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ESTIMATES COMMITTEE
(1958-59)

FORTY-FOURTH REPORT
(SECOND LOK SABHA)

MINISTRY OF HEALTH
PUBLIC HEALTH

PART II

LOK SABHA SECRETARIAT
NEW DELHI
March, 1959
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CORRIGENDA
TO
FORTY-FOURTH REPORT OF THE ESTIMATES COMMITTEE ON THE MINISTRY OF HEALTH ON THE SUBJECT "PUBLIC HEALTH" PART II

Page (ii), line 4; for 'Pl ns' read 'Plans'
Page 3, para 9, line 4; for 'allowed' read 'followed'
Page 5, line 1; for 'viz...' read 'viz.'
Page 5, para 18, line 3; insert ',' between 'be' and 'not'
Page 10, para 33, line 12; for 'subsidise' read 'subsidised'
Page 12, para 36, line 7; for 'from' read 'form'
Page 12, para 37, line 6; delete '.' between 'between' and 'Primary'
Page 32, para 97, line 3; for '.' between 'However' and 'random' read ','
Page 33, para 102, line 4; for 'nutrition' read 'nutritious'
Page 36, para 110, line 28; for 'excise' read 'exercise'
Page 41, line 33; delete ',' after 'Advisory'
Page 49, Activity (i), line 2; for 'tices' read 'practices'
Page 51, line 1; insert ',' between 'Medical' and 'Annual'
Page 55, S.No.2, line 5; for 'formula e' read 'formulate'
Pages 56-67, head lines; insert '1', '2' & '3' in the lines provided, for three columns respectively.
Page 61, S.No.32, line 1; for 'ommittee' read 'Committee' and for 'wou d' read 'would'
Page 63, S.No.43, line 6; for 'thay' read 'that'

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* Elected w.e.f. 28.8.1958 *vice* Shri Mahavir Tyagi resigned.
** Elected w.e.f. 17.9.1958 *vice* Shri J. Rameshwara Rao resigned.
@ Elected w.e.f. 23.9.1958 *vice* Smt. Renuka Ray resigned.
@@ Elected w.e.f. 23.9.1958 *vice* Shri Nemi Chandra Kasliwal resigned.
† Elected w.e.f. 17.12.1958 *vice* Shri Vijayram Raju resigned.

INTRODUCTION

I, the Chairman, Estimates Committee, having been authorised by the Committee to submit the Report on their behalf, present this Forty-fourth Report on the Ministry of Health on Public Health Part II.

2. The Committee wish to express their thanks to the Secretary and other officers of the Ministry of Health for placing before them the material and information that they wanted in connection with the examination of the Estimates. They also wish to thank the representatives of the Indian Medical Association for giving evidence and making valuable suggestions to the Committee.

BALVANTRAY G. MEHTA,
Chairman,
Estimates Committee.

NEW DELHI;
The 13th March, 1959.
Phalguna 22, 1880 (*Saka*).

I. MEDICAL RESEARCH

A. *Historical Background*

The present organisation of medical research in India is the result of progressive development over the last 60 years. In the beginning, it was mainly in the hands of some British I.M.S. Officers who either carried out research work of their own or were deputed by the Government of India with some special assignments. In 1897, Ronald Ross, while working in Secunderabad, discovered that the mosquito transmitted malaria. Haffkine invented vaccine for plague in 1899.

2. The first bacteriological laboratory in India was founded at Agra in 1892. Later, in 1900 the Pasteur Institute of India was opened at Kasauli. Kasauli was also selected for the Central Research Institute which was established there in 1906. In Bombay, a laboratory was opened for the manufacture of plague vaccine on a large scale as a result of Haffkine's invention.

3. An important step in the direction of advancement of medical research was taken by the Government of India in the creation of Indian Research Fund Association in 1911. The objects in establishing it were to initiate, aid, develop and co-ordinate medical scientific research in India, to promote special inquiries and to assist institutions for the study of diseases, their prevention, causation and remedy. Over a number of years the Indian Research Fund Association (I.R.F.A.) together with the Medical Research Department of the Government of India formed the main base for the organisation of medical research in the country. For well over three decades, the Association, although hampered by its limited resources, continued to sponsor a variety of researches in the field of medicine and public health on a limited scale.

4. The Bhore Committee observed in 1945 that the number of suitable medical research workers and facilities for training them were inadequate. That Committee regretted the almost complete absence of research in medical colleges and the lack of facilities for training young alert minds in the country in the scientific approach to the study of medical problems, and referred to the serious diminution of research in Central and Provincial Laboratories which were becoming increasingly pre-occupied with the manufacture of biological products required by State Governments for medical and public health use. It emphasised the need for undertaking research on a broader basis and for making funds freely available for the purpose.

B. *Indian Council of Medical Research*

5. In 1950, the name of Indian Research Fund Association was changed to Indian Council of Medical Research which was established

as a registered body under the Societies Registration Act, XXI of 1860. The chief aims and objects of the Council as set forth in its Memorandum of Association, are as follows:—

(i) The prosecution and assistance of research, the propagation of knowledge and experimental measures generally, in connection with the causation, mode of spread, and prevention of diseases, primarily those of communicable nature;

(ii) To initiate, aid, develop and co-ordinate medical scientific research in India and to promote and assist institutions for the study of diseases, their prevention, causation and remedy;

(iii) To finance enquiries and researches;

(iv) To exchange information with other institutions, associations and societies interested in the same objects, and especially in the observation and study of diseases in the East, and in India in particular;

(v) To offer prizes and to grant scholarships, including travelling scholarships, in furtherance of the objects of the Council; and

(vi) The doing of all such other lawful things as are incidental or conducive to the attainment of the above objects.

6. The constitution, scope and functions of the Council are given at Appendix I. From the membership of the Governing Body and Scientific Advisory Board of the Indian Council of Medical Research it is seen that experts of Ayurvedic and other indigenous systems of medicine are not represented on the Council. As these systems for treatment of the disease are also useful and important and are being given recognition by the Government of India, *the Committee are of the opinion that it would be useful, if some qualified experts of Ayurvedic and other systems are appointed on the Governing Body of the Council so that researches in these systems of medicine can be properly directed and intensified. They suggest that a special Advisory Committee of the Indian Council of Medical Research may also be constituted for research in Ayurvedic and other indigenous systems of medicine.*

7. The Committee learnt that the Governing Body of the Indian Council of Medical Research meets only once a year. *The Committee recommend that it should meet more frequently to assess and guide the research programme more actively and also to formulate research programme for future needs of the country. Similarly the Scientific Advisory Board and Advisory Committees which also meet once a year should meet more often to tackle comprehensively the current research problems and also to prepare plans for future according to the changing needs of the country.*

8. The Committee were informed that the recruitment of staff to the Indian Council of Medical Research was not made through U.P.S.C. The selection was made by a Sub-Committee but the final selection was made by the Director on the basis of the recommendations of the Sub-Committee. The Members of the Selection Sub-Committee consist of departmental people only. *The Committee are of the opinion that it would be desirable to associate some non-officials and heads of other research institutions on the Selection Sub-Committee of the Indian Council of Medical Research.*

9. In order to attract the best talent for appointments in the Council, all the posts were advertised in all the leading English papers. The list of newspapers maintained by the Ministry of Home Affairs for issuing advertisements was being allowed by the Council. The Committee noted that the advertisements were not issued in the Indian language papers. *The Committee suggest that advertisements for recruitment to vacancies in the Indian Council of Medical Research may be issued in all the important news papers including Indian language papers, within the normal allotment of funds.*

10. The Committee were informed that the Indian Council of Medical Research is largely responsible for Medical Research in the country. But they find that a large number of Institutions conducting medical research are at present under the control of the Council of Scientific and Industrial Research *viz.*, the Central Drug Research Institute, Lucknow, the Indian Institute of Biochemistry and Experimental Medicine, Calcutta, Public Health Engineering Institute, Nagpur, Central Food Technological Research Institute, Mysore, etc. *The Committee feel that the Institutes which conduct researches in health matters should be under the Ministry of Health. The Committee, therefore, suggest that the feasibility of transferring the Central Drug Research Institute, Lucknow and other institutions which deal mainly with health problems from the Council of Scientific and Industrial Research to the Indian Council of Medical Research under the Ministry of Health may be examined by the Government.*

C. *Activities of the Council*

11. The objects of the Council are two-fold, firstly to find out the medical and health problems of the people with special reference to applied sciences and to prepare plans for their research and secondly to find solutions to public health problems. In India, as communicable diseases and mal-nutrition are the causes of a large number of deaths and produce great adverse effect on the health of the nation, solutions to public health problems are of special importance.

12. *The Committee feel that the work in the field of medical research is being done in an* ad hoc *manner. There is a pressing need for nation-wide planning and co-ordination among all research institutions in the country, especially as there are certain problems which are of interest to the Indian Council of Medical Research, the Council of Scientific and Industrial Research and the Indian, Council of Agricul-*

tural Research in their different aspects. For instance, proper disposal of human excreta is of great interest from the point of view of Public Health. It is of interest to the Council of Agricultural Research because of its manurial value and to the Council of Scientific and Industrial Research who would have to produce less synthetic manures if more of natural manures can be made available. *The Committee, therefore, recommend that the research work may be done in a comprehensive and co-ordinated manner and suitable priorities fixed for tackling various subjects of research and allocating them to the various institutions.*

13. *The Committee feel that the work of co-ordination between Indian Council of Medical Research, Council of Scientific and Industrial Research and Indian Council of Agricultural Research is of considerable importance. The Committee were informed that in the meeting of the Sub-Committee of the Governing Body, a proposal was put forth that it would be desirable to have a Standing Committee of Directors of the three Councils—I.C.A.R., C.S.I.R. and I.C.M.R. The Committee suggest that the Ministry of Health and other Ministries concerned should take early steps to set up this Standing Committee and include in it certain non-official members also to achieve better co-ordination.*

14. *The Committee also suggest that it would be useful to have once in a while, a joint conference of the members of the C.S.I.R., I.C.A.R. and I.C.M.R., for discussing common problems including items of research which might be of interest to all, with a view to maintain close co-ordination and also to avoid overlapping of efforts.*

D. *Financial Assistance to the Institutions*

15. One of the chief objects of the Council is to give financial assistance for medical enquiries and researches to research institutes and medical colleges. The two institutions, *viz.*, (i) The Nutrition Research Laboratory, Coonoor and (ii) the Virus Research Centre, Poona are, however, entirely maintained and controlled by the Council. The Council invites each year proposals from medical colleges, research institutions and other interested workers all over the country for carrying out research in medical and allied scientific subjects. Such of the proposals, as are approved by the Scientific Advisory Board of the Council, are given financial assistance.

16. With regard to the maintenance of research institutions under the direct control of the Indian Council of Medical Research, *the Committee are of the view that the Council should not burden itself with the day to day administration of research institutions. Its main functions should be (i) the formulation of policy in regard to the future development of medical research in India, (ii) stimulation of research activities in the States, universities and medical colleges, and (iii) co-ordination of such research activities throughout the country as recommended by the Bhore Committee. The Committee, therefore,*

suggest that the two institutions, viz. . . (i) The Nutrition Research Laboratory, Coonor and (ii) The Virus Research Centre, Poona at present under the control of the Indian Council of Medical Research, should have their own governing bodies instead of being managed directly by the Council.

17. The Indian Council of Medical Research has also been maintaining the two Professional Chairs (i) the Chair of Bacteriology and Pathology, and (ii) the Chair of Protozoology at the School of Tropical Medicine, Calcutta, since 1922-23. The Committee understand that at present no specific period or time has been earmarked for research work by the two professors apart from attending to routine duties. *The Committee suggest that the whole position may be reviewed with a view to ensuring that the professors maintained by the Indian Council of Medical Research devote sufficient time to research. They should be mainly engaged on research work for fulfilling the object of the establishment of the Chairs by the Indian Council of Medical Research.*

E. *Medical Research on National Basis*

18. According to Dr. A. L. Mudaliar, the approach to the problems of medical research should be more broad-based and that the manner in which medical research is to be encouraged should be not merely by assisting individual workers in different places, but by establishing centres of medical research with full time workers. The Committee agree with these views and *suggest that the approach of the Indian Council of Medical Research should be more broad-based and the manner of encouraging medical research by assisting individual workers in different places may be combined with the establishment of centres of medical research with full time workers who will be available for tackling specific problems in the field of medical research. In this connection the Committee also suggest that the feasibility of establishing a chain of laboratories doing medical research on the same lines as is done by the Council of Scientific and Industrial Research may be examined.*

19. Medical Research, both in quality and in quantity, in this country, cannot be compared with the research activities in many of the other advanced countries of the world. *The Committee, therefore, suggest that medical research should be taken up on a national scale and every medical institution and medical research scholar properly utilised so that some substantial results may be produced. The feasibility of having more schemes and wider fields of work with better finances being made available for this purpose in the Third Plan should be examined.*

20. The Committee understand that private pharmaceutical concerns or drug houses in foreign countries conduct research and spend millions of pounds and dollars on the discovery of new drugs. The funds which are utilised for such researches, in case they are liable to tax, are exempt from taxes in some of the Western countries.

This exemption serves as a stimulant to private concerns to utilise more money for research purposes. *The Committee suggest that Government should examine the question of tax relief in its application to our country.*

F. *Manufacture of Drugs discovered by I.C.M.R.*

21. With regard to the practical use of the results of the research in medical, public health and nutritional fields being made for the welfare of the people in the country it has been stated that the researches made by the Council are made known to the people and the State and Central Governments through various means. The Committee understand that the results of medical research are not being promptly utilised and made available for the use of common man. *The Committee are of the opinion that it would be desirable for the Government to undertake manufacture on a 'no prifit, no loss' basis of drugs etc. discovered as a result of various useful researches carried out with the help of Indian Council of Medical Research. Factories attached to the Medical Stores Depots of the Ministry of Health and other institutions like the Haffkine Institute, Bombay, and the School of Tropical Medicine, Calcutta may be utilised for the purpose. The Committee suggest that the Indian Council of Medical Research should undertake investigations to find out suitable ways and means of large scale application of the findings as a result of medical research and to that end an extension service similar to that adopted by the institutions under the Council of Scientific and Industrial Research should be instituted. The Committee also recommend that some machinery should be devised to encourage private pharmaceutical concerns to utilise the results of the researches made under the guidance of the Indian Council of Medical Research so that the benefits of the same may be made available to the common man without undue time lag.*

G. *Central Medical Library*

22. The Indian Council of Medical Research maintains a Library at the Central Institute, Kasauli. There are about 5,000 books in the Library. The Library has been built up with considerable efforts spread over many years and has a large number of old journals besides the books. The Committee understand that there is a proposal to move the Library to Delhi and amalgamate it with the Central Medical Library, Delhi, as and when it is established.

23. As there is no proper medical library to loan books to research workers in the country, *the Committee recommend that the proposal to establish the Central Medical Library should be expedited and the feasibility of opening branches of this Library in the five zones of the country explored.*

H. *Miscellaneous*

24. *The Committee are of the opinion that it is desirable that a policy be laid down to have non-technical administrative help in the*

medical colleges apart from the technical people to relieve the professors and principals of their routine administrative burden and thus enable them to devote more time to research and teaching. Suitable steps may then be initiated in consultation with the State Governments and the universities for the implementation of this policy.

25. The Government of India has established in Delhi the Indian National Documentation Centre under the control of the Council of Scientific and Industrial Research. The Committee were informed that the medical section of the Indian National Documentation Centre is not yet fully developed. The Indian Council of Medical Research is still carrying out the medical aspect of the work of this Centre as the Centre is not yet able to take over such work. *The Committee suggest that early steps should be taken to transfer this work to the Indian National Documentation Centre to which it legitimately belongs. Expert medical opinion should be made available to the Documentation Centre to enable it to assess the value of the medical documents.*

26. In the past there was a general paucity of experienced doctors in India. The opening of a number of new medical colleges and institutions during the First and Second Plan period has caused a further drain on the existing medical personnel of the country. Further the establishment of a number of national laboratories and technological research institutes has made the position still more acute. In the circumstances, experienced medical personnel are not available, which are greatly needed for work in medical research. *The Committee, therefore, suggest that in view of the general shortage of experienced medical personnel in the country, the knowledge and experience of outstanding retired medical personnel might be utilised on full or part-time basis for rapid development of medical research work, provided the legitimate aspirations of younger men are not unduly thwarted.*

II. PRIMARY HEALTH CENTRES

A. Introduction

27. The idea of developing Primary Health Centres as the focal points for the development of curative and preventive health services in the rural areas was presented in concrete form for the first-time by the Health Survey and Development Committee in 1946. The attainment of the objective of covering the countryside by such Centres in the form in which it was visualised by that Committee has, however, not been possible so far. In the Community Development Programme initiated in the beginning of the First Plan, the provision of a Primary Health Centre was included as an essential part. A scheme for health survey in Community Project areas was also included in the First Plan for assessing the contribution of Community Projects to the development of the health of the people.

28. When the Community Development Programme was extended in the form of National Extension Service Blocks, financial considerations precluded the provision of a Health Centre in each Block. The absence of such centres was, however, keenly felt and it was considered that without them the utility of the development blocks would be reduced considerably. The Ministry of Health, therefore, formulated a scheme for the establishment of Primary Health Centres in selected National Extension Service Blocks in 1954, and a sum of Rs. 50 lakhs was provided in the revised First Plan of the Ministry of Health for the grant of subsidy to States for opening such Centres. The scheme envisaged the establishment of a Health Centre with a dispensary at the headquarters of the Block area with an average population of 66,000 from where a team of health workers would cover the surrounding area, looking after the health needs of the area in both curative and preventive aspects. Seventy-four centres were established during the First Plan period by various States with Central assistance.

29. In the Second Plan, a provision of about Rs. 19 crores has been made for the establishment of about 2,000 Primary Health Centres in the National Extension areas in the States. During 1956-57 and 1957-58, 152 and 284 Cenres were opened respectively by the State Governments. Apart from the Primary Health Centres in the N.E.S. Blocks which were proposed to be opened by the State Governments with Central assistance during the Second Plan, it was also proposed to open approximately 1,000 Centres in Community Development Areas under the Ministry of Community Development. The Committee, however, learnt that with effect from the 1st April, 1958, the distinction between the N.E.S. Blocks and Community Development Blocks has been abolished. According to the new arrangement with effect from that date, two stages in the programme, namely Stage I and Stage II have been proposed for the development of Community Development Pro-

grammes in the States. Stage I will be the intensive development stage, while Stage II will be the post-intensive stage. It has been stated by the representative of the Ministry of Health that the budgets of the Ministries of Health and Community Development in this respect have been pooled and now the assistance is given on a uniform pattern. It is now expected that 3,000 Primary Health Centres will be opened by the end of the Second Plan. *The Committee recommend that a quarterly assessment of progress, made in the opening of new Centres, should be made, if the tempo is to be sufficiently increased to reach this target. Further the Committee recommend that the entire country should be covered by Primary Health Centres as quickly as possible without lowering the staffing pattern of these Centres and for this purpose a suitable target date may be fixed in consultation with the State Governments. Availability of medical personnel should be carefully taken into consideration while fixing the target date.*

30. The Committee learnt that there is no proper machinery to evaluate the work of the various Health Centres opened in the N.E.S. Blocks. Assessments are made from time to time with the assistance of UNICEF by sending some officers from the Directorate General of Health Services and the UNICEF representative. *The Committee feel that an objective study of the functioning of Primary Health Centres is necessary to evaluate the work done by such Centres so far, and learn from the experience gained. They, therefore, suggest that some organisation like the Programme Evaluation Organisation for the Ministry of Community Development may be established for the Ministry of Health for this and such other purposes.*

B. *Location of Primary Health Centres*

31. The Committee understand that at present in certain areas, a Primary Health Centre is located at a place where a dispensary already exists although there are many places in the area without this facility and further some of the Centres are not even located at a central place. *The Committee suggest that the location of a Primary Health Centre should be carefully worked out, to provide medical facilities to all in a comprehensive manner taking all relevant factors into account.*

C. *Staff Pattern*

32. The Bhore Committee had recommended 6 Medical Officers for a long term programme of Primary Health Units and 2 Medical Officers for their short-term programme. It has, however, been explained that due to practical difficulties, such as paucity of medical practitioners and limited financial resources, the staff at each Primary Health Centre has been limited to the minimum health staff under one medical officer. At present each Primary Health Centre consists of one medical officer, one health visitor, 4 midwives, one compounder, one sanitary inspector and other ancillary staff. As only one doctor is sanctioned, the Health Centre remains without any doctor if the only doctor at its disposal falls ill or is otherwise not

available. Besides, one doctor cannot do justice to his duties at the Primary Health Centre which according to the Scheme are as under:—

> "The Medical Officer will be incharge of public health and medical activities in his area. Regular visits will be paid by the medical officer and by the health visitor (or nurse) to the sub-centres for the purpose of supervising and guiding the work of the auxiliary nurse-midwives, giving them all the necessary assistance and consultation. The medical officer will be responsible for the promotion of all measures designed to prevent and combat communicable diseases in the area under his charge. He will also hold clinics for the local population and that of surrounding villages. He will guide and supervise the activities of the sanitary inspectors and will maintain the necessary liaison with the nearest hospital and with the district public health services, including the public health laboratory where one has been established."

The Committee, therefore, suggest that the feasibility of having two doctors one of whom should be preferably a woman, at each Health Centre, should be examined.

D. *Financial Implications*

33. The Committee learnt that prior to 1st April 1958, the pattern of Central assistance to the State Governments was a subsidy of 75 per cent of the initial non-recurring expenditure upto a total of Rs. 37,200 on each Primary Health Centre as shown below subject to a limit of Rs. 30,000 in respect of cost of buildings:—

		Rs.
1.	Cost of equipment	6,000
2.	Furniture	600
3.	Bedding and clothing	600
4.	Buildings	30,000
	Total	37,200

The Central Government also subsidise State Governments in respect of recurring expenditure during the period of the Second Plan for the maintenance of each Primary Health Centre upto a total of Rs. 20,120 per Centre per year in the following proportions:—

	Central Govt.'s Share	State's Share
First 6 months	100%	Nil
Next 12 months	66·66%	33·33%
Next 12 months	50%	50%
Next 30 months	33·33%	66·66%

34. The pattern of Central assistance to Primary Health Centres, started after 1st April, 1958, is as under:—

(a) *Non-recurring*—upto a ceiling of Rs. 67,500 on each unit as shown below:—

(i) Buildings: Rs. 60,000 or 75% of the actual expenditure whichever is less on buildings (both for the Centre and residential quarters for the staff). This sum also includes the cost of construction of suitable accommodation for Family Planning Clinics in the main buildings for the Centre and staff quarters.

(ii) Equipment: Rs. 7,500 for equipment, furniture, bedding and clothing.

(b) *Recurring*:—

(i) Drugs: Rs. 2,000 per annum

(ii) Staff: Rs. 6,500 per annum

It has been further decided that the Central assistance indicated above will be apportioned between the Ministries of Health and Community Development as follows:—

	Ministry of Health	Ministry of Community Development
Non-recurring		
Buildings	87½%	12½%
Equipment	Nil	100%
Recurring		
Drugs	Nil	100%
Staff	Nil	100%

E. *Primary Health Centres and Other Health Services in Villages*

35. The Committee find that every programme contemplating prevention of a communicable disease in villages has got its separate staff. There are special staffs working in villages for carrying out Malaria Control/Eradication Programme, Filaria Control Programme, Leprosy Control Programme etc. The people in villages are bewildered by so many experts who come now and then for some specific problems. Besides, much time and money are wasted in going and coming back of so many people which can be saved if only a few are made responsible for all the activities throughout a year. Such persons who have to deal daily with the villages will also become familiar with the rural population who can then be expected to co-operate fully with the various health programmes.

36. In this connection, the Committee would like to refer to the following observations in the "Second Five Year Plan":—

> "In the early stages, certain services such as those for the control of malaria, filaria, tuberculosis, venereal diseases and leprosy may have to be rendered by special staff but, after adequate control has been attained, such services should from part of and be integrated with the normal activities of a health unit. This integration will be greatly facilitated if during the period of the second plan full co-ordination of activities can be established between such specialised services and the health units. The staff employed in each health unit should ultimately be such as to enable the unit to provide the basic services as well as specialised services relating to malaria and other diseases. In order that these services may reach the public throughout the area which a health unit serves, the provision of transport has considerable practical importance. It will also facilitate the removal of urgent cases to hospitals. It is desirable that a broad uniform pattern for the structure and functions of a health unit should be accepted throughout the country. As far as possible new dispensaries should not be started on the old lines and existing dispensaries should be converted into health units."

The Committee recommend that early steps should be taken to implement the above proposals.

37. As regards the co-ordination maintained at present in the various schemes contemplating curative and preventive services, it was stated by the representative of the Ministry of Health that the district officer was in overall control of everything that happens in the district and thus there was integration at the district level. There is, however, at present no liaison between. Primary Health Centres, district hospitals and medical college hospitals. The Committee feel that in theory there may be some co-ordination by the district officer, but in practice, the district officer has so many duties imposed on him that he cannot even find time to look after his district hospital well, not to speak of Primary Health Centres. It is understood that a patient directed by the Primary Health Centre to medical college hospital or district hospital is treated like one among a thousand patients and may not be admitted or given any other special attention. *The Committee suggest that the Primary Health Centres should be linked with the district hospitals and medical college hospitals so that any serious case sent by a Primary Health Centre is admitted in one of those hospitals and information, as to the treatment given and after-care necessary, is sent to the Primary Health Centre when the patient is discharged. In addition, experts from district hospitals etc. should visit the Primary*

Health Centres periodically to help the rural doctors and to see that proper standards of medical care are maintained at the Primary Health Centres.

38. The Committee are also of the opinion that there is urgent need to change the thinking on the subject of Community Health so that instead of treating the individual as the unit, the family is considered as a unit for all health work. The Study Group of the Committee that visited the Health Centre at Singur (including its sub-centre at Nasibpur) observed that a system of maintaining continuous health records of the families had been introduced. *The Committee suggest that a beginning should be made in certain Primary Health Centres to maintain such family health records which would in course of time be extended all over. These records will give the medical history of each family and throw considerable light on the standard of health of the community served by the Centre and ways and means of improving it.*

F. *Staff Quarters*

39. The Study Group of the Committee which visited the Nasibpur sub-Centre of the Singur Health Centre (West Bengal) found that staff quarters had not been provided for all the staff. It is generally recognised that without proper residential facilities being available to the staff of Health Centres, they will not be in a position to discharge their duties satisfactorily. One of the reasons why the doctors are not always prepared to serve in rural areas is the want of proper residential accommodation. *The Committee, therefore, suggest that the facility of quarters should be extended to all the staff attached to various Health Centres. Rural people may be asked to help in providing such accommodation.*

G. *Doctors and Auxiliary Medical Personnel for Rural Areas*

40. The Committee understand that many of the schemes in villages or in some of the hilly areas have not been fulfilled due to reluctance on the part of the doctors to serve in those areas. Qualified doctors usually want to serve in cities as these are developed areas where they can get all the amenities of city life and impart good education to their children. Moreover lack of facilities for consultation leads to intellectual starvation for young doctors working in rural areas. The Committee have already suggested a remedy for this in Paragraph 37. In order to make the jobs in the rural areas more attractive, several States have introduced a system of giving some rural allowance to qualified doctors for serving in rural areas. A statement of what is given by the different States in this respect is enclosed as Appendix II. It is seen from the statement that certain State Governments are not giving any such allowance and that there is great variation among those State Governments who have been giving such allowances. *The Committee suggest that the Central*

Government should make efforts to see that all State Governments do give such an allowance and to bring about a certain measure of uniformity in this respect in a phased manner.

41. The Committee further learnt that in the 4th meeting of the Central Council of Health it was resolved that there is a vital need for fully qualified doctors to serve in rural areas and the Centre should give adequate subsidy to improve the term of service of rural doctors. This resolution of the Central Council of Health has not been carried out and it is stated that at the time when the Second Plan was drafted, it was decided that no subsidy should be given. *The Committee, however, feel that such a subsidy on the part of the Centre may serve a useful purpose in remedying the existing State of affairs in the country and, therefore, suggest that the question may be reviewed again.*

42. In this context, the Committee would also like to narrate the views of the Prime Minister expressed by him while inaugurating the Seminar of the Contributory Health Service Scheme Medical Officers held at Vigyan Bhavan, New Delhi on the 18th May, 1958:

> "It is often said that one of the difficulties in the way of providing medical services in villages or some of our hilly areas is that doctors, young and old, do not at all like to go there. It is because the amenities of city life are not available there. I do not question their desire to have those amenities, but I think that doctors should recognise and should also inculcate in the young, whom they often teach in the medical colleges that it is essential for us and for them to go to the villages and to the hill areas and all the remote places.
>
> Since long I am of the opinion that it should be made compulsory and obligatory on the part of a medical student who has taken a degree etc. to spend a year or two in the village before beginning his career. I believe some years back we did make a rule about doctors in government service, that is that they should spend some time in the rural areas. We want medical help to go to our villages, but leave that out for the moment. I think it is essential for the training of young man and woman to go and work there. He or she must know the conditions that prevail there. He or she must know how to meet those conditions."

The Committee suggest that the Ministry should devise a suitable scheme to give a concrete shape to the above idea so as to ensure that every medical graduate spends at least two years in the rural area, after graduation, preferably after he has acquired some experience in medical practice.

43. Besides doctors, auxiliary medical personnel is also not available to the required extent in the villages. *The Committee are of the opinion that the Ministry should work out a scheme of giving elementary training for preventive work to the practising Hakims, Vaids etc. who are already working in rural areas and to make use of all these hundreds of thousands of workers scattered throughout the country in a properly co-ordinated pattern of Health Service. This scheme should also envisage a proper system of linking up with centres of more highly skilled medical care so that serious cases can be brought up for better treatment. Thus all available skill and talent would be able to function in a co-ordinated pattern for the relief of human suffering and prevention of disease and the present atmosphere of rivalry and competition between different systems would be replaced by healthy co-operation. This suggestion implies that the auxiliary personnel should be picked up from amongst those already in the field and in fact all of them should serve as auxiliary personnel, reaching all the corners of the country.*

H. *Urban Health Centre, Chetla*

44. The Committee learnt that an Urban Health Centre was set up at Chetla (West Bengal) under the joint auspices of the Government of India, UNICEF, WHO, the Government of West Bengal and the Corporation of Calcutta. It was set up at an approximate capital cost of Rs. 15 lakhs and a contemplated recurring annual cost of Rs. 8 lakhs. It is the only urban health centre at present. The objectives of this Centre are as under:—

(i) to organise a model health centre which will serve as a demonstration, training and research centre for the All India Institute of Hygiene and Public Health.

(ii) to help in improving the standard of routine services given by the Corporation of Calcutta upto demonstration level.

45. *The Committee, while noting with satisfaction that good work is being done at this Centre, are of the opinion that the tempo of activities should be further accelerated, so that it may not only serve as an adequate training centre for the All India Institute of Hygiene and Public Health, but also as a means of effectively supplying various health needs in the area and thus serve as a model for such centres in other big cities as and when established, without interfering with the main object of the Centre.*

46. The Study Group of the Committee while visiting this Centre, incidentally observed that the name-plates and sign-boards in the Centre were in Bengali and in English. The Committee feel that at least in all Institutions under the management of the Central Government the official language of the Union, Hindi, should also be utilised for this purpose. *They, therefore, recommend that it would be useful for the Union Government to issue a general directive that in all*

Institutions under the management of the Central Government, name-plates and sign-boards should also be in the official language of the Union, in addition to the use of the regional languages.

I. *Orientation Training and R.C.A. (Research-cum-Action) Centres*

47. The Committee learnt that three O.T. and R.C.A. Centres have been opened at Singur (West Bengal), Poonamallee (Madras) and Najafgarh (Delhi) with assistance from the Ford Foundation and the U.S. Technical Co-operation Mission. The Centres are intended to provide short periods of orientation and training in basic public health and health education practice to medical and health personnel and health instructors engaged in health activities under the various health development programmes and to meet the requirements of non-medical personnel for the rapidly growing primary health centres in Community Development and N.E.S. Blocks.

48. The R.C.A. project aims at analysing the complex problems of poor environmental sanitation and finding a simple, direct and workable approach to it. The R.C.A. Projects which are situated at Najafgarh, Poonamallee and Singur are working at present in association with the O.T. Centres at these places and are engaged in studying through social workers under the guidance of social scientists, the villagers' beliefs, attitudes and habits with a view to provide the basis for health education programme for these areas which can be planned and implemented with success. The representative of the Ministry informed the Committee that the UNICEF assistance scheme envisages one or two demonstration districts in every State where such centres will be developed. *The Committee suggest that more orientation training and R.C.A. (Research-cum-Action) Centres may be opened on the basis of population i.e., one Centre to serve a population of say two or three crores.*

III. TRAINING IN PUBLIC HEALTH COURSES

A. *All India Institute of Hygiene and Public Health*

(a) INTRODUCTION

49. The All India Institute of Hygiene and Public Health was established in Calcutta on 30th December, 1932. It was built and equipped by the Rockefeller Foundation while the Government of India agreed to meet the recurring cost of staff and maintenance. The aim of the Institute is to provide instruction in the methods of preventive and social medicine and for research in associated fields for the requirements of medical protection and positive health of large units of population comprising rural and urban areas.

(b) TRAINING

50. One of the main objectives of the Institute is to provide up-to-date instruction in the principles and methods of preventive medicine. For this purpose it imparts instruction in various courses as enumerated below:—

Degree course

Master of Engineering (Public Health)

Diploma Course

Diploma in Public Health
Licentiate in Public Health
Diploma in Maternity and Child Welfare
Diploma in Industrial Hygiene
Diploma in Nutrition
Diploma in Dietetics

Certificate Course

Public Health Nursing
Biometric Technique
Nutrition
Laboratory Technique
Industrial Hygiene
Public Health Engineering
Health Education
Maternity and Child Welfare
Orientation in Public Health

51. The Committee learnt that at present majority of the seats in various courses started by the All India Institute of Hygiene and Public Health are reserved for students sponsored by the State Governments. For instance, out of 81 eligible applications received from the State sponsored candidates during the year 1958-59 for the D.P.H. courses, 57 students are stated to have been admitted and out of 71 eligible applications received from the private candidates only 5 are stated to have been admitted. *The Committee are of the opinion that instead of keeping the field of public health a closed preserve for a few, employed in government service, training in public health courses should be thrown open to private candidates to attract talented persons to this line of work. They, therefore, suggest that various public health courses should be opened to private candidates having an aptitude for this kind of work and at least an adequate percentage of seats should be kept for those who wish to specialise in public health out of their own free choice. For this purpose number of seats should be increased and expansions effected, if necssary.* This is particularly necessary in view of the fact that the State Governments are all the time advertising for doctors with training in public health.

52. The Committee further learnt that a few seats remained vacant in the past in certain courses started by the All India Institute of Hygiene and Public Health due to the fact that candidates of the State Governments who were offered the seats did not join the courses. *The Committee suggest that a panel of names of other students desirous of joining the courses should be maintained so that if any candidate does not join the course, another candidate may be offered the vacant seat, and thus the training capacity of the Institute may be utilised to the maximum possible extent.*

(c) LIBRARY

53. The Study Group of the Committee which visited this Institute learnt that the Library of the Institute remains closed on Sundays. *The Committee are of the opinion that the Libraries attached to all the educational institutions should be particularly kept open on Saturdays and Sundays so that the students may make use of them during their leisure time. The example of the National Library, Calcutta, which observes only three holidays in a year is worth emulation.*

(d) BUILDING FOR THE PUBLIC HEALTH ENGINEERING

54. The Committee learnt that the plans of the building for the Public Health Engineering in the All India Institute of Hygiene and Public Health could not be got ready during the years 1956-57 and 1957-58 resulting in non-utilisation of Rs. 3·5 lakhs provided in those two years for the construction of the building. It has been explained that preliminary plans were drawn for the demolition of the existing Servants' Block and to construct a multiple storeyed building in its place. In the meanwhile the Superintending Engineer was consulted whether an alternative arrangement could be made without demolish-

ing the servants' quarters. The Senior Architect paid a visit to this place and in consultation with the Architect of the Corporation of Calcutta,, is drawing up revised plans for the new building. Soil testing is also stated to have been done for considering the number of floors that the new building can take. The C.P.W.D. has, however, not yet finalised their finding regarding the selection of the site etc. and the construction of the building has not yet been started. The Committee consider this an unfortunate state of affairs *and suggest that special steps should be taken to ensure the completion of the building at an early date.*

(e) RE-AIRCONDITIONING OF THE BUILDING

55. The Committee were informed that there was a proposal to re-aircondition the Institute building as a whole. In this respect, it has been stated that the existing two air-conditioning plants of the Institute are too old and have outlived their normal life and that as a result, these plants go frequently out of commission and they are not in a position to take up any additional load for air-conditioning the Library, Lecture Rooms etc. *The Committee suggest that during these days of stringent financial conditions, re-airconditioning of the whole building should not be resorted to and only such rooms should be air-conditioned which are absolutely necessary for scientific research.*

B. *Training of Lady Health Visitors, Dais etc.*

(a) TRAINING OF LADY HEALTH VISITORS

56. The Committee were informed that a Centrally assisted scheme for the training of Health Visitors for rural areas under the Community Development Projects was started in 1954-55 at 8 Health Schools in various States besides one at the Lady Reading Health School, Delhi. The training course was of two categories, one of 1½ years for Health Visitors only and the other an integrated course of 2½ years for Midwifery-*cum*-Health Visitors.

57. The Committee understand that during the Second Plan period, it is proposed to train 1,260 Health Visitors with Central assistance. For this purpose, the existing 9 Health Schools have been expanded and 6 new schools established at Bareilly, Allahabad, Rajkot, Ranchi, Indore and Trivandrum. The Committee learnt that the position on 31-3-1958 regarding the training of Health Visitors at the Lady Reading Health School Delhi and the Schools opened/ expanded by the State Governments with Central assistance under the Five Year Plans was as follows:—

	Admitted for Training	No. qualified
Health Visitors' Course	627	461
Integrated Mid-wifery-*cum*-Health Visitors' course.	1037	117
Total	1664	578

58. *The Committee were, however, surprised to learn that though the scheme for the training of Lady Health Visitors during the Second Plan was only a continuation from the First Plan, the Scheme for the Second Plan was sanctioned at the end of* 1956-57 *thus resulting in non-utilisation of Rs.* 3,90,799 *during that year. The Committee regret this delay on the part of authorities and suggest that such recurrence should be avoided in future.*

(b) TRAINING OF DAIS

(i) *The Problem*

59. In the rural areas of the country, most of the deliveries are conducted by dais (trained or untrained) because the hospital facilities have not been adequately developed. Untrained dais use old methods without the help of any modern equipment. Such methods are dangerous both to the child and the mother. It is, therefore, very essential that only a trained dai should conduct a delivery, using modern methods and equipment.

60. The Committee regret that the Ministry of Health have not got correct statistics as to the number of deliveries being conducted in the rural areas by trained and untrained dais. To meet the requirements of various villages for trained dais it is necessary that a correct assessment of the existing position is made. The Committee are of the opinion that such an assessment can easily be made at least in those areas where Primary Health Centres have been established. *They, therefore, suggest that the Ministry should carry out a sample survey to find out how many deliveries in the areas served by the Primary Health Centres are being attended to by trained dais, the staff of the Health Centres and by untrained dais, so that the extent of the problem could be known and necessary provision made for additional trained dais including normal replacements.*

(ii) *The scheme for Training*

61. The Committee learnt that the Government of India have sanctioned a Centrally assisted scheme under the Second Plan for the Training of 36,000 dais at an estimated cost of Rs. 90 lakhs with a view to improving their standard of practice. Under this scheme, 150 units for the training of dais will be established in States, each unit covering a population of about 66,000. A total of approximately 60 dais are expected to be trained in each unit in a year, in two batches of 30 each. There will thus be one dai for 1,000—1,500 population or one dai for every 50 births. The Central assistance is Rs. 13,200 per unit per annum, for meeting the cost of kits for the dais (Rs. 3,000) and their refills (Rs. 3,000) and for cash rewards to dais (Rs. 7,000) trained at these units.

62. The Committee were informed that 140 units for training of dais have already been sanctioned and over a thousand dais are now under training. The progress of the scheme has, however, been

delayed to some extent due to the delay in implementing the scheme for the Primary Health Centres with which the training of dais has been tied up. Primary Health Centres' staff is being used in the initial stages to train dais in each area served by a Centre. 12 to 15 dais have been recruited in most of the units for the training. *The Committee suggest that the feasibility of fixing suitable age-limit for the dais selected for training may be examined.*

63. As regards the supply of kits fitted with necessary equipments etc. to dais and their refilling, the representative of the Ministry informed the Committee that the question of the replenishment of the dais' kits was taken up with the Ministry of Finance at a very high level and they came to the conclusion that it was not possible. That is why the scheme had to be tied up with the Primary Health Centres to provide replenishments from the funds available for the Health Centres. The representative of the Ministry of Finance, however, informed the Committee that the proposal of the Ministry of Health to give refills for the dais' kits was considered by the Departmental Finance Committee presided over by the Minister of Revenue and Civil Expenditure in February, 1957. At this meeting the Finance Secretary agreed to dais being supplied with refills free during the Plan period, even after the training period, but considered that the States should bear an equal share of this expenditure as eventually they must accept responsibility for the proper working of this scheme. This view was accepted by the representatives of the Health Ministry. It was agreed that this part of the Scheme (refills for the dais' kits) should be treated separately from the training scheme. The final proposal which subsequently came to the Ministry of Finance from the Ministry of Health was that the cost of refills should be made a part of the Primary Health Centres' budget so far as training of dais in the National Extension Blocks was concerned and the same pattern of assistance for recurring expenditure, as in the case of the Primary Health Centres, should be adopted also for these refills. It was proposed by the Directorate General of Health Services that when the training was outside the Primary Health Centres, provision of refills should be the responsibility of the State Government or the Local body concerned as most of the States had provision for dais' training and funds could be found by the States from other medical centres which are not part of the Primary Health Centres. This proposal was accepted by the Ministry of Finance.

64. *The Committee feel that for the efficient working of dais in villages it is necessary that the dais should be under the supervision of a health visitor and that there should be a scheme for supplying them with carefully fitted kits and for refilling of the kits after each delivery they conduct.* The dais even after training very often use the old methods if there is no supervision and there is no system of replenishments. The Committee regret that a proposal to have such arrangements was not implemented, though the Finance Ministry had agreed to 50 per cent. of the expenditure being met by the Central Govern-

ment and the rest being met by the State Governments. A small amount is provided for this purpose in the budget of the Primary Health Centres which is most inadequate and cannot possibly meet the need of replenishing the kits of all the dais in the areas. *The Committee suggest that a workable scheme should be prepared and implemented to provide for supply and refilling of kits of dais regularly in the rural areas. In the absence of Maternity Home Service for all, this is the least that must be done.*

65. In the context of the training of dais, nurses etc. the Committee would like to mention that at present while there is such an acute shortage of nurses, some of the nurses are not finding employment. It is stated that certain States have surplus doctors, nurses etc. but the other States are not prepared to take them on a permanent basis due to local prejudice. Even when they are employed by another State, they do not get equal chances of promotions etc. with the result that they feel insecure. *It is an incongruous position that on the one side there is the problem of shortage of technical personnel while on the other, technical personnel is under-employed or unemployed. The Committee suggest that this position should be discussed in the Central Council of Health and suitable solution worked out in the overall national interest.*

C. Training in Public Health Engineering

66. The implementation of the National Water Supply and Sanitation Programme under the Second Plan demands adequate and professionally qualified Public Health Engineering staff for the initiation, execution and supervision of Public Health Engineering works. It is, therefore, necessary to provide training facilities for a substantial number of engineers and auxiliary personnel in Public Health Engineering. The Committee understand that for this purpose a scheme has been included in the Second Plan which envisages the following courses of training:—

(i) Post-graduate course in Public Health Engineering (10 months).

(ii) Short term training course for Engineers (3 months).

(iii) Short term training course for Engineering subordinates (3 months).

(iv) Short term training course for Sanitary Inspectors as aides to Public Health Engineers (3 months).

(v) Water Works Operators' course (1 month).

67. The training imparted in these various courses till 1957-58 as against the targets laid down during the Second Plan is as under:

	Target during Second Plan	Progress upto 1957-58
(i) Engineers in the post-graduate course	250	46
(ii) Engineers in the short term course	800	38
(iii) Engineering Subordinates in the short-term training course	1800	102
(iv) Sanitary Inspectors	750	
(v) Water works operators	500	22

68. The Committee find that the progress in the first two years of the Second Plan is wholly unsatisfactory. There have also been huge shortfalls in expenditure as compared with the budgeted estimates in these two years in respect of the scheme 'Training in Public Health Engineering'. The figures of budgeted estimates and expenditure for these two years are as under:

Year	Budget Provision	Expenditure	Shortfall
	Rs.	Rs.	Rs.
1956-57	4,00,000	31,656	3,68,344
1957-58	8,00,000	1,87,800	6,62,200

69. The Committee were informed that the training in these various courses was at present being imparted at the All India Institute of Hygiene and Public Health, Calcutta and at the Engineering College at Guindy. A post-graduate course had also been started at Roorkee. The representative of the Ministry stated that the response of the State Governments was poor when the various courses were started but now the State Governments were being given advance information and the response had improved.

70. The Committee were informed that one of the difficulties in the execution of Water Supply and Sanitation Scheme had been that many of the States did not have a separate public health engineering organisation and such activities were being carried on under the Public Works Departments. When the persons working at present in Public Works Departments of the States get training in public health engineering and go back, it is not sure that they will be put on the public health engineering jobs. *The Committee feel that there should be a separate public health engineering organisation in every State so that the experts working in the direction of public health, continue to work in the jobs for which they were trained, gain experience and contribute their quota to the speedy implementation of the public health schemes.*

IV. FAMILY PLANNING

A. *Introduction*

71. It is widely recognised that the success of the schemes of economic development in the country will be considerably hampered if due attention is not paid to the problem of growing population. According to one estimate if the fertility remains unchanged, the population of India in 1986 will be about double the 1956 figure (775 million). National income and resources will also improve during this period. If the national income is doubled it will still mean that we will be forced to remain at the present level of food consumption and standard of living. It is, therefore, obvious that birth rate must be reduced to stabilise the population at a "level consistent with the requirements of national economy".

72. Limitation of families is a method acknowledged throughout the world for keeping the population figures within bounds so that they may not overreach resources. It is necessary to ensure that the future population rise is not so steep as to nullify the good effect of the gradual increase in production aimed at under the Five Year Plans.

B. *Five Year Plans*

73. Appreciating the gravity and urgency of the problem both for the individual and the community a sum of Rs. 65 lakhs was allocated by the Central Government in the First Plan of the Ministry of Health for a Family Planning Programme. It is stated that this provision was determined, not so much by financial consideration, as by an appreciation of the nature of the task to be attempted and the time needed for adequate preparation. The specific tasks were (i) to obtain an accurate picture of factors contributing to the rapid population increase, (ii) to discover suitable techniques of family planning, (iii) to devise methods by which knowledge and techniques of family planning could be widely disseminated, and (iv) to make advice on family planning an integral part of the service rendered by Government hospitals and public health agencies.

74. The Ministry of Health set up a Family Planning Research and Programmes Committee in May, 1953. This was followed in May, 1954 by the establishment of a Family Planning Grants Committee for examining and recommending applications for financial assistance for family planning work and research. The allotment for family planning under the Plan was to be used for providing grants to State Governments, local bodies and voluntary organisations for training, education and research and for meeting the cost of a Central Organisation. During the First Plan period a total expenditure of Rs. 18·5 lakhs was incurred. Grants-in-aid were offered to 205 family planning clinics

maintained by voluntary organisations, State Governments and local bodies and 147 clinics were opened during the First Plan period. *The Committee regret to note that there have been considerable shortfalls during the First Plan. Considering the necessity and urgency of the problem they are of the view that pre-planned and co-ordinated steps are urgently necessary on the part of the authorities concerned to utilise effectively the amount provided for during the Second Plan.*

75. During the Second Plan a provision of Rs. 497 lakhs—Rs. 400 lakhs at the Centre and Rs. 97 lakhs in States—has been made for family planning. The figures of budget estimates and expenditure incurred under the scheme during the first two years of the Second Plan are as under:—

(Rs. in lakhs)

Year	Budget Provision	Expenditure	Shortfall
1956-57	30.00	9.12	20.88
1957-58	25.00	26.13	..

The Committee were informed that shortfall during 1956-57 was largely due to the delay in the finalisation of the Scheme. The main reason for this delay was stated to be that there was practically no separate organisation in the States for tackling this problem. Central Family Planning Board was established on 1st September, 1956. The Officer on Special Duty (now designated Director, Family Planning) was appointed on 27th September, 1956. The first meeting of the Central Family Planning Board was held on the 27th October, 1956. State Governments were offered financial assistance to appoint State Family Planning Officers on 21st December, 1956. The Standing Committee of the Family Planning Board was formed on 2nd January, 1957, and the First meeting was held on 18th January, 1957. Thus the programme started to make headway really at the close of 1956-57 and beginning of 1957-58.

76. The allocation of the Second Plan provision for Family Planning is as under:—

(Rs. in lakhs)

Central Organisation	8·00
Service	373·25
Training	15·75
Education	50·00
Research	50·00
TOTAL	497·00

C. *Central Organisation*

77. The Central Family Planning Board which was set up in 1956 has the Union Health Minister as its Chairman. The present composition of the Board and its functions are enclosed as Appendix III.

The Board lays down broad principles of policy. A standing committee with the Secretary of the Ministry of Health as Chairman has also been set up which undertakes scrutiny of various proposals relating to family planning and to deal with other cognate matters.

78. The Committee learnt that at the State level, Family Planning Boards have been formed in all the States except Jammu and Kashmir and the Family Planning Officers have been appointed in the States of Andhra, Bombay, Kerala, Madras, Mysore, Punjab, Rajasthan, Uttar Pradesh and West Bengal. Family Planning work is being looked after by the Maternity and Child Welfare Officer of Health in Assam, Bihar, Jammu and Kashmir and Himachal Pradesh. The work of family planning in Delhi is being looked after by the Assistant Deputy Health Officer of the Delhi Corporation.

D. *Service*

79. The Committee were given to understand that during the Second Plan period it is proposed to open 500 clinics in urban and 2000 in rural areas. Each clinic normally serves a population of 50,000 in urban and 66,000 in rural areas. At such centres all contraceptives are given free to those with income less than Rs. 100 p.m., at half price to those with income between Rs. 100 to Rs. 200 p.m., and at cost price to those with income above Rs. 200 p.m. In addition, foam tablets and sheaths are given free to all in rural clinics, irrespective of income. Details of expenditure allotted for an urban and rural centre are stated to be as follows:

	Urban	Rural
Non-recurring	Rs.	Rs.
Equipment, furniture, publicity material, etc.	2,000	500
Contraceptives for sale	500	500
TOTAL	2,500	1,000
Recurring		
1 woman doctor and 1 part time male doctor	5,000	..
1 Health Visitor or Social Worker or Field Worker	3,000	3,000
1 peon	1,000	..
Foam tablets for free distribution	1,000	1,000
Contingencies	500	1,000
TOTAL	10,500	5,000
GRAND TOTAL	13,000	6,000

80. The State Governments, Local Bodies and Voluntary Organisations are being assisted by the Central Government in this programme according to the following pattern:

Non-recurring expenditure— 100%
Recurring Expenditure:—

	State Govts. and Local Bodies	Voluntary Organisations	
		Urban	Rural
	per cent	per cent	per cent
First Year	80	100	100
Second Year	70	80	100
Third Year	50	80	100
Fourth Year	30	80	100
Fifth Year	20	80	100

The Committee find from the above details that no doctor (male or female) is sanctioned for family planning clinics in rural areas according to the present pattern of expenditure while one full time woman doctor and one part-time male doctor are sanctioned for every family planning clinic in urban area. For the rural areas the present arrangement is that the doctors in charge of Primary Health Centres are supposed to give advice on family planning also. The Committee, however, feel that the doctors at the Primary Health Centres are so much pre-occupied with their normal duties that they cannot devote time to this additional work. The result is that the family planning clinics in rural areas are left to inexperienced midwives or nurses or health visitors. In the cities it is possible to have the part-time services of doctors for family planning, while it is not possible to have such part-time services in villages. *The Committee, therefore, suggest that full-time doctors (preferably lady doctors) may be appointed for family planning clinics in rural areas and part-time services of general practitioners utilised for this purpose in the cities.*

81. The Committee were informed that during 1956-57 grants were sanctioned for 7 rural and 13 urban clinics. The target figure for clinics upto March, 1958, was 370 clinics (300 rural and 70 urban). Against this target, 309 rural and 166 urban clinics were reported to have been opened during 1956—58. The number of clinics reported to have been opened by 15th November, 1958 is 812 (488 rural and 324 urban) against the target of 600 rural and 150 urban clinics. The Committee find from these figures that while the target for opening clinics in rural areas has not been achieved, the target for opening clinics in urban areas has been exceeded. The representative of the Ministry, however, informed the Committee during the evidence that the Ministry propose to reduce grants to urban family planning clinics and to concentrate on rural family planning clinics. *The Committee feel that in view of the fact that about 82 per cent of the population live in villages, this proposal is commendable and should be implemented early.*

82. The Committee also feel that family planning service is likely to get a greater momentum if the clinics are associated with maternity and child health centres. At present, however, in most of the States, maternity and child health and family planning are administered by separate officers. In this connection, the representative of the Ministry stated that any tendency to consider maternity and child health and family planning as separate is being discouraged and gradually the intention is to integrate family planning with maternal and child health. *The Committee suggest that this process of integration should be expedited, and family planning advice should form part of the work of all the antenatal and post-natal clinics and the same officer should be in charge of these activities at all levels. The new family planning clinics being started should also take up maternity and child welfare work.*

83. The Committee learnt that grants for opening clinics in medical teaching institutions are sanctioned at 100 per cent non-recurring and 100 per cent recurring during the plan period irrespective of the sponsor being State Government/Local Body/Voluntary Organisation. But only a few institutions are stated to have availed of such financial assistance. *The Committee feel that more concerted efforts are necessary on the part of the Ministry to open family planning clinics in all the medical teaching institutions in the country and to see to it that all doctors and medical auxiliaries are automatically trained in family planning in their normal course of training.*

E. *Training*

84. Trained personnel are essential for the success of any programme. The Committee learnt that a Family Planning Training and Research Centre was established on 15th March, 1957 in Bombay to provide scientific training in family planning to doctors, nurses, health visitors and social workers. 149 persons have been trained so far at this Centre. Further a Rural Training Demonstration and Experimental Centre has been developed at Ramanagram, where 87 persons have been trained so far. Stipends are paid to the trainees at the rate of Rs. 150 per month to doctors, Rs. 100 per month to social workers and Rs. 75 per month to health visitors. Travelling allowance is also paid to trainees from voluntary organisations. Each trainee receiving a stipend is required to execute a surety bond to the effect that after completion of training he or she would serve the State/Local Body/Voluntary Organisation for a period of at least three years.

85. The Study Group of the Committee which visited the Family Planning Training and Research Centre at Bombay noticed that the Centre was hard-pressed for accommodation and clerical staff. *The Committee, therefore, suggest that early measures should be taken to provide adequate accommodation and staff to the Centre. The Committee also suggest that some assessment of research work done at the Centre should also be made.*

86. The Committee understand that at present there is only one Family Planning Training and Research Centre which is located at Bombay. Another State is stated to have come forward with proposals for opening such a centre but it is yet under the consideration of the Government of India. *The Committee suggest that it would be desirable to open at least one Family Planning Training and Research Centre in each region.*

87. The Committee learnt that besides opening the two training centres at Bombay and Ramanagram, a grant of Rs. 8,000/- was sanctioned in November, 1957 to Family Planning Association of India for a touring training team. 475 persons had been trained by this team upto 15th November, 1958. It is now proposed to form 10 additional touring teams. Further, Governments of Andhra Pradesh, Kerala, Bombay, Uttar Pradesh and West Bengal have been requested to open one training centre each for welfare workers. Similar grants to voluntary organisations are under consideration.

88. The Committee further learnt that the State Governments have been requested to develop 42 well established urban clinics into Regional Training Centres. Two such centres, one in Madras and one in West Bengal, have been started. *Ad hoc* courses are also being conducted wherever facilities exist. 406 persons have so far been trained in short term courses conducted in Delhi, Nagpur, Jamnagar, Rajkot, Junagadh, Amravati and Calcutta.

89. The number of persons trained during First Plan was 67. During the Second Plan (upto September, 1958) the number reported to have been trained is 1,117. The representative of the Ministry informed the Committee during the course of evidence that at present there is so much enthusiasm for the family planning scheme, that there is no dearth of candidates for training. There are actually more candidates than the facilities for training. *The Committee suggest that by opening adequate number of training centres in each State, the required number of trained personnel, so essential for the success of the family planning programme, should be made available and utilised for the purpose of imparting necessary training to those desirous of receiving it.*

90. As regards the training imparted in family planning to women staff working in the community development and N.E.S. Blocks, the Committee learnt that this aspect was discussed with the Ministry of Community Development at the Community Development Commissioners' Conference held at Mount Abu. They have agreed to include family planning as a subject in all their training centres in community development. *The Committee are glad to learn this. They suggest that the position should be periodically reviewed jointly by the Ministries of Health and Community Development to ensure that the training facilities available for the personnel engaged in the work of Community Projects are adequately and properly used for imparting training in family planning and the personnel so trained work under medical supervision.*

F. *Education*

91. It has been stated by the experts that family planning to be effective for regulation of population growth has to be practised over prolonged periods. This pre-supposes a strong motivation on the part of the common people. To create such motivation, the Committee understand that the Ministry had distributed by the end of 1957-58 290.000 posters in English and regional languages and thousands of pamphlets and folders. Films have been made available to different agencies, radio programmes have been started and children's fair and exhibitions have been organised. Further attitude surveys are being carried out in some of the field investigations and additional information will be collected by he Demographic Research Centre. Social workers and health visitors in family planning clinics are conducting family planning education and imparting knowledge to individual couples. *The Committee, however, feel that in addition to the measures adopted by the Ministry to create a strong motivation on the part of the common people in favour of family planning, it is necessary to enlist the active cooperation and support of non-official social welfare organisations, which should be provided necessary facilities for helping in the work.*

92. In this context, the Committee would also like to draw attention to the following views of the Prime Minister:—

> "I have no doubt that the vast numbers of people in India would welcome family planning and population control from every point of view.
>
> "In any matters concerning what may be called social reform we have enthusiasts who in the excess of their enthusiasm, do not pay too much attention to the commonsense of the situation, to the fact that they have to deal with human beings who have to be won over, who have to be educated, who may not be able to understand a certain viewpoint and there is a tendency for the enthusiasts to feel angry and irritated when other people do not function as they want them to function.
>
> "How to get into his (the peasant's) mind? That is a difficult thing to do, for anyone sitting around such a table. We think of convincing each other. We may or may not convince. We argue. The poor peasant does not argue. He does or does not understand. So always in all our activities, specially activities relating to social problems, relating to influencing mass opinion we have always to keep in mind that we must speak in a language which is understood, is simple, not a complicated language, not ideologies, but a language which promotes fairly definite images in their minds.

"We think far too much in terms of the educated or semi-educated class of which we are members, though naturally we have to influence them, convert them because in any event they are the leading persons who carry the message. Therefore, it is important to convert those people but if that conversion of mind is only to that upper layer and they also speak a language which is understood only by that upper layer, then obviously from the point of view of family planning and population control, it has to go down to a large number of rural people in the language they understand."

The Committee suggest that the views of the Prime Minister mentioned above should be properly emphasised to all the workers working in the field of family planning.

G. *Research*

93. The Committee were informed that research in contraceptives is being carried out at the Contraceptive Testing Unit, Indian Cancer Research Centre, Bombay, the All India Institute of Hygiene and Public Health, Calcutta and Pharmacology Department, Lucknow University, Lucknow. Suitable contraceptives are tested at the contraceptive testing units and recommended for use in the family planning clinics. Medical and Biological research is also undertaken by the Indian Council of Medical Research. Several other research studies on the various methods of family planning such as rhythm method, foam tablets and other contraceptives have been and are being carried out in selected centres.

94. The Committee understand that the progress in family planning depends to a large extent on providing necessary advice and service based on acceptable, efficient, harmless and economic methods. The large population of the country may be willing to agree to family planning if cheap, efficient and harmless contraceptives are available. In this connection, the Committee learnt that studies in the effiectiveness of oral contraceptives are being carried out in the All India Institute of Hygiene and Public Health, Calcutta and Central Drugs Research Institute, Lucknow. *The Committee hope that these experiments will be successful and those that are found useful produced on a large scale to be within the reach of an ordinary person.*

95. Incidentally, the Committee would like to mention that it has been noticed that contraceptives are being sold indiscriminately on the pavements in Bombay and other big cities. *They suggest that suitable steps should be taken to see that properly tested and suitable contraceptives are sold only under medical advice for family planning to married couples so as to avoid their misuse.*

V. MISCELLANEOUS

A. *Nutrition*

(a) INTRODUCTION

96. Proper nutrition helps not only to reduce sickness but also to promote abundance of health and vigour. Faulty nutrition is directly or indirectly responsible for a large amount of ill health in the community. It has been stated in the Second Plan that as it would not be possible to provide nutrition at optimum level to everybody, priority in improving nutrition should be given to vulnerable groups of the population namely, expectant and nursing mothers, infants, toddlers, pre-school children and children of school going age. Any damage to proper growth and development which may occur in these age groups owing to under-nutrition or mal-nutrition cannot be entirely made good even by providing adequate nutrition at a later age.

(b) NUTRITION OF SCHOOL STUDENTS

97. The Committee regret to learn that a uniform and systematic nutritional survey of all the school children in different States has not been carried out so far. However, random nutritional surveys of school children were undertaken from time to time in different States. College students were, however, not included in these surveys. The school going children examined in diverse areas and at different times during these surveys exhibited frank signs attributable to a deficiency of one food factor or other. Mal-nutrition is widely prevalent among the low income groups in all parts of the country. Generalised growth retardation seems to be a universal feature. In addition specific signs attributable to deficiencies of Vitamin A (xerosis, Bitot's spots etc.), Vitamin B complex (Angular stomatitis and glossitis) and protein are frequently encountered in varying proportions in the different regions.

98. *The Committee are of the view that a comprehensive programme for improving the standard of health of school children is necessary and should be based on scientific data made available on the basis of sample surveys already conducted or to be undertaken. In this connection, the Committee were informed that the Ministry propose to appoint an expert Committee presided over by a leading public man interested in the subject to examine the lines on which health surveys of school children should be conducted and also to suggest ways and means for the promotion of nutrition among school children. The Committee feel that this is a good proposal because if the health of the school children deteriorates, the future of the country is at stake. They, however, suggest that this Committee should also indicate as to how the various efforts in this direction made by the*

different agencies can best be co-ordinated. They further suggest that such a Committee should consider the feasibility of harnessing the medical profession through the local medical associations for the purpose.

99. The Study Group of the Estimates Committee which visited the Nasibpur Health Centre (a sub-centre of Singur Health Centre—West Bengal) learnt that the schools in the area are often visited by the authorities of the Centre and children found deficient in nutrition are advised to come to the Centre. *The Committee are of the opinion that proper surveys regarding the nutritional status of school children should be carried out by every Primary Health Centre periodically and steps should be taken to remove the causes of deficiencies in school children found out by such surveys. They are further of the opinion that a beginning should be made in a limited area, say, in certain Primary Health Centres areas to supplement the diet of school students and to expand the scheme gradually so as to cover the whole country. They are also of the view that local medical personnel in the area could be harnessed in this work.*

(c) MULTI-PURPOSE FOOD

100. The Study Group of the Estimates Committee which visited the Central Food Technological Research Institute, Mysore, learnt that to meet the need of the country for a cheap protein rich food, the Institute developed the multi-purpose food with adequate complements of vitamins and minerals to remove the deficiencies of these nutrients in the normal Indian diet. The multi-purpose food is comparatively cheap and does not involve any change in the food habits of the people. At present there is provision to manufacture about one ton of multi-purpose food per day at the Central Food Technological Research Institute, Mysore.

101. The Committee were informed that as a result of the preliminary discussion between the UNICEF, the Ministry of Health and the Ministry of Food and Agriculture, a technical committee has been formed in the Ministry of Food and Agriculture which is exploring the possibility of expanding the production of multi-purpose food. *The Committee suggest that in view of its nutritional value, production of multi-purpose food on a commercial basis should start early with international assistance from UNICEF, if necessary. The feasibility of selling the multi-purpose food at a subsidised price to overcome the widely prevalent protein mal-nutrition in the country may be examined.*

102. To an enquiry of the Committee as to whether it is feasible to develop an industry in Public Sector, to utilise fully the gains of researches carried out at the Central Food Technological Research Institute, Mysore specially in regard to certain cheap nutrition food like Indian multi-purpose food, Tapioca Macaroni, Baby food etc. and to sell the products through a net work of co-operative societies, fair

price shops etc. on 'no profit, no loss' basis, the representative of the Ministry informed the Committee that the Institute referred to was not under their control but the suggestion would be passed on to the sister Ministry. *As the Committee consider that both the production and sale of cheap nutritious food are equally important, they suggest that the proposal may be examined by the Ministry of Health in consultation with the concerned Ministry.*

(d) DISTRIBUTION OF PRODUCTS RECEIVED FROM THE UNICEF

103. The Committee learnt that the health authorities of each State work out a plan of distribution for M.C.H. feeding and school feeding separately indicating therein the details about the number of beneficiaries, total quantity of milk powder required for the whole financial year for each programme separately and lodge the request through the State Government and the Central Ministry of Health to the UNICEF. The Ministry of Health/Directorate General of Health Services examine these requests and thereafter forward them to the UNICEF for necessary action.

104. As regards the distribution of such products the Committee were informed that at the State level, the State liaison officer is responsible for distribution of milk and other products. In most cases, the liaison officer is also the Director of Health Services. However, in some States like Bombay and West Bengal there are separate liaison officers. State Co-ordination Committees have been formed in a few States to co-ordinate all the milk programmes in order to avoid overlapping. At the District level, the District Medical Officer is associated with this work. He is also assisted in some States by the District Co-ordination Committee which has been formed to co-ordinate all milk programmes. *The Committee suggest that Advisory Committees should be formed at all levels for distribution of milk and other products received from international agencies like the UNICEF consisting of representatives of (a) the Ministry of Health (b) State Governments/ concerned Directorates and (c) the non-official agencies connected with social service instead of doing this work through the various Health Directorates.*

105. The Committee further learnt that products received from the international agencies like UNICEF are being supplied to needy and expectant mothers through Government or semi-Government maternity centres. Private maternity centres are not supplied with these products. *The Committee suggest that these products may be supplied to private maternity centres also under the guidance of the Advisory Committees referred to above. The Committee also suggest that the feasibility of decentralising the receipt and storage of these products received from the UNICEF may be examined.*

(e) PUBLICITY

106. The Committee would like to mention the following views of Dr. A. L. Mudaliar, expressed in a memorandum to the Committee about Nutrition:—

> "It is very desirable that in large institutions, there should be persons who will advise on nutritional problems. Hotels, hostels, big business concerns with cafeteria and many others should try to see that nutritional values are made known to the public. There is very little of publicity of the nutritional values in the regional languages and literature on this subject will be found very useful, but more than that will be the practical example set up by the manner in which these suggestions are incorporated in large establishments such as those mentioned above."

107. The Committee were informed in this respect that equivalent terms of the different foodstuffs, whose values have been worked out in Health Bulletin No. 23, have been translated in all the regional languages. Small pamphlets and leaflets in Hindi on balanced diet, diet of the expectant mothers etc. have also been published in Hindi by the Health Publicity Section of the Directorate General of Health Services. *The Committee suggest that to give publicity to the nutritional values of different types of food in the regional languages, the Ministry should arrange radio talks and publish interesting and illustrative articles, books and pamphlets in attractive style, instead of Bulletins written in a technical manner which are hard to understand by the ordinary people. The Committee also suggest that suitable standard menus rich in nutritive values should be devised and introduced in various institutions such as hotels, hostels, guest houses, rest houses, prisons, hospitals etc. under the management of Government. The feasibility of opening model kitchens to demonstrate the correct way of cooking and preserving nutritious ingredients may also be examined.*

(f) GENERAL

108. In the context of Nutrition, the Committee would also like to mention that in certain areas the food habits of the people are deficient in some respects resulting in prevalence of certain deficiency diseases. *They suggest that special measures should be taken to study this aspect, and to evolve and popularise for these areas suitable supplementary diet which would contain the elements that are lacking in their present diet.*

109. The Committee understand that certain areas have a high incidence of certain specific diseases like night blindness among the Adivasi population in Panchmahal District of the Bombay State and if Vitamin A is supplied on a mass scale in the form of fish oil or in any

other form, an early and effective solution can be found for this disease. *They, therefore, suggest that the Ministry of Health should carry out a survey of the areas where there are certain specific diseases and find out the causes and assist the State Governments appropriately in eliminating those causes.*

B. *Directorate General of Health Services*

(a) Functions of the Directorate

110. The Committee were informed that the Ministry of Health was responsible for laying down the policy and reviewing the execution of policy with regard to all health matters, whereas the Directorate General of Health Services functioned as the Chief Executive for implementing and executing that policy and also for acting as the store house of technical knowledge and information. The broad activities of the Directorate General of Health Services within the frame work of policy laid down by the Central Ministry of Health are enclosed as Appendix IV. The D.G.H.S. performs the functions in an advisory capacity and the executive functions rest with the State Governments. It also renders advice to the Ministry of Health in the matter of laying down policy for the implementation of National Health Schemes like the National Malaria and Filaria Control Programmes, National Water Supply and Sanitation Scheme, Mass B.C.G. Vaccination Programme, Leprosy Control Scheme, Family Planning Scheme etc. The Committee observe that the Directorate General of Health Services is required to perform both advisory and executive functions, besides the administration of 43 subordinate offices under it. Thus it appears that at present there is no clear demarcation of functions between the Secretariat of the Ministry and the Directorate General of Health Services. Roughly, the Directorate gives technical advice besides being concerned with the planning and supervision of various development schemes and the Secretariat of the Ministry functions as the administrative wing. In actual practice there is a good deal of overlapping. *The Committee feel that a clear demarcation of functions between the two appears to be necessary. The functions of the Directorate should be to do administration, to render technical advice to the Ministry and to excise supervision and give guidance to the various subordinate offices. The Secretariat should limit itself to advising the Minister in framing the policies and examining schemes of national importance formulated by the Directorate and to maintaining co-ordination with the sister Ministries, Planning Commission and State Governments.*

(b) Staff

111. The Committee learnt that there was a great expansion in the activities of the Directorate during the Second World War. The

comparative position with regard to the pre-war strength, post-war strength and the present strength of the Directorate is indicated below:

	Pre-war (in 1939)	Post-war (in 1946)	Present (in 1958)
1. Officers (Gazetted)	7	45	88
2. Non-gazetted staff including technical staff	49	406	531
3. Class IV Staff	20	173	202

A detailed statement showing the staff position is enclosed as Appendix V. The Committee feel that the strength of non-technical Class III and Class IV staff in the various sections of the office of the Directorate General of Health Services is on the high side. *They, therefore, suggest that the O. and M. Division should carry out a job analysis to find out what reduction in the strength of staff can be effected by rationalising the work, if necessary.*

(c) STATISTICAL REPORTS

112. The Committee are surprised to learn that the latest annual statistical report of the Directorate General of Health Services relates to the year 1953 which is completely out of date. The reports for the years 1954-56 have been compiled but have not yet been finalised for publication and that for 1957 has not been prepared at all. The Committee feel that this is an unhappy state of affairs. *They suggest that suitable steps should be taken with a view to ensure regular and prompt publication of statistical report every year.*

113. Apart from the non-availability of up-to-date statistics making an objective study of Health problems extremely difficult, the Committee find that at present there is lack of reliable statistics in relation to Health and Disease in this country. In the absence of such data it is not easy to plan for the future. *The Committee, therefore, suggest that the Government should look into the question of collecting reliable vital statistics throughout the country by improving the existing machinery, by subsidising or running model Statistical Centres, Statistical Bureaus and training men for Statistical Services for the various States.*

(d) CONTROL ON EPIDEMICS

114. Epidemics of various diseases occur in certain parts of the country frequently and it is seen that medicines required to control such epidemics are not sent to such parts in time. *The Committee are of the opinion that the State Governments by themselves are often not in a position to control the impending epidemics and to store the required vaccines, sera etc. The Committee, therefore, suggest that there should be some machinery in the Directorate General of Health Services to keep itself well informed about the impending epidemics,*

availability of preventive sera etc. and to take adequate measures for the prompt supply of essential medicines to the State Governments at a moment's notice.

C. *Central Health Education Bureau*

115. As stated in the First Plan all progress in public health depends ultimately on the willing consent and co-operation of the people and their active participation in measures intended for individual and community health protection. Considering how much illness is the result of ignorance of simple hygienic laws or indifference to their application in practice, no single measure is productive of greater returns in proportion to outlay than health education.

116. The Central Health Education Bureau was sanctioned in October, 1955, and deals with the health publicity part of the health education work. In addition to the Assistant Director General of Health Services (Health Education) who was appointed in November, 1956, one Deputy Assistant Director General (Health Education) joined the Bureau in the year 1957-58. The Bureau undertakes the preparation of health pamphlets, folders, leaflets, posters, booklets etc. It publishes the monthly health bulletin "Swasth Hind". The Bureau has also a film unit and a Library.

117. The Committee thus find that one of the functions of the Central Health Education Bureau is to interpret the services of the Central Health Ministry so as to win support for the maximum use of its various services. *They suggest that the functions of the Bureau should not be restricted to the interpretation of the services only of the Central Health Ministry but should also cover the Health Services as such obtaining in the country. The Bureau should lay greater emphasis on spreading ideas about the positive aspect of how to maintain good health than on how to cure disease.*

118. The Committee understand that there is a scheme to assist the State Governments in setting up State Health Education Bureaus where they are not in existence. *The Committee suggest that this scheme should be implemented early. They also suggest that there should be close co-ordination between the Central and State Health Education Bureaus.*

119. The Committee further learnt that a sum of Rs. 2,25,972 only has been spent during the years 1956-57 and 1957-58 for the Scheme "Central Health Education Bureau" against a planned provision of Rs. 17·75 lakhs. It is stated that savings will be diverted to Malaria Eradication and Water Supply and Sanitation Schemes. *The Committee suggest that this should be done early and the reasons for the excess plan provision should be analysed so that excessive estimates are avoided in future.*

D. *Miscellaneous*

(a) Training and Research in Medical Statistics

120. The Committee learnt that out of Rs. 10 lakhs provided in the Second Plan for the training and research in Medical Statistics only Rs. 30,000 could be utilised uptil 1957-58. It was explained that the scheme had not yet been finalised. It is, therefore, obvious that the entire amount cannot be usefully spent during the Plan period. *The Committee suggest that the Scheme should be finalised soon, the financial requirements for the remainder of the Plan period correctly assessed, and the balance out of the Plan provision of Rs.* 10 *lakhs diverted for other pressing requirements.*

(b) Publicity of Plan Schemes

121. The Committee understand that the Ministry of Health brings out at present small pamphlets describing a particular scheme. The Committee feel that it would be economical and useful if all the schemes of that Ministry are described in one pamphlet. *The Committee, therefore, suggest that the Ministry of Health should bring out a pamphlet both in English and Hindi giving details of all the Centrally administered and Centrally sponsored schemes so as to give publicity to these schemes and send a copy of such pamphlet to every Member of Parliament and if possible to every Member of the State Lagislature also. In this connection the Committee also suggest that it would be useful to associate the Members of Parliament with various Committees appointed by the Ministry to deal with the problems of Medical Services and Public Health.*

(c) Prohibitive Cost of Medical Treatment

122. The Committee have already dealt, elsewhere, with the question of inadequate medical facilities particularly in rural areas and have recommended that the entire country should be covered by Primary Health Centres as quickly as possible and that for this purpose, a suitable target date may be fixed in consultation with the State Governments.

123. However, even in the urban areas, where the medical facilities are available to a much greater extent, it has been noticed that these are available often at an exorbitant cost which is not normally within the reach of the common man. *While appreciating the fact that medical education including specialisation in its various branches is expensive, the Committee feel that there is scope for standardisation of fees for the various types of medical services rendered, so that the*

results of modern medical research are brought within the reach of the average citizen of the country. The Committee, therefore, suggest that this aspect of the problem should be carefully looked into by the Committee proposed to be appointed by the Ministry of Health referred to in para 8 of the Committee's Thirty-seventh Report.

NEW DELHI;
The 13th March, 1959.
Phalguna 22, 1880 (Saka).

BALVANTRAY G. MEHTA,
Chairman,
Estimates Committee.

APPENDIX I

(*vide* para 6)

Constitution, Scope and Functions of the Indian Council of Medical Research

The affairs of the Council are controlled and managed by a Governing Body which consists of 17 official and non-official members. The Union Health Minister is the President, and Secretary to the Government of India, Ministry of Health, is its Vice-President. The Director-General, and one of the Deputy Director-Generals, of Health Services selected by the Government, the Director-General of Armed Forces Medical Services, and the Director-General of Council of Scientific and Industrial Research are its members. The Directors of three, out of ten medical and other Research Institutions are also among the official members. Among its non-official members include an elected representative of the Council of the Indian Science Congress Association, three representatives of Universities in India, three members of Parliament, two from Lok Sabha and one from Rajya Sabha. Maharaja of Parlakimedi is the life member of the Governing Body of the Council.

The Governing Body appoints a Committee called "Scientific Advisory Board", which consists of 16 members. The Board advises and assists the Governing Body in all scientific and technical matters. The Director-General of Health Services, Government of India, is the Chairman of the Board. Seven members are appointed in respect of their medical research experience in the various branches of medical science, three of whom are appointed for their special experience in physiology or pharmacology, in nutrition and in parasitology respectively. Two members are appointed in public health work, one of whom has experience in industrial hygiene. Two members are appointed having experience in Clinical Research, and four members in respect of their experience of a general nature such as health administration, maternity and child welfare, medical statistical work, etc. The tenure of the members except that of the Director-General of Health Services and Maharaja of Parlakimedi is three years. The Director of the Council is the Secretary of the Board.

The main work of the Council is done by the Scientific Advisory Board. After the main problems are formulated by the Governing Body of the Council, the research work conducted under the advice of the Board is started by the Advisory Committee and Sub-Committees. There are 12 Advisory Committees and 13 Sub-Committees. The present compositions of the Governing Body, and the Scientific Advisory Board are as under :—

GOVERNING BODY

1. Shri D. P. Karmarkar,
   Minister of Health, Government of India, New Delhi . *Chairman*
2. Shri V. K. B. Pillai I.C.S.,
   Secretary to the Government of India, Ministry of Health, New Delhi.

3. Lieut.-Colonel Jaswant Singh,
Director-General of Health Services, New Delhi.

4. Lieut.-Colonel V. Srinivasan,
Deputy Director-General of Health Services, New Delhi.

5. Dr. M. S. Thacker,
Director-General, Scientific and Industrial Research, Old Mill Road, New Delhi.

6. Lieut.-General B. Choudhury,
Director-General of Armed Forces Medical Services, Ministry of Defence, New Delhi.

7. Dr. H. I. Jhala, Director,
Haffkine Institute, Bombay.

8 Dr. N. Jungalwalla,
Director, All India Institute of Hygiene & Public Health, Calcutta.

9 Dr. N. Veeraraghavan,
Director, Pasteur Institute of Southern India, Coonoor.

10 Maharaja Shri Krishna Chandra Gajapati Narayan Deo,
Maharaja of Parlakimedi District Ganjam.

11. Dr. J. N. Mukherjee,
10, Puran Chand Nahar Avenue, Calcutta-13.

12. Dr. N. S. Hardikar, M.P.
10, Akbar Road, New Delhi.

13. Dr. Ram Goti Banerje, M.P.,
160-C, South Avenue, New Delhi.

14 Dr. Sushila Nayar, M.P.,
1, Curzon Lane, New Delhi.

15. Dr. Dukhan Ram,
Vice-Chancellor, Bihar University, Patna.

16. Dr. Inderjit Singh,
Professor of Physiology, S. N. Medical College, Agra.

17. Dr. Subodh Mitra,
4, Chowringhee Terrace, Calcutta-20.

18. Dr. C. G. Pandit,
Director, Indian Council of Medical Research, New Delhi. *Secretary*

SCIENTIFIC ADVISORY BOARD

1. Lieut.-Colonel Jaswant Singh,
   Director-General of Health Service , New Delhi. *Chairman*
2. Dr. A. K. Basu,
   Director of the Department of Surgery, Institute of Post Graduate Medical Education and Research, 244, Lower Circular Road, Calcutta.
3. Brigadier C. C. Kapila,
   Director of Research & Health, Directorate-General, Armed Forces Medical Services, New Delhi.
4. Dr. M. L. Chakravarty,
   Professor of Physiology, Medical College, Calcutta.
5. Dr. H. P. Dastur,
   Medical Officer, Department of Industrial Medicine, Tata Services (Private) Ltd., Bombay House, Bombay.
6. Dr. Dukhan Ram,
   Vice-Chancellor, Bihar University, Patna.
7. Dr. B. C. Guha,
   Head of the Department of Applied Chemistry, University College of Science & Technology, 92, Upper Circular Road, Calcutta.
8. Dr. Inderjit Singh,
   Professor of Physiology, S. N. Medical College, Agra.
9. Dr. N. Jungalwalla,
   Director, All-India Institute of Hygiene & Public Health, Calcutta.
10. Dr. V. R. Khanolkar,
    Director, Indian Cancer Research Centre, Tata Memorial Hospital, Parel, Bombay-12.
11. Dr. N. V. Modak,
    'Udyam', Shivaji Park, Bombay-28.
12. Major K. N. Rao,
    Director of Medical Services, Andhra Pradesh, Hyderabad-Deccan.
13. Lieut.-Colonel Sangham Lal,
    Professor of Surgery, All-India Institute of Medical Sciences, New Delhi.
14. Dr. Sushila Nayar, M.P.,
    1, Curzon Lane, New Delhi.

15. Dr. H. Trapido,
Deputy Director, Virus Research Centre, Poona.

16. Dr. P.N. Wahi,
Professor of Pathology, S.N. Medical College, Agra.

17. Dr. C.G. Pandit,
Director, Indian Council of Medical Research, New Delhi., *Secretary*.

APPENDIX II

(*Vide* para 40)

Statement showing the amounts being given by each State as additional rural allowance to qualified doctors serving in rural Areas

State	Amount being given as additional rural allowance to qualified doctors serving in rural areas	Remarks
1	2	3
1. Andhra Pradesh	Nil	The proposal is under consideration of the State Government.
2. Assam	Rs. 15/- to Rs. 30/- p.m. for remoteness of locality, loss of practice, hazarduous nature of work etc.	Proposal under consideration to enhance the rates of allowance from Rs. 75/- to Rs. 200/- p.m.
3. Bihar	Medical Officers in Health Centres are given a non-practising allowance, the rate of which is Rs. 125—300 to Officers in the State Medical Service and Rs. 75/- p.m. to Sub-Asstt. Surgeons.	
4. Bombay	Rs. 50/- p.m. in addition to special pay of Rs. 50/- p.m. to the Medical Officers in charge of Primary Health Centres.	
5. J. & K.	Nil	
6. Kerala	Rs. 50/- p.m.	
7. Madhya Pyadesh	Nil	The proposal is under consideration of the State Government.

1	2	3
8. Madras .	Rs. 50/- p.m. as non-practising allowance and Rs. 50/- p.m. Rural Health Allowance	
9. Mysore .	Nil .	The proposal is under consideration of the State Government.
10. Orissa .	Rs. 135/- p.m.	
11. Punjab .	Nil .	Do.
12. Rajasthan .	Rs. 75/- and Rs. 50/- p.m. to Class I and Class II respectively.	
13. U. P. .	Nil	Do.
14. West Bengal	Rs. 200/- p.m. as public Health allowance except in case of L.M.F. doctors in charge of Union Health Centres or serving in Thana Health Centres who are in receipt of allowance at the rate of Rs. 100 p.m. only.	

APPENDIX III

(*Vide* para 77)

Present composition of the Central Family Planning Board and its Functions

(*i*) *Present Composition*

1.	The Union Minister of Health	Chairman
2.	The Minister of Revenue and Civil Expenditure	Member
3.	Smt. M. Chandrasekhar	Member
4.	Smt. Durgabai Deshmukh, Chairman, Central Social Welfare Board	Member
5.	Dr. J. C. Ghosh, Member of Planning Commission (since dead)	Member
6.	Dr. John Mathai, Chairman, Governing Body, Demographic Teaching and Research Centre, Bombay. — Replaced by Smt. Renuka Ray, M.P.	Member
7.	Smt. Dhanvanthi Rama Rau, President F. P. Association of India, Bombay	Member
8.	Shri C. P. Gidwani (Since dead)	Member
9.	Smt. Anasuyabai Kale (Since dead)	Member
10.	Smt. Savitri Nigam	Member
11.	Dr. S. C. Sen	Member
12.	Prof. P. C. Mahalanobis	Member
13.	Smt. Soundaram Ramchandran	Member
14.	Smt. Shakuntala Paranjpe	Member
15.	Secretary, Planning Commission	Member
16.	Joint Secretary, Ministry of Finance	Member
17.	Secretary, Ministry of Health	Member
18.	Director General of Health Services	Member
19.	Director Family Planning, Ministry of Health	Secretary

(*ii*) *Functions*

(*a*) Research and studies on inter-relationship between economic, social and population changes, on reproductive patterns, attitudes and motivations affecting the size of the family.

(*b*) Educating public opinion on matters of family planning.

(*c*) Advice and necessary service in family planning as an integral part of the public health activities through hospitals, health centres and clinics.

(*d*) Facilities for the training of personnel in family planning.

(*e*) Formulation of schemes for the improvement of the health of mothers and children and for bringing about better conditions of family living.

(*f*) Research on and the production of contraceptives.

(*g*) Literature and periodicals in furtherance of the objectives of the schemes.

APPENDIX IV

(*Vide* para 110)

Broad activities of the Director General of Health Services within the framework of policy laid down by the Central Ministry of Health

(i) to regulate and observe national and international quarantine tlces and the administration ot port he»lth ;

(*ii*) to promote, in consultation with State Governments, the regulatio n and development of medical, pharmaceutical, dental and nursing professions and to lay down and enforce appropriate standards of education for these professions;

(*iii*) to promote, in consultation with State Governments, the establishment and maintenance of all drugs standards ;

(*iv*) to procure, stock and supply drugs, medical and surgical instruments and appliances and sundries to civil hospitals and dispensaries ;

(*v*) to work out and develop health projects in collaboration with international organisations like W.H.O., UNICEF and under the T.C.A. and Colombo Plan ;

(*vi*) to develop medical and public health programmes under the Five Year Plan;

(*vii*) to promote enquiries into and collect statistical and other information relating to particular health problems and co-ordinate efforts in that direction and collect and exchange information regarding development of medical sciences and health administration;

(*viii*) to promote water supply and sewage disposal works in urban and rural areas, planning and administering the National Water Supply and Sanitation Programme and other environmental sanitation problems , training of P.H. Engineers and auxiliary engineering personnel ;

(*ix*) to arrange medical treatment of Central Government Servants residing in New Delhi and Delhi through the Contributory Health Scheme ;

(*x*) to promote and organise health education; and

(*xi*) to plan and execute the following important schemes of the Government of India;

(*a*) National Malaria & Filaria Control Programme

(*b*) Family Planning Scheme

(*c*) B.C.G. Vaccination Scheme

(*d*) Goitre Control Scheme

(*e*) Primary Health Centres

(*f*) Leprosy Control Scheme

(*g*) V. D Control Scheme

APPENDIX V

(*Vide* para 111)

Statement showing the staff position of the Directorate General of Health Services

Designation of the post	1955-56 sanctioned strength	Actual strength working	1956-57 Sanctioned strength	Actual strength working	1957-58 Sanctioned strength	Actual strength working	Remarks
1	2	3	4	5	6	7	8
Demand No. 48.—Medical Services							
A. 1 (1).—Headquarters Establishment							
1. D.G.H.S.	1	1	1	1	1	1	
2. Dy. D.G.H.S.	1	1	1	1	1	1	
3. Additional D.D.G. (M)	1	1	1	1	1	1	
4. A.D.Gs. (Medical, C.H.S., Stores & Planning)	3	3	4	3	4	2	
5. S.A.	1	1	1	1	1	1	

6. D.A.D.G. (Medical Report & Stores)	Annual	2	1	3	1	3	1	
7. Junior Architects		2	..	2	1	2	1	
8. C.N.S.		1	1	1	1	1	1	Post redesignated as Nursing Adviser.
9. D.A.D.G. (Medical C.H.S.)		1	..	..	..	..	..	
10. Statistician		1	1	1	1	1	1	
11. Chief Librarian		1	1	1	1	1	1	
12. Asstt. Architects		4	3	5	5	6	5	
13. O.S.D. (C.D.)		..	..	..	..	1	1	
14. Director (C.H.S.)		..	..	1	1	1	1	
15. St. Officer (Planning)		..	..	1	..	1	..	
16. A.O. (C.H.S.) 17. O.S. (G) 18. O.S.D. (O. & M.) 19. A.O.		4	4	4	4	4	4	Posts redesignated as Dy. Directors (Administration).

A. 1 (4).—D.T.A.B. including I.P.C. & Admn. of the Drugs Acts & Rules.

1. D.C. (India)	1	1	1	1	1	1	
2. Advisory Chemist	1	1	1	..	1	1	Post redesignated as Dy. D.C. (I).
3. A.D.C. (India)	1	1	2	1	2	1	
4. Asstt. Secy. I.P.C	1	..	1	1	1	..	

1	2	3	4	5	6	7	8
Demand No. 49—Public Health							
A. 1.—Headquarters Estt.							
1. Addl. D.D.G. (P.H.) .	1	..	1	1	1	1	
2. Adv. in T.B. . . .	1	1	1	1	1	1	
3. A.D.Gs. (P.H.), (I.H.) Instt. .	3	2	3	3	3	2	
4. Adv. in M. & C.W. . .	1	1	1	1	1	1	
5. D.A.D.G. (P.H.) . .	1	1	1	..	1	1	Post re-designated as D.A.D.G. (I.H.)
6. O.S.D. (Nutrition) . .	1	1	1	1	1	1	
7. T. B. Officer . . .	1	1	1	1	1	1	
8. O.S.D. (UNICEF) . .	1	1	1	1	1	1	
A. 3.—Central V. D. Organisation							
1. Adv. in V. D. . . .	..	..	1	..	1	1	
A. 5.—Goitre Pilot Project in India							
1. O.S.D. (Goitre) . .	..	..	..	..	1	1	
A. 6.—Establishment of C.H.E.B.							
1. A.D.G. (H.E.) . . .	1	..	1	1	1	1	
2. D.A.D.G. (H.E.) .	1	..	1	..	1	1	
3. Asstt. Editor . . .	1	1	1	1	1	1	

C. 5.—Central B.C.G. Organisation

1. B.C.G. Officer . . .	1	1	1	1	1	1	
2. P.O. (B.C.G.) . . .	1	1	1	1	1	1	
3. St. Officer (.B.C.G.) .	1	1	1	1	1	1	
4. A. O. (B.C.G.) . .	1	1	1	1	1	1	Redesignated as Deputy Director (Administration,)

E. 6.—Central Public Health Engineering Organisation

1. D.D.G. (P.H.E.) . .	1	..	1	..	1	1	
2. A.D.G. (P.H.E.) . .	..	..	1	..	1	1	
3. D.A.D.G. (P.H.E.) . .	2	2	5	2	5	4	
4. Junior P.H.E. . . .	2	1	4	2	4	2	
5. Sanitary Chemist Biologist .	..	..	1	..	1	1	
6. Ground Water Geologist .	..	..	1	..	1	..	

E. 4(1).—Family Planning.

1. Assistant Director (F.P.) .	..	..	..	..	1	1	
2. Statistician (F.P.) . .	1	1	1	1	1	1	
3. OSD (F.P.)	1	1	1	1	1	1	Redesignated as Director Family Planning.

1	2	3	4	5	6	7	8
Non-Gazetted Staff including Section Officers (Gazetted)							
1. Section Officers . .	21	20	29	28	33	32	
2. Non-Gazetted Superintendents	4	4	3	3	2	2	
3. Assistants/U.D. Clerks .	153	147	163	135	164	148	
4. L. D. Clerks . . .	144	144	183*	172	207*	191	
5. Stenographers . . .	23	21	34	26	33	29	
6. Steno-typists . . .	2	1	2	2	5	5	
7. Librarian	1	..	1	..	1	1	
8. Statistical Asstt. . .	4	3	3	2	3	3	
9. Computors . . .	9	2	9	9	10	9	
10. Asstt. Superintendent Medical Store Depot . . .	1	1	1	1	1	1	
11. Other Technical Staff .	47	25	66	34	105	43	
12. Class IV Staff . .	156	137	180	165	201	173	

*4 Lower Division Clerks are getting an allowance of Rs. 20/- each for doing shorthand work.

*1 Lower Division Clerk is getting an allowance of Rs. 20/- p.m. for doing cash work in the Contributory Helth Service Scheme.

*1 Lower Division Clerk is getting an allowance of Rs. 25/- p.m. for doing cash work in the main office.

APPENDIX VI

Statement showing the summary of Conclusions/Recommendations

Serial No.	Reference to Para No. of the Report	Summary of conclusions/recommendations
1	2	3
1	6	The Committee are of the opinion that it would be useful, if some qualified experts of Ayurvedic and other indigenous systems of medicine are appointed on the Governing Body of the Indian Council of Medical Research so that researches in these systems of medicine can be properly directed and intensified. They suggest that a special Advisory Committee of the Council may also be constituted for research in Ayurvedic and other indigenous systems of medicine.
2	7	The Governing Body of the Indian Council of Medical Research meets only once a year. The Committee recommend that it should meet more frequently to assess and guide the research programme more actively and also to formulate research programme for future needs of the country. Similarly the Scientific Advisory Board and Advisory Committees which also meet once a year should meet more often to tackle comprehensively the current research problems and also to prepare plans for future, according to the changing needs of the country.
3	8	The Committee are of the opinion that it would be desirable to associate some non-officials and heads of other research institutions on the Selection Sub-Committee of the Indian Council of Medical Research which at present consists of departmental people only.
4	9	The Committee suggest that advertisements for recuirtment to vacancies in the Indian Council of Medical Research may be issued in all the important newspapers including Indian language papers within the normal allotment of funds.

5	10	The Committee feel that the Institutes which conduct researches in health matters should be under the Ministry of Health. The Committee, therefore, suggest that the feasibility of transferring the Central Drug Research Institute, Lucknow and other institutions which deal mainly with health problems from the Council of Scientific and Industrial Research to the Indian Council of Medical Research under the Ministry of Health may be examined by the Government.
6	12	The Committee feel that the work in the field of medical research is being done in an *ad hoc* manner. There is a pressing need for nationwide planning and co-ordination among all research institutions in the country, especially as there are certain problems which are of interest to the Indian Council of Medical Research, the Council of Scientific and Industrial Research and the Indian Council of Agricultural Research in their different aspects. The Committee, therefore, recommend that the research work may be done in a comprehensive and co-ordinated manner and suitable priorities fixed for tackling various subjects of research and then allocating them to the various institutions.
7	13	The Committee feel that the work of co-ordination between Indian Council of Medical Research, Council of Scientific and Industrial Research and Indian Council of Agricultural Research is of considerable importance. In the meeting of the Sub-Committee of the Governing Body of Indian Council of Medical Research, a proposal was put forth that it would be desirable to have a Standing Committee of the Directors of the three Councils. The Committee suggest that the Ministry of Health and other Ministries concerned should take early steps to set up this Standing Committee and include in it certain non-official members also to achieve better co-ordination.
8	14	The Committee suggest that it would be useful to have once in a while, a joint conference of the members of the Council of Scientific and Industrial Research, Indian Council of Agricultural Research and Indian Council of Medical Research for discussing common problems including items of research which might be of interest to all, with a view to maintain close co-ordination and also to avoid over-lapping of efforts.
9	16	The Committee are of the view that the Indian Council of Medical Research should not burden itself with the day to day administration of research institutions. Its

		main functions should be (*i*) the formulation of policy in regard to the future development of medical research in India, (*ii*) stimulation of research activities in the States, universities and medical colleges and (*iii*) co-ordination of such research activities throughout the country, as recommended by the Bhore Committee. The Committee, therefore, suggest that the two institutions *viz.* (*i*) The Nutrition Research Laboratory, Coonoor and (*ii*) The Virus Research Centre, Poona, at present under the control of the Indian Council of Medical Research should have their own governing bodies instead of being managed directly by the Council.
10	17	At present no specific period or time has been earmarked for research work by the two professors maintained by the Indian Council of Medical Research at the School of Tropical Medicine, Calcutta. The Committee suggest that the whole position may be reviewed with a view to ensuring that the professors maintained by the Indian Council of Medical Research devote sufficient time to research. They should be mainly engaged on research work for fulfilling the object of the establishment of the professional chairs by the Indian Council of Medical Research.
11	18	The Committee suggest that the approach of the Indian Council of Medical Research should be more broad-based and the manner of encouraging medical research by assisting individual workers in different places may be combined with the establishment of centres of medical research with full time workers, who will be available for tackling specific problems in the field of medical research. In this connection the Committee also suggest that the feasibility of establishing a chain of laboratories doing medical research on the same lines as is done by the Council of Scientific and Industrial Research may be examined.
12	19	The Committee suggest that medical research should be taken up on a national scale and every medical institution and medical research scholar properly utilised so that some substantial results may be produced. The feasibility of having more schemes and wider fields of work with better finances being made available for this purpose in the Third Plan should be examined.
13	20	The Committee understand that the funds utilised by the private research institutions, concerns or drug houses for conducting medical research are exempt from taxes.

1	2	3
		in some of the western countries in case they are liable to tax. The Committee suggest that Government should examine the question of tax relief in its application to our country.
14	21	The Committee are of the opinion that it would be desirable for the Government to undertake manufacture on a 'no profit no loss' basis of drugs etc. discovered as a result of various useful researches carried out with the help of Indian Council of Medical Research. Factories attached to the Medical Stores Depots of the Ministry of Health and other institutions like the Haffkine Institute, Bombay, and the School of Tropical Medicine, Calcutta may be utilised for the purpose. The Committee suggest that the Indian Council of Medical Research should undertake investigations to find out suitable ways and means of large scale application of the findings as a result of medical research and to that end an extension service similar to that adopted by the institutions under the Council of Scientific and Industrial Research should be instituted. The Committee also recommend that some machinery should be devised to encourage private pharmaceutical concerns to utilise the results of the researches made under the guidance of the Indian Council of Medical Research so that the benefits of the same may be made available to the common man without undue time lag.
15	23	The Committee recommend that the proposal to establish the Central Medical Library should be expedited and the feasibility of opening branches of this Library in the five zones of the country explored.
16	24	The Committee are of the opinion that it is desirable that a policy be laid down to have non-technical administrative help in the medical colleges apart from the technical people to relieve the professors and principals of their routine administrative burden and thus enable them to devote more time to research and teaching. Suitable steps may then be initiated in consultation with the State Governments and the Universities for the implementation of this policy.
17	25	The Indian Council of Medical Research is still carrying out the medical aspect of the work of the Indian National Documentation Centre as the Centre is not yet able to take over such work. The Committee suggest that early steps should be taken to transfer this work to the Indian National Documentation

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		Centre to which it legitimately belongs. Expert medical opinion should be made available to the Documentation Centre to enable it to assess the value of the medical documents.
18	26	The Committee suggest that in view of the general shortage of experienced medical personnel in the country, the knowledge and experience of outstanding retired medical personnel might be utilised on full or part time basis for rapid development of medical research work, provided the legitimate aspirations of younger men are not unduly thwarted.
19	29	The Committee recommend that a quarterly assessment of progress made in the opening of new Centres should be made, if the tempo is to be sufficiently increased, to reach the target of 3000 Primary Health Centres by the end of the Second Plan. Further the Committee recommend that the entire country should be covered by Primary Health Centres as quickly as possible without lowering the staffing pattern of these Centres and for this purpose a suitable target date may be fixed in consultation with the State Governments. Availability of medical personnel should be carefully taken into consideration while fixing the target date.
20	30	The Committee feel that an objective study of the functioning of Primary Health Centres is necessary to evaluate the work done by such Centres so far, and learn from the experience gained. They, therefore, suggest that some organisation like the Programme Evaluation Organisation for the Ministry of Community Development may be established for the Ministry of Health for this and such other purposes.
21	31	At present in certain areas, a Primary Health Centre is located at a place where a dispensary already exists although there are many places in the area without this facility and further some of the Centres are not even located at a central place. The Committee suggest that the location of a Primary Health Centre should be carefully worked out to provide medical facilities to all in a comprehensive manner taking all relevant factors into account.
22	32	The Committee suggest that the feasibility of having two doctors one of whom should be preferably a woman, at each Health Centre, should be examined.

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23	36	The Committee recommend that early steps should be taken to implement the proposals mentioned in the Second Five Year Plan about the Health Units (referred to in para 36 of the Report).
24	37	The Committee suggest that the Primary Health Centres should be linked with the district hospitals and medical college hospitals so that any serious case sent by a Primary Health Centre is admitted in one of those hospitals and information, as to the treatment given and after-care necessary, is sent to the Primary Health Centre when the patient is discharged. In addition experts from district hospitals etc. should visit the Primary Health Centres periodically to help the rural doctors and to see that proper standards of medical care are maintained at the Primary Health Centres.
25	38	The Committee suggest that a beginning should be made in certain Primary Health Centres to maintain family health records which would in course of time be extended all over. These records will give the medical history of each family and throw considerable light on the standard of health of the community served by the Centre and ways and means of improving it.
26	39	The Committee suggest that the facility of quarters should be extended to all the staff attached to various Health Centres. Rural people may be asked to help in providing such accommodation.
27	40	The Committee suggest that the Central Government should make efforts to see that all State Governments do give rural allowance to qualified doctors for serving in rural areas and to bring about a certain measure of uniformity in this respect in a phased manner.
28	41	In the 4th meeting of the Central Council of Health it was resolved that there is a vital need for fully, qualified doctors to serve in rural areas and the Centre should give adequate subsidy to improve the term of service of rural doctors. The resolution of the Central Council of Health has not been carried out. The Committee feel that such a subsidy on the part of the Centre may serve a useful purpose in remedying the existing state of affairs in the country and, therefore, suggest that the question may be reviewed again.

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29	42	The Committee suggest that the Ministry should devise a suitable scheme to give a concrete shape to the idea of the Prime Minister, (mentioned in para 42 of the Report) so as to ensure that every medical graduate spends at least two years in the rural area, after graduation, preferably after he has acquired some experience in medical practice.
30	43	The Committee are of the opinion that the Ministry should work out a scheme of giving elementary training for preventive work to the practising Hakims, Vaids etc. who are already working in rural areas and to make use of all these hundreds of thousands of workers scattered throughout the country in a properly co-ordinated pattern of Health Service. This scheme should also envisage a proper system of linking up with centres of more highly skilled medical care so that serious cases can be brought up for better treatment. Thus all available skill and talent would be able to function in a co-ordinated pattern for the relief of human suffering and prevention of disease and the present atmosphere of rivalry and competition between different systems would be replaced by healthy co-operation. This suggestion implies that the auxiliary personnel should be picked up from amongst those already in the field and in fact all of them should serve as auxiliary personnel, reaching all the corners of the country.
31	45	The Committee while noting with satisfaction that good work is being done at the urban Health Centre at Chetla (West Bengal), are of the opinion that the tempo of activities should be further accelerated so that it may not only serve as an adequate training centre for the All India Institute of Hygiene and Public Health, but also as a means of effectively supplying various health needs in the area and thus serve as a model for such Centres in other big cities as and when established, without interfering with the main object of the Centre.
32	46	The ommittee recommend that it wou d be useful for the Union Government to issue a general directive that in all Institutions under the management of the Central Government name plates and signboards should also be in the official language of the Union in addition to the use of the regional languages.
33	48	The Committee suggest that more orientation training and RCA (Research-*cum*-Action) Centres may be opened on the basis of population *i.e.* one Centre to serve a population of say two or three crores.

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34	51	The Committee are of the opinion that instead of keeping the field of public health a closed preserve for a few, employed in government service, training in public health courses should be thrown open to private candidates to attract talented persons to this line of work. They, therefore, suggest that various public health courses should be opened to private candidates having an aptitude for this kind of work and at least an adequate percentage of seats should be kept for those who wish to specialise in public health out of their own free choice. For this purpose number of seats should be increased and expansions effected, if necessary. This is particularly necessary in view of the fact that the State Governments are all the time advertising for doctors with training in public health.
35	52	A few seats remained vacant in the past in certain courses started by the All India Institute of Hygiene and Public Health due to the fact that candidates of the State Governments who were offered the seats did not join the courses. The Committee suggest that a panel of names of other students desirous of joining the courses should be maintained so that if any candidate does not join the course, another candidate may be offered the vacant seat, and thus the training capacity of the Institute may be utilised to the maximum possible extent.
36	53	The Library of the All India Institute of Hygiene and Public Health remains closed on Sundays. The Committee are of the opinion that the Libraries attached to all the educational institutions should be particularly kept open on Saturdays and Sundays so that the students may make use of them during their leisure time. The example of the National Library, Calcutta which observes only three holidays in a year is worth emulation.
37	54	The Committee suggest that special steps should be taken to ensure the completion of the building for the Public Health Engineering in the All India Institute of Hygiene and Public Health at an early date.
38	55	The Committee suggest that during these days of stringent financial conditions, re-air-conditioning of the whole building of the All India Institute of Hygiene and Public Health should not be resorted to and only such rooms should be air-conditioned which are absolutely necessary for scientific research.

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39	58	The Committee were surprised to learn that though the scheme for the training of Lady Health Visitors during the Second Plan was only a continuation from the First Plan, the Scheme for the Second Plan was sanctioned at the end of 1956-57 thus resulting in non-utilisation of Rs. 3,90,799 during that year. The Committee regret this delay on the part of authorities and suggest that such recurrence should be avoided in future.
40	60	The Committee suggest that the Ministry should carry out a sample survey to find out how many deliveries in the areas served by the Primary Health Centres are being attended to by trained *dais*, the staff of the Health Centres and by untrained *dais*, so that the extent of the problem could be known and necessary provision made for additional trained *dais* including normal replacements.
41	62	The Committee suggest that the feasibility of fixing suitable age limit for the *dais* selected for training may be examined.
42	64	The Committee feel that for the efficient working of *dais* in villages, it is necessary that the *dais* should be under the supervision of a Health Visitor and that there should be a scheme for supplying them with carefully fitted kits and for refilling of the kits after each delivery they conduct. They suggest that a workable scheme should be prepared and implemented to provide for supply and refilling of kits of *dais* regularly in the rural areas. In the absence of Maternity Home Service for all, this is the least that must be done.
43	65	It is stated that certain States have surplus doctors, nurses, etc. but the other States are not prepared to take them on a permanent basis due to local prejudice. Even when they are employed by another State, they do not get equal chances of promotions etc., with the result thay they feel insecure. It is an incongruous position that on the one side there is the problem of shortage of technical personnel while on the other, technical personnel is underemployed or unemployed. The Committee suggest that this position should be discussed in the Central Council of Health and suitable solution worked out in the over-all national interest.
44	70	The Committee feel that there should be a separate public health engineering organisation in every State

1	2	3
		so that the experts working in the direction of public health, continue to work in the jobs to which they were trained, gain experience and contribute their quota to the speedy implementation of the public health schemes.
45	74	The Committee regret to note that there have been considerable shortfalls during the First Plan under Family Planning Programme. Considering the necessity and urgency of the problem, they are of the view that pre-planned and co-ordinated steps are urgently necessary on the part of the authorities concerned to utilise effectively the amount provided for during the Second Plan.
46	80	The Committee suggest that full-time doctors (preferably lady doctors) may be appointed for family planning clinics in rural areas and part-time services of general practitioners utilised for this purpose in the cities.
47	81	The Ministry of Health propose to reduce grants to urban family planning clinics and to concentrate on rural family planning clinics. The Committee feel that in view of the fact that about 82 per cent of the population live in villages, this proposal is commendable and should be implemented early.
48	82	It was stated that at present any tendency to consider maternity and child health and family planning as separate is being discouraged by the Ministry of Health and gradually the intention is to integrate family planning with maternal and child health. The committee suggest that this process of integration should be expedited and family planning advice should form part of the work of all the ante-natal and post-natal clinics and the same officer should be in-charge of these activities at all levels. The new family planning clinics being started should also take up maternity and child welfare work.
49	83	The Committee feel that more concerted efforts are necessary on the part of the Ministry to open family planning clinics in all the medical teaching institutions in the country and to see to it that all doctors and medical auxiliaries are automatically trained in family planning in their normal course of training.

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50	85	The Committee suggest that early measures should be taken to provide adequate accommodation and staff to the Family Planning Training and Research Centre at Bombay. The Committee also suggest that some assessment of research work done at the Centre should be made.
51	86	The Committee suggest that it would be desirable to open at least one Family Planning Training and Research Centre in each region.
52	89	The Committee suggest that by opening adequate number of training centres for family planning in each State, the required number of trained personnel, so essential for the success of the family planning programme, should be made available and utilised for the purpose of imparting necessary training to those desirous of receiving it.
53	90	The Committee are glad to learn that the Ministry of Community Development have agreed to include family planning as a subject in all their training centres in community development. They suggest that the position should be periodically reviewed jointly by the Ministries of Health and Community Development to ensure that the training facilities available for the personnel engaged in the work of Community Projects are adequately and properly used for imparting training in family planning and the personnel so trained work under medical supervision.
54	91	The Committee feel that in addition to the measures adopted by the Ministry to create a strong motivation on the part of the common people in favour of family planning, it is necessary to enlist the active co-operation and support of non-official social welfare organisations, which should be provided necessary facilities for helping in the work.
55	92	The Committee suggest that the views of the Prime Minister with regard to family planning (mentioned in para 92 of the Report) should be properly emphasised to all the workers working in the field of family planning.
56	94	The Committee hope that the experiments being conducted in regard to oral contraceptives will be successful and those that are found useful produced on a large scale to be within the reach of the ordinary person.

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57	95	The Committee suggest that suitable steps should be taken to see that properly tested and suitable contraceptives are sold only under medical advice for family planning to married couples so as to avoid their misuse.
58	98	The Committee are of the view that a comprehensive programme for improving the standard of health of school children is necessary and should be based on scientific data made available on the basis of sample surveys already conducted or to be undertaken. In this connection the Committee were informed that the Ministry propose to appoint an expert Committee presided over by a leading public man interested in the subject to examine the lines on which health survey of school children should be conducted and also to suggest ways and means for the promotion of nutrition among school children. The Committee feel that this is a good proposal because if the health of the school children deteriorates, the future of the country is at stake. They, however, suggest that this Committee should also indicate as to how the various efforts in this direction made by the different agencies can best be co-ordinated. They further suggest that such a Committee should consider the feasibility of harnessing the medicel profession through the local medical associations for the purpose.
59	99	The Committee are of the opinion that proper surveys regarding the nutritional status of school children should be carried out by every Primary Health Centre periodically and steps should be taken to remove the causes of deficiencies in school children found out by such surveys. They are further of the opinion that a beginning should be made in a limited area, say in certain Primary Health Centres areas to supplement the diet of school students and to expand the scheme gradually so as to cover the whole country. They are also of the view that local medical personnel in the area could be harnessed in this work.
60	101	The Committee suggest that in view of its nutritional value, production of multi-purpose food on a commercial basis should start early with international assistance from UNICEF, if necessary. The feasibility of selling the multi-purpose food at a subsidised price to overcome the widely prevalent protein mal-nutrition in the country may be examined.

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61	102	As the Committee consider that both the production and sale of cheap nutritious food are equally important, they suggest that the proposal to develop an industry in Public Sector, to utilise fully the gains of researches carried out at the Central Food Technological Research Institute, Mysore specially in regard to certain cheap nutritious food like Indian multi-purpose food, Tapioca Macaroni, Baby Food etc. and to sell the products through a net work of co-operative societies, fair price shops etc. on "no profit, no loss" basis, may be examined by the Ministry of Health in consultation with the concerned Ministry.
62	104	The Committee suggest that Advisory Committees should be formed at all levels for distribution of milk and other products received from international agencies like the UNICEF consisting of representatives of (*a*) the Ministry of Health (*b*) State Governments/concerned Directorates and (*c*) the non-official agencies connected with social service instead of doing this work through the various Health Directorates.
63	105	The Committee suggest that the products received from the International agencies like UNICEF may be supplied to private maternity centres also under the guidance of the Advisory Committees referred to in para 104, of the Report. The Committee also suggest that the feasibility of decentralising the receipt and storage of these products received from the UNICEF may be examined.
64	107	The Committee suggest that to give publicity to the nutritional values of different types of food in the regional languages, the Ministry should arrange radio talks and publish interesting and illustrative articles, books and pamphlets in attractive style instead of Bulletins written in a technical manner which are hard to understand by the ordinary people. The Committee also suggest that suitable standard menus rich in nutritive values should be devised and introduced in various institutions such as hotels, hostels, guest houses, rest houses, prisons, hospitals etc. under the management of Government. The feasibility of opening model kitchens to demonstrate the correct way of cooking and preserving nutritious ingredients may also be examined.

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65	108	In certain areas the food habits of the people are deficient in some respects resulting in prevalence of certain deficiency diseases. The Committee suggest that special measures should be taken to study this aspect and to evolve and popularise for these areas suitable supplementary diet which would contain the elements that are lacking in their present diet.
66	109	The Committee suggest that the Ministry of Health should carry out a survey of the areas where there are certain specific diseases and find out the causes and assist the State Governments appropriately in eliminating those causes.
67	110	It appears that at present there is no clear demarcation of functions between the Secretariat of the Ministry and the Directorate General of Health Services. Roughly the Directorate gives technical advice besides being concerned with the planning and supervision of various development schemes and the Secretariat of the Ministry functions as the administrative wing. In actual practice there is a good deal of overlapping. The Committee feel that a clear demarcation of functions between the two appears to be necessary. The functions of the Directorate should be to do administration, to render technical advice to the Ministry and to exercise supervision and give guidance to the various subordinate offices. The Secretariat should limit itself to advising the Minister in framing the policies and examining schemes of national importance formulated by the Directorate and to maintaining coordination with the sister Ministries, Planning Commission and State Governments.
68	111	The Committee suggest that the O. & M. Division should carry out a job analysis to find out what reduction in the strength of staff of Directorate General of Health Services can be effected by rationalising the work, if necessary.
69	112	The Committee suggest that suitable steps should be taken with a view to ensure regular and prompt publication of annual statistical report of the Directorate General of Health Services every year.
70	113	The Committee suggest that the Government should look into the question of collecting reliable vital statistics throughout the country by improving the existing machinery, by subsidising or running model Statistical Centres, Statistical Bureaus and training men for Statistical Services for the various States.

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71	114	The Committee are of the opinion that the State Governments by themselves are often not in a position to control the impending epidemics and to store the required vaccines, sera etc. The Committee, therefore, suggest that there should be some machinery in the Directorate General of Health Services to keep itself well informed about the impending epidemics, availability of preventive sera etc., and to take adequate measures for the prompt supply of essential medicines to the State Governments at a moment's notice.
72	117	One of the functions of the Central Health Education Bureau is to interpret the services of the Central Health Ministry so as to win support for the maximum use of its various services. The Committee suggest that the functions of the Bureau should not be restricted to the interpretation of the services only of the Central Health Ministry but should also cover the Health Services as such obtaining in the Country. The Bureau should lay greater emphasis on spreading ideas about the positive aspect of how to maintain good health than on how to cure disease.
73	118	The Committee suggest that the scheme to assist the State Governments in setting up State Health Education Bureaus, where they are not in existence, should be implemented early. They also suggest that there should be close co-ordination between the Central and State Health Education Bureaus.
74	119	A sum of Rs. 2,25,972 only has been spent during the years, 1956-57 and 1957-58, for the Scheme " Central Health Education Bureau" against a planned provision of Rs. 17·75 lakhs. It is stated that savings will be diverted to Malaria Eradication and Water Supply and Sanitation Schemes. The Committee suggest that this should be done early and the reasons for the excess plan provision should be analysed so that excessive estimates are avoided in future.
75	120	Out of Rs. 10 lakhs provided in the Second Plan for the training and research in Medical Statistics only Rs. 30,000 could be utilised uptil 1957-58. It was explained that the Scheme had not yet been finalised. It is, therefore, obvious that the entire amount cannot be usefully spent during the Plan period. The Committee suggest that the Scheme should be finalised soon, the financial requirements for the remainder of the Plan period correctly assessed, and the balance out of the Plan provision of Rs. 10 lakhs diverted for other pressing requirements.

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76	121	The Committee suggest that the Ministry of Health should bring out a pamphlet both in English and Hindi giving details of all the Centrally administered and Centrally sponsored schemes so as to give publicity to these schemes and send a copy of such pamphlet to every Member of Parliament and if possible to every Member of the State Legislature also. In this connection the Committee also suggest that it would be useful to associate the Members of Parliament with various Committees appointed by the Ministry to deal with the problems of Medical Services and Public Health.
77	123	While appreciating the fact that medical education including specialisation in its various bracnhes is expensive, the Committee feel that there is scope for standardisation of fees for the various types of medical services rendered, so that the results of modern medical research are brought within the reach of the average citizen of the country. The Committee, therefore, suggest that this aspect of the problem should be carefully looked into by the Committee proposed to be appointed by the Ministry of Health, referred to in Para 8 of the Committee's Thirty-seventh Report.

APPENDIX VII

Analysis of recommendations contained in the Report

I. *Classification of recommendations*:— TOTAL

A. Recommendations for improving the organisation and working:

1 to 3, 5 to 11, 15 to 18, 20, 21, 23, 25, 28, 30, 31, 37, 39, 41 to 46, 48, 50, 53, 54, 62, 63, 67, 69, 70 to 73 & 76 . 42

B. Recommendations for improving and/or extending the welfare activities in the country :

4, 12 to 14, 19, 22, 24, 26, 27, 29, 32 to 34, 36, 40, 47, 49, 51, 52, 55, 56 to 61, 64 to 66 & 77 30

C. Recommendations for effecting economy :

35, 38, 68, 74 & 75 5

II. *Analysis of the more important recommendations directed towards economy*:—

Serial No.	No. as per summary of recommendations	Particulars
1	2	3
1	35	A panel of names of those students desirous of joining the courses at the All India Institute of Hygiene and Public Health, but not selected, should be maintained so that if any candidate does not join the course another candidate may be offered the vacant seat and thus the training capacity of the Institute may be utilised to the maximum possible extent.
2	38	Only such rooms of the building of the All India Institute of Hygiene and Public Health should be air-conditioned which are absolutely necessary for scientific research.
3	68	The O. & M. Division should carry out a job analysis to find out what reduction in the strength of staff of Directorate General of Health Services can be effected by rationalising the work, if necessary.

1	2	3
4	74	A sum of Rs. 2,25,972 only has been spent during the years 1956-57 and 1957-58 for the Scheme " Central Health Education Bureau" against a planned provision of Rs. 17·75 lakhs. It is stated that savings will be diverted to Malaria Eradication and Water Supply and Sanitation schemes. This should be done early and the reasons for the excess plan provision should be analysed so that excessive estimates are avoided in future.
5	75	Out of Rs. 10 lakhs provided in the Second Plan for the training and research in Medical Statistics only Rs. 30,000 could be utilised uptil 1957-58. It was explained that the scheme had not yet been finalised. The scheme should be finalised soon, the financial requirements for the remainder of the Plan period correctly assessed, and the balance out of the Plan provision of Rs. 10 lakhs diverted for other pressing requirements.

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