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Health Policy and Programmes in the Light of Covid- 2019 in Haryana: A Study

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ABSTRACT

Health is now universally regarded as an important index of social development. The health is both cause and effect of poverty, illiteracy and ignorance. Despite significant strides that have been made by the third world countries like India in eradicating epidemics like plague, and small pox as also in containing malaria, the state of health n these societies today, particularly in India, continues to be greatly unsatisfactory. 2020 has been a most unprecedented year. No one, anywhere in the world could have predicted the kind of havoc COVID-19 created, not just in overwhelming the health systems but also challenging economic growth, industrial progress and overall life and morale of the population. Under the dynamic and farsighted leadership of the Hon'ble Prime Minister, Sh. Narendra Modi ji, India could tackle the pandemic through a wide range of public health and social measures along with timely identification, testing, isolation, quarantine and treatment facilities provided across the primary, secondary and tertiary level facilities. Hon'ble Union Minister for Health & Family Welfare steered the vision of Hon'ble PM, as a strong multi-sectoral effort with a 'whole- of-Government' and 'whole-of-society' approach to provide advisories, guidelines and services to the entire country even as the pandemic kept evolving. WHO proclaimed health as a fundamental right of every individual and society.

Key Words: Planning, Plague, Quarantine, Treatment, Facilities, Pandemic Health Policy and Programmes in the Light of Covid- 2019 in Haryana: A Study

Health is now universally regarded as an important index of social development. The health is both cause and effect of poverty, illiteracy and ignorance. Despite significant strides that have been made by the third world countries like India in eradicating epidemics like plague, and small pox as also in containing malaria, the state of health n these societies today, particularly in India, continues to be greatly unsatisfactory. This may be seen from excessive incidence of child and infant mortality and by low expectation of life at birth. The first five year plan had appropriately emphasized that "nothing can be considered of higher importance than the health of the people which is a measure of their energy and capacity as well as of the potential of man hours for productive work in relation to the total number of persons maintained by the nation. For the efficiency of industry and of agriculture, the health of the worker is essential consideration.[1]"

Meaning and Definitions of Health Policy

Health, as defined by World Health Organization (WHO 1948), is a state of complete physical, mental and social well-being and not merely the absence of a disease or infirmity to lead a socially and economically productive life. WHO proclaimed health as a fundamental right of every individual and society. Good health is a prerequisite of one's active participation in varied domains of life. Health, being a wider concept, embraces the impact of diverse type of health services ranging from preventive to the curative in nature. Health is influenced by a number of factors such as adequate food, basic sanitation, life styles, genetic factors, environmental hazards, and communicable disease. Thus, health care embraces a multitude of services provided to individuals or communities for promoting. Maintaining, monitoring or restoring health.

Health is not only basic to leading a happy life for an individual but it is also necessary for all productive activities in the society:"Health is a function of the overall integrated development of the

[1] The first five-year plan, planning commission, government of India, p.468.

society and the health status is one of the indicators of the quality of life[2]". Health is not only thing, but that everything else, without health is nothing" that's why "health is called wealth". Health is foremost priority in everybody's life. The whole development cycle of the people depends upon intellectual caliber, curiosity and constructive thinking, but all these qualities depend on their good health. If we forget the health component, then we forget the vital factor in the development, namely the human being, his creative energy, his physical energy.

The concept of basic minimum needs owes its origin to the circumstances such as the high incidence of poverty; wide disparity in the level of development of social services and social infrastructure in various part of the country. In the programme of the world bank for reducing absolute poverty, art of the effort has to do with what is commonly called "basic needs". The conceptual work makes it clear that the pursuit of basic needs is not a distinct development strategy in itself; it can only be regarded as a principal objective of development that can be, and has been, achieved through a variety of development strategies. The distinct emphasis that the basic needs objectives brings to a development strategy is a heightened concern for the achievement of the ultimate goals of the whole population with respect to consumption, particularly in education and health. This does not mean that the concept of basic needs is primarily a welfare concept. Indeed, improved health of the society often makes a significant contribution to increased health facilities.

Health policy and programmes in India

Health planning in India is an integral part of national social-economic planning. The guidelines for national health planning were provided by committees appointed by government of India. The main ones were Bhore Committee 1946, Mudaliar Committee 1962, Chadha Committee 1963, Mukherji Committee 1965 & 1968, Kartar Singh Committee 1973, and Shrivastava Committee 1975[3]. India was the first country in the world to start with National Family Welfare Programme in 1951. Government of India, under the Ministry of health and family welfare, started national malaria control programme in 1953, Malaria eradication programme in 1958, national Filaria control programme in the same year, national Tuberculosis Control programme in 1962, and Rural health scheme 1977.

There have been a series of legislations related to health. Some important enactment are the Indian medical council act 1933, madras public health act 1939, and employees state insurance act 1948. The central council of health and planning was constituted in 1952 to facilitate co-ordination of health policies between the central and the state governments. Under the constitution of India, states are largely independent in matters relating to the delivery of health care of their people. Each state has developed its own system of health care which is independent of the central government. The centre makes the ministries. Thus, health is a state subject and each state has developed its own pattern to suit its policy and convenience. The people at large receive health care through public sector, private sector, indigenous system of medicines, voluntary health agencies, and vertical health programmes. The policies, plans, programmes, and budgets of the government sector hospitals are approved and allocated by the State Health Directorate and the State Health Department.

Impact of COVID-19 on Health Policies in India:

2020 has been a most unprecedented year. No one, anywhere in the world could have predicted the kind of havoc COVID-19 created, not just in overwhelming the health systems but also challenging economic growth, industrial progress and overall life and morale of the population.

Under the dynamic and farsighted leadership of the Hon'ble Prime Minister, Sh. Narendra Modi ji, India could tackle the pandemic through a wide range of public health and social measures along with timely identification, testing, isolation, quarantine and

[2] P.Hanumantha Rayappa and T.V.Sekhar, "Social Welfare Administration, administration of health services in S.Ramanthan, (Ed.) landmarks in Karanataka Administration (Uppal, New Delhi, 1998) p.317.

[3] G. Anjaneyulu, Challenges before public health organizations national health programmes", Indian Journal of Public Health XXXXVI (2002): 131-132.

treatment facilities provided across the primary, secondary and tertiary level facilities. Hon'ble Union Minister for Health & Family Welfare steered the vision of Hon'ble PM, as a strong multi-sectoral effort with a 'whole- of-Government' and 'whole-of-society' approach to provide advisories, guidelines and services to the entire country even as the pandemic kept evolving.

Today we have least number of Covid-19 cases, highest recovery rate, least number of deaths due to Covid-19 and now moving towards a Greater Win by developing Vaccines against the dreaded disease. Hon'ble PM of India launched the world's largest Covid Vaccination Drive on 16.01.2021.

Government of India is committed to ensure the highest possible level of health and well-being of all, at all ages, through a preventive and promotive healthcare orientation in all developmental policies and universal access to good quality health care services, without anyone having to face financial hardship. Towards this end, MoHFW is implementing various schemes, programmes and national initiatives to provide universal access to the quality healthcare. During the pandemic strategies and guidelines for enabling continued delivery of essential RMNCH+A services were developed and disseminated to all States/UTs. Select health facilities established as Quarantine Centres, Covid Care Centres and COVID Hospitals in the States which were duly supported by the Centre. Now, the health ministry is working closely with partners to ensure vaccines are accessed by the population in a systematic and phased manner, in line with global protocols.

Public Grievance Cell:

Public Grievances Redressal Mechanism is functioning in the MoHFW as well as in the Subordinate/Attached offices of the Dte. GHS and CGHS, Central Government Hospitals, Autonomous Bodies under the Ministry and public sector undertakings (PSU) as per various guidelines issued from time to time by the GoI through the Department of Administrative Reforms and Public Grievances. Grievances (DARPG). It is a web-based portal wherein a citizen can register his/her grievance online directly with the concerned ministries/ departments. The Joint Secretary dealing with the W&PG Section is designated as the nodal officer for the DoHFW and all Director/DS level officers have been made nodal officers for their respective divisions within the Department. Regular monitoring is conducted to ensure qualitative, quantitative and expeditious disposal of public grievances.

Status of disposal of public grievances during 2020-21 on CPGRAMS portal (as on Source: Annual Report of Health and Family Welfare in India, New Delhi. (31.12.2020)

Year	*Brought forward Grievance as on 01-01-2020*	*Grievance(s) received from 01-01-2020 to 31-12-2020*	*Grievance(s) disposed off from 01-01-2020 to 31-12-2020*	*Balance as on 01-01-2020 to 31-12-2020*
2020-21	*1,297*	*29,641*	*28,798*	*2,140*

Information System & Facilitation Centre

To strengthen the Public Redressal Mechanism in the MoHFW, an Information & Facilitation Centre is functioning adjacent to Gate No. 5, Nirman Bhawan, New Delhi. The Centre, inter- alia, provides:

- Information and guidelines to avail financial assistance from Rashtriya Arogya Nidhi and Health Minister's Discretionary Grant
- Guidelines and instructions regarding issue of 'No Objection Certificate' to Indian Doctors to pursue higher medical studies abroad
- Information and guidelines relating to CGHS and queries relating to the work of the Ministry
- Receiving petitions/suggestions on Public Grievances. General queries relating to the Ministry that were received in the Information and Facilitation Centre were disposed off, to the satisfaction of all concerned.

Centralized Public Grievance Redressal and Monitoring System:

The CPGRAMS is an online web-enabled system over the National Informatics Centre's ICT Network (NICNET) developed by the National Informatics Centre (NIC), in association with Directorate of Public Grievances (DPG) and Department of Administrative Reforms and Public Grievances (DARPG). It is a web-based portal wherein a citizen can register his/her grievance online directly with the concerned ministries/ departments. The Joint Secretary dealing with the W&PG Section is designated as the nodal officer for the DoHFW and all Director/DS level officers have been made nodal officers for their respective divisions within the Department.

Procurement

The Division procures vaccines for the Universal Immunization Programme (UIP). Action to procure vaccines is initiated well in advance, normally a year ahead, to ensure timely availability of vaccines for the Programme. During 2020– 21, tenders for procurement of the following vaccineshave been floated as of 31.12.2020, duly adhering to all relevant provisions including the Public Procurement Make in India Order, 2017 as amended from time to time and directions/ guidelines issued to realise Aatmanirbhar Bharat:

- 2020–21: Japanese Encephalitis (JE), BCG, Tetanus and Diphtheria (Td) vaccine
- 2021–22: Pentavalent Vaccine, Diphtheria, Pertussis, and Tetanus (DPT), Hepatitis B, Td, Pentavalent, Measles and Rubella (MR), JE vaccine

Procurement related schemes

Year	Total Procurement (Value-wise)	Programme
2015–16	Rs. 52.85 crore	Family Welfare Programme (FWP) and National Vector Borne Disease Control Programme (NVBDCP)
2016–17	Rs. 240.75 crore	FWP, NVBDCP, RNTCP (Revised National Tuberculosis Control Programme)
2017–18	Rs. 1391.78 crore	FWP, NVBDCP, RNTCP, NACP (National AIDS Control Programme), NVHCP (National Viral Hepatitis Control Programme) & UIP (Universal Immunization Programme)
2018–19	Rs. 2068.65 crore	FWP, NVBDCP, RNTCP, NACP, NVHCP & UIP.
2019–20	Rs. 2310.43 crore	FWP, NVBDCP, RNTCP, NACP, NVHCP & UIP
2020–21	Rs. 3357.68 crore till 11.12.2020.	FWP, NVBDCP, RNTCP, NACP, NVHCP, UIP, Central Drugs Standard Control Organisation (CDSCO), Child Health & COVID-19 Procurement

Source: Annual Report of Health and Family Welfare Government of India 2020-21

NATIONAL HEALTH MISSION

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12.04.2005, to provide accessible, affordable and quality health care to the rural population, especially vulnerable groups. The main programmatic components include Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and control of Communicable and Non-Communicable Diseases (NCDs). The NHM envisages universal access to equitable, affordable and quality health care services to all citizens through systems and institutions that are accountable and responsive to people's needs.

The Union Cabinet vide its decision dated 01.05.2013 approved the launch of the National Urban Health Mission (NUHM) as a sub-mission of an over-arching NHM, with NRHM being the other sub-mission. Further, the Union Cabinet vide its decision dated 21.03.2018 approved the continuation of NHM from 01.04.2017 to 31.03.2020. The Department of Expenditure, vide their OM dated 10.01.2020 accorded approval for the interim extension of NHM for a period till 31.03.2021 or till the date the recommendations of the 15th Finance Commission would come into effect, whichever was earlier.

Major Achievements Under NHM/ NRHM Comprehensive Primary Health Care (CPHC) through Ayushman

Bharat-Health and Wellness Centres (HWCs)

Ayushman Bharat aims to holistically address health (covering prevention, promotion and ambulatory care), at primary, secondary and tertiary level by adopting a continuum of care approach. In the lifetime of an individual, the primary healthcare services cater to 80-90% of health care needs. The preventive and promotive health care needs are largely for the improved health care outcomes and quality of life of the population.

A few States/UTs have already started rolling out these additional packages of services in a phased manner.

Launching Ayushman Bharat - Pradhan Mantri Jan

1. **Arogya Yojana (AB-PMJAY):** The scheme provides health insurance coverage up to Rs. 5.00 lakh per family per year to around 10.74 crore poor and vulnerable families (nearly 50 crore individuals) who have been identified based on the Socio-Economic Caste Census (SECC) data.

Service Delivery at AB-HWCs

- So far, approvals for more than 1,04,860 Ayushman Bharat-Health & Wellness Centres

have been accorded to the States/ UTs (except Delhi) and as reported by the States/UTs on the AB-HWC Portal, 50,927 Health & Wellness Centres have been operationalized till 1st December, 2020 which includes 28,320 SHC level AB- HWCs, 18,972 PHC level AB-HWCs and 3,635 UPHC level AB–HWCs

- As per the data update done by the States/ UTs in HWC Portal, till 04.12.2020, about

7.31 crore screenings done for Hypertension and about 5.93 crore screenings done for Diabetes at these AB-HWCs. Similarly, these functional AB-HWCs have done more than

6.96 crore screenings for common cancers (3.67 crore for oral cancer, 1.34 crore for cervical cancer in women and 1.95 crore screenings for breast cancer in women).

- Further, as on 4th December 2020, 44.35 lakh Yoga/Wellness Sessions have been conducted in operational HWCs

- The primary healthcare team at the SHC level AB-HWCs is headed by Community Health Officers (CHO), who are also BSc/ GNM Nurse or Ayurveda Practitioner trained in primary care and public health skills and certified in a six months Certificate Programme in Community Health or Graduate from Integrated nursing curriculum. Other members of the team are male and female Multi-Purpose Workers (MPW) and Accredited Social Health Activists (ASHAs). The training programme is being carried out with the support from

Implementation of Ayushman Bharat School Health and Wellness Ambassadors Initiative in all the schools and the students as Health and Wellness Messengers to take forward the importance of promotive healthcare with the parents and peers. It is planned that there will be more than 75,000 Ambassadors by 15th August 2022.

Convergence with Fit India movement and carrying forward the importance of Fit Health Worker Campaign started last year on regular basis.

Implementation of Ayushman Bharat Continuum-of-Care Centres (ABCCs) as per the established protocol to have free and smooth follow-up of cases at the community through HWCs. Preventive Healthcare through population- based enumeration of population for common NCDs and important communicable diseases such as Leprosy and TB. It is planned that more than 7.5 crore cumulative screenings of common NCDs, three common cancers of Oral, Breast and Cervical cancers and communicable diseases of TB and Leprosy through AB-HWCs will be achieved by 15th August 2022.

Mainstreaming of AYUSH

Mainstreaming of AYUSH has been taken up by allocating AYUSH services in 7,785 PHCs, 2,748 CHCs, 496 DHs, 4,022 health facilities above SC but below block level and 371 health facilities other than CHC at or above block level but below district level.

National Ambulance Services (NAS)

Under the NHM, GoI provides technical and financial support for emergency medical services in States/UTs through a functional National Ambulance Service (NAS) network linked with a centralized toll-free number 108/102. Dial 108 is an emergency response system, primarily designed to attend to patients of critical care, trauma and accident victims etc. Dial 102 services essentially consist of basic patient transport aimed to cater to the needs of pregnant women and children though other categories which are also taking benefit and are not excluded. The JSSK entitlements e.g. free transport from home to facility, inter facility transfer in case of referral and drop back for mother and children are the key focus of the 102 service. Over the years there has been an overall improvement in ambulance service under NHM mainly in availability and accessibility.

With the advent of 102/108 services (NAS) the EMS in India has expanded exponentially

and geographically, shifting focus from being a "transport vehicle concept" to a "lifesaving emergency medical transportation"; injury centric to covering all emergencies; and urban-centric to being pan-India. All this has led to the improved response time, for every patient in reaching the hospital for timely care.

Presently, 35 States/UTs have the facility where people can dial 108 or 102 telephone number for calling an ambulance. Presently, 10,599 Dial- 108, 605 Dial-104 and 9,875 Dial-102 Emergency Response Service Vehicles are supported under NHM, besides 5,412 empaneled vehicles for transportation of patients, particularly pregnant women and sick infants from home to public health facilities and back.

National Mobile Medical Units (NMMU)

The vision of the NHM is universal access to equitable, affordable and quality health care services. Health care service delivery through Mobile Medical Units (MMUs) under NHM is one of the key strategies to facilitate access to public health care at the doorstep particularly to people living in remote, difficult, under-served and unreached areas.

Mobile Medical Units are envisaged to provide primary care services including preventive and promotive care for common communicable and NCDs, RCH services, carry out screening activities and provide referral linkage to appropriate higher facilities. The MMUs also undertake Information, Education and Communication (IEC) sessions on a range of health topics related to RCH, communicable diseases, including vector borne diseases (VBD), healthy lifestyle and behaviour changes, etc. MMUs also provide point of care diagnostics such as hemoglobin (Hb), blood glucose, pregnancy testing, urine microscopy, albumin and sugar.

Workers (ASHA): The ASHA programme is a key component of the community processes element of NHM which intends to achieve the goal of increasing community engagement with the health system. The programme was initially launched in the year 2006 in 18 high focus States and tribal areas and later expanded to the rest of the country in 2009. Based on the equipment analysis on BMMP dashboards, States/ UTs proposed procurement of medical equipment in ECRP on the basis of approvals given by the Executive Committee of the State Health Society.

The MoHFW also drafted a COVID-19 repository for India on effective management of the pandemic. Major areas like manufacturing of ventilators, N95 masks, personal protection equipment (PPE) kits, procurement of equipment, research and development and service delivery were described in detail in the repository is a key component of the NHM. ASHAs are honorary volunteers who receive performance- based incentives for a varied set of activities (nearly 40 tasks approved at the national level) related to maternal and child health (MCH), communicable diseases and NCDs for community level health interventions. There are 10.61 lakh ASHAs across the country in rural and urban areas (except Goa and Chandigarh) under the NHM who act as a link between the community and the public health system. **There are 10.61 lakh ASHAs across the country in rural and urban areas (except Goa and Chandigarh) under the NHM who act as a link between the community and the public health system.**

Over the last 15 years, ASHAs have been widely acknowledged for their substantial contribution in improving access to care for community in areas ranging from RMNCH+A to communicable diseases and more recently to NCDs. ASHAs also played a key role in the country's response for prevention and management of COVID-19. During the pandemic, in addition to performing tasks related to the pandemic, ASHAs continued to support community members in accessing EHSs such as ANC, Immunization, safe delivery and treatment adherence for chronic illnesses.

The Union Cabinet approved an increase in the amount of routine and recurring incentives under NHM for ASHAs that will now enable them to get at least Rs. 2000 per

month against the earlier allocated Rs 1000. As part of the ASHA benefit package launched in 2018, social security benefits like life insurance, accident insurance and pension were extended to all eligible ASHAs and ASHA Facilitators through the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY)

ASHAs during the pandemic, all ASHAs and ASHA facilitators were also covered under the Pradhan Mantri Garib Kalyan Package for coverage under insurance scheme of Rs. 50 lakh in case of loss of life due to COVID-19 or accidental death on account of COVID-19 related duty. To support the ASHAs and ASHA facilitators for undertaking additional tasks related to COVID-19, incentives and benefits were modified as below:

An incentive of Rs. 1000 per month was introduced to support ASHAs and Rs. 500 per month for ASHA Facilitators for undertaking activities related to COVID-19 Assured payment of routine and recurring incentive of Rs. 2000 per month. All ASHAs and ASHA facilitators were covered under the Pradhan Mantri Garib Kalyan Package for coverage under the insurance scheme of Rs. 50 Lakh in case of loss of life due to COVID-19 or accidental death on account of COVID-19 related duty.

Swachh Swasth Sarvatra:

This is a joint initiative of the MoHFW and Ministry of Drinking Water and Sanitation and was launched in December 2016 to achieve better health outcomes through improved sanitation and increased awareness on healthy lifestyle. Under this initiative, one-time grant of Rs.10 Lakh is provided to the non-Kayakalp awardee CHC located in the open defecation free (ODF) Blocks as a resource for improving the deficiencies found in the Kayakalp assessment, so that by the time the next assessment is due they can become a Kayakalp awardee.

Kayakalp Award Scheme

This was launched on 15.05.2015 under the 'Swachh Bharat Abhiyaan'. The scheme encourages public health facilities to demonstrate high levels of cleanliness, adherence to hygiene, sanitation and infection control practices. Exemplary performances are recognised through cash prizes and citation. The scheme has made a significant and positive impact in terms of enhanced cleanliness in the facilities, improved aesthetics, enhanced patient satisfaction, hygiene promotion, etc. The number of health facilities meeting the benchmark score of 70% or more and qualifying for the Kayakalp awards has increased from 100 facilities in FY 2015-16 to 6620 in FY 2019-20. As of 11.11.2020, nearly 12 Central Government (more than 80%), 352 DHs, 1459 SDHs/CHCs, 3675 PHCs, 808 UPHCs, 7 UCHCs and 307 HWCs have scored more than 70%. A total of 6620 facilities were awarded under this scheme in FY 2019-20 as per data received from 30 States/UTs upto 11.11.2020.

In the year 2020, States/UTs are grappling to complete their peer and external assessments because of the COVID-19 pandemic. However, with the launch of methods and protocols for virtual assessment, the pace of progress has picked up. It is expected that most of the States would be able to declare the Kayakalp awards by the end of January 2021. As of 13.11 2020, Haryana is the only State to declare its Kayakalp awards for 2020- 21 with 149 facilities scoring over benchmark score of 70%. translates to an estimated 2,25,000 people, developing ESKF annually. MoHFW launched programme guidelines for Hemo-dialysis services under the PMNDP in 2016 for implementation of services at DH level under NHM. Guidelines of the National Dialysis Programme including the Model Request for Proposal (RFP) for PPP were developed and released on 7.04.2016.

Special Attention Paid During COVID-19:

The pandemic had a high chance of producing high morbidity in the elderly and in patients with associated co-morbidities. These patients are, therefore, not only more

prone to acquire infection but also develop severe diseases as compared to the general population. A guideline for dialysis in reference to COVID-19 infection was formalised and shared with all States/UTs for compliance. The main focus was on precautions to be taken by the administration and dialysis staff of a dialysis unit while performing Haemo- dialysis of a general patient or one suffering from COVID-19. These guidelines helped the States in implementing good disinfection and disposal practices in the dialysis unit. subsequently for other health facilities. These standards are accredited by the International Society for Quality in Healthcare (ISQua) and recognised by IRDA and NHA.

Programme Objectives

To improve quality of care in DHs and other health facilities

• Bring down hospital acquired infections (HAI) by promoting cleanliness, hygiene and sanitation.

Strategies for accelerating the pace of decline *in MMR*

A. Janani Suraksha Yojana (JSY):

The JSY is a safe motherhood intervention under NHM. It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among pregnant women.

B. Janani Shishu Suraksha Karyakar (JSSK):

The JSSK builds on the phenomenal progress of the JSY scheme; the GoI launched the Janani Shishu Suraksha Karyakaram (JSSK) on 01.06,2011. The initiative entitles sallpregnant women delivering in public health institutions to have absolutely free and no expense delivery, including caesarean section. Their entitlements include free drugs, consumables, free diet during stay, free diagnostics and free blood transfusion, if required. This initiative also provides free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements were put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. In 2013, the scheme was expanded to cover complications during ante-natal and post- natal period and also sick infants up to 1 year of age. Utilisation of public health infrastructure by pregnant women increased significantly as a result of JSY & JSSK. As per HMIS April-June 2020-21, nearly 17% pregnant women received free drugs, 19% pregnant women received free diagnostics, 19% pregnant women received free diet, 7% pregnant women received free transport (home to the facility) and 7% pregnant women received free transport (drop back).

Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA):

PMSMA was launched by the Ministry of Health & Family Welfare in June, 2016. Under PMSMA, all pregnant women in the country are provided fixed day, free of cost assured and quality Antenatal Care. The Abhiyan also involves private sector's health care providers as volunteers to provide specialist care in Government facilities. So far (as on 05.01.21), over 2.63 crore ANC check-ups have been conducted by over 6000 volunteers in over 17,000 Government facilities. Also more than 20 lakh high risk pregnancy cases were identified across the country.

Janani Suraksha Yojana(JSY)

The JSY is a safe motherhood intervention under NHM. It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among pregnant women. It is a Centrally Sponsored Scheme, which integrates cash assistance with delivery and post-delivery care and has identified ASHAs as an effective link between the government and pregnant women.

The scheme focuses on pregnant woman with a special dispensation for States that have

low institutional delivery rates, namely, the States of Assam, Bihar, Chhattisgarh, Jharkhand, Jammu and Kashmir, Ladakh, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand are categorised as Low Performing States (LPS)

Cash Assistance for Home Delivery:

BPL pregnant women, who prefer to deliver at home, are entitled to a cash assistance of Rs.500

COVID – 19 Pandemic Management

The Safdarjung Hospital has been actively involved in the management of COVID– 19 patients as per the guidelines of ICMR and instructions of Dte. GHS and MoHFW i.e. haemogram, coagulation profile and biomarkers in positive patient etc. Some of its key efforts in supporting the response to COVID-19 include:

Converting the entire Super facilities in NEB and other departments for TrueNAAT, COVID-19 Rapid Antigen Test and COVID-19 Elisa test

i. Starting the SARI Ward with concurrence of District Magistrate in New Emergency Block, for separate management of sub- acute respiratory illness cases

ii. Constituting a dedicated Core team for COVID-19 management consisting of doctors from Anesthesia, Medicine, Respiratory department etc and creating a separate section in SSB for patients of Gyne & Obs and Pediatrics

iii. Conducting a Training programmer for JR/ SR/Nursing staff and Intern on weekly basis to deal with COVID-19 management

iv. Organising awareness programmes on hand washing steps, social distancing, importance of masks and use of sanitization in hospital for prevention of COVID–19 for patients and their relatives coming to the hospital in addition to hospital staff working in various locations of SJH/VMMC

v. Setting up a separate fever clinic and sample collection centre (RTPCR) for COVID-19 patients in the Old Casualty Block, SJH

vi. Maintaining uninterrupted patient care services in most departments of the hospital and providing regular Dialysis for Non-

COVID-19 patients engaging separate ambulances

Health policy and administration in Haryana

The state of Haryana was carved out of the erstwhile composite Punjab on 1st November 1966 under the Punjab Reorganization Bill passed by Parliament on 10th September, 1966. The origin of the name Haryana is associated with Hari-Ka-Ana (Place where Hari, the God Vishnu came) or Hariyali (greenery)[4]. Haryana is a small state as compared to many other states in terms of the size of its area (44,212 sq. kms.). Haryana is situated on the threshold of the national capital, Delhi. As a result, a distinct regional identity of Haryana has been carved out by the hills and rivers on different sides.

Administrative set-up of Health Department in Haryana

As per the constitution, health is a state subject and it was the main responsibility of state government to provide health services within the state and in this matter the local bodies also assist the state governments. The state executive consisted of political executive (i.e. Chief Minister and Council of Ministers) and the permanent executive (i.e. the chief secretary, secretary and director health services). All the powers of executive are vested in the Governor of state (under act, 161) and further there is a council of ministers headed by chief minister (art 163(1)) to aid and advise the governor in the exercise of his executive functions. Thus, the chief minister and the council of ministers constitute

[4] K.C. Yadav,"Haryana' the land and the people". Haryana Research Journal, vol,pp1-8.

the real chief executive at the state level with the governor as a titular head. The administrative apparatus of the health administration in the state of Haryana had been distributed in three levels on the basis of head quarter field relation viz.

- The Secretariat
- The Directorates
- Field Offices/Agencies.

The state government required efficient and dynamic health organisation at the state level to ensure effective and efficient primary health care delivery system at the all the levels with in the state especially at the grass root and rural level. In the subsequent paragraphs the organizational structure of health care machinery in the state of Haryana.

Conclusion and Suggestions

The nation which is in the process of development cannot afford to ignore the importance of health of its people, health both as an input and output is directly linked with the development; whenever the health component is forgotten, the vital factor in the development is forgotten at the same time. Therefore, all the countries of the world are striving hard to work out policies and programme to ensure better health care for the citizens of their respective countries. The design of administrative system was a basic aid to the achievement of its primary objectives if the design was unsound the achievement of objectives was likely to fall short of expectations. The development of health and medical services had been promoted greatly it seemed apparent that parallel advance has not to be made in the art and science of public health administration. The delivery of health services had become more cumbersome a process due to technological, social and economic advances. To reap the benefits of modernization. Report of UN had pinpointed that a growing awareness has emerged for the need of more efficient administration, management and delivery of health care services, which will have to be adapted to local conditions.

Suggestions:

On the basis of field observations and response of patients and Doctors/Medical Staff during the course of study, some suggestions have been put forth:

1. There is a need to reform the administrative set-up for handling the health Policy and Programmes. For the successful policy execution a sound administrative system is needed. Hence different agencies responsible for health programmes/schemes should be integrated so that all kinds of information is available for patients in the health institutions. There should be transparency in the process of identification of Beneficiaries, disbursement of funds etc. This is likely to create a feeling of trust among the Beneficiaries.
2. The government should decide to make the required funds available for Special Component Plan and if the adequate funds are not available then money has to be taken out from general plans of central ministries/departments and state/UT's is to patients. Only then level of Special Component Plan can be raised to full fill the requirements of Health Policies and Programmes.
3. Whenever a new plan or scheme is to be formulated for the welfare of citizens, there is a need to notice the gaps, bottlenecks and lacunae of the previous plan or schemes so that these can be removed and an alternative and improved scheme can be formulated.

4. The allocation made under Health Policies and Programmes should be used by the seats in such a way so as to conform to the guidelines provided by the centre. The practice of using Health Policies and Programmes should be dispensed with. It has to be used by the states only for income generating for health schemes.
5. Most of the complaints in regard to Health Policies and Programmes are about wrong identification of beneficiaries, unawareness on part of targeted communities. In this regard, It is suggested that efforts should be made to inform the people about these benefits. Wide publicity needs to be given to these schemes have to be motivated to come forward and be benefited from these schemes. In this field, When the real deserving ones would voluntarily come forward, the problem of bogus entries would automatically vanish. The selection of Beneficiaries for a specific scheme should depend upon the requirement of the prospective Beneficiaries. This will help in ensuring that only the deserving one will be benefited through these schemes.
6. The Benefits from most of the schemes are not percolating to the lower levels among patients but are being enjoyed by well-off section among them. Hence more emphasis needs to be given on health facilities in rural areas. They need to be informed of various schemes for patients. When they would be able to understand that they are not required to spend anything on the health facilities. They are need to be informed that their brethren in urban areas are being benefited from these schemes. The poor people are residing in rural areas are required to be made aware of the importance of health facilities.
7. The existing level of average assistance per beneficiary is very low and does not make any lasting impact on the income level of the target groups. So it is suggested that there should be scope of flexibility in financing these schemes. The level of financial assistance should be increased so as to ensure optimal return and thus beneficiary in the real.
8. As the issues related to weaker sections of the society require a delicate handling, the professional skills of the medical staff of the health department in Haryana need to be strengthened. This can be done by providing training to these medical staff in such matters.

It is also suggested that, there should be proper posting of staff with adequate equipments, proper supervision of the work of the staff by way of proper guidance and regular inspection by the senior officer. For proper guidance and supervision, it is necessary that the senior officer should have required specialization, experience and quality of leadership. Thus while making posting due consideration should be given to the qualification and experience of the senior officers. Towards the end of my humble research efforts it can be surely that the field of health policy and programmes is very washed and this thesis may be just a drop of water in the vast ocean of knowledge. However, I have made an earnest effort to cover all the aspects of Health Policy and Administration: Study of Haryana State, but might have overlooked sum aspects which may be taken up by the future researchers in this field. Further, this research work has also brought out some issues which can be taken up by the future researchers for their studies.

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