Conclusions

The establishment of colonial rule created avenues of modern reform in public health services. The health and hygiene however did not initially was the priority of governance but still the colonial regime introduced new concept of health and hygiene based on modern sciences and technologies. The major concern of colonial government was initially for the soldiers of British East Company. Public health was not the responsibility of colonial state for a long period of time. Initially they concentrated on prevention and sanitization but later they introduced modern system of health services based on western medicine. Consequently a number of hospitals and dispensaries came into existence.

When British Government was taking initiative to modernize Indian health system, at that time Indians followed indigenous and traditional method of the health and medicine. *Hakims* and *vedhyas* were to treat people. Their treatment was completely based on herbs and plants which called Unani (Islamic/Graeco-Arabic) and Ayueveda (Hindu) medical system and traditional source of treatment. Western medicine was often the preferred option, but in other cases, especially medication for common diseases, it generally was not. Nor did all Indians have easy access to Western medicine. Rural areas continued to be poorly served by dispensaries and Western-trained practitioners' right through to Independence in 1947. Women were also much less exposed to Western medicine than men, because the latter often forbade them from attending dispensaries and hospitals. Consequently, while the numbers attending such institutions increased under colonial rule, the proportion of women remained consistently low for most of the colonial period. Efforts designed to penetrate the veil of the *zenana*, such as the Countess of Dufferin's Fund to supply medical women for India, were generally limited in scope and tended to concentrate on women of high caste.

During nineteenth century the growing consciousness of women's issues and efforts of Indian reformers ensured preliminary maternity and child health services for women. The Indian reformers were though struggling hard to attain better health facility, still the women's health was neither seen as a matter of individual right for women nor as a means to mitigate the gender inequality during the colonial rule. Moreover the contemporary health facilities suffered from severe handicap of the shortage of medical and nursing staff.

A proper Public Health Ministry came to function only after 1920 with the passage of the Local Self-Government Act. The responsibility to tackle the epidemics and funding of rural health was now put on the shoulder of the District Boards and Union Boards. But they failed to cope with the situation because of scanty reasons and scarcity of health personal. The district dispensaries set up in rural areas were ill-equipped to tackle the health problems. Many municipalities and local boards were unable to raise sufficient revenue for vital sanitary reforms. More government aid and better supervision on the local bodies were necessary. A more concerted effort by government to assist the local bodies would undoubtedly have done much to improve the situation. Although mortality due to epidemic disease was reduced in the 20th century by the remedial measures, there was no remarkable progress in their prevention and eradication programme. What was followed with regard to anti-epidemic policy and public health developments were small scale measures. In comparison of public health in western countries, India was far behind in public health services.

By the second half of the nineteenth century there was shift in policy leading to the development of institutional set up of health services. Consequently number of hospitals and dispensaries started increasing. The exclusive hospitals for women and children also came into being through private and government initiatives. To provide these hospitals with women doctors and nursing staff medical colleges for the women were established and their number increased.

These health facilities did not adequately served the purpose of Indian population nevertheless played an important role in the development of public health services in India after independence. The expansion of medical services required legislations to control and regulate the different category of medical staffs for which laws were enacted.

The United Nations declaration of Human Rights (UNDHR) is an important document that considerably influenced the first extensive effort to reform health services in India. The Bhore Committee Report (1946) was first extensive initiative of reform of health services based on the guidelines of UNHDR. The constitution of India though incorporated health under Directive Principles but later in the light of guidelines and covenants of international organisations, and, Articlr 20 of Fundamental Rights, Indian Judiciary has recognized right to health as fundamental right. In the same manner the Indian government has also ratified the

recommendations of several international declarations on women's health, most importantly Beijing Declaration and Cairo Submit, and therefore is also committed to ensure equal right to physical and mental health for women.

In India the different factors are responsible for poor health of women. The poverty is one of the most important factors for poor health of Indian population in general and women in particular. The caste and class too reinforces patriarchy which plays a crucial role in the distribution of resources, therefore are one of the important impediment in creating disparity in the society. The gender inequality is another important reason responsible for poor health and hygiene of women. The Indian government has taken both the legislative as well as health planning measures to ensure better health facilities for women.

The two important documents which later influenced the Five Year Planning and other planning on health are (1) the recommendations of the National Health and Development Committee 1946 and (2) the report of the National Planning Committee, 1948. Both the committees expressed their concern and worries about the high rate of mortality as well as morbidity prevailing among mothers and children of our country. The scenario of maternal mortality was miserable. Maternal Mortality Rate (MMR) in certain provinces was as high as 12.9/1000 live birth and fifty percent of the maternal deaths were due to puerperal sepsis and anaemia. The Working Group on Population Policy of 1980 considered 'women as the best votaries of family welfare programme" and replaced the view of 'motherhood' by 'womanhood'.

After 1980s the scenario of health services marks a clear departure from the prescription of Bhore committee report. The National Health Service that the Bhore Committee had predicted, which would be available to one and all irrespective of their ability to pay got subjected to the market forces in this sector. The enclave pattern of development of the health sector continued even at present–the miserable, the villagers, women and other underprivileged sections of society, in other language, the majority still does not receive access to affordable basic health care of any reliable quality.

From beginning of the first two Five Year Plans the basic structural framework of the public health care delivery system remained unchanged. Urban areas continued to get over three-fourth of the medical care resources, whereas rural areas received "special attention" under the Community Development Program (CDP). The CDP was failing even before the Second Five Year Plan began. The

government's own evaluation reports confessed this failure. In the remainder of second five year plan and in the commencement of the third five year program, there were nearly 4500 maternity and child welfare centre, each servicing a population varying to 10,000 to 25,000. One third of these centres were situated in the urban regions. In the Third plan, it was proposed to link the maternity and child health services of the primary health units with extended facilities in referral and district hospitals. The emphasis shifted to rural employment programs like National Rural Employment Program (NRHP), Jawahar Rozgar Yojana and Employment Assurance Scheme. Women's empowerment emerged as a major issue of development in the nineties and schemes like Development of Women and children in rural areas, micro-credit programs etc. were suggested and all such schemes were later integrated into the Swaranjayanti Gram Swarozgar Yojana.

The Sixth Plan (1980-85) 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). Accordingly, priority was given to the implementation of programs for women under different sectors of agriculture and its allied activities of dairying, poultry, small animal husbandry, handlooms, handicrafts, small-scale industries, etc. Women Employment Program was introduced in 1982 with assistance from the Norwegian Development Agency (NORDA). For the child health the Sixth Five Year Plan reiterated the approach and strategy outlined in the Fifth Plan, and promoted consolidation and expansion of the programs started earlier.

In the Seventh Five Year Plan the Planning Commission constituted Steering Groups for different sectors. Two new schemes of Support to Training and Employment (STEP) and Awareness Generation Program for Rural and Poor Women (AGP) were introduced.

The Eighth Plan (1990-95) adopted the strategy to ensure that benefits of development from different sectors do not bypass women and special programs were implemented to complement the general development programs.

The Ninth Plan (1997-2002) established two important alterations in the conceptual scheme for planning for women. First, 'Empowerment of Women' became one of the nine primary objectives of the Ninth Plan. The overture of the Plan was to create an enabling environment where women can freely practice their rights both inside and outside the household. Secondly, the Ninth Plan attempted convergence of

existing services, resources, infrastructure and manpower available in both women-specific and women-related sectors.

In the Tenth Five Year Plan (2002-07), Planning Commission constituted three Working Groups under the Chairpersonship of Secretary of the Department, namely, (a) Working Group on Empowerment of Women, (b) Working Group on Child Development and (c) Working Group on Improving Nutritional Status of Population with Special Focus on Vulnerable Groups.

The WHO has estimated that India, at present, is spending 4.5 per cent of gross domestic product (GDP) on health, of which 0.9 per cent is public expenditure. India ranks thirteenth from the bottom in terms of public spending on health. The Central Statistical Organization (CSO) reported that final government expenditure on health (which does not include expenditure on family welfare) for 1998-99 is Rs. 10,588 crore, accounting for 0.6 per cent of GDP. For the same year the plan and non-plan expenditure of 26 States and the Central Ministry of Health and Family Welfare alone comes to Rs. 16,771 crore or 0.95 per cent of the GDP.

The following table records the financial assistance given to family welfare. through different five year plans.

Table: 9 Pattern of Investment on Health and Family Welfare (Rs. Crores)[1]

Period	Total Plan Investment	Health	%	Family Welfare	%
First Plan (Actuals) (1951-56)	1,960.00	65.20	3.33	0.10	0.10
Second Plan (Actuals) (1956-61)	4,672.00	140.80	3.01	5.00	0.11
Third Plan (Actuals) (1961-66)	8,576.50	225.90	2.63	24.90	0.29
Annual Plan (Actuals) (1966-69)	6,625.40	140.20	2.12	70.40	1.06
Fourth Plan (Actuals) (1969-74)	15,778.80	335.50	2.13	278.00	1.76
Fifth Plan (Actuals) (1974-79)	39,426.20	760.80	1.93	491.80	1.25

[1] Duggal Ravi, 'Evolution of Health Policy in India' 18th April 2001, www.cehat.org , see Source: Indian Planning Experience – A Statistical profile, Planning Commission, Government of India, New Delhi, 1998

Annual Plan (Actuals) (1979-80)	11,650.00	268.20	2.30	116.20	1.00
Sixth Plan (Actuals) (1980-85)	1,09,291.70	2025.20	1.85	1387.00	1.27
Seventh Plan (Actuals) (1985-90)	2,18,792.60	3,688.60	1.69	3,120.80	1.43
Annual Plan (Actuals) (1990-91, 91-92)	1,23,120.50	1,965.60	1.60	1,805.50	1.47
Eighth Plan (Actuals) (1992-97)	4,85,457.20	8,137.60	1.68	5,972.80	1.23
Ninth Plan (outlay) (1997-2002)	8,59,200.00	*19,374.11	2.25	15,120.20	1.76
Tenth Plan (outlay) 2002-2007	18903968.25	2176734.30	3.68	725048.73	1.23
Eleventh Plan (outlay) 2007-2012		136147.00	-	13043.01	-

*Note i) *: includes outlay of Rs. 266.35 crores for the department of ISM&H.*

Women's health has remained an important issue of discussion at National and International level, and time to time various schemes and programmes are recommended. The Indian government also formulated different programmes and schemes to ensure better health facilities for women.

1. The National Rural Health Mission (NRHM) was launched on 12th April 2005, throughout the country, with an objective to reduce the Maternal Mortality Rate, the Infant Mortality Rate and the Total Fertility Rate.
2. The Janani Suraksha Yojana (JSY) an ambitious scheme launched for safe motherhood intervention under the National Rural Health Mission (NRHM) implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women.
3. Janani- Shishu Suraksha Karyakarm (JSSK) aimed to provide free and cashless health care services to pregnant women including normal deliveries, caesarean operations and sick new born (up to 30 days after birth) in Government health institutions, in both rural and urban areas, was approved in May 2011.
4. The state of Madhya Pradesh launched a scheme called Janani Express Scheme in which private transport operators made vehicles available on a 24x7 basis.
5. Integrated Child Development Services (ICDS) Scheme, which was launched in1975.

6. The National Maternity Benefit Scheme (`NMBS) introduced in 2001.

These schemes and other subsidiary schemes by the state governments have proved beneficial for the women's health. But still a lot more is to be done to improve the delivery of these schemes.

The globalization has affected the world in different manner. At the one hand it has opened the barriers of the countries of the world for free flow of men and material while on the other hand it has also created enormous opportunity for the exploitation of weaker section by the dominant class. The forces of market operating have creating inequality in the society which has ushered a new era of exploitation. In the same manner the globalization has affected the health of women.

One of the important effects of the globalization on women's health is the de-regulated experimentation of drugs on women. The free movement of drugs and medical technology as an effect of globalized economies under poorly regulated environments has resulted in its illegal application and experimentation on women. For instance, the liberalization of drug imports made it possible for Quinacrine an anti-malarial drug that has been developed as an alternate for chemical sterilization for women to be imported and tested by private doctors in India even though it had not passed the required toxicology tests and was the subject of significant controversy worldwide.

The opening of the world economy has also led to the influx of foreign capital in India. This is an important factor influencing the public and private partnership in the health sector. Moreover the influx of foreign Non-governmental Organizations is also important for achieving the target of health for all through proper legal framework to regulate them.

The growth of technology is also another global phenomenon which has influenced the prospect of women's health in both ways. The technology has definitely made life easy but has also exposed women's body for different experiments. The birth control technology, stem cell research and other researches related with infertility and to provide alternate has adversely affected body of women, their control over their body, and their social position.