# "Health & Development Programmes and Policies of Govt. for Women in India"

**Bina Rai**
Asst. Professor (Political Science) R.G. (P.G.) College, Meerut, Uttar Pradesh, India

## Abstract

The World Health Organization defines health as a state of complete physical, mental, and social well-being, not merely absence of disease or infirmity. In recent years, this statement has been amplified to include the ability to lead "a socially and economically productive life". India has made considerable progress in social and economic development in recent decades, as improvements in indicators such as life expectancy, infant mortality and literacy demonstrate. However, in women's health have lagged behind gains in other areas. The cultural norms that particularly affect women's health are the attitudes to marriage, age of marriage, the value attached to fertility and the sex of the child and the ideal role demanded of the women by social conventions. The age of marriage and fertility rate have important demographic implications. Cultural insistence on the marriage of women in early phase of their childbearing period leads to high fertility rate and each additional child is a burden on the mother affecting her physical and mental health. The process, therefore starts at an early age and has very adverse consequences on women's health, particularly at the time of pregnancy and childbirth. From their childhood, girls are taught not to complain and to maintain strict secrecy about their physical troubles

**KEYWORDS:**Gross National Income, National Health Policy, Nutrition, Fertility and family planning, maternal mortality, Adolescent Health, MTP Act.

## Introduction

The fact that substantial sections of Indian population suffer from serious deprivations vis-a-vis a set of commonly acknowledged basic needs, such as adequate food, shelter, clothing, basic health care, primary education, clean drinking water and basic sanitation - is well known. In this regard, one may recall some sentences from the address to the country by the President of India on the occasion of the Independence Day 2000:

"Fifty years into the life of our Republic we find that justice - social, economic and political - remains an unrealized dream for millions of our fellow citizens. The benefits of our economic growth are yet to reach them. We have one of the world's largest reservoirs of technical personnel, but also the world's largest number of illiterates, the world's largest middle class, but also the largest number of people below the poverty line, and the largest number of children suffering from malnutrition. Our giant factories rise out of squalor, our satellites shoot up from the midst of the hovels of the poor. Not surprisingly, there is sullen resentment among the masses against their condition erupting often in violent forms in several parts of the country. Tragically, the growth in our economy has not been uniform. It has been accompanied by great regional and social inequalities.

Many a social upheaval can be traced to the neglect of the lowest of society, whose discontent moves towards the path of violence".

Such an acknowledgement by the former President of the multidimensional deprivations afflicting millions of citizens is a damning indictment of the key failures of the Indian society. Indeed, the major shortcoming of the State-led economic transformation in India after independence is not the lack of economic growth or industrialization (as is often portrayed in some quarters), - on the contrary, in these respects Indian performance has been at least respectable - but it is in the realm of policies and processes that could have facilitated the fulfillment of the above noted basic needs. Moreover, there is some concern that with reference to some of these basic needs the prospects may have worsened relatively during what is commonly described as the period of economic reforms (i.e. the period since July 1991 onwards).

India today, is the world's third largest economy in terms of its Gross National Income (in PPP terms) and has the potential to grow larger and more equitably, and to emerge to be counted as one of the developed nations of the world. India today possesses as never before, a sophisticated arsenal of interventions, technologies and knowledge required for providing health care to her people. Yet the gaps in health outcomes continue to widen. On the face of it, much of the ill health, disease, premature death, and suffering we see on such a large scale is needless, given the availability of effective and affordable interventions for prevention and treatment. "The reality is straightforward. The power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in a comprehensive way, and on an adequate scale".

Health and health care development has not been a priority of the Indian state. This is reflected in two significant facts. One, the low level of investment and allocation of resources to the health sector over the years – about one percent of GDP with clear declining trends over the last decade. And second the uncontrolled and very rapid development of an unregulated private health sector, especially in the last two decades. Yes, we have a health policy document but it took 35 years after Independence for the government to make a health policy statement in 1982-83. And it is no coincidence that such a policy statement came only after the 1978 Alma Ata Declaration of the World Health Assembly – Health for All by year 2000 AD. But this does not mean that there was no health policy all these years. There was a distinct policy and strategy for the health sector, albeit an unwritten one. This was reflected through the Five Year Plans of the Central government. This, despite the fact that health is a state subject.

At the state government level there is no evidence of any policy initiatives in the health sector. The Central government through the Council of Health and Family Welfare and various Committee recommendations has shaped health policy and planning in India. It has directed this through the Five Year Plans through which it executes its decisions. The entire approach has been program based. The Centre designs national programs and the states have to just accept them. The Centre assures this through the fiscal control it has in distribution of resources. So, essentially what is a state subject the Centre takes major decisions.

However it is important to note that this Central control is largely over preventive and promotive programs like the Disease Control programs, MCH and Family Planning,

which together account for between half and two-thirds of state budgets. Curative care, that is hospital and dispensaries, has not been an area of Central influence and in this domain investments have come mostly from the state's own resources. Structured health policy making and health planning in India is not a post-independence phenomena. In fact, the most comprehensive health policy and plan document ever prepared in India was on the eve of Independence in 1946. This was the `Health Survey and Development Committee Report' popularly referred to as the Bhore Committee. This Committee prepared a detailed plan of a National Health Service for the country, which would provide a universal coverage to the entire population free of charges through a comprehensive state run salaried health service. Such a well-studied and minutely documented plan has not as yet been prepared in Independent India.

It was not until 1983 that India adopted a formal or official National Health Policy. Prior to that health activities of the state were formulated through the Five year Plans and recommendations of various Committees. For the Five Year Plans the health sector constituted schemes that had targets to be fulfilled. Each plan period had a number of schemes and every subsequent plan added more and dropped a few. Here I point out some remarkable five year plans.

The **third Five Year Plan** launched in 1961 discussed the problems The Third Five Year Plan highlighted inadequacy of health care institutions, doctors and other personnel in rural areas as being the major shortcomings at the end of the second Five Year Plan. It was in the **5th Plan** that the government ruefully acknowledged that despite advances in terms of infant mortality rate going down, life expectancy going up, the number of medical institutions, functionaries, beds, health facilities etc., were still inadequate in the rural areas. This shows that the government acknowledged that the urban health structure had expanded at the cost of the rural sectors. This awareness is clearly reflected in the objectives of **5th Five YearPlan** which were as follows:

- Increasing the accessibility of health services to rural areas through the Minimum Needs Programme (MNP) and correcting the regional imbalances.
- Referral services to be developed further by removing deficiencies in district and sub-division hospitals.
- Intensification of the control and eradication of communicable diseases.
- Affecting quality improvement in the education and training of health personnel.
- Development of referral services by providing specialists attention to common diseases in rural areas.

The methods by which these goals were to be achieved were through the MNP, the MPW training scheme, and priority treatment to backward and tribal areas.

Major innovations took place with regard to the health policy and method of delivery of health care services. The reformulation of health programmes was to consolidate past gains in various fields of health such as communicable diseases, medical education and provision of infrastructure in rural areas. This was envisaged through the MNP which would "receive the highest priority and will be the first charge on the development outlays under the health sector. It was an integrated packaged approach to the rural areas.

**The Sixth Plan** was to a great extent influenced by the **Alma Ata declaration of Health for All by 2000 AD (WHO, 1978) and the ICSSR - ICMR report (1980).** The plan conceded that "there is a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which is availed of mostly by the well to do classes. It is also realized that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services" (Draft FYP VI, Vol. III, 1978, 250).

The plan emphasized the development of a community based health system. The strategies advocated were:

a) Provision of health services to the rural areas on a priority basis.

b) The training of a large cadre of first level health workers selected from the community and supervised by MPWs and medical officers of the PHCs.

c) No further linear expansion of curative facilities in urban areas; this would be permitted only in exceptional cases dictated by real felt need or priority.

The plan emphasized that horizontal and vertical linkages had to be established among all the interrelated programmes, like water supply, environmental sanitation, hygiene, nutrition, education, family planning and MCH. The objective of achieving a net reproduction rate of 1 by1995 was reiterated. (FYP VI, 1980, 368)

This plan and the **seventh plan** too, like the earlier ones make a lot of radical statements and have recommend progressive measures. But the story is the same - progressive thinking and inadequate action. Whatever new schemes are introduced the core of the existing framework and ideology remains untouched. The underprivileged get worse off and the already privileged get better off. The status quo of the political economy is maintained. However, the Sixth and the Seventh plans are different from the earlier ones in one respect. They no longer talk of targets. The keywords are efficiency and quality and the means to realize them is privatization. Privatization is the global characteristic of the eighties and the nineties and it has made inroads everywhere and especially in the socialist countries.

Our rural health care schemes cover just a few diseases. Contrast our health care efforts with that of china’s recently announced well thought of program of spending $124 billion to modernize its national health care system in the next three years.

The National Health Policy (NHP) in light of the Directive Principles of the constitution of India recommends "universal, comprehensive primary health care services which are relevant to the actual needs and priorities of the community at a cost which people can afford". Providing universal health care as a goal is a welcome step because this is the first time after the Bhore Committee that the government is talking of universal comprehensive health care.

In 1983, the Government for the first time adopted **a National Health Policy,** (prior to that the actions of the Government in the health sector were guided by the Five Year Plans and recommendations of various committees), and its major recommendations was: “universal, comprehensive primary health care services which are relevant to the actual

needs and priorities of the community at a cost which people can afford". Then after a period of eighteen years, the Draft National Health Policy 2001 was announced towards the end of 2001 and was adopted by the Central Government in the year 2002. This new National Health Policy (henceforth NHP) candidly acknowledges that India's public health care system is grossly short of defined requirements, functioning is far from satisfactory, that morbidity and mortality due to diseases that are curable continues to be unacceptably high, and resource allocations are generally insufficient. However, the 1983 NHP's goal "of providing universal, comprehensive primary health care services" does not even find a mention in this new policy document.

The above analysis clearly indicates that the 1983 NHP did not reflect the ground realities adequately. The tasks enunciated in the policy were not sufficient to meet the demands of the masses, especially those residing in rural areas. The 1983 NHP goal, is far from being achieved. The present paradigm of health care development has in fact raised inequities, and in the current scenario of structural adjustment the present strategy is only making things worse. That is, committing increasing resources in favor of health priorities where gains in terms of efficiency override the severity of the health care problems, questions of equity and social justice. So powerful has been the World Bank's influence, that the WHO too has taken an about turn on its Alma Ata Declaration. WHO in its "Health for All in the 21st Century" agenda too is talking about selective health care, by supporting selected disease control programs and pushing under the carpet commitments to equity and social justice. India's health policy too has been moving increasingly in the direction of selective health care - from a commitment of comprehensive health care on the eve of Independence, and its reiteration in the 1983 health policy, to a narrowing down of concern only for family planning, immunization and control of selected diseases. Hence, one has to view with seriousness the continuance of the current paradigm and make policy changes which would make primary health care as per the needs of the population a reality and accessible to all without any social, geographical and financial inequities. The **Ninth Plan** also reviews population policy and the family planning program. In this review too it goes back to the Bhore Committee report and says that the core of this program is maternal and child health services. Assuring antenatal care, safe delivery and immunization are critical to reducing infant and maternal mortality and this in turn has bearing on contraception use and fertility rates.The 9th Plan period is coming to a close and a review of all its innovative suggestions shows that we have once again failed at the ground level. We have been unable to translate these ideas into practice. And despite all these efforts one can see the public health system weakening further. The answer is found in the 9th Plan itself. It laments that all these years we have failed to allocate even two percent of plan resources to the health sector. The same reason has killed the initiative shown in the 9th Plan process at the start itself by continuing the story of inadequate resource allocations for the health sector.

On the eve of the **10th Plan,** the draft **National Health Policy 2001** has been announced and for the first time feedback invited from the public. "Universal, comprehensive, primary health care services", the NHP 1983 goal, is not even mentioned in the NHP 2001 but the latter bravely acknowledges that the public health care system is grossly short of defined requirements, functioning is far from satisfactory, that morbidity and mortality due to easily curable diseases continues to be unacceptably high, and resource

allocations generally insufficient -"It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services."

It has been strongly argued by many that this new NHP is riddled with confusions and contradictions as it only proposes numerous impressive principles and goals but does nothing to ensure that these are realized on the ground. On the other hand it can also be argued that this new NHP is an attempt towards legitimizing the ongoing privatization of the health care system of the country. The avowedly stated objective of the new NHP is to achieve an acceptable standard of good health amongst the general population of the country. As mentioned earlier, NHP 2002 is quite explicit in its acknowledgement of the poor state of affairs in the health sector; it also recognizes globalization as a concern with a critical view of TRIPS and its impacts, envisages regulation of the private health care sector, and proposed to increase the expenditure on primary health care.

**Women and Health**

Now the question about women's health in India. India has made considerable progress in social and economic development in recent decades, as improvements in indicators such as life expectancy, infant mortality and literacy demonstrate. However, improvements in women's health have lagged behind gains in other areas. India is one of the few countries where males significantly outnumber females, and its maternal mortality rates in rural areas are among the world's highest. Health is both an important factor in the achievement of status as well as an indicator of social status, particularly for women. The health of Indian women is intrinsically linked to their status in society. Indian women have low levels of both education and formal labor force participation. They typically have little autonomy, living under the control of their fathers, then their husbands and finally their sons.

Due to the wide variation in cultures, religions, and levels of development. It is not surprising that women's health varies greatly from region to region. All of these factors exert a negative impact on the health status of Indian women. The health status of women includes their mental and social condition, as affected by prevailing norms and attitudes of society, in addition to their biological and physiological problems. Society delineates women's role partly according to their biological functions and partly from prevailing attitudes regarding their physical and mental capacity. The health care facilities offered by a community in the form of medical, particularly maternity services for women, are significant index of the emphasis that community places on the health of its women. Some studies in both the developed and developing countries by WHO have shown a definite link between low status of women and deficiencies in the knowledge and utilization preventive health services.

The indicators of women's health status in India can be drawn from the following sources:

- Nutrition
- Fertility and family planning
- Maternal mortality
- Access to health care services

Overall government spending on health represents only about 1.3% of gross domestic product. In addition to general health services provided to all people. Public sector services to meet the specific health and nutritional needs of women are provided through the family welfare program of the ministry of health and family welfare and the ICDS Program of the ministry of Human Resources Development.

The Directorate of Family Welfare was established in the year 1976 as a part of the Directorate of Health Services subsequently around 1992-93, the department of Family Welfare was separately administratively from Director of Health Services .The need to reduce the IMR, MMR & TFR, it became imperative to have an independent organizational set up for the Directorate of Family Welfare on the pattern of similar directorates countrywide.

Directorate of Family of Welfare is responsible for planning, coordinating, monitoring, supervising and evaluating activities with other agencies of Govt. including NGO's in the following primary health care activities:

1. To facilitate provision of antenatal and natal services to pregnant women.
2. To facilitate implementation of Post-partum program.
3. To facilitate provision of family planning services (Basket of contraceptives, female/male sterilization, Counseling etc.)
4. Implementation of UIP (Universal Immunization Program).
5. Surveillance of VPD (Vaccine Preventable Diseases) Services
6. Implementation of Pulse Polio Program.
7. Implementation of PC & PNDT (Pre conception & Pre Natal Diagnostic Techniques Act 1994 Prevention of Sex Selection) and MTP (Medical Termination of Pregnancy) Act.
8. Co-ordination and execution of IEC activities through Mass Education Media.
9. Procurement of State Specific vaccines such as MMR, Typhoid & Pentavalent Vaccines. Stocking, maintaining cold chain, disbursing vaccines and family welfare logistics to all health providing agencies in the state.
10. To monitor performance and quality of family welfare activities by NGO's and release of Grant-in-Aid to them.
11. To facilitate provision of Adolescent Health Services in the state

**Government's Health Programmes and Schemes**

The Ministry of Women and Child Development has come up with several schemes deciding the norms of child nutrition. These are:

•**National Guidelines on Infants and Young Child Feeding**: these guidelines emphasize the importance of breast feeding. Breast feeding must commence immediately

after birth and continue exclusively for six months before other forms of milk are introduced. Appropriate and adequate complementary feeding must commence thereafter and breast-feeding can continue for up to two years.

•**National Nutrition Policy**: was adopted by the Government of India in 1993 under the aegis of the Department of Women and Child Development. It advocated a multi-sectorial strategy for eradicating malnutrition and achieving optimum nutrition for all. The policy advocates the monitoring the nutrition levels across the country and sensitizing government machinery on the need for good nutrition and prevention of malnutrition. The National Nutrition Policy also includes the Food and Nutrition Board, which develops posters, audio jingles and video spots for disseminating correct facts about breastfeeding and complementary feeding.

•**The Integrated Child Development Services Scheme**: is one of the most comprehensive schemes on child development in the country and perhaps in the world. The Ministry has been running the scheme since 1975 in pursuance of the National Policy for Children. It aims at providing services to pre-school children in an integrated manner so as to ensure proper growth and development of children in rural, tribal and slum areas. This centrally sponsored scheme also monitors nutrition of children.

•**Udisha**: in Sanskrit means the first rays of the new dawn. It is a nationwide training component of the World Bank assisted Women and Child Development Project.Udisha has been cleared with an outlay of about Rs.600 crores for five years. UNICEF is also a technical collaborator in the Project. The programmes aims to train child care workers across the country. Its scope reaches as far are remote villages.

•**National Policy for Children**: lays down that the State shall provide adequate services towards children, both before and after birth and during the growing stages for their full physical, mental and social development.

•National Plan of Action for Children includes goals, objectives, strategies and activities for improving the nutritional status of children, reducing Infant Mortality Rate, increasing enrolment ratio, reducing dropout rates, universalization of primary education and increasing coverage for immunization.

**Other Schemes Include:**

1. BalikaSamriddhiYojana (BSY)
2. KishoriShakti Yojana (KSY)
3. Nutrition Program for Adolescent Girls (NPAG)
4. Central Adoption Resource Agency(CERA)
5. Rajiv Gandhi National Crèche Scheme For the Children of Working Mothers
6. General Grant-in-Aid Scheme
7. National Crèche Fund

**Maternal Health:**

Maternal Health refers to the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the healthcare dimensions of preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality.Directorate of

Family Welfare is involved in coordinating, monitoring & supervising all the health agencies in the state providing maternal health for quality care to pregnant mothers, promotion of safe delivery and post-partum care.In addition, DFW is also involved in implementation of maternal health schemes like:

**JANANI SURAKSHA YOJANA (JSY):**

It is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and infant mortality by promoting institutional delivery among the poor pregnant women. It integrates cash assistance to pregnant women belonging to SC, ST and BPL category for delivery and post-delivery care. The accredited social health activist (ASHA) is being identified as an effective link between the Government and the pregnant women to facilitate in implementation of this program.

**JANANI SHISHU SURAKSHA KARYAKRAM (JSSK)**:

Under this scheme free and cashless services will be provided to all pregnant women irrespective of any caste or economic status including normal deliveries and caesarean operations and to sick infants (from birth to 1 year of age) in all Government health institutions in both rural and urban areas. JSSK supplements the cash assistance given to a pregnant woman under Janani Suraksha Yojana and is aimed at mitigating the burden of out of pocket expenses incurred by pregnant women and sick infant. Besides this, it would be a major factor in enhancing access to public health institutions and help bring down the Maternal Mortality and Infant mortality rates.

The Free Entitlements under JSSK would include: Free and Cashless Delivery, Free C-Section, Free treatment of sick infants up to 1 year, Exemption from User Charges, Free Drugs and Consumables, Free Diagnostics, Free Diet during stay in the health institutions for 3 days in case of normal delivery and 7 days in case of caesarean section, Free Provision of Blood, Free Transport from Home to Health Institutions, between facilities in case of referral and also Drop Back from Institutions to home after discharge from the Govt. facility. Free Entitlements for Sick Infants till 1 year after birth similarly include free treatment, free drugs and consumables, free diagnostics, free provision of blood, Exemption from user charges, Free Transport from Home to Health Institutions, between facilities in case of referral and free drop Back from Institutions to home.

**MATRI SHISHU SURAKSHA YOJNA (MSSY):**

This is a new scheme to be implemented through Directorate of Family Welfare, Govt. of NCT of Delhi and will be funded by Department for the Welfare of SC/ST/OBC/Minorities, Delhi. Under this scheme financial assistance of Rs.1000/- will be given to poor pregnant SC woman of Delhi during 3rd trimester of pregnancy for providing nutritional support to the pregnant woman. It will prevent under nutrition and anemia in pregnant women thereby reducing pre-mature and under weight babies thus reducing both Maternal and Neonatal Morbidity and Mortality.

**Adolescent Health:**

Adolescents (10-19 years) represent over one-fifth of the population. During this transition period they undergo physical, emotional, social, behavioral and reproductive changes. This in turn may have serious social, economic and public health implications. It is imperative to address these issues at the appropriate time by skilled personnel as they are the future human resource of the country. 70% of the adulthood morbidity and mortality can be prevented by right kind of behavior and habits during this phase of life. Since adolescents are not a homogenous group, flexible and need based interventions are called for. Delhi state is committed to the cause of Adolescent Health and is imparting Adolescent Health services through 291 Adolescent health clinics named as "DISHA (Delhi Initiative for Safe Guarding Health of Adolescents" clinics. These services are being provided between 8:00 A.M. to 2:00 P.M. on all working days and in a dedicated manner every Saturday from 12.00 to 2.00 p.m.

The Services provided are an amalgamation of Preventive, Promotive, Curative and Referral services on Growth and development, Sexual & Reproductive Health, Nutrition, Contraception and Behavioral issues. In order to address their issues in a non-judgmental, empathetic and holistic manner these clinics have been mainstreamed in an integrated manner in already existing Health care delivery units- dispensaries, hospitals and M&CW centers. Adolescent Health Services are being catered to both married and unmarried adolescents.

**Weekly Iron & Folic Acid Supplementation Program (WIFS)**

This program entails administration of IFA tablet free of cost every Wednesday once a week for 52 weeks in a year. The target beneficiaries are school going boys and girls of 6th to 12th class enrolled in Govt./Govt. Aided/NDMC schools and cantonment board schools and out of school Adolescent girls (10-19 year) in AnganwadiCentres. This tablet has to be swallowed with water after meals (not to be chewed). The department is entrusted with the implementation of WIFS Program in AnganwadiCentres through ICDS Project.

**The Pre- conception and Pre- natal diagnostic techniques Act (PC and PNDT Act)** enacted in 1994 seeks to address this problem legally. It is the end product of extensive deliberations among all stake holders i.e. the people's representatives, medical practitioners and the civil society. The PNDT Act focuses on the need to eliminate the illegal practice of sex determination and female feticide and echoes the collective concern of the people's representative and the civil society.

**MTP Act**

The Indian abortion law is governed by the Medical Termination of Pregnancy (MTP) Act, which was enacted by the Indian Parliament in the year 1971. The MTP Act came into effect from April 1, 1972 and was amended in 1975 and 2004.The Medical Termination of Pregnancy (MTP) Act of India clearly states the conditions under which a pregnancy can be ended or aborted, the persons who are qualified to conduct the abortion and the place of implementation. MTP Act has been decentralized in Delhi and DFW is

engaged in Co-ordination and overall supervision of implementation of the MTP Act at the State level.

**Conclusion:**

Indian women have high mortality rates, particularly during childhood and in their reproductive years. The health of Indian women is intrinsically linked to their status in society. Research on women's status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens. While women in India face many serious health concerns, this profile focuses on only five key issues: reproductive health, violence against women, nutritional status, unequal treatment of girls and boys, and HIV/AIDS. Because of the wide variation in cultures, religions, and levels of development among India's 29 states and 7 union territories, it is not surprising that women's health also varies greatly from state to state. Changes need to be made in the allocation of resources so that funding is linked to states performance in implementing the new approach, as well as to population size and funding needs. Specific steps by the government are needed to improve the quality of India's health care services. These include integrating family planning and maternal and child health services; prioritizing needs at the field level; training fieldworkers; including auxiliary nurse-midwives(ANMS) and traditional birth attendants; protecting at-risk female children; accelerating anemia prevention and control efforts.The government can take several steps to meet women's health needs in addition to strengthening services. Through legal legislation, legal enforcement and IEC (Information, Education, & Communication). NGOs and women's groups, will make services more responsive to women and improve utilization and impact. Mass media and interpersonal communication should be used to improve knowledge and practices related to contraception, safe sex, safe motherhood practices, nutrition, HIV/AIDS prevention and gender relationship. Such strategies must be decentralized in order to respond to local sociocultural variations. In addition, fieldworker training should emphasize that communication is a two way process and that workers should take into account the beliefs and traditions of clients when offering health and family planning information and services. Community support and participation are essential to facilitate the planning and delivery of health-care services. Involving women's groups is especially effective in improving women's access to services and increasing sensitivity to women's needs.

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