

## Perspectives on Health and Nutrition

Good health should be the basic objective of any development effort. The concept of human development as defined by UNDP, rests on the three pillars of knowledge, health and livelihoods. The notion that people's life chances or their health and longevity are central to their socio-economic status, is now accepted as a necessary component of development and planning. In India, health is increasingly seen as a basic component of social sector support and not merely a department isolated from mainstream planning initiatives.

Health as defined by World Health Organization (WHO), is more than just the absence of disease. It is a state of complete physical, mental and social well-being. It is a goal in its own right. Health is central to social and economic development. It is a means to achieve and sustain development

Health and disease are closely related to environmental, social, cultural, political and economic factors. The empowerment of women, for instance, is one of the most important determinants of health. Other determinants of health are tightly interwoven with interactions between individuals and their social, cultural, and political contexts

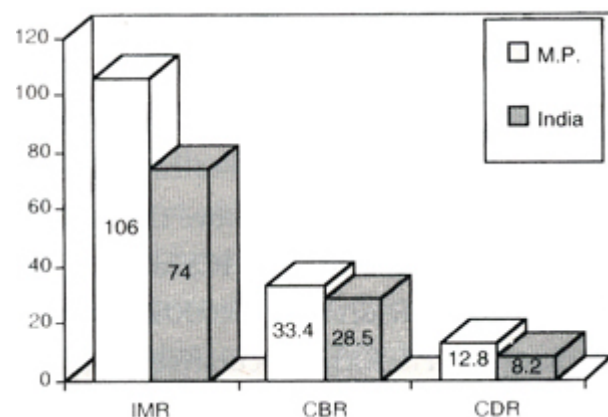
As a means of achieving sustainable development, and as a goal of development by itself, health assumes a very important role- Society and its institutions must therefore appreciate the responsibility of promotion of health- This implies that promotion of the health of the people is not only the responsibility of the health sector; social and economic policies should be evaluated against their net contribution to human health and well-being. The health of a human being is a measure of happiness, welfare and well-being, and the ability to live a long and disease-free life as a

productive member of society The guiding principle of health care should be the elimination of poverty, ignorance and ill health. The Constitution of India directs the state to regard raising the level of nutrition and the improvement of public health as one of its primary duties.

### STATUS OF HEALTH IN MADHYA PRADESH

Madhya Pradesh is quite backward in the field of health, and a look at most health indicators given in Figure 4-1 shows that the performance of the state is well below the Indian average. Along with Uttar Pradesh, Bihar and Rajasthan, Madhya Pradesh accounts for the largest portion of mortality and morbidity of India. The reasons for this backwardness are not difficult to see. Other indicators of social and economic development in these states are also very

**Figure 4-1**  
**Comparison of Health indicators of Madhya Pradesh with India**



Source : Sample Registration System

**HEALTH**

low: they have the poorest literacy rates, lowest school enrollments, highest number of drop-outs, and lowest per capita incomes.

**HEALTH CARE DELIVERY INFRASTRUCTURE**

At the state government level, there are separate departments for Public Health and Medical Education. Under these two departments there are the Directorates of Public Health, Medical Education, Indian Systems of Medicine, Dana Assisted Health Care Project, and the Controller of Food and Drugs.

The main responsibility of looking after the public health needs of the people is with the Directorate of Public Health. The main officer of the health system in the district is the Chief Medical and Health Officer (CMHO).

At the village level the multi purpose health worker (MPW) is responsible for the delivery of curative, preventive and promotive health services. There is one male and one female MPW for one sub-health centre (SHC). The nationally accepted norms are for one SHC for a population of 3,000 in tribal areas and for a population of 5000 in other areas. For a population of 20,000 in tribal areas, and 30,000 in other areas there is a sector level primary health centre (PHC). Every sector PHC has a doctor, and a male and a female supervisor to supervise the work of the MPWs. At the block level there is a block level primary health centre which has indoor facilities for 6 beds. Above the PHC there is a community health centre (CHC) for a population of 80,000 in tribal areas, and 1,20,000 in other areas. The CHC has greater facilities for curative health, including facilities for specialists. Every district has a district hospital (there are 42 district hospitals in Madhya Pradesh. Though the remaining three, namely Gwalior,

**JAN SWASTHYA RAKSHAK**

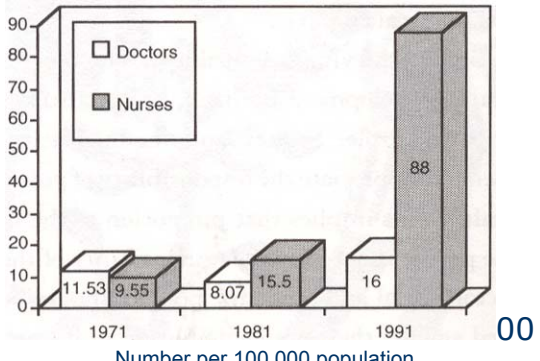
Educated unemployed youth from villages will be trained under TRYSEM in giving curative services for minor illnesses and for the delivery of public health services in villages. These “jan swasthya rakshaks” will be licensed by the Zilla Panchayat for practicing in the villages. They will charge the village community a small amount for these services. This will give the village youth an opportunity for gainful employment, and also make some contribution towards the well-being of their own people. This will also, to an extent, solve the problem of lack of trained manpower in the health sector

**Table 4-1  
Health Infrastructure in Madhya Pradesh**

	Institutions required as Per Norms			Available at Present		
	Non-Triba	Triba	Total	Non-Triba	Triba	Total
Sub Health Centre	5923	5383	12310	5877	4858	11938
PHC	1153	807	1960	1058	783	1841
CHC	290	198	488	85	85	190

Source: Health Department, Govt. of Madhya Pradesh

**Figure 4-2  
Health Manpower in Madhya Pradesh**



Source: Ravi Duggal et al, 'Health Expenditure across States', Economics and Political weekly

Rewa and Raipur, have other hospitals) which are the secondary level referral hospitals, the primary level referral hospitals being the CHCs. The state has 6 medical colleges, and one college of dentistry. All medical colleges have hospitals attached to them. These hospitals are the tertiary level referral hospitals, and provide specialized health care of all kinds.

At the district level, the CMHO is assisted by senior programme officers who look after their individual health programmes. Apart from this, there is a district training center headed by a district training officer, a media wing headed by the district media officer, and the supporting staff for accounts and general administration.

In terms of medical personnel, both doctors, and nurses have increased in the state over the last few years. However, it is still far from satisfactory, and well below the national average. The state government is considering some innovative ideas like the Jan Swasthya Rakshak Scheme of barefoot doctors to solve this problem.

The number of health institutions has increased in the state over the years as can be seen from Table 4-2.

However, if we look at infrastructure for rural areas, the availability of buildings of rural health institutions is still very poor. In terms of buildings required sanctioned centres, 74 per cent of sub-health centres still need a building, 55 per cent PHCs and 73 per cent

CHCs need a building. Some buildings are being constructed under externally aided projects, like India Population Project-6, and Danida Assisted Health Care Project. The state government has also taken a decision to construct sub-health centre buildings using the funds under Jawahar Rozgar Yojna (JRY).

**TABLE 4-2  
HEALTH INSTITUTIONS IN  
MADHYA PRADESH: 1961-1991**

Year	Hospitals			Beds		
	Rural	Urban	Total	Rural	Urban	Total
1961	0.24	2.23	0.53	-	-	30.75
1965	0.13	1.86	0.40	-	-	39.39
1971	-	-	0.40	-	-	36.70
1976	-	-	0.43	-	-	39.64
1981	0.17	1.95	0.53	3.21	146.28	32.24
1986	0.13	1.89	0.51	2.99	147.18	34.59
1988	0.17	2.00	0.58	4.37	145.26	36.03
1991	0.65	0.48	0.61	43.38	21.37	38.27

Figures given are per 100,000 population.

### IMPORTANT HEALTH CARE ISSUES IN MADHYA PRADESH

In spite of difficulties in socio-economic development, Madhya Pradesh has made some impressive progress in the last few years. The infant mortality rate of the state which was 216 in 1941, has dropped to 106 in 1991 according to the sample registration system (SRS). According to the National Family Health Survey (NFHS) conducted in 1992 the IMR of Madhya Pradesh is only 85.2. The crude birth rate and crude death rate of the state has shown a steady fall over the last three years as shown in Table 4.3 (SRS data). The indicators of maternal and child health have however not shown similar improvement. While the state has made substantial progress in decentralisation, other areas of child survival and safe motherhood have not received equal attention.

It is probably due to this over-emphasis on immunisation at the expense of programmes of control of other equally important diseases that the state has not been able to achieve the desired results in maternal and child health. While vaccine preventable diseases (vpd)

account for only 21 per cent of childhood mortality, 28 per cent of childhood mortality is caused by acute respiratory infections (ARI), and another 28 per cent is caused by diarrhoeal diseases. One must remember that almost half of infant mortality is actually neonatal mortality.

Apart from ARI, a very substantial proportion of mortality among new-born children is directly related to unsafe motherhood practices. The important causes are neonatal tetanus (NNT) which can be prevented by two injections of tetanus toxoid (TT) during pregnancy; low birth weight, which is a direct consequence of poor nutritional status of the mother; neonatal septicemia and NNT which are largely the result of not following aseptic precautions during delivery; and birth injuries and birth asphyxia which can be prevented by good obstetric care. The other major cause of infant mortality is premature delivery.

Good antenatal care, and good obstetric care are also necessary to reduce the maternal mortality rate which is also very high for Madhya Pradesh. The major causes of maternal mortality are given in Figure 4.4. Deaths due to most of these causes are preventable by taking proper precautions in the antenatal, intrapartum and postpartum periods.

**Child Survival**

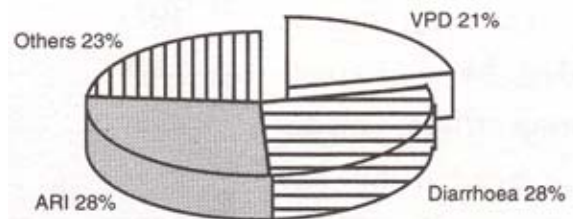
*Vaccine preventable diseases*

The coverage levels of immunisation in, as reported by the state government health system, have improved significantly over the last few years. For example, OPT achievements went up from below 80 per cent to 96.7 per cent from 1994-95, and measles vaccination from 81.4 per cent to 99.6 per cent in the same period. However, the morbidity and mortality due to vaccine

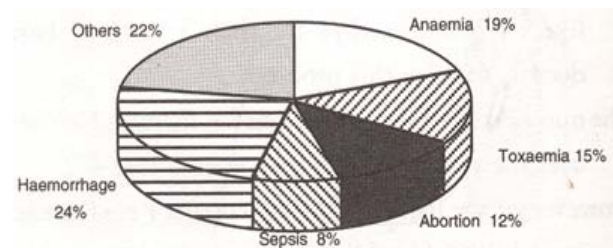
TABLE 4-3 REDUCTION OF CBR AND CBR IN MADHYA PRADESH (LAST THREE YEARS)			
	1991	1992	1993
CBR	35.8	34.9	33.4
COR	13.8	12.9	12.8

Source: Sample, Registration Scheme

**Figure 4-3  
Causes Of Mortality**



**Figure 4-4  
Causes of Maternal  
Mortality**

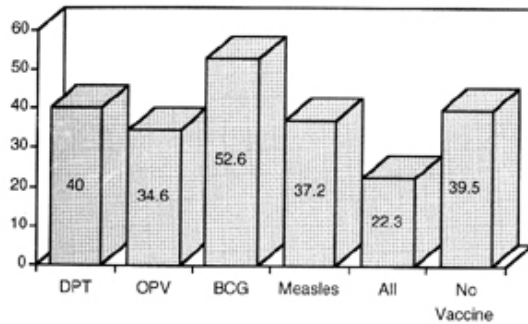


[Source: Registrar General of India

preventable diseases have not reduced proportionately. It is necessary to analyse the reasons for this.

One of the reasons may be higher reporting than actual coverage levels, and this can be seen from the data reported by NFHS on coverage levels for various antigens. This data compares well with the data of coverage evaluation surveys conducted every year by UNICEF. The survey shows that actual coverage is much lower than the reported coverage. However, it is heartening to note that even the coverage evaluation

**Figure 4-5**  
**Coverage in Immunisation**  
**(by independent evaluation)**



Source: NFHS

Figures given are coverage levels in present for children below one year who have received all doses  
Figures relate to 1982

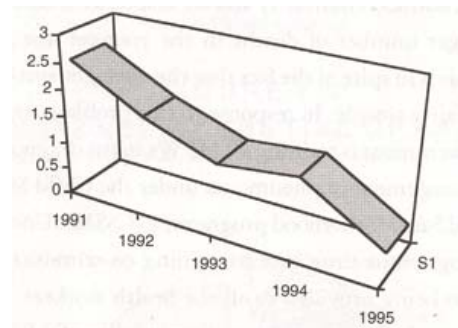
surveys have shown an improvement in coverage levels in the last few years. Another reason for continued high mortality and morbidity due to VPDs may be the fact that very little immunisation is done during the first half of the year. It is only near the end of the year that the system picks up speed, and high coverage levels are achieved. Thus, children remain unprotected for a significant period of their early life. A third reason may be the existence of low coverage pockets, where the level of immunity remains low and epidemics

continue to occur. Whatever be the reason, the goals of elimination of neonatal tetanus, control of measles, and eradication of polio remain a challenge for the state, at the present moment.

*Control of diarrhoeal diseases*

Diarrhoea is a major cause of childhood mortality and morbidity in the state. According to estimates, almost 28 per cent of childhood mortality is because of diarrhoeal diseases.

**Figure 4-6**  
**Case Fatality rate for Diarrhoea**



CFR: Number of deaths per 100 cases  
Source: State Health Department  
Figures for 1995 and upto july

Every child under 5 suffers from one or two episodes of diarrhoea every year. Non availability of safe drinking water and insanitary conditions are the two major factors responsible for such a high prevalence of diarrhoea. The state government launched the Rajiv Gandhi Mission for the Control of Diarrhoeal Diseases on August 20, 1994. The objectives of the Mission are the reduction in mortality due to diarrhoea by 70 per cent and reduction in cases of diarrhoea by 70 per cent by 2000 AD.

According to the National Family Health Survey (NFHS, 1992) 22.1 per cent children suffering from diarrhoea were given ORS, 16.5 per cent children were given home solutions, and 33.5 percent children were given some form of ORT. Since then there has been significant increase in the use of ORT. As a result of this the case fatality rate has been reduced significantly. The efforts of the Mission are likely to bring down the case fatality rate further.

*Control of acute respiratory infections*

Acute respiratory infections (ARI) account for 28 per cent of childhood mortality and are responsible for an even larger number of deaths in the younger age group. This is in spite of the fact that the management of ARI is fairly simple. In response to this problem, the state government is training all MPW s in the diagnosis and management of pneumonia under the Child Survival and Safe Motherhood programme (CSSM). Under this programme drug kits containing co-trimoxazole are also being provided to all the health workers.

However, there are problems of availability of ARI medicines ‘over the counter’ (OTC), and, limitations of coverage of this programme. There is need for focusing on this problem, to ensure availability of drugs and greater coverage through government and private providers.

*Safe Motherhood*

As seen earlier, the health of the mother and safe delivery, while being important in themselves, are also very important for the health of the child. Maternal health has not received as much attention in Madhya Pradesh as should be its due. According to NFHS, only one quarter of pregnant women get antenatal check-ups from doctors. Only half of them get tetanus toxoid immunisation, and less than half receive iron folic acid tablets during

**RAJIV GANDHI MISSION FOR THE CONTROL OF DIARRHOEAL DISEASES: STRATEGIES**

*For prevention of cases:*

- Safe drinking water through hand pumps, chlorinating of wells, use of chlorine tablets.
- Promote sanitation-sanitary latrines, drainage, hand-washing, garbage disposal, etc.

*For prevention of deaths:*

- Promote CRT-home-available fluids, ORS, continued feeding, timely referral.
- Exclusive breast feeding.
- Rational diarrhoea treatment
- Prevention and control of epidemics.

**RATH YATRA WITH A DIFFERENCE**

The Rajiv Gandhi Mission for Control of Diarrhoeal Diseases launched a Rath Yatra in April-June 1995. Raths carrying video equipment and folk artists were flagged off by the Chief Minister. These raths went to all the block headquarters and many other large villages of the state. The raths carried the message of sanitation, safe drinking water and ORT. During this period, jathas of volunteers traveled on foot to all the gram panchayats of the state, taking with them the message of prevention and control of diarrhoea to every corner of the state.

**HEALTH**

pregnancy. This is one of the main reasons for a large proportion of babies being born with low birth weight, and with deficiencies of various kinds. This is also the reason for such a large number of neonatal tetanus cases in Madhya Pradesh.

A look at Figure 4-8 will show that professional help is not available to most women at the time of delivery. While only 14 per cent deliveries are attended by doctors, in 71 per cent deliveries no trained person is available at the time of delivery. The NFHS estimated that around 83 per cent of all deliveries took place at home, as against only 11.5 per cent in the public sector.

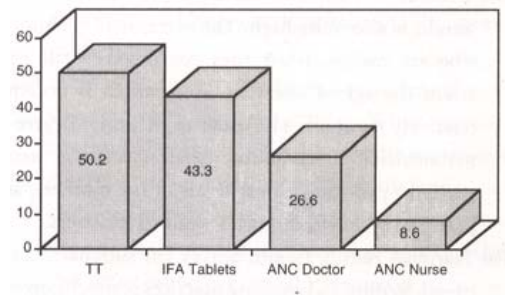
The Government of Madhya Pradesh has started a scheme of training traditional dais to solve this problem. The aim is to make at least one trained dai available in every village. The salient features of the dai training scheme are given in the box below.

**Nutrition**

*Protein energy malnutrition (PEM)*

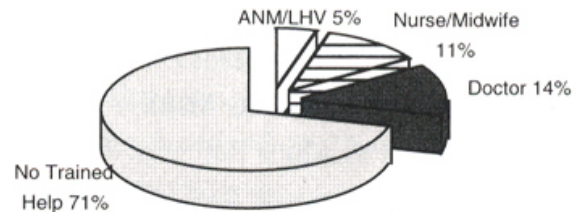
Madhya Pradesh has a severe problem of protein energy malnutrition. Though there has been a reduction in their numbers over the last few years, the number of malnourished children in Madhya Pradesh still remains despairingly high. It is a matter of great concern that more than 50% percent of the state's children are malnourished.

**Figure 4-7 Antenatal Care**



Source:NFHS. Figures given are percentage of pregnant women who received this services

**Figure 4-8 Assistance at the time of Labour**



Source:NFHS.

**DAI TRAINING IN MADHYA PRADESH**

- One day to be trained for every village.
- Training will be of one month duration.
- Training in good hospitals under specialist supervision.
- Emphasis on practical training, hands-on experience.
- Stipend from TRYSEM and CSSM combined.
- Reporting fees to be given to trained dais.

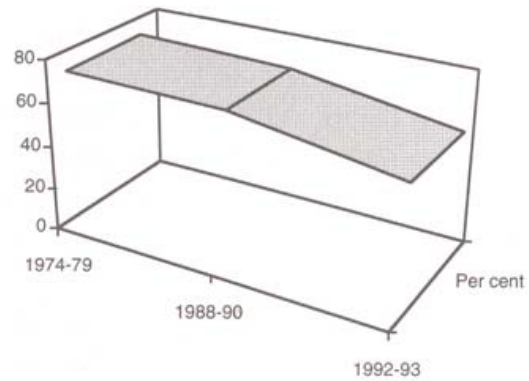
The number of children who are born with low birth weight is also quite high. The percentage of children who are malnourished rises continuously till they attain the age of one year, after which it becomes relatively constant. The cause of this high degree of malnutrition in children, therefore, can be traced partly to poor nutritional levels of the mothers, and partly to breast-feeding and weaning practices.

The National Family Health Survey has summarised the breast-feeding and weaning practices of the children in Madhya Pradesh. While the good practice of continuing breast-feeding the child till almost two years of age is widely prevalent, most of the children are not given supplementary solid mushy food along with breastfeed till a much later age. This is the most important reason for the increase in the number of malnourished children with the increase in age. Another area of concern is the relatively low level of exclusively breast feeding for the first three months, and the percentage of mothers giving bottle feeds being higher than one would expect in a state like Madhya Pradesh.

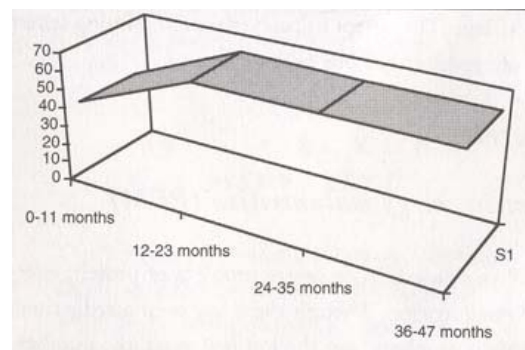
There are many factors which influence the level of nutrition of the people of the state. The most important factors are summarised in the chart.

Most of the factors described in the chart are self explanatory. Availability of food however, needs explanation.

**Figure 4-9**  
**Prevalence of underweight:**  
 Children below 4 years  
 Source: NNMB 1974-90, NFHS 1992-93



**Figure 4-10**  
**Prevalence of underweight:**  
 Among Children by age in months  
 Source: NNMB 1974-90, NFHS 1992-93



**FACTORS INFLUENCING NUTRITION**

Availability of food

Poverty

Drought

Maternal empowerment and education

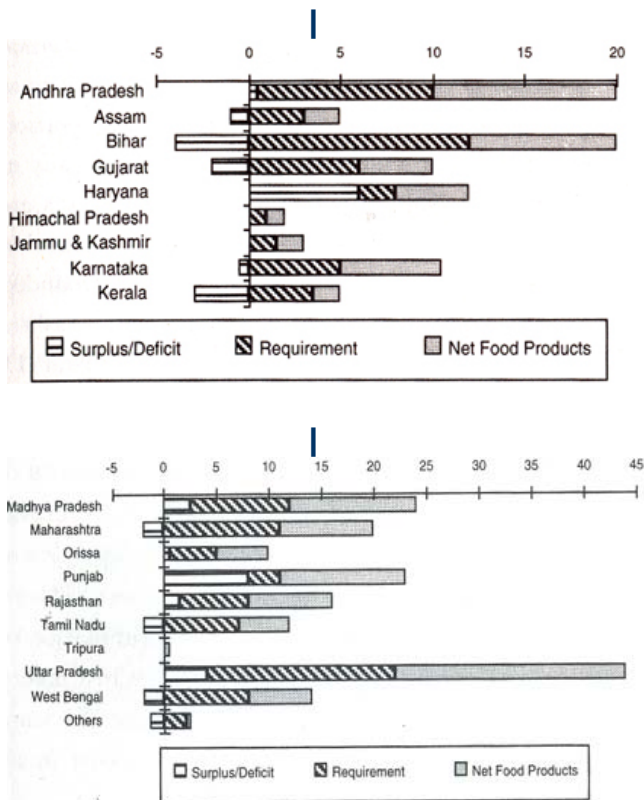
Breast-feeding and weaning practices

Vicious circle of low nutrition and child-bearing

Special problems of vulnerable groups like the landless, slum dwellers and tribals



**Figure 4-11**  
**Food grain Availability in States**  
 (Taken from State of India's Health, VHAI)



Source: Compiled from ICMR data()1986 in million tonnes

As can be seen from Figure 4-11, showing food grain availability, there is no direct correlation between food production and its availability to the poor. Though Madhya Pradesh has surplus food production, it also has a very large population suffering from PEM. This fact is also borne out from the prevalence of PEM in the country in spite of large buffer stocks of food. The Mid-Day Meal Programme which is to be launched from October 2, 1995, in the state is an effort to correct this imbalance.

Besides the Mid-Day Meal Programme, the state government runs other supplementary nutrition programmes like the Integrated Child Development Services (I CDS) and the Special Nutrition Programme (SNP) in certain urban slums.

The effect of empowerment through education of women also deserves a little elaboration. When women are educated, they can appreciate better the importance of nutrition, and contribute directly to the level of nutritious food in daily intakes of the family. Education will also enable them to utilise the indigenous knowledge that many of them, especially women of the tribes of Madhya Pradesh, possess on nutrition and nutritious foods, in combination with modern knowledge. Similarly when women earn, they are known to spend more on nutrition of the family, and can even influence decisions in the family, ensuring greater and more knowledgeable spending on nutrition.

*Micronutrient malnutrition*

The issue of micronutrient malnutrition is equally important. The three most important micronutrients are iron, vitamin A and iodine. Though data is not available for a proper assessment on the prevalence of iron and vitamin A deficiency in the state, it is known that the deficiency of both these micronutrients is widely prevalent. To counter this, health programmes give iron folic acid tablets to pregnant women, and vitamin A to children at the age of 9 months with the measles vaccination, and thereafter at six-monthly intervals till the age of two years. However the coverage levels are quite low, and efforts need to be intensified to attain universal coverage.

Iodine deficiency has received greater attention in the state. The state government launched the Rajiv Gandhi Mission for the Elimination of Iodine

Deficiency Disorders on August 20, 1994. The Mission has conducted a survey of the entire state. According to this survey, iodine deficiency is prevalent in the entire state, but it is significantly higher in the eastern part of the state and in the two western districts of Dhar and Jhabua. The goals of this Mission are to eliminate iodine deficiency in the state by 1997, ensure availability of iodised salt in all villages by mid-1995, ensure that by 1997 all salt sold in the state is iodised, i.e. 90 per cent of salt samples show > 15 ppm iodine. The Mission has met with considerable success.

#### **RAJIV GANDHI MISSION FOR THE ELIMINATION OF IODINE DEFICIENCY DISORDERS**

- All salt traders of the state have pledged not to sell non-iodised salt.
- Major awareness campaign through Panchayati Raj institutions, and NGOs.
- Involvement of Literacy Mission and Education Department.
- More than one lakh salt samples taken every month.
- Commitment to achieve the goal of the Mission by January 26, 1996, before the stipulated goal of achieving by 1997.

#### ***Other Diseases***

Other important diseases for Madhya Pradesh are malaria, leprosy, tuberculosis, and blindness due to cataract. According to the NFHS 1992, 33.5 per cent of people suffer from partial blindness, and 47.3 per cent suffered from malaria in the past three months.

The state has a substantial portion of the total malaria load of the country, with over 10 per cent of

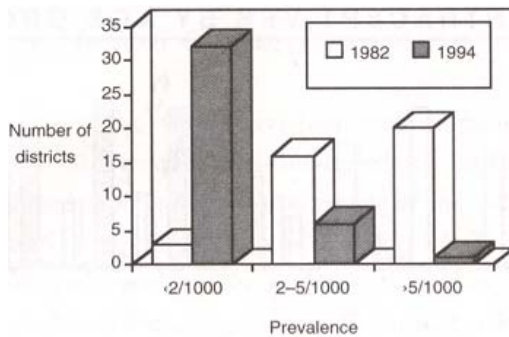
malaria cases in India from the state. Moreover, Madhya Pradesh has about 12 per cent of the total Plasmodium falciparum (Pf) cases of the country, a particularly severe form of malaria. Malaria accounts for a substantial proportion of morbidity and mortality in the state, especially in the densely forested tribal areas. Special efforts are needed to control this menace. What makes control of malaria difficult is the fact that the state is surrounded by high prevalence states on all sides—Maharashtra (13 per cent of all malaria cases in India), Gujarat (11 per cent), Rajasthan (12 per cent), and Orissa (15 per cent of all malaria cases in India).

The state has made remarkable progress in the control of leprosy. The number of districts with a high prevalence of leprosy has been continuously going down. The overall prevalence of leprosy has also been reduced to a large extent. However the goal of elimination of leprosy is still distant. The prevalence of leprosy is very high in the districts of Chhattisgarh region. The state government has launched multi-drug therapy in all the districts to attack this problem.

The National Tuberculosis Control Programme suffers from financial constraints, and the resources for drugs, and x-rays are highly inadequate. Coupled with this is the problem of low patient compliance. The problem of tuberculosis deserves far greater attention by the state than is being accorded at present.

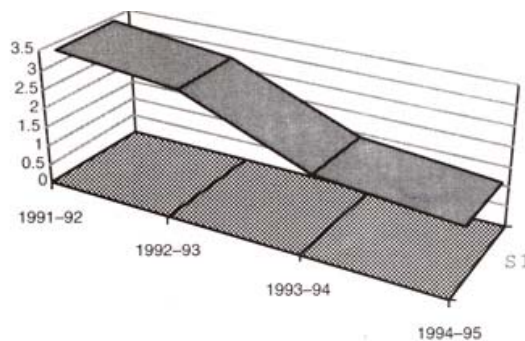
The National Blindness Control Programme has been launched in the state with the help of the World Bank. The state is attempting to clear all the backlog of cataract operations within the project period of years. Under the project, a large infrastructure of operation rooms and eye beds will be created in the state.

**Figure 4-12**  
**Prevalence of Leprosy**



Source: State Government Health Department

**Figure 4-13**  
**Prevalence of Leprosy**



Source: State Government Health Department

*Family Planning*

Madhya Pradesh has a very high birth and fertility rate. The crude birth rate of Madhya Pradesh according to the Sample Registration System is now 33.4. The fertility rate, according to NFHS, for the three-year period prior to the survey in 1992-93 is 3.9.

High population growth throws developmental efforts out of gear. The state has been making steady progress towards a high couple protection rate, and

a low birth rate. It can be seen from Figure 4-14 (that the couple protection rate has increased to 49. It can also be seen that this increase in (he couple protection rate has been mainly due to an increase in the use of spacing methods. This has also resulted in a reduction in CBR which, in the corresponding period, has come down from 35.8 in 1991 to 33.4 in 1993.

The National Family Health Survey has clearly shown that awareness about contraceptive methods is quite high in the state, and yet it also shows that (he actual use of contraceptive methods is low. This gap between awareness and actual use can be due to attitudinal problems, or due to a poor service delivery mechanism.

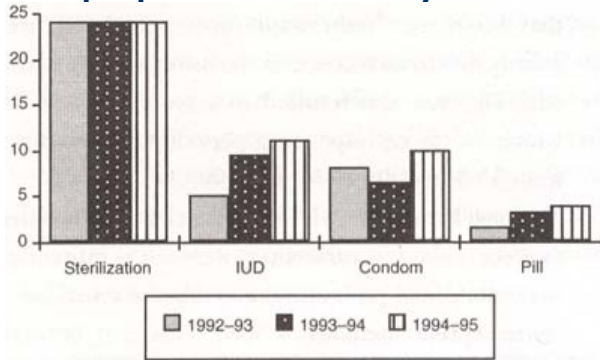
Poor service delivery can be seen from Figure 4-15. This graph shows that the only family planning service, which is delivered mainly by the government system, is sterilisation. It is the private system, which takes care of the needs of spacing methods of the community. It points to the urgent need to reorient the government system towards the family planning needs of the community, and place more emphasis on spacing methods.

It can be seen from Figure 4-16 that though women with less number of children either do not want children or at least do not want them for the next two years, yet they are not using contraceptives. This is clearly a failure of the system to deliver much needed services to the beneficiaries.

Similar conclusions can be drawn by studying the desire of women for more children, and actual use of contraceptives by them, by age group. It can be seen that women of lower age groups do not immediately desire children, and yet do not use contraceptives. If this data is analysed together with the fact that the public sector does not usually provide family planning services relating to spacing methods, the cause of high fertility will be easily understood.

**Figure 4-14**

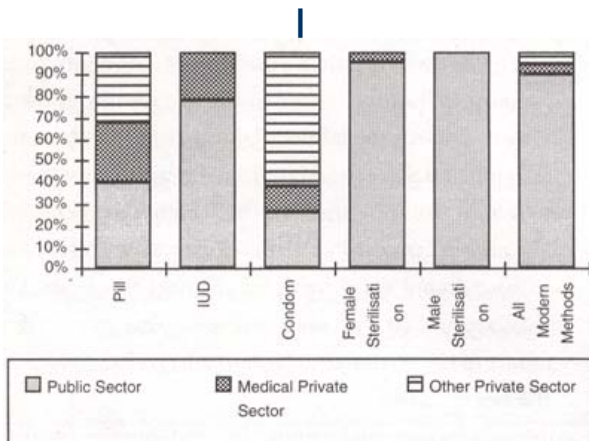
**Couple protection in Madhya Pradesh**



Source: State Government Health Department

**Figure 4-15**

**Source of Contraceptive Methods**



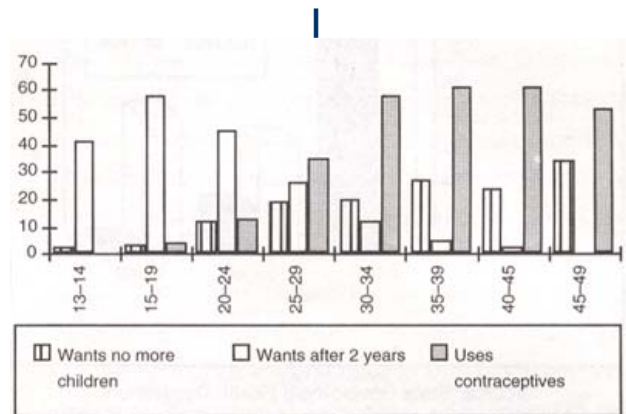
Source:NFHS

Figures given are percentages

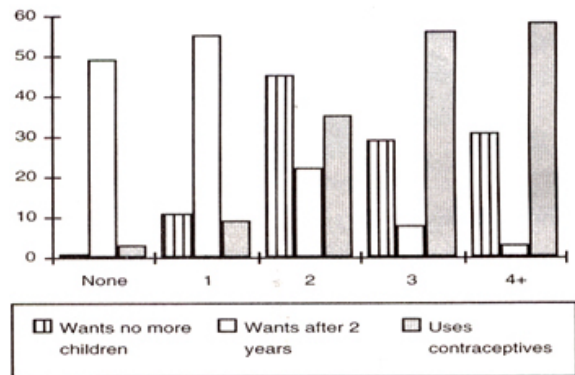
In short we need to go beyond talking about increasing awareness. Now is the need to change attitudes. The public sector should start placing more emphasis on spacing methods, and should provide good quality

**Figure 4-16**

**COMPARISON OF DESIRE FOR HAVING CHILDREN WITH USE OF CONTRACEPTIVES BY AGE GROUP**



**Comparison of desire for having children with use of Contraceptives by number of living children**



Source:NFHS

Figures given are percentages

**GOVERNMENT INITIATIVES**

Many new initiatives have been taken by the state government to increase the efficiency of the delivery mechanisms in the health sector in the last

three years, which have resulted in improved functioning of the sector. Some of these new initiatives are as follows.

### *Village Health Committees*

Village health committees have been constituted in each village. One couple who is interested in health activities, and is acceptable to the people of the village is selected from a neighbourhood of every 15-20 households, and these couples constitute the village health committee. The village health committee is responsible for the information, education and communication activities in the village. The committee also motivates the villagers to accept the relevant state sponsored programmes of the department. The committee is a lively link between the health worker and the village community.

#### **VILLAGE HEALTH COMMITTEES**

- One VHC in each of the 71 ,000 villages of state
- Couples are made members of VHC to focus on the family
- One couple for a neighbourhood of 15-20 house holds
- Selection based on choice of the community,
- Panchayat, members made members of VHC
- VHCs actively involved in solving health problems

### *Training and Supervision*

Training of health workers has been an important activity in the last few years. It has resulted in capacity building in the government for

communication, supervision, monitoring, motivation, etc. During the last 3 years, all health workers have been trained under IPP6, and are now being trained under the CSSM programme. An induction course has been started for newly appointed doctors, so that they can be trained in the national programmes and their role in the department. Supervisory capability has been definitely improved at all levels by training. The emphasis laid on the supervisory role of sector doctors has resulted in better supervision and improved performance.

### *Monitoring*

Improvement in monitoring has resulted in timely problem solving and better performance. The reporting system also appears to have improved considerably, Regular meetings are held every month at sector, block, district, division and state level. All programmes are regularly monitored in these meetings. The Department of Public Health brings out a monthly health bulletin regularly giving the progress in all programmes. Monitoring is followed by feedback to the lower levels about the areas where improvement is desired with constructive suggestions about how to bring about this change.

### **PRIVATE AND ALTERNATE SYSTEMS OF MEDICINE**

A survey conducted by Mode Research in Madhya Pradesh in 1993, showed that of the respondents studied, 19 per cent used only government institutions for health care and 36 per cent used government as well as private institutions. Though the majority use government institutions, a large number of 44 per cent “always go to a private doctor”. This clearly shows the importance of private medical care in the state and serves as a reminder that any attempt to better health needs to

involve the government and the private medical care community equally. Greater involvement of private practitioners in meeting the health needs of the people, to the extent possible, is something that needs to be explored further by the government.

Apart from the allopathic system of medicine there are the Indian systems of medicine (such as ayurveda, and unani), and the homeopathic system of medicine. The former category of medicines has a wide network of practitioners all over the state and provides reliable, effective, and cheaper alternate cures for many illnesses. Ayurveda, followed by unani and homeopathy, are popular in the state, and their relatively cheaper medicines and cures, the availability of practitioners, and effectiveness in dealing with some chronic diseases like asthma, piles, liver disorders, asyitis, paralytic group of diseases, respiratory diseases, etc., have led to a good demand base.

Under the Indian systems of medicines, the related health directorate covers ayurveda, unani, homeopathy and naturopathy. In spite of the shortage of funds and proper infrastructure in the state, there is a substantial demand for the ayurvedic system all over the state and for unani in certain areas.

Due to non-availability of funds, ayurveda hospitals are unable to provide the prescribed diet to indoor patients and medicines to outdoor patients (a sum of Rs. 8 per indoor patient and Re. 0.50 per outdoor patient are sanctioned by the Health Department). Doctors prescribe medicines, but no medicines have been bought for over four years. There is no laboratory or research center for these systems in the state.

There is a case for encouraging research, development and increased coverage of Indian systems of medicine in view of their cost-effectiveness for the poor, particularly where these systems are shown to provide effective treatments.

**PROBLEMS OF THE HEALTH DELIVERY SYSTEMS**

The problems of the government health system may be grouped under two broad headings:

- Financial problems
- Managerial problems

**Financial Problems**

The table below gives the proportion of the budget of the Health Department in the state budget.

Rs. In lakhs			
Year	State Budget	Health Budget	Per cent
1990-91	73350.6	3141.5	4.28 %
1991-92	79555.7	3524.6	4.43 %
1992-93	87629.6	3811.4	4.35 %
1993-94	91874.5	4060.3	4.42 %

Source: Department of Health, Government of Madhya Pradesh

It is clear from the table that on an average the health budget is just about 4.2 per cent of the state budget. Moreover, since almost 35 per cent of the money in the health budget comes from Government of India, the Health Department gets only about 3 per cent of the state's resources. This is also true of the Eighth Plan in general. The allocation for the Health Department is only 2.69 per cent of the total Eighth Plan for the state.

More disturbing is the fact that the revenue expenditure on health as a percentage of total

expenditure by the state has been continuously decreasing. This decrease in the availability of money for health and related activities has had a diverse effect on the delivery of health services in the state.

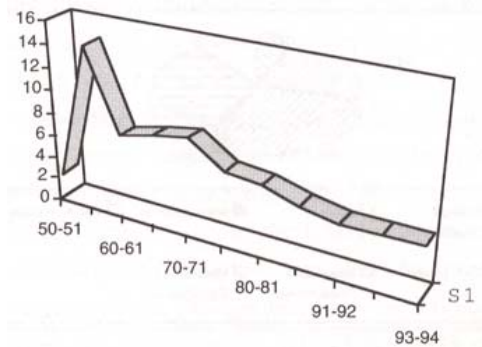
The per capita expenditure on health is represented in Figure 4-18. It can be seen that the per capita expenditure on health in Madhya Pradesh is one of the lowest in the country, being higher than only Bihar and Uttar Pradesh. This clearly shows that health has not received the attention due to this important sector by planners. If we want rapid improvement in the health system, increase in resource allocation will be immediately necessary.

Within the resources available in the health budget, very little money is used for the problems which have been outlined above as the most important public health problems of our state. Only 0.57 per cent expenditure is on maternal and child health, and 9.34 per cent on national disease programmes. Greater emphasis and resources need to be devoted to delivery of primary health care, rather than secondary, tertiary and curative health services.

This resource constraint has resulted in a situation where the government is not in a position to propose any new scheme. Even the continuation of old schemes is difficult. It is difficult to properly maintain the existing health infrastructure and to deliver services effectively, due to fiscal constraints.

For example, only Re. 0.50 is spent per outdoor patient and Rs. 2.50 per indoor patient on medicines, and this needs to be more than doubled. To provide at least one ambulance for each of the 42 district hospitals, 77 civil hospitals, 190 CHCs, and 269 block PHCs, 414 new ambulances are needed. For purchasing new equipment and maintaining existing equipment and buildings, an annual cost of Rs. 6.75 crore is necessary. The maintenance and replacement of furniture, beds, linen in the.

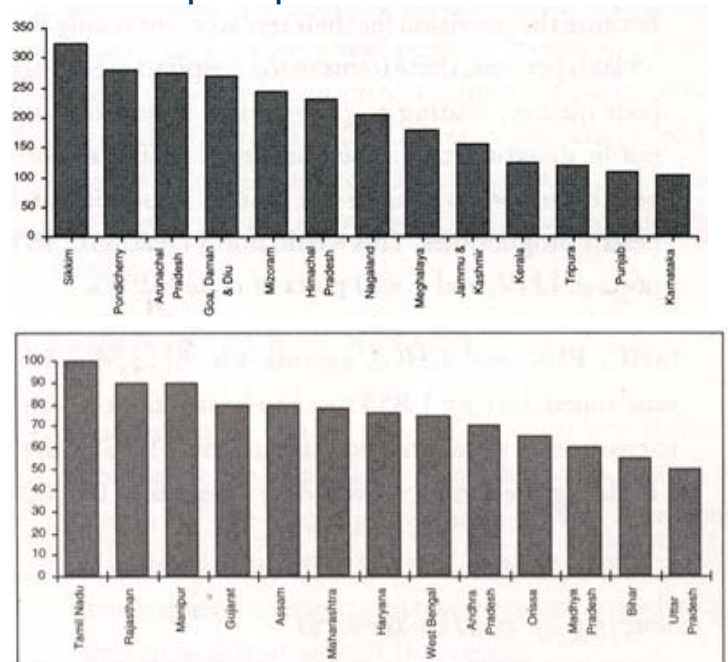
**Figure 4-17**  
Revenue Expenditure on Health as a Percentage of Total Government Expenditure



Source: Health expenditure across States, Part I, Economic and Political weekly, April 15 1995. Ravi Duggal et al.

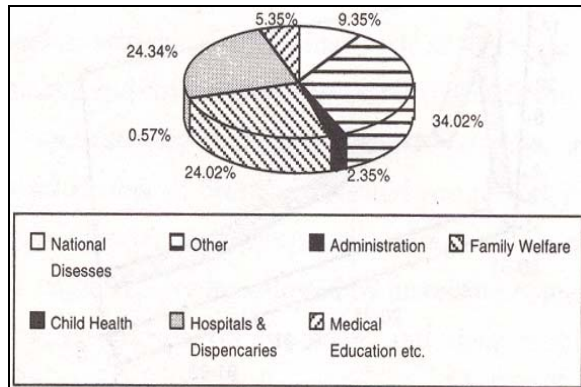
Figures given for 1993-94 are revised estimates

**Figure 4-18**  
Per capita Expenditure on Health



Source: Health expenditure across States, Part I, Economic and Political weekly, April 15 1995. Ravi Duggal et al. Figures given for 1993-94 are revised estimates

**Figure 4-19**  
**EXPENDITURE ON HEALTH UNDER**  
**DIFFERENT HEADS**  
**(As a percentage of the total health**  
**expenditure)**



Source: Health expenditure across States, Part I, Economic and Political weekly, April 15 1995. Ravi Duggal et al.

Figures given for 1993-94 are revised estimates. Figures are in percentages.

hospitals according to the prescribed replacement schedule requires Rs. 7.50 crore every year. Because the provision for their replacement is only Rs. 75 lakh per year, these items in the hospitals are of very poor quality, leading to problems of sanitation, and public dissatisfaction. The state needs to staff all sub health centres, to achieve the desired results in rural health programmes. This would imply creation of 485 posts of LHV, and 1,820 posts of male MPWs.

As per norms, the state needs 15,821 health institutions (SHC, PHC and CHC), against which 13,967 are sanctioned, leaving 1,854 more to be sanctioned. Just to ensure that all sanctioned institutions (13,967) have a building the total cost would be in excess of Rs 500 crore.

*Financing of health services*

If we put together all the additional funds needed for minimal maintenance, new equipment and

buildings and consumables as outlined above, the amount comes to roughly Rs. 30 crore annually. Additional funds needed for basic minimum capital infrastructure amounts to over Rs. 500 crore. Comparing these figures with the state budget, we see that the recurring annual funds needed amount to only 0.34 per cent of state's budget for 1992-93 (7.9 per cent of health budget). This is an achievable figure. The funds required for capital infrastructure amount to 5.7 per cent of the state's budget (0992-93), and are more than the total annual health budget. Substantial additional capital outlays will be needed for capital infrastructure.

While there is no doubt that state investment in health care needs to be stepped up in order to mobilise such large volume of funds, we also need to look at sources outside the government. This is also necessary for the financial sustainability of programmes, to ensure quality of delivery, and to ensure that investments made in the past do not fall apart due to lack of resources.

Cost recovery is an important issue that is related to the sustainability of public health programmes. Cost recovery is neither desirable nor possible where it has the effect of limiting the access of the poor to health services, but it must be explored in better-off areas, where there is a willingness to pay for reliable services. Additionally, in rural areas, even poor rural patients may regard it more desirable to have access to regular and efficient health care services close by, even if these services are partially funded by fees from the users, rather than to have to travel miles to get basic health care, especially where travel and physical costs are prohibitive.

The options are community participation in managing and funding health services in a participatory manner, even if contributions are small; encouraging private investment in health, both private medical facilities and services and private investment in government and public facilities and



services; and increased state investments in basic health. Government needs to concentrate resources on aspects of health which will not find private investment, and which will directly and particularly benefit the poor.

Government health expenditure, planning and programmes should also take a look at possible reduction in expenditure on tertiary facilities, and reorienting expenditure towards primary and preventive health care. There is a need for encouraging private investment in areas outside essential services.

The health system must also seriously examine and act on all possibilities of promoting alternate Indian systems of medicine which provide accessible and cheaper forms of health care and have a base of practitioners and traditions in all parts of the state. Promoting such alternate systems will also ease the pressure on the formal health system, and costs for the government as well as the people.

### **Managerial Problems**

Certain management-related issues of the government health system have affected programme delivery in health. These are discussed below.

- *Doctors.* There are no doctors in 375 of the 1,841 state PHCs, whereas many urban hospitals have surplus doctors. Apart from this, approximately 50 doctors are on unauthorized leave at any given time. This has resulted in poor quality of services in the rural health institutions. An attempt was made by the state in 1993 to remedy the situation to a certain extent by posting doctors in remote single-doctor PHCs, and insisting that they join in their place of posting. However the situation has worsened in the last year.
- *Health Workers.* There are complaints that many health workers do not stay at their headquarters. Though, in many cases, these complaints are true, many health workers face genuine difficulty in staying in their headquarters, as there are no houses for them. Most of these health workers are women, many of whom are unmarried young women, and they find it difficult to stay in their headquarters under these circumstances.
- *Decentralisation.* A major malaise of the health set-up is over-centralisation of authority. All the authority in a district is centralised in the Chief Medical and Health Officer. This results in the CMHO becoming overloaded with unproductive work, and a lack of initiative in other officers. Delegation of sufficient financial and administrative authority to block level officers and to hospital superintendents is needed to improve delivery of services to the people.
- *Departmental reorganisation.* The department needs rationalisation and reorganisation of posts. This is necessary for better delivery of services and better cadre management. For example, there are many subjects in which there are very few posts of specialists, while there is the need for a greater number of posts. Similarly, the District Health Officer is not being used as well as he/she should be. The post of a Block Medical Officer is needed to improve health services in the field.

### **GENDER ISSUES IN HEALTH**

The discussion on health will not be complete without discussing the importance of gender issues related to health. While health problems of women have been discussed in the earlier sections, a more comprehensive discussion on women's empowerment and its relationship to health in general is necessary.

In general it can be said that women's empowerment is not only helpful to the improvement of the health status of the community, but is an absolute prerequisite for it. A comparison between the index of women's advancement (WDI) (calculated by adding percentage of female literacy, percentage of women gainfully employed, and percentage of unmarried women in the age group 15-19), and infant mortality rates of districts of Madhya Pradesh in spite of some fluctuations shows the general trend is that where ever the index of women advancement is low, the IMR is high.

This becomes clearer when we compare the districts at either end of the spectrum. Thus, Morena, Bhind and Shivpuri, which have a very low index of maternal development, have a high IMR. On the other hand, Indore, Bhopal and Durg have a high index of maternal development and a low IMR.

This correlation can be explained on the basis of many hypothesis. The more important ones are:

1. Better education leading to better marriage, and better Incomes.
2. Better education leading to better nutrition and health related knowledge, and better care during sickness.
3. Greater role in decision-making in the household by women.
4. Higher age of marriage, better spacing of children, better spacing of available resources, and services.

Whatever be the reason it cannot be denied that empowerment of women will lead to better health for the community.

Traditionally health has generally been considered the responsibility of women. Thus almost 80 per cent sterilisation operations are performed on women; it is women who take care of the child during illness and brings it to the health care institution for immunisation, etc.; women are responsible for the drinking water and nutrition needs of the family..

### KAYAKALP

Maharaja Yashvantrao Holkar Hospital is one of the biggest health institutions in the state of Madhya Pradesh located at Indore, serving Indore and neighbouring districts and bordering states. Established in 1959, the institution got into a poor state, and the condition of the building severely deteriorated. Private wards were occupied by the doctors and other hospital staff. The institution became the shelter home for homeless people beside population of rodents, bed-bugs and mosquitoes. Wastage also piled up wherever it found space.

The condition of the hospital became a matter of concern when the plague hit Gujarat. The need for immediate and complete renovation of the hospital was felt. As the funds from the state government departments were getting delayed, the district administration undertook the responsibility through the District Red Cross Society, and made an open appeal for people's participation and public donations. A work strategy was designed and a steering committee with various other coordinating committees were formed.

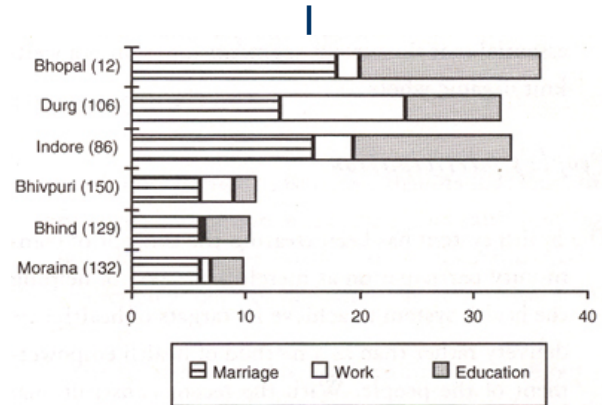
A decision to collect nominal registration fees from the patients was taken and the amount collected was deposited in the account of

'Patient Welfare Samiti' to provide free health services to the poor and for better maintenance of the hospital. A sum of 'Rs. 55 lakh was' collected through people's participation, especially efforts of the Indore Press club which collected material worth about Rs. 8 lakh. Different groups and individuals came together as a helping brigade (NGO's, associations, faculty members of the Medical College, doctors and other staff of MY Hospital); and it seemed as if a whole populace had joined. The main activities were classified, as (a) vacating the hospital building and making alternative arrangements; (b) operation rodent control; (c) repairing, whitewashing and painting (d) scientific area management. The goal of Kayakalp of MY Hospital took just about a month. (Based on a report by Red Cross Society, Indore)

**SANJIVINI ABHIYAN**

A similar but smaller experiment was, carried out in Satna where the district authorities took the lead in encouraging local participation in a major public hospital. Volunteer citizens' participation was brought to manage cleanliness and hygiene of the hospital, and renovation of buildings. This effort is known as the Sanjivini Abhiyan and is running very successfully.

**Figure 4-20**  
**Index of Women Advancement**  
(Selected districts of Madhya Pradesh)



This has resulted in women getting over-burdened with the task of providing good health to the community, while men have more or less abdicated their responsibility

There is also a necessity for men to share more responsibilities. The concept of responsible fatherhood needs to be popularised.

**ISSUES IN HEALTH CARE**

The health sector is an important social sector with direct implications for the quality of life. It also indirectly assists in development and productivity. It is important, therefore, to ensure that increased resources are made available to this sector and to see that whatever resources are provided they are equitably distributed with emphasis on the tenets of primary health care, for the benefit of the people, not forgetting the rural masses and the poor. The primary health care concept is not restricted to the provision of services and infrastructure at the periphery alone. Health care delivery should be seen as a continuum, a spectrum that ranges from basic care delivered by the community itself at one end to the most evolved

tertiary care facility at the other extreme. The entire chain is needed if any part of the system is to work at optimal efficiency. It is essential that the various segments function as a well knit organic whole.

### *People's participation*

The health system has been treating the concept of community participation as merely a method of helping the health system to achieve its targets of health care delivery rather than as a method of health empowerment of the people. With the recent constitutional introduction of gram panchayats in the state, people's participation will not be merely passive acceptance of health care but would progress towards the ideal of an active partnership and a dynamic decision-making role for the community.

Active steps should be taken to make the health services relevant by ensuring that planning exercises are carried out at all levels – particularly at the block level – annually. The Janpad sabha, and the Gram Panchayats must be involved in this activity and in the delivery of the health services. The state would do well to initiate block and district-level planning ensuring people's involvement through the Panchayat system, making the health care delivery system more of the people and for the people.

In a significant move in this direction, the state government in a recent cabinet decision has declared the formation of Rogi Kalyan Samitis all across the state as societies that will manage all state-owned hospitals. This scheme places the management of the hospitals in the hands of the users. The Rogi Kalyan Samitis will be set up at different levels managing district, block and other hospitals, and will have panchayat representatives, district officials, and all people who donate more than Rs. 1 lakh towards the hospitals as members. To be implemented from next year, all matters

pertaining to hospitals will be managed by them, including fund management.

Non-governmental and voluntary organisations have been very successful in implementing health-related programmes, especially concerned with basic health, managing reach remote and inaccessible areas, and motivating the people through extension and communication. Though Madhya Pradesh does not have a very strong tradition of NGOs and voluntary effort, unlike neighbouring Gujarat and Rajasthan, there are some good examples in the state such as the Sanjivini Abhiyan in Sarna, the Ramakrishna Mission in Raipur, the Rural Development Service Society (ROSS, Silvani) in Raisen. The state should encourage NGOs and voluntary effort in health, and specially involve them in basic health, women and child health, community health, and health delivery to the poor and in remote areas.

### *Information management*

One of the stumbling blocks in planning is the non availability of local-level statistics. Apart from this, the staff and managers of health programmes and health delivery systems, either at the primary health centre or the district level, are not trained to look critically at data or to plan interventions in the broad area of public health. The data collected should have direct relevance to public health for managerial interventions. The process of district-level health planning and programme designing and management needs a support base of knowledge and skills which should be brought together and developed in districts.

In spite of extensive data collection at the sub-health centre level, no reliable statistics are available to those who can use this data in a meaningful manner. The format of record-keeping and reporting is generally not designed with either

health care or local-level utilisation in mind, but is primarily an accounting system for generation of numerical data.

The system of accounting rather than reporting meaningful statistics can often be misleading. While the state reports that the immunisation coverage is more than 80 per cent, several coverage evaluation studies have revealed immunisation coverage in the state to be about 30-40 per cent only. Neither figure is wrong in itself; the first is the accountant's view, the second is from the perspective of a health scientist. Added to this is the problem of over-reporting of desired targets in many programmes, for example immunisation coverage.

One aspect that needs attention is that the vast majority of the people living in the villages are unaware of the health and medical services available to them. When people are informed about the arrangements and availability of health services, the utilization of services provided for will increase.

Health education cannot be imported by doctors or health workers alone. Material for appropriate health education and information for transmission to the public must be devised jointly by the medical profession (who would provide the technical information), sociologists and anthropologists (who would translate it into a form acceptable by the people), and educationist (who are trained to communicate). What has been missing in mass communication initiatives is involvement of mass communication and media experts in design, planning and implementation.

## SUMMING UP

By way of conclusion, it must be said that Madhya Pradesh's balance-sheet of outcomes related to health is not yet satisfactory and the goal of Health for All remains a challenging one for the state, at least within this century.

While part of the solution is clearly to direct more resources to the formal health sector, persistent and singular problems require unique and innovative solutions. Programme coverage needs to be extended through strategies aiming at the involvement of persons from the target population centres. The local communities need to be empowered by upgrading their human resources to tackle their health care problems (at least for preliminary diagnosis and preventive treatment). Cost recovery options need to be explored. Extension programmes in the traditional sense need to be reinforced with innovative strategies where the target communities will themselves be able to provide doctors from amongst themselves or from their immediate vicinity. State strategies, institutional programmes and people's initiatives in Madhya Pradesh must seek the answers to their problems by finding comrades and activists amongst those who need their services the most—the people of Madhya Pradesh.