HUNDRED AND THIRTY-NINTH REPORT

PUBLIC ACCOUNTS COMMITTEE (1988-89)

(EIGHTH LOK SABHA)

FAMILY WELFARE PROGRAMME

MINISTRY OF HEALTH AND FAMILY WELFARE
(DEPARTMENT OF FAMILY WELFARE)

LOK SABHA SECRETARIAT
NEW DELHI

December 1988/Agrahayana 1910 (Saka)

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CORRIGENDA TO 139TH REPORT OF PAC (8TH LOK SABHA)

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(i) 12 February, 1987

(ii) 20 March, 1987

(iii) 24 November, 1987

(iv) 2 December, 1987

(v) 28 December, 1987

(vi) 29 December, 1987

(vii) 6 December, 1988

*Not printed. One cyclostyled copy laid on the Table of the House and 5 copies placed in Parliament Library.

PUBLIC ACCOUNTS COMMITTEE
(1988-89)

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@ Appointed w.e.f. 7.12.1988 *vice* Shri Kalpnath Rai ceased to be a member of the Committee on his appointment as a Minister of State.

INTRODUCTION

I, the Chairman of the Public Accounts Committee, as authorised by the Committee, do present on their behalf, this 139th Report on Paragraph 22 of the Report of the Comptroller and Auditor General of India for the year 1984-85, Union Government (Civil), Volume I relating to Family Welfare Programme.

2. The Report of the Comptroller and Auditor General of India for the year 1984-85, Union Government (Civil), Volume I was laid on the Table of the House on 7 May, 1986.

3. In this Report, the Committee have expressed the opinion that even though the Family Welfare Programme has been in operation for more than thirty-five years with an expenditure of over Rs. 2400 crores incurred thereon upto the end of Sixth Five Year Plan, it has not been able to check the growth of population at all. According to the Committee the nature of the population problem has not been perceived in the right perspective in spite of the initial urgency of the population control expressed by the planners in the First Five Year Plan. The Programme has been implemented without any enthusiasm like any other routine programme with the result that the growth rate of population remained unabated. The Programme being a 'Centrally Sponsored Scheme' though implemented by State/Union Territory Governments, the Ministry of Health and Family Welfare should take steps to identify the weak-spots in the programme management from every possible angle.

4. Taking note of the wide variations in the programme acceptance and demographic situation in different States, the Committee have expressed the view that population problem in the poor performing States and regions cannot be understood or tackled by a single uniform national strategy and as such there has to be multiple strategies to suit inter-state and inter-regional diversities. The Committee have accordingly, desired that the flexibility in approach and financial powers in implementing special schemes for different regions and areas and specific groups should be provided to State Governments to enable them to effectively implement the Programme according to realities of the situation.

5. The method of sterilisation has been the main plank in the Government strategy in meeting the family planning targets. Since the younger age groups may not be inclined to adopt sterilisation being a terminal

method, the Committee have desired that efforts to promote non-terminal methods should be directed towards these target groups.

6. The Committee have desired the Government to introduce necessary administrative machinery for securing effective inter-sectoral coordination at all levels to attack the multi-dimensional population problem. The Committee have also desired such a system to ensure that the socio-economic development programmes of various Ministries/Departments are restructured to motivate people in favour of small family norm.

7. The Committee have viewed that promotion of Family Welfare Programme has to be obligatory for all official mass media channels especially radio and television which can not only cross the barriers of illiteracy but also have a comparatively wider and more powerful reach than other channels. The Committee have therefore desired the Ministry of Information and Broadcasting to take appropriate steps for greater and effective utilisation of these channels for spreading the messages appropriate for acceptance of family planning.

8. The Committee have pointed out that proper delivery of services is very essential not only to enlarge the acceptability of programme infrastructure but also to generate demand in favour of adoption of family planning. Therefore, endeavour will have to be made to ensure the suitability of a person for a particular family planning method so as to avoid any mishap creating demoralising effect on others.

9. Expressing deep concern over the poor performance of Family Planning Programme in the four major States of Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh, the Committee have viewed that programme management in these States needs serious attention for improving their current levels of performance. The Committee have therefore, recommended a special cell at the central level exclusively for these States to ensure proper supervision and effective implementation of the Programme.

10. For facility of reference and convenience, the observations and recommendations of the Committee have been printed in thick type in the body of the Report and have also been reproduced in a consolidated form as Appendix V to the Report.

11. The Committee place on record their appreciation of the assistance rendered to them in the matter by the Office of the Comptroller and Auditor General of India.

12. The Committee would like to express their thanks to the officers of the Ministry of Health and Family Welfare (Deptt. of Family Welfare) for the cooperation extended by them in giving information to the Committee.

13. The Committee are also thankful to Prof. Ashish Bose, Population Research Centre (Institute of Economic Growth), Delhi and Shri K. Srinivasan, Director, International Institute for Population Sciences, Bombay for giving their valuable suggestions to the Committee for implementation of this desirable programme.

NEW DELHI;
6 December, 1988

15 Agrahayana, 1910 (Saka)

AMAL DATTA
Chairman,
Public Accounts Committee.

REPORT

CHAPTER I

FAMILY WELFARE PROGRAMME IN RETROSPECT

1.1 The first census conducted after independence of the country in 1951 revealed that the population had increased to 361 million registering a decennial change of 13.31% during the decade 1941-51. Realising that "a situation in which shortage of capital equipment rather than of labour is the main limiting factor in development a rapidly growing population is apt to become more a source of embarrassment than of help to a programme for raising standards of living", the framers of India's First Five Year Plan (1951-56) recognised the urgency of the problem of family planning and population control. They came to the conclusion that population control could "be achieved only by the reduction of the birth-rate to the extent necessary to stabilise the population at a level consistent with the requirements of national economy". The Government made an allocation of Rs. 6.5 million in the First Plan period for the Family Planning Programme. This was the genesis of the first government level family planning programme in the world in 1952. The Programme has since become and integral part of socio-economic development plans of the country and has gained substantially in terms of allocation of financial and human resources in each successive Plan.

1.2 In 1966, a Department of Family Planning was constituted in the Ministry of Health and Family Planning at the Centre to give technical and administrative direction and guidance to the Programme and effective coordination of its various facets. From 1966-67, the Programme was made time bound and target-oriented. During the "plan holiday" (1966-69), it was integrated with the maternal and child health (MCH) services. The Programme was renamed as 'Family Welfare Programme' in 1977-78. Presently, the Family Welfare Programme seeks to promote on a voluntary basis, responsible and planned parenthood with 'two child norm' through independent choice of family planning method, best suited to the acceptors. Family Planning services are supposed to be offered through the total health care delivery system. The Programme is a 'Centrally Sponsored Scheme' to be implemented by the States and full cost of the Programme is met by the Union Government which provides assistance both in cash and kind. An expenditure of over Rs. 2400 crores had been incurred on the Programme upto the end of Sixth Five Year Plan. The Union Government

in the Department of Family Welfare (Ministry of Health and Family Welfare) retains the major initiative and provides overall direction and coordination to the Programme. Implementation by the States/Union Territories are meant to be through a network of Rural and Urban Family Welfare Centres and sub-centres. Local bodies, voluntary organisations and organised sectors are also involved in this Programme.

1.3 The implementation of the Programme during the Sixth Five Year Plan (1980-85) was test checked by Audit and their review as appearing in paragraph 22 of the Report of the Comptroller and Auditor General of India for the year 1984-85, Union Government (Civil), Volume I is reproduced in Appendix I to the Report.

Population of India

1.4 Today, the population of the world has crossed five billion figure and India, with estimated 776 million people in 1987, is second in population-size only to the People's Republic of China which has a population of 1059.5 million (1985 estimates). With only 2.4 per cent of the total world area, India today sustains more than 15 per cent of the world population. The demographic situation in the country presents a dismal picture. While the density of population per square km. in China and the world as a whole is 110 and 34 respectively (at 1983 estimates), the corresponding figure for India is as high as 216 as per 1981 census and 245 at the latest reckoning for the year 1987 (as worked out by the Expert Committee on Population Projections). The annual rate of population increase in India is also substantially higher at 2.28% (1981 Census) as against just 1.2%, in China and 1.8% for the world as a whole during the years 1980-83.

1.5 Yet another alarming feature of population in India is its broad-based age pyramid. According to 1961, 1971 and 1981 censuses, the percentage distribution of population by age-groups has been as under:

Age-group	1961 Census	1971 Census	1981 Census
0-14 years	41.1	42.0	39.6
15-29 years	25.0	24.0	25.8
30-44 years	18.0	17.8	17.4
45 years and above	15.9	16.2	17.2

With the young age structure holding large potential for a rapid population growth in future years, India even today faces an uphill task

of maintaining minimal living standards for its people with limited resources.

1.6 *Growth of population in independent India*

The decennial censuses are the major source of data on the demographic trends in the country and the statement showing the census population of the country between the years 1941 and 1981 with latest 1987 projections is reproduced below:

Census population of India between 1941 and 1981 with latest 1987 projection

Census Year	Total Population (Millions)	Decennial change (percent)	Average Annual Growth Rate (exponential) (percent)	Density of Population (per sq. km.)	Birth Rate (per 1000 Population)	Death Rate (per 1000 Population)
1	2	3	4	5	6	7
1941	318.7	—	1.33	103	45.2	31.2
1951	361.1	13.31	1.25	117	39.9	27.4
1961	439.2	21.64	1.96	142	41.7	22.8
1971	548.2	24.80	2.20	173	41.2	19.0
1981	685.2	25.00	2.25	216	37.2	15.0
1987	776.3*	—	1.99*	245*	32.7@	11.7@

@ S.R.S. Provisional estimates for 1985.

* [illegible] as worked out by the Expert Committee on [illegible] Projections. It is however, seen from reply to Lok Sabha starred Question No. 189 (8th August 1988) that the Natural Growth Rate at National level, as per latest estimates of sample Registration System (SRS), is reported as 2.15 per cent for the year 1986 as against the Growth Rate of 1.99 per cent projected by the Expert Committee on [illegible] Projections.

It can be seen from the above table that the percentage of decennial change of population from the 1951 census [illegible] has been progressively increasing over the preceding decades touching a new high at 25% during the decade 1971-81. In terms of absolute numbers, 78 million people were added during 1951-61, 109 million during 1961-71 and 137 million during 1971-81. The table also reveals the widening gap between the high birth and falling death rates over the successive censuses. According to last three census figures, while the death rate had declined from 27.4 per thousand to 15.0 per thousand between 1951 and 1981, the corresponding reduction in birth-rate was only marginal viz. from 39.9 per thousand to 37.9 per thousand.

1.7 Although certain demographic goals for reduction in birth rate were made explicit at the beginning of various plans, the achievements in targeted years had fallen much short of planned targets as is evident from the following information furnished by the Ministry.

Year	Desired demographic goals, India 1962-78		Actual Achievement in targeted year
	Specified demographic objective in terms of Crude Birth Rate (CBR)	Year by which the goal was to be achieved	
1962	25	1973	34.6
1966	25	as expeditiously	
1968	23	1978/79	33.3
1969	32	1974/75	34.5
Beginning of Plan	25	1979-1981	33.8
1974	30	1979	33.7
Beginning of Plan	25	1984	33.8
April 1976	30	1978/79	33.3
(I Population Policy)	25	1983/84	33.7
April 1977	30	1978/79	33.3
(II Population Policy)	25	1983/84	33.7
January 1978 (Central Council of Health)	30	1982/83	33.8
National Health Policy	31	1985	32.7*

* Provisional

1.8 In fact, the data obtained from Sample Registration System reveals that the crude birth rate has been oscillating around 33 per thousand population from 1977 onwards with no sign of decline despite the fact that the number of couples protected is claimed to have risen from 24.6 million (22.5 per cent of eligible couples) in 1977-78 to 40.7 million (32.1 per cent) in 1984-85.

1.9 The Working Group on Population Policy set up by the Planning Commission which submitted its Report in May 1980 felt that the future fertility goals should, *inter alia*, be linked to the levels of mortality of population particularly infant mortality and the Group accordingly recommended the adoption of the long term demographic goal of reducing the net reproduction rate (NRR) to one by 1996 for the country as a whole and by 2001 in all the States. The implications of attaining NRR of 'I' by 1996 were as follows:

(a) Birth Rate — to be reduced from 33 in 1978 to 21 in 1996.

(b)	Death Rate	—	to be reduced from around 14 in 1978 to 9 in 1996
(c)	Infant Mortality Rate	—	Below 60 per thousand live births in 1996
(d)	Effective couple Protection Rate	—	60% in 1996 as against 22% in 1973 (It was 32% at the end of Sixth Plan as against a target of 36.6%)

Subsequently, the National Health Policy (1983) targeted Net Reproduction Rate of one by the year 2000 AD, and a review conducted by the Planning Commission indicated that this goal would be reached only by the period 2006-11.

1.10 The Committee are of the opinion that even though Family Welfare Programme has been in operation for more than thirty-five years and an expenditure of over Rs. 2400 crores has been incurred upto the end of Sixth Plan it has not been able to check the growth of population at all. While the demographic goals in terms of crude birth rate had been frequently announced and readjusted, the planned targets had remained elusive with birth rate reigning high in the past and stagnating around 33 per thousand population from 1977 onwards. This failure to achieve a swift decline in birth rate has resulted in alarming increase in the population. The high birth rates have also resulted in a broad-base age pyramid with 40 per cent of the population below 14 years of age, which not only raises the dependency burden on the country but would also result in a continuing high fertility rate in the coming years.

1.11 The Committee consider that the nature of the population problem has not been perceived in the right perspective in spite of the initial urgency of the population control expressed by the planners in the First Five Year Plan. The Family Welfare Programme has been implemented without enthusiasm like any other routine programme with the result that the growth rate of population remained unabated. The Committee are at a loss to understand as to how and why the birth rate has remained stationary at 33 since 1977 despite the fact that couple protection rate has gone up considerably from 22.5 per cent in 1977 to 34.9 per cent by March, 1986. During their examination of this subject, the Committee have been informed of various difficulties at the programme implementation stage. When though the implementation of the programme is done by the State Governments it is mainly the responsibility of the Central Government to ensure that the objectives of the programme are being achieved in accordance with the frame work of formulated policies and timely remedial measures are taken to remove deficiencies. Lamentably, as admitted by the Special Secretary

(Department of Family Welfare) before the Committee the programme has not been given the seriousness it deserved in view of the mammoth socio-economic implications it has for the country. Considering the utmost importance of Family Welfare Programme in socio-economic development of the country, the Committee desire that the Ministry of Health and Family Welfare (MOHFW) should take urgent steps to indentify the weak-spots in the programme management from every possible angle so as to ensure immediate effective remedial measures. In the light of the recent report of Registrar General based on SRS data that the birth rate has not fallen as per projections made by the Expert Committee on Population Projections, the Committee would like the MOHFW to take suitable steps to closely monitor the programme at an appropriately higher level periodically so as to ensure its effective implementation.

CHAPTER II

POLICY AND APPROACH

General

2.1 India is the first country in the world to adopt a government programme for family planning in 1952. In recommending a Programme for family planning, the First Five Plan stated:

> "It is apparent that population control can be achieved only by the reduction of the birth-rate to the extent necessary to stabilise the population at a level consistent with the requirements of national economy. This can be secured only by the realisation of the need for family limitation on a wide scale by the people. The main appeal for family planning is based on consideration of health and welfare of the family. Family limitation or spacing of the children is necessary and desirable in order to secure better health for the mother and better care and upbringing of children. Measures directed to this end should, therefore, form part of the public health programme."

2.2 The belief that there was already some intrinsic demand for family planning services and that supply would induce demand, prompted the Government to open family planning clinics during the First Plan. The people were expected to go on their own to these clinics to demand and receive family planning services.

In the Third Plan, this 'clinical approach' of the first two plans was replaced by an 'extension education approach' aimed at bringing the message and the services to the people in the far corners of the country through a network of health and family planning centres in rural and urban areas and involving voluntary organisations and local leaders. In respect of the different methods of family planning, a 'cafetaria approach' was adopted which left the choice of the method to the acceptor.

Family Planning Methods and their Targets

2.3 At present, the following methods are made available under the programme.

A. Terminal methods

(i) Vasectomy
(ii) Tubectomy (usually carried out through the surgical techniques of mini lap and laparoscopic tubal occlusion).

B. Intra-Uterine-Two types of devices are used i.e. Devices Lippe's loop and Copper T-200 (CuT)

C. Oral Pills

D. Conventional Contraceptives

2.4 A statement showing the yearwise targets and achievements of different family planning methods is enclosed as Appendix II. It would be seen from the statement that the targets of sterilisation have been comparatively higher than other methods and that there had been shortfalls in the achievements of the targets excepting in a few years.

2.5 When enquired about the methodology adopted by the Ministry for fixation of targets under different methods of family planning, the Ministry furnished the following information.

> "The Seventh Plan Document categorises all the States and Union Territories in accordance with the year by which NRR of one is to be reached. It is assumed that a Couple Protection Rate of 60% will, by and large, lead to attainment of NRR of one. This demographic goal is kept in view while determining the targets for States/Union Territories. The States are also requested to send their proposals of annual targets in line with the achievement of a Couple Protection Rate of 60% by the specified years. The method preference, i.e. method-mix of new acceptors varies from State to State. It was decided to fix the sterilisation targets for each State and Union Territory at the level of targets which were fixed for the year 1986-87. While determining the targets for other methods, i.e. IUD Insertions and CC/OP Users, the following factors were taken into account.
>
> 1. The year by which Couple Protection Rate of 60% is to be achieved.
> 2. The proposals of targets sent by the States/Union Territories for the year 1987-88.
> 3. Method preference for the year 1985-86.
> 4. Levels of performance and targets of 1985-86 and 1986-87."

Allocation of Funds

2.6 According to the Ministry, the State-wise allocation of funds for implementation of family welfare programme depends on overall availability of resources, expenditure incurred by the States during preceding

year as per laid down pattern, the past preformance, future targets and infrastructure sanctioned.

Disquieting Features of Indian Population

2.7 According to Sample Registration System (SRS), the birth rate in the country has been stagnating around 33 per thousand in the last 8-9 years. Large States like Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan which constitute 40 per cent of the country's population have still very high birth rates in the range of 40. The total fertility rate (which indicates the total number of children expected to be born per woman during the entire span of reproductive period) in these States lie in the range of 5.0 to 6.0 as against All India level of 4.5. Infant mortality rate, which is one of the proximate determinants of fertility, is still very high, being 57 in urban areas, 105 in rural areas and All India level of 95 per thousand live births (SRS-1985). The infant mortality rates in the aforementioned large States are also of a high order in the range of 105-140 per thousand live births.

2.8 The paper "India's Population—Demographic Scenario" prepared by the Department of Family Welfare (August 1987) reveals that while linking the demorgraphic scenario with the family planning performance, it emerges that:

(a) The estimated couple protection rates as on 31st March 1987 for the four large States show that excepting M.P., the other lie in the range 20-26 per cent as against the States like Gujarat, Haryana, Maharashtra, Punjab who have reached more than 50 per cent CPR.

(b) Among the Vasectomy and Tubectomy acceptors, mean (wife's) age of acceptor is 31.8 years and 30.3 years and the mean number of living children 3.3 and 3.5 respectively.

(c) An estimate on the age-group of contraceptive acceptors shows that only 15 per cent of those in the age groups 15-29 years have been protected as against 55 per cent in the age group of 30-44 years.

2.9 The population problem in India is complicated by deep rooted religious beliefs and social attitudes favouring large families. Moreover, there are large inter-State variations and diversities in the socio-economic and cultural milieu within the country.

2.10 Research studies disclose the following as the main inhibiting factors to wider adoption of family planning:

(i) While increase in the age of marriage for females has favourable

implications on the process of fertility decline, the social customs and traditions in India have long favoured early marriages. Although the practice of child marriage has been on the decline, the mean age of marriage in India is still much lower than other countries. According to 1981 Census figures, the mean age of marriage for females was 18.3 years. Census figures also reveal that about 7 per cent of the females in 10-14 years of age group were married and the percentage of married females in 15-19 years of age was about 44. The situation in the four major States is much worse where the percentage of married women in the age group of 15-19 years is more than 60. In the nation as a whole, an estimated 4.5 million marriages take place annually of which three million are estimated to be in the age group of 15-19 years.

Coupled with this, the broad-base of the age pyramid of India's population (with 40 per cent of population below 14 years of age) holds the potential for the rapid population growth in the future years. According to the paper prepared by the Department of Family Welfare (August 1987), the number of couples in reproductive age-group will, in next 14 years, increase to around 170 million from the present level of 130 million.

(ii) A Research study was commissioned by the Ministry of Health and Family Welfare in mid-August 1985. The results of the study regarding acceptable family size have shown a pronounced male preference. Research study has concluded that 3-child family is acceptable provided the sex composition is "two sons and one daughter".

The Operations Research Group in a study in U.P. has found that "to have a second son about 60 per cent of the couples are willing to have three or more daughters". The desire for male progeny is because, traditionally, males play various supporting, economic, social and psychological roles and also perform the necessary religious rites in some societies.

(iii) One of the major factors influencing fertility is the level of education. With the increase in the level of education, the fertility shows a declining trend. The same is true with respect of adoption of Family Planning Programme. Adoption rate increases with increase in educational level of respondents.

The following statement gives the trend in General Fertility Rate (GFR), Total Fertility (TF) and Total Marital Fertility (TMF) by level of education. It shows that there is a decline in fertility rates with increase in the level of education.

Fertility indicators by level of education

Level of Education	GFR		TF		TMF	
	Rural	Urban	Rural	Urban	Rural	Urban
1	2	3	4	5	6	7
1. Illiterate	140.4	117.2	4.74	4.00	5.48	4.93
2. Upto primary	122.3	106.7	3.85	3.27	4.98	4.46
3. Upto Matric	99.2	84.6	3.61	2.61	4.90	4.23
4. Matric & above	81.3	75.4	2.48	1.88	4.67	4.01
All literates (2+3+4)	111.1	88.9	3.56	2.58	4.16	4.27

Source: Office of the Registrar General, India, Ministry of Home Affairs, New Delhi. 'Trends and differentials in fertility 1979.'

Another study conducted by Operations Research Group (ORG), Baroda reveals the expected trend in Family Planning adopters with respect to level of education. This shows that acceptance rate increases with increase in the level of education. Among couples with illiterate wives the proportion of contraceptive users was only 22 per cent. Among these whose wives were educated upto primary level the proportion of acceptors was 39 per cent while for Matric and above group it was as high as 45 per cent.

Distribution of adopters by level of education of wife

Level of Education	Total No. of eligible couples	No. of adopters	Percentage
1	2	3	4
Illiterate	81,667	18,044	22.1
Upto primary	16,146	6,285	38.9
Upto Matric	15,912	7,035	44.2
Upto Hr. Secondary and Technical	1,521	686	45.1
Graduate & Above	1,755	827	47.1

But the Indian education scene is still characterised by the high level of illiteracy. According to 1981 census, the percentage of illiterates to total population is as high as 63. The census statistics also revealed that while the percentage of literate males stood at 46.89, the corresponding figure for females was a meagre 24.82 per cent.

(iv) There is a clear two-way co-relationship between fertility and poverty in India as brought out in a survey conducted by the Registrar General in the year 1979, as would be seen from the following table:

Per capita monthly expenditure	Total marital fertility rate	
	Rural	Urban
Below Rs. 50	6.05	5.72
Rs. 51-Rs. 100	4.78	4.62
Rs. 101 and above	3.49	2.97

However, about 220 million people in the country are living below the poverty line, modestly defined as those having monthly per capita expenditure of Rs. 76/- for rural areas and Rs. 88/- in urban areas at 1979-80 price level.

Socio-Economic Measures Promoting Family Planning

2.11 The Third Plan recognised that the "objective of stabilising the growth of population over a reasonable period must be at the very centre of planned development." The Plan emphasised the need for social policies such as education of women, opening up of new employment opportunities for them and raising of the age of marriage. The plan also provided for sex and family life education and advice on such other measures as might be necessary to promote the welfare of the family. The Fifth Plan also stressed the need for population education besides programme integration with channels like functional literacy workers education, special welfare and other outlets.

2.12 In recognition of the fact that the country could not wait for economic development to bring about a change in the attitudes of people to limit the size of families as the process of development itself is stiffled by population growth, the Sixth Plan set 'limiting the growth of population' as one of the main objectives of plan. The Plan, therefore, envisaged that family planning cannot be the sole responsibility of any one Department but of Government as a whole. The Plan stressed on the need for integrated approach and coordination of activities and role of education especially female education in reducing the fertility.

2.13 During their examination of the subject, the Committee examined the Department of Education, Women and Child Development and Rural

Development to ascertain as to what extent other socio-economic development schemes are being implemented in relation to family planning.

2.14 The representative of the Department of Education stated that 'Population Education' issue was certainly in the consciousness of the people concerned with the curriculum but no systematic population education project was taken up until 1980 when an UNFPA assisted Population Education Project was developed which had coordinated Education, Health and Family Welfare. He further stated that in seventies some work was done in this field but it was not systematic as was being done presently. A formal evaluation of the project was conducted in 1986 which had brought out certain weaknesses of the project and an attempt was being made to remove these shortcomings in the second cycle of the project. It was also stated that the programme of population education was also being implemented in Adult Education Literacy Programme.

2.15 The representative of the Department of Women and Child Development informed the Committee that their main programmes had been for child and mother care-children below the school going age and pregnant women and nursing mothers. These groups, according to the witness, are most sensitive groups to family welfare programme. It was further stated that a sample survey carried out in the blocks where the Departmental programme (Integrated Child Development Service) was in position, revealed that the birth-rate in ICDS blocks was a little over 24 per thousand as against all India average of 33 per thousand of population.

The Committee have also been informed that realising the need for a long term perspective for the overall development of women, the nodal Department of Women and Child Development have been working out a National Perspective Plan for Women 1987-2000. The Plan proposes education, vocational training, supportive services and overall development of Women.

2.16 During evidence, the representative of the Department of Rural Development informed the Committee that his Department had also organised training programme for beneficiaries in which there was a module of family planning which could be reconsidered and made more intense. He stated that the Report of the GVK Rao Committee (December, 1985) had recommended rationalisation of staff at the block levels so that it could be pooled i.e., people working in different lines could be directed to work towards one single objective for part of the day. He further stated that if at block levels the staff given under various centrally sponsored schemes by the Central Government and the staff of the State Government departments was put under a joint command, then it could be used both for family planning and other departmental works more effectively. He also informed that major recommendation on the aspect of

rationalisation of staff of various departments was pending in the Planning Commission.

On being pointed out that such a concept was abandoned in the past, the representative of the Ministry of Health and Family Welfare stated that subsequently every department had felt the need to come together because all the workers should know what people of other departments were doing. This, according to the witness, might be relevant to family planning people thereby achieving greater effectiveness and utilisation of the programme. He further added that the rationalisation of staff at district and block level would provide a good opportunity to the workers to do their publicity and some method could be found at the block level to incorporate these things.

2.17 When enquired as to how the programme having bearing with family planning activities are coordinated, the Committee was informed that the need for evolving the effective inter-sectoral integration of family welfare programme pertaining to other developmental departments had been recognised and developing of such a mechanism at the Central and State level is under consideration of Government.

2.18 The Committee note that while the Ministry of Health and Family Welfare have prescribed a uniform Family Welfare Programme for the entire country, statistics reveal that there are wide variations in the programme acceptance and demographic situation in the different States. The performance of the programme in the major States of Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan continues to be poor due to various socio-economic factors. The acceptance of family planning among certain communities and identifiable groups in the country is also much lower than the national averages due to religious susceptibilities and social attitudes. The Committee are of the opinion that the population problem in the poor performing States and regions cannot be adequately understood or tackled by a single uniform national strategy and as such there has to be multiple strategies to suit inter state and inter regional diversities. For the wider acceptance of the programme, it is imperative that the sensitive issues of religious beliefs and hard attitudes is tackled by the States after taking the advice and help of experts and the States also take special steps to identify the thrust areas requiring priorities and differential approaches. The Committee feel that the flexibility in approach and financial powers in implementing special schemes for different regions and areas and specific groups should be provided to State Governments so that they are in a position to effectively implement the programme according to realities of the situation.

2.19 The major long-term demographic goal to be achieved for the country, as specified in the National Health Policy, is to reach the Net Reproduction Rate of Unity (NRR=1) by the year 2000 A.D. which in turn

is said to depend upon attaining gross birth rate of 21 per thousand. The attainment of this goal is said to depend on achieving, *inter alia,* 60 per cent, effective couple protection rate by that year. The Committee are distressed to note that no target for effective couple protection has been set for different age groups of the females although the potential for births are very different for women of different age groups. The Committee recommend that women of the 15-29 age group should be the main target group and methods, priorities and policies should be formulated and adjusted mainly towards controlling births to desired level in that age group. The Committee feel that this task can be accomplished by proper and earnest implementation of the programme by motivating the couples especially those in the younger age groups.

2.20 The programme statistics on the couples effectively protected by various family planning methods at the end of Sixth Five Year Plan (1985) reveal that more than 77 per cent of acceptors used the terminal method of sterilisation and the protection from other family planning methods was only about 22 per cent. These statistics also reveal that the mean age (by the age of wife) of acceptors of vasectomy and tubectomy was 31.8 years and 30.3 years respectively and the mean number of living children of these acceptors was 3.3 and 3.5 respectively. The Committee feel that while the method of sterilisation has been the main plank in the Government strategy in meeting the family planning targets, generally the older couples in the age group 30 plus have been taking recourse to this method only after attaining the desired family size of 3-4 children thus defeating the very purpose of the programme. Set against these dimensions of performance statistics, an estimate on the age of contraceptive acceptors reveals that the percentage of protected couples in the prime reproductive age group 15-29 years is only 15 as against 55 per cent in the upper age group of 30 to 44 years. The Committee are distressed that the Government strategy has not succeeded in providing required contraceptive protection to the eligible couples in the younger age groups which in fact deserve top most priority for the success of family planning and population control. The Committee are of the opinion that since the younger age groups may not be inclined to adopt sterilisation which is a terminal method, efforts to promote non-terminal methods should be directed towards these target groups. Taking into account the fact that the birth rate continues to be static since 1977 despite the increase in couple protection rate during this period, the Committee desire that the Family Welfare Programme should be given a reorientation and projected as a programme taking care of the health and welfare of the parents and their children by emphasising the need for avoiding early pregnancy and spacing after the first child. The Committee also desire the programme functionaries to simultaneously motivate the couples with lesser number of living children, say 2 to adopt the terminal method.

2.21 The 1981 Census figures highlight that the mean age of marriage for females in the country is 18.3 years and that about 51 per cent of married females are less than 19 years of age. The Committee feel that the low mean age of marriage for females in the country is yet another critical area requiring priority attention from the Government. Although the provisions of Child Marriage Restraint (Amendment) Act, 1978 prescribe 18 years as the minimum legal age for the marriage of the female, the Government have hardly taken recourse to enforcement of this law. According to the Revised Strategy for National Family Welfare Programme— Approach and Action Plan prepared by the Ministry, the existing provisions of the law are full of loopholes and the process of implementation of the Act is outmoded. Considering the fact that marriage at a higher age would help in reducing the birth rate, the Committee would urge the Government to initiate urgent steps to plug the lacunae in the existing law and ensure its proper implementation in the country. The Committee also desire the Government to closely examine the feasibility of introducing compulsory registration of marriages in the country. The compulsory registration of marriages would not only ensure observance of the legal requirement of minimum age at marriage but would also provide useful information to programme functionaries.

2.22 The Committee note that the studies made in the past have revealed that the higher female literacy brings down the rate of fertility. The Committee, however, find that female literacy in the country is as low as 24.82 per cent as per the 1981 census. Moreover, the social perception to have male children is still a pre-dominating factor in the society in retarding the growth of family planning. The Committee feel that it is imperative that intensive and effective measures are taken to bring about a radical change in the attitude of the people so as to project the female as an asset rather than a liability. The Committee have been informed that a National Perspective Plan for Women is being worked out in the Department of Women and Child Development to promote education and overall development of women. The Committee trust that the Government will initiate urgent steps to introduce this Plan in the near future so that the process of changing the social attitudes of the people towards females is set in motion with a view to affecting fertility behaviour in the country.

2.23 The Committee are concerned to note that while various socio-economic development programmes having a bearing on family planning have been initiated in various Ministries / Departments during different plan periods, the Government have not yet developed any administrative machinery to have closer inter-sectoral linkages and proper coordination of the programmes. The Committee have been informed that the matter relating to development of a mechanism for inter-sectoral integration of family welfare programme at Central and State levels is under consideration of Government of India. The Committee cannot but emphasise the urgent

need for securing effective inter-sectoral coordination at all levels to attack the multi-dimensional population problem. The Committee trust that the necessary mechanism would be introduced soon. The Committee would also desire such a system at Central level to not only identify further areas where family planning could be introduced as an integral activity but also to ensure that the socio-economic development programmes of other Ministries / Departments are restructured to motivate people in favour of small family norm. The Committee would like to be apprised of precise action taken by the Government in this regard.

CHAPTER III

PLAN OUTLAY AND EXPENDITURE

3.1 The figures of outlay and expenditure on Family Welfare Programme from First Plan onwards to the end of Sixth Plan as furnished by the Ministry are given in the following table:

(Rs. in crores)

Period	Outlay	Expenditure
First Plan (1951-56)	0.7	0.1
Second Plan (1956-61)	5.00	2.2
Third Plan (1961-66)	27.00	24.9
Inter Plan (1966-69)	82.9@	70.5
Fourth Plan (1969-74)	285.8@	284.4
Fifth Plan (1974-78)	285.6@	409.0
1978-80	228.0@	226.1
Sixth Plan (1980-85) (Plan outlay Rs. 1078.0 crores)	1308.0@	1385.4
Total	2223.0	2402.6

@ Budget provision.

It would be seen from the table that although the expenditure on Family Welfare Programme could not absorb the plan allocations upto the end of Inter-Plan period, it continued to record increase in each Plan period over the succeeding Plan and started picking up an increasing tempo from the Fourth Plan onwards. In relative terms, the percentage increase of expenditure on the Programme in the Fifth Plan over the Fourth Plan was 44 and that of the Sixth Plan over the Fifth Plan was 239. It would also be seen from the table that the expenditure on the programme registered an excess over the outlay in the Fifth and Sixth Plans.

3.2 Explaining the reasons for excess expenditure during the Fifth Plan, the Ministry stated that an excess expenditure of Rs. 102.90 crores was incurred during the year 1976-77 alone which recorded the highest number of acceptors of terminal methods. The main factor which contributed to

this excess expenditure was the compensation paid to the acceptors of terminal methods (Rs. 89.68 crores). The other services recording excess expenditure were: Rural Family Welfare Services, transport, post-partum Programme, maintenance of District Family Welfare Bureaux and procurement of Nirodh for commercial distribution.

3.3 During Sixth Plan, there was an excess expenditure of Rs. 307.0 crores as compared to the plan outlay of Rs. 1078.0 crores. The Ministry informed that though the expenditure during the Sixth Plan exceeded the plan outlay, the year wise expenditure was well within the corresponding revised estimates as may be seen from the table given below:—

(Rs. in crores)

Year	6th Plan outlay	Plan outlay	Revised Estimates	Expenditure
1980-81		140.00	131.94	124.55
1981-82		155.00	168.48	168.08
1982-83	1078.00	245.00	294.58	294.63
1983-84		330.00	374.73	374.04
1984-85		438.00	439.95	425.09
Total	1078.00	1308.00	1409.68	1385.39

3.4 However, the excess expenditure of Rs. 307.0 crores with reference to Sixth Plan outlay was under the following heads:—

(i) Compensation to acceptors of terminal methods (Rs. 169.00 crores).

(ii) Village Health Guides Scheme (Rs. 47.00 crores).

(iii) Other Services and Supplies (Rs. 42.00 crores)

(iv) Direction and Administration (Rs. 24.00 crores)

(v) Urban Family Welfare Services
(Rs. 13.00 crores)

(vi) Replacement of condemned vehicles
(Rs. 8.00 crores)

(vii) Rural Family Welfare Services
(Rs. 4.00 crores)

3.5 On being asked to intimate the reasons for excess expenditure on compensation to the acceptors of terminal methods when there was a shortfall of 21 per cent in achieving the targets of Sterilisations during the Sixth Plan, the Ministry stated that the outlay of Rs. 140.0 crores provided for the purpose of 'compensations' by the Planning Commission was resource based and the expenditure on the basis of actual performance of sterilisations and IUD insertions was Rs. 309.39 crores at the prevailing rates of compensation so payable. The Ministry also stated that had there been 100% achievement of the targets, the excess expenditure would have been to the order of Rs. 230.0 crores.

Financial allocation during Seventh Five Year Plan

3.6 A Working Group on Population Stabilisation and Maternal and Child Health Care for Seventh Plan was constituted by the Planning Commission in August 19, 1983. One of the terms of reference of this Working Group was "to quantify financial requirements of the programme for the Seventh Plan period and prepare plan outline yearwise for the next five years spelling out clearly the objectives, estimated cost, phasing in terms of financial and physical components of the programme".

3.7 This Working Group suggested several programmes in Health and Family Welfare and worked out the cost for each such programme. The estimated cost as worked out by this Working Group for Family Welfare and MCH Services for the Seventh Plan period was Rs. 7189.70 crores. The Planning Commission, however, made an allocation of Rs. 3256.0 crores for Family Welfare Programme during the Seventh Plan. The Committee have been informed that these allocations were finalised long before the revised strategy for Family Welfare Programme was formulated by the Ministry and that the present level of allocations was quite inadequate in view of the various initiatives forming part of the revised strategy. The Ministry stated that considering the importance of the Programme, it was expected that there might not be much difficulty in getting additional financial allocations from the Planning Commission However, Planning Commission expressed its inability to provide additional funds due to overall resource constraints.

3.8 During evidence, the representative of Planning Commission stated that enough emphasis had been laid on the programme and larger allocations had been made in each successive plan. He further stated that the programme had not been relegated to a back seat.

3.9 On enquiry, the Planning Commission intimated that the following factors were taken into consideration while allocating funds for the programme during the Seventh Plan:—

(i) the need and requirement of various schemes to be implemented under the Programme;

(ii) the overall availability of funds for the plan;

(iii) the order of national priority of different programmes; and

(iv) the expenditure incurred under the Programme during the Sixth Plan and the capacity of the Programme to absorb additional funds.

3.10 The Planning Commission, however, stated that they were very much alive to the importance of the Family Welfare Programme and its role in checking population growth and the question of allocation of additional resources for the programme would be considered depending on the needs of the Programme and the availability of funds.

3.11 The Committee observe that there has been wide gaps between the plan outlays and the actual expenditure on the Family Welfare Programme during different plan periods. While the Programme could not absorb the various plan allocations upto the end of Inter-Plan period (1966-69), the actual expenditure exceeded the paln allocations during the Fifth and Sixth Plans. These wide gaps between the plan allocations and the actual expenditure are indicative of inefficient handling and defective planning of the Programme. It has been conceded by the Ministry that for 100 per cent achievement of the physical targets of terminal methods during Sixth Plan period, the excess expenditure over the plan-allocations would have been to the tune of Rs. 230.0 crores. It is thus, apparant that physical targets had not been properly co-related to financial targets and that plan allocations have been made without proper appreciation of the needs of the Programme in totality. The Committee hope that the Government would in future privade for realistic plan outlays for family welfare with physical and financial targets duly inter-linked and inter-related.

3.12 The Committee have also been informed that the present level of allocations is a major constraint in speedily implementing the various initiatives forming part of revised strategy for Family Welfare Programme.

Notwithstanding the fact that the Seventh Plan allocations were finalised much before the formulation of revised strategy, the Committee do not accept the Planning Commission's view that additional resources for the Programme would be considered, *inter-alia*, on the basis of availability of funds. Considering the pressure and alarming consequences the population growth has on the socio-economic developmental plans in the country, the Committee desire that Family Welfare Programme should be given top priority in the allotment of resources which should be need based rather than resource based. The Committee in this regard cannot but express deep anguish over the unabated growth of population in the Country. As valuable time has already been lost without achieving the desired results, the Committee urge the Government to make available necessary resources in time so as to effectively tackle the gigantic problem and to implement revised strategy for Family Welfare Programme.

CHAPTER IV

FINANCIAL MANAGEMENT AT CENTRAL LEVEL

4.1 Family Welfare Programme is a centrally sponsored scheme for which cent per cent assistance, as per approved pattern, is made available by the Central Government to the State/UT Governments and they in turn provide the same to the local bodies and voluntary organisations in addition to the institutions run by them. However, in exceptional cases the supplies in kind are made available directly to voluntary organisation and the adjustment of cost is carried out against the amounts due to the State Governments.

4.2 According to the prescribed procedure, the grants in aid to States are released provisionally on the basis of trend of expenditure and anticipated expenditure/admissibility. These grants are subject to the adjustment on receipt of audited figures of expenditure from the concerned Accountants General (As.G.) who examine the expenditure in detail having due regard to the pattern of admissibility. On the basis of audited figures of expenditure furnished by the concerned As. G., the amount held up under objection is recovered from the States. In other words, any amount over and above the prescribed pattern is to be borne by the States themselves. The Ministry have also furnished details of recoveries effected from the State Governments on receipt of audited figures of expenditure. It is further seen from these details that the requests of the State Governments for payment of arrears assistance were examined latest upto the period ending 1980-81. It is also seen from the audit paragraph that certain records/accounts, required to be maintained under rules, were not maintained by the Ministry. The deficiencies as pointed out by audit are discussed in succeeding paragraphs.

(a) Though the Nirodh Commercial Distribution Scheme had been in existence since 1968, the Ministry had neither maintained ledger accounts indicating the amounts due against each distribution agency nor prepared any consolidated proforma accounts. According to the Ministry, the ledger accounts were not maintained since inception of the scheme as the subsidized sale of Nirodh under the F.W. Programme was not treated as a commercial activity. During the course of scrutiny of the accounts for the year 1983-84, the audit party of C&AG of India observed that Nirodh Commercial Distribution Scheme was a commercial activity. Accordingly preparation of ledger account from 1984-85 had been taken in hand.

When enquired whether adequate records with the Ministry were available to complete the ledger accounts of earlier periods with a view to calculating the exact amount outstanding against each of the distributing agency, the Ministry informed that it would not be possible to get complete information needed for preparation of ledger accounts prior to 1984-85 as the old records of the Ministries and the Medical Store Depots were normally weeded out after three years. The Ministry however, stated that action had already been taken to maintain ledger accounts for each company and also for preparing proforma accounts for 1985-86. Further, the Medical Store Depots had been requested to help complete the record of supply vis-a-vis sale.

(b) Miscellaneous Purpose Fund (Fund) was created from May 1976 and a portion of compensation amount on account of sterilisation/IUD was to be credited to it for utilisation by the concerned State/UT Government according to a prescribed pattern and within a specified time-limit. The unspant balance in the Fund was to be treated as lapsed and refunded to the Central Government. The State Governments were required to maintain proforma accounts and to forward annually an extract thereof to Central Government. However, proforma accounts were not sent by the State Governments. It is also learnt from audit that in certain cases either no separate Fund was created or the money was utilised for purposes other than the one specified, instead of refunding to Central Government.

The Ministry stated that all the State Gopvernments had been requested to furnish proforma accounts for the years 1976-85 but no reply had been received from the State Governments. The Ministry also stated that if it transpired on receipt of accounts that the expenditure from the Fund was not as per the prescribed pattern, it would have to be borne by the concerned State Government and the corresponding amount would be adjusted against the future grants to be released to such a State.

(c) The audit sub-para 22.11(b) has pointed out that 59 organisations had not furnished utilisation certificates for grants of Rs. 59.29 lakhs given by the Central Government for the period 1976-83. It has also highlighted that the registers maintained in the Ministry to watch annual statements showing details of assets created out of grants released were incomplete.

In reply to above audit observations, the Ministry stated that the register for grants in aid as prescribed in the General Financial Rules had been prepared for 1985-86 and had been updated upto September 1986. The information pertaining to earlier years was being obtained and the entries would be completed shortly.

(d) As regards audit observations on cases where expenditure on various heads had been incurred by the State Governments in excess of the

prescribed pattern of central assistance, the Ministry stated that the excess expenditure would be adjusted against the subsequent grants in aid due to State Government on receipt of audited figures of expenditure. The Ministry also stated that the Finance Secretary and the C&AG had been requested to impress upon the State Accountants General to audit the expenditure under family welfare programme within a year following the close of financial year to which the expenditure pertained so as to ensure that inadmissible expenditure, if any, incurred by the State was adjusted expeditiously.

Assistance in kind

4.3 Audit has also pointed out that during 1980-85 assistance in kind valuing Rs. 92.30 lakhs was not accounted for in 7 States/UTs and materials costing Rs. 21.34 lakhs given to 2 States were not adjusted by the central Government against the grants payable to these States.

4.4 According to the Ministry, the supplies in kind are made available directly to State Governments through the manufactures and only a small qunatity is kept at the Medical Stores Depots (MSDs) to meet the urgent requirements of the State Governments. For the purpose of accountal of assistance in kind, the manufacturing companies at the time of tender of supplies for inspection prepare 9 copies of the Inspection Note indicating the supplies tendered and among others, a copy of the said note is sent to the Ministry by the Inspecting officer as compliance report. Similarly, the Medical Stores Depots also send a monthly statement of stocks and despatches. On the basis of reports so received in the Ministry, a State-wise statement of supplies and its value for the period March to February, is prepared for issue of financial sanction for assistance in kind and copies of these sanctions are sent to State Governments for verification and accountal in their accounts.

4.5 The Ministry also stated that the compliance of the laid down procedure was planned to be monitored through submission of quarterly reports but the same were not being received from most of the State Governments. Further, a consolidated statement, based on the information received from the Inspecting Officers, firms and M.S.Ds as well as provisional consumption of supplies reported by the State Governments to the Department, was prepared and sent to State Governments for verification but the response to that was also not encouraging.

4.6 It is disquieting to note that the Ministry have not maintained various records and accounts relating to the release of assistance to various State/ UT Governments and other bodies. The facts relating to non-maintenance of records of sales under Nirodh Commercial Distribution Scheme, inadequate records of release of grants-in-aid to voluntary organisations and the

absence of proforma accounts on Miscellaneous Purpose Fund is clearly indicative of lack of financial discipline in the Ministry. Non-preparation of ledger accounts is not a justification at all for failure to match amount due against each distribution agency under the Nirodh commercial Distribution Scheme because to discharge its responsibility, the Ministry should have ensured that proper control records were devised for the scheme in existence for the last two decades.

4.7 What is still more disturbing is the fact that Ministry have not succeeded in proper accountal of the supplies in kind made available to the State/UT Governments. Although efforts for maintaining current records and accounts are stated to have been made by the Ministry, the fact, however, remains that the Ministry have displayed an apathetic attitude towards general financial principles. Considering the fact that old records of the Ministry and the Medical Stores Depots are weeded out after three years and going by Ministry's own admission, the Committee are inclined to conclude that it would be well nigh impossible for the Ministry to complete some of their old accounting records. The Committee wonder how weeding out of records would have been permitted when they are needed for watching recoveries/adjustments and whether the prescribed precautions were not observed before grant of sanction for weeding out. The Committee express their displeasure over the total lack of financial control in the Ministry of Health and Family Welfare (Department of Family Welfare) and recommend that a comprehensive report on the position in regard to the specific observations of Audit and action taken thereon may be furnished.

4.8 In the circumstances, the Committee emphasise the need for earnest efforts to complete the accounting records as far as possible so as to effectively regulate the release of funds on Family Welfare Programme. The Committee would also like the Ministry to introduce an efficient system to keep a proper vigil over the general system of financial management and accounting control. The Committee also desire the Ministry to devise suitable ways and means to receive from the State/UT Governments timely information on the supplies in kind and its value received by them so that the financial santions issued by the Central Government can take into account the actual supplies in kind.

CHAPTER V
MONITORING AND EVALUATION

5.1 The monitoring and evaluation of the F.W. Programme at the Central level is carried out by the Evaluation and Intelligence (E&I) Division in the Department of Family Welfare on the basis of family welfare performance statistics collected from the States/UTs every month according to prescribed pattern and time schedule. The Department has prescribed forms for maintenance of Records at various levels and for returns for regular and timely flow of information from the peripheral units.

Information System

5.2 The monthly performance data are compiled primarily at the peripheral units and sent to the District Family Welfare Bureau which in their turn compile the data for entire district and send the consolidated reports to the State Family Welfare Bureau (Demographic and Evaluation Cells). These are consolidated at the State level and various periodical reports on the performance of different facets of the programme are sent to the Central Department of Family Welfare (E&I Division). Quarterly report on sterilisation performance has also been introduced to study the extent of popularity of various techniques of tubectomy operations with effect from 26 May, 1982. Besides, annual returns on the socio-economic characteristics of acceptors; districtwise couple protection rate; distribution of eligible couples by age of wife etc. and half-yearly reports on MCH services are also collected.

5.3 According to the Ministry, a new system of integrated records and reporting of Health and Family Welfare (MIES) was introduced at district and PHC levels in January 1982. This MIES was reviewed in the State Demographers' Conference held in October 1982 and it was decided that keeping in view the urgency of the monitoring of the Programme, the performance data may continue to be mounted in the existing system till the new MIES is fully stabilised. However, this system was again reviewed in All India Conference of State Demographers (28-30 May, 1986) in which it was recommended to constitute a Committee to rationalise and streamline the returns and manuals in conformity with the current requirements and those of the near future. The Department of F.W. is stated to have initiated action in pursuance of this recommendation.

5.4 According to the information available with the Committee, the All India

Conference of State Demographers (28-30 May, 1986) highlighted certain shortcomings/areas requiring improvement in the present family welfare information system. Some of the important points brought out in the Conference were as follows:—

(i) The records, returns and manuals under the programme were prescribed at the inception of the programme and rationalisation of these formats had become opportune since the programme had grown into many dimensions.

(ii) It was recognised that in many States, the eligible couple registers (ECRs), even if maintained were not updated systematically. In a few States, getting the printed registers has been a problem due to financial constraints.

(iii) The MIES (the implementation of which is being monitored by the Central Bureau of Health Intelligence) was not being effectively implemented in most of the States. As it was, it covered only a few districts in many States.

5.5 The Committee during their visit to some of the PHCs in the States of Madhya Pradesh and Uttar Pradesh in January, 1988 noticed that the records/registers were not properly maintained at the PHC level, even the basic vital statistics such as number of births or the number of eligible couples within their area were not available and the records did not provide any useful information on contraceptive prevalence etc.

Sample Survey Agencies

5.6 Periodic field evaluation of family welfare performance is undertaken by Central Evaluation Teams, Regional Health Offices and the State Demographic and Evaluation (D&E) Cells.

5.7 In order to ascertain the extent of discrepancies in reported performance, the eligibility status of acceptors and the status of the maintenance of records and returns at the peripheral level, there are eight field evaluation units under the E&I Division of the Central Department of Family Welfare to carry out sample checks in their respective zones with headquarters spread over the country. Besides, Regional Health Officers have also been involved in the sample check activity. The system adopted by these teams involves personally contacting the sample of acceptors to check the genuineness of the acceptor through their traceability, verification or recorded demographic particulars, eligibility status, confirmation of actual availing of services etc. Further, the extent of follow-up services provided to the acceptors as well as verification of

reported performance statistics with reference to monthly progress reports and records maintained at different levels are also being carried out.

5.8 Each Evaluation team visits one State every month covering 2 districts for sample verification. In each district, 2 PHCs and one Urban FW Centre are selected by the team on the basis of performance. Each team consisting of five members is expected to select about 500 acceptors for field verification in each district. The Regional Directors alongwith the Evaluation Officer discusses the salient field observations of the team with the State authorities immediately after completion of team's field work so as to enable the State Government to initiate required remedial steps. The teams also submit detailed reports to the Department of Family Welfare on the basis of which the major findings are fed back to the concerned State Government.

5.9 Similar evaluation work is being done by 17 Regional Offices for Health and Family Welfare and 17 State Demographic and Evaluation Cells and monthly and quarterly reports respectively are being received from them in the Department of Family Welfare. According to the information made available to the Committee, the field evaluation conducted by D&E Cells is expected to cover 2 to 5 per cent of acceptors.

5.10 The audit para has pointed out that the percentage of acceptors selected for verification by the aforesaid sample survey agencies continued to decline during the years 1980-84 and that the sample verification of acceptors by all methods, conducted by D&E Cells, was less than one percent during 1980-84. It has also brought out that the reports in a considerable number of cases were not received from the D&E Cells and the Regional Health Offices during the years 1980-84.

5.11 In reply to the audit observations, the Ministry have stated (January 1985) that the number of acceptors every year had been increasing whereas there had been no increase in the staff and that the fall in the percentage verification was inevitable.

5.12 The Audit para has also highlighted that it was noticed in sample surveys that follow-up services were not provided to 55 per cent of the acceptors during 1980-81, 42 per cent during 1981-82, 61 per cent during 1982-83 and 56 per cent during 1983-84. The survey teams also reported that (a) 18.12 per cent (1980-81), 17.80 per cent (1981-82), 53.30 per cent (1982-83) and 18.40 per cent (1983-84) of sample cases could not be located for reasons such as person not living in the area, wrong address etc., and (b) of the contacted cases, 0.50 per cent in 1980-81, 0.30 per cent in 1981-82, 0.70 per cent in 1982-83 and 0.80 per cent in 1983-84 were of ineligible categories.

5.13 The Committee note that various performance statistics on family welfare activities at different levels are being received through the States/ Union Territories by the E&I Division of the Department of Family Welfare (MOHFW) with a view to carrying out the monitoring and evaluation of the F.W. Programme at Central level. However, the returns and manuals prescribed at the inception of the programme are continued to be used while the new MIES system, introduced in 1982, is yet to be effectively implemented in most of the States. This fact amply brings out that the Ministry have failed in taking appropriate and timely action in developing an information system in conformity with the changing requirements of the programme. The Committee are now informed that the Department of Family Welfare has initiated action to rationalise and streamline the returns and manuals. The Committee would like to know the results of such an exercise as well as steps taken to introduce the new formats.

5.14 The Committee observe that the performance data are compiled primarily at the peripheral units. During their visit to some of the PHCs in the States of Madhya Pradesh and Uttar Pradesh in January 1988, the Committee noticed that the records maintained at those centres were neither fully informative nor maintained in a manner so as to reveal vital statistics on various family welfare activities. Now that the Ministry intend to rationalise the various formats of records, the Committee hope that appropriate training courses for the workers and the supervisors from the peripheral level onwards would also be organised well in time so as to upgrade their skills in maintaining the relevant records.

5.15 The Committee have been informed that in many States the Eligible Couple Registers (ECRs) even if maintained are not being updated systematically and that the supply of printed ECRs has been a problem due to financial constraints. The Committee consider that besides being a vital document for organising the working programme of family welfare field workers, a systematically maintained ECR can be an effective management tool in devising appropriate strategies according to the felt needs of the people in a particular area. The Committee trust that the Ministry would make available the necessary funds for supplying the printed registers besides ensuring that these registers are systematically maintained and periodically updated. The Committee would also like to point out that definite responsibility would have to be defined for personnel engaged in maintenance and supervision of these registers to ensure enforcement of accountability.

5.16 The Committee note from the Audit Paragraph that while the sample verification of acceptors by State D&E Cells was less than one per cent as against the prescribed limit of two per cent, the performance of the other two sample survey agencies viz., Central Evaluation Teams and Regional Health Offices also continued to decline in terms of percentage of acceptors

selected for verification in each successive year during the period 1980-84. In this connection, the Committee are unable to appreciate the reply of the MOHFW that the number of acceptors every year had been increasing whereas there had been no increase in the staff and that the fall in the percentage verification was inevitable. Keeping in view the growing dimensions of the programme, it is highly desirable that the activities of evaluating agencies are periodically expanded and extended especially when the sample surveys are highlighting poor quality of services.

5.17 The fact that as high as 53.30 per cent of sample cases could not be traced in a particular year due to wrong addresses etc., speaks volumes about the need to monitor and evaluate objectively the performance statistics of the Family Welfare Programme. To ensure vigorous monitoring of the implementation of the programme, the Committee desire that at least 10 per cent, of sample verifications of acceptors by all methods as well as beneficiaries of MCH services should be prescribed for the agencies engaged in evaluation of this Programme of national importance. This percentage of sample verification by the sample survey agencies must be insisted upon and the bottlenecks in achieving the desired level of performance of these agencies like shortage of staff etc., should be urgently removed. The Committee fell that an intensive and regular evaluation of programme backed by immediate and proper follow-up action against the erring officials would go a long way in improving the quality and effectiveness of the programme.

CHAPTER VI

INFORMATION, EDUCATION AND COMMUNICATION

(a) *General*

6.1 The Family Welfare Programme seeks to provide on a voluntary basis, responsible and planned parethood with "two-child norm", through independent choice of the family planning methods best suited to the acceptor. Accordingly a major task under the Programme is to inform educate and motivate the eligible couples in the reproductive age-span to adopt one of the methods of spacing and limiting their children. According to the Ministry, various methods of family planning are being popularised through the mass media and interpersonal communication to help the people to select and practice a method according to their choice and needs.

6.2 Mass Education Media (MEM) activities are being organised through State Governments, Voluntary Organisations and Central media units of the Ministry of Information and Broadcasting (I&B). At the State level, State Mass Education and Media Organisations coordinae and monitor the MEM activities carried out by various media personnel from district to PHC levels. In addition, there are also Inter-Media Publicity Coordination Committees to coordinate media activities carried out by the units of Ministry of I&B in close collaboration with the State Mass Education and Media Officers. The Department of Family Welfare also undertakes Information, Education and Communicating (IEC) activities by giving messages on delaying the marriage and the arrival of first child etc. besides running a Mass Mailing Unit.

6.3 Funds for these activites are provided by the Ministry of Health and Family Welfare under the scheme 'Information, Education and Communication' and the allocations *vis-a-vis* expenditure on these activities during the Fifth, Sixth and Seventh plan period are as follows:

(Rs. in lakhs)

	Plan outlay	Expenditure
5th Plan	1312.68	975.89
6th Plan	3200.00	3490.62
7th Plan	10500.00	968.61*

*During 1985-86.

6.4 The Coordination of these activities is done by the media Division of the Ministry of H&FW which also obtains reports and returns from media units of I&B Ministry and MEM set ups of the State Governments.

6.5 During evidence, the representative of the Ministry of H&FW informed the Committee that a number of surveys, carried out recently, had provided a systematic assessment of the family planning scene and that according to these surveys the earlier communication efforts had borne fairly good dividends in the sense that there was over 90 per cent awareness of the family planning and over 60 per cent of people hold a positive attitude but the percentage of eligible couples who actually adopt a family planning method was only 33.

6.6 It was further stated that the findings of recent surveys had confirmed the need to penetrate deeper and take up family planning as a part and parcel of social change and the Ministry had been trying to move family planning communication away from a stereotyped demographic perspective and propagandeering approach to broader social communication.

6.7 As regards the extent of knowledge the couples have about various family planning methods, the ORG Survey (1983) has revealed that at national level about 95 per cent of the people were aware of both vasectomy and tubectomy. Among the temporary methods, the awareness of condom was highest (54%), followed by IUD (43%) and pill (36%). This Survey has also revealed that at national level 62 per cent of people were not aware of various MCH services being provided by the Government. The awareness was at its lowest ebb in the North and East Zones where about 68 per cent of the couples were not aware of these services.

6.8 The Evaluation Report on Family Planning Programme (Planning Commission - May 1986) has revealed discouragingly long time lag between awareness and adoption. According to the Report, out of 1024 adopters interviewed during the course of study, 781 (76.3 per cent) reported time lag between awareness and acceptance; 457 (44.6 per cent) between acceptance and adoption; and 930 (90.8 per cent) between awareness and adoption. In the case of as high as 76.3 per cent of the

adopters reporting time lag, the time lags involved between awareness and adoption varied as widely as two to eight years or more. The different reasons given by adopters reporting time-lag were: fears and misconceptions; desire for children (male, female or more); objections/discouragement from friends, relatives and spouse; medical/health grounds etc. "Fear and misconceptions" also accounted for 61.1 per cent of respondents for not adopting family planning methods. The other reasons given by non-adopters were: family planning harmful to health, no faith in family planning methods and no knowledge of family planning methods.

6.9 The Committee observe that although the awareness of the family welfare programme is stated to be over 90 per cent, there is still a wide gap between those who hold a positive attitude and those who actually adopt family planning method. It is surprising that while 95 per cent of people are aware of terminal methods of both vasectomy and tubectomy, the awareness of non-terminal methods is lower being 54 per cent for condom followed by 43 per cent for IUD and 36 per cent for pill. What is more distressing is the fact that 62 per cent of people are not aware of the various MCH services being provided by the Government. These facts illustrate that the various components of the family welfare programme and MCH services have not been effectively delivered to the masses.

6.10 Yet another disturbing feature is the long time-lag, varying as widely as two to eight years or more, involved between awareness and adoption. The fact that 'fears and misconception' is the main reason for non-adoption of family planning methods by a large number of persons demonstrates that the communication efforts made by the concerned agencies/functionaries have neither succeeded in removing misgivings nor in imparting correct knowledge about the programme.

6.11 As the "responsible and planned parenthood with two-child norm" is a new concept in the traditional Indian society, the Committee feel that the wide gap between the awareness and adoption of family planning calls for rethinking on the aspects of communication strategy. Besides disseminating information on various methods of family planning, the communication strategy must aim at removal of wide spread social and psychological barriers to the use of family planning services. The Committee, therefore, desire that the Government should take immediate steps to devise a suitable communication strategy which could reach and effectively deliver the messages required to bring about the desired change in the family norms and motivate people to accept and adopt family planning before it is too late.

(b) *Inter-personal Media*

6.12 The study on 'Evaluation of Media Reach and Effectiveness' (conducted by the National Institute of Health and Family Welfare) has

revealed that in urban areas only a third of the respondents were visited by family welfare workers at their homes as compared to 58 per cent in rural areas. In the respondents' opinion, family welfare workers did not make adequate efforts to integrate MCH and family planning information. As regards 'group meetings', only 14 per cent of the respondents reported "ever" attending a family planning meeting. In general, the reach of interpersonal media seemed to be poor. As reported by respondents, in a majority of cases interpersonal contacts were of the touch-and-go type in respect of both home visits and group meetings. The study also highlighted that the interpersonal channels were used to create general awareness i.e., to do the job of mass media. The strength of interpersonal channels in personalising communication needs and motivating people was not exploited.

6.13 The Working Group on Population Policy (Planning Commission-May 1980) also stated that serious measures were necessary to improve the morale of the extension workers and to equip them better to communicate with people and motivate them, since contraceptive services required a personalised approach.

6.14 The Evaluation Report on Family Planning (Planning Commission-1986) has highlighted that on an average an adopter had talked on the subject of adoption with 5.4 persons and about eighty per cent had followed the advice given. It indicates that adopters not only have multiplier effect but also can play the role of good voluntary extension agents of the family planning programme.

6.15 In the opinion of the Committee, interpersonal media can provide vital support to individual communication needs of the people in an area so sensitive as marital relations and reproductive behaviour. The Committee note that the reach of interpersonal media is poor and that these channels were used only to create general awareness rather than in personalising communication needs and motivating the people. The Committee conclude that the potential of this media has been only marginally exploited. The Committee, therefore, desire that suitable steps should be taken to improve the effective use of this media by equiping the peripheral level staff through appropriate training and regular reorientation on all aspects of the family welfare programme. The main plank of the interpersonal media should be to inform the eligible couples on all the methods of family planning clearly differentiating between terminal and non-terminal methods so as to remove the widespread hesitations superstitions and fears in the minds of non-adopters of family planning. The Committee also desire that an effective supervisory system should be devised to improve the performance of these workers besides increasing their reach to cover all the eligible couples in their area.

6.16 Keeping in view the fact that advice and experience of the adopters of family planning can be much more convincing than only guidance and education, the Committee feel that the involvement of adopters as voluntary extension agents of family planning programme would have a better effect on the non-adopters. With this end in view, the Committee recommend that a suitable scheme should be drawn to use the adopters for propagating family planning among non-adopters. A package of better health and follow-up care alongwith some incentive to the adopters can induce them to play the role of voluntary extension agents of the family planning programme. Besides being effective, such a scheme would be viable in economic terms.

(c) *Media Units of Ministry of Information and Broadcasting*

6.17 The Central Media Units of the Ministry of Information and Broadcasting involved in MEM activities are Directorate of Field Publicity, Directorate of Song and Drama, Films Division, Directorate of Advertising and Visual Publicity (DAVP), Press Information Bureau (PIB), All India Radio (AIR) and Doordarshan.

6.18 A broad based multi-media programme for promoting family welfare programme was formulated during 1966-67. The pattern of the activities formulated under this programme in consultation with the Planning Commission, Ministries of Finance and I&B, provided for additional inputs which are being provided to the Media Units of the Ministry of I&B for stepping up their support to the Family Welfare Programme. The inputs included family welfare programming in AIR, Field publicity, Song & Drama Division, DAVP etc. The idea was that besides the normal support, the additional units would be used for stepping up the campaign through various media and in specific areas. The pattern of providing additional inputs to the media units of Ministry of I&B has been reviewed from time to time. As a result of this, financial support for the six regional inputs provided to the PIB and Song & Drama Division was withdrawn. With the expansion of the network of television, the family welfare cell was subsequently sanctioned out of family planning funds for Doordarshan in 1983. The budgetary support to I&B was reduced from Rs. 400 lakhs to Rs. 210 lakhs in the year 1986-87 (BE stage), as it was felt that sufficient support was not coming from the media units and also that I&B Ministry should be able to provide motivational support to the programme out of their own funds and resources. Later, it was felt that sudden withdrawal of Ministry of Health and Family Welfare's support would give a set back to the motivational programme being carried on by the media units of I&B Ministry. Therefore, the budgetary support to I&B was raised again to Rs. 400 lakhs in September 1986.

6.19 On being enquired whether the Ministry of I&B had been charging anything from the Government departments for broadcast of their prog-

rammes, the representative of the Ministry of I&B stated during evidence that as per rules prescribed by the Government, the Ministry charged the money for advertisement of family welfare programme both on radio and television but for the programmes like discussions on contraceptives and the like, the Department did not have to pay anything.

Doordarshan

6.20 According to the information furnished by the Ministry of I&B, Doordarshan has been telecasting programmes on family welfare right from its inception. On an average all Doordarshan Kendras have been putting out 9 to 10 programmes per month during the year 1986-87 which has been increased to 50 programmes per month in 1987-88. During the last few months, Doordarshan has been accommodating a one minute spot on family welfare messages at 9.00 P.M. which is generally considered to be the prime time in National Programme. For the rural viewers, most of the programmes dealing with family welfare messages are being put out directly or indirectly by the regional kendras between 5.30 P.M. and 8.40 P.M. Kendras have also started putting out family welfare spots in regional languages between 7.00 P.M. and 7.30 P.M. Advertisements on family planning methods are also accepted.

6.21 These programmes include short of slogans of 30 seconds to 1½ minutes as well as long programmes of about 30 minutes duration. On an average about 25 minutes per week are given from every kendra of Doordarshan. So far as percentages of broadcast are concerned, family welfare programmes in the regional hour are around 1.5% to 2% of the total transmission time.

6.22 On being enquired whether the time given to family welfare programme was sufficient considering the fact that various components of the programme like child mortality, immunisation etc. were also to be highlighted, the Director General Doordarshan conceded that it was rather low and that they aimed to increase it.

6.23 As regards the advertisement format on television, the Director General Doordarshan informed the Committee that the Doordarshan was giving a one minute programme in the form of advertisement free at 9.00 P.M.

6.24 The Audit para has brought out that an expenditure of Rs. 16.18 lakhs was incurred through Doordarshan during the years 1980 to September, 1984. Out of 50 TV Films on Family Welfare undertaken for production at a cost of Rs. 22.71 lakhs, 38 films were completed till March, 1984. The films were being telecast infrequently and there was no inter-exchange of films among different Kendras.

6.25 In reply to these observations, Doordarshan stated that films were exhibited more than once if there was public demand for their exhibition. Further, most of the films were produced in regional languages which could be telecast only by the kendras of the regional languages and as such inter exchange of films was not possible.

All India Radio (AIR)

6.26 All the Stations of AIR broadcast programmes on family welfare in the languages of their respective listening zones. The network of 36 Family Welfare Units at equal number of Stations originates specially devised programmes on family welfare according to the new strategy for National Family Welfare programme. AIR uses various formats for family welfare programme such as interviews, discussions, plays, stories, slogans, questions-answers etc.

6.27 AIR received audio tapes containing spots/jingles on family welfare from the Ministry of Health and Family Welfare. These are despatched to 88 Stations as specified by the Ministry of Health and Family Welfare for broadcast in the free time on primary channels. The brodcast of the spots/jingles has been permitted free of charge from all primary channels. The number of such broadcasts should not exceed two minutes in each transmission.

6.28 However, time has to be bought on the commercial broadcasts from AIR, Delhi which is presently broadcasting one spot of 30 seconds duration. The time has been booked by the Ministry of Health and Family Welfare.

6.29 The study* entitled 'Evaluation of Media Reach and Effectiveness' revealed that the family planning reach of radio was very high and a big majority (64%) of listeners had received some family planning message on radio.

This reach of radio further increases, as the study revealed that about half of the family planning listeners reported that they shared and discussed with others the messages heard on radio. This very high family planning reach of radio was further confirmed by another finding which showed that as many as three-fourths of the respondents favoured the use of radio for disseminating family planning information.

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*A collaborative Study (1985) by National Institute of Health and Family Welfare, New Delhi; International Institute of Population Studies, Bombay; Population Centre, Bangalore; Population Research Centre, Lucknow; Gandhigram Institute of Rural Health and Family Welfare Trust; and Population Research Centre, Patna.

6.30 The Committee note that the MOHFW have been providing additional inputs to the various media units of the Ministry of I & B in accordance with the pattern of activities formulated under the multimedia programme for stepping up the campaign on family welfare programme. The provision for additional inputs to the Ministry of I & B has been reviewed from time to time and the financial support adjusted accordingly. In 1986-87, the budgetary support to Ministry of I & B was reduced by the MOHFW on the grounds that sufficient support was not coming from the media units and that the Ministry of I & B should provide motivational support to the Family Welfare Programme from their own funds. The financial support to I & B was subsequently raised to original level in consideration of the fact that sudden withdrawal of funds would give a set back to motivational programme. The Committee further note that the MOHFW have also to pay for their programmes in advertisement format on commercial channels as per normal rules except where free time is alloted on radio or television.

6.31 The Committee consider that neither the grounds for withdrawal of budgetary support in 1986-87 nor the grounds for restoration later were based on reasoned thinking and on a practical approach for implementation of such serious programmes as family welfare. The Committee consider that the problem of population control is a primary issue before the nation and every Ministry/Department of the Government have to contribute their share in propagating the messages of Family Welfare Programme. The Ministry of I & B, being responsible for dissemination of information for raising the level of people's consciousness, have a vital role in mobilising popular support in favour of family planning. The Committee would accordingly emphasise the need for very close coordination between MOHFW and Ministry of I & B and desire that the various media units of the Ministry of I & B should be strengthened with a view to further stepping up the family welfare campaign in coordination with the MOHFW. Given the resource constraints, the Committee would also like the pattern of providing additional inputs to various media units of Ministry of I & B reviewed in consultation with the Planning Commission.

6.32 The Committee are of the view that promotion of family welfare programme has to be obligatory for all official mass media channels especially radio and television which can not only cross the barriers of illiteracy but also have a comparatively wider and more powerful reach than other channels. In the opinion of the Committee, the present allocation of time for family welfare programmes on radio and television is rather low and this area needs improvement. The Committee would therefore like the Ministry of I & B to allocate fixed minimum time along-side qualitatively improving the programmes on radio and television for giving communication support to the various dimensions of family welfare programme. The Committee are of the opinion that promotion of this programme of national

importance should not be viewed in a commercial context and maximum support should be given for spreading the messages deemed necessary to control the population growth. The Committee would like the Government to consider allotment of free time on commercial Broadcasting Service of AIR (Vividh Bharati) which has a mass appeal particularly in the rural areas. The Committee would also like the timings of broadcast/telecast on the family welfare programmes to be so adjusted as to have full impact on the target groups. The Committee would urge the Ministry of I & B to take immediate and appropriate steps for greater and effective utilisation of these channels in consultation with the MOHFW and to use most of the popular programmes to spread the messages appropriate for acceptance of family planning over a wide millieu.

6.33 The Committee consider that involvement of well-known personalities from different fields such as films, sports, politics etc. in propagating social and family planning messages through mass media channels would go a long way in creating better impact on the audience. The Committee would like the Government to initiate necessary action in this regard.

Film Division

6.34 The Films Division has been producing family welfare films with the help of their own staff and 'outside' producers on their approved panel. Funds to the Films Division have been allocated out of the family welfare budget for production/distribution of family welfare films with a view to stepping up the film support to the Programme. A small news-film production unit set up in the Department of Family Welfare was also handed over to the Films Division in December, 1979. Films Division had earlier been producing/releasing in the Cinema theaters around 12 films in a year and preparing/distributing prints for screening by over one thousand film projectors functioning in the Family Welfare Bureau for showing Family Welfare Films in the rural and semi rural areas. In 1985, the Government set up an 'Expert Group' to evaluate the usefulness of work being done by the Family Welfare Film unit and the Expert Group came to the conclusion that the unit was performing useful function and was cost effective.

6.35 The Study on 'Evaluation of Media Reach and Effectiveness' has revealed that the film as a medium has a fairly high reach (59%). But a majority of the people (73%) reported having 'never' seen any family planning film. Only 23% of the respondents reported having seen some. The significance of even this low exposure to family planning films gets further minimised considering the fact that only a half of the number of exposed persons reported discussions organised by the workers during or following the film although such discussions are considered necessary to

reinforce and clarify the messages. The study also revealed that the films seemed to be out of pace with the rapid changes and growth of the programme and were still geared to themes which were necessary initially when the programme was initiated in the country.

6.36 The audit para [sub-para 22.9 (iii)] has brought out that Rs. 315.62 lakhs were spent through Films Division during 1980-85 for production/ prints of films on family welfare. Out of 164 films targeted for production during 1980-84, only 91 films were produced and 31 films subjects were deleted/deferred leaving a balance of 42 films subjects at the end of 1983-84. It has also pointed out that 709 prints of films made during 1980-84 had not been distributed (October, 1984).

6.37 While confirming the audit observations, the Films Division stated that for achieving a particular target in a particular year, it is necessary to have atleast double the number of targeted subjects in the production programme. Further, the film production is continuous process where certain films have to be kept in pipeline and certain number of films are completed and remaining subjects carried forward to the next year. As regards the delay in supplying the prints, the Films Division stated that it was mainly on account of doubing in different languages and in making the formats of titles in different sizes.

6.38 The Committee note that although about 19 per cent of the family welfare subjects on the original production programme of the Films Division during the period 1980-84 were either deleted or deferred, the Films Division could not complete even this reduced production programme in time. In addition, there was also delay in supplying the prints of the films. The Committee feel that the reasons given for slow progress in Films Division are such as could have been foreseen and avoided by proper planning on the part of the executing agency. The Committee hope that concrete measures would now be taken by the Ministries of Health and Family Welfare and I & B to ensure that Films Division take appropriate steps for timely production and distribution of films on family welfare.

6.39 The Committee further note that the film medium is being used in family welfare programme for a considerable period of time and that the Department of Family Welfare have produced family welfare films through Films Division and arranged for their screening through various units of Family Welfare Bureaux etc. Yet a recent study has revealed that a majority as large as 73 per cent has reported never seeing a family planning film. Even the limited exposure to family welfare films has not been organised properly as the necessary discussions alongwith the film show took place only in about 50 per cent of the cases. What is still more disquieting is the fact brought out by the study that the films seemed to be out of pace with the changing requirements of the programme. It is obvious

from these facts that the use of this medium has been quite disproportionate to the heavy investments made in it. Accordingly the Committee desire that study on the cost-benefit ratio of the medium of the film as against other mass-media channels like Radio and Television may be conducted with a view to ensuring that the expenditure on various mass-media channel is effectively utilised.

6.40 The Committee also feel that special care should be taken to make these films more imaginative and interesting with a view to creating desired impact on the audience as also to make them more receptive to the concept, desirability and methods of family planning. The Government may also examine the feasibility of utilising the services of eminent personalities in the field so that the films have much greater impact.

6.41 In the context of the majority of population of India being in rural areas, the Committee consider it necessary for the MOHFW to ensure that an intensive programme for regular screening of Family Planning shorts in all villages is drawn and executed without linking such screening with the special week drives alone.

CHAPTER VII

FAMILY WELFARE SERVICES

7.1 The Family Welfare Programme is implemented by the States/Union Territories. The services under the Programme are offered through the total health care delivery system and provided through a net work of Sub-centres, Primary Health Centres (PHCs), Rural Family Welfare Centres (RFWCs), Post-partum Centres, Urban Family Welfare Centres (UFWCs) etc. The details of the organisations of the Family Welfare Programme in States appear at Appendix III.

Infrastructure

7.2 (a) Rural:

The position of rural infrastructure in terms of number of centres functioning at the end of Sixth Plan as against its total requirements is as follows:

Infrastructure	No. as on 1-4-1985	Total requirements*
1	2	3
Sub-Centres	82,946	1,37,000
Primary Health Centres	11,029 (7284 PHCs & 3745 Subsidiary Health Centres).	23,000
Community Health Centres	655	5,417
Rural Family Welfare Centres**	5,433	—

According to the 7th Plan Document, as against the Sixth Plan target of 40,000 sub-centres, the likely achievement during the Plan period is 35,509

*As indicated in 7th Plan Document (p. 398)

**No RFWCs were sanctioned after 1-4-1980 as new PHCs are catering to the needs of population.

sub-centres. The position in respect of PHCs is better as 3702 PHCs have been established as against the Sixth Plan target of 1600 PHCs.

(b) Urban:

The following infrastructure was available in the urban areas at the end of Sixth Plan.

Infrastructure	No. as on 1-4-1985
Post-partum Centres	
(i) at district level	554
(ii) at sub-divisional level	555
Urban Family Welfare Centres	2583
Health Posts	611

7.3 During evidence, the representative of the MOHFW informed the Committee that it required a considerable effort to reach out to the entire population in the country and that the required infrastructure to tackle the family welfare programme would be available by the end of Seventh Plan. He also admitted that the Urban areas were not fully covered as their health system did not necessarily come under the State Health System. He further added that the Ministry was in the process of finding out a system by which they could find individual agencies to channelise the family welfare programme. It was also stated during evidence that the Ministry had decided to provide assistance to voluntary agencies desirous of taking up specific area and population in the Urban areas where no strong infrastructure existed.

Voluntary Organisations

7.4 The need for involvement of voluntary organisations in undertaking family planning and welfare has been continuously stressed during successive plans. The exact number of voluntary organisations involved in the Family Welfare Programme is not available with the Ministry as the grants-in-aid to voluntary organisations are mostly sanctioned through the State Governments. However, 350 voluntary organisations are estimated to be actively involved in the Programme. In the rural areas, 52 family welfare projects are being implemented by voluntary organisations.

7.5 Replying to a question on the role of voluntary organisations in the Programme, the representative of the MOHFW informed the Committee during evidence:

> "I have been trying to get the figures of what is the percentage of contributions and what are the various targets of family welfare by voluntary agencies. They run about 7 per cent or 8 per cent of a year of sterilisations for the whole country."

7.6 The Ministry have, however, furnished performance of voluntary organisations during the year 1985-86 in respect of only 15 States/Union Territories as the information in respect of remaining States/Union Territories were not available. These performance statistics have revealed that the percentage achievement of voluntary organisations as against corresponding State's total figures was high as 15.1 (Maharashtra) for sterilisations, 10.1 (Gujarat) for IUD and 8.7 (Gujarat) for equivalent CC users.

7.7 The grants-in-aid to voluntary organisations are sanctioned under the approved pattern schemes as per details at Appendix IV. There is also a Central Sector Scheme for Experimental Innovation Projects, being administered by the Ministry to encourage experimental and innovative concepts determined by the regional peculiarities. Some organisations have also been assisted under USAID assisted scheme "Project Voluntary Organisations for Health".

7.8 The State Government have been delegated powers for giving grants-in-aid to voluntary organisations in regard to approved pattern schemes. The grants to voluntary organisations are released on the basis of their performance which is monitored by the State Family Welfare Departments and the State Level grants-in-aid Committee on which Regional Director (H&FW) of the Central Ministry is a member. Annual targets are also set for the voluntary organisations.

7.9 Under the approved patterns scheme, there is however, no scheme for giving grants-in-aid to voluntary organisations for MCH services. The MCH services, if any, provided by the voluntary organisations are treated as a part of their supplementary efforts for a better health care amongst the population they serve and as such non-submission of performance for MCH services by some voluntary organisations receiving grants-in-aid would not affect the release of grants-in-aid which was meant for family planning services under the approved pattern schemes.

7.10 On being enquired about the steps taken to involve large number of voluntary organisations in the Family Welfare Programme, the MOHFW furnished the following information:

(i) A Standing Committee on Voluntary Action (SCOVA) has been constituted to encourage innovative schemes for rural areas and urban slums. The Committee provides consultancy services besides identifying voluntary organisations which can promote family welfare in unserved areas;

(ii) The State Government are being advised to consider setting up of Committees on the lines of SCOVA at State level and their views have been sought on institutionalising the voluntary structure by indentifying 3 voluntary organisations at district level and nominating one of them as the lead organisation;

(iii) Voluntary Organisations engaged in social welfare and development activities are being projected through their respective Departments for taking up activities with a focus on F.W. Programme;

(iv) A rolling fund of Rs. 5 lakhs is provided to the Family Planning Association of India (FPAI) for encouraging involvement of small voluntary organisations in the family welfare network. FPAI has already involved 4 integrated rural family welfare projects; and

(v) The Ministry have also constituted a Committee on formulation of models for Health and Family Welfare Programme for guidance to voluntary organisations.

The reasons for inadequate infrastructure:

7.11 The Seventh Plan documents, while reviewing the progress made during Sixth Plan, stated that despite extensive infrastructure, the States had not been able to provide adequate number of doctors, nurses and other paramedical staff in the health care units set up under the Minimum Needs Programme mainly due to the fact that trained staff had not been available. It further highlighted that the training of unipurpose health workers for converting them into multi-purpose workers received a setback as the States were not able to resolve issues relating to unification of cadres and rationalisation of pay-scales of multipurpose workers.

7.12 According to audit observation, the percentage shortfall in availability of staff at various levels in rural infrastructure was 23 as on 1st April, 1984. The Ministry conceded that the shortage of staff at various levels did have an adverse effect on the implementation of the programme. The ministry also intimated that the ban on filling up of all vacant posts (except Family Welfare Health Assistants) under the Programme in the States/UTs had been relaxed. On the basis of latest information furnished by the States, 86 per cent of the staff is stated to be in position.

7.13 According to the Ministry, although there is no shortage of Medical officers in the country, there has been deployment problems of posting the doctors in rural areas. There were vacancies during the last two plan periods in the cadre of Auxillary Nurse Midwife and Female Health Asstt. mainly due to inadequate training capacity and higher attrition rate for these categories of personnel. However, training facilities have been strengthened through centrally sponsored schemes and there would be no shortage by the end of 7th Plan.

7.14 According to the Ministry, the following constraints are generally experienced in establishment of infrastructural facilities:

(i) There are sometimes problems in the location of sites, hiring of accommodation and posting of trained ANMs in the sub-centres.

(ii) Land for the opening of a PHC is to be donated by the community and the site may not be convenient for delivery of health care services and in some cases it may be located out of reach of the community. The establishment of PHCs is covered under Minimum Needs Programme which is a State Sector Programme and the State Governments are not always able to provide the requisite funds for PHCs due to resource constraints.

(iii) Four specialists at the community health centres are rarely available in all centres. As such some CHCs have to be run with one or two specialists only. The staff of the CHC is covered under MNP and finance is the constraint for the States. Thus, these centres tend to remain understaffed.

(iv) Non-availability of doctors at PHCs is also a constraint in operationalising the facilities because of lack of housing and other facilities in rural areas.

7.15 In order to overcome these constraints, the Ministry have initiated certain steps, such as, issuance of guidelines to States for the selection of site for centres; laying down special norms for the opening of new centres in terms of less coverage of population in tribal, backward and hilly areas and provision of lands to State Governments to construct residential buildings for the doctors in rural areas. Besides, 8th Finance Commission has also awarded special concessions in terms of Rural Allowance for the Doctors of PHCs.

7.16 It is seen from the audit paragraph that out of 82,946 sub-centres functioning on 1.4.1985, the construction of buildings had been completed for 24 per cent sub-centres and the work was in progress in 5 per cent sub-

centres. The audit paragraph has highlighted certain cases where (i) works sanctioned were not taken up or delayed due to non-availability of land; and (ii) buildings were not occupied for want of electric and water facilities and approach roads.

Utilisation of existing facilities

7.17 It is vital for the promotion of Family Welfare Programme that the facilities and the services provided through the existing infrastructure are perceived favourably by the people. But several studies have shown that the utilisation of existing infrastructure is sub optimal due to various reasons such as inaccessibility and lack of credibility of services. A Study on "Facility Utilisation and Management of Family Welfare Programme in Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh" conducted by the Indian Institute of Management, Ahmedabad (1985) has brought out the following salient findings on the infrastructure and its utilisation:

(i) Poor quality of services and non-availability of health staff were damaging the image of government health facilities in these States.

(ii) Significant shortfalls were found in the availability of male and female workers in all the States.

(iii) Workers and doctors were not staying at the duty places assigned to them.

(iv) The field workers and officers were not receiving guidance and support from their supervisors.

(v) Maintenance of buildings, vehicles, refrigerators and other costly equipment were found to be very poor in all the States.

7.18 According to this Study, poor quality of services and frequent complaints of lack of appropriate post-operative follow-up and care has resulted in relative under-utilisation of facilities and lowering the image and credibility of the health infrastructure.

The surveys conducted under this Study also highlighted certain inadequacies in the administrative structure and functioning in these States. It also brought out that there was lack of proper Management Information System to ensure proper monitoring and supervision of the programme in these States. According to the Ministry, the action on the findings of these survey reports lies primarily on part of the State Governments concerned and the role of the Ministry will be merely confined to ensuring that action on the various points contained in the Survey Report is taken by the State Governments concerned. The Ministry also stated that the copies of the Survey Reports had already been sent to State Governments concerned for

follow-up action at their end and that these states had been allotted to two Joint Secretaries in the Ministry. These Officers are stated to be reviewing periodically the follow-up action as and when they go on tours to these States.

7.19 The Audit paragraph has also highlighted that it was noticed in sample surveys that the follow up services were not provided to 55 per cent of the accepters during 1980-81, 42 per cent during 1981-82, 61 per cent during 1982-83 and 56 per cent in 1983-84. Audit has also pointed out that in certain States, oral pill users were not examined before and after putting them on oral pills within the prescribed period and also that in one State insertion of copper 'T' was being done by untrained personnel.

7.20 According to the prescribed procedure, the number of cases of laparoscopic tubectomy to be performed per team per day is 30 at a fully equipped PHC/camp and 100 at an up graded PHC. It is, however, learnt from audit that in Orissa, the number of laparoscopics performed in an upgraded PHC by a single doctor on a particular day came to 337. Further in Tamil Nadu the number of operations recorded by a single doctor in a camp averaged 320 a day in one district and 300 a day in another district. The number exceeded 500 on six days in both the districts.

7.21 The Ministry informed that the number of largest laparoscopic tubectomies was necessitated in Orissa due to unexpectedly high response and that the State Government did not allow to compromise the quality aspect at the cost of quantitative objective as expert surgeons were available. As for the cases reported in Tamil Nadu, the Ministry stated that an expert team was deputed to investigate, examine and survey the concerned districts. The team verified 114 cases of acceptors and noted that the failure rate was 1½% to 2%. The team also noted that one private surgeon had performed 300-500 cases in a single day during 1983-85 with the help of local Government Medical Officer and the staff of Collectorate.

7.22 On being asked as to how the Ministry ensured quality of services, the representative of the MOHFW informed during evidence that a regular evaluation of the programme on a sample basis was being made in which the acceptors were contacted and enquired about the facilities and the follow up services. In reply to a question on the areas where services needed improvements he stated that the programme functionaries being technically skilled should know how to render services besides possessing communication skills and these were the most critical areas identified by the Ministry.

7.23 During evidence, the Committee was also informed by the representative of Indian Council of Medical Research (ICMR) that the ICMR had made a study evaluating the quality of services in 55 PHCs geographi-

cally distributed to different parts of the country. The study revealed that the quality of services did not necessarily depend on what physical infrastructure the Government had put in but on the form in which it was acceptable to the community. The study, *inter-alia*, concluded that the only way to improve the quality of family welfare services was good counselling and follow up services.

Maternal and Child Health (MCH) Services:

'7.24 In order to make the programme of the MCH services more effective and acceptable, the MCH services were integrated with the Programme during "plan holiday" (1966-69). These services have since been considerably strengthened so as to enhance and assure child survival rate in the country. In 1978, an Expanded Programme of Immunisation (EPI) was introduced with the objective of reducing the morbidity and mortality and disabilities due to various diseases by making free vaccination services easily available to all eligible children and women by 1990. Recognising the potential of immunisation as a low cost effective technique, an intensified programme of "Universal Immunisation" has also been launched from 1985-86.

7.25 There is no separate cadre of field officers for delivering MCH services which are provided through the existing health delivery systems. Services are made available in the hospitals, dispensaries, MCH Centres in the urban areas and PHCs in the rural areas. The health workers also organise outreach sessions in the sub-centres and villages which are within the easy reach of health centres. As such, the maintenance of cold chain system for retaining the potency of vaccines is of paramount importance for effective delivery of immunisation services. The various cold chain equipments currently in use at different levels are vaccine carriers, cold boxes, refrigerators etc. Of course, refrigerator is a vital equipment for storing the vaccines at required temperatures at district and PHC levels. The Central Government have supplied a large number of refrigerators to States under various national programmes.

7.26 However, the test check conducted by audit has revealed that a large percentage of refrigerators at different levels were not in working condition. The audit has also pointed out that at various centres the vaccines were being kept without refrigeration and sent to field, centres also without adequate cold chain system.

7.27 The Ministry informed that various steps, as given below, had been taken to keep the cold chain systems at various levels in order:

(i) Issuance of sanction for creation of the post of cold chain officer at State level and of the post of refrigerator mechanic at district level.

(ii) Supply of Refrigerator Repair Kit's under U.I.P.

(iii) Routine monitoring including that of cold chain system'.

Mobility of the Staff

7.28 In order that various agencies engaged in discharge of family welfare services could effectively and expeditiously perform their responsibilities, mobility of services and the personnel assumes paramount importance. It is, however, learnt from audit that against the requirement of 7226 vehicles the number of vehicles available with the States/UTs for carying out family welfare activities at different levels was 7060 at the end of Sixth Plan period. According to audit, a good percentage of these vehicles were off the road awaiting condemnation/replacement.

7.29 According to the Ministry, every endeavour is made to make good the shortfall so that programme does not suffer for want of mobility. The Ministry have also furnished a statement which reveals that as against the total entitlement of 7752 vehicles the total available vehicles with the States/UTs are 7795 i.e. availability is more than entitlement.

7.30 The Committee have been informed that the work of grass root level functionaries had increased with the scope of Programme and the multi-purpose workers, in particular, were severely handicapped due to lack of mobility. These MPWs have a fairly large jurisdictional area and they have to collect the vaccines from the PHCs before going to the villages to immunize the children and return the unutilised vaccine to the PHC on the same day.

Improved Programme Management

7.31 According to the Ministry, the following steps have been taken for achieving excellence in programme management:

(i) States have been given flexibility to suggest their own requirements of staff based on a model suggested by the Ministry.

(ii) Crash training programmes have been drawn up for strengthening technical services for medical officers at PHC level and LHVs and ANMs at PHC and sub-centre level.

(iii) Laparoscopic training centres have been sanctioned in certain States for improving the quality of services.

(iv) The performance of the States is being periodically reviewed at various levels and feed back sent to the States for correcting imbalances in the programme performance.

7.32 The Committee are concerned to note that adequate health infrastructure through which family welfare services are offered, has not yet been provided both in rural and urban areas in the country. During evidence, the representative of the MOHFW stated that the required infrastructure would be available by the end of the Seventh Plan. The Committee apprehend that since the targeted additions for the sub-centres and PHCs during the Seventh Plan are substantially higher than the achievements in establishing the aforesaid centres during Sixth Plan period, it may not be possible to achieve the targets. The Committee further note that certain components of rural health infrastructure are covered under Minimum Needs Programme, which is a State Sector Programme, and the State Governments sometimes express their inability to provide funds for the purpose due to resource constraints. The non-availability of medical and para-medical staff is also stated to be an area of concern as no centre is considered functional unless the sanctioned staff is in position.

7.33 The Committee urge the Government to take care of the anticipated difficulties in advance and initiate proper action after due consultation with the State Governments and other concerned agencies so as to ensure timely completion of the planned health infrastructure which would go a long way in ensuring smooth implementation of family welfare programme. Simultaneously, concerted efforts should also be made to arrange adequate training facilities and placement of medical and para-medical staff upto the sub-centre level so as to make the infrastructure really operational.

7.34 The Committee have been informed that the land for establishment of health centres is required to be donated and in certain cases it may be located out of reach of the community thus leading to non-utilisation or under-utilisation of the facilities. The Committee would like the Ministry to evolve a proper system of assessing the suitability of site before taking up construction of the project.

7.35 The Committee note that voluntary organisations have been playing a significant though limited role in programme implementation especially in urban areas. The Committee further note that in addition to constituting a committee to formulate models for guidance to voluntary organisations, the MOHFW have also provided rolling funds to the Family Planning Association of India to encourage involvement of small voluntary organisations in the family welfare network. While appreciating these steps, the Committee feel that there is urgent need to initiate further concrete steps for larger involvement of voluntary organisations so as to supplement the Governmental efforts in providing family welfare services especially in the areas where programme infrastructure is week inadequate or non-existent.

7.36 The Committee note that grants-in-aid to voluntary organisations are released under the approved patterns schemes which do not provide for

grants to these organisations for MCH services. The Committee consider that the involvement of voluntary organisations in the family welfare programme would be handicapped until the delivery of complete services under family welfare are made available by these organisations to the population they serve. The Committee would like the MOHFW to review their schemes for release of grants to voluntary orgainsations in the light of changing requirements of the programme and also to encourage the existing and the new voluntary organisations to undertake family welfare activities on a continuing basis preferably in unserved areas. The Committee also desire the MOHFW to develop a suitable system which should not only provide guidance but also periodically review both the physical and financial performance of voluntary organisations.

7.37 The Committee are constrained to observed that in spite of heavy investments on family welfare services the existing infrastructure and facilities have not been optimally utilised by the people due to reasons like inaccessibility, poor quality of services and lack of appropriate follow-up care. The Committee also gather from Audit that laparoscopic tubectomies have been performed at various PHCs far in excess of prescribed norms and follow up services to accepters of family planning were not provided to as large a percentage as 61. From these facts, the Committee are inclined to conclude that there is no effective administrative control over the programme implementation machinery to ensure the compliance of medical and technical requirements.

7.38 The Committee consider that certain family planning methods require proper medical interventions at various stages and a proper delivery of services is very essential not only to enlarge the acceptability of the programme infrastructure but also to generate demands in favour of adoption of family planning. Every endeavour should be made to ensure the suitability of a person for a particular family planning method so as to avoid any mishap creating demoralising effect on others. The Committee desire that comprehensive guidelines on medical and technical aspects of various family planning methods be made available to programme functionaries in the first instance. The Government should also clearly define the job responsibilities of all categories of medical and technical staff so as to pin-point their accountability in cases of inadequate delivery of services. The Committee would also like the supervisory system to be strengthened and expanded so as to monitor and enforce the quality of services delivered through the programme infrastructure. The findings of sample surveys on deficiencies in implementation of programme should be brought to the notice of concerned State Governments as soon as detected and remedial measures, including disciplinary action against erring officials, ensured.

7.39 The Committee further note that technical and communication skills of the programme functionaries are identified as the most critical areas

requiring improvement. As both these skills cover the entire gamut of the programme implementation, the Committee desire that in service reorientation training programmes at regular intervals should be organised to improve the capabilities of the service personnel.

7.40 The Committee are concerned to note that 'coldchain' system for retaining the potency of the vaccines have not been properly maintained at various health centres. The non-availability of various equipments and defective refrigeration facilities calls for due attention towards scientific management of inventories. The Committee desire that some sort of financial powers to the doctors at PHC level should be delegated so as to enable them to discharge their responsibilities of management effectively.

7.41 The Committee also feel that the programme requirements have considerably expanded thus necessitating improved mobility of the programme functionaries. While the public transport system in certain areas is not adequate to cater to the needs of these functionaries who have a large jurisdictional area, the use of vehicles supplied under the programme may be a costly proposition. The Committee suggest that a system of providing loans to para-medical staff etc. for purchase of bicycles or mopeds for their official use would enhance the mobility and efficiency of these workers. The Committee would like that while a fixed allowance for POL costs may be granted to workers, the responsibility for keeping the vehicles in order should squarely rest with the concerned officials.

7.42 The Committee are deeply concerned at the poor programme performance in the 4 major States of Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh. These States which account for about 40 per cent population of the country, have substantially higher infant mortality and birth rates and lower couple protection rates in comparison to national levels. According to a study conducted in 1985 by Indian Institute of Management, Ahmedabad on facility utilisation and programme management in these four States, the poor quality of services and lack of appropriate follow-up and care in these States has not only resulted in relative under-utilisation of health facilities but have also lowered the credibility of health infrastructure. The Committee are informed by the Ministry that follow-up action on the findings of this study report lies primarily with the State Governments concerned and the role of the Ministry is merely confined to ensuring that follow-up action on the points contained in the study report is taken by the respective State Governments. However, these States have been allotted to two Joint Secretaries in the Ministry who in addition to their normal duties, review periodically the follow-up action as and when they go on tours to these States. The Committee are not at all satisfied with this casual

approach of the Ministry towards these low performing States and are of considered view that the programme management in these States needs serious attention for improving their current levels of performance.

7.43 The Committee therefore, recommend that a special cell comprising experts under the charge of a Joint Secretary be created in the Ministry of Health & Family Welfare (Department of Family Welfare) exclusively for these four States with the objective of ensuring proper supervision and effective monitoring of programme implementation in these States. Besides providing suitable guidance, the proposed cell should ensure that attention is given on priority basis to these States in the matter of providing adequate system of delivery of services relating to family planning including MCH, giving publicity through various media units of Ministry of I & B, encouraging involvement of voluntary orgainsations etc.

7.44 For the effective and efficient functioning of the Special Cell recommended in the preceding paragraph, there is need for setting up similar cells at the State level also. The Committee would like the Ministry to persuade these four State Governments to establish similar cells at Secretariat or Directorate level to oversee and monitor the implemenation of the programme by the peripheral units. For meeting the additional expenditure on the cells so created, adequate financial assistance should be provided by the Ministry to the State Governments concerned so that the programme is not hamstrung for want of funds. The cell should identify the specific problems, if any, experienced by the peripheral units and the difficulties being encountered in the programme implementation and tackle them by suitably modifying the strategies according to the realities of the situations so as to speedily improve the programme achievements. If need be, the special cell in the Ministry of Health & Family Welfare may be consulted in this regard.

7.45 The Committee consider that the Family Welfare Programme should be taken as a national movement and a willing and determined cooperation should be obtained from the people from all walks of life. Since the main stress of the programme is essentially in villages and the acceptance of small family norm is intrinsically connected with the socio-economic development, the Committee are of the view that a committed involvement of administration is very vital for the rural population to be suitably educated on the family welfare measures and the objectives of the programme. The Committee therefore, recommend that a scheme aimed at providing overall guidance on the socio-economic measures being initiated by the Government for the rural people, may be formulated with a view to promoting wider acceptance of small family norm in rural India. The proposed scheme should involve civil servants above a particular level who may be asked to adopt a set of 3 to 4 villages for overall development. Such officials must visit the adopted villages once a month and interact with people on the

entire range of socio-economic development programmes being implemented by the Government for the rural population. The officers may also seek the active cooperation of the village heads and Panchayats in propagating the programme.

7.46 The Committee are of the opinion that this gigantic task cannot be accomplished solely by Government efforts and it is imperative that private and public sectors are equally made conscious of the programme as a national commitment for whole-hearted support and implementation. The Committee, therefore, desire that the involvement of private and public sector industries particularly the major groups, should be sought and a scheme drawn up for implementation of the programme by them in their respective organisations.

NEW DELHI;
6 December, 1988
15 Agrahayana, 1910(Saka)

AMAL DATTA
Chairman
Public Accounts Committee.

APPENDIX I
(Vide Para 1.3 of the Report)

Paragraph 22 of the Report of the C&AG of India for the year 1984-85—Union Government (Civil)-Volume I

22. *Family Welfare Programme*

22.1 *Introductory.*—The Family Planning Programme (Programme) was introduced in the First Five Year Plan in 1952. From 1966-67, it was made target oriented and time bound. Maternal and Child Health Care Services (MCH Services), designed to improve the health of mothers and children, were also integrated with it during the Fourth Plan period. The Programme was renamed as 'Family Welfare Programme' in 1977-78. The main objectives of the Programme were:-

(a) to bring down the birth rate from 41.2 per thousand population in 1966 to 32, 30 and 25 by March 1974, March 1979 and March 1984 respectively, through sterilisations (vasectomies and tubectomies), insertions of intra-uterine contraceptive devices (IUD), popularising the use of conventional contraceptive devices (CC) and of oral pills; and

(b) to promote the health of mothers and children by providing pre/post natal MCH Services through immunisation, vaccinations and other prophylactic treatment.

The programme is a Centrally Sponsored Scheme. In addition to cash assistance, the Central Government also provides assistance in kind in the form of contraceptives, equipment, vaccines, drugs, etc. It is implemented by the States/Union Territories (UTs) through a net work of Rural and Urban Family Welfare Centres and Sub-Centres. Local bodies/voluntary organisation and the organised sector were also involved in the programme. With the introduction of Integrated Services of Maternal and Child Health Care and Health and Family Welfare, no new Rural Family Welfare Centres (RFWCs) were opened after April 1980. The Primary Health Centres (PHCs) opened after April 1980 were to take care of the functions of the RFWCs. The Department of Family Welfare in the Ministry of Health and Family Welfare provides over-all directions and co-ordination to the Programme.

Against the projected outlay of Rs. 914.95 crores during 1952 to 1979-80,

expenditure of Rs. 1017.15 crores was incurred on the implementation of the Programme and Rs. 314.16 lakh sterilisations, 81.51 lakh IUD insertions and 30.69 lakh equivalent CC and Oral Pill Users were covered upto 1979-80. The implementation of the Programme during the Sixth Five Year Plan (1980-85) was test checked by Audit in the Ministry and in 18 States and 4 UTs. Important points noticed are given in the succeeding paragraphs.

22.2 *Over-all Performance*

22.2.1. *Financial performance.*—The Sixth Five Year Plan envisaged a total outlay of Rs. 1078 crores, against which a total expenditure of Rs. 1489.97 crores was incurred under various sub-programmes (details given in Annexure I).

Total grants given in cash and kind to 26 States/UTs for the Programme were Rs. 1304.67 crores (State/UT-wise break-up given in Annexure II).

(i) Though the expenditure on implementation of the Programme excceded the outlay by 38 *per cent* during the Plan period, there was shortfall in achievement of targets in some crucial areas, *e.g.*, in sterilisation : 21 *per cent*, in IUD : 18 *per cent* and in equivalent CC and Oral Pill users : 15 *per cent* during the same period.

(ii) The all-India average assistance per hundred couples during the respective years of the Plan period in cash and kind was as under:-

Year	In cash	In kind
	(In rupees)	
1980-81	967	66
1981-82	1266	86
1982-83	2240	126
1983-84	2781	163
1984-85	3109	175

(iii) During 1980-85, assistance in kind valuing Rs. 92.30 lakhs was not accounted for in 7 States/UT (Bihar, Haryana, Kerala, Madhya Pradesh, Manipur, Nagaland and Delhi) and materials costing Rs. 21.34 lakhs supplied to 2 States (Kerala Rs. 13.27 lakhs and Bihar Rs. 8.07 lakhs) were not adjusted by the Central Government against the grants payable to these States.

(iv) States have been drawing funds in excess of their requirements and the amounts remaining unspent at the close of the financial year were either utilised in subsequent years or treated as States' receipts/revenue deposits. In Himachal Pradesh and Orissa, unspent balance of Rs. 103.09 lakhs at the close of the financial years during 1977-84 were taken as States' receipts/revenue deposits.

22.2.2 *Physical Performance*

22.2.2.1 It was envisaged to protect 36.56 *per cent* eligible couples effectively by the end of Sixth Plan. The achievements, *vis-a-vis*, targets during 1980-81 to 1984-85 were as under:-

Year	Percentage of eligible couples protected	
	Target	Achievement
1980-81	24.74	22.70
1981-82	26.63	23.70
1982-83	29.46	25.90
1983-84	33.69	29.20
1984-85	36.56	31.90

The percentage of eligible couples effectively protected was consistently lower than the all-India average protection rate in 17 States/UTs including Uttar Pradesh 10.80 to 16.70, Bihar 11.90 to 16.80, Rajasthan 13.50 to 19.30, Assam 18.50 to 24.70 and Madhya Pradesh 21.30 to 29.20. However, the protection rate in West Bengal, which remained higher than the all-India average during 1980-81 and 1981-82 declined during 1982-83 (25.70 *per cent*), 1983-84 (28.00 *per cent*), and 1984-85 (29.00 *per cent*).

22.2.2.2 The Fifth Plan objective of reducing the birth rate from 35 per thousand population at the beginning of the Plan to 30 per thousand population at the end of the Plan (1978-79) could not be achieved (all-India birth rate in 1979 stood at 33.1 per thousand population as per Sample Registration of the Registrar General, India). As against the envisaged birth rate of 33.3, 32.8 and 32.3 per thousand population during the first three years of the Sixth Plan respectively, the all-India annual birth rate was 33.7, 33.9 and 33.8 during 1980, 1981 and 1982. While the targets for 1983-84 and 1984-85 were fixed at 31.4 and 30.4 per thousand population respectively, the achievement figures for these years were not available. The States in which birth rate was more than 9 *per cent* above

the all-India annual birth rate during all these years were Uttar Pradesh (16.91, 16.81 and 14.20), Bihar (12.17, 15.34 and 10.36), Madhya Pradesh (10.09, 10.91 and 13.91) and Rajasthan (14.84, 9.44 and 12.43). Information for 1983 and 1984 was not available with the Ministry (October 1985).

22.2.2.3 The cumulative position of achievement of physical targets during Sixth Plan period was as below:-

Details of Programme	Targets	Achievements	Percentage shortfall of targets
		(in lakhs)	
Sterilisations	220.37	174.40	20.86
IUD Insertions	87.76	71.67	18.33
Equivalent CC and Oral Pill Users	110.00	93.09	15.37

22.2.2.4 Sterilisation, being a sure and one time method, continues to be the most widely accepted method of contraception. As a result of mid-term appraisal of the Sixth Plan in August 1983, the target of 220 lakh sterilisations, as originally envisaged, was increased to 240 lakhs. However, even the originally envisaged targets could not be achieved at the end of the Plan. In sterilisation, the all-India achievement of targets during the Plan period was 79 *per cent.*

Laparoscopic tubectomy, a technique of female sterilisation through abdominal approach with the help of laparoscope is performed by well trained surgeons/gynaecologists. During test check of records in States/UTs the following points were noticed:-

(a) In Madhya Pradesh, there were 169 doctors trained in laparoscopic tubectomy. However, out of 165 laparoscopes available only 138 were supplied to trained surgeons/Divisional Joint Directors and 27 laparoscopes were lying in stock. Laparoscopic camps were to be held by surgeons who had done more than 500 laparoscopics. It was noticed that only 44 trained surgeons were declared as camp surgeons. In August 1984, while 18 districts had no camp surgeon, the number of camp surgeons available in the remaining 28 districts ranged between 1 and 6 in each district. In the absence of the required number of camp surgeons, private surgeons were engaged in camps who in addition to boarding and lodging and travelling

expenses, were also paid laparoscopes' rental of over Rs. 9.29 lakhs during 1981-82 to 1983-84. In 14 districts test checked, the percentage of laparoscopics done by private surgeons was, 97, 84, and 35 during 1981-82, 1982-83 and 1983-84 respectively. In 2 districts of Tamil Nadu, despite availability of 2 laparoscopes and doctors trained in laparoscopic technique with experience of sufficient numbers of operations to function as team heads, the entire operations were got done by a single private surgeon in camps during April 1983 to March 1984 resulting in an avoidable expenditure of Rs. 4.23 lakhs.

(b) In Maharashtra, the department had no information regarding the number, of Medical Officers trained in laparoscopic tubectomy. The percentage of tubectomies performed by laparoscopic technique to the total sterilisation operations performed was 14, 34 and 25 during 1981-82, 1982-83 and 1983-84 respectively.

(c) In Phulbani district of Orissa, laparoscopic sterilisations could not be introduced (May 1984) because the laparoscope supplied to the district in March 1984 was defective.

(d) In Pondicherry, a laparoscope purchased in April 1980 (value Rs. 0.19 lakh) was used only for diagnosis. Laparoscopic sterilisation was started in September 1983 on receipt of a second instrument (value Rs. 0.53 lakh) and by the end of December 1983, 13 sterilisations were done even though no one using that technique had been trained (May 1984).

(e) Laparoscopic tubectomy, which got momentum in 1982-83, showed a decline in 1983-84 by 57 *per cent* in Andhra Pradesh, partly due to camp approach involving discharge of acceptors on the day of operation itself in disregard of the guidelines.

(f) Number of cases to be operated per team per day is 30 at a fully equipped PHC/Camp and 100 at an upgraded PHC. However in some PHCs in Orissa, laparoscopics ranging between 69 and 189 were performed on certain days during 1983-84 and the number of laparoscopics performed in an upgraded PHC by a single doctor on a particular day came to 337. In Maharashtra, during 1983-84 the number of laparoscopics performed during a day ranged between 65 and 126. In 39 Centres of West Bengal, 14498 operations ranging from 35 to 335 per camp per day were done (1982-84) by a single team. In Andhra Pradesh, some surgeons had performed 144 laparoscopics per day. In Tamil Nadu, number of operations recorded by a single doctor in a camp averaged 320 a day in one district and 300 a day in

another district. The number exceeded 500 on six days in both the districts.

(g) In Goa, Daman & Diu, operation theatres for sterilisation in two Rural Primary Health Centres, remained unused, one from February 1982 and the other from November 1983 (June 1984) due to non-availability of qualified doctors. It was stated that one operation theatre was put to use in July 1985.

(h) In one district of Tamil Nadu, 86 persons, found unsuitable for operation by the screening Government doctors, were operated by the visiting private surgeon in the camps between August 1983 and February 1984.

22.2.2.5 In IUD, the all-India achievement of targets during 1980-85 was 81.67 *per cent*, ranging between 15 *per cent* in Meghalaya and 199.60 *per cent* in Punjab. The percentage achievement of targets during 1980-85 was less than the all-India achievement in 21 States/UTs including 9 States/UTs (Andhra Pradesh, Bihar, Kerala, Meghalaya, Tamil Nadu, Tripura, Dadra and Nagar Haveli, Goa, Daman and Diu and Lakshadweep) and Ministry of Railways which had shortfall exceeding 50 *per cent*.

22.2.2.5(i) In 10 districts of 4 States, there was excess reporting of IUD insertions as compared to IUDs available/consumed during 1980-84—1767 cases (9.35 *per cent*) in 2 districts of West Bengal, 1151 cases (38.66 *per cent*) in 5 districts of Madhya Pradesh, 610 cases (5.43 *per cent*) in one district of Orissa and 499 cases (18.04 *per cent*) in 2 districts of Jammu and Kashmir.

22.2.2.5(ii) In Uttar Pradesh, while the total number of loops distributed during the year 1981-82 to 1983-84 was 5.18 lakhs, the number of beneficiaries was shown as 6.77 lakhs. A test check of 7 districts also revealed that no records of the follow-up action about expulsion of loops and Copper 'T' (required to be done after every three and five years respectively) were kept in any case, though 16.83 lakh IUD cases done during 1973-80 had become due for replacement by the end of 1984-85.

22.2.2.6 In equivalent CC Users, the all-India achievement of targets at the end of the Plan period was 83.80 *per cent*. While the States/UTs of Assam, Haryana, Manipur, Meghalaya, Punjab, Uttar Pradesh, Andaman and Nicobar Islands, Arunachal Pradesh and Pondicherry had exceeded the targets, 14 other states/UTs and Ministries of Railways and Defence had recorded less than the all-India average achievement at the end of 1984-85; the shortfall in achievement was more than 50 per cent in Bihar, Jammu and Kashmir, Kerala, Nagaland, Tamil Nadu, West Bengal, Dadra and Nagar Haveli and Delhi.

22.2.2.7 The total number of oral pill users was 9.31 lakhs against a target of 10 lakhs by the end of 1984-85, constituting an achievement of 93.10 *per cent*. Excepting Haryana, Maharashtra, Meghalaya, Sikkim, Tripura, Uttar Pradesh and Arunachal Pradesh, the achievement in other States/UTs was less than the all-India percentage; the shortfall in achievement was more than 50 *per cent* in Assam, Bihar, Himachal Pradesh, Jammu and Kashmir, Kerala, Manipur, Nagaland, Orissa, Rajasthan, Tamil Nadu, West Bengal, Andaman and Nicobar Islands, Chandigarh, Dadra and Nagar Haveli, Delhi and Ministries of Railways and Defence. The Ministry stated (January 1985) as follows:—

"It is true that in some States performance is below target. It is not possible to have uniformity of performance. Some States do better in sterilisation others in IUD and some in CCs. It depends upon the felt needs of the people in a given State".

22.2.2.8 A test check of performance of the programme through voluntary agencies brought out that (a) in Andhra Pradesh, against total State performance, the voluntary organisations and local bodies had shown percentage achievement of sterilisation and IUD ranging from 13 to 17 and 10 to 13, respectively during 1979-83 and (b) in Uttar Pradesh during 1981-83, the percentage achievement of targets declined from 116 to 71 in respect of sterilisations and from 187 to 94 in respect of IUD insertions. Fourteen out of 32 (1981-82), 12 out of 35 (1982-83) and 5 out of 33 (1984-85) grantee institutions did not report performance of MCH Services.

22.3 *Infrastructure*

22.3.1 *Rural Family Welfare Centres (RFWCs).* — There were 7,284 Primary Health Centres, 5,433 Rural Family Welfare Centres and 82,946 Sub-Centres as on 1st April 1985 to render Family Welfare Services.

The following points in regard to construction of buildings and provision of staff were noticed:—

(i) According to the performance budget of the Ministry for 1985-86, the position/availability of buildings for RFWCs was as below:—

	Position as on				
	1-4-1980	1-4-1981	1-4-1982	1-4-1983	1-4-1984
1. No. of Rural Family Welfare Centres functioning	5,408	5,420	5,428	5,433	5,433
2. No. of Rural Family Welfare Centres with Buildings:					
(a) Completed	2,675	2,837	3,078	3,255	3,255
(b) In progress	681	666	707	691	691
3. No. of additional Rural Family Welfare Centres' buildings sanctioned	91	300	51	200	—

Against 82,946 Sub-Centres functioning as on 1st April 1985, construction of buildings had been completed for 19,861 Sub-Centres (24 *per cent*). Construction work was in progress in 3,928 Sub-Centres (5 *per cent*).

(ii) A test check in the States/UT brought out the following:—

(a) Works sanctioned during 1978-80 were not taken up or were delayed due to non-availability of land for 101 buildings in 3 States (80 in Uttar Pradesh, 15 in Kerala and 6 in West Bengal). In Bihar, construction of 32 buildings sanctioned during 1978-82 and in Uttar Pradesh, 35 buildings for which estimates had been submitted in 1982 were not taken up or were delayed for want of administrative approval. In Nagaland the construction of a Centre was stopped due to a court case.

(b) In Uttar Pradesh, out of 532 buildings completed till March 1984, 213 buildings were not occupied for want of electric and water facilities and approach roads. These included 10 RFWCs and 9 Sub-Centres (costing Rs. 24.67 lakhs) in 3 districts. In Pondicherry, 2 buildings constructed at a cost of Rs. 2.97 lakhs were not handed over for want of electric fittings; the department stated (October 1985) that one Centre had since been taken over by them. In Rajasthan, one Centre completed at a cost of Rs. 0.67 lakh in 1972 could not be occupied as it was located far away from the town.

(c) In Kerala, Central assistance at P.W.D. rates for construction of staff quarters and administrative blocks in 54 PHCs was approved by the Central Government during 1978-79 to 1980-81. The construction works in 40 PHCs originally entrusted to the P.W.D. in September 1978 and August 1979 were subsequently given to a Society, for speedy execution on the ground that the work was not started in any of the PHCs by that time by P.W.D. The works approved in 10 PHCs during 1980-81 were also entrusted to the Society in June 1981. No agreements were executed specifying the terms and conditions, rates, etc. and there were also no sanctioned estimates and administrative/technical sanction from the competent authority. By August 1985, work at 44 Centres was completed at a cost of Rs. 233.21 lakhs against Rs. 200.57 lakhs admissible as Central assistance at P.W.D. rates.

The Society was also entrusted with the construction of Mini-polyclinics in 12 taluk headquarters hospitals and an operation theatre and six bedded ward in a PHC at an estimated cost of Rs. 15.85 lakhs without calling for tenders and without executing any agreements regarding terms and conditions, rates, etc; there was also no sanctioned estimates and administrative/technical sanction from the competent authority. Even though the rules prescribed by the Central Government for utilisation of Miscellaneous Purpose Fund stipulated that the Fund "can on no account be utilised for construction activities", it was decided to meet expenditure on these works from the Miscellaneous Purpose Fund. It was noticed that 2 polyclinics, operation theatre and ward constructed at a cost of Rs. 2.63 lakhs and handed over in 1978, were not put into use for want of equipment, furniture and water supply arrangements. It was stated in 1985 that the polyclinic had since been put into use and the information about the commissioning of one building was awaited (November 1985).

(iii) With a view to increasing facilities for sterilisation and medical termination of pregnancy at peripheral level, the Sixth Five Year Plan envisaged renovation and remodelling of IUD rooms into operation theatres in 833 PHCs. It was noticed that out of 833 PHCs approved by the Central Government for this purpose only 616 PHC had been selected for such renovation by the States till March 1985; of these, construction work had been completed only in respect of 2 PHCs. Four States/UTs (Jammu and Kashmir, Meghalaya, Arunachal Pradesh and Delhi), which were given approval for 28 PHCs for renovation, had not made any such selection; selection of PHCs in 7 States/UTs (Andhra Pradesh, Bihar, Gujarat, Himachal Pradesh, Uttar Pradesh, West Bengal and Andaman and Nicobar Islands) ranged between 29 and 58 *per cent.*

(iv) The position of availability of staff as on 1st April, 1984 was as below:—

Category	Required	Available	Percentage shortfall
Medical	6,327	5,395	15
Para-medical	68,925	55,523	19
Other Staff	20,514	12,692	38
TOTAL	95,766	73,610	23

During test check, it was noticed that in 2 States (Himachal Pradesh and Madhya Pradesh) 477 sanctioned Sub-Centres were not functioning/not opened for want of requisite staff. The Ministry stated (January 1986) that 100 *per cent* staff could never be in position because of leave, suspension, retirement, etc. In any case, Central funds were released only for the staff in position. Funds were not released for vacant posts.

22.3.2 *Urban Family Welfare Centres (UFWCs)*

(i) There were 2,583 UFWCs (including 349 run by local bodies, 299 by voluntary organisations and 479 by PP Centres) functioning in the country on 1st April 1983, as against the requirement of 2,872 Centres based on 1981 Census. Against 800 additional Centres envisaged in the Sixth Five Year Plan, sanctions for establishment of 700 Centres were issued during 1980-83. Test check in the States showed that as against the requirement of 979 Centres in the States of Madhya Pradesh, Tamil Nadu and West Bengal, only 532 Centres were functioning as on 31st March, 1984 (Data for the subsequent period were not available with the Ministry).

(ii) The staff position as on 30th June, 1983 of 2,371 State run urban Centres including those attached to PP Centres as ascertained by the Ministry revealed the following position (information after 30th June, 1983 was not available with the Ministry):—

Category	Required	Available	Percentage Shortfall
Medical	1,466	1,166	20
Para-medical	5,369	4,476	17
Other staff	1,505	1,250	17
TOTAL	8,340	6,892	17

(iii) Three Centres run by local bodies in 3 States (Assam, Kerala and Uttar Pradesh) and 42 Centres run by voluntary organisations in 7 States/UTs (Assam, Gujarat, Haryana, Maharashtra, Rajasthan, Chandigarh and Delhi) stopped functioning in March 1982. The Ministry had not ascertained the reasons for their dis-continuation and about the utilisation of the assets created out of non-recurring grants released to them through the States/UTs.

22.3.3 *Vehicles*

22.3.3.1 Against the requirement of 7,226 vehicles, the number of vehicles at the disposal of States/UTs for carrying out the Family Welfare activities at differtent levels was 7,060 at the end of March 1985.

The shortage of vehicles was more pronounced in Haryana (28.78 *per cent*), Arunachal Pradesh (18.97 *per cent*), Madhya Pradesh (13.75 *per cent*) and Kerala (11.30 *per cent*).

22.3.3.2 Test check brought out the following points:—

(a) Bihar had 671 vehicles against the requirement of 766 vehicles as on 31st March, 1985; of these 537 vehicles were in use and 134 vehicles were off the road awaiting condemnation. Uttar Pradesh had 1,153 vehicles during 1984-85 but only 948 were stated to be in use and the remaining vehicles awaited condemnation/replacement (October 1985).

(b) Against 560 vehicles in the RFWCs, there were only 500 drivers in Uttar Pradesh during the period 1980-85.

(c) In Nagaland, 9 Jeeps were provided to 8 PHCs and one SDMO though only 3 of these PHCs were functioning as Family Welfare Centres.

(d) In Madhya Pradesh, Orissa and Uttar Pradesh, Rs. 41.6 lakhs

were spent in excess of the norms for P.O.L. and on repairs and maintenance of vehicles during 1978 to 1984.

22.3.4 *Training of staff*

22.3.4.1 Under the Programme, training is imparted to the medical and para-medical personnel through 7 Central Training Institutes and 47 Health and Family Welfare Training Centres in the States/UTs. In addition, 44 Lady Health Visitor (LHV) Promotional Schools and 411 Auxilary Nurse-Midwife (ANM) Training Schools are functioning in the country for training in the respective fields. Dais (Traditional Birth Attendants) and Health Guides are trained at the PHCs, Sub-Centres, etc.

22.3.4.2 The following points were noticed from the records of the Ministry and the States:

(a) Each Dai was to be provided with a midwifery kit to enable her to conduct safe and hygienic deliveries. Out of 5.15 lakh trained Dais, only 3.30 lakh Dais were supplied with such kits upto March 1985. Ministry stated (January 1985) that in future the kits would be procured directly by the States so that these could be supplied to Dais immediately after training.

(b) In Madhya Pradesh, 26 schools for Health Assistants (Female) were under-staffed, the under-staffing in the category of Principals being 46 *per cent* and the Public Health Tutors 49 *per cent*. Ministry stated (January 1985) that with the sanctioning of 6 Regional Teacher Training Institutes in the State all the vacancies would be filled in within 2 years.

(c) In Orissa, 140 LHV students qualifying 2½ years course during November 1970 to January 1977 were not issued any diploma cetificates as the school was not recognised by the Indian Nursing Council.

(d) In Bihar, Rs. 3.17 lakhs were spent on 167 ANMs admitted on fake certificates during 1979-80 to 1983-84.

(e) In Gurdaspur district of Punjab, an expenditure of Rs. 1.34 lakhs had been incurred on deployment of hostel staff of the Training School during 1981-84, without establishment of any hostel (May 1985).

22.4 *Compensation to Acceptors*

22.4.1 The scheme of providing cash incentives to acceptors of sterilisation and IUD by way of compensation for loss of wages has been in

existence since 1964 and 1965 respectively. The pattern of Central assistance for payment of compensation which included incentive money to acceptors, cost of drugs/dressings, diet and transport charges and motivators' fees, etc., applicable from 25th February 1983 was at the rate of Rs. 180 per vesectomy, Rs. 200 per tubectomy and Rs. 12 per IUD insertion. During 1980-85 expenditure of Rs. 309.39 crores was incurred by way of compensation. The following points were noticed during test check:—

(a) In Kerala, 5 institutions run by voluntary organisations were paid compensation amount of Rs. 27.19 lakhs during 1976-85 even though these institutions charged fees for consultation, anaesthesia, rent of bed, cost of medicines, operation charges, etc., from acceptors of tubectomy. In Himachal Pradesh, in one district, transport money of Rs. 1.12 lakhs was paid in 7,492 cases although in such cases free transport was provided by the department.

(b) Compensation money was spent in excess of the ceiling limits as per the prescribed pattern of Central assistance in 3 States — Rs. 85.59 lakhs in Kerala during 1980-84, Rs. 20.73 lakhs in Orissa during 1978-83 and Rs. 12.33 lakhs in Uttar Pradesh during 1978-81. Expenditure on medicines in excess of admissible limit was noticed in 3 other States—Rs. 3.48 lakhs in Jammu and Kashmir during 1974-75 and 1978-83, Rs. 2.41 lakhs in Manipur during 1983-84 and Rs. 2.02 lakhs in one district of Maharashtra in 1982-83.

(c) In 3 States/UT (Andhra Pradesh, Himachal Pradesh and Delhi), Rs. 360.35 lakhs drawn during 1970-85 and advanced to various subordinate untis/other Organisations were awaiting adjustment (March 1985).

(d) In Manipur, out of 427 sterilisation cases involving payment of Rs. 0.77 lakh in 224 cases (18 vasectomy and 206 tubectomy), the medical officers who were shown to have conducted operations at certain stations, were not actually present in these stations on those days.

22.4.2 Miscellaneous Purpose Fund (Fund), was created from May 1976 and a portion of compensation amount on account of sterilisation / IUD was to be credited to it. The Fund was to be utilised for (i) meeting expenditure on *ex-gratia* relief, treatment of post-operative complications and providing facilities for recanalisation; and (ii) purposes relating to the implementation of the family welfare programme (including MCH) and community participation, POL / repairs of family welfare vehicles, purchase of equipment and storage facilities, expanding MCH and E.P.I.

Coverage (especially the polio immunisation programme), providing cold chain facilities, etc. The accruals under the Fund during a financial year were to be utilised within that year. However, from May 1982, the State / UT Governments were permitted to utilise 50 *per cent* of the accruals during the last quarter (further limited to actual unspent amount of that quarter) upto September of the following financial year. The entire unspent balance, thereafter, was to be treated as lapsed and was to be refunded to the Central Government. The States / UTs were required to maintain proforma accoutns of the accruals to, and expenditure from the Fund and to forward annually an extract thereof to the Government. It was noticed that:

(a) Proforma accounts had not been sent by the State Governments. The Ministry stated (January 1986) that proforma pertaining to maintenance of accounts of the Fund was being sent to the State Government.

(b) A separate Fund was not kept in Bihar, Karnataka, Punjab, Delhi and Goa, Daman and Diu. The Ministry stated (January 1986) that all the State Governments had been instructed to keep a proper account of the Fund.

(c) In 7 States (Andhra Pradesh, Himachal Pradesh, Kerala, Madhya Pradesh, Maharasthra, Orissa and West Bengal), Rs. 178.14 lakhs were utilised from the Fund during 1976-84 on purchase of motor cars, jeeps, projectors, oxygen cylinders, iron safes, and other items not contemplated in Government of India orders. Maharashtra alone accounted for an expenditure of Rs. 134.14 lakhs, out of which Rs. 105 lakhs were spent on purchase of vehicles.

(d) In 4 States (Himachal Pradesh, Jammu and Kashmir, Kerala and Orissa), Rs. 126.28 lakhs out of the money accumulated under the Fund, were not utilised within the time limit and allowed to accumulate instead of refunding it to Central Government (January 1985).

In 3 States/UT (Andhra Pradesh, Himachal Pradesh and Pondicherry), Rs. 35.88 lakhs which should have been treated as lapsed and refunded to Government were retained and utilised beyond the specified dates.

(e) In 3 States (Himachal Pradesh, Jammu and Kashmir and Orissa), details of utilisation of Rs. 11.64 lakhs advanced to local bodies and various other functionaries for creation of

permanent assets, community awards, motivation moneys, etc., during 1977-83 were still awaited (January 1985).

(f) In Orissa, in one district, Rs. 1.25 lakhs were paid as motivation fee during 1978-84 although the acceptors of sterilisation were self-motivated. In another district, *ex-gratia* payment of Rs. 5,000 each was made after delays of 4 years and 8 months in one case and 2 years and 9 months in another case during December 1978 to March 1983.

22.5. *Nirodh (Condom) and Oral Pills*

22.5.1 *Nirodh*

22.5.1.1 *Free Distribution.*–Purchase of condoms made centrally by the Ministry for distribution to the States / UTs. During the years 1980–85, 10,164.75 lakh pieces of condoms valued at Rs. 22.82 crores were purchased for free distribution. As per inventory norms, buffer stock of 25 to 30 *per cent* of the targeted requirements are to be maintained. The following points were noticed :-

(i) Purchases were made without correlating the holdings available with State Governments and with the Medical Stores Depots, as shown below:—

Year	Opening Balance with		Purchased during the year	Total	Targeted requirements including buffer stock	Excess in- holding
	States/Uts	M.S. Depots				
					(Figures in lakhs)	
1980-81	1,853.00	516.37	1,090.00	3,459.37	2,847.69	611.68
1981-82	1,799.14	400.15	942.50	3,141.79	2,847.69	294.10
1982-83	1,735.56	124.61	2,240.00	4,100.17	3,278.06	822.11
1983-84	2,151.11	246.54	3,092.25	5,489.90	3,744.00	1,745.90
1984-85	2,813.91	114.00	2,800.00	5,727.91	5,281.30	446.61

The Ministry stated (January 1985) that Nirodh was distributed in the States through various channels numbering more than 5 lakhs spread all over the country and in the interest of the programme as well as to avoid shortage of supplies at any point of time, supplies of larger quantities than required based on targets had been procured.

Further, the distribution of condoms was much less than the holdings available with the States/UTs as shown below :-

Year	Total holdings	Distribution	Percentage of distribution with reference to total holdings
	(Figures in lakhs)		
1980-81	3,162.34	1,363.20	43.10
1981-82	3,264.67	1,529.11	46.84
1982-83	3,879.31	1,728.20	44.55
1983-84	5,311.51	2,497.60	47.02
1984-85	5,200.65	3,088.26	59.38

12 States/UTs had shown annual distribution of condoms at less than 50 *per cent* of the total holdings ranging between 5.78 *per cent* (Nagaland) to 46.53 *per cent* (Bihar) during 1980–85.

(ii) It was noticed that reconciliation of stocks in hand with the States/UTs from year to year had not been made. It was stated in January 1985 that the stock balance with the States/UTs was 2,813.91 lakhs as per records of the Ministry against 747.60 lakhs as per States/UTs records. No efforts were made to reconcile these discrepancies. However, the Ministry in October 1985 worked out the opening stock balance with States/UTs for 1984-85 as 1,940.09 lakh pieces by taking nil balance as on 1st December, 1981 pending receipt of inventories from 8 States/UT (Andhra Pradesh, Bihar, Jammu & Kashmir, Meghalaya, Nagaland, Rajasthan, Sikkim and Delhi).

(iii) Test check in States brought out the following points :-

(a) In Kerala, basic records were not kept at peripheral units to verify whether 178.82 lakh condoms, stated to have been distributed during 1975–84, had reached the actual users.

(b) As per records maintained by the Ministry, Uttar Pradesh was supplied 367.30, 300.00, 250.00 and 491.20 lakh pieces of condoms and the State had distributed 289.30, 347.00, 356.90, and 429.40 lakh pieces during the years 1981-82, 1982-83, 1983-84 and 1984-85 respectively. However, the records maintained by the State Government showed that only 31, 90, 130 and 417.35 lakh pieces of condoms were received by the State and only 25.36, 57.88, 159.44 and 329.16 lakh pieces were distributed during the repective years.

(c) Distribution of Nirodh in excess of the available stock holdings

ranging from 5,785 to 1.25 lakhs was noticed in 12 PHCs of Madhya Pradesh during 1980-81 to 1983-84.

(d) In Chandigarh, the number of CC Users reported to Government of India was more than those recorded at the reporting units. The excess reporting ranged from 27 to 41 *per cent* during 1980-81 to 1982-83.

22.5.1.2 *Commercial Distribution.*–The Nirodh Commercial Distribution Scheme was launched in September 1968 with the objective of making condoms available to the masses at subsidised rates in the country through over 4 lakh retail dealers of 13 major distribution agencies, including private agencies. During 1980–85, the distribution of condoms was 198.15 crore pieces, of which, 92.90 crore pieces were distributed under commercial distribution scheme. The total expenditure incurred on the scheme, including the subsidy of Rs. 20.85 crores was Rs. 40.94 crores during 1980–85.

Though the scheme had been in existence since 1968, the Ministry had not maintained ledger accounts indicating the amounts due, remittances received and amounts outstanding against each distribution agency. The Government had also not prepared any consolidated proforma accounts.

At the instance of Audit, the Ministry worked out from their records that 13 companies had been issued 65.22 lakh gross condoms of sale value (at subsidised rate) of Rs. 538.76 lakhs during 1980–85; the companies had remitted Rs. 471.19 lakhs and balance of Rs. 67.57 lakhs was recoverable from them, of which 3 companies accounted for Rs. 50.23 lakhs. The Ministry stated (January 1985) that the sale proceeds were remitted by the companies after the goods were sold by them and not on receipt of supplies from M. S. Depots; the question of early remittance of sale proceeds had been taken up with the companies.

22.5.2 *Oral Pills.*—Oral contraceptives in the form of oral pills introduced into the programme in 1974 on selective basis was extended fully in 1977. The purchase of oral pills for their supply to States/UTs is made centrally by the Ministry. The total expenditure incurred upto March 1985 was Rs. 335.44 lakhs out of which Rs. 289.80 lakhs pertained to 1980—85. The distribution of oral pills to acceptors is made through trained para-medicals after screening the acceptor through a check-list and the acceptor is also required to be examined by a doctor within 3 months of acceptance. The following points were noticed:—

(a) Purchases and distribution were being made by the Ministry without making any correlation between the stocks of oral pill, available with these agencies and their own Medical Stores Depots and their

actual utilisation. During 1980—85, however, 233.38 lakh oral pill cycles were procured and 238.68 lakh cycles were supplied to the States; of which, only 174.17 lakh cycles were utilised, leaving 64.5 lakh unutilised cycles (constituting 27.02 *per cent* of those supplied during 1980—85 along).

(b) In Haryana, Punjab and 9 Rural Family Welfare Centres of 4 districts of Gujarat, oral pill users were not examined before and after putting them on oral pills within the prescribed period. The reports and records of follow-up cases for side effects, contra indication, etc., were also not available in 15 districts—Kerala (3), Andhra Pradesh (7) and Gujarat (5).

(c) The details and records of drop out cases were not available in Kerala and in 7 out of 8 district Bureaux in Bihar. The number of drop out cases of oral pill users in Punjab rose from 1,763 during 1980-81 to 47,970 in 1983-84, for which reasons could not be ascertained.

22.6 *All India Hospital Post Partum Scheme (Scheme)*

Starting from 1969, the Government of India decided to include the All India Hospital Post Partum Scheme in the Five Year Plans as the Post Partum (Post delivery) period was considered to be the point of highest motivation for family welfare. The scheme approved by the Government for the first time in 1969-70 in 59 medical institutions was expanded gradually and by 1984-85 it covered 554 institutions, almost all medical colleges (104), 2 post-graduate medical institutions, 375 district hospitals and other government hospitals, 30 local bodies and 43 hospitals run by voluntary organisations.

With a view to improving health status of expectant/nursing mothers and children in rural areas, Sixth Plan envisaged post-partum facilities to be provided at 400 sub-district level hospitals, where six-bedded sterilisation wards were to be set up and labour rooms upgraded/renovated and surgical equipment, vehicles etc., were to be provided. However, only 50 sub-district level hospitals could be provided with such facilities till March 1984 (information for subsequent period not available with the Ministry). The selected institutions were categorised under 3 types—A, B and C depending upon the number of obstetric (OB) and abortion (AB) cases dealt with annually.

The scheme included provision of additional inputs to respective centres in the form of (a) additional medical, para-medical and publicity staff, (b) separate sterilisation wards with buildings, equipment, beds and (c) vehicles, audio visual equipment, etc. The expenditure

on the scheme during 1971—85 was Rs. 6,195 lakhs. The following points were noticed:—

(i) For monitoring and evaluation, co-ordination committees were to be set up in each Centre and at National level, a set of monthly/quarterly/six monthly/yearly statistical returns were to be received from participating Centres by the Ministry. The Ministry had no information about the formation of co-ordination Committees at the Centres. The Ministry stated (January 1986) that the States had been asked to constitute the committees where these had not been formed.

(ii) The Ministry did not analyse the data on targets and performance of Centres in respect of sterilisation, IUD and other methods with reference to the number of living children for direct and indirect acceptors to assess their performance as envisaged in the scheme, reportedly, due to paucity of staff. However, during 1980—85, the all-India percentage shortfall in achievement of targets of total acceptors through sterilisations ranged between 38 and 61 and through other methods between 37 and 61. The achievement of targets of total acceptors in 17 States/UTs was less than the All-India achievement of 62.10 *per cent* during 1984-85, the shortfall being more than 50 *per cent* in Assam, Bihar, Kerala, Manipur, Meghalaya, Orissa, Rajasthan, Tripura, West Bengal, Chandigarh, Mizoram and Pondicherry.

The minimum target for sterilisation beds provided to the Centres was 35 tubectomies per bed per annum upto March 1980 and 45 thereafter, for claiming maintenance grant of Rs. 2,400 per annum per bed. While the all-India performance per bed improved during 1980—85 (from 48 in 1980-81 to 83 in 1984-85), 8 States/UTs during 1983-84 and 7 States/UTs during 1984-85 could not achieve the minimum targets; the shortfall in performance per bed per annum was more pronounced (above 30 *per cent*) in Meghalaya, Sikkim, Goa, Daman and Diu, Orissa and Bihar.

(iii) Each Centre was to have a sterilisation ward, an operation theatre and a room for field staff. Out of 554 Centres, sterilisation wards were wanting in 127(22.92 *per cent*), operation theatres in 131 (23.64 *per cent*) and rooms for field staff in 338 (61.01 *per cent*) Centres as on 31st March 1985.

(iv) A test check in States/UTs brought out the following further points:—

(a) Construction of buildings for 41 centres sanctioned in 8 States/UTs (Andhra Pradesh, Bihar, Himachal Pradesh, Punjab, Maharashtra, West Bengal, Chandigarh, and Delhi) during 1971 to June 1984 was not taken up. In Delhi, construction of one Centre, sanctioned in

March 1981, could not start as funds provided were inadequate and in Himachal Pradesh, funds amounting to Rs. 3.15 lakhs released from 1976 to 1982 for construction of one sterilisation ward and two operation theatres were diverted to other construction works. In Chandigarh, Rs. 1.05 lakhs released during 1971 to 1977 were not used for construction work; the money was utilised (Rs. 0.24 lakh) for office expenses during 1971—73 and the balance of Rs 0.81 lakh was lying unutilised in the Personal Ledger Account of the Centre.

(b) Buildings constructed for 11 Centres in 7 States/UTs (at a cost of Rs. 24.58 lakhs) were either not put to use for want of equipment, electric and water supply, or were used for other purposes.

(v) In Karnataka, for 39 Centres, only 17 vacuum aspirators, 7 microscopes and 2 opthalmoscopes were available (March 1984). In Uttar Pradesh, for 74 Centres at district level and 58 Centres at Tehsil level (opened in 1984-85), 39 projectors and 3 tape recorders were made available; 5 projectors and 11 tape recorders were lying with the Directorate. In Madhya Pradesh, 7 Centres were not provided with funds for equipment.

(vi) The staff position in the Centres during 1983-84 (data for 1984-85 not available) was as under:—

Category of Staff	Required	Available	Percentage shortage
Medical	1,581	1,041	34
Para-medical	1,704	1,114	35
Other Staff	1,396	941	33
TAL	4,681	3,096	34

The Ministry stated (January 1986) that the State Governments had been asked to fill up the vacant posts

(vii) To meet the growing demand of trained personnel in insertion of Copper 'T' particularly in PHCs, the scheme envisaged in 1978/79, training of LHVs and PHNs in the insertion of Copper 'T' at 106 Centres run by medical institutions and district level hospitals having services of gynaecologists. The Ministry had not kept any watch over progress of work in this regard. Test check in States/UTs showed that (a) no training was

provided in Jammu and Kashmir and Manipur, (b) one Centre in Delhi had not evolved any training programme and another Centre had not provided training since May 1981, (c) in Tamil Nadu, in 6 districts test checked, out of 578 LHVs to be trained 85 were trained in 3 districts and no training was provided in other districts (d) in Bihar, insertion of Copper 'T' was being done by untrained ANMs and (e) in Uttar Pradesh, out of 16,867 ANMs in position as on 1st April, 1985 only 5,075 were trained in insertion of Cu 'T' the State Government attributed non-utilisation of stocks of Cu 'T' to non-availability of staff trained in its insertion.

(viii) For better health for mothers and children under MCH Supplementary programme, the Centres were to undertake specifically (a) ante-natal and postnatal care including prevention against nutritional anaemia, multi-vitamin treatment and protection against tetanus by immunisation and (b) protection of children against diptheria, tetanus and whooping cough by immunisation, against nutritional anaemia by prophylaxis and against blindness amongst children by administration of iron and folic acid tablets and vitamin 'A' solution.

It was observed that during 1980—84 only about 50 *per cent* of the pregnant mothers registered at the Centres had deliveries in the hospitals and only 23 *per cent* had been immunised against Tetanus Toxoid (TT). Infants immunised against DPT were only 10 *per cent;* 11.4 *per cent* (9.30 lakhs) of expectant mothers had been administered third dose of TT from 1980-81 to 1983-84 though as per immunisation schedule, only 2 doses of TT and a booster dose were to be given.

(ix) No physical targets were fixed for the sub-district level hospitals (sub-district level Centres) and, therefore, the performance of these Centres could not be evaluated. The Ministry stated (January 1986) that physical targets would be fixed after a review of the functioning of the programme in these Centres.

22.7. *Area Projects*

To give a fillip to the programme, particularly in the backward areas of the country, 5 Area Projects (excluding 2 projects taken up in April 1984) were taken up in 1980/1981 in 53 districts of 12 States (Orissa, Andhra Pradesh, Uttar Pradesh, Madhya Pradesh, Tamil Nadu, Gujarat, Haryana, Himachal Pradesh, Maharashtra, Punjab, Bihar and Rajasthan) for intensive development of health and family welfare infrastructure in 794 PHCs with partial financial assistance from foreign agencies. These projects were designed to increase and strengthen in about 5 years, facilities and manpower for providing health and Family Welfare Services in an integrated manner. The ultimate objectives of these projects were

the reduction of fertility and reduction of maternal and child mortality and morbidity. Particulars of these projects are given in Annexure III A.

The following points were observed:—

(i) *Progress of expenditure and reimbursement thereof*

(a) The total expenditure incurred on these projects from their commencement till June 1985 was Rs. 171.55 crores against the total projects' cost of Rs. 281.61 crores (60.92 *per cent*). The completion period of projects in 9 States, originally envisaged to be 1985, was extended for periods ranging from 6 to 14 months; however, the progress of expenditure in the States of Andhra Pradesh, Gujarat and Rajasthan continued to be slow as shown in Annexure III B.

(b) The reimbursement claims to the foreign agencies were to be made periodically at certain specified intervals in terms of the agreements made. The details of reimbursement claimed and received from 1980-81 to 1985-86 (upto September 1985 were as follows:—

Foreign Agency	Reimbursement		Balance due
	Claimed	Received	
	(Rupees in crores)		
ODA	14.92	12.39	2.53
World Bank	35.83	34.26	1.57
DANIDA	23.86	20.67	3.19
USAID	23.08	13.33	9.75
UNFPA	21.70	20.65	1.05
TOTAL	119.39	101.30	18.09

The pace of reimbursement of expenditure on construction in respect of USAID assisted project was slow, because the USAID did not admit claims for reimbursement in respect of construction unless the construction of the whole unit was completed and necessary completion certificates issued by the P.W.D. authorities. Against a claim of Rs. 15.57 crores filed for construction works, the amount reimbursed was

Rs. 8.40 crores. The Ministry stated (January 1986) that Department of Economic Affairs had been approached to expedite the USAID reimbursement.

The UNFPA project in Bihar proposed to be taken up in April 1980 was extended from time to time; further extension for 5 years with effect from 1-1-1986 was under consideration of the Government of India. Against an expenditure of Rs. 11.29 crores incurred, claims of Rs. 7.78 crores were preferred; the reimbursement received was however, Rs. 5.77 crores (October 1985). No reimbursement was allowed for the period April 1981 to December 1983 for expenditure of Rs. 3.47 crores because construction activities could not be undertaken. In the absence of supporting documents, the entire expenditure on construction, amounting to Rs. 1.59 crores for the period April 1983 to September 1984, was not admitted and Rs. 3.31 crores reimbursed in December 1984 were treated as advance.

(ii) *Non-conduct of bench mark survey*

A bench mark survey (baseline survey) is essential to know the status at the commencement of the project so that at the end of the project the impact of the project could be evaluated. It was noticed that the base line surveys had not been finalised except in respect of Orissa, Andhra Pradesh, Uttar Pradesh, Rajasthan and Bihar.

(iii) *Shortfall in construction of buildings*

The construction of 9,728 buildings (comprising 8,321 Sub-Centres with or without LHV quarters and 1,407 buildings for RFWCs, PHCs, uproded PHCs, Training Annexes/Sheds, Staff quarters, etc.) was envisaged during the entire project period. The progress in this regard upto March 1985 was that 5,427 buildings (55.79 per cent) had been completed including 4,705 Sub-Centres. The percentage shortfall in completion of construction was more pronounced in 6 States; it ranged between 37.20 (Punjab) and 91.71 (Bihar). It was further noticed that (a) in Maharashtra, out of 316 buildings completed till March 1984, 169 buildings could not be handed over for use due to non-electrification and 6 sub-centres handed over in Osmanabad district had not started functioning (June 1984) for want of the requisite staff and (b) in Orissa, a mid-term review of the building programme conducted by the joint team of the Government of India and U.K. Experts in 1983 pointed out poor quality of work, especially lesser use of cement in concrete work and delays in completion of buildings. Poor construction in staff quarters in one PHC and LHV quarters in 3 sub-centres was reported by the Medical Officer of the Project Area. Two upgraded sub-centres in one PHC, constructed in 1983, were not occupied (May 1984) due to poor construction.

(iv) *Supply of equipment to staff*

During test check, it was noticed that (a) in Madhya Pradesh, 25 *per cent* Health Guides, 40 *per cent* Dais and 14 *per cent* MPWs in position in 8 districts had not been provided with necessary kits and 38 *per cent* Health Guides in 3 districts were not supplied with the required manuals (March 1984), (b) in Punjab, Health Guides had not been provided with kits, training manuals and quarterly supply of medicines and (c) in Maharashtra, 3,333 kits for training CHV, due by June 1984, had not been received from a firm, who had been paid Rs. 5 lakhs in advance in March 1984.

(v) *Miscellaneous*

In one of the projects in Orissa, it was observed that (a) most of the furniture and equipment costing Rs. 6.94 lakhs purchased for sub-centres during 1980-83 had not been distributed, (b) out of 6 sets of "Faxil" (low cost printing equipment) purchased at a cost of Rs. 2.69 lakhs during 1980—82, 3 machines had not been used and 2 machines were out of order, (c) out of 3 vehicles purchased at a cost of Rs. 3.70 lakhs during 1983-84 for transport of students, one vehicle was lying idle and unregistered since July 1983 (August 1984) and (d) two films costing about Rs 3.16 lakhs, completed in 1983, had not been released for exhibition pending clearance from the censors (July 1984).

22.8 *Maternal and Child Health Care (MCH) Services*

22.8.1 MCH services were recognised as an integral part of the programme during the Fourth Plan. The acceptance of the small family norm is dependent on the confidence amongst the parents about the survival chances of their children, which is sought to be achieved through MCH Services by protection of (a) mothers against tetanus and nutritional anaemia and (b) children against diptheria, whooping cough (pertussis) and tetanus, polyomyelitis, typhoid, tuberculosis and anaemia as well as blindness due to Vitamin 'A' deficiency.

The physical performance of the MCH Services during Sixth Plan period was as under:—

Details of programme	Targets	Achievements	Percentage achievements	States/UTs showing achievement below 40 percent
	(Number in crores)			
Polio	3.10	2.65	85.48	Arunachal Pradesh, Bihar and Sikkim

1	2	3	4	5
Diptheria Pertussis Tetanus (DPT)	7.25	5.00	68.97	Assam, Bihar, Manipur, Tripura and West Bengal.
Typhoid	5.08	2.10	41.34	Assam, Bihar, Kerala, Madhya Pradesh, Orissa, Rajasthan, Sikkim, Uttar Pradesh and West Bengal.
Prophylaxis against blindness among children due to Vitamin 'A' deficiency.	12.59	9.78	77.68	Bihar, Rajasthan, Manipur and Tripura.

The Ministry stated (January 1986) that the shortfall in achievement in some States was mainly due to inadequate availability of infrastructure and the under reporting of beneficiaries was also a cause of shortfall.

22.8.2 Refrigerator is a cal equipment which helps in retaining the potency of vaccines. A large number of refrigerators were supplied by the Government of India under various national programmes. Many refrigerators were also purchased directly by the State Health Authorities. According to the information available with the Ministry, the position of refrigerators available with the States/UTs at the end of August 1985 was as below:—

Placement at	Information available from	Total number of refrigerators	In working condition	Not in working condition		
				Repairable	Non-repairable	Total
State Head quarters	25 States/ UTs	786	638	NA	NA	148
District level	25 States/ UTs	2657*	1520	NA	NA	1137*
Primary Health Centres	31 States/ UTs	6958	5052	1364	542	1906

*The working condition of 501 refrigerators in Uttar Pradesh and 10 refrigerators in Andaman and Nicobar Islands was not available.

Test check conducted in the States/UTs brought out the following:-

(i) In Kerala, out of 50 refrigerators purchased in 1978 at a cost of Rs. 1.95 lakhs, delay of one to two years was noticed in installation of 5 refrigerators supplied to one district (Trivandrum), 3 refrigerators were not installed and 11 were not working since January 1981 (June 1984).

(ii) In Orissa, 3 PHCs of Ganjam and 7 PHCs of Cuttack district, not having cold chain facilities were keeping vaccines with them. In Kerala, during the period 1981—84, 38.73 lakh doses of DPT and 26.98 lakh doses of TT vaccines (which were required to be kept at +4° to +8° C) were transported in card-board package from the manufacturing point by road at day temperature and in one storing depot which received 12.46 lakh doses of TT, 15.73 lakh doses of DT and 13.35 lakh doses of DPT during 1981—84, the vaccines were being kept without refrigeration and sent to field centres also without refrigeration.

(iii) In Punjab, the stock registers of PHCs did not indicate the availability of vaccine carrier kits; it was not clear as to how the temparature required for maintenance of potency of vaccines was maintained during their transportation from the PHCs to the sub-centres. In Orrisa 29, sub-centres of Cuttak district were not supplied with thermocole boxes and in Ganjam district having 211 sub-centres, only 106 thermos flasks were supplied for carrying vaccines (June 1984). In Nagaland, even though funds were provided for the purchase of thermocoles, none of the Family Welfare Centres was provided with thermocole boxes and in one sub-division, 540 vials of Triple Antigen were kept without refrigeration for 10 months in 1982-83. In Uttar Pradesh, in 24 RFWCs test checked, only 165 thermocole boxes were supplied by the end of 1983-84, against the requirement of 382 boxes.

(iv) As per the guidelines, the unused live polio vaccines at the sub-centres were to be discarded daily. It was noticed that in 4 sub-centres of Punjab, the unused vaccines were kept and used for much longer periods ranging from 16 days to 120 days.

22.8.3 *Exaggerated and wrong reports*

(i) For 1982-83 and 1983-84, the performance in immunisation and prophylaxis were correlated with the utilisation of vaccines as reported by the Stated to the Government of India. After allowing the prescribed 10 *per cent* wastage of vaccine, it was found that some States / UTs had shown the consumption of vaccine in excess of the requirements—in such cases, the possibility of excess wastage,

pilferage or overdosage could not be ruled out; some States/UTs had reported excess performance—it would be due to either exaggerated or incorrect reporting or under dosage of vaccine to the beneficiaries as shown in the tables as follows:—

(a) (i) Excess consumption of vaccine (1982-83)

Name of vaccine	Number of States/UTs involved	Doses required	Doses consumed	Percentage of excess consumption of vaccines shown	States / UTs showing pronounced excess consumption in percentage
		(Number in lakhs)			
Tetanus Toxoid	21	134.87	184.30	37	Mizoram (361 *per cent*, Goa, Daman & Diu (261 *per cent*), Jammu and Kashmir (197 *per cent*), Meghalya (182 *per cent*), Rajasthan (100 *per cent*), Tamil Nadu (22 *per cent*), Pondicherry (92 *per cent*), Delhi (83 *per cent*), Bihar (82 *per cent*), Punjab (72 *per cent*), Orissa (67 *per cent*) and Haryana (54 *per cent*).
DPT	3	22.85	29.17	28	—
DT	6	32.48	39.52	22	Goa, Daman and Diu (200 *per cent*) and Delhi (77 *per cent*).
Typhoid	8	38.47	61.50	60	Exceeded 100 *per cent* in Bihar, Madhya Pradesh and Orissa.
Polio	6	23.95	30.07	26	Tripura (106 *per cent*), Jammu and Kashmir (44 *per cent*) and Orrisa (42 *per cent*).
Vitamin 'A' solution	9	67.31	110.98	65	Sikkim (638 *per cent*), Meghalaya (224 *per cent*), West Bengal (106 *per cent*), Pondicherry (93 *per cent*), Madhya Pradesh (76 *per cent*), Himachal Pradesh (57 *per cent*), and Goa, Daman and Diu (57 *per cent*).

(a) (ii) Excess consumption of vaccine (1983-84).

Name of vaccine	Number of States / UTs involved	Doses required	Doses consumed	Percentage of excess consumption of vaccines shown	States / UTs showing pronounced excess consumption in percentage
		(Number in Lakhs)			
Tetanus toxoid	2	15.77	20.80	32	Rajasthan (35 *per cent*).
DPT	7	93.52	116.12	24	Manipur (152 *per cent*), Nagaland (134 *per cent*), Meghalaya (81 *per cent*),Delhi (73 *per cent*) and West Bengal (37 *per cent*).
Typhoid	8	58.72	98.08	67	Jammu & Kashmir (779 *per cent*), West Bengal (246 *per cent*), Bihar (187 *per cent*). and Karnataka 143 *per cent*).
Polio	8	73.85	93.97	27	Manipur (337 *per cent*), Bihar (58 *per cent*), Karnataka (38 *per cent*) and Jammu and Kashmir (28 *per cent*).
Vitamin 'A' Solution	10	172.24	257.56	50	Goa, Daman and Diu (167 *per cent*), Orissa (119 *per cent*), Andhra Pradesh (99 *per cent*), Tamil Nadu (61 *per cent*), West Bengal (59 *per cent*) and Madhya Pradesh (52 *per cent*).

(b) (i) Excess reporting of performance (1982-83).

Vaccines involved	No.of States/UTs involved	Performance reported	Actual performance that could have been achieved with the vaccine consumed	Percentage of excess reporting	States showing pronounced excess reporting
		(Number in lakhs)			
DPT	14	158.87	96.74	64	Manipur (1950 *per cent*), Karnataka (414 *per cent*), Mizoram (311 *per cent*). Andhra Pradesh (130 *per cent*), Andaman & Nicobar Islands (80 *per cent*) and Madhya Pradesh (56 *per cent*).
DT	4	41.21	29.26	41	—
Typhoid	5	26.78	08.53	214	Tamil Nadu (222 *per cent*), Uttar Pradesh (194 *per cent*) and Himachal Pradesh (93 *per cent*).
Polio	6	44.11	32.20	37	Uttar Pradesh (144 *per cent*).
Vitamin 'A' Solution	1	24.33	14.92	63	

(b) (ii) Excess reporting of performance (1983-84)

Vaccines involved	No. of States/ UTs involved	Performance reported	Actual performance that could have been achieved with the vaccine consumed	Percentage of excess reporting	States showing pronounced excess reporting
		(Number in lakhs)			
TT	2	40.97	33.59	22	— —
DPT	7	90.81	69.71	30	Andaman & Nicobar Islands (229 *per cent*), Jammu and Kashmir (102 *per cent*) and Bihar (89 *per cent*).
DT	11	103.73	73.28	42	Andhra Pradesh (91 *per cent*), Chandigarh (77 *per cent*) and Gujarat (62 *per cent*).
Typhoid	3	32.41	19.71	64	Tamil Nadu (130 per cent).
Polio	1	11.57	09.39	23	—
Vitamin 'A' Solution	1	47.71	22.26	114	Maharashtra.

(ii) The test check revealed that:—

(a) While there was excess reporting by 26.60 *per cent* in DPT, 35.10 *per cent* in DT, 36.90 *per cent* in TT and 18.90 *per cent* in Vitamin 'A' during certain months of 1982-83 and 1983-84, in 4 districts of Kerala, with reference to the vaccines/solution utilised, records of 3 districts during certain other months showed that vaccines were utilised in excess of requirements, the percentage variations being 13.3, 20.8, 32.2 and 64.8 for DPT, DT, TT and Vitamin 'A' solution, respectively.

(b) In 24-Parganas district of West Bengal, test check of 9 Centres during 1980-81 to 1983-84 showed that 21,129 doses of Vitamin 'A' were reported to have been administered though three was no stock of Vitamin 'A'.

(c) An investigation into cases of wrong reporting brought out that (i) in 3 districts of Bihar, instead of taking the last dose of a course of immunisation as one person covered, each dose of a course administered to a person was taken separately in arriving at the figures of achievement.

(ii) In Orissa too, in one PHC of Cuttack district, actual beneficiaries of DPT and Polio were 788 and 414 in 1982-83. but the achievement was shown as 1848 and 1192 respectively by adding various doses given to the same persons, (iii) in Gujarat, in one Centre, second and third doses of DT and DPT were not administered during 1982-83 due to the Auxiliary Nurse-cum-Midwife being on leave, but the target was deemed to have been achieved and (iv) in Nagaland in 2 Centres, achievements in polio vaccination were inflated during 1983; in one Centre where only one dose each of polio vaccine was administered to beneficiaries, the report showed polio immunisation cycle as having been completed and in another hospital, only 372 beneficiaries received complete doses of polio, but progress reports showed 2167 cases.

22.8.4 *Non-utilisation of stocks before expiry date*

In 2 Hospitals of Nagaland, 157 ampules of triple antigen in March 1981 and 16.59 lakh Iron and Folic Acid tablets in November 1983 crossed their expiry dates while in stock, due to delays in supplies by State Family Welfare Bureau to the field offices. In Kerala, 1.04 lakh doses of DPT (costing Rs. 0.50 lakh) crossed expiry date in 1980 before their issue by the Family Welfare Bureau. In Cuttack district of Orissa, none of the 8830 women targeted for TT injections in 7 PHCs were immunised during the year in spite of availability of adequate stock of vaccine. The Ministry stated (January 1986) that States of Nagaland and Kerala will be requested to ensure timely utilisation of drugs to minimise wastage in future.

22.8.5 *Inadequate Stock Accounts*

In Uttar Pradesh, the closing balances shown by the department during 1982-83, 1983-84 and 1984-85 were less by 12.14 lakh doses for DPT, 16.30 lakh doses for DT and 29.21 lakh doses for TT vaccines, as compared to the figures worked out in Audit. The differences could not be explained by the department. In Kerala, one voluntary organisation which was provided 11,350 doses of DPT and 10,660 doses of TT vaccines free of cost during 1977-78 to 1982-83, had not kept separate accounts of the vaccines utilised even though it was invariably charging Rs. 6 per dose of the vaccine in all cases.

22.9 *Media Activities*

For strengthening the support to the programme, funds are provided to various media units of the Ministry of Information and Broadcasting. Against Sixth Plan outlay of Rs. 11 crores for media activities, an expenditure of Rs. 14.72 crores was incurred during 1980-85. Information collected from some of the media units brought out the following points:—

(i) Rs. 172.25 lakhs were spent during 1980—85 through Directorate of Field Publicity. The overall shortfall in achievement of targets of oral communication (seminars, symposia, group discussions, healthy baby show contests, debates, elocution contests, etc.) was 78 *per cent* during 1980—83, the shortfall being more pronounced in Madhya Pradesh (89 *per cent)* and Bihar and Rajasthan (76 *per cent).* The all-India percentage short-fall of photo exhibitions was 55 and it exceeded 70 *per cent* in 2 regions (North East Gauhati and North West Ambala and Nahan) and 60 *per cent* in 6 regions (Madhya Pradesh, East-West Gujarat, Karnataka, Maharashtra and Goa, Orissa and Uttar Pradesh). Information for 1983—85 was not available. The Ministry stated (January 1985) that the impact of publicity could not be judged only by fixing/achieving targets; conditions differed from region to region and from place to place, in areas like the North Eastern regions, Rajasthan and Madhya Pradesh, problems of long distances and difficult terrain were also in the way of achieving the general norms on the whole; however, efforts were made to achieve the desired norms.

(ii) Through Doordarshan, an expenditure of Rs. 16.18 lakhs was incurred during 1980-85 (upto September 1984). Out of 50 T.V. films on family welfare undertaken for production at a cost of Rs. 22.71 lakhs, 38 films were completed till March 1984. Test check brought out that the films were being telecast infrequently; only one film was telecast twice and all others only once

(5 in 1981-82, 15 in 1982-83, 12 in 1983-84 and 2 in 1984-85) and there was no inter-exchange of films among different Kendras (information for 1984-85 was not available). The Ministry stated (January 1985) that films were assigned to private producers and production of films could not always be completed with in the financial year in which they were taken up due to elaborate procedure of committees, which scrutinise and approve the proposals. Further the Doordarshan had issued instructions that the films should be shown as often as possible and that whenever feasible these be interchanged amongst various Kendras.

(iii) Through Films Division, Rs. 315.62 lakhs were spent during 1980-85 for production/prints of films on family welfare. Out of 164 films targeted for production during 1980-84, only 91 films were produced (shortfall : 55.49 per cent). Out of the former, 31 film subjects were deleted/deferred, leaving a balance of 42 film subjects at the end of 1983-84 (information for 1984-85 was not available). The Ministry stated (January 1985) that due to delays in sanction/appointment of staff, additional equipment and required additional accommodation the desired production capacity had not been achieved.

709 prints of various films made during 1980-84 (11 in 1980-81, 12 in 1981-82, 89 in 1982-83 and 597 in 1983-84) had not been distributed (October 1984). The cost of these prints was not intimated (information for 1984-85 was not available). The Ministry stated (January 1985) that action had been taken to distribute the films.

22.10 *Monitoring and Evaluation*

The Evaluation and Intelligence Division in the Department is monitoring and evaluating the programme in the country right from the peripheral level through various reports and returns from the States/UTs supported by sample verification of acceptors through field checks by each of the 17 States Demographic and Evaluation Cells and Regional Health Offices and Central Evaluation Teams, etc. States are addressed periodically sport-lighting the irregularities regarding (a) reported performance, (b) recorded demographic particulars of acceptors and (c) the eligibility status of acceptors.

(i) *Discrepancies in reports/returns of State Agencies*

Test check of reports/returns of State agencies brought out the following

discrepancies:—

Name of State/UT	Nature of discrepancy
Gujarat	— The Post Partum Centre (PP) in Panchamahals district in its report to the Directorate had included 473 sterilisation cases referred to it by the RFWCs which also stood included by the centres in their reports to the Directorate during 1979-83.
Orissa	— As against the actual number of 4001 institutions functioning during 1982-83, the number of institutions shown functioning as per half yearly/annual consolidated reports was 3348.
	— The total of 611479 live births, still births and abortions did not correspond to the total number of 734369 deliveries reported to have been conducted during 1979-81 and 1982-83.
	— In one PP entre the figures of 1498 tubectomies during 1980-81 and 1982-83 and 1518 IUD cases during 1978-83 as per target/ achievement register did not tally with the figures of 1403 tubectomies and 1376 IUD cases as per compensation payment register.
Delhi	— The figures of 673 sterilisation, 1706 IUD insertions and 44 CC users of one UFW Centre were incorrectly taken as 457, 1715 and 3 respectively, in the Directorate during 1981-84.

(ii) *Performance of Sample Survey Agencies*

In sample survey, it was noticed that follow-up services were not

provided to 55 *per cent* of the acceptors during 1980-81, 42 *per cent during* 1981-82, 61 *per cent* during 1982-83 and 56 *per cent* during 1983-84 according to the Regional Health Offices/Central Evaluation Teams.

The Survey teams also reported that (a) 18.12 *per cent* (1980-81), 17.80 *per cent* (1981-82), 53.30 *per cent* (1982-83) and 18.40 *per cent* (1983-84) of sample cases selected for verification could not be located for reasons such as, persons not living in the area, persons having left the area permanently / temporarily, wrong address, etc., and (b) of the contacted cases, 0.50 *per cent in* 1980-81, 0.30 *per cent in* 1981-82, 0.70 *per cent in* 1982-83 and 0.80 *per cent* in 1983-84 were of in-eligible categories like "unmarried/widow/ widower/separated", "wife above 45 years", "spouse already sterilised", "very old men," etc.

(iii) Special point relating to working of the 3 agencies are mentioned below:—

Sample verification by	Remarks
1	2
Demographic and Evaluation Cells.	— Sample verification of acceptors by all methods was less than one *per cent* as against the prescribed limit of 2 *per cent* during 1980-84; of the number of cases so selected, 5 States (Gujarat, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh) accounted for 65 to 79 *per cent* in the respective years. Out of 17 cells, no reports had been received from 3 in 1980-81, 6 in 1981-82 and 5 each in 1982-83 and 1983-84.
Regional Health Offices	— The percentage of acceptors selected for verification declined from 0.14 in 1980-81 to 0.07 in 1981-82 and 1982-83 and to 0.04 in 1983-84.
	— During 4 years ending March 1984, out of 17 offices no reports were received from 6 in 1980-81, 8 in 1981-82, 11 in 1982-83 and 6 in 1983-84.

1	2
Central Evaluation Teams	— The percentage of acceptors selected for verification declined from 0.42 in 1980-81 to 0.36 in 1981-82, 0.19 in 1982-83 and 0.17 in 1983-84.
	— The percentage of acceptors selected varied from State to State during 1980-84; it ranged from 0.09 (Gujarat) to 13.75 (Sikkim) in 1980-81, 0.05 (Madhya Pradesh) to 6.71 (Pondicherry) in 1981-82, 0.02 (Maharashtra) to 2.55 (Tripura) in 1982-83 and from 0.04 (Maharashtra) to 8.36 (Sikkim) in 1983-84. The Ministry stated (January 1985) that the number of acceptors every year had been increasing, whereas, there had been no increase in the staff and that the fall in the percentage verification was inevitable.

22.11 *Other points of interest*

(i) *Disbursement of grants to local bodies and voluntary organisations*

(a) In Uttar Pradesh, one grantee institution in Varanasi which performed only post delivery sterilisations was paid Rs. 4.74 lakhs during 1978-85 in excess of admissible grant.

(b) 59 Organisations had not furnished utilisation certificates for grants of Rs. 59.29 lakhs given by the Central Government for the period 1976-83 including Rs. 14.29 lakhs given to 24 organisations upto March 1980. Utilisation certificates amounting to Rs. 3,725.84 lakhs had not been received in 5 States (Gujarat for Rs.3,711.21 lakhs for 1976-85, Uttar Pradesh for Rs. 13.58 lakhs for 1976-84 and Rajasthan for Rs. 1.05 lakhs for 1980-83).

The registers maintained in the Ministry to watch annual statements showing details of assets created out of grants released were incomplete in as much as they did not indicate the amount of grant released for creation of assets, details of assets actually created and follow up action with defaulting grantee institutions.

(ii) *Cases of excess expenditure*

In 4 Post Partum Centres of 2 States (Bihar and Kerala), staff in excess

of the approved pattern had been sanctioned, resulting in excess expenditure of Rs. 7.93 lakhs upto March 1985.

In 2 Post Partum Centres of Bihar, 2 projectionists were in position since 1981 but projectors were not provided. In one Post Partum Centre of West Bengal, a driver was in position from October 1978 to April 1983, though no vehicle was provided, similarly, in 3 districts, Rs 1.54 lakhs were spent on 6 drivers from 1977 to March 1984 even though no vehicles were available for their services.

In Jammu and Kashmir, extra expenditure of Rs. 18.62 lakhs was incurred on account of payment of monthly salaries from April 1974 onwards instead of honorarium to the field workers in RFW Sub-centres.

In Pondicherry, expenditure amounting to Rs. 3.79 lakhs was incurred in excess of the amount admissible on construction of 2 P.P. Centres.

(iii) *Cases of Misappropriation / Non-accountal of Stores, etc.*

(a) In Uttar Pradesh, misappropriation / Pilferage / embezzlement of stocks worth Rs. 16.31 lakhs was noticed during 1976-79.

(b) In 11 districts of Haryana and 7 districts of Punjab non-accountal / short accountal of stores valueing Rs. 12.49 lakhs was noticed during 1974-83.

Summing up

— Though the expenditure (Rs. 1,489.97 crores) on implementation of the programme exceeded the projected outlay (Rs. 1078 crores) by 38 *per cent* during the Sixth Five Year Plan, the shortfall in achievement of targets in sterilisation, IUD and equivalent CC and Oral Pill users was 21, 18 and 15 per cent respectively. The increase of targets of sterilisation from 220 to 240 lakhs as a result of mid-term appraisal of Sixth Plan was not implemented. The target of protection of 36.56 *per cent* of eligible couples effectively has not been achieved by the end of the Plan.

— In the case of 82946 Sub-centres as on 1st April 1985 there was a shortfall of 71 *per cent* in the construction of their buildings (June 1985).

— The Sixth Plan envisaged renovation and re-modelling of IUD rooms into operation theatres in 833 PHCs, against which only 616 PHCs, were selected upto March 1985; of these, construction had been completed only in respect of 2 PHCs.

— The overall shortfall in availability of staff as on 1st April 1984 was to the extent of 15, 19 and 38 *per cent* in respect of medical, para-medical and other staff respectively in Rural Family Welfare Centres.

— Out of 5.15 lakh trained Dais only 3.30 lakhs were supplied with kits required for safe and hygenic delivery.

— In three States (Kerala, Orissa and Uttar Pradesh) compensation money of Rs. 118.65 lakhs was spent in excess of admissible limits.

— In three States/Union Territory adjustment of Rs. 360.35 lakhs advanced (1970-85) to various subordinate units/other organisations was awaited.

— Proforma Accounts of Miscellaneous Purpose Fund were awaited from the State Governments. In 7 States, Rs. 1.78 crores were utilised during 1976-84 for purposes not contemplated under the orders.

— 10,164.75 lakh condoms, costing Rs. 22.82 crores, were purchased for free distribution without correlating holdings available with the States and Medical Stores Depots. The stock accounts in the Ministry were also incomplete due to non-receipt of annual inventories from the States.

— 92.90 crores condoms were distributed through private agencies. The Ministry had not kept any upto date accounts of the amount due, remittances received and outstanding in respect of each distribution agency. Data gathered at the instance of Audit showed balance of Rs. 67.57 lakhs recoverable from 13 companies.

— Out of 233.38 lakh oral pill cycles procured during 1980-85, Only 174.17 lakh cycles were utilised.

— Against the envisaged Post-Partum facilities at 400 sub-district level hospitals during the Sixth Plan period only 50 sub-district level hospitals could be provided with such facilities (September 1985).

— Out of 554 Post-Partum Centres, sterilisation wards were not set up in 127 (22.92 *per cent*), operation theatres in 131 (23.64 *per cent*), and rooms for field staff in 338 (61.01 *per cent*) PP Centres as on 31st March 1985 there was over-all shortage of 34 *per cent* staff in the PP Centres during 1983-84.

— Construction of buildings for 41 PP Centres sanctioned in 8 States/UTs during 1971 to June 1984 was not taken up. Buildings constructed for 11 Centres at a cost of Rs. 24.58 lakhs in 7 States/UTs were either not put to use or were used for other purposes.

— For intensive development of health and family welfare infrastructure in 794 PHCs, 5 Area Projects were taken up with partial financial assitance from foreign agencies. However, out of 9,728 buildings (including 8,321 Sub-centres) envisaged for construction, only 5,427 buildings (55.79 *per cent)* had been completed. Out of Rs. 119. 39 crores claimed as reimbursement of expenditure in respect of these projects, an amount of Rs. 18.09 crores was yet to be recovered.

— The shortfall in coverage of immunisation against Polio, DPT, Typhoid and prophylaxis against blindness due to Vitamin 'A' deficiency ranged between 15 and 59 *per cent* during 1980-85. Out of 10,401 refrigerators provided at State/District /PHCs levels, for retaining the potency of vaccines.

— 3191 (31 *per cent*) were not in working condition. In Nagaland, 16.59 lakh Iron and Folic Acid Tablets crossed their expiry date in November 1983 while in stock, due to delays in supplies by State Family Welfare Bureau.

— Against the Sixth Plan outlay of Rs. 11 crores for Media Activities, expenditure of Rs. 14.72 crores was incurred. In the Directorate of Field Publicity the shortfall in achievement of targets (1980-83) was 78 and 55 *per cent* in oral communication and Photo Exhibition respectively; in Doordarshan 38 T.V. Films were completed till March 1984 (against 50 undertaken for production) but these were telecast very infrequently.

— Sample Surveys brought out that follow-up services were not provided to 55, 42, 61 and 56 *per cent* Acceptors of Family Welfare Methods in 1980-81, 1981-82, 1982-83 and 1983-84 respectively.

— 59 organisations had not furnished utilisation certificates for grants of Rs. 59.29 lakhs released by the Central Government during 1976-83. Such certificates for Rs.37.11 crores had not been received in Gujarat, mostly in respect of District Panchayats.

ANNEXURE I

Statement showing outlay and expenditure during Sixth Five Year Plan

(Rupees in crores)

Sub-Programme	Sixth Plan Allocations 1980-85	Budget Estimates 1980-85	Expenditure 1980-85
1. Direction and Administration	46.50	70.52	70.69
2. Rural Family Welfare Services	384.80	388.83	388.64
3. Urban Family Welfare Services	20.00	33.72	33.49
4. Maternal and Child Health Care Services	41.00	66.42	62.42
5. Transport	24.50	38.88	32.49
6. Compensation	140.00	309.50	309.39
7. *Other Services and Supplies	103.00	305.79	297.17
8. Mass Education	32.00	36.56	34.45
9. Training Research and Statistics	51.80	63.60	62.38
10. International Cooperation and other Expenditure	166.40	121.69	120.99
11. Health Guides	68.00	77.89	77.86
TOTAL	1,078.00	1,513.40	1,489.97

*Includes Nirodh, Oral Pills, Post-Partum Centres, Family Welfare Programme in Railways, Defence, Posts and Telegraphs, Ministry of Labour and Employment, etc.

ANNEXURE II

Central assistance released to States and Union Territories with legislatures during 1980—85

State and Union Territory	Cash	Kind	Total
		(Rupees in crores)	
1. Andhra Pradesh	114.97	5.19	120.16
2. Assam	26.15	1.47	27.62
3. Bihar	87.88	2.85	90.73
4. Gujarat	77.33	5.52	82.85
5. Haryana	30.07	3.08	33.15
6. Himachal Pradesh	25.35	0.78	26.13
7. Jammu and Kashmir	7.86	0.61	8.47
8. Karnataka	65.30	4.34	69.64
9. Kerala	43.06	2.06	45.12
10. Madhya Pradesh	93.11	5.45	98.56
11. Maharashtra	124.37	10.38	134.75
12. Manipur	4.55	0.21	4.76
13. Meghalaya	3.27	0.17	3.44
14. Nagaland	1.51	0.13	1.64
15. Orissa	75.11	2.69	77.80
16. Punjab	41.44	3.23	44.67
17. Rajasthan	54.56	2.99	57.55
18. Sikkam	1.32	0.06	1.38
19. Tamil Nadu	79.59	3.99	83.58
20. Tripura	5.23	0.19	5.42
21. Uttar Pradesh	190.35	10.95	201.30
22. West Bengal	75.63	4.45	80.08
23. Arunachal Pradesh	0.31	0.04	0.35
24. Goa, Daman and Diu	2.05	0.12	2.17
25. Mizoram	1.66	0.13	1.79
26. Pondicherry	1.44	0.12	1.56
GRAND TOTAL	1,233.47	71.20	1,304.67

ANNEXURE III-A

Statement showing the States/Funding Agencies under Area Projects

Sl. No.	State (with No. of Districts and PHCs)	Funding Agency	Project Cost	Foreign commitment
			(Rupees in crores)	
1.	Orissa (132 PHCs in 5 districts)	Overseas Development Agnecy, U.K. (ODA).	39.42	18.27
2.	Andhra Pradesh (62 PHCs in 3 districts)	World Bank	81.96	46.00
3.	Uttar Pardesh (148 PHCs in 6 districts).	World Bank		
4.	Madhya Pradesh (58 PHCs in 8 districts).	Danish International Development Agency (DANIDA)	42.10	27.15
5.	Tamil Nadu (61 PHCs in 2 districts)			
6.	Gujarat (37 PHCs in 2 districts).			
7.	Haryana (21 PHCs in 3 districts).			
8.	Himachal Pradesh (24 PHCs in 3 districts).	United States Agency for International Development (USAID).	51.79	40.00
9.	Maharashtra (29 PHCs in 3 districts).			
10.	Punjab (31 PHCs in 3 districts).			
11.	Bihar (149 PHCs in 11 districts).	United Nations Funds for Population Activities (UNFPA).	66.34	60.79
12.	Rajasthan (34 PHCs in 4 districts).			
	TOTAL		281.61	192.21

ANNEXURE III-B

Progress of Expenditure

States	Date of Project cost		Expenditure	Percentage of expenditure to cost	Termination period extended to	
	Commencement	Termination				
			(Rupees in lakhs)			
Orissa	August 1980	July 1985	3942.29	2502.54	63.48	September 1986
Andhra Pradesh	April 1980	March 1985	2372.36	1537.20	64.80	December 1985
Uttar Pradesh	April 1980	March 1985	5823.64	4515.38	77.54	December 1985
Madhya Pradesh	November 1981	October 1986	2334.30	1135.51	48.64	
Tamil Nadu	November 1981	October 1986	1875.80	1073.15	57.21	
Gujarat	August 1980	September 1985	1185.34	748.71	63.16	March 1976
Haryana	"	"	773.87	628.64	81.23	"
Himachal Pradesh	"	"	1100.37	1085.21	98.62	"
Maharashtra	"	"	1330.27	1127.41	84.75	"
Punjab	"	"	789.72	727.84	92.16	"
Bihar	January 1981	March 1988	5251.85	1128.59	21.49	
Rajasthan	July 1980	June 1985	1381.19	945.09	68.43	March 1986
TOTAL			28161.00	17155.27	60.92	

APPENDIX-II

(Vide Para 2.4 of Report)

Year-wise achievement of targets of Family Planning Methods, All-India (since 1966-67)

(Figures in thousands)

Year	Sterilisations			I.U.D. Insertions			Eq. C.C. Users			Eq. O.P. Users		
	Target	Achievement	Achievement%	Target	Achievement	Achievement%	Target	Achievement	Achievement%	Target	Achievement	Achievement%
1	2	3	4	5	6	7	8	9	10	11	12	13
1966-67	1,263	887	70.2	4,199	910	21.7	2,300	465	20.1	—	—	—
1967-68	1,543	1,840	119.2	2,057	669	32.5	2,057	475	23.1	—	—	—
1968-69	2,109	1,665	79.0	791	479	60.5	2,109	961	45.6	—	—	—
1969-70	2,215	1,422	64.2	702	459	65.3	2,431	1,509	62.1	—	—	—
1970-71	2,600	1,330	51.2	900	476	52.9	4,800	1,963	40.9	—	—	—
1971-72	2,079	2,187	105.2	831	488	58.8	3,829	2,354	61.5	—	—	—
1972-73	5,697	3,122	54.8	949	355	37.4	4,258	2,398	56.3	—	—	—
1973-74	2,268	942	41.6	669	372	55.5	4,303	3,010	70.0	—	—	—
1974-75	2,000	1,354	67.7	600	433	72.1	3,500	2,521	72.0	—	—	—

1	2	3	4	5	6	7	8	9	10	11	12	13
1975-76	2,492	2,669	107.1	912	607	66.6	4,358@	3,528@ (3,495)	80.9@	—	32	—
1976-77	4,299	8,261	192.2	1,137	581	51.1	4,690	3,692@ (3,634)	78.7@	—	58	—
1977-78	3,990+	949	23.8	1,000	326	32.6	5,000@	3,253@ (3,175)	65.1@	—	78	—
1978-79	3,965	1,484	37.4	600	552	91.9	4,000@	3,469@ (3,387)	86.7@	—	82	—
1979-80	3,049	1,778	58.3	1,149	635	55.2	5,003	2,987	59.7	500	82	16.4
1980-81	2,896	2,053	70.9	791	628	79.4	5,042	3,718	73.7	495	91	18.4
1981-82	2,896	2,792	96.4	791	751	94.9	5,042	4,439	88.0	495	120	24.2
1982-83	4,522	3,983	88.1	1,512	1,097	72.5	6,502	5,765$$	88.7	503	183	36.4
1983-84	5,900	4,532	76.8	2,500	2,134	85.4	7,900	7,661$	97.0	1,100	729	66.3
1984-85	5,823	4,085	70.1	3,183	2,562	80.5	10,000	8,505$$$	85.1	1,000	1,290	129.0
1985-86*	5,560	4,899	88.1	3,244	3,274	100.9	9,515	9,385$$$$	98.6	960	1,357	141.3

$	Includes 1.01 million C.C. Users under full cost commercial sales of condoms.
$$	Includes 1.08 million C.C. Users under full cost commercial sales of condoms.
$$$	Includes 1.02 million C.C. Users under full cost commercial sales of condoms.
$$$$	Includes 0.89 million C.C. Users under full cost commercial sales of condoms.
*	Figures provisional.
@	Includes equivalent Oral Pill Users also.
+	Targets (levels of expectation) not insisted upon for the year.
Note:	Figures in brackets relate to Equivalent Conventional Contraceptive Users.

APPENDIX III

(*Vide* Para 7.1 of Report)

Organisation of Family Welfare Programme in States

A Family Welfare Bureau has been set up in each State Directorate of Health and Family Welfare. The organisation of the programme at the State level is as follows:

Family Welfare Programme State Level Organisation

Director of Health Services

or

Director of Health Services and
Director of Medical Services

or

Director of Health Services
Director of Medical Services and
Director of Medical Education

Additional / Joint / Deputy Directors
for individual programme
Additional / Joint Director-cum-State
Family Welfare Officer.

Programme Wing	Media	M.C.H.	Demographic & Evaluation Wing	Training Wing	Administrative Wing

For the districts, there is a Family Welfare Bureau with technical and secretariat staff. By 1985, 410 District Family Welfare Bureaux were functioning. The organisation of the programme at the district levels is as follows:

Family Welfare Programme District Level Organisation

Chief Medical Officer

or

Civil Surgeon (Curative) &
District Health Officer
(Health & Family Welfare)

or

Civil Surgeon (Curative)
District Health Officer (Health)
& District F. W. Officer

or

Civil Surgeon (Curative) & District Health Officer & FW Officer (for Health and FW & MCH Programme)
Assisted by an Additional District Health Officer & FW Officers

	Civil Surgeon	Disrict Health Officer	District FW Officer
1.	District Hospital	1. I / c of Rural Health Services & PHC	FW & MCH Programmes through rural family health centres which are under Civil Surgeon
2.	Urban FW Programme	2. May or may not be I / c of Taluka Level Hospitals	
3.	May or may not be I / c of all Taluka / sub-divisional level hospitals		
4.	May or may not be I / c or Curative Services at PHC		

At the PHC level, in addition to the general PHC set up, a family welfare component consisting of one additional physician and some supporting staff has been provided. A family welfare Centre has also been added as a building component of a PHC. However, the entire PHC functions as an integrated Unit.

At the sub-centre level, additional sub-centres to reach a level to meet the specifications laid down under the Multipurpose Workers Scheme have been established. In 1978 the Government of India had laid down that there will be a sub-centre for a population of 5000 with a male and female MPW. The organisation of the programme at the PHC level is as under:

Organisation of Primary Health Centre

District level	— Chief Medical Officer Deputy Chief Medical Officer
Block level	— Medical Officers (2-3 per PHC) MO(i) MO(ii) MO(iii) Block Extension Educator for the whole PHC & Health Assistant (Female) & Health Assistant (Male) One for each 20,000 population.
Sub-Centre level	— One sub-centre for each 5,000 population with one Multipurpose Worker (female) and one MPW (male).
	(COMMUNITY ORGANISATION ASSISTED BY GOVERNMENT)
	One Community health worker and one trained birth attendant for each village. (roughly 1,000 population)

The network of referral services is as under:

REFERRAL SERVICES

Community

Community Health Worker (CHW)

Multipurpose Health Wokers of Health Assistants	Primary Health Centre
Selected PHCs / Taluka level Hospital	District Hospital
Medical College Hospital	Specialised Medical Institution

APPENDIX IV

(*Vide* Para 7.7 of Report)

Gist of schemes under which assistance under the Family Welfare Programme is admissible to voluntary organisations

1. (a) *Urban Family Welfare Centres:*— These Centres provide Family Welfare Services including Maternity and Child Health Care in the Urban Areas. Grants are sanctioned as per approved pattern for meeting the expenditure on staff, contingencies, non-recurring items like equipment, furniture etc.

(b) It has been decided that no new Urban Family Welfare Centres may be opened in view of the implementation of the Urban Revamping Scheme. However, this scheme in its reorganised form is presently being considered for such towns which have a population of more than 2 lakhs due to financial constraints. The reorganisation of the Urban Family Welfare Centre in the towns which have population of less than two lakhs would be taken up subsequently. The proposals for re-organisation are considered on the recommendation of the State Government.

2. *Post-Partum Centres:*—These have a Maternity Centre and Hospital-based approach to the Family Welfare Programme. Assistance for staff, building for operation theatre and sterilisation wards, equipment etc. are provided.

3. *Sterilisation beds in hospitals:*—Under this scheme which aims at providing facilities for tubectomy operations in hospitals run by voluntary organisations, a maintenance grant of Rs. 3000/- per bed per annum is being released to voluntary organisations through the State Governments concerned, provided a target of 60 tubectomies per bed per annum is achieved by the concerned organisations.

4. *A.N.M. Training Schools:*—These schools receive financial assistance in the form of inputs for construction of buildings, residential accommodation for Trainees, equipment, vehicles, staff and stipend to the trainees.

5. *Family Welfare Leader's Camps:*—For organising Family Welfare Leaders Camps, especially in rural areas for imparting knowledge, informa-

tion and motivation, grants at the rate of Rs. 300/- per camp are provided.

6. *Population Research Centres*:—These Centres undertake population research for which financial assistance is provided as per pattern, for meeting the expenditure on staff, contingencies, data processing, publications etc.

7. *Experimental / Innovative Projects*:—Projects not conforming to any particular pattern but which are viable and aim to provide motivation, communication, educational activities and services or otherwise of innovative nature are provided financial assistance.

8. *Family Welfare Projects is organised sector*:—These projects are taken up with UNFPA / ILD assistance Funds for these projects released by Central Govt.

9. *Training in Laparoscopic Sterilisation and Supply of Laparoscopic*:— Scheme provides for Training Post-Graduate / Diploma / Degree in obestetrics and Gynaecology Masters in Surgery to members of IMA alongwith their team of operation theatre, Nurse and O.T. Technician, for 15 days and provides Travelling and Daily Allowances and conveyance charges.

IMA members are also eligible for purchase of Laparoscope with a Government subsidy limited to 50% of cost of Laparoscope, subject to a ceiling of Rs. 20,000/- in each case. Training Centres are located in Delhi, Jaipur, Baroda, Hubli, Bombay and Hyderabad, Proposals are to be submitted through Indian Medical Association Headquarter who will disburse the assistance and training [illegible].

Financial assistance for items at 1 to 5 is provided through the State Governments / U. Ts. concerned who have been delegated the power. In respect of schemes 6 to 9 [illegible] is provided by Central Government direct.

APPENDIX—V

Statement of observations and recommendations

S.No.	Para No.	Ministry/ Deptt.	Observation/recommendation
1	2	3	4
1.	1.10	Health (Family Welfare)	The Committee are of the opinion that even though Family Welfare Programme has been in operation for more than thirty-five years and an expenditure of over Rs. 2400 crores has been incurred upto the end of Sixth Plan it has not bee able to check the growth of population at all. While the demographic goals in terms of crude birth rate had been frequently announced and readjusted, the planned targets had remained elusive with birth rate reigning high in the past and stagnating around 33 per thousand population from 1977 onwards. This failure to achieve a swift decline in birth rate has resulted in alarming increase in the population. The high birth rates have also resulted in a broad-base age pyramid with 40 per cent of the population below 14 years of age, which not only raises the dependency burden on the country but would also result in a continuing high fertility rate in the coming years.
2.	1.11	-Do-	The Committee consider that the nature of the population problem has not been perceived in the right perspective in spite of the initial urgency of the population control expressed by the planners in the First Five Year Plan. The Family Welfare Programme has been implemented without enthusiasm like any other routine programme with the result that the growth rate of populatio remained unabated.

1	2	3	4
			The Committee are at a loss to understand as to how and why the birth rate has remained stationary at 33 since 1977 despite the fact that couple protection rate has gone up considerably from 22.5 per cent in 1977 to 34.9 per cent by March, 1986. During their examination of this subject, the Committee have been informed of various difficulties at the programme implementation stage. Even though the implementation of the programme is done by the State Governments it is mainly the responsibility of the Central Government to ensure that the objectives of the programme are being achieved in accordance with the frame work of formulated policies and timely remedial measures are taken to remove deficiencies. Lamentably, as admitted by the Special Secretary (Department of Family Welfare) before the Committee the programme has not been given the seriousness it deserved in view of the mammoth socio-economic implications it has for the country. Considering the utmost importance of Family Welfare Programme in socio-economic development of the country, the Committee desire that the Ministry of Health and Family Welfare (MOHFW) should take urgent steps to identify the weak-spots in the programme management from every possible angle so as to ensure immediate effective remedial measures. In the light of the recent report of Registrar General based on SRS data that the birth rate has not fallen as per projections made by the Expert Committee on Population Projections, the Committee would like the MOHFW to take suitable steps to closely monitor the programme at an appropriately higher level periodically so as to ensure its effective implementation.
3.	2.18	**Health (Family Welfare)**	The Committee note that while the Ministry of Health and Family Welfare have prescribed a uniform Family Welfare Programme for the entire country, statistics reveal that there are wide variations in the programme acceptance and demographic situation in the different

1	2	3	4
			States. The performance of the programme in the major States of Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan continues to be poor due to various socio-economic factors. The acceptance of family planning among certain communities and identifiable groups in the country is also much lower than the national averages due to religious susceptibilities and social attitudes. The Committee are of the opinion that the population problem in the poor performing States and regions cannot be adequately understood or tackled by a single uniform national strategy and as such there has to be multiple strategies to suit inter state and inter regional diversities. For the wider acceptance of the programme, it is imperative that the sensitive issues of religious beliefs and hard attitudes is tackled by the States after taking the advice and help of experts and the States also take special steps to identify the thrust areas requiring priorities and differential approaches. The Committee feel that the flexibility in approach and financial powers in implementing special schemes for different regions and areas and specific groups should be provided to State Governments so that they are in a position to effectively implement the programme according to realities of the situation.
4.	2.19	Health (Family Welfare)	The major long-term demographic goal to be achieved for the country, as specified in the National Health Policy, is to reach the Net Reproduction rate of Unity (NRR-1) by the year 2000 A.D which in turn is said to depend upon attaining gross birth rate of 21 per thousand. The attainment of this goal is said to depend on achieving, *inter alia*, 60 per cent effective couple protection rate by that year. The Committee are distressed to note that no target for effective couple protection has been set for different age groups of the females although the potential for births are very different for women of different age groups. The Committee recommend that women of the 15-29 age group should be the main target group and methods, priorities and policies should be for-

1	2	3	4
			mulated and adjusted mainly towards controlling births to desired level in that age group. The Committee felt that this task can be accomplished by proper and earnest implementation of the programme by motivating the couples especially those in the younger age groups.
5.	2.20	Health (Family Welfare)	The programme statistics on the couples effectively protected by various family planning methods at the end of Sixth Five Year Plan (1985) reveal that more than 77 per cent of acceptors used the terminal method of sterilisation and the protection from other family planning methods was only about 22 per cent. These statistics also reveal that the mean age (by the age of wife) of acceptors of vasectomy and tubectomy was 31.8 years and 30.3 years respectively and the mean number of living children of these acceptors was 3.3 and 3.5 respectively. The Committee feel that while the method of sterilisation has been the main plank in the Government strategy in meeting the family planning targets, generally the older couples in the age group 30 plus have been taking recourse to this method only after attaining the desired family size of 3-4 children thus defeating the very purpose of the programme. Set against these dimensions of performance statistics, an estimate on the age of contraceptive acceptors reveals that the percentage of protected couples in the prime reproductive age group 15-29 years is only 15 as against 55 per cent in the upper age group of 30 to 44 years. The Committee are distressed that the Government strategy has not succeeded in providing required contraceptive protection to the eligible couples in the younger age groups which in fact deserve top most priority for the success of family planning and population control. The Committee are of the opinion that since the younger age groups may not be inclined to adopt sterilisation which is a terminal method, efforts to promote non-terminal methods should be directed towards these

1	2	3	4
			target groups. Taking into account the fact that the birth rate continues to be static since 1977 despite the increase in couple protection rate during this period, the Committee desire that the Family Welfare Programme should be given a reorientation and projected as a programme taking care of the health and welfare of the parents and their children by emphasising the need for avoiding early pregnancy and spacing after the first child. The Committee also desire the programme functionaries to simultaneously motivate the couples with lesser number of living childrens, say 2 to adopt the terminal method.
6.	2.21	Health (Family Welfare) and Law and Justice	The 1981 Census figures highlight that the mean age of marriage for females in the country is 18.3 years and that about 51 per cent of married females are less than 19 years of age. The Committee feel that the low mean age of marriage for females in the country is yet another critical area requiring priority attention from the Government. Although the provisions of Child Marriage Restrain (Amendment) Act, 1978 prescribe 18 years as the minimum legal age for the marriage of the female, the Government have hardly taken recourse to enforcement of this law. According to the Revised Strategy for National Family Welfare Programme—Approach and Action Plan prepared by the Ministry, the existing provisions of the law are full of loopholes and the process of implementation of the Act is outmoded. Considering the fact that marriage at a higher age would help in reducing the birth rate, the Committee would urge the Government to initiate urgent steps to plug the lacunae in the existing law and ensure its proper implementation in the country. The Committee also desire the Government to closely examine the feasibility of introducing compulsory registration of marriages in the country. The compulsory registration of marriages would not only ensure observance of the legal requirement of minimum age at marriage but would also provide useful information to programme func-

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7.	2.22	Health (Family Welfare) and Human Resource Development (Deptt. of Education and Deptt. of Women & Child Development)	The Committee note that the studies made in the past have revealed that the higher female literacy brings down the rate of fertility. The Committee, however, find that female literacy in the country is as low as 24.82 per cent as per the 1981 census. Moreover, the social percaption to have male children is still pre-dominating factor in the society in retarding the growth of family planning. The Committee feel that it is imperative that intensive and effective measures are taken to bring about a radical change in the attitude of the people so as to project the female as an asset rather than a liability. The Committee have been informed that a National Perspective Plan for Women is being worked out in the Department of Women and Child Development to promote education and overall development of women. The Committee trust that the Government will initiate urgent steps to introduce this Plan in the near future so that the process of changing the social attitudes of the people towards females in set in motion with a view to affecting fertility behaviour in the country.
8.	2.23	Health (Family Welfare)	The Committee are concerned to note that while various socio-economic development programmes having a bearing on family planning have been initiated in various Ministries/Departments during different plan periods, the Government have not yet developed any administrative machinery to have closer intersectoral linkages and proper coordination of the programmes. The Committee have been informed that the matter relating to development of a mechanism for inter-sectoral integration of family welfare programme at Central and State levels is under consideration of Government of India. The Committee cannot but emphasise the urgent need for securing effective inter-sectoral coordination at all levels to attack the multi-dimensional population problem. The Committee trust that the necessary mechanism would be introduced soon. The Committee would also desire such a system at Central level to not only identify further areas where family planning could be introduced as an integral

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			activity but also to ensure that the socio-economic development programmes of others Ministries/Departments are restructured to motivate people in favour of small family norm. The Committee would like to be apprised of precise action taken by the Government in this regard.
9.	3.11	Health (Family Welfare) and Planning Commission.	The Committee observe that there has been wide gaps between the plan outlays and the actual expenditure on the Family Welfare Programme during different plan periods. While the programme could not absorb the various plan allocations upto the end of Inter-Plan period (1966-69), the actual expenditure exceeded the plan allocations during the Fifth and Sixth Plans. These wide gaps between the plan allocations and the actual expenditure are indicative of inefficient handling and defective planning of the Programme. It has been conceded by the Ministry that for 100 per cent achievement of the physical targets of terminal methods during Sixth Plan period, the excess expenditure over the plan-allocations would have been to the tune of Rs. 230.0 Crores. It is thus, apparent that physical targets had not been properly co-related to financial targets and that plan allocations have been made without proper appreciation of the needs of the Programme in totality. The Committee hope that the Government would in future provide for realistic plan outlays for family welfare with physical and financial targets duly inter-linked and inter-related.
10.	3.12	Do.	The Committee have also been informed that the present level of allocations is a major constraint in speedily implementing the various initiatives forming part of revised strategy for Family Welfare Programme. Notwithstanding the fact that the Seventh Plan allocations were finalised much before the formulation of revise strategy, the Committee do not accept the Planning Commission's view that additional resources for the Programme would be considered, *inter-alia*, on the basis of availability of funds. Considering the pressure and alarming consequences the population growth has on the socio-economic developmental plans in the country, the Committee desire that Family Welfare Programme should be given top priority in the allotment of resources which should be need

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			based rather than resource based. The Committee in this regard cannot but express deep anguish over the unabated growth of population in the country. As valuable time has already been lost without achieving the desired results, the Committee urge the Government to make available necessary resources in time so as to effectively tackle the gigantic problem and to implement revised strategy for Family Welfare Programme.
11.	4.6	Health (Family Welfare)	It is disquieting to note that the Ministry have not maintained various records and accounts relating to the release of assistance to various State/UT Governments and other bodies. The facts relating to non-maintenance of records of sales under Nirodh commercial Distribution Scheme, inadequate records of release of grant-in-aid to voluntary organisations and the absence of proforma accounts on Miscellaneous Purpose Fund is clearly indicative of lack of financial discipline in the Ministry. Non-preparation of ledger accounts is not a justification at all for failure to Match amount due against each distribution agency under the Nirodh Commercial Distribution Scheme because to discharge its responsibility, the Ministry should have ensured that proper control records were devised for the scheme in existence for the last two decades.
12.	4.7	Do.	What is still more disturbing is the fact that Ministry have not succeeded in proper accountal of the supplies in kind made available to the State/UT Governments. Although efforts for maintaining current records and accounts are stated to have been made by the Ministry, the fact however, remains that the Ministry have displayed an apathetic attitude towards general financial principles. Considering the fact that old records of the Ministry and the Medical Stores Depots are weeded out after three years and going by Ministry's own admission, the committee are inclined to conclude that it would be well nigh impossible for the Ministry to complete some of their old accounting records. The Committee wonder how weeding out of records would have been permitted when they

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			are needed for watching recoveries/ adjustments and whether the prescribed precautions were not observed before grant of sanction for weeding out. The Committee express their displeasure over the total lack of financial control in the Ministry of Health and Family Welfare (Department of Family Welfare) and recommend that a comprehensive report on the position in regard to the specific observations of Audit and action taken thereon may be furnished.
13.	4.8	Do.	In the circumstances, the Committee emphasise the need for earnest efforts to complete the accounting records as far as possible so as to effectively regulate the release of funds on Family Welfare Programme. The Committee would also like the Ministry to introduce an efficient system to keep a proper vigil over the general system of financial management and accounting control. The Committee also desire the Ministry to devise suitable ways and means to receive from the State/UT Governments timely information on the supplies in kind and its value received by them so that the financial sanctions issued by the Central Government can take into account the actual supplies in kind.
14.	5.13	Do.	The Committee note that various performance statistics on family welfare activities at different levels are being received through the States/Union Territories by the E & I Division of the Department of Family Welfare (MOHFW) with a view to carrying out the monitoring and evaluation of the F.W. Programme at Central level. However, the returns and manuals prescribed at the inception of the programme are continued to be used while the new MIES system, introduced in 1982, is yet to be effectively implemented in most of the States. This fact amply brings out that the Ministry have failed in taking appropriate and timely action in developing an information system in conformity with the changing requirements of the programme. The Committee are

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			now informed that the Department of Family Welfare has initiated action to rationalise and streamline the returns and manuals. The Committee would like to know the results of such an exercise as well as steps taken to introduce the new formats.
15.	5.14	Do.	The Committee observe that the performance data are compiled primarily at the peripheral units. During their visit to some of the PHCs in the States of Madhya Pradesh and Uttar Pradesh in January 1988, the Committee noticed that the records maintained at those centres were neither fully informative nor maintained in a manner so as to reveal vital statistics on various family welfare activities. Now that the Ministry intend to rationalise the various formats of records, the Committee hope that appropriate training courses for the workers and the supervisors from the peripheral level onwards would also be organised well in time so as to upgrade their skills in maintaining the relevant records.
16.	5.15	Do.	The Committee have been informed that in many States the Eligible Couple Registers (ECRs) even if maintained are not being updated systematically and that the supply of printed ECRs has been a problem due the financial constraints. The Committee consider that besides being a vital document for organising the working programme of family welfare field workers, a systematically maintained ECR can be an effective management tool in devising appropriate strategies according to the felt needs of the people in a particular area. The Committee trust that the Ministry would make available the necessary funds for supplying the printed registers besides ensuring that these registers are systematically maintained and periodically updated. The Committee would also like to point out that definite responsibility would have to be defined for personnel engaged in maintenance and supervision of these registers to ensure enforcement of accountability.

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17.	5.16	Do.	The Committee note from the Audit Paragraph that while the sample verification of acceptors by State D&E Cells was less than one per cent as against the prescribed limit of two per cent, the performance of the other two sample survey agencies viz., Central Evaluation Teams and Regional Health Offices also continued to decline in terms of percentage of acceptors selected for Verification in each successive year during the period 1980-84. In this connection, the Committee are unable to appreciate the reply of the MOHFW that the number of acceptors every year had been increasing whereas there had been no increase in the staff and that the fall in the percentage verification was inevitable. Keeping in view the growing dimensions of the programme, it is highly desirable that the activities of the evaluating agencies are periodically expanded and extended especially when the sample surveys are highlighting poor quality of services.
18.	5.17	Do.	The fact that as high as 53.30 per cent of sample cases could not be traced in a particular year due to wrong addresses etc., speaks volumes about the need to monitor and evaluate objectively the performance statistics of the Family Welfare Programme. To ensure vigorous monitoring of the implementation of the programme, the Committee desire that at least 10 per cent, of sample verifications of acceptors by all methods as well as beneficiaries of MCH services should be prescribed for the agencies engaged in evaluation of this Programme of national importance. This percentage of sample verification by the sample survey agencies must be insisted upon and the bottlenecks in achieving the desired level of performance of these agencies like shortage of staff etc., should be urgently removed. The Committee feel that an intensive and regular evaluation of programme backed by immediate and proper follow-up action against the erring officials would go a long way in improving the quality and effectiveness of the programme.

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19.	6.9	Do.	The Committee observed that although the awareness of the family welfare programme is stated to be over 90 per cent, there is still a wide gap between those who hold positive attitude and those who actually adopt family planning method. It is surprising that while 95 per cent of people are aware of terminal methods of both vasectomy and tubectomy, the awareness of non-terminal methods is lower being 54 per cent for condom followed by 43 per cent for IUD and 36 per cent for pill. What is more distressing is the fact that 62 per cent of people are not aware of the various MCH services being provided by the Government. These facts illustrate that the various components of the family welfare programme and MCH services have not been effectively delivered to the masses.
20.	6.10	Do.	Yet another disturbing feature is the long time-lag, varying as widely as two to eight years or more, involved between awareness and adoption. The fact that 'fears and misconception' is the main reason for non-adoption of family planning methods by a large number of persons demonstrates that the communication efforts made by the concerned agencies/functionaries have neither succeeded in removing misgivings nor/in imparting correct knowledge about the programme.
21.	6.11	Do.	As the "responsible and planned parenthood with two-child norm" is a new concept in the traditional Indian society, the Committee feel that the wide gap between the awareness and adoption of family planning calls for rethinking on the aspects of communication strategy. Besides disseminating information on various methods of family planning, the communication strategy must aim at removal of wide spread social and psychological barriers to the use of family planning services. The Committee, therefore, desire that the Government should take immediate steps to devise a suitable communication strategy which could reach and effectively deliver the messages required to bring about the

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			desired change in the family norms and motivate people to accept and adopt family planning before it is too late.
22.	6.15	Do.	In the opinion of the Committee, interpersonal media can provide vital support to individual communication needs of the people in an area so sensitive as marital relations and reproductive behaviour. The Committee note that the reach of interpersonal media is poor and that these channels were used only to create general awareness rather than in personalising communication needs and motivating the people. The Committee conclude that the potential of this media has been only marginally exploited. The Committee, therefore, desire that suitable steps should be taken to improve the effective use of this media by equiping the peripheral level staff through appropriate training and regular reorientation on all aspects of the family welfare programme. The main plank of the interpersonal media should be to inform the eligible couples on all the methods of family planning clearly differentiating between terminal and non-terminal methods so as to remove the widespread hesitations superstitions and fears in the minds of non-adopters of family planning. The Committee also desire that an effective supervisory system should be devised to improve the performance of these workers besides increasing their reach to cover all the eligible couples in their area.
23.	6.16	Do.	Keeping in view the fact that advice and experience of the adopters of family planning can be much more convincing than only guidance and education, the Committee feel that the involvement of adopters as voluntary extension agents of family planning programme would have a better effect on the non-adopters. With this end in view, the Committee recommend that a suitable scheme should be drawn to use the adopters for propagating family planning among non-adopters. A package of better health and follow-up care alongwith some incentive to the adopters can induce them to play the role of voluntary extension agents of the family

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			planning programme. Besides being effective, such a scheme would be viable in economic terms.
24.	6.30	Health (Family Welfare)/ Information & Broadcasting.	The Committee note that the MOHFW have been providing additional inputs to the various media units of the Ministry of I&B in accordance with the pattern of activities formulated under the multimedia programme for stepping up the campaign on family welfare programme. The provision for additional inputs to the Ministry of I&B has been reviewed from time to time and the financial support adjusted accordingly. In 1986-87, the budgetary support to Ministry of I&B was reduced by the MOHFW on the grounds that sufficient support was not coming from the media units and that the Ministry of I&B should provide motivational support to the Family Welfare Programme from their own funds. The financial support to I & B was subsequently raised to original level in consideration of the fact that sudden withdrawal of funds would give a set back to motivational programme. The Committee further note that the MOHFW have also to pay for their programmes in advertisement format on commercial channels as per normal rules except where free time is allotted on radio or television.
25.	6.31	Do.	The Committee consider that neither the grounds for withdrawal of budgetary support in 1986-87 nor the grounds for restoration later were based on reasoned thinking and on a practical approach for implementation of such serious programmes as family welfare. The Committee consider that the problem of population control is a primary issue before the nation and every Ministry / Department of the Government have to contribute their share in propagating the messages of Family Welfare Programme. The Ministry of I & B being responsible for dissemination of information for raising the

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			level of people's consciousness, have a vital role in mobilising popular support in favour of family planning. The Committee would accordingly emphasis the need for very close coordination between MOHFW and Ministry of I & B and desire that the various media units of the Ministry of I & B should be strengthened with a view to further stepping up the family welfare compaign in coordination with the MOHFW. Given the resource constraints, the Committee would also like the pattern of providing additional inputs to various media units of Ministry of I & B reviewed in consultation with the Planning Commission.
26.	6.32	-Do-	The Committee are of the view that promotion of family welfare programme has to be obligatory for all official mass media channels especially radio and television which can not only cross the barriers of illiteracy but also have a comparatively wider and more powerful reach than other channels. In the opinion of the Committee, the present allocation of time for family welfare programmes on radio and television is rather low and this area needs improvement. The Committee would therefore like the Ministry of I & B to allocate fixed minimum time along-side qualitatively improving the programmes on radio and television for giving communication support to the various dimensions of family welfare programme. The Committee are of the opinion that promotion of this programme of national importance should not be viewed in a commercial context and maximum support should be given for spreading the messages deemed necessary to control the population growth. The Committee would like the Government to consider allotment of free time on commercial Broadcasting Service of AIR (Vividh Bharati) which has a mass appeal particularly in the rural areas. The Committee would also like the timings of broadcast / telecast on the family welfare programmes to be so adjusted as to have full impact on the target groups. The Committee would urge the Ministry

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			of I & B to take immediate and appropriate steps for greater and effective utilisation of these channels in consultation with the MOHFW and to use most of the popular programmes to spread the messages appropriate for acceptance of family planning over a wide millieu.
27.	6.33	-Do-	The Committee consider that involvement of well-known personalities from different fields such as films, sports, politics etc. in propagating social and family planning messages through mass media channels would go a long way in creating better impact on the audience. The Committee would like the Government to initiate necessary action in this regard better impact on the audience. The Committee would like the Government to initiate necessary action in this regard.
28	6.38	-Do-	The Committee note that although about 19 per cent of the family welfare subjects on the original production programme of the Films Division during the period 1980-84 were either deleted or deferred, the Films Division could not complete even this reduced production programme in time. In addition, there was also delay in supplying the prints of the films. The Committee feel that the reasons given for slow progress in Films Division are such as could have been foreseen and avoided by proper planning on the part of the executing agency. The Committee hope that concrete measures would now be taken by the Ministries of Health and Family Welfare and I & B to ensure that Films Division take appropriate steps for timely production and distribution of films on family welfare.
29	6.39	-Do-	The Committee further note that the film medium is being used in family welfare programme for a considerable period of time and that the Department of Family Welfare have produced family welfare films through Films Division and arranged for their screening through various units of Family Welfare Bureaux etc. Yet a recent study has revealed

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			that a majority as large as 73 percent has reported never seeing a family planning film. Even the limited exposure to family welfare films has not been organised properly as the necessary discussions alongwith the film show took place only in about 50 percent of the cases. What is still more disquieting is the fact brought out by the study that the films seemed to be out of pace with the changing requirements of the programme. It is obvious from these facts that the use of this medium has been quite disproportionate to the heavy investments made in it. Accordingly the Committee desire that study on the cost-benefit ratio of the medium of the film as against other mass-media channels like Radio and Television may be conducted with a view to ensuring that the expenditure on various mass-media channel is effectively utilised.
30	6.40	-Do-	The Committee also feel that special care should be taken to make these films more imaginative and interesting with a view to creating desired impact on the audience as also to make them more receptive to the concept, desirability and methods of family planning. The Government may also examine the feasibility of utilising the services of eminent personalities in the field so that the films have much greater impact.
31	6.41	Health (Family Welfare)	In the context of the majority of population of India being in rural areas, the Committee consider it necessary for the MOHFW to ensure that an intensive programme for regular screening of Family Planning shorts in all villages is drawn and executed without linking such screening with the special week drives alone.
32	7.32	-Do-	The Committee are concerned to note that adequate health infrastructure through which family welfare services are offered, has not yet been provided both in rural and urban areas in the country. During evidence, the representative of the MOHFW stated that the required infrastructure would be available by the end of the Seventh Plan. The Committee apprehend that since the targeted additions for the sub-

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			centres and PHCs during the Seventh Plan are substantially higher than the achievements in establishing the aforesaid centres during Sixth Plan period, it may not be possible to achieve the targets. The Committee further note that certain components of rural health infrastructure are covered under Minimum Needs Programme, which is a State Sector Programme, and the State Governments sometimes express their inability to provide funds for the purpose due to resource constraints. The non-availability of medical and para-medical staff is also stated to be an area of concern as no centre is considered functional unless the sanctioned staff is in position.
33	7.33	-Do-	The Committee urge the Government to take care of the anticipated difficulties in advance and initiate proper action after due consultation with the State Governments and other concerned agencies so as to ensure timely completion of the planned health infrastructure which would go a long way in ensuring smooth implementation of family welfare programme. Simultaneously, concerted efforts should also be made to arrange adequate training facilities and placement of medical and para-medical staff upto the sub-centre level so as to make the infrastructure really operational.
34	7.34	-Do-	The Committee have been informed that the land for establishment of health centres is required to be donated and in certain cases it may be located out of reach of the community thus leading to non-utilisation or under-utilisation of the facilities. The Committee would like the Ministry to evolve a proper system of assessing the suitability of site before taking up construction of the project.
35	7.35	-Do-	The Committee note that voluntary organisations have been playing a significant though limited role in programme implementation especially in urban areas. The Committee further note that in addition to constituting a committee

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			to formulate models for guidance to voluntary organisations, the MOHFW have also provided rolling funds to the Family Planning Association of India to encourage involvement of small voluntary organisations in the family welfare network. While appreciating these steps, the Committee feel that there is urgent need to initiate further concrete steps for larger involvement of voluntary organisations so as to supplement the Governmental efforts in providing family welfare services especially in the areas where programme infrastrucure is weak inadequate or non-existent.
36	7.36	-Do-	The Committee note that grants-in-aid to voluntary organisations are released under the approved patterns schemes which do not provide for grants to these organisations for MCH services. The Committee consider that the involvement of voluntary organisations in the family welfare programme would be handicapped until the delivery of complete services under family welfare are made available by these organisations to the population they serve. The Committee would like the MOHFW to review their schemes for release of grants to voluntary organisations in the light of changing requirements of the programme and also to encourage the existing and the new voluntary organisations to undertake family welfare activities on a continuing basis preferably in unserved areas. The Committee also desire the MOHFW to develop a suitable system which should not only provide guidance but also periodically review both the physical and financial performance of voluntary organisations.
37	7.37	-Do-	The Committee are constrained to observe that in spite of heavy investments on family welfare services the existing infrastructure and facilities have not been optimally utilised by the people due to reasons like inaccessibility, poor quality of services and lack of appropriate follow-up care. The Committee also gather from Audit that laparoscopic tubectomies have been performed at various services PHCs far in excess of

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			prescribed norms and follow up services to accepters of family planning were not provided to as large a percentage as 61. From these facts, the Committee are inclined to conclude that there is no effective administrative control over the programme implementation machinery to ensure the compliance of medical and technical requirements.
38	7.38	Do-	The Committee consider that certain family planning methods require proper medical interventions at various stages and a proper delivery of services is very essential not only to enlarge the acceptability of the programme infrastructure but also to generate demand in favour of adoption of family planning. Every endeavour should be made to ensure the suitability of a person for a particular family planning method so as to avoid any mishap creating demoralising effect on others. The Committee desire that comprehensive guidelines on medical and technical aspects of various family planning methods be made available to programme functionaries in the first instance. The Government should also clearly define the job responsibilities of all categories of medical and technical staff so as to pin-point their accountability in cases of inadequate delivery of services. The Committee would also like the supervisory system to be strengthened and expanded so as to monitor and enforce the quality of services delivered through the programme infrastructure. The findings of sample surveys on deficiencies in implementation of programme should be brought to the notice of concerned State Governments as soon as detected and remedial measures, including disciplinary action against erring officials, ensured.
39	7.39	-Do-	The Committee further note that technical and communication skills of the programme functionaries are identified as the most critical areas requiring improvement. As both these skill cover the entire gamut of the programme implementation, the committee desire that in ser-

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			vice reorientation training programmes at regular intervals should be organised to improve the capabilities of the service personnel.
40	7.40	-Do-	The Committee are concerned to note that 'cold-chain' system for retaining the potency of the vaccines have not been properly maintained at various health centres. The non-availability of various equipments and defective refrigeration facilities calls for due attention towards scientific management of inventories. The Committee desire that some sort of financial powers to the doctors at PHC level should be delegated so as to enable them to discharge their responsibilities of management effectively.
41	7.41	-Do-	The Committee also feel that the programme requirements have considerably expanded thus necessitating inproved mobility of the programme functionaries. While the public transport system in certain areas is not adequate to cater to the needs of these functionaries who have a large jurisdictional area, the use of vehicles supplied under the programme may be a costly proposition. The Committee suggest that a system of providing loans to para-medical staff etc. for purchase of bicycles or mopeds for their official use would enhance the mobility and efficiency of these workers. The Committee would like that while a fixed allowance for POL costs may be granted to workers, the responsibility for keeping the vehicles in order should squarely rest with the concerned officials.
42.	7.42	-Do-	The Committee are deeply concerned at the poor programme performance in the 4 major States of Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh. These States which account for about 40 per cent population of the country, have substantially higher infant mortality and birth rates and lower couple protection rates in comparison to national levels. According to a study conducted in 1985 by Indian Institute of Management, Ahmedabad on facility utilisation and programme management in these four States, the poor quality of services and lack of

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			appropriate follow-up and care in these States has not only resulted in relative under-utilisation of health facilities but have also lowered the credibility of health infrastructure. The Committee are informed by the Ministry that follow-up action on the findings of this study report lies primarily with the State Governments concerned and the role of the Ministry is merely confined to ensuring that follow-up action on the points contained in the study report is taken by the respective State Governments. However, these States have been allotted to two Joint Secretaries in the Ministry who in addition to their normal duties, review periodically the follow-up action as and when they go on tours to these States. The Committee are not at all satisfied with this casual approach of the Ministry towards these low performing States and are of considered view that the programme management in these States needs serious attention for improving their current levels of performance.
43.	7.43	-Do-	The Committee therefore, recommend that a special cell comprising experts under the charge of a Joint Secretary be created in the Ministry of Health & Family Welfare (Department of Family Welfare) exclusively for these four States with the objective of ensuring proper supervision and effective monitoring of programme implementation in these States. Besides providing suitable guidance, the proposed cell should ensure that attention is given on priority basis to these States in the matter of providing adequate system of delivery of services relating to family planning including MCH, giving publicity through various media units of Ministry of I & B, encouraging involvement of voluntary orgainisations etc.
44.	7.44	-Do-	For the effective and efficient functioning of the Special Cell recommended in the preceding paragraphs, there is need for setting up similar cells at the State level also. The Committee

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			would like the Ministry to persuade these four State Governments to establish similar cells at Secretariat or Directorate level to oversee and monitor the implementation of the programme by the peripheral units. For meeting the additional expenditure on the cells so created, adequate financial assistance should be provided by the Ministry to the State Governments concerned so that the programme is not hamstrung for want of funds. The Cell should identify the specific problems, if any, experienced by the peripheral units and the difficulties being encountered in the programme implementation and tackle them by suitably modifying the strategies according to the realities of the situation so as to speedily improve the programme achievements. If need be, the special cell in the Ministry of Health & Family Welfare may be consulted in this regard.
45.	7.45	Health (Family Welfare) Dept. of Personnel.	The Committee consider that the Family Welfare Programme should be taken as a national movement and a willing and determined cooperation should be obtained from the people from all walks of life. Since the main stress of the programme is essentially in villages and the acceptance of small family norm is intrinsically connected with the socio-economic development, the Committee are of the view that a committed involvement of administration is very vital for the rural population to be suitably educated on the family welfare measures and the objectives of the programme. The Committee therefore, recommend that a scheme aimed at providing overall guidance on the socio-economic measures being initiated by the Government for the rural people, may be formulated with a view to promoting wider acceptance of small family norm in rural India. The proposed scheme should involve civil servants above a particular level who may be asked to adopt a set of 3 to 4 villages for overall development. Such officials must visit the adopted villages once a month and interact with people on the entire range of the socio-economic development programmes being im-

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			plemented by the Government for the rural population. These officers may also seek the active cooperation of the village heads and Panchayats in propagating the programme.
46.	7.46	Health (Family Welfare)	The Committee are of the opinion that this gigantic task cannot be accomplished solely by Government efforts and it is imperative that private and public sectors are equally made conscious of the programme as a national commitment for whole-hearted support and implementation. The Committee, therefore, desire that the involvement of private and public sector industries particularly the major groups, should be sought and a scheme drawn up for implementation of the programme by them in their respective organisations.