** are usually specialists in a particular branch of public health such as mother and child health, family planning, nutrition, tuberculosis, leprosy, health education, etc.

AT THE DISTRICT LEVEL

The district is the most crucial level in the administration and implementation of medical /health services. At the district level there is a district medical and health officer or CMO who is overall responsible for the administration of medical /health services in the entire district.

Bhore Committee (1946) recommended integrated services at all levels and the setting up of a unified health authority in each district. The principal unit of administration in India is the district under a collector. There area 619 districts in India. Each district has 6 types of administration areas.

i. Subdivisions

ii. Tehsils (talukas)

iii. Community development blocks

iv. Municipalities and corporations

v. Villages

vi. Panchayaths

Most of the districts in India are divided into two or more subdivisions, each in charge of an assistant collector or sub-collector. Each division is again divided into tehsils in charge of a Tehsildar. A tehsil usually comprises between 200 and 600 villages.

Since the launching of the community development programme in India in 1952, the rural areas of the district have been organised into blocks known as **community development blocks.** The block is a unit of rural planning and development and comprises approximately 100 villages and about 80,000 to 1,20,000 population in charge of a block development officer.

Finally, there are the village panchayaths, which are institutions of rural local self-government.

The urban areas of the district are organised into the following local self-government:

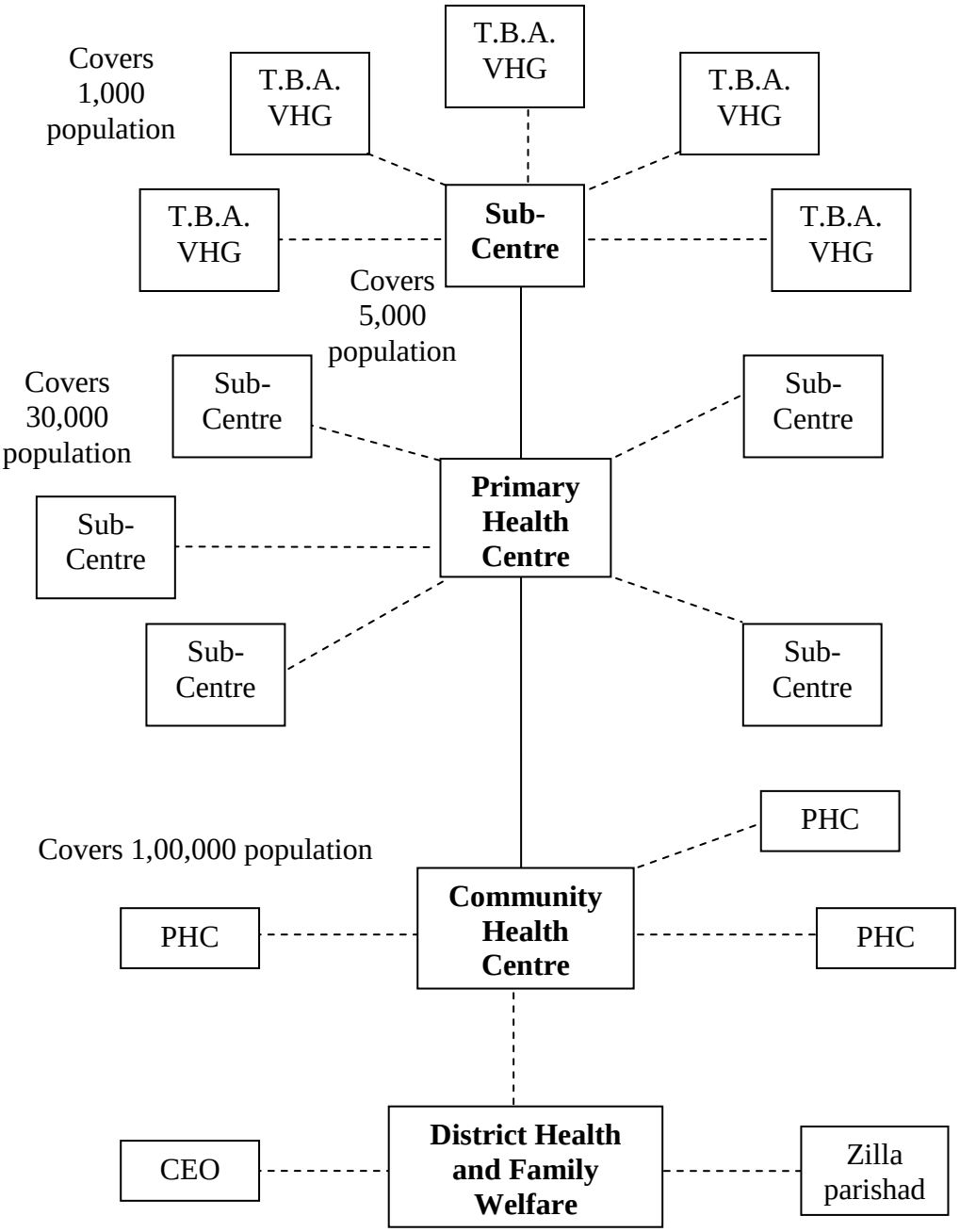
- Town area committee – 5,000 – 10,000
- Municipal boards – 10,000 – 2,00,000
- Corporations – population above 2,00,000.

The **towns area committees** are like panchayaths. They provide sanitary services.

The **municipal boards** are headed by a chairman/president, elected usually by the members. The term of a municipal board ranges between 3 and 5 years. The functions of a municipal board are construction and maintenance of roads, sanitation, and drainage, street lighting, water supply, maintenance of hospitals and dispensaries, education, registration of births and deaths, etc.

Corporations are headed by mayors. The councillors are elected from different wards of the city. The executive agency includes the commissioner, the secretary, the engineer, and the health officer. The activities are similar to those of the municipalities but on a much wider scale.

Primary Healthcare Infrastructure of District Level



PANCHAYATHI RAJ

The panchayath Raj is a 3-tier structure of rural local self-government in India linking the villages to the district. The three institutions are:

a. Panchayath – at the village level.

b. Panchayath samithi – at the block level.

c. Zilla parishad – at the district level.

The panchayathi Raj institutions are accepted as agencies of public welfare. All development programmes are channelled through these bodies. The panchayathi Raj institutions strengthen democracy at its root and ensure more effective and better participation of the people in the government.

At the village level

The panchayathi Raj at the village level consists of:

1. The gram sabha

2. The gram panchayath

3. The nyaya panchayath

At the block level

The panchayathi raj agency at the block level is the panchayath samithi. The panchayathi samithi consists of all sarpanchs of the village panchayaths in the block. The block development officer is the ex-officio secretary of the panchayath samithi.

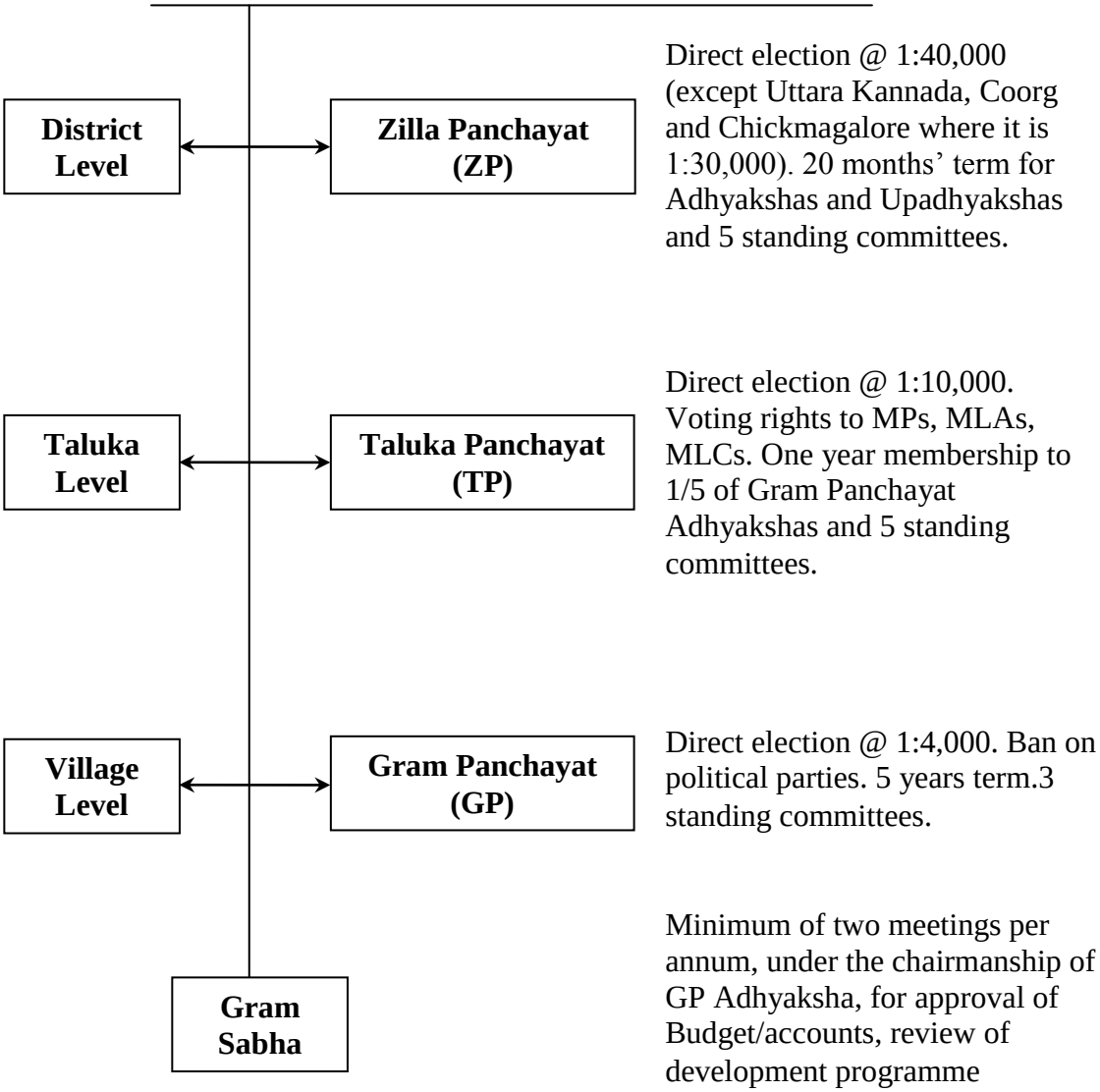
The prime function of the panchayat samiti is the execution of the community development programme in the block.

The block development officer and his staff give technical assistance and guidance to the village panchayaths engaged in the development work.

At the district level

The zilla parishad is the agency of rural local self-government at the district level. The members of the zilla parishad include all leaders of the panchayath samithis in the district, MPs, MLAs of the district, representatives of SC, SD and women, and 2 persons of experience in administration. The collector of the district is a non-voting member. Thus, the membership of the zilla parishad is fairly large varying from 40 to 70.

The zilla parishad is primarily supervisory and coordinating body. Its functions and powers vary from state to state. In some states, the zilla parishads are vested with the administrative functions.



Healthcare systems

The healthcare system is intended to deliver the healthcare services. It constitutes the management sector and involves the organisational matters. It operates in the context of the socioeconomic and political framework of the country. In India, it is represented by five major sectors and agencies which differ from each other by the health technology applied and by the source of funds for the operation.

i. Public health sector

ii. Private sectors

iii. Indigenous system of medicine

iv. Voluntary health agencies

v. National health programmes

Primary healthcare in India

It is a three-tier system of healthcare delivery in rural areas based on the recommendations of the Shrivastav Committee in 1975.

1. **Village level:** The following schemes are operational at the village level:

    a. Village health guides scheme

    b. Training of local dais

    c. ICDS scheme

2. **Sub-centre level:** This is the peripheral outpost of the existing health delivery system in rural areas. They are being established on the basis of one sub-centre for every 5000 population in general and one for every 3000 population in hilly tribal and backward areas. Each sub-centre is manned by one male and one female multipurpose health worker.

    Functions

    - Mother and child healthcare
    - Family planning
    - Immunisation
    - IUD insertion
    - Simple laboratory investigations

3. **Primary health centre level:** The Bhore committee in 1946 gave the concept of a primary health centre as a basic health unit to provide as close to the people as possible. The Bhore committee aimed at having a health centre to serve a population of 10,000 to 20,000. The national health plan, 1983 proposed reorganisation of primary health centres on the basis of one PHC for every 30,000 rural population in the plains, and one PHC for every 20,000 population in hilly, tribal and backward areas for more effective coverage.

Functions of the PHC

a. Medical care.

b. MCH including family planning.

c. Safe water supply and basic sanitation.

d. Prevention and control of locally endemic diseases.

e. Collection and reporting of vital statistics.

f. Education about health.

g. National health programmes as relevant.

h. Referral services.

i. Training of health guides, health workers, local dais, and health assistants.

j. Basic laboratory services.

Community health centres

As on 31st March 2003, 3076 community health centres were established by upgrading the primary health centres, each CHC covering a population of 80,000 to 1.20 lakh with 30 beds and specialist in surgery, medicine, obstetrics and gynaecology, and paediatrics with x-ray and laboratory facilities.

Functions

1. Care of routine and emergency cases in surgery.

2. Care of routine and emergency cases in medicine.

3. 24-hour delivery services including normal and assisted deliveries.

4. Essential and emergency obstetric cases including surgical interventions.

5. Full range of family planning services including laparoscopic services.

6. Safe abortion services.

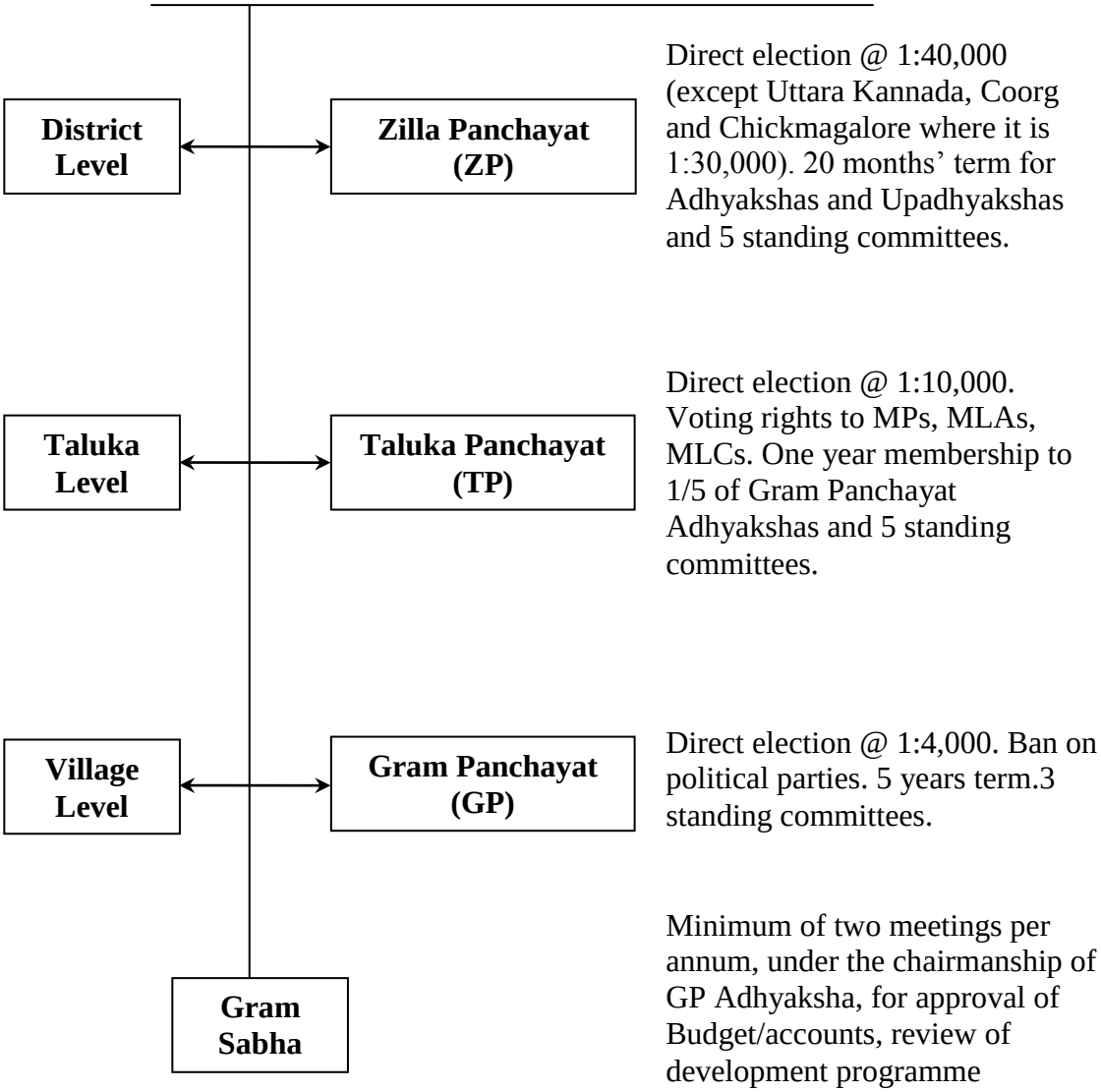
7. Newborn care.

8. Routine and emergency care of sick children.

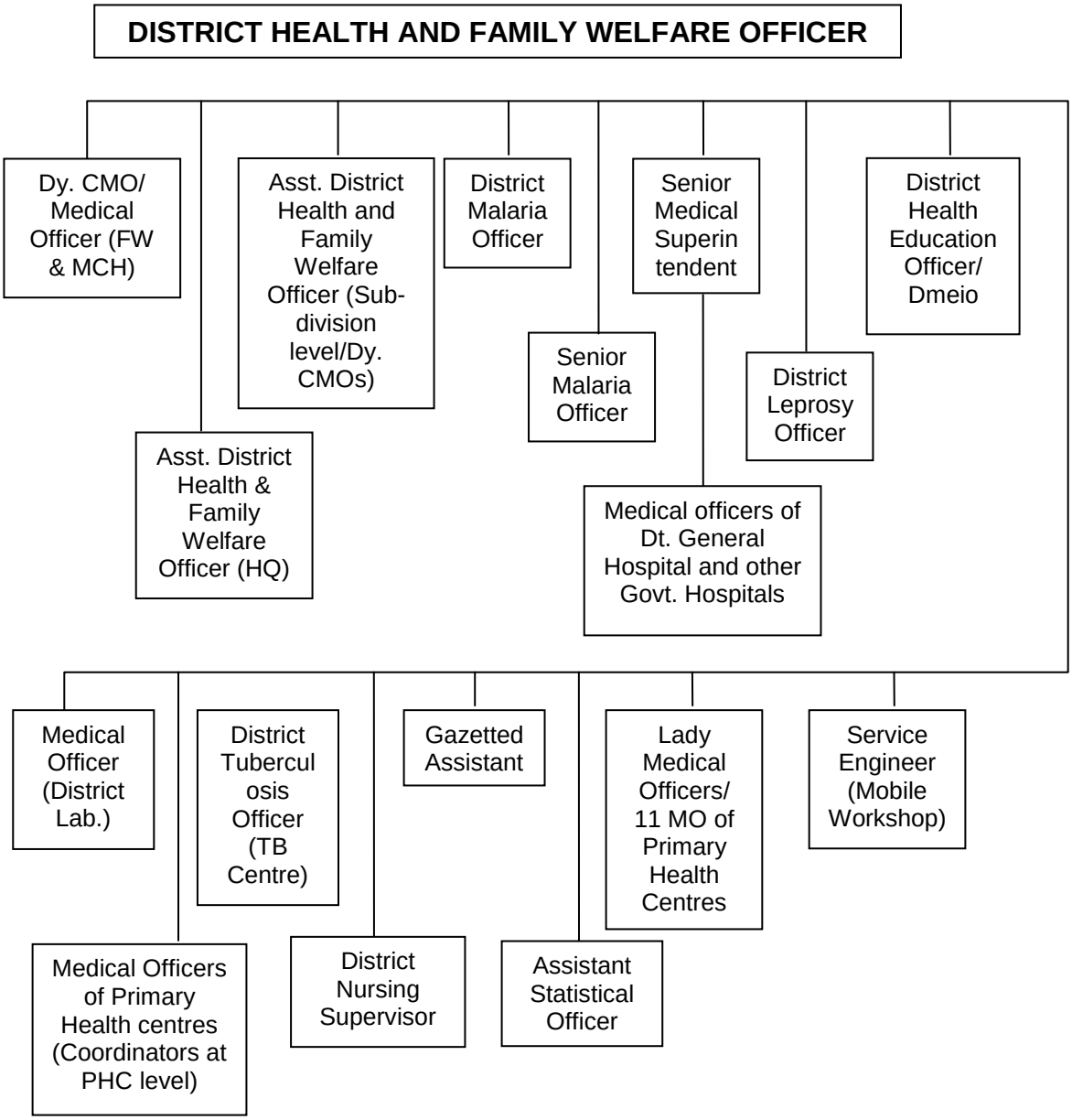
9. Other management including nasal packing___, tracheostomy, foreign body removal, etc.

10. All national health programmes should be delivered.
11. Blood shortage facility.
12. Essential laboratory services.
13. Referral services.

Organisational Structure of Panchayat Raj Institutions



Organisational structure of health department at district level



5. HEALTH CARE DELIVERY SYSTEM IN INDIA

INTRODUCTION

Health is the birth right of every individual. Today health is considered more than a basic human right; it has become a matter of public concern, national priority and political action. Our health system has traditionally been a disease-oriented system but the current trend is to emphasize health and its promotion. The nursing profession exists to meet the health need of the people. Unprecedented changes have occurred in the structure of our society, in lifestyles, in specific and technological advances.

Health is a multi dimensional with physical, biological, economical, social, cultural and vocational. Health is not static. A person who is healthy now may not be healthy the next moment. Public has become more aware and emphasizing on health, health promotion, wellness and self care. Emphasis has shifted from a focus on cure to a focus on prevention and health maintenance. This has led to a evolution of a wide range of health promotion techniques, and programmes including multiphasic screening, life time health monitoring programs.

Selected health care definitions:

- Health: According to WHO, health is defined as "a dynamic state of complete physical, mental and social well-being not merely an absence of disease or infirmity."
- Health care services: It is defined as "multitude of services rendered to individuals, families or communities by the agents of the health services or professions for the purpose of promoting, maintaining, monitoring or restoring health."

Definitions of health care delivery:

- Health care delivery system refers to the totality of resources that a population or society distributes in the organisation and delivery of health population services. It also includes all personal and public services performed by individuals or institutions for the purpose of maintaining or restoring health.

  Stanhope(2001)

- It implies the organisation, delivery staffing regulation and quality control.

  J.C.Pak(2001)

- Health care delivery system is the organisation by which health care is provided.

  Wikipedia(2005)

- A collection of fragmented services provided on free for service basis by numerous organisations and providers. **Laddy Susan**

Components of Health System:

- Concepts e.g. health and disease

- Ideas e.g. equity coverage, effectiveness, efficiency, impact.
- Objects e.g. hospitals, health centres, health programms
- Persons e.g. providers and consumers

Philosophy of Health Care Delivery System:

- Every one from birth to death is part of the market potential for health care services.
- The consumer of health care services is a client and not customer.
- Consumers are less informed about health services than anything else they purchase.
- Health care system is unique because it is not a competitive market.
- Restricted entry in to the health care system.

Goals/Objectives of Health Care Delivery System:

1) To improve the health status of population and the clinical outcomes of care.
2) To improve the experience of care of patients families and communities.
3) To reduce the total economic burden of care and illness.
4) To improve social justice equity in the health status of the population.

PRINCIPLES OF HEALTH CARE DELIVERY SYSTEM:

1. Supports a coordinated, cohesive health-care delivery system.
2. Opposes the concept that fee-for-practice.
3. Supports the concept of prepaid group practice.
4. Supports the establishment of community based, community controlled health-care system.
5. Urges an emphasis be placed on development of primary care
6. Emphasizes on quality assurance of the care
7. Supports health care as basic human right for all people.
8. Opposes the accrual of profits by health-care-related industries.
9. Supports individuals unrestricted access to the provider, clinic or hospital.
10. Urges that in the establishment of priorities for health-care funding, resource be allocated to maintain services for the economically deprived.
11. Supports efforts to eliminate unnecessary health care expenditures and voluntary efforts to limit increase in health care costs.

12. Endorses to provide age old with special health maintenance.
13. Supports public and private funding.
14. Condemns health care fraud.
15. Supports the establishment of a national health care budget.
16. Supports universal health insurance.

FUNCTIONS OF HEALTH CARE DELIVERY SYSTEM:

1) To provide health services.
2) To raise and pool the resources accessible to pay for health care.
3) To generate human and physical sources that makes the delivery service possible.
4) To set and enforce rules of the game and provide strategic direction for all the different players involved.

CHARACTERS OF HEALTH CARE DELIVERY SYSTEM:

1) Orientation toward health.
2) Population perspective.
3) Intensive use of information.
4) Focus on consumer.
5) Knowledge of treatment outcome.
6) Constrained resources.
7) Coordination of resources.
8) Reconsideration of human values.
9) Expectations of accountability.
10) Growing interdependence**.**

Financing

There are generally five primary methods of funding health care systems

1. Direct or Out-of-Pocket payment.
2. General Taxation,
3. Social Health Insurance,
4. Voluntary or private health insurance, and

Health care systems models

- Purely *private enterprise* health care systems are comparatively rare. Where they exist, it is usually for a comparatively well-off subpopulation in a poorer country with a poorer standard of health care–for instance, private clinics for a small, wealthy expatriate population in an otherwise poor country. But there are countries with a majority-private health care system with residual public service eg medicare, medicaid.
- The other major models are *public insurance systems*:
    - **Social security health care model**, where workers and their families are insured by the State.
    - **Publicly funded health care model**, where the residents of the country are insured by the State.
    - **Social health insurance**, where the whole population or most of the population is a member of a sickness insurance company.

HEALTH CARE DELIVERY SYSTEM

The health care delivery system is vast and complex. There are number of agencies are operators to provide health care facilities and services to the people. They may be broadly divided into:

(1) Private agencies,
(2) Voluntary agency
(3) Government agencies.

1). **Private agencies** are the agencies, where the care is provided on the basis of fee-for service in a one-to one relationship, for example private-practitioner, nursing home etc.

2. **Voluntary agencies** are the traditional, non-official organization established by groups of philanthropic civic-minded individuals in response to the health social needs within this community. Voluntary health agencies are supported by voluntary contributions and/ or fee for service, an accountable to the supporters of the agency to third party, payment sources.

3. **Government agencies** are official health agencies operating at the local, state, federal and international levels. They are tax supported, their functions are mandated by la, - and they emphasize health promotion and disease prevention. Official health agencies are accountable the citizens and the government through an official, appointed or elected board.

HEALTH CARE DELIVERY SYSTEM IN INDIA

In India it is represented by five major sectors or agencies which differ from each other by health technology applied and by the source of fund available. These are**:**

I. PUBLIC HEALTH SECTOR

A. Primary Health Care

Primary health centres.

Sub- centres.

B. Hospital/Health Centres

Community health centres.

Rural health centres.

District hospitals/health centre.

Specialist hospitals.

Teaching hospitals.

C. Health Insurance Schemes

Employees State Insurance.

Central Govt. Healh Scheme.

D. Other Agencies

Defence services.

Railways.

II. PRIVATE SECTOR

A. Private hospitals, polyclinics, nursing homes and dispensaries.

B. General practitioners and clinics.

III. INDIGENOUS SYSTEMS OF MEDICINE

- Ayurveda
- Sidda
- Unani
- Homeopathy
- Naturopathy
- Yoga
- Unregistered practioners.

IV. VOLUNTARY HEALTH AGENCIES

V. NATIONAL HEALTH PROGRAMMES

Model of Health Care System in India

The "inputs" are the health status or health problems of the community, they represent the health needs and health demands of the community. Since resources are always limited to meet the many health needs, priorities have to be set.

The "health care services" are designed to meet the health needs of the community through the use of available knowledge and resources. The services provided should be comprehensive and community based.

The "health care system" is intended to deliver the health care services, it constitutes the management sector and involves organizational matters.

The "output" is the changed health status or improved health status of the community which is expressed in terms of lives saved, deaths averted, diseases prevented etc

I PUBLIC HEALTH SECTOR

A. Primary Health Care In India

- In 1977 government of India launched a rural health scheme, based on the principles of "Placing people's health in people's hands'
- As a signatory to Alma-Ata Declaration, the government of India is committed to achieving the goal of Health care approach which seeks to provide universal health care at a cost which is affordable.
- Keeping in view the WHO goal of "Health for All" by 2000 AD, the government of India evolved a National Health Policy in 1983.
- Keeping in view the Millennium Developmental Goals, the government of India revised the draft of National Health Policy in 2001.

Principles of primary Health Care

1. Equitable distribution
2. Community participation
3. Intersectoral coordination
4. Appropriate technology
5. Preventive in Nature
6. Man power development.

Comparison of infracture in India and Karnakaka

	Karnataka	India
District Hospitals	24	615
CHC	254	3346
PHC	1681	23236
SUB CENTRES	8143	146026

Primary Health Centre

Primary Health Centers are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-centers for curative, preventive and promotive health care.

A typical Primary Health Centre covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with4-6 indoor/observation beds. It acts as a referral unit for 6 sub-centers and refer out cases to CHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level.

In order to provide optimal level of quality health care, a set of standards are being recommended for Primary Health Centre to **be called Indian Public Health Standards (IPHS) for PHCs**. The launching of National Rural Health Mission (NRHM) has provided this opportunity.

Assured services or Functions of Primary health centres:

Assured services cover all the essential elements of preventive, promotive, curative and rehabilitative primary health care.

This implies a wide range of services that include:

1. **Medical care:**
    - OPD services: minimum 4 hours in the morning and 2 hours in the evening.
    - 24 hours emergency services
    - Referral services
    - In-patient services (6 beds)
2. **Maternal and Child Health Care including family planning:**
    - Antenatal care: Early diagnosis, minimum three antenatal check up, identification and management of high risk pregnancies, nutrition and health

counseling, minimum laboratory investigation urin albumin, test ofr syphilis, chemoprophylaxis for malaria in high endemic area as per NVDCP.

- Intra-natal care. (24-hour delivery services both normal and assisted**)**
- Postnatal Care.(Janani Suraksha Yojana (JSY)) Minimum 2 postpartum visit, initiation of breast feeding health education on hygiene, contraception etc,
- New Born care.
- Care of the Child.
- Family Planning

3. Medical Termination of Pregnancies using Manual Vacuum Aspiration (MVA) technique. (Wherever trained personnel and facility exists)
4. Management of Reproductive Tract Infections / Sexually Transmitted Infections:
5. Nutrition Services (coordinated with ICDS)
6. School Health
7. Adolescent Health Care
8. Promotion of Safe Drinking Water and Basic Sanitation
9. Prevention and control of locally endemic diseases like malaria, Kalaazar, Japanese Encephalitis, etc
10. Disease Surveillance and Control of Epidemics
11. Collection and reporting of vital events
12. Education about health/Behaviour Change Communication (BCC**)**
13. National Health Programmes including Reproductive and Child HealthProgramme (RCH), HIV/AIDS control programme, Non communicable disease control programme etc
14. Referral Services.
15. Training: ASHA, ANM, LHV
16. Basic Laboratory Services
17. Monitoring and Supervision:
18. AYUSH services as per local people's preference (Mainstreaming of AYUSH)
19. Rehabilitation
20. Selected Surgical Procedures

Objectives of Sub-centres:

- To provide basic Primary health care to the community.
- To achieve and maintain an acceptable standard of quality of care.
- To make the services more responsive and sensitive to the needs of the community.

Assured services or Functions of Primary health centers:

Assured services cover all the essential elements of preventive, promotive, curative and rehabilitative primary health care. This implies a wide range of services that include:

1. **Maternal and Child Health Care including family planning:**
    - Antenatal care: Early diagnosis, minimum three antenatal check up, identification and management of high risk pregnancies, nutrition and health counseling, minimum laboratory investigation urin albumin, test ofr syphilis, chemoprophylaxis for malaria in high endemic area as per NVDCP.
    - Intra-natal care: Promotion of institutional deliveries, skilled reference at home deliveries. Minimum 2 postpartum visit, initiation of breast feeding health education on hygiene, contraception etc,
    - Others: Provison of facilities under Janani Suraksha Yojna and NRHM.
    - Postnatal Care:
    - Child health: Essential New born care, promotion of exclusive breast feeding, immunization of all children, prevention and control of all childhood disease.
2. **Family planning and contraception:** Education motivation and counseling to adopt family planning motheds,provision of contraception**.**
3. Counseling and appropriate referral for safe abortion services for those in need.
4. Adolescent health care:
5. Assistance to school health services.
6. Control local endemic diseases such as Malaria, filariasis etc.
7. Disease surveillance
8. Water quality monitering**:** Disinfection of water sources
9. Promotion of sanitation including use of toilets and appropriate garbage disposal.
10. Field visits
11. Community needs assessment
12. Curative services: Provide treatment for minor ailments, referral service, organizing health day once in month at anganvadi.

13. Training coordination and monitering: Training of traditional birth attendants ASHA community health volunteers, omonitering of water quality.
14. National Health Programmes
15. Record of Vital Events

Man Power

Manpower	**Existing**	**Proposed**
Health worker(female) Auxillary Nurse Midwife	1	2
Health worker(male) Multi Purpose Worker	1	1
Viluntary worker(paid rs 100 per month as honorarium)	1	1

The staff of the Sub center will have the **support of ASHA (Accredited Social Health Activists)** wherever the ASHA scheme is implemented **/ similar functionaries at village level in other areas**. ASHA is primarily a trained woman volunteer, resident of the village-married/widow/divorced with formal education up to 8th standard preferably in the age group of 25-45 years. The general norm is one ASHA per 1000 population. The job functions of ANM, Male Health worker, ASHA and AWW in the context of coordinated functions under NRHM.

A. HOSPITALS AND HEALTH CENTRES

Community Health Centers

Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary. The secondary level of health care essentially includes

Community Health Centers (CHCs), constituting the First Referral Units (FRUs) and the district hospitals. The CHCs were designed to provide referral health care for cases from the primary level and for cases in need of specialist care approaching the centre directly. 4 PHCs are included under each CHC thus catering to approximately 80,000 populations in tribal / hilly areas and 1, 20,000 population in plain areas. CHC is a 30 bedded hospital providing specialist care in medicine, Obstetrics and Gynecology, Surgery and Pediatrics. These centers are however fulfilling the tasks entrusted to them only to a limited extent. The launch of the National Rural Health Mission (NRHM) gives us the opportunity to have a fresh look at their functioning.

NRHM envisages bringing up the CHC services to the level of Indian Public Health Standards. Although there are already existing standards as prescribed by the Bureau of Indian Standards for 30-bedded hospital, these are at present not achievable as they are very resource-intensive. Under the NRHM, the Accredited Social Health Activist (ASHA) is being envisaged in each village to promote the health activities. With ASHA in place, there is bound to be a groundswell of demands for health services and the system needs to be geared to face the challenge. Not only does the system require upgradation to handle higher patient load, but emphasis also needs to be given to quality aspects to increase the level of patient satisfaction.

Objectives of Indian Public Health Standards (IPHS) for CHCs:

- To provide optimal expert care to the community
- To achieve and maintain an acceptable standard of quality of care
- To make the services more responsive and sensitive to the needs of the community.

Functions of CHCs:

Every CHC has to provide the following services which can be known as the *Assured Services:*

1. Care of routine and emergency cases in surgery:
    - This includes Incision and drainage, and surgery for Hernia, hydrocele, Appendicitis, hemorrhoids, fistula, etc.
    - Handling of emergencies like intestinal obstruction, hemorrhage, etc.
2. Care of routine and emergency cases in medicine:
    - Specific mention is being made of handling of all emergencies in relation to the National Health Programmes as per guidelines like Dengue Haemorrhagic fever, cerebral malaria, etc. Appropriate guidelines are already available under each programme, which should be compiled in a single manual.
3. 24-hour delivery services including normal and assisted deliveries
4. Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions
5. Full range of family planning services including Laproscopic Services
6. Safe Abortion Services
7. New-born Care
8. Routine and Emergency Care of sick children
9. Other management including nasal packing, tracheostomy, foreign body removal etc.

10. All the National Health Programmes (NHP) should be delivered through the CHCs.
11. Others**: B**lood storage facility, Essential laboratory services, Referral (transport).

HOSPITALS

India's Public Health System has been developed over the years as a 3-tier system, namely primary, secondary and tertiary level of health care. District Health System is the fundamental basis for implementing various health policies and delivery of healthcare, management of health services for defined geographic area. District hospital is an essential component of the District health system and functions as a secondary level of health care, which provides curative, preventive and promotive healthcare services to the people in the district.

Every district is expected to have a district hospital linked with the public hospital/health centres down below the district such as Sub-district/Sub-divisional hospitals, Community Health Centres, Primary Health Centers and Sub-centres. As per the information available, 609 districts in the country at present are having about 615 District hospitals. However, some of the medical college hospitals or a sub-divisional hospital is found to serve as a district hospital where a district hospital as such (particularly the newly created district) has not been established. Few districts have also more than one district hospital.

Objectives for district hospitals:

The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the people of the District. The specific objectives of IPHS for DHs are:

i. To provide comprehensive secondary health care (specialist and referral services) to the community through the District Hospital.
ii. To achieve and maintain an acceptable standard of quality of care.
iii. To make the services more responsive and sensitive to the needs of the people of the district and the hospitals/centres from which the cases are referred to the district hospitals

Definition

The term District Hospital is used here to mean a hospital at the secondary referral level responsible for a District of a defined geographical area containing a defined population.

Grading of district hospitals:

The size of a district hospital is a function of the hospital bed requirement, which in turn is a function of the size of the population it serves. In India the population size of a district varies from 35,000 to 30,00,000 (Census 2001). Based on the assumptions of the

annual rate of admission as 1 per 50 populations and average length of stay in a hospital as 5 days, the number of beds required for a district having a population of 10 lakhs will be around 300 beds. However, as the population of the district varies a lot, it would be prudent to prescribe norms by grading the size of the hospital as per the number of beds.

Grade I: District hospitals norms for 500 beds

Grade II: District hospitals norms for 300 beds

Grade III: District hospitals norms for 200 beds

Grade IV: District hospitals norms for 100 beds

The disease prevalence in a district varies widely in type and complexities. It is not possible to treat all of them at district hospitals. Some may require the intervention of highly specialist services and use of sophisticated expensive medical equipments. Patients with such diseases can be transferred to tertiary and other specialized hospitals. A district hospital should however be able to serve 85-95% of the medical needs in the districts. It is expected that the hospital bed occupancy rate should be at least 80%. **Functions**

1. It provides effective, affordable healthcare services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in co-operation with agencies in the district that have similar concern. It covers both urban population (district headquarter town) and the rural population in the district.
2. Function as a secondary level referral centre for the public health institutions below the district level such as Sub-divisional Hospitals, Community Health Centres, Primary Health Centres and Sub-centres.
3. To provide wide ranging technical and administrative support and education and training for primary health care.

Essential Services

Services include OPD, indoor, emergency services.

Secondary level health care services regarding following specialties will be assured at hospital:

Consultation services with following specialists:

- ✓ General Medicine
- ✓ General Surgery
- ✓ Obg & Gyne
- ✓ Paediatrics including Neonatology
- ✓ Emergency (Accident & other emergency) (Casualty)
- ✓ Critical care (ICU)
- ✓ Anaesthesia

- ✓ Ophthalmology
- ✓ ENT
- ✓ Orthopaedics
- ✓ Radiology
- ✓ Dental care

Para clinical services

- Laboratory Services
- X-Ray Facility
- ECG
- Blood transfusion and storage facilities
- Physiotherapy
- Dental Technology (Dental Hygiene)
- Drugs
- Pharmacy

Support Services

- ➢ Medico-legal/post-mortem
- ➢ Ambulance services
- ➢ Dietary services
- ➢ Security services.
- ➢ Waste management
- ➢ Ware housing/central store
- ➢ Maintenance and repair
- ➢ Electric Supply (power generation and stabilization)
- ➢ Water supply (plumbing)
- ➢ Heating, ventilation and air-conditioning
- ➢ Transport
- ➢ Communication
- ➢ Medical Social Work
- ➢ Nursing Services
- ➢ Sterilization and Disinfection

C. HEALTH INSURANCE:

There is no universal health insurance in India. Health Insurance is at present is limited to industrial workers and their families.

1. **Employees State Insurance Scheme:** It was introduced by an act of parliament in 1948. It covers employees drawing wages not exceeding Rs. 10,000 per month. The act provides
    - Medical benefits
    - Sickness benefits
    - Disabled benefits
    - Maternity benefits
    - Dependent benefits
    - Funeral benefits
2. **Central Government Health Scheme:**

    This scheme was introduced in New Delhi in 1954 to provide comprehensive medical care to Central Government employees. The schemes based on the principles of cooperative effort by the employee and the mutual advantage of both.

    Facilities under the scheme include:

    - Outpatient care through a network of dispensaries.
    - Supply of necessary drugs.
    - Laboratory and x-ray investigation.
    - Domiciliary visits.
    - Hospitalisation facilities at Govt as well as private hospitals recognized for the purpose.
    - Special consultation.
    - Paediatric services including immunization.
    - Antenatal, natal and postnatal services.
    - Emergency treatment.
    - Supply of optical and dental aids at reasonable rate.

OTHER AGENCIES:

Defence Medical Services:

Defence services have their own organization for medical care to defence personnel under the banner “Armed Forces Medical Services”. The services are provided are integrated and comprehensive.

Health Care of Railway Employees: The Railways provide comprehensive health care services through the agencies of Railway Hospitals, Health Units and Clinics. Environmental sanitation is taken care of by Health Inspectors in big stations. Health check-up of employees is provided at the time of recruitment and thereafter at yearly intervals.

II -PRIVATE AGENCIES:

In a mixed economy such as India's, private practice of medicine provides a large share of the health services available. There has been a rapid expansion in the number of qualified allopathic physicians to 7.5 lakhs in 2005 and doctor population ration is 1:1428. Most of them they concentrate in urban areas. They provide mainly curative services. Their services are available to those who can pay. The private sector of health care services is not organised.

III-INDEGINOUS SYSTEMS OF MEDICINE:

The practioners of indigenous system of medicine provide the bulk of medical care to the rural people. Ayurvedic physicians alone are estimated to be about 4.5lakhs. Nearly 90% of ayurvedic physicians serve the rural areas. To promote this these indigenous systems Indian government established Indian Council For Indian Medicine in 1971. AYUSH is the new approach on this. Which encompasses Ayurveda, Yoga, Unani, Sidda, Homeopathy.

Objectives of **AYUSH**:

- To upgrade the educational standards in the Indian Systems of Medicines and Homoeopathy colleges in the country.
- To strengthen existing research institutions and ensure a time-bound research programme on identified diseases for which these systems have an effective treatment.
- To draw up schemes for promotion, cultivation and regeneration of medicinal plants used in these systems.
- To evolve Pharmacopoeial standards for Indian Systems of Medicine and Homoeopathy drugs.

IV-Voluntary Health Agencies:

A voluntary health agency may be defined as an organization that is administered by an autonomous board which holds meetings, collects funds for its support, chiefly from private sources and expands money, whether with or without paid workers, in conducting a programme directed primarily to furthering the public health by providing health services or health education by advancing research or legislation for health or by a combination of these activities.

The voluntary health agencies in India are:

- Indian Red Cross Society
- Hind Kusht Nivaran Sangh
- Indian Council for Child Welfare
- Tuberculosis Association of India
- Bharat Sevak Samaj
- Central Social Welfare Board
- The Ksturba Memorial Fund
- Family Planning Association of India
- All India Women's Conference
- The All- India Blind Relief Society
- Professional Bodies like TNAI, IMA, AIDA etc
- International Agencies like Rockfeller Foundation, CARE, Ford Foundation etc.

V-NATIONAL HEALTH PROGRAMMES

Since India became free, several measures have been undertaken by National Government to improve the health of the people. Prominent among these measures are the National Health Programmes. Which have been launched by the Central Government for control/eradication of the communicable diseases, improvement of environmental sanitation, raising the standard of nutrition, control of population and improving rural health. Various international agencies like WHO, UNICEF, UNFPA etc have been providing technical and material assistance in the implementation of these programmes.

National Health Programmes are:

- National Vector Borne Disease Control Programme
- National Leprosy Eradication Programme
- Revised National Tuberculosis Control Programme
- National AIDS Control Programme
- National Programme for Control of Blindness
- Iodine Deficiency Disorders Programme
- Universal Immunization Programme
- National Rural Health Mission
- Reproductive and Child Health Programme

- Yaws Eradication Programme
- National Cancer Control Programme
- National Guinea- Worm Eradication Programme
- National Cancer Control Programme
- National Mental Health Programme
- National Diabetes Control Programme
- National Programme for Control and Treatment of Occupational Disease
- Nutritional Programme
- National Surveillance Programme for Communicable Disease
- Integrated Disease Surveillance Programme
- National Family Welfare Programme
- National Water Supply and Sanitation Programme
- Minimum Needs Programme
- 20-Point Programme

Need For an Alternatenative Health Systems of Health Care:

- The present system is limited to the urban areas**.**
- It has greater emphasis on curative aspects rather than preventive and promotive aspects care.
- It is expensive.
- Inadequacy and misdistribution of resources for health services
- There is lack of clear-cut referral system.
- There is lack of intersectoral collaboration and community involvement.
- Over centralization of authority.
- There is insufficient orientation and training of the primary health care staff and there is also lack of proper job descriptions resulting in poor implementation of the projects.
- The unsuitable working hours of the personnel in the rural areas.

6. ORGANIZATION AND FUNCTIONS OF NURSING SERVICES

Nursing service administration is a complex of elements in interaction. It results in output of clients whose health is unavoidably deteriorating, maintained or improved through input of personnel and material resources used in an orderly process of nursing services.

According to **Frances Reiter**, organisation of nursing services should be such that the professional nurse practitioner will be helped to

1) Fulfil her professional role and take her rightful place within the professional health team

2) Develop a collaborative relationship with her colleagues

3) Devote herself to the improvement of professional practice as well as provision of care.

4) Direct and plan the care given by group of Auxiliary workers.

According to the W.K. Kellong Foundation, two definitions for service administration are:

I. Nursing Service Administration is a co-ordinated system of activities which provides Provides all of the facilities necessary for the rendering of nursing care of patients

2. Nursing Service Administration is the system of activities directed toward the nursing care of patients and includes in the establishment of over all goals and policies with in the aims of health agency and provision for organization, personnel and facilities to accomplish these goals in the most effective and economical manner through cooperative efforts of all members of the staff co-ordinating the services with other departments of the administration

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AIMS OF NURSING SERVICE ADMINISTRATION

Primary Objective:

The provision for continuous individualized service to the patient including, whatever is necessary, physically or psychologically, so bring him back to self directive activity towards his own health. And also provide the optimum nursing care of patients

The criteria for a well organized Nursing service listed in 1965 by The National League for Nursing the following:

- **A written statement of the Philosophy, Purpose and Objectives of the Nursing services:** The statement of the purpose or believes of the nursing service is in keeping with hospitals belief regarding patient care and is approved by administration. The purpose and objectives are understood by all the nursing staff which implies that they are discussed with them that copies are available.
- **A Plan of Organization:** Commonly diagrammed as an organization chart, the plan indicates areas of responsibility, to whom and for whom each person is

accountable, and the major channels of formal communication.

- **Policy and Administrative Manuals:** Over and above but consonant with the policies established for the operation of the hospital, policies are established within the department to guide the nursing staff. These might include the items such as regulation for exchange of information when tours of duty changes and regulations for charting nurses notes etc.
- **Nursing Practise Manual:** Written procedures are available as evidence that standards of performance have been established for safe, effective care, taking into consideration the best use of available resources and person. Procedures are reviewed and revised at regular intervals, after consultation with these concerned with implementation of procedures.
- **Nursing service budget:** This is a statement of plans for the nursing service expressed in accounting terms; it is one segment of over all hospital budgets. The nursing service budget is concerned primarily with four budget form salary, supplies and expenses, equipped and capital expenditure. Steps involved in preparation of the budget include analyzing past operation and anticipating factors which will affect future income and expense.
- **A master staffing pattern:** this helps the director of nursing service to visualize the equitable distribution of nursing personnel among the various nursing units. It serves as a guide in planning vacation coverage, as a time table for replacement of personnel, as a support for budgetary request, as an aid in forecasting future needs.
- **Plans for appraisal of nursing:** In addition to the provision of supervision there are one or more techniques for the continuous evaluation of nursing care such as ward conferences, nursing rounds, analysis of accident reports, patient and employee opinion pools, and the nursing audit.
- **Nursing service administrative meetings:** the opportunity for free communication and a share in planning and evaluation is provided through regular meeting of the director of nursing or her representative with day, evening and night assistants, with supervisors, head nurses and total nursing staff. Records of these meetings include reports of decision and recommendations will be considered and administrative decisions will be reported.
- **Advisory committees:** Membership on standing committees provides for the active participation of staff members in problem solving. Each committee has a clear statement or purpose and its membership is appropriate to the purpose. These committees are advisory to the director of nursing.
- **Adequate Facilities, Supplies and Equipment:** The director of nursing or her representative evaluates periodically the adequacy or facilities in terms of patient and personnel needs. She requests needed new or expanded facilities in discussion with the hospital administrator and when necessary, these by documented evidence of need. Consideration for .providing the nursing service with adequate tools for safe and effective care is evidenced by the development and use of inventories of equipment and standards for supplies, the availability of supplies in relation to storage and the economical use of supplies.

- **Written job Descriptions and Job Specifications:** Help prevent duplication of functions. Qualification for' each category of personnel are defined in terms of responsibilities to be assumed. The e job descriptions and specification help to assure the objective selection of personnel.

- **Personnel Records:** They arc kept on each staff member including such information as application for employment, records of interview, verifications of credential, letters of acceptance, chronological records of assignment and attendance salary, performance evaluation etc and if employment is terminated, summery statement.

- **Personnel Policies:** Personnel policies reflect an analysis of the total job of nursing in accordance with the types of functions to be performed, the quality and quantity of service to be maintained and the purpose for which the hospital exists. They are personnel centered but based on the needs of the institution- The personnel policies are detailed enough to show current condition of employment and future opportunities within the institution. Personnel policies are reviewed and revised at regular intervals.

- **Health Services:** The plan of health care for employees is' set forth In written policies which govern pre-employment physical examinations, periodic re-examinations, and provision for diagnostic, preventive and therapeutic measures, including emergency service. Health records are confidential. Administrative personnel with the responsible physician determine what information on the health record may be made available for administrative purposes.

- **In-service Education of Nursing Personnel:** Programmes are conducted which provide orientation to help the new employee adjust to anew environment and duties. Skill training- to provide the employee with the skills and attitudes required for the job and to keep the employee abreast of changing methods and new techniques.

- **Meeting with personnel from other departments:** The opportunity for communication, a share in planning evaluation and cooperation, coordination of activities, is provided through regular meetings of the director of nursing with the administrator, other department heads, with members of the medical staff, with the committee for the improvement of the care of the patient and other groups involed in providing patient care.

FUNCTIONS OF A HOSPITAL NURSING SERVICES

The first essential in administrative planning is that the plan should be based on the clearly defined objectives, another director of nursing service, in cooperation with her staff, will therefore need to formulate objectives, which will obviously be in accordance with policy laid down.

- To give the highest possible quality of nursing care in terms of total patient needs this will

involve spiritual, psychological, social, rehabilitative and educational needs as well as physical.

- To assist the physician in the medical care of the patient and to carry out the therapy as prescribed.
- To promote the programme of in-service education to provide facilities for the clinical instruction necessary for the basic and post basic preparation of nurses and of auxillary nursing personnel.
- To promote and encourage nursing studies in order that quality of performance may be improved and maximum utilization of personnel obtained.
- To evaluate the quality of nursing services and continuously build facilities and prepare personnel to improve upon this quality.
- To promote participation in the allied health organization and supportive community activities.

Planning and organising nursing service at various levels – local, regional, national, and international

Placement of nurses in the healthcare organisation

A high power committee on nursing and nursing profession was set up by the Government of India in July 1987 under the chairmanship of Smt. Sarojini Vasadapan, an eminent social worker and former chairperson of Central Social Welfare Board with Smt. Rajkumari Sood, Nursing Advisor to Government of India, as the member secretary. The terms of reference of the committee were as follows:

a. Looking into the existing working conditions of nurses with particular reference to the status of the nursing care services both in rural and urban areas.

b. To study and recommend the staffing norms necessary for providing adequate nursing personnel to give the best possible care, both in the hospitals and community.

c. To look into the training of all categories and levels of nursing, midwifery personnel to meet the nursing manpower needs at all levels of health service and education.

d. To study and clarify the role of nursing personnel in the healthcare delivery system including their interaction with other members of the health team at every level of health services management.

e. To examine the need for organisation of the nursing services at the national, state, district, and lower levels with particular reference to the need for planning and implementing the comprehensive nursing care services with the overall healthcare system of the country at their respective levels.

f. To look into all other aspects which the committee may consider relevant with reference to their terms of reference.

g. While considering the various issues under the above norms of reference, the committee will hold consultations with the state governments.

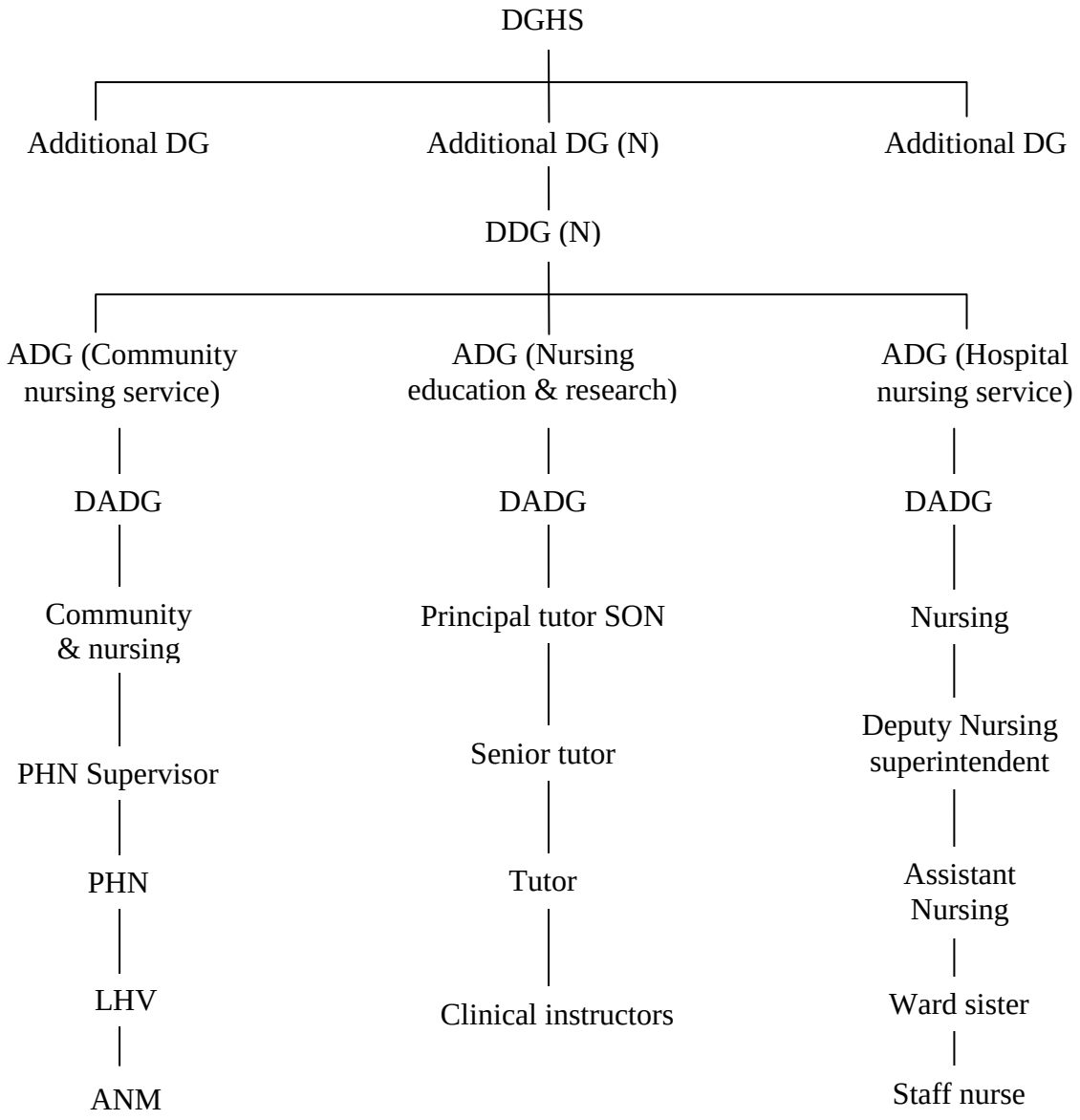
Their recommendations on the organisation of nursing services at central, state and district levels, and the norms of nursing service and education are given below.

Placement of nurses at the central level

At the central level there is a post of nursing advisor in the medical division of Directorate General of Health Services. The nursing advisor is directly responsible to the Deputy Director General (Medical). The nursing advisor is assisted by nursing officer and support staff for all his/her work. She/he advises the DGHS, Ministry of Health and Family Welfare as well as other ministries and departments, for example, railways, labour, Delhi Administration, etc. on all matters of nursing services, nursing education, and research. The nursing advisor also takes care of administration aspects of Raj Kumari Amrit Kaur College of Nursing and Lady Hardinge Health School, Delhi.

There is a post of deputy nursing advisor at the rank of Assistant Director General (ADG-Nsg) in the training division of Department of F. W. Presently the deputy nursing advisor deals with training of ANMs, dais, health supervisor, etc. There is no direct linkage between the nursing advisor and deputy nursing advisor as there are independent posts.

Nursing organisational set up at the central level



Note

a. The positions up to the DADG level are proposed to be at the office of the directorate general of health services. Positions below the level of DADG are to exist at the institutions governed by the central government.

b. The principal of the College of Nursing will be equal to the rank of ADAG (N) and will be eligible for promotion to the post of DDG (N) addl DG (N).

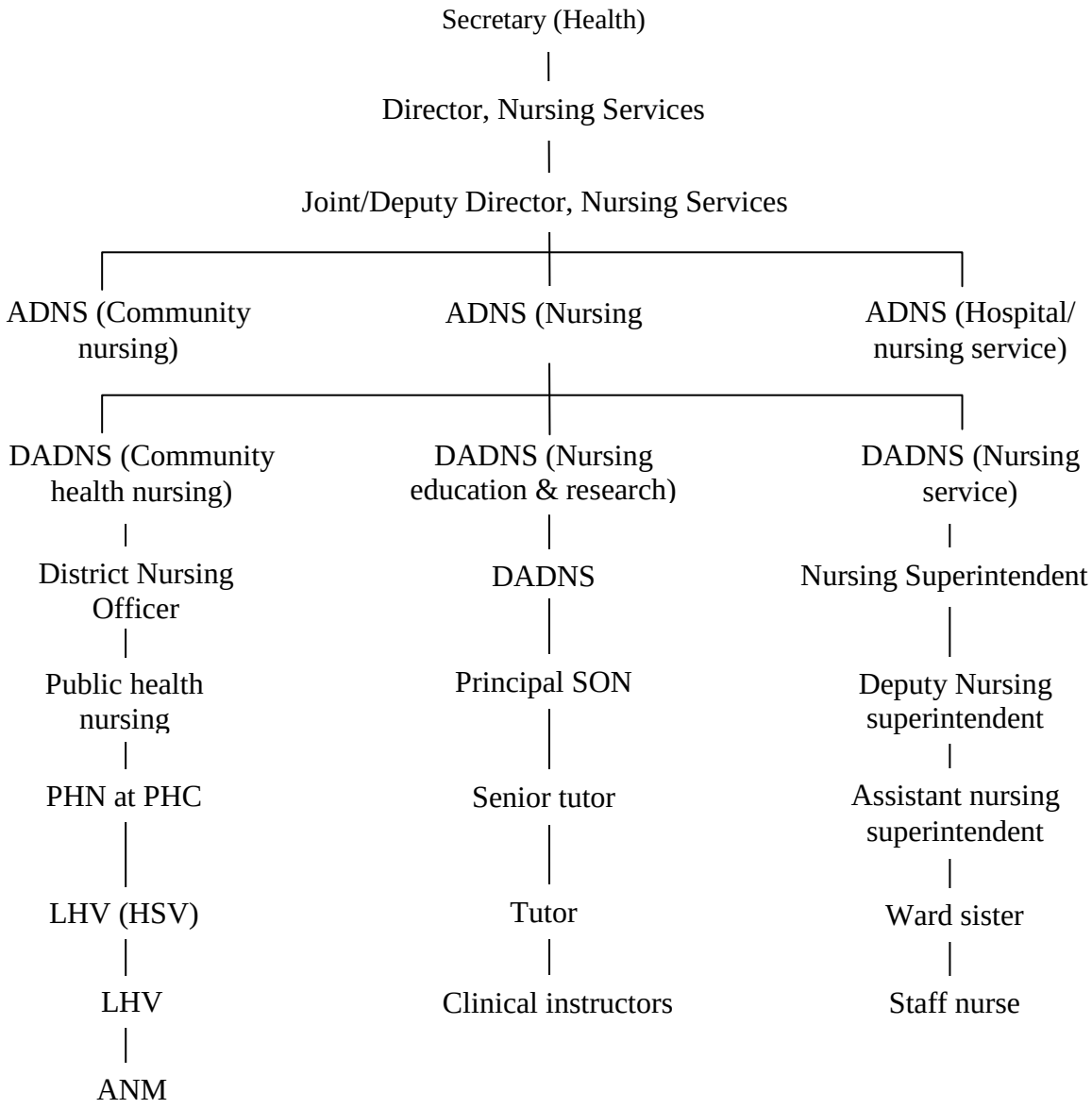
Placement of nurses at state level

There is no proper and definite pattern of nursing structure in the state directorates except the state of West Bengal. Usually one or two nurses are posted with varying

designations, e.g., in Tamilnadu there is one assistant director nursing who is responsible to Director, Medical Services, and Director, Medical Education.

In Maharashtra, two nurses work, one each in the office of the Director, Medical Education, and Director, Health Services.

Recommended organization at state level (union territory level)



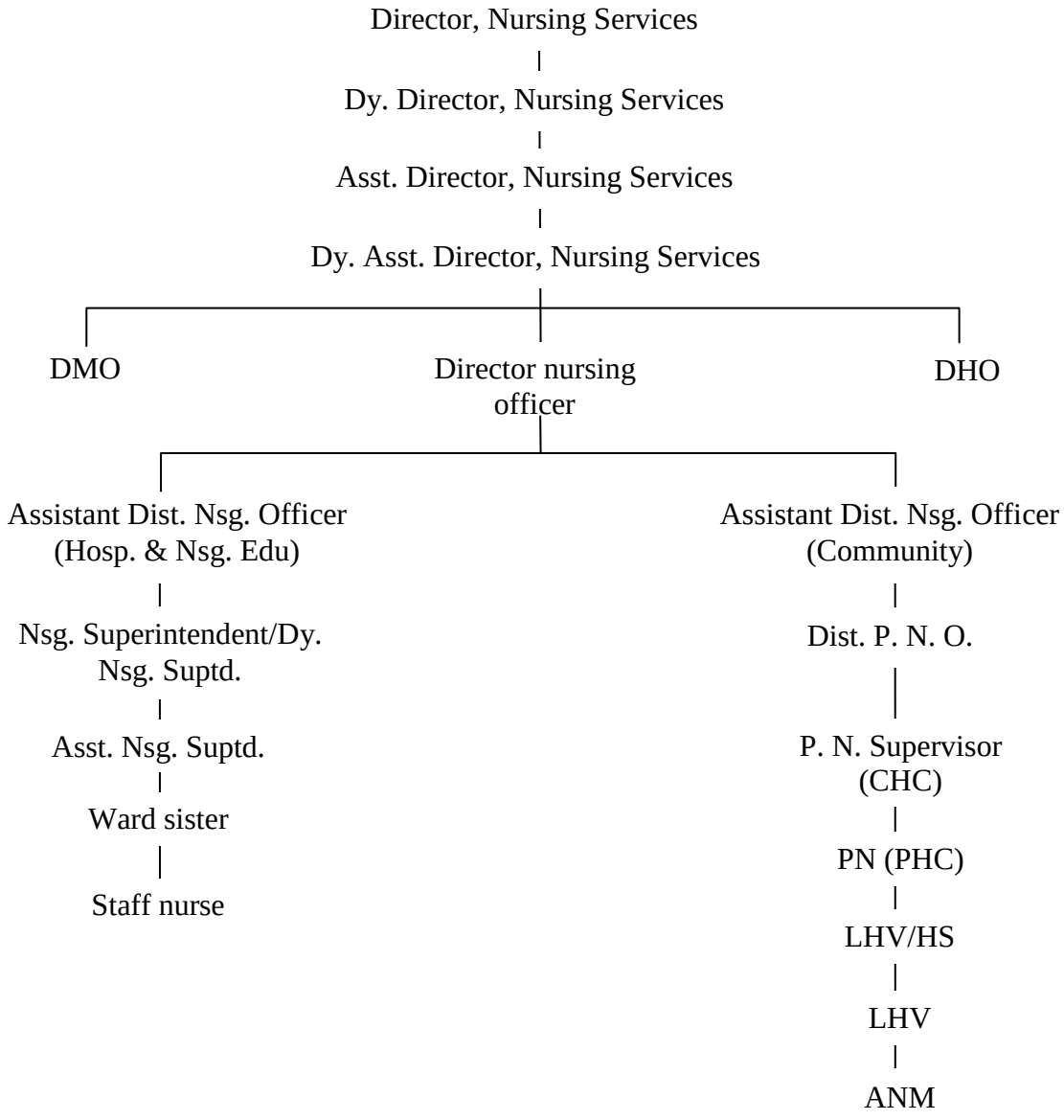
Note

The Principal, College of Nursing will be equal to the rank of ADNS and will be eligible for promotion to the post of DDNS/DNS. The salary scales and structure of the staff of colleges of nursing will be as per norms of the Indian Nursing Council and the UGC.

Placement of nurses at district level

Nurses, public health nurses, lady health visitors, auxiliary nurse midwives, etc. have played vital role in providing healthcare services at various levels in both urban and rural areas of the district. They have been the mainstream in providing primary healthcare services in the rural and urban areas from the very beginning.

Today, the ANM designated as multipurpose health worker is the key health worker rendering multipurpose healthcare services in the rural area. In this context, the professional nurses have a major role to play in providing support, guidance, supervision to ANMs (MAPHW-F) and also in rendering direct comprehensive healthcare services which is beyond the competency of the ANMs.



The above recommended organisational set up will need full administrative and financial support of the government. It will look after the overall nursing components,

development of nursing standards, norms, policies, ethics, recruitment, selection and placement roles__ for both hospitals and community health nursing, development in speciality nursing, higher education in nursing, and research. These will promote professional autonomy and accountability.

Conclusion

The purpose of health administration at the centre and local level is to improve the health status of the population. The scope of health services varies widely from country to country and is influenced by general and ever-changing national, state, and local health problems.

Bibliography

1. Park, K., "Preventive and Social Medicine", 19th Edition, M/s. Banarasidas Bhanot Publishers, Jabalpur, 2007.

2. Goel, S. L., "Healthcare System and Its Management, Health Organisation and Structure", 1st Volume, 2001, Deep and Deep Publishers, New Delhi.

3. Basavanthappa, B. T., "Nursing Administration", 2nd Edition, Jaypee Brothers Publishers, New Delhi, 2008.

4. S. L. Goel, R. Kumar. Management of hospitals – hospital administration in the 21st century", Vol. 4, 2002, Deep and Deep Publication, New Delhi.

5. S. P. Ranga Rao, "Administration of primary health centres in India", 1st edition, 1993, Mittal Publications, New Delhi.

6. Lucita M. Nursing: Practice and public health administration. Current concepts and trends. New Delhi: B. I. Churchil Livingstone Pvt. Ltd.; 2002.

Journals

1. Primary healthcare. The WHO report, 2008. Now more than ever. WHO.

Organization and Functions of Nursing Services and Education At

INSTITUTIONAL LEVEL – AT HOSPITAL,

INTRODUCTION

Nursing services is an important component of hospital and health services. A hospital may be soundly organized, beautifully situated and well equipped, but if the nursing care is not of high quality the hospital will fail in its responsibility. Although there is a historical association between medicine and nursing, as both of them are involved in direct patient care, one of the persistent problems is that of defining what nursing care should be, and what is distinctive about it. Nursing has to function within structured as well as unstructured pattern of relationship, and numerous external factors affect the nurses. Although with a proper organization of nursing services and defining their function appropriately in hospital and community we can improve the standard of the profession.

ORGANIZATION OF NURSING SERVICES AND EDUCATION

- **Director of nursing**

Nursing services must function under a senior competent nursing administrator – variously called as director of nursing, nursing superintendent, principal matron, or matron-in-chief. She is responsible to the hospital administrator for overall programme and activities of nursing care of all patients in the hospital. Nursing programme is administered by her through appropriate planning of services, determining nursing policies in collaboration with hospital management and nursing procedures in collaboration with nursing staff, giving general supervision, delegation of responsibility, coordination of interdepartmental nursing activities', and counselling the hospital administration on nursing problems.

She has a dual role: the first one is the administrative responsibility towards hospital administration, and the second one is the coordinating of all professional activities of nursing staff with those of medical staff.

The role of the nursing superintendent starts in a new hospital from helping to establish the overall goals, policies and organization, and facilities to accomplish these goals in the most effective and efficient manner. The functional elements of the role of nursing superintendent includes the following

→ Formation of the aims, objectives and policies of nursing services as an integral part of hospital service
→ Staffing based on nursing requirements in relation to accepted standard of medical care
→ Planning and directing nursing services
→ Maintaining supplies and equipments

→ Budgeting
→ Records and reports

- **Nursing supervisor**

Each department or clinical division, e.g. Medical, surgical, obstetrical, operation theatres, outpatient department, nurseries, etc. should have a supervisor. As they may be more than one nursing unit in each division or department, supervisors have a general administrative and coordinating function within their respective division. However, supervisors will also have limited clinical functions

- **Head nurse / nursing tutor**

A head nurse is assigned to a nursing unit, or ward, or a section of department. She works under the general direction of the supervisor of the division.

- **Staff nurse / clinical instructor**

Staff nurses are employed at the 'floor' level for carrying out skilled bedside nursing. This is the real work force of the hospital upon whose competency, state of training and dedication depend the success of the nursing department.

- **student nurse**

Students nurse cannot be employed on nursing duties except under supervision of fully qualified staff nurses.

POLICIES AND PROCEDURES

In order that a good standard of nursing care be maintained, the nursing superintendent should develop written policies and procedures to serve as a guides for nurses of the various units of the hospital. Important topics that should be incorporated are as follows

- Organisation
- Status and relationship
- Responsibilities
- Staffing pattern, shift pattern
- Departmental functions
- Requisitioning of supplies
- Utilization, care and maintenance of equipment
- Nursing procedures, coordination with domestic services
- Handling of the patients clothing and valuables
- Isolation technique
- Transfer of patients
- Record and reports

- Private nurses
- Use of restraints
- Procedure following death of patients

FUNCTIONS

Of hospital in nursing services and education

- As a basic function, to assist the individual patient in performance of those activities contributing to his health or recovery that he would otherwise perform unaided has had the strength will, or knowledge.
- As an extension of the above basic function, to help and encourage the patients to carry out the therapeutic plan initiated by the physician
- As a member of health team, to assist other members of the team to plan and carryout the total programme of care

AT COMMUNITY

PHCs (Primary Health Care)

Introduction

The PHC is the first contact point between the village community and the medical officer. These are established and maintained by the state government under minimum needs/ basic minimum services programme. It acts as a referral unit for six sub centre and has 4-6 beds. A PHC covers population of 30000 in plain area and 20000 in hilly remote and tribal area. The activities of PHC's involve curative, preventive, promotive and family welfare services. The number of PHC's functioning in the country is 22975.

Definition

Primary health centre is the basic structural and functional unit of public health services for rendering primary health care in peripheral areas.

Elements of PHC

e- Ensure safe water supply
l- Locally endemic disease control
E- Education/ expanded programme on immunization
m- Maternal and child health
e- Environmental sanitation
n- Nutritional services
t- Treatment of minor aliments
s- School health services

Standards of PHC

The IPHHS for PHCs has been prepared keeping in view the resources available with respect to functional requirement for PHCs with minimum standards such as-

- Building

- Man power
- Instrument
- Equipments
- Drugs
- Other facilities

The standards prescribed are , a PHC covering 20000-30000 population with six beds on well the block level PHC are ultimately going to be upgraded as CHC with 30 beds of providing specialized services.

The objectives of IPHS for PHCs are:-

→ To provide comprehensive primary health care to the community through the PHC

→ To achieve and maintain an acceptable standards of quality of care

→ To make the services more responsible and sensitive to the needs of the community

Staffing pattern

The man power that should be available in the PHC is as follows

STAFF	**EXISTING**	**RECOMMENDED**
Medical officer	1	3(at least 1 female)
AYUSH practitioner	-	1
Accountant manager	-	1
Pharmacist	1	2
Nurse midwife(staff) nurse	1	5
Health worker	1	1
Health educator	1	1
Health assistant (m/f)	2	2
Clerks	2	2
Laboratory technician	1	2

Driver	1	OPTIONAL / vehicle may be from out side
Class IV	4	

Major role of nurse in PHC

- Facilitative role
- Developmental role
- Clinical role
- Supportive role
    - ✓ Supervision
    - ✓ Training
    - ✓ Management
    - ✓ Programme planning
    - ✓ Policy making
    - ✓ Programme implementation
    - ✓ Programme evaluation

CHCs (community health centres)

Introduction

The community health centres are established and maintained by state government under MNP/BMS programme. It has 30 indoor beds with x-ray labour room, operation theatre, and laboratory facilities. It is managed by four medical specialists i.e. surgeon, physician, gynaecologist and paediatrician. On 31st march 2003, 3076 CHC were established each covering a population of 80000 to 1.20 lakh. The community health officer is selected from the supervisory category of staff at PHC and district level with minimum 7 years experience in rural health programmes. CHC serves as a referral centre for 4 PHCs and also provide facilities for obstetric care specialist consultant.

Definition

Community health centres are the non profit community governed health organizations that provide primary health care, health promotion and community development services, using them inter disciplinary terms of health providers.

Principles

- Excellence
- Innovations
- Accountability
- Collaboration
- Accessibility
- Integrity
- Environment

Elements

- Primary care
- Illness prevention
- Health promotion
- Community capacity building
- Service integration

Standards of CHC

In order to provide quality care in CHCs IPHS are being prescribed to provide optimal expert care to the community and achieve and maintain an acceptable standards of quality of care. These standards would help to monitor and improve the functioning of CHCs.

CHCs has to provide the following services like

→ Care of routine and emergency cases in surgery

→ Care of routine and emergency cases in medicine

→ 24 hour delivery services

→ Essentials of emergency obstetric care.

→ Full range of family planning services including laparoscopic services

→ Safe abortion services

→ New born care

→ Routine and emergency care of sick children

→ Other management of medical and accidental conditions

→ All the national health programmes should be delivered through CHCs

Like

- ✓ RNTCP
- ✓ HIV/AIDS control programme
- ✓ National vector born disease control programme
- ✓ National leprosy irradiation programme
- ✓ National control programme for control of blindness

→ Others

- ✓ Blood storage facility
- ✓ Expert laboratory services
- ✓ Referral services

CONCLUSION

Rural population takes the help of PHCs and CHCs for meeting the health needs. According to the new Indian public health standards all the staffing pattern, component and activities has been recorded for PHC and CHC, the ultimate aim is to strengthen the first referral centres and make each independent to handle the minor and some emergency cases

BIBLIOGRAPHY

1. B.M Sakharkar, principles of hospital administration and planning, 2nd edition, 2009, jaypee brothers medical publishers(p)Ltd New Delhi, page no: 97-105
2. Park. K, text book of preventive and social medicine, 20th edition, BB publishers, page no: 805-815
3. S. Kamalan, essentials in community health nursing practices, 1st edition, JP brothers medical publishers, new Delhi, page no: 152- 159
4. Krishna Kumari Gulani, community health nursing ,principles and practices, 1st edition 2005, Kumar publishing house, Delhi, page no: 590- 607
5. B.T Basavanthappa, Nursing administration, 1st edition 2002, jaypee brothers medical publishers Delhi, 540- 579, 450- 473, 386- 409, 165- 198

7. HEALTH PLANNING

A health plan is a predetermined course of action that is firmly based on the nature and extent of health problems, from which are devised priority goals (WHO)

Health planning is the phase of the total process which leads from the policy statements to the concrete identification of the populations whose needs and demands will be served, the indication of the types of activities that will be performed for those population, with their general attributes and the specification of the type of instruments that will be required to carry out the activities.

-DrMontoya

National Health Planning is the orderly process of defining Community Health Problems, identifying unrnet needs and surveying the resources to meet them, establishing priority goals that are realistic and feasible and projecting administrative action to accomplish the purpose of the program.

-WHO

Objectives of Health Planning

Health planning is an integral part of the overall socioeconomic development. It is in essence an organized, conscious and continual exercise to select the best available alternatives which can meet the health needs of the people.

Country Health Planning is essentially a national effort. It has been successfully employed in Burma, Nepal and Thailand.

CHPs main objectives are:

1. To clarify the nature of existing health problems within the total social, cultural, economic and political context,
2. To clarify interrelationships between the health sector, its components and various social and economic factor,
3. To identify national objectives, as far as possible, in quantifiable terms,
4. To identify new and existing program areas,
5. To help elaborate alternative strategies and to produce feasible programs for choice by decision making,
6. To define mechanism for the formulation and implementation of projects and to suggest procedures as a long-term goal, for a more rational allocation of resources in the field of health, and.

Levels of Planning

Planning and policies are interrelated, policy determine the principle for action and planning provides the instruments for the application of policy and review. Polio decisions are needed in the planning process and defining its goals and limitations. The planning proc has various possible feedback effects on policy.

Input ---------- _Political system and processes

Classification ----------. Policy ---------- Policy changes
Coordination etc

basic decisions of framework which enables and guides the process of

Plan formulation

'

Implementation

'

Impact on reality

Relationship between policy and plan

The planning process.

- Requires explicit policy statements, thus bringing subjects to the political arena
- Should reflect the rationale of the policies, show how they can be implemented, and indicate their financial and other implications,
- Provides the policy making with instruments for dialogue, coordination, mobilization of resources, and continuity of action,
- Impact on the national situation should influence future policy making.

There are mainly three levels in planning:
i. central level,
ii. intermediate level and
iv. peripheral level

Central Level

At central level, authorities will laid down the directional planning often called policy planning, is concerned with setting of the framework of an intent philosophy within which the program will function.
The authority of central level is responsible for:

- Laying down broad policies and guidelines for socioeconomic development,
- Defining overall goals and objectives,
- Giving rough indication of the allocation of available funds and other resources to the various government departments or sectors of economy, and
- Coordinating the planning activities of these departments and sectors as well

as the plans submitted by them. This authority should be strong enough to have its decisions adapted by the Government.

For the health plan, administrative capacity at the central level is generally vested in planning committee in the Ministry of Health. Usually the committee has a wide range of responsibilities as follows:

- Establishing policies, goals and standards relating to overall health planning,
- Reviewing the overall health plan developed by the National Health Planning Unit,
- Coordinating the implementation of the health plan,
- Collaborating with national planning authorities and with responsible persons in that social and health services, universities and Public Works departments,
- Cost-analysis, budgeting and acquiring adequate funds relating,
- Establishing standards relating to services, personnel equipment, architectural design of health institution, etc.
- Coordinating research related to health and health planning,
- The continuing evaluation of progress, and
- Advising administrative authorities at the intermediate and peripheral levels.

Intermediate Level

At intermediate level authorities will lay down the administrative planning. Administrative planning is concerned with the overall implementation of the policies developed and with the mobilization and coordination of the personnel and material available in the administrative unit for the effectuation of the service. It is for this goal that general objectives, procedures and regulations are usually set. Hence, the responsibility of the authorities of this level are mainly managerial and technical, one of their principal task being the expression in cooperation with development planners of the centrally established standards in terms of the detailed requirements of the situation at that level.

They will also involve some or all of the following:

1. Detailed budgeting,
2. Assessment of planning initiative of the peripheral level,
3. Estimation of supplies and equipment required for implementation of health plan at the intermediate level,
4. Coordination of the purchase and supply of equipment,
5. Determination of staff requirements for health institutions and services, and
6. The training and provision of adequate number of essential personnel.

Peripheral Level

The operational planning is carried out at peripheral level. It is concerned with the actual delivery of the services to the public. In general this responsibility is one of the field rather than office staff, although supervisory, consultative and administrative

staff serve in an advisory and to some extent in a controlling capacity. Although, field staff do planning that is integral to their own responsibilities, the administrative staff must assure a sound agency plan that allows for local variations without subverting the policies established by the policy planning group or failing to comply with reasonable directions and general objectives established by the administrative planning group agency as a whole.

At the peripheral level, planning authorities will be responsible for:

a. Informing the authorities at the intermediate level of local problems that must be taken into account in detailed planning
b. Securing the cooperation of local bodies, and
c. Coordinating health activities carried out by basic health services, health centres and general practitioners.

The authorities also are involved in the design and onsite supervision of the construction of local health services facilities and of accommodation for service personnel an students with the preparation of detailed lists of necessary supplies and equipment with the listing of staff requirements and the selection and training of intermediate an junior staff with the preparation of job descriptions standards, working procedures and program of operational research.

Constraints of Health Planning

There are a number of factors which stand on the way of effective health planning as follows:

- Lack of adequate health information system for planning and monitoring and ultimately for evaluation.
- Natural resistance to change.
- The relatively low priority often accorded to health by political decision makers and the public.
- Absence of trained health administrators and health planners.
- Time lag between planning and implementation.
- Lack of adequate inters professional communication.
- The inflexibility of educational system.
- Inefficient administrative practices.
- Inadequate coordination of planning between the different sectors of socioeconomic development.

LEVELS OF PLANNING IN INDIA

The Planning Commission of India gave considerable importance to Health Programs in the Five Year Plans. For purposes of planning, the health sector has been divided into the following subsector.

1. Water supply and sanitation
2. Control of communicable diseases
3. Medical education, training and research
4. Medical care including hospitals, dispensaries and primary health centers.
5. Public health services
6. Family planning; and
7. Indigenous systems of medicine.

The emphasis has changed from Plan to Plan depending upon the felt-needs of the people and technical considerations.

Central Level

At the Union Level, we have Planning Commission and associated bodies who look into all the aspects of Planning in India as follows:

Planning Commission

The Planning Commission was thus established on 15th March, 1950 by Cabinet resolution with its functions defined as follows:

a. Make an assessment of the materials, capital and human resources of the country, including technical personnel, and investigate the possibilities of augmenting such of these resources as are found to be deficient in relation to the nation's requirements.
b. Formulate a plan for the most effective and balanced utilization of the country's resources.
c. On a determination of priorities, define the stages in which the plan should be carried out and propose the allocation of resources for due completion of each stage.
d. Indicate the factors which are tending to retard economic development and determine the conditions which, of view of the current social and political situation, should be established for the successful execution of the plan.

Role of the Planning Commission Planning*:*

- Commission essentially an advisory body of the Government. It has neither constitutional nor even statutory authority. It is only when the plan formulated by the Commission is approved by the Cabinet that it receives the necessary sanction.
- The Government of India set up a Planning Commission in 1950 to make an

assessment of the material, and capital human resources of the country, and to draft developmental plans for the most effective utilization of these resources.

- ❖ The Planning Commissions consist of a Chairman, Deputy Chairman and 5 members.
- ❖ The Planning Commission works through 3 major divisions-Program Advisers, General Secretariat and Technical Divisions which are responsible for scrutinizing and Technical Divisions which are responsible scrutinizing and analyzing various schemes and projects to be incorporated in the Five Year Plans.

The Prime Minister of India has been the Chairman of the Planning Commission. The Prime Minister attends only the most important meetings of the Commission and maintains a certain amount of detachment from its day-to-day work. The day-to-day work of the Commission is looked after by a Deputy Chairman of the rank of the Cabinet Minister. The other members of the Commission are Union Ministers for Finance, Defence and Human Resource Development and six full time members, who have the rank of the Minister of State. There is normally a full-fledged Secretary to the Planning Commission but sometimes he is designated as Member-Secretary of the rank of the Minister of State.

Office of the Commission: The office of the Planning Commission consists of three types of branches

i) general branches,
ii) subject branches, and
iii) house keeping branches.

(i). The general branches either carry out studies related to the plan as a whole, rather than to any particular sector of it or coordinate the work of the various subject branches. There are altogether 10 general branches in the Planning Commission perspective planning, statistics and surveys, economic plan coordination and program administration, resources and scientific research international trade and development, labour and employment, public cooperation and information and publicity.

(ii).***The subject branches*** are altogether twelve in number, e.g. agriculture, community development and cooperation, local works, irrigation and power, oil and minerals, village and small industries, transport and communications, education, health, housing and social welfare.

(iii). The main housekeeping branches are administration and general coordination.

The staff of the planning commission comprises of administrators, technical officers and secretarial and other junior personnel. Most of them are economists and statisticians but there are also a number of physical scientists.

Advisory bodies: In an economy of the size and complexity of India there is a need to consult, from time to time, other knowledgeable people, especially non official experts, at various stages of formulation as well as implementation of the plans in regard to general policy at different levels technical, administrative and political. This objective is sought to be achieved through a number of standing bodies in the form of panels, advisory committees or consultative committees.

The most important advisory bodies are:

- Consultative committee of Members of Parliament for the Planning Commission
- The Prime Minister's informal consultative committee for planning.

The first Committee which is presided over by the Minister of Planning consists of about 30 members, 20 from the Lok Sabha (lower House) and 10 from the Rajya Sabha (Upper House).

The main object of this committee is to provide a forum for detailed discussions between Members of Parliament and the Members of the Planning Commission on the principles and problems of planning in a manner which is not practicable on the floor of Parliament.

The second Committee is a much smaller body and comprises representatives of the political groups in Parliament and is presided over by the Prime Minister himself. It gives an opportunity to the opposition leaders to take an intimate part in the work of planning and thus helps in making the plan something more than a document prepared merely by the Government.

Associated bodies: It is obviously impossible for a single organization to deal effectively. The Planning Commission has, therefore to take continuous help from a number of associated bodies.

The most important associated bodies are the Central Ministries. These Ministries are closely associated with work of planning not only through their various executive departments, research institutes and advisory committees, on many of which the Planning Commission itself is represented, and this facilitates a two-way interaction of ideas.

The Ministry of Finance has naturally closest relation with the Planning Commission as finance plays a most important role in any planning exercise.

Apart from the Central Ministries, there are two official organizations. They are:

i) The Reserve Bank of India and
ii) The Central Statistical Organization,

Which are closely associated with the work of the Planning Commission. There is an economics department in the Reserve Bank, which keeps a close touch with the work of the Commission and undertakes a number of important studies on financial and banking matters for the Commission.

The Central Statistical Organization is responsible for organizing the collection of all statistical data required for the purpose of planning. The Director General of the Central Statistical Organization is also the Ex-officio Head of the Statistics and Survey Division of the Planning Commission.

National development council*:* The National Development Council (NDC) is the advisory body which could be said to rival the Planning Commission itself in importance. Its creation was suggested by the Commission in the Draft Outline of the first 5 year plan, where it is said that the need had arisen for a forum at which, from time to time, the Prime Minister of India and the Chief Ministers of the States can review the working of the Plan and of its various aspects. Its establishment (6 August, 1952) was effected by Cabinet resolution.

It defined its **functions** as follows:

i. To review the working of the National Plan from time to time

ii. To consider important questions of social and economic policy effecting national development,

iii. To recommend measures for the achievement of the aims and targets set out in the National Plan, including measures to secure the active participation of the administrative services, ensure the fullest development of the less advanced regions and sections of the community and through sacrifices borne equally by all citizens, build up resources for national development.

It consists of the Prime Minister, the Chief Ministers of the States, and the members of the Planning Commission, but its meetings are usually attended by others as well. Ministers of the Central Government with an interest in the items included on its agenda invariably attend, States sometimes send one or two Ministers in addition to Chief Ministers, and "outsiders" such as eminent economists or the Governor of the Reserve Bank of India are often called on to give advice.

State Level

At the state level, there is State Planning Department directly under the control of Chief Minister. This department undertakes liaison with the Central Planning Commission and various departments including Health and FW of the State to Co-ordinate their development programs and formulates the development plan for the State.

District and Block Level

Next to the State level are district and block levels. This is done jointly by the Officers of the various development departments including Health and Family Welfare. Working at these respective levels and the members of the District Councils or Block Councils and/ or the non official representatives. District Collectors and Block Development Officers are responsible for necessary coordination at the district and block levels respectively. An attempt is being made to carry the process of planning further down to the village level and it has been also tried out in certain areas.

8. FIVE YEAR PLANS

The five year plans were conceived to re-build rural India, to lay the foundations of industrial progress and to secure the balanced development of all parts of the country. Recognizing "health" as an important contributory factor

Objectives

The broad objectives of the health programs during the five year plans have been:

1. Control or eradication of major communicable diseases;
2. Strengthening or the basic health services through the establishment of primary health centres and sub centres;
3. Population control; and
4. Development of health manpower resources.

First Five Year Plan

Prior to the commencement of the first five year plan, the health status of the people of India was very low, which includes:

- Lack of hygienic environment sanitation conducive to healthy living
- Low resistance power due to lack of adequate diet
- Prevalence of malnutrition and poor nutrition
- Lack of proper housing, supply of pure drinking water and proper disposal of human wastes
- Lack of medical care
- Lack of general and health education, and
- Low economic status.

And inadequate financial resources and lack of trained health personnel the whole program of health developments was tied with a broader program of social development.

While considering the above facts, a seven point public health program with the following priorities formed the basis of the first five year plan:

1. Provision of water supply and sanitation.
2. Control of malaria.
3. Preventive health care of the rural population through health units and mobile units.
4. Health Services for mothers and children.
5. Education and training and health education.
6. Self-sufficiency in drugs and equipment.
7. Family planning and population control.

During this plan period the public sector outlay was Rs. 2,356 crores of which Rs. 140 crores (5.9%) were allotted for health programs. The.actual expenditure, however, amounted to Rs. 1960 crores and Rs. 101 crores respectively.

Second Five Year Plan 1956-61

The second five year plan was continuation of the development efforts commenced in the first plan. It included all communicable diseases in addition to control of malaria. The specific objectives were:

1. Establishment of institutional facilities to serve as a basis from which services could be rendered to the people both locally and in surrounding territories.
2. Development of technical manpower through appropriate training programs.
3. Intensifying measures to control widely spread communicable diseases.
4. Encouraging active campaign for environmental hygiene.
5. Provision of family planning and other supporting services for raising Health standard of the people.

The different areas emphasized during the second FYP were:

i. Health care services in rural and urban areas
ii. Medical education and training
iii. Medical research
iv. Indigenous systems of medicine
v. Control of communicable diseases
vi. MCH and family planning and
vii. Health education.

During this period, the public sector outlay was Rs. 4,800 crores, of which 225 crores were allotted to the health programs. The actual expenditure, however, amounted to Rs. 4,672 crores and 215 crores respectively.

Third Five Year Plan 1961-66

The objectives of the third five year plan were in tune with the first and second five year plans except that integration of public health with maternal and child welfare, nutrition and health education was planned. In general, the third five year plan focused on the following areas:

- Water supply environmental sanitation (rural and urban)
- Health care (hospitals and dispensaries)
- Control of communicable diseases
- Medical education, research and training
- Other services-health education, school health, MCH, mental health, health insurance
- ISM and Family Planning.

While continuing the program initiated in the previous plan period, greater emphasis was placed on preventive health services and on the eradication and control of communicable diseases.

During this period the public sector outlay was Rs. 7,500 crores, of which, Rs. 341.80 crores allotted for health programs. The actual expenditure, however, amounted to Rs. 8,577 crores and Rs. 357 crores respectively.

Annual Plans 1966-69

The fourth FYP which was to commence from April 1966 was postponed till 1969 due 59 uncertain economic situation in the country (due to Indo-Pak war). During this intervening period, (1966 to 69) was covered by Annual plans with an outlay of Rs. 6,756 crores in the public sector of which the expenditure on health programs was Rs. 316 crores (4.7%).

Fourth Five Year Plan 1969-74

During this period the revised estimate of public sector outlay was 16,774 crores, of which Rs. 1,156 crores (7.2%) were allotted to health sector. Certain objectives of the Mudaliar Committee were the base for the fourth five year plan in relation to health. These are as follows:

- To provide an effective base for health services in rural areas by strengthening the primary health centres,
- Strengthening of sub divisional and district hospitals to provide effective referral services for primary health centre, and
- Expansion of the medical and nursing education and training of paramedical personnel to meet the minimum technical manpower requirements.

In the fourth plan, public health and medical programmes had been divided into the following broad categories:

- Medical education, training and research,
- Control of communicable diseases,
- Medical care including hospitals, dispensaries and PHCs,
- Other public health services, and
- Indigenous systems of medicine.

In this period, efforts were made to strengthen the primary health centre complex in the rural areas for undertaking preventive and curative health services and for ensuring the maintenance phase of the communicable diseases control and eradication programs.

Achievements from First FYP to Fourth FYP

The emphasis of the plan was on removing imbalance in respect of medical facilities and strengthening the health infrastructure in rural areas, specific objectives to be pursued during the plan were:

- Increasing accessibility of health services to rural areas,
- Correcting regional imbalance,
- Further development of referral services by removing deficiencies, in district and sub divisional hospitals,
- Integration of health, family planning and nutrition,
- Intensification of the control and eradication of communicable diseases especially malaria and small pox,
- Quantitative improvement in the education and training of health personnel by

converting unipurpose workers to multipurpose workers,

- Development of referral services by providing specialists attention to common diseases in rural areas.

During this plan period "minimum needs program" (MNP) to be operated through the State Government is considered to be of great importance and field certain targets like one PHC for 1,00,000 population, one sub enter for 10,000 population, correcting deficiencies related to establishment of these health centres and up gradation of one in every 4 PHC to the status of a 30 bedded rural hospital with specialised services. These targets of the MNP could not be achieved due to changes in national political systems.

Sixth Five Year Plan 1980-85

In the beginning the sixth five year plan was formulated against the background of a perspective covering a period of 15 years from 1980-81 to 1994-95. The main objectives were:

- Progressive reduction in the incidence of poverty and unemployment.
- To step up the rate of growth of the Indian economy.
- Promoting policies for controlling the population growth through voluntary acceptance of the "small family norm".
- To improve the quality of life of the people in general through "minimum needs program". The sixth plan laid emphasis on-health care, control of communicable diseases, hospital and dispensaries in urban / rural areas, medical education, research, training, ISM and homeopathy, other programs and family welfare.

Minimum needs program, which was started during fifth plan continued with same objective as follows:

Minimum Needs Programs (MNP)

MNP was first introduced in fifth FYP to combat poverty. The State has a duty to provide the basic needs of life to every citizen-need in terms of health, food, education, water, shelter, etc. MNP is the expression of the commitment of the Government for the socioeconomic development of the community particularly the underserved and underprivileged segment of population.

Government considers investment in health as investment in human resources development and as such primary health care forms are essential and integral component of the MNP. It is a broad intersectorial master plan for providing the minimum basic needs of the people of the land including the following in revising MNP 1978.

1. Elementary education,
2. Adult education,
3. Rural health,
4. Rural water supply,
5. Rural road,

6. Rural electrification,
7. House sites/houses for rural landless labourers,
8. Environmental improvement of slums,
9. Nutrition.

The basic principles to be observed in the implementation of the minimum needs program are:

1. The facilities under MNP are provided on priority basis first only in those areas which are at present underserved, so that the disparities from area to area are eliminated and every segment of the population is assured of minimum essential facilities.
2. Intersectorial area project so that all the facilities unde the MNP are provided as a package to a broad area. This would ensure a greater impact of the facilities provided. For this purpose, it is necessary to develop an effective inter department coordination mechanism at State and District levels to ensure that the various departments get responsibility for implementation of MNP for selected area.

Eighth Five Year Plan (1992-97)

The ultimate goal of the eighth plan is the Human Development, in many facets. It is towards fulfilling this goal that the eighth plan accords priority to the generation of adequate employment opportunities to achieve near-full employment by the turn of the century building up of the people's institutions, control of population growth, universalization of elementary education, eradication of illiteracy, provision of safe drinking water and primary health facilities to all, growth and diversification of agriculture to achieve self-sufficiency in food grains and generate surpluses for exports. So, in this 5 year plan, employment generation, population control, literacy, education, health, drinking water and provision of adequate food and basic infrastructure are listed as priorities. All these aspects contribute to the health of the people.

In relation to **health,** this plan period has the following:

The health facilities should reach the entire population by the end of the eighth plan. The "Health for All" paradigm must take into account not only the high risk vulnerable groups, i.e. mother and child, but must also focus sharply on the underprivileged segments within the vulnerable groups. "Towards Health for the underprivileged" may be key strategy for the health for all by the year 2000.

The structural framework for the delivery of health, programs must undergo a meaningful re orientation, IS a way that the underprivileged themselves become the subjects of the process and not merely its objects. This can only be done through emphasising the community based system. Such systems must provide the base and basis of health planning, recognizing health and education, as key entry points for harnessing community development efforts. These systems must be reflected in the planning of infrastructure with about 30,000 population as the Unit.

Ninth Five Year Plan (1997-2002)

From the First Five Year Plan onwards, the Central and State governments have been making sincere efforts to build primary, secondary and tertiary care centres and to link them through appropriate referral systems. The Health Survey and development Committee headed by Sir Joseph Bhore submitted report in 1946 and recommended the establishment of well-structured and comprehensive health services with a sound basic health care infrastructure, laying equal importance on the need for safe drinking water supply, housing and sanitation.

During the Ninth Five Year Plan efforts will be made to explore the health status of the population by optimizing coverage and quality of care by: a) identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents and drugs, and b) enhancing the efficiency of the health system.

The approach during the Ninth Plan will be to:

1. Enhance the quality of the primary health care in urban and rural areas by providing an optimally functioning the primary health care system as part of the basic minimum services.
2. Improve the efficiency of existing health care infrastructure at primary, secondary and tertiary care setting through institutional straightening and improvement of referral linkages.
3. Promote the development of human resource for health, adequate in quantity and appropriate in quality, so that access to essential health care service is available to all, and there is improvement in the health science, update knowledge and upgrade skills of all workers and promote cohesive team work.
4. Increase the involvement of voluntary, private organizations and self-help groups in the provision of the health care and ensure inter-sectoral coordination in implementation of health related activities.
5. Enable the Panchayat Raj institutions in planning and monitoring of health programmes at the local levels so that there is greater accountability to promote inter-sectoral co-ordination and utilize local and community resources for health care.
6. Improve the effectiveness of existing programmes for control of communicable diseases; achieve the horizontal integration of ongoing vertical programmes at the district and taluk levels; strengthen the disease surveillance with focus on rapid recognition, reporting and response at district level; promote the distribution of the vaccines of assured quality at affordable cost; improve water quality and environment sanitation
7. Develop and implement integrated non-communicable disease prevention and control programme within the existing health care infrastructure.
8. Undertake screening for common nutritional deficiencies, especially in vulnerable group and initiate appropriate remedial measures; evolve and effectively implement programmes for improving nutritional status; including

micronutrient status of the population.

9. Strengthen programmes for prevention, detection and management of health consequences of the continuing deterioration of the eco-systems; establish link between data from ongoing environmental monitoring as also data on health status of the population residing in the area.
10. Improve the safety of the work environment and workers health in organized and unorganised industrial and agricultural sectors, especially among vulnerable groups.
11. Develop capabilities at all levels for emergency and disaster prevention and management; implement appropriate management systems for emergency disaster, accident and trauma care at all levels of health care
12. Ensure effective implementation of the provision for food and drug safety, strengthen the food and drug administration both at the Centre and in the states
13. Increase the involvement of Indian system of medicine and homeopathy practitioners in meeting the health care needs of the population
14. Enhance research capability with a view to strengthening basic, clinical and health system research aimed at improving the quality and outreach of services at various levels of health care.

During the Ninth Five Year Plan, the objectives will be to;

- Establish an education commission of health sciences with the assigned responsibility of planning and producing health manpower that is appreciate in quantity to present and projected needs of the health system
- Strengthen the educational process for all categories of the health professional at all the levels so that health care profession poses necessary knowledge and have appropriate skills, health programme orientation and people orientations
- Ensure continuing knowledge and skill up gradation of all health care providers through continuing education programme with emphasis on multi-professional problem-solving learning strategies.

Tenth Five Year Plan (2002-2007)

During the Tenth Plan, efforts will be further intensified to improve the health status of the population by optirnizing coverage and quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents and drugs.

The approach during the Tenth Plan will be to improve access to, and enhance the quality of primary health care in urban and rural areas by providing an optimally functioning primary health care system as a part of Basic Minimum Services and to improve the efficiency of existing health care infrastructure at primary, secondary and tertiary care settings through appropriate institutional strengthening, and improvement of referral

linkages.

The monitor able targets for the Tenth Five Year Plan and beyond are as follows (29).

1.Reduction of poverty ratio by 5% points by 2007, and by 15% points by 2021;
2.All children in school by 2003; all children to complete 5 years of schooling by 2007;
3.Reduction in gender gaps in literacy and wage rates by at least 50% by 2007;
4.Reduction in the decadal rate of population growth between 2001 and 2011 to 16.2%;
5.Increase in literacy rate to 75% within the plan period;
6.Reduction of infant mortality rate to 45 per 1000 live births by 2007 and 28 by 2012.
7.Reduction of maternal mortality ratio to 2 per 1000 live births by 2007 and to 1 by 2012; and
8.All villages to have sustained access to potable drinking water within the Plan period.

ELEVENTH PLAN (2007-2012)

1. Income & Poverty
    - Create 70 million new work opportunities.
    - Reduce educated unemployment to below 5%.
    - Raise real wage rate of unskilled workers by 20 percent.
2. Education
    - Reduce dropout rates of children from elementary school from 52.2% in 2003-04 to 20% by 2011-12
    - Develop minimum standards of educational attainment in elementary school, and by regular testing monitor effectiveness of education to ensure quality
    - Increase literacy rate for persons of age 7 years or above to 85%
3. Health
    - Reduce infant mortality rate to 28 and maternal mortality ratio to 1 per 1000 live births
    - Reduce Total Fertility Rate to 2.1
    - Provide clean drinking water for all by 2009 and ensure that there are no slip-backs
    - Reduce malnutrition among children of age group 0-3 to half its present level

4. Women and Children
    - Raise the sex ratio for age group 0-6 to 935 by 2011-12 and to 950 by 2016-17
    - Ensure that at least 33 percent of the direct and indirect beneficiaries of all government schemes are women and girl children
    - Ensure that all children enjoy a safe childhood, without any compulsion to work
5. Infrastructure
    - Ensure electricity connection to all villages and BPL households by 2009 and round-the-clock power.
    - Ensure all-weather road connection to all habitation with population 1000 and above (500 in hilly and tribal areas) by 2009, and ensure coverage of all significant habitation by 2015
    - Connect every village by telephone by November 2007 and provide broadband connectivity to all villages by 2012
    - Provide homestead sites to all by 2012 and step up the pace of house construction for rural poor to cover all the poor by 2016-17
6. Environment
    - Increase forest and tree
    - Attain WHO standards of air quality in all major cities by 2011-12.
    - Treat all urban waste water by 2011-12 to clean river waters.
    - Increase energy efficiency by 20 percentage points by 2016-17.

9. VARIOUS COMMITTEES REPORTS ON HEALTH

Bhore committee

Health Survey and Development Committee

The health survey and development committee, generally referred and popularly known as the Bhore committee. Although this committee was set up by British Colonial Authorities, was greatly influenced by the aspiration of the national movement. It was set up under propitious circumstances in 1943, when the freedom movement was nearing its climax and the end of colonial rule was in sight.

This committee was appointed by British Government of India in October 1943 under the chairmanship of Sir Joseph Bhore.

The Government of India appointed this committee in 1943 to make broad survey of the then existing health conditions and health organizations in the country and to make recommendations for further development.

The guiding principles adopted by the committees proposals for future health development in the country were:

- No individual should be denied to secure adequate medical care because of inability to pay for it.
- In view of the complexity of modem medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutions facilities necessary for proper diagnosis and treatment.
- The health program must from the very beginning, lay special emphasis on preventive work.
- As much medical relief and preventive health care as possible should be provided to the vast rural population of the country.
- The health services should be located/placed as close to the people as possible to ensure the maximum benefit to the communities to be served.
- It is essential to secure the active cooperation of the people in the development of the health program to stimulate health consciousness through health education.
- Health development must be entrusted to ministries of Health who enjoy the confidence of the people and are able to secure their cooperation.
- The doctor of the future should be a social physician protecting the people and guiding them to healthier and happier life. The basic training to the doctor should be designed to equip him for such social duties.
- The large amount of preventable suffering and mortality in the country mainly the result of an inadequate provision in respect of certain fundamental factors like environment conducive to healthful living, adequate nutrition, health protection to all members of the community irrespective of their ability to pay for it and the active cooperation of the people.
- The extent of provision of hospitals and dispensaries in rural areas has been considerably less than that in urban areas.

- Any expenditure of money and effort on improving the national health in gilt-edged investment yielding immediate and steady returns in increased productivity.
- Under the conditions existing in the country, medical service should be free to all without distinction and that should be through the channel of general and local taxation. It will for the governments of the future to decide ultimately whether medical services should remain free to all classes of people or whether an insurance scheme would be more suitable.
- For ensuring adequate health service for the vast rural population of the country and for overcoming the difficulty experienced in the past in attracting medical practitioners to the countryside, the most satisfactory method of meeting the situation would be to provide a whole time salaried service, thus enabling governments to ensure that doctors are made available where their services are most needed.

Recommendations

Bhore committee presented its report in 4 volumes in 1946 in which the committee observed if the nation's health is to be built, the health programs should be developed on a foundation of preventive health work and that such activities should proceed side by side with those concerned with the treatment of patients. Some of the main recommendations are as follows:

1. Integration of preventive and curative services at all administration level,
2. Development of Primary health centres in 2 stages. In short-term measure PHC in rural area should cater to a population of 40,000 with a secondary health centre to serve as a supervisory, coordinating and referral institution. For each PHC two medical officers, 4 public health nurses, one nurse, 4 midwives, 4 trained dais, 2 sanitary inspectors, 2 health assistants, one pharmacist and 15 other class IV employees. In long-term program (also called 3 million plan) of setting up PHC with 75 bedded hospital, for each 10,000- to 20,000 population and secondary units with 650-bedded hospitals with 2500 beds and,
3. Major changes in medical education which includes 3 months training in preventive and social medicine to prepare social physicians.

Health Survey and Planning Committee (1962)

As a result of launching several national health programs mostly of vertical nature around late 50's and early 60's actually end of second 5-years plan, 1956-61, a fresh outlook at the health needs and resources was called for to provide guidelines for national health planning in the context of 5 years plans.

The Government of India in the Ministry of Health set up a Committee in 1959 to undertake the review of the developments that have taken place since the publication of the Report of the Health Survey and Development Committee (Bhore Committee) in 1946 with a view to formulate further Health programs for the country in the third and subsequent 5 years *plan periods.*

The terms of reference of this Committee were: (i) the assessment (or evaluation) in medical relief and public

ealth since the admission of the Health Survey and Development. The terms of

references of the Committee are as follows: Committee's Report, (ii) review the first and second 5 year plans health plan projects; and (iii) formulation of recommendations for the future plan of the health

evelopment in the country.

Dr A Lakshminarayanaswami Mud aliar, Vice Chancellor, Madras University, was appointed Chairman of the Committee. The main committee was divided into six sub-committees to look into various aspects: (i) Professional Education and Research, (ii) Medical Relief, (iii) Public Health including Environmental Hygiene, (iv) Communicable Diseases, (v) Population problem and Family planning, and (vi) Drugs and Medical stores.

Recommendations

The Mudaliar Committee found the quality of services provided by the Primary Health Centers, inadequate, and advised strengthening of the existing primary health centers before starting new PHCs. It also suggested to strengthen the subdivisional and district hospitals so that they may effectively function as referred centers.

The main recommendations of Mudaliar Committee were:

- Consolidation of advanced efforts and achievements made in the first two 5 year plans in the field of health.
- Equipping district hospitals with specialist services.
- Need for regionalisation of health services, i.e. setting up of regional structures between the state and district head quarters.
- Each primary health center should serve not more than 40,000 people.
- The quality of care provided by the primary health center needs improvement.
- Integration of medical and health services should be achieved as already suggested by the Bhore Committee.
- Constitution of an All India Health Service on the pattern of Indian Administrative Service.

Chadha Committee (1963)

In the last 50s and early 60s the Government of India was, therefore seized with the problem of integrating the maintenance phase of the malaria eradication program with the general health services in the country consisting of subcenters, primary health centers, and district level organizations. The Government of India appointed a committee under the chairmanship of Dr MS Chadha, the then Director General of Health Services to study the arrangements necessary for the maintenance phase of the NMEP. The Committee known as "special committee on the preparation of entry of the NMEP into maintenance phase."

The committee recommended that the "vigilance" operations in respect of the NMEP should be the responsibility of the general health services, i.e. primary health centers at the block level. It also recommended that the vigilance operations through monthly home visits should be implemented through basic health workers.

The committee recommended that then existing malaria surveillance worker (MSW) may be changed into auxiliary health workers/basic health workers, one per 10,000 population supported and supervised by sanitary inspectors/health inspectors at the rate of one per 20-25,000 population for which an additional post of health inspector was to be

created in each of the blocks.

It recommended creation of the post oflaboratory technicians at the PHC and a post of a family planning field worker (FPFW) and family planning health assistant (FPHA) at the rate of one per 30,000 population to take care of the emerging problem of population growth and therefore, intensifying family planning measures.

It recommended that the services of the extension educator should be utilized for all the national health programs.

And it also recommended that the basic health workers envisaged as "multipurpose" workers to look after additional duties of collection of vital statistics and family planning in addition to malaria vigilance.

Mukherjee Committee (1965)

During the implementation of the Chadha Committee's recommendations by some of the states, it was realized that basic health workers (BHW) could not function effectively as multipurpose workers, and as a result the malaria vigilance operations had suffered and also the work of the family planning program could not be carried out satisfactorily. In 1965, this matter brought to the notice of central health council and discussed at the meetings.

A committee was appointed by the Government of India during 1965 to review the strategy of family planning, under the chairmanship of Shri Mukherjee, the then secretary of Health to the union Government.

The committee recommended separate staff for the family planning program. The family planning assistants (FP A) were to undertake family planning duties only. The BHWs were to be utilized for the purpose of other than family planning.

The Committee also recommended to delink the malaria activities from family planning so that the latter would receive undivided attention of its staff, the recommendation accepted by the Government of India.

Mukherjee Committee (1966)

When the meeting of Central Council of Health held in Bangalore during 1966, some of the states were finding it difficult to take over the whole burden of the maintenance phase of malaria and other mass programs like family planning, small pox, leprosy, trachoma, etc. due to paucity of funds and brought this matter to Council and discussed it. The recommendations of the committee were:

- There should be one FPFW for every two subcenters.
- That an extra post of LHV should be created so that one LHV is available for 40,000 population.
- That part-time workers for motivating population for acceptance of IUD should be appointed with honorarium.
- That at the block and district levels, education leaders be appointed for intensifying motivational campaign and be paid honorarium of Rs. 600/- per annum.
- That the government doctors may be provided incentives which should also be available to part-time private medical practitioners in terms of honorarium of Rs. 100

per month.

Jungalwalla Committee (1967)

The Central Council of Health at its meeting held at Srinagar in 1964, taking note of the importance and urgency of integration of health services and elimination of private practice by government doctors, appointed a committee known as the "Committee on integration of health services" under the chairmanship of Dr N Jungalwalla, Director, to examine the various problems including those of service conditions and submit a report to the central government in the light of these consideration. The report was submitted in 1967.

The Committee defined "Integrated health services" as:

1. A service with an unified approach for all problems instead of a segmented approach for different problems, and
2. The medical care of the sick and conventional public health programs functioning under a single administrator and operating in unified manner at all levels of hierarchy with due priority for each program obtaining a point of time.

Recommendations

The committee recommended integration from the highest to the lowest level in the services, organization and personnel. The main steps recommended towards integration were:

a. Unified care
b. Common seniority
c. Recognition of extra qualifications
d. Equal pay for equal work
e. Special pay for specialized work
f. No private practice
g. Good service conditions.

Kartar Singh Committee (1974)

As a result of launching of several national health programs, there .occurred tremendous variations in the categories of manpower requirement, which posed problems in terms of providing integrated services. This feasibility of integrating various categories of health manpower to the grass root level to provide integrated services having become available, the Government of India constituted a committee in 1972 known as "The committee on multipurpose workers under health and Family Planning" under the chairmanship of Sri Kartar Singh, Additional Secretary, Ministry of Health Family planning of the Union Government. So the committee came to be *popularly* known *as "Kartar* Singh commiittee."

The terms of reference of the committee were to study and make *recommendations on:*

1. Structure for integrated services *at* the *peripheral* and supervisory levels,
2. The feasibility of having multipurpose / bipurpose workers in the field,
3. The training requirement of such workers, and

4.The utilisation of mobile service units set-up under family planning program for integrated *medical,* public health and family planning services operating from Tehsil/ Taluq level.

Recommendations

Its main recommendations were:

a. That the present day ANMs to be replaced by the newly designated "Family Health Workers" and the present day Basic Health workers (BHW), Malaria Surveillance worker (MSW), Vaccinators, Health Education Assistant of Trachoma (HEAT) and FPHAs to be replaced by "Male Health workers".

b. The present day LHV s to be replaced by the newly designated "Female Health Supervisor" and creation of such additional posts (to supervise the female health workers) and clubbing of the posts of Health Inspectors, Sub- Inspectors, Malaria Surveillance Inspectors, Vaccinators, Supervisors together to make them into; "Male Health Supervisors" (to supervise 3-4 male health workers).

c. For proper coverage, there should be one primary health center for a population of 50,000.

d. Each primary health center should be divided into 16 subcenters each having a population of about 3000 to 3500 depending upon topography and means of communication.

e. Each subcenters to be staffed by team of one male and one female health worker.

f. There should be a male health supervisor to supervise the work of 3 to 4 male health workers and a female health supervisor to supervise the work of 4 female health workers.

g. *The* doctor in charge of a *primary health centre should* have the overall charge of *all* the supervisors and health workers in *his* area.

h. The program for having MPWs first to be introduced in areas where malaria is in maintenance phase and small pox has been controlled and later to other areas as malaria passes into maintenance phase or small pox controlled.

Shrivastav Committee (1975)

The issue of developing alternative strategy for the delivery of health services and rationalisation of the health manpower both in terms of number of personnel as well as categories of personnel had been engaging the attention of the Govt. of India from time to time. The Govt. of India in the Ministry of Health and Family Planning had in November 1974 set-up a "Group on Medical Education and Support Manpower" under the chairmanship of Dr JB Shrivastav, then the DGHS was established to focus on this issue.

The terms of reference of this committee were as follows:

1. To devise a suitable curriculum for training a cadre of health assistant conversant with basic medical aid preventive and nutritional services, family welfare, maternity and child welfare activities so that they can serve as link between the qualified *medical* practitioners and the multipurpose workers, thus forming an effective team to deliver health care, family welfare and nutritional services to the people.

2. Keeping in view the recommendations made by the earlier committees on Medical Education, specially the Medical Education Committee (1968) and the Medical Education conference (1970), to suggest suitable ways and means for implementation of these recommendations, and to suggest steps for improving the existing medical educational processes so as to provide due emphasis on the problems particularly relevant to national requirements, and
3. To make any other suggestions to realise the above objectives and matters incidental thereto.

Recommendations

After carefully examining various reports and papers relevant to the subject including the recommendations of as many as 12 conferences and committees, held earlier, Shrivastav Group, made following major recommendations:

1. A nationwide network of efficient and effective services suitable for our conditions, limitations and potentialities should be evolved
2. Steps should be taken to create bands of paraprofessionals or semi professional health workers from the community itself to provide simple, protective, preventive and curative services which are needed by the community
3. Between the community and the primary health center, there should be two cadres, health workers and health assistants.
   a. Health workers should be trained and equipped to give simple, specified remedies for day-to-day illness.
   b. Health assistants would work as intermediaries between the health workers and primary health centres. They also should be trained and equipped to give simple specified remedies for simple illnesses according to their level of technical competence.
4. The primary health center should be provided with an additional doctor and nurse to look after the maternal and child health services.
5. The possibility of utilizing the services of senior doctors at the Medical college, regional, district/ taluk hospitals for brief periods at PHC should be explored.
6. The primary health center as well as taluk hospital, district hospital, regional institution or medical college hospitals should each develop living and direct links with the community around them, as well as with one another within a total referral services complex.

The Government of India should constitute under an Act of parliament of Medical and Health Education Commission for coordinating and maintaining standards in Medical and Health education on the pattern of University Grants Commission

Mehta Committee 1983

The "Medical Education Review Committee" was headed by Shri Mehta, known as Mehta Committee 1983. The PartI of the report deals with medical education in all its aspects, but there is a major recommendation regarding the establishment of Universities of Medical Sciences and Medical and Health Education

Commissions.

Part-Il of the report specifically deals with the lack of availability of health manpower data in India, recommendations regarding the methods of updating such data and manpower projections for doctors, nurses and pharmacists.

The working group on medical education, training and manpower planning as one amongst eight working groups appointed by planning commission for formulating the VII 5-year plan had brought out some basic issues such as restructuring of organizational set-up, management reforms, decentralized planning.

The Group recommended that emphasis and high priority should be given to train paraprofessional and auxiliary personnel, so as to correct imbalances, it also laid down priorities for training of manpower given below:

1. Training and development of auxiliary personnel
2. Training and development of paraprofessional personnel
3. Basic and pre-service / induction training in public health management
4. Continuing education in health management and public health
5. Undergraduate medical education, and
6. Postgraduate medical education.

Committees Constituted by Govt of India with Regard to Nursing and Nursing Profession

Report of the Nursing Committee to Review Conditions, Emoluments, etc. of the Nursing Profession, Govt. of India, Ministry of Health and FW, Shetty Report (Shetty Committee, 1954)

The initial move for the appointment of the Nursing Committee was made by the then Union Minister for Health, Rajkumari Amrit Kaur, in her inaugural speech at the second meeting of the Central Council of Health held at Rajkot on 8th, 9th, 10th February, 1954. She emphasised the importance of good nursing and drew attention to the many factors that hindered its development. In pursuance of this resolution, the Government of India constituted a Committee on 19th May, 1954 under the Chairmanship of Shri Shetty and Ms. TK Adranvala, Nursing Advisor to Govt. of India as the Member Secretary.

The terms of reference of the Committee were as follows:

a. To survey the existing facilities for teaching in nursing, conditions of work and emoluments of the various grades of nurses.
b. To assess the minimum requirements of the country as a whole in respect of nurses and to recommend specific measures to overcome the shortage. The Committee should particularly examine whether teaching cannot be imparted on a large scale in the regional languages or if this is not feasible at present, whether admission qualifications can be lowered without materially affecting adversely the quality of service rendered to the community by the nurses.
c. To examine the existing conditions of service and emoluments admissible to nurses in the various States and State-aided institutions and to make necessary recommendations for their improvement so as to attract educated young women from

good families to the profession.

In making these recommendations, the financial resources of the States so that it may be feasible to introduce uniform scales of salary and other conditions of service for nurses throughout the country.

The Committee visited some States, held 2 meetings and obtained information from State Nursing Councils and individual nurses.

Recommendations

a. The appointment of a Superintendent of Nursing services in each State.
b. Combining the Nursing service for hospitals and that for the public health field into one service. Inclusion of experience of Public Health and Domiciliary Nursing in the basic course for nurses and midwives.
c. In planning to provide an adequate Nursing service, the immediate goal to be the provision of a minimum standard of Nursing in the existing hospitals and public health services. The number required to be assessed on the following basis:

Hospitals: One Nurse (also qualified in midwifery for women's and maternity services) including students to 3 patients in hospitals used for the training of Nurses and Midwives. The teaching and administrative staff in special departments should not be included in the number of Nurses. One nurse, also qualified in midwifery for women's and maternity services to 5 patients in all other hospitals.

Domiciliary midwifery*:* One Midwife to 100 births in rural areas. In towns and cities; in compact areas one Midwife to 150 births.

Public health field*:* One Public Health Nurse or Health Visitor to 10,000 of the population.

As midwifery practice by Dais is likely to continue for some years, a provision is to be made for Dais to be trained and for them to be required to work under supervision.

Nursing Education

a. Recruitment of additional students, and the necessary staff for supervision and teaching, in the existing training centers as a first step towards increasing the number of Nursing personnel.
b. Creation of posts for Nursing staff in institutions and in the public health field to absorb the additional number of nurses who will be trained.
c. The appointment of Auxiliary Nurses and Midwives to supplement the Nursing service in the hospitals or wards which are not used for training Nurses. Establishment of training centers in District Headquarters hospitals for Auxiliary Nurses and Midwives.
d. Improvement in conditions of training of nurses.
   Priority to be given to:
   - Provision of adequate living accommodation,
   - Proper facilities for practical work, and adequate training for Sister Tutors and Ward Sisters,
   - Proper care of students' health,

- Raising of educational standard wherever possible, and
- Shorter working hours.

e. Better publicity to the potentialities of nursing as a career.

f. Special consideration to be given to personality and home background when recruiting students, provided that they meet other minimum requirements. Selection Committee to be constituted with Medical and Nursing Superintendents and Sister Tutors on it.

g. Ordinarily, married women, unless widowed and separated from their husbands, not be admitted for training. Students not to be allowed to marry during their training period.

h. Minimum requirements for admission to training schools to be in accordance with the regulations of the Indian Nursing Council.

i. Medium of instruction to be decided by each State.
Individual training centers should also have the discretion to decide on this question.

j. Setting up a system of counselling for students, an experienced sister been assigned to a group of students for this purpose.

k Students to be required to be resident during training.

1. Students may be required to execute a bond to give up to two years of service on completion of their training.

Nursing Service

a. Nurses, qualified for the purpose should be associated with the selection of Nursing personnel. In recruitment too much centralization should be avoided.

b. Provision of adequate quarters for nurses.

c. Improvement in working conditions by an increase in staff, provision of linen and other supplies necessary to carry out good nursing, and shorter working hours. Inquiry into routine hospital practice with a view to modify or simplify it wherever necessary.

. d. Proper provision for a periodical physical examination and for treatment during illness. Facilities to carry out proper isolation technique wherever it is necessary.

e. Provision of pension or provident fund.

f. Holding of regular staff meetings. Establishment of refresher courses for all categories of the Nursing staff. Granting of facilities for further study.

g. Providing temporary service or part-time work for married women who have household responsibilities.

h. Recruitment of men as student nurses be in proportion to the employment open to them.

i. Exchange of nurses between different states to be encouraged.

j. Each PHC had only 2 LHVs/PHNs.

k. Lack of promotional avenues for ANMs.

l. Reduction in the period of training of ANMs from 2 years to eighteen months and raising the entrance qualification to Matriculation or equivalent with science and biology.

Report of Expert Committee on Health Manpower Planning, Production and Management, Ministry of Health and FW, Govt. of India, New Delhi (Bajaj Committee, 1986)

This Committee reviewed the state of Nursing education at the 10+2 level and has predicted the Nursing Manpower required.

Nursing education: The Committee strongly recommends health related vocational courses for Auxiliary Nurse Midwife (Female Health Worker). To provide for vertical mobility to the products of the vocational courses. 10% seats to be reserved in higher technical courses.

Nursing manpower requirements*:* Number of Nurses required.

Prediction for 1991 on the basis of 0.73 beds per thousand population for 1991.

The difference between present bed strength of 0.6 bed per 1000 population and 1 bed for 1000 population required by 2000 AD have been split equally between three plan periods, i.e. 1986-90, 1991-95 and 1996-2000 AD (See the following Tables 15.1 and 15.2).

In addition to the above, 74361 Traditional Birth Attendants will be required.

9. NATIONAL HEALTH POLICY

The Ministry of Health and Family Welfare, Govt. of India, evolved a National Health Policy in 1983 keeping in view the national commitment to attain the goal of Health for All by the year 2000. Since then there has been significant changes in the determinant factors relating to the health sector, necessitating revision of the policy, and a new National Health Policy-2002 was evolved.

Objective of the policy

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions.

To achieve an acceptable standards of good health amongst the general populations of the country.

The approach would be to increase access to decentralized public health system by establishing new infrastructure in the existing institutions.

Over-riding importance would be given to ensure a more equitable access to health services across the social and geographical expanse of the country. Primacy will be given to preventive and first line curative initiatives at the primary health level.

The policy is focused on those diseases which are principally contributing to disease burden such as tuberculosis, malaria, blindness and HIV/AIDS. Emphasis will be laid on rational use of drugs within the allopathic system. To translate the above objectives into reality, the Health Policy has laid down specific goals to be achieved by year 2005, 2007, 2010 and 2015.

Need for national health policy

- Population stabilization
- Medical and Health Education
- Providing primary health care with special emphasis on the preventive, promotive and rehabilitative aspects
- Re-orientation of the existing health personnel
- Practitioners of indigenous and other systems of medicine and their role in health care

NATIONAL HEALTH POLICY - 2002

Introduction

National Health Policy was last formulated in 1983, and since then there have been marked changes in the determinant factors relating to the health sector. Some of the policy initiatives outlined in the NHP-1983 have yielded results, while, in several other areas, the outcome has not been as expected.

Current scenario

Financial resources: The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 17 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure.

Equity: In the period when centralized planning was accepted as a key instrument of development in the country, the attainment of an equitable regional distribution was considered one of its major objectives.

Delivery of national public health programmes

- Extending public health services
- Policy of devolving programmes and funds in the health sector through different levels of the Panchayati Raj Institutions.
- Need for specialists in ‘public health’ and ‘family medicine’
- Use of generic drugs and vaccines
- Urban health, Mental health, Women’s health
- Information, education and communication
- Health research and National disease surveillance network
- Health statistics and Medical ethics
- Enforcement of quality standards for food and drug
- Regulation of standards in para medical disciplines
- Environmental and occupational health
- Providing medical facilities to users from overseas
- Globalization on the health sector

Objectives

- ✓ The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country.
- ✓ Decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions.
- ✓ Ensuring a more equitable access to health services across the social and geographical expanse of the country.
- ✓ Emphasis will be given to increasing the aggregate public health investment through a substantially increased contribution by the Central Government.
- ✓ Strengthen the capacity of the public health administration at the State level to render effective service delivery.

National Health Policy - 2002 goals to be achieved by 2015

- ➢ Eradicate Polio and Yaws Eliminate Leprosy Eliminate Kala-azar - 2005
- ➢ Eliminate Lymphatic Filariasis -2005
- ➢ Achieve zero level growth of HIV / AIDS -2010
- ➢ Reduce mortality by 50% on account of TB, Malaria and other vector and water borne diseases -2015
- ➢ Reduce prevalence of blindness to 0.5% -2007
- ➢ Reduce IMR to 30/100 And MMR to 100/Lakh -2010
- ➢ Increase utilization of public health facilities from current level of < 20% to > 75% -2010
- ➢ Establish an integrated system of surveillance, National Health Accounts and Health Statistics. -2010
- ➢ Increase health expenditure by Government as a % of GDP from the existing 0.9% to 2.0% -2010
- ➢ Increase share of central grants to constitute at least 25% of total health spending - 2005
- ➢ Increase state sector health spending from 5.5 to 7% of the budget -2005

NHP-2002-POLICY PRESCRIPTIONS

Financial resources

The paucity of public health investment is a stark reality. Given the extremely difficult fiscal position of the State Governments, the Central Government will have to play a key role in augmenting public health investments.

The State Governments would also need to increase the commitment to the health sector. In the first phase, by 2005, they would be expected to increase the commitment of their resources to 7% of the budget; and, in the second phase, by 2010, to increase it to 8% of the budget.

Equity

To meet the objective of reducing various types of inequities and imbalances- interregional; across the rural –urban divide; and between economic classes- the most cost-effective method would be to increase the sectoral outlay in the primary health sector. Such outlets afford access to a vast number of individuals, and also facilitate

preventive and early stages curative initiative, which are cost effective.

Delivery of National Public Health Programmes

This policy envisages a key role for the Central Government in designing national programmes with the active participation of the State Government. The policy ensures the financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. To optimize the utilization of the public health infrastructure at the primary level, NHP-2002 envisages the gradual convergence of all health programmes under a single field administration.

The State of Public Health Infrastructure

The decentralized Public health services outlet has become practically dysfunctional over large parts of the country. On account of resource constraints, the supply of drugs by the State Governments is grossly inadequate. The patients at the decentralized level have little use for diagnostic services, which in any case would the patient, are not getting any therapeutic drugs privately.

Extending Public Health Services

This policy envisages that, State Governments would consider the need for expanding the pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian Medicine and Homeopathy. Simple services/ procedures can be provided by such practitioners even outside their disciplines, as part of the basic primary health services in underserved areas. NHP-2002 envisages that the scope of the use of para medical manpower of allopathic disciplines, in a prescribed functional area adjunct to their current functions, would also be examined for meeting simple public health requirements. NHP-2002 also recognizes the need for States to simplify the recruitment procedures and rules for contract employment in order to provide trained medical manpower in under served areas.

Role of Local Self-Government Institutions

NHP-2002 lays great emphasis upon the implementation of public health programmes through local self-government institutions. The structure of the national disease control programmes will have specific components for implementation through such entities. The Policy urges all State Governments to consider decentralizing the implementation of the programmes to such Institutions by 2005.

Norms for Health Care Personnel

Minimal statutory norms for the deployment of doctors and nurses in medical institutions need to be introduced urgently under the provisions of the Indian Medical Council Act and the Indian Nursing Council Act, respectively. These norms can be progressively reviewed and made more stringent as the medical institutions improve their capacity for meeting better normative standards.

Education of Health Care Professionals

This Policy envisages the setting up of a Medical Grants Commission for funding new Government Medical and Dental Colleges in different parts of the country. Also, it is envisaged that the Medical Grants Commission will fund the up gradation of the infrastructure of the existing Government Medical and Dental Colleges of the country, so as to ensure an improved standard of medical education.

To enable fresh graduates to contribute effectively to the providing of primary health services as the physician of first contact, this Policy identifies a significant need to modify the existing curriculum. A need-based, skill-oriented syllabus, with a more significant component of practical training, would make fresh doctors useful immediately after graduation. The Policy also recommends a periodic skill-updating of working health professionals through a system of continuing medical education.

Need for Specialists in 'Public Health' and 'Family Medicine'

In order to alleviate the acute shortage of medical personnel with specialization in the disciplines of 'public health' and 'family medicine', the Policy envisages the progressive implementation of mandatory norms to raise the proportion of postgraduate seats in these disciplines in medical training institutions, to reach a stage wherein l/4th of the seats are earmarked for these disciplines. It is envisaged that in the sanctioning of postgraduate seats in future, it shall be insisted upon that a certain reasonable number of seats be allocated to 'public health' and "family medicine'.

Nursing Personnel

In the interest of patient care, the policy emphasizes the need for an improvement the ratio of nurses vis-à-vis doctors/beds. In, order to discharge their responsibility **a** model providers of health services, the public health delivery centers need to make beginning by increasing the number of nursing personnel. The Policy anticipates that with the increasing aspiration for improved health care amongst the citizens, private health facilities will also improve their ratio of nursing personnel vis-à-vis doctors/ beds.

The Policy lays emphasis on improving the skill-level of nurses and on increasing the ratio of degree-holding nurses vis-à-vis diploma-holding nurses. NHP-2002 recognizes the need for the Central Government to subsidize the setting up and the running of training facilities for nurses on a decentralized basis. The Policy recognizes the need for establishing training courses for super-specialty nurses required for tertiary care institutions.

Use of Generic Drugs and Vaccines

To encourage the use of only essential drugs in the private sector, the imposition of fiscal disincentives would be resorted to. The production and sale of irrational combinations of drugs would be prohibited through the drug standards statute.

Urban Health

NHP-2002 envisages the setting up of an organized urban primary health care structure. Since the physical features of urban settings are different from those in rural areas, the policy envisages the adoption of appropriate population norms for the urban public health infrastructure. The structure conceived under NHP-2002 is a two-tiered one: the primary centre is seen as the first-tier, covering a population of one lakh, with a dispensary providing an O.P.D. facility and essential drugs, to enable access to all the national health programmes; and a second-tier of the urban health organization at the level of the Government general hospital, where reference is made from the primary centre.

Mental Health

NHP-2002 envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would involve the diagnosis of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff.

In regard to mental health institutions for in-door treatment of patients, the Policy envisages the upgrading of the physical infrastructure of such institutions at Central Government expense so as to secure the human rights of this vulnerable segment of society.

Information, Education and Communication

NHP-2002 envisages an IEC policy, which maximizes the dissemination of information to those population groups which cannot be effectively approached by using only the mass media. The focus would therefore be on the interpersonal communication of information and on folk and other traditional media to bring about behavioral change. The IEC programme would set specific targets for the association of PRIs/NGOs/Trusts in such activities.

Health Research

This Policy envisages an increase in Government-funded health research to a level of 1% of the total health spending by 2005, and thereafter, up to 2% by 2010. Domestic medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and malaria, as also on the sub-types of HIV/AIDS prevalent in the country. Research programmes taken up by the Government in these priority areas would be conducted in a mission mode.

Role of Private Sector

This Policy welcomes the participation of the private sector in all areas of health activities—primary, secondary or tertiary. This Policy envisages the enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/ medical institutions by 2003.

Role of Civil Society

NHP-2002 recognizes the significant contribution made by NGOs and other institutions of the civil society in making available health services to the community. In order to utilize their high motivational skills on an increasing scale, this Policy envisages that the disease control programmes should earmark not less than 10% of the budget in respect of identified programme components, to be exclusively implemented through these institutions. The policy also emphasizes the need to simplify procedures for government-civil society interfacing in order to enhance the involvement of civil society in public health programmes.

National Disease Surveillance Network

This Policy envisages the full operationalization of an integrated disease control network from the lowest rung of public health administration to the Central Government, by 2005. The programme for setting up this network will include components relating to the installation of database handling hardware; IT inter-connectivity between different tiers of the network; and in-house training for data collection and interpretation for undertaking timely and effective response. This public health surveillance network will also encompass information from private health care institutions and practitioners.

Health Statistical

The Policy envisages the completion of baseline estimates for the incidence of the common diseases—TB, malaria, blindness—by 2005. The Policy proposes that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling, under an appropriate statistical methodology. The policy also recognizes the need to establish, in a longer timeframe, baseline estimates for non-communicable diseases, like CVD, cancer, diabetes; and accidental injuries, and communicable diseases like Hepatitis and JE.

Women's Health

NHP-2002 envisages the identification of specific programmes targeted at women's health. The Policy notes that women, along with other underprivileged groups, are significantly handicapped due to a disproportionately low access to health care.

Medical Ethics

NHP-2002 envisages that, in order to ensure that the common patient is not subjected to irrational or profit-driven medical regimens, a contemporary code of ethics be notified and rigorously implemented by the Medical Council of India.

By and large, medical research within the country in the frontier disciplines, such as gene-manipulation and stem cell research, is limited. The policy recognizes that a vigilant watch will have to be kept so that the existing guidelines and statutory provisions are constantly reviewed and updated.

Enforcement of Quality Standards for Food and Drugs

NHP-2002 envisages that the food and drug administration will be progressively strengthened, in terms of both laboratory facilities and technical expertise. The policy

envisages that the standards of food items will be progressively tightened up at a pace which will permit domestic food handling/manufacturing facilities to undertake the necessary up gradation of technology so that they are not shut out of this production sector.

Regulation of Standards in Para Medical Disciplines

NHP-2002 recognises the need for the establishment of statutory professional councils for paramedical disciplines to register practitioners, maintain standards of training, and monitor performance.

Environmental and Occupational Health

This Policy envisages that the independently-stated policies and programmes of the environment-related sectors be smoothly interfaced with the policies and the programmes of the health sector, in order to reduce the health risk to the citizens and the consequential disease burden.

NHP-2002 envisages the periodic screening of the health conditions of the workers, particularly for high-risk health disorders associated with their occupation.

Providing Medical Facilities to Users from Overseas

To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sectors, NHP-2002 strongly encourages the providing of such health services on a payment basis to service seekers from overseas. The providers of such services to patients from overseas will be encouraged by extending to their earnings in foreign exchange, all fiscal incentives, including the status of "deemed exports", which are available to other exporters of goods and services.

Impact of Globalization on The Health Sector

The Policy takes into account the serious apprehension, expressed by several health experts, of the possible threat to health security in the post-TRIPS era, as a result of a sharp increase in the prices of drugs and vaccines. To protect the citizens of the country from such a threat, this policy envisages a national patent regime for the future, which, while being consistent with TRIPS, avails of all opportunities to secure for the country, under its patent laws, affordable access to the latest medical and other therapeutic discoveries.

10. National Population Policy of India

National Population Policy of India was formulated in the year 2000 with the long term objective of achieving a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection. The immediate objective of the policy is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the TFR (Total Fertility Rate) to replacement levels by 2010, through vigorous

implementation of inter-sectoral operational strategies. TFR is the average number of children each women would have in her lifetime.

National Population Policy pursues to achieve following Socio-Demographic goals by 2010:

- Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- Make school education up to age 14 free and compulsory, and reduce dropouts at primary and secondary school levels to below 20 percent for both boys and girls.
- Reduce infant mortality rate to below 30 per 1000 live births.
- Reduce maternal mortality ratio to below 100 per 100,000 live births.
- Achieve universal immunization of children against all vaccine preventable diseases.
- Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.
- Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.
- Achieve 100 per cent registration of births, deaths, marriage and pregnancy.
- Contain the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organization.
- Prevent and Control communicable diseases.12. Integrate Indian Systems of Medicines (ISM) in the provision of reproductive and child health services, and in reaching out to households.
- Promote vigorously the small family norm to achieve replacement levels of TFR.
- Bring about convergence in implementation of related social sector programs so that family welfare becomes a people cantered programme.

It also addresses national aspirations outlined in Vision 2016 and the countrys commitment to the implementation of the internationally agreed compacts and policy frameworks such as

AYUSH

The Indian Systems of Medicine and Homoeopathy (External website that opens in a new window) (ISM&H) were given an independent identity in the Ministry of Health and Family Welfare in 1995 by creating a separate Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (External website that opens in a new window) (AYUSH) in November 2003.

The infrastructure under AYUSH sector consists of 1355 hospitals with 53296 bed capacity, 22635 dispensaries, 450 Undergraduate colleges, 99 colleges having Post Graduate Departments, 9,493 licensed manufacturing units and 7.18 lakh registered practitioners of Indian Systems of Medicine and Homoeopathy in the country.

Budget: An outlay of Rs.775 crore has been allocated for the Department during the Tenth Five-year Plan. The Plan allocation for 2006-07 is Rs. 381.60 crore.

Subordinate Offices

- Pharmacopoeial Laboratory for Indian Medicine (PLIM)
- Homoeopathic Pharmacopoeial Laboratory (HPL)
- Ayurved Hospital, Lodhi Road, New Delhi

BIBLIOGRAPHY

1. A.A Baker, "psychiatric disorder in obstetric" Blackwell scientific publication oxfort and edinguigh 1967, 1st edition, 34-44.
2. S.P Kaplan and Sadocks, "synopsis of psychiatry", 1998 williams and wilkens, manyland USA, 8th edition, 19-21.
3. M.S Bhatia, "a concised textbook on psychiatric nursing", 3rd edition, CBS publisher, 170-179.
4. JN Vyas & Niraj Ahuja. Text Book of Post Graduate Psychiatry. 2nd edition, vol-II, New Delhi: Jaypee Publishers: 773-781.