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Health Programs in a Developing Country- why do we Fail?

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Abstract

Background: Developing countries, including India, face similar problems in implementation of health programs and thus have shown poor progress on the Millennium Development Goals. Many of these countries are also facing epidemiological transition and facing a dual disease pattern, which leads to increasing burden on the limited resources, leading to program failure. This review is undertaken to look at the possible reasons for program failure focusing on India.

Methods and Findings: A SWOT (Strengths, Weakness, Opportunities and Threats) analysis has been undertaken to review the National Health Programs in India. Any program's inadequacy in achieving its goal can be attributed to one or more of the following: (1) Technical insufficiency, (2) Administrative inanity and (3) Operational incapacity. Even a single distraction of any of these determinants can be enough deterrent causing program-failure. Poor communication about benefits of health due to lack of awareness, poor use of healthcare informatics, insufficient management training, lack of financial resources and limited collaboration with other healthcare organizations were found to lead to program failure.

Conclusions: Poverty mitigation, reduction of inequalities, health care financing, strengthening of public health information system, health education and communication, positive life style changes are some of the important domains on which the success of a program depends.

Keywords: Health programs; Program failure; Developing country; Implementation

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Background

Chronic disease now makes up almost one-half of the world's burden of disease, creating a double burden of disease when coupled with those infectious diseases that are still the major cause of ill health in developing countries [1]. The disease patterns are similar in developing countries, and so the problems in implementation of the health programs are similar, with problems like lack of resources, poverty and ignorance. Yet, diseases manifest themselves differently in different countries, and their cultural contexts are best understood in the countries themselves. Social stigmas, discrimination, and government policies and health systems alter the best practices for combating these diseases in different countries. In Thailand, where sex trade is prevalent, HIV/AIDS program obtains primary importance, whereas in Russia, intravenous drug use is the single most important factor in the spread of the disease. Many of these countries are also facing epidemiological transition and facing

a dual disease pattern, which leads to increasing burden on the limited resources, leading to program failure. India being a developing country, the problems in implementing health programs would be similar to any other developing country, but since it is a diverse country, with many national programs being implemented, it was decided to review the health problems focused to India, which can be considered true for any other developing country.

India attained freedom some 67 years back and since then several measures have been undertaken by the Government to improve the health of the people. Prominent among these measures are the National health programs, which have been launched by the Government for the control/eradication of communicable/non-communicable diseases, improvement of potable water supply and sanitation, raising the standards of nutrition, population welfare and control, and improving health care access and delivery, to name a few.

Health care delivery in India has molded over years of experiences and experimentations. Sadly, the Midas touch of 'Health for All' remains a fleeting dream as we keep wondering why our programs fail. The reasons could be many like suboptimal performance of many of our national programs and our inability to hit the bull's eye in time and sustain along with. It has become almost legendary that we are excellent planners but bad implementers; bearing in our minds that providing for the dream picture in a diverse country like India is a very tough challenge, we must also consider the scopes and need for impeccable planning against the background of scarce resources [2].

The public health initiatives over the years have contributed significantly to the improvement of several indicators, but morbidity and mortality levels in the country are still unacceptably high. 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. 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 [3]. Access to public health services is nominal health standards are grossly inadequate; and benefits from the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. There are many infectious diseases which the system has failed to respond to, either in terms of prevention or access to treatment [3]. Added to this is a growing burden of non-communicable disease. Substantial constraints on capacity exist across each of the six key health system components, namely governance, health financing, health workforce, health information, medical products and technology and health care delivery. Though India has witnessed some progress in meeting the MDG targets by 2015, progress has been inconsistent.

Materials and Methods

We made a line list of all the National Health Programs in the country and carried out a SWOT (Strengths, Weakness, Opportunities and Threats) analysis to look at the reasons for the failure of National Health Programs in India. We have looked at available literature for various programs and their implementation in India as well as other developing countries as India is a developing country and the problems are nearly similar. We then summarized the gaps in the implementation of various programs and discussed the reasons of poor program performance.

Reasons of program failure

Program policies and plans are formed with involvement of many stakeholders like bureaucrats, technocrats, representatives of research organizations, community members, nongovernmental/community based organizations and community representatives. Involvement of all stakeholders and coordination amongst them leads to greater ownership for the program during implementation. The coordination between policy makers and program implementers is far from what is desired for effective rolling out of health programs. Policy and programs are framed with inadequate knowledge of existing bottlenecks at the field level [4].

The history of health programs dates back to 1951, when India became the first country to adopt National Family Welfare Scheme. [4] Predictions about future health of individuals and populations in India remain uncertain as health care demand, access and utilization depends on economic conditions, which is mostly unstable. The amount of public fund that India invests in health care is very small compared to other emerging economies. The total expenditure for health is only 1.62% of the whole budget out of which the National Health Mission has a share of less than one percent [5]. The government is deviating from the core strategies of the National Health Mission-there is no increase in allocation for the health sector. Poor communication disrupts the continuity of care, and then this fragmentation leads to inefficiencies in the entire system. Inefficiencies, in turn, deplete financial and other resources. Other common weaknesses include poor use of healthcare informatics, insufficient management training, a lack of financial resources, and an organizational structure that limits collaboration with other healthcare organizations.

In India, migration of rural communities to urban areas is on rise due to rural impoverishment, rapid industrialization and urbanization. The primary health care system is not structured and organized in urban areas, unlike rural areas. The local urban administration, i.e., municipality is expected to provide both preventive and curative services to the urban population. However, the infrastructure and manpower of municipalities are not sufficient to cater to the needs of the growing urban population, particularly the migrant influx. Though there are less number of health facilities (clinics), their functioning, facilities and attitude of staff definitely influence the utilization by the people. Problems of accessibility, including long distances to the nearest clinic, scarce public transport and lack/mismatch of time, etc. continue to be major access barriers. Issues related to affordability in terms of treatment costs and loss of income due to visits to clinics, costs of drugs, etc. were also major obstacles. Though India is only 29% urbanized, one fourth of the urban population, constituting over 80 million people, live below poverty line.

Insufficiency of health services and poverty leaves a considerable percentage of this population with little or no access to basic healthcare facilities [6]. An understanding of the healthcare utilization associated with migration has the potential to influence health policy and provision of health services through an appreciation of the differential needs of urban communities. Organizational capacity includes management, strategies, and decision making that contributes to the research process. These skills are invaluable in helping researchers, clinicians, and program directors in emerging and developing countries use resources effectively, assemble teams, network, and form partnerships.

According to Mohapatra SC [2] any program's inadequacy in achieving its goal can be attributed to one or more of the following: (1) Technical insufficiency, (2) Administrative inanity and (3) Operational incapacity. Even a single distraction of any of these determinants can be enough deterrent causing program-failure. However, there exists an evident synergism upon coexistence (**Figure 1**).

Technical insufficiency: is a reflection of inexperienced strategists designing programs without an insight of what would happen on the ground or failure of some technique adopted. If we look at the working pattern of some of our front-line workers, technical insufficiency can be understood. The Auxillary Nurse Midwife (ANM) as well as the Anganwadi Worker (AWW) responsible for maternal and child health care are both supposed to be from the community they serve. The AWW is supposed to maintain 24 registers, which is an impossible feat. The ANM also spends 45% of her time in record keeping and about 25% time in travel when all activities of the health sector are supposed to be implemented through the her only, a humanly impossible task. The selection of Accredited Social Health Activist (ASHA), key worker under National Rural Health Mission (NRHM) is amenable to local manipulation and the training ambitiously over- academic. Here again, it is difficult to name a program which does not involve ASHA. The spectrum of ASHA's job responsibility simply goes on widening day-by-day, unnecessarily diluting and compromising her operational capacities. Non demarcation of job responsibilities and allotment of the same job to more than one functionary is again a frequently encountered problem. Meanwhile, we have entirely forgotten that the trained staff in the form of multipurpose health worker (male) remains underutilized. The Medical Officer posted at the PHC is busier with administrative renderings than patient care despite the fact that he was never trained for resource management during his MBBS education. Moreover, most authoritative powers are now vested either with the local leaders (a cost for decentralization and community ownership) making the medical officer a vulnerable soft target for all criticisms [2].

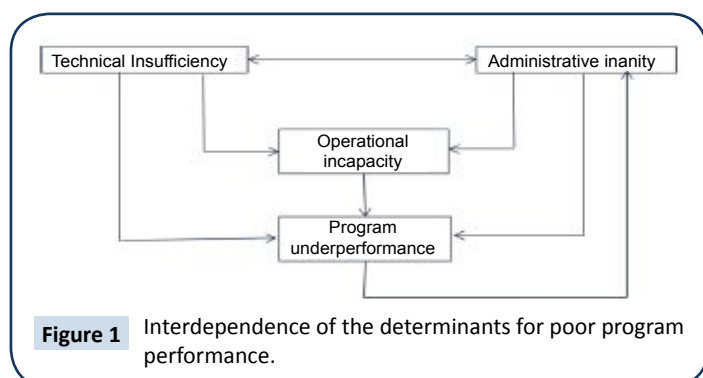
Administrative inanity: has on many occasions led to chaotic deadlocks for health programs. The NRHM was launched for a period of seven years (2005-2012) while the recruitment of ASHAs continued till 2010. Hence, the ASHAs who were recruited in the system later did not get appropriate training in handling the drugs and equipments. If the administrative inanity is to be reckoned, these subtle deviances would emerge as the major culprits in the form of nonuse or misuse of drugs and equipments. Another administrative issue is whether the community level workers be paid a fixed remuneration or performance-linked incentive or just be asked to work as volunteers. Our programs ask for the voluntary workers to spend only a small amount of time on their health-related duties, leaving time for other breadwinning activities, although community demand often requires full-

time performance. The honorarium received in return (if any) is inadequate. This results in high drop-out rates and the ultimate collapse of programs [2].

Operational incapacity: is perhaps the conduit through which technical and administrative flaws seep into programs and paralyze them. The reason for poor performance of workers could be many. Inadequate or delayed remuneration (monetary, recognition and reward), inadequately trained/motivated staff, recruitment of staff in defiance to the requisite qualification, lack of monitoring supervision, job-overloading, and little job and career enhancement opportunity, etc. are a few to account. The trainers for the grass root workers do not maintain a uniform quality either. Intersectoral coordination is expected at the grass root level, e.g. between ANM and AWW while many-a-times the portfolio ministers do not coordinate with each other. The best examples for this are enumerated by the numerous semantic changes to family planning program and the launch of different generations of malaria or tuberculosis control programs. However, a program that fails to get a face-lift loses the affection of administrative spheres and despite the huge infrastructural built-up already accomplished and it spirals downwards [2].

Review of the success/failure of certain programs

Poverty alleviation program: Despite various strategies to alleviate poverty, hunger, malnourishment, illiteracy and lack of basic amenities continue to be a common feature in many parts of India. Though the policy towards poverty alleviation has evolved in a progressive manner, over the last five and a half decades, it has not undergone any radical transformation. Government policies have also failed to address the vast majority of vulnerable people who are living on or just above the poverty line. It also reveals that high growth alone is not sufficient to reduce poverty. Butsch [7] concluded that the governmental health care services, which should in theory, provide subsidized or free treatment to the poorest are not able to reach their target group. Proximity to available services, lack of knowledge about such services, or having special needs have also been noted to be significant barriers to health care or service access. Knowledge about the services, variable work schedules, service hours often highlighted as barriers to healthcare access. Without the active participation of the poor, successful implementation of any program is not possible. Food subsidies are provided to those who have ration cards but to obtain it a person requires a valid "proof of identity" and a "proof of residence" issued by a government agency [8]. Home births are common in India, and birth registration rates are poor. Uttar Pradesh and Bihar, the home states of many migrants, have birth registration rates of 6.5% and 1.6% respectively, as a result of which many migrants lack valid documents when they arrive in their new settlements and hence are bereft of the subsidies due to them [9]. Moreover, since the vast majority of such people stay in slums and squatter settlements in the new city, they don't even have a proof of residence and hence benefits of health programs don't reach them. So far every government which has stepped into power has catered to the dreams of the 'haves'. The haves have access to government patronage, foreign investment, liberal tax concessions and sufficient capital.



Nutrition programs: Despite substantial improvement in health and well-being after independence, under-nutrition still remains a silent emergency in India. About 40% of the world's malnourished children and 35% of the developing world's low-birth weight infants live in India [10]. Approximately 2 million children die in India every year, accounting for one in five child deaths in the world. If children were well nourished, more than half of these deaths could be prevented. Concerted national efforts have been made to provide such supplementary nutrition to children, with a view to improve their nutritional status. However, no project or program can be expected to reach or provide for all those in need. The Mid-day Meal (MDM) Program provides for school children, who are beyond 5 years of age. It suffers from many operational problems of food being insufficient to meet the needs of the child, or adulterated or in short supply. The Integrated Child Development Services (ICDS) Scheme serves 0-6 year old children, but its reach and coverage is limited and there is inadequate coverage of children below 3 years of age, i.e to those who are at greatest risk of malnutrition. Moreover, there are irregularities in food delivery to anganwadis, compounded with inadequate training of workers, poor supervision, and lack of community ownership and participation. According to NFHS-3, though 81.1% children <6 years of age were covered by the AWCs in the country, only 28.8% actually received the services (NFHS -3) [11]. In the ICDS-III baseline/ICDS-II end line survey, the majority of AWCs reported disruptions in the food supply during the preceding 3 months period [12]. An evaluation by the National Institute of Public Co-operation and Child Development (NIPCCD) showed that food distribution had ceased for periods longer than 90 days in 27% of the AWCs [13]. The National Nutritional Anaemia Prophylaxis Program came into existence since 1970 but even after 4 and half decades, half the population remains anaemic. Issues like iron tablets causing gastritis, storage instability of iron formulations, and unpleasant side-effects, lack of proper health care delivery system in urban slums, patients' acceptance of iron supplements, late registration/no registration of pregnant women, high drop-out rate from antenatal care, poorly defined implementation procedures, logistics problems, scant supervision, and insufficient monitoring. IFA tablets are mostly not consumed since it is thought to be "free and will not work" [2]. Moreover, many people are vegetarians and may have anaemia because of Vitamin D and/or folate deficiency. Even with this knowledge, Vitamin B12 is not supplemented in the Nutritional Anaemia Prophylaxis Program. Iron supplementation should always be combined with other forms of public health interventions that are potentially effective in containing iron deficiency anaemia in a specific epidemiological, clinical, and nutritional context (e.g., nutritional education, control of hookworm infection, fertility regulation, and control of other prevailing micronutrient deficiencies)

Programs on communicable diseases: India's progress on communicable disease control is mixed. National programs provide universal coverage for less than 10% of all mortalities and 15% of all morbidities. Over 75% of communicable diseases are not part of existing national programs. Overall, communicable diseases contribute to 24.4% of the entire disease burden [3]. Diseases like Polio, Neonatal Tetanus and Yaws has been

eliminated. In Leprosy, though there has been a significant reduction, but after a reduction of an annual incidence of 120,000 cases, there is stagnation, with new infective cases and disabilities being reported [3]. In AIDS control, progress has been good with a decline from a 0.41% prevalence rate in 2001 to 0.27% in 2011- but this still leaves about 21 lakh persons living with HIV, with about 1.16 lakh new cases and 1.48 deaths in 2011 [3]. In malaria there has been a significant decline, but there are also the challenges, of resistant strains developing and of sustaining the gains, in a disease known for its cyclical reemergence and focal outbreaks. Viral Encephalitis, Dengue and Chikungunya are on the increase, particularly in urban areas and there are no effective measures to address them [3]. Mosquitoes developing resistance to D.D.T or Chloroquin is one of the reasons for technical failure of national vector-borne disease control program. Changes in vector bionomics and agent behavior cannot be ruled out [2]. Performance in disease control programs is largely a function and reflection of the strengths of the public health systems. Surveillance is good for diseases like Polio, where there is political will and global attention. In spite of this the exercise becomes useless if government changes or some natural calamity occurs. The opportunity cost to programs for other diseases like diarrhea, malnutrition, RCH related morbidities, etc. when calculated could be enormous and intimidating. Added to this is constant resource crunch, weak logistics and inadequate infrastructure, the three main reasons leading to all national health programs doing badly.

Out of the communicable disease programs, if we analyse the failure of any one program, like the Revised National Tuberculosis Control Program (RNTCP), the challenges and bottle-necks which appear through various literature is mind boggling. The tuberculosis burden is close to 211 cases and 19 deaths per 100,000 populations and there are rising problems of multi-drug resistant tuberculosis. Though these are significant declines from the MDG baseline, India still contributes to 24% of all global new case detection. There is controversy regarding the efficacy of the 6-month regimen that is recommended under RNTCP in TB meningitis and TB of bones and joints cases compared with the 9-12 month regimen recommended by some experts [14]. Ramachandran et al. showed that even after a decade of RNTCP implementation, there is still a lack of awareness among patients about the availability and quality of free diagnostic and treatment facilities locally under RNTCP. These patients use facilities from hospitals, medical colleges or private practitioners [15]. More than half of the total TB patients bypass RNTCP services and are either treated in private sectors or are untreated. In India, 75% of doctors (6 million) are based in private practice and only 0.31% is implementing RNTCP [16]. Most of the private practitioners still have practically no access to information or training programs, which accounts for the disparity in their management strategies. The RNTCP provides free diagnostic and treatment services to benefit the poor and vulnerable groups of the society people most in need of free services are not accessing or utilizing these services. One of the key challenges in achieving this objective is to address the reasons behind inter/intra-district disparities in program performances, since problems persist more in the poorer and backward districts (low agricultural productivity, unemployment, and critical gaps in physical and

social infrastructure) of the country. Under the RNTCP, there is a need to co-ordinate between policy makers, practitioners, non-governmental organizations and other stakeholders in setting the foundations for development of specific tools, guidelines, and activities that are aimed at increasing access to TB services for the poor. Treatment can be given only to people captured in the diagnostic net, but it does not capture all infectious cases, leading many patients to seek private healthcare, where non-standard treatment is widespread and follow up is poor, contributing to development of drug resistance. Even those captured in the RNTCP become non-infectious only after they have shed the bacilli for several weeks.

Programs on Non-communicable diseases: Non-Communicable Diseases (NCDs) are the leading cause of adult mortality and morbidity worldwide. NCDs are rapidly increasing globally and have reached epidemic proportions in many countries, largely due to industrialization, socioeconomic development, rapid urbanization, demographic and lifestyle changes. As per the NCD country profile 2014 published by World Health Organization, overall mortality due to NCDs was 60%. The disease specific share was as follows: Cardiovascular Diseases-26%, Cancers-7%, Diabetes-2%, COPD-13%, Other NCDs-12% [17]. With the largest number of diabetic patients, India leads the world with earning the dubious distinction of being termed the “Diabetes Capital of the World”. Impaired Glucose Tolerance (IGT) is also a mounting problem in India. It has been noticed that with every diagnosed case of diabetes there is at least one undiagnosed case of glucose intolerance. So the actual population at risk would be much greater than our current estimate. Around 35% of IGT sufferers go on to develop type-2 diabetes [18]. The behavior modification strategies needed to bring about a reduction of NCDs requires changes in social policies which pose several difficulties. Revenue is generated by the Government on sale of alcohol, tobacco and processed food, and mass media benefits by advertisements. So any attempt to restrict these is thwarted by market forces. The rich and poor divide is another deterrent, as the rich have the means to adopt a healthy behavior, thus preventing diseases in them. Poor are also exposed to other risks like indoor air pollution, and poor nutritional status. Unless policies create an enabling environment, health education alone will not be effective. Moreover, migration from rural to urban areas leads people to move away from traditional high fibre home cooked food to purchased and processed food, high in energy, sugar, salt and fat. Physical activity has given way to mechanization, too.

Programs on mother and child: In many developing countries, lots of births occur outside a hospital and not many women are assisted by trained health workers either before or after birth. Further, access to state of the art tools is limited. This situation greatly affects the health of mother and child and can result in prenatal and neonatal mortality. Countdown to 2015 indicators to track country and global progress towards achievement of Millennium Development Goals 4 and 5 have not been met in most developing countries, including India. Women’s utilization of maternal health care facility is an important health issue with regard to the wellbeing and survival of both the mother and her child. The Janani Suraksha Yojana (JSY) has caused an iconic upsurge in institutional delivery. However, The JSY needs strengthening

in preparing JSY plans (facility, district and state), proper and periodic monitoring for adherence to the guidelines and strong financial planning and developing robust communication activity plan for community mobilization. Not all sub-centers are JSY accredited leading to excessive demand at the JSY integrated sub-centers and non-utilization of those not offering the Yojana. Such administrative lacunae hamper the program implementation and sustained acceptance by the community. Though the number of institutional deliveries has increased, provision of quality antenatal and postnatal services is lacking due to severe healthcare workforce crunch. Out of pocket expenses and user charges for transport, admission, diagnostic tests, medicines and consumables and fees for caesarian operation are incurred by pregnant women in many cases. Immunisation is one of the most cost effective interventions for disease prevention. Yet the success of the Universal Immunisation Program is constrained by implementational issues like non-uniform coverage, poor monitoring and surveillance, high dropouts, poor cold chain management and injection safety. Health education in India focuses on only knowledge-based interventions without looking at felt needs and ground reality and does not reach the remote corners and vulnerable sections. Quality of training is also doubtful and training of health educators is not done regularly. The involvement of the NGOs as a public-private-partnership endeavor under NRHM/ RCH-II for providing hands-on technical support to the field staff is a commendable strategy but this also, if without the supervision -vision of medical college teachers, could result in poor training ; performance mostly proving counter-productive [2].

Family planning program: In developing countries 220 million women have unmet need of contraception due to lack access to contraceptives and family planning information or services. Less than 20 percent of women in Sub-Saharan Africa and barely one-third of women in South Asia use modern contraceptives. In 2012, an estimated 80 million women in developing countries had an unintended pregnancy; of those women, at least one in four resorted to an unsafe abortion [19]. Patriarchal structure of society compounded with variety of social norms is the main hindrance to the successful implementation of the program in the developing world, where women are not empowered to take decisions for family planning. Some other key factors are traditional social attitudes and illiteracy. Some governments who lack the initiative have failed to provide basic infrastructure to tackle this or to facilitate public-private partnership to run family planning programs. Forced vasectomy in late 1970s (a classic for administrative blunder) had boomeranged back on the Government of India giving a massive jolt to our family planning program [2]. The total unmet need for family planning according to NFHS-3 was 13.2% [10]. The reasons cited are fear of side effects, limited knowledge about methods, poor involvement of males, opposition of family planning by family member, reliance on breast feeding and poor health systems delivery.

Water supply and sanitation: Millennium Development Goal (MDG) 7 targeted the reduction by half of the world’s population without sustainable access to safe drinking water and basic sanitation by 2015, but even at the end of 2015 India is lagging behind, with the country having the world’s highest number of

open defecators (597 million people or 48% of the population) [20]. About 60% of the generated solid waste is collected and disposed of, but only half of it in a sanitary manner. The study of the "Economic Impact of Inadequate Sanitation in India", conducted by the World Bank's South Asia Water and Sanitation Unit, claims that the lack of toilets and decent sanitation costs India nearly US\$ 54 billion a year, or 6.4% of its GDP. This is mainly through premature deaths, especially of children, treatment for hygiene-related illnesses, and lost productivity [21]. The National Water Supply and Sanitation Program, launched in 1954, could not achieve its targets of achieving 100% urban/rural water supply, 50% urban and 25% rural sanitation because of financial difficulties, institution problems, inadequate human resources, lack of political commitment, lack of sectoral coordination, insufficient community involvement, poor water supply, lack of hygiene education and insufficient information and communication [22].

Conclusion

Political or economic instability; increasing demand by patients and physicians for expensive medical technology that is not cost-effective; inability of health care delivery system in reaching the remote corners of society; increasing budget deficits; a growing uninsured population; and increasing pressure to reduce healthcare costs lead to program failure. Poverty mitigation, reduction of inequalities (between the haves and have-nots), health care financing, strengthening of public health information system, health education and communication (to promote preventive self-care and risk reduction) life style changes are some of the important domains on which the health of population depends. Health of populations also depends on reducing mortality and morbidity, efficient health care delivery systems in private and public sectors and attention to vulnerable sections.

Program monitoring and evaluation (M and E) are important components of a program and are critical to sound strategic planning which requires complex set of co-ordinated action. A list of tentative indicators is required as well as sustainable systems for surveillance has to be developed, which is not carried out leading to program failure.

Recommendations

WHO envisages that constraints common to multiple health programs should be tackled in an integrated manner. The health system could be strengthened by resolving the issue of the shortage of staff and by creating parallel staff for the private sector through Public Private Partnerships. Medical colleges should be actively involved by undertaking activities such as training of health functionaries and performing operational research to evaluate health programs and find solutions to program failure. There should be active attempts to decentralize the program decisions at district, state, and medical college levels. It's high time we find a way towards Universal Health Coverage than treating the illnesses. Models are many. Technology is also the way to health. Mobile phones could be one of the world's most important health tools, already in use in many countries [23]. M-Health can be very effective to provide health workers with training materials at a low cost as well as to bridge the gap between women and trained healthcare providers.

A combination of technical as well as behavior change would lead to increased availability of necessary health services during pregnancy, better referral and monitoring system and overall positive attitude of the community towards availing health services and improved motivation and responsiveness of service providers towards the urban poor, and this in turn can lead to success of health programs.

References

- 1 (2005) World Health Organization (WHO). Preventing Chronic Disease: A Vital Investment Geneva.
- 2 Mohapatra SC, Mohapatra M, Mohapatra V (2016) Health Care Delivery System in India. In: A Treatise on Health Management.
- 3 (2015) Draft National Health Policy 2015 - Ministry of Health & Family Welfare.
- 4 Lenka SR, Kar SS (2012) Effective implementation of national health Programs: issues and challenges. National journal of Medical Research 2: 528-529.
- 5 (2014) India Today 2014: India's health woes: Budget for the National Health Mission remains stagnated at Rs 19,000 crore.
- 6 Urban Health Resource Center. Improving access of healthcare to the urban poor in India.
- 7 Butsch C (2008) Access to healthcare in the fragmented setting of India's fast growing agglomerations – a case study of Pune. In: Bohle, H.G. und K. Warner (Hrsg.): Megacities. Resilience and Social Vulnerability 10: 62-72.
- 8 Sengupta Paramita and Benjamin AI (2016) Countdown 2015: An assessment of basic provision to migrant families in the urban slums of Ludhiana, North India. Environment and Urbanization. 28: 569–582.
- 9 Abbas R, Varma D (2014) Internal Labor Migration in India Raises Integration Challenges for Migrants. Migration Information Source, Migration Policy Institute.
- 10 Braun VJ, Ruel M, Gulati A (2008) Accelerating progress toward reducing child malnutrition in India. A concept for action, International Food Policy Research Institute.
- 11 NFHS III Report 2005-06. Govt. of India and International Institute of Population Sciences.
- 12 Bredenkamp C, Atkin JS (2004) India's Integrated Child Development Services Scheme –meeting the health and nutritional needs of children, adolescent girls and women.
- 13 (1992) National Institute of Public Co-operation and Child Development. National Evaluation of Integrated Child Development Services. NIPCCD, New Delhi.
- 14 (2006) Tuberculosis: Clinical diagnosis and management of tuberculosis, and measures for its prevention and control. London: Royal College of Physicians pp: 215.
- 15 Ramachandran R, Muniyandi M, Gopi PG, Wares F (2010) Why do tuberculosis suspects by pass local services to attend tuberculosis sanatorium? Lung India 27: 111-114.
- 16 (2011) World Health Organization. WHO Report on Global Tuberculosis Control: Epidemiology, Strategy, Financing. Geneva.
- 17 (2014) World Health Organization. Non communicable disease country profiles 2014.
- 18 Verma R, Khanna P, Bharti (2014) National Programme on prevention and control of diabetes in India. AMJ 5: 310-315.
- 19 (2015) Family Planning - Bill & Melinda Gates Foundation. HYPERLINK "<http://www.gatesfoundation.org/What-We-Do/Global-Development/Family-Planning>" www.gatesfoundation.org/What-We-Do/Global-Development/Family-Planning. Accessed on: 15.5.16.
- 20 (2014) WHO/UNICEF Joint Monitoring Programme. Progress on sanitation and drinking-water: 2014 update, WHO/UNICEF, Geneva and New York.
- 21 The economic impacts of inadequate sanitation in India. Available from: <https://www.wsp.org/sites/wsp.org/files/publications/wsp-esi-india.pdf>. Accessed on: 16.3.16.
- 22 Kishore J (2014) National Health Programs of India. National Policies and Legislations Related to Health. Century Publications.
- 23 Mohapatra SC, Sengupta Paramita, Gupta VP. Universal Health Coverage: A New Initiative. The Journal of Community Health Management, April-June 2016;3(2):47-48