Seventh Five Year Plan - 1985-90 - Vol II, GOI, Planning Commission
Sectoral Programmes & Devt. New Delhi Oct 1985.

Chapter 11 — Health + FW.

Achievements	~~Since Independence~~ 1941-51	1985-86
(1) Life expectancy	27.4 yrs	54.71 yrs est.
(2) IMR	50's 146/1000 LB	1981 — 110/1000 LB
(3) per capita expenditure on Health	— Rs 1.50 in 55-56	— Rs 27.86 in 81-82

(4) Build up of health infrastructure —

	1979-80	'85
Subcentres	47,517	83,000
PHC's + Subsidiary HC's	7,399	11,000
CHC's	749	650.

(5) Plague + spox eradicated
(6) Malaria brought under considerable control
(7) Mortality from cholera + related dis. considerably brought down.
(8) Significant indigenous capacity est. for prod. of drugs, pharmaceuticals, vaccines, sera + hospital + other equipment.

TB 11.11 continued to be a major health problem.

a) Control operations augmented considerably by ensuring adequate supplies of quality anti TB drugs + equipment.

b) Progr. to detect + bring under Rx new TB cases was stepped up. Exam. of Sputum at PHC level is being pursued with vigour on a target oriented basis.

c) This is backed by a network of 358 DTC's, ?100 TB clinics (urban) + 45,000 TB beds in the country

d) VII^th Plan target to raise the no. of cases detected from 30% to 50% has been partially realised.

(Can pvt sector perform public health functions? Has this ever happened esp. controlling TB? Control of TB is the responsibility of public health & family is the pvt sector)

Related factors (partly resp. for poor implement) - Personnel

a) MPW Trg :- "Trg -- not progressed satisfactorily"
- lack of rationale of pay scales of MPW's by States - a serious impediment to successful progress of the Scheme
- Pop" norms for postings not been generally followed.

b) Min. Needs Prog - norms for PHC's/SC's/CHC's + staffing - Targets not met :
- shortage of construction materials like cement & steel
- in some States shortages of dr's, nurses, ANM's, FMW's
∴ intake of ANM's for trg ↑ ↑
subcentres est. in public/rented bldgs.
full financial assistance provided to States to train PH personnel
? what do! - (M) MPW's, LT's
certain States resp - value health + give it greater →
cf. TN, Kar, NE, Goa,

c) Leadership/lobbying — is diffuse & more internally divided in TB than in leprosy — where progr. was "segmented & converted to NLEP based on strategies & policies formulated by a high level committee."
(Also in malaria — NMEP & MRC are much stronger)
Backing/support of international orgs also strong on the above 2 issues & in a relatively positive way.

d) Other communicable diseases — filaria, STD, diarrhoeal dis
"Most concerned control programmes suffer from poor management + monitoring"

e) Sec & Tertiary Care "Referral linkages are weak & need strengthening"

f) RCHTC - 1st phase 106 med. colls, Rs 16 L/unit"; "obj. not achieved to desired extent" d/o (i) lack of commitment to progr. at all levels (ii) slow progress in utilis" of central funds (iii) absence of efforts in restructuring teaching + training progs at state level?

medical profession has lost its way - itself

Seventh Plan – Objectives, Goals + Strategy

Committed to HFA 2000 AD & PHC as main instrument of action.

a) For control + eradic: of communicable diseases, programme implementation at all levels needs strengthening, with strict adherence to the sharing of the costs of the programme by State Govts. (Can we get info abt – Kar + Central share of costs for NTP – from TBUnit at DGHS Delhi + Tech JD (TB) B'lore)

b) Trg + educ: of dr's + paramedical personnel needs a thorough overhaul. Teaching + learning have to be related to the health probs of the people. Medical trg must be need based, problem centred + community oriented.

- HITK Manag: support + supervision need considerable strengthening
- Med. Res. + TSM.

Programme thrusts in 7th 5 Yr. Plan.

a) Consolidating infrastr – constr:, trg, personnel, equip etc.
b) extending HPW's scheme.
c) integr: of HITK, FW + MCH (incl. financial integr:) (imp)
d) ↑ com. participn:, village health committees, ↑ participn: by village
e) ↑ UHC's, ↑ subcentres, trg of PHW's, ↑ lab facilities
f) orient:, HIS etc
g) services in urban areas.
h) Communicable dis control –

- TB "Optimum utilisation of the existing network of DTC's + tools besides the establishment of additional units where needed for further extension would be the main planks of the national TB control progr. Provision of essential xray + lab. equipment would also be ensured under the progr. towards the objective of ↑ the detection rate to 2 million new cases per annum against the present detection rate of 1·2 million cases per annum. Steps would be taken to

provide extensive health education, produce health edu. material & to involve the community & medical & paramedical personnel in the programme. In respect of both TB & leprosy, enduring efforts have to be made to ensure early detection & compliance with therapy.

— ME, Trg & Manpower Dev.

- ↓ in quantity of ME, make it more need based and community oriented
- CE for all staff, supportive trg, on the job trg, trg of paraprofessionals
- States to dev. own manpower dev. activities, dist. level planning.

— Med & HFW Service Research

a) in communicable diseases, controlled clinical trials to improve chemo-therapy regimes for treatment of TB & leprosy, besides operational research to improve detection of cases & case holding would be accorded priority. . . .

Drug Control & Medical Stores Organisation

11.46 Measures initiated for balancing demand & supply of essential & life saving drugs, strengthening vaccine prod. units, rationalis of pattern of drug prod., import & distn systems for providing the specialities of PHC etc would be strengthened in the 7th Plan. The drug industry is poised for rapid growth. This places further responsibility on both the Central & State level drug control organisation responsible for regulating the quality of drugs. The Central & State Organisations would, therefore, need to be adequately strengthened in the 7th Plan Period. Zonal Offices of the Central Drug Control Organis., Central Drug Lab, Calcutta, & Central Indian Pharmacopoeia Lab Ghaziabad & Junc as appellate labs under the Drugs & Cosmetics Act & assist the States also need to be strengthened & properly equipped

(State sector pick slowly expanding capacity, ? if/to retain the WB/IMF/US internal pressure to limit the Govt. sector)

From perspective of poor — a strong Public Sector is vital to support them in their plight.

In view of its vital role + added responsibilities in furthering the promotion of health care + F.W. progs, the Medical Stores Organis°. (MSO) to be strengthened as follows —

a) improvement + expansion of storage facilities
b) strengthening, improving + modernising quality control at govt. Medical Depots.
c) improvement + modernising existing manufacturing facilities
d) strengthening + expanding personnel components of MSO
e) adn. & sound inventory control sys. + rationalis°. of sys. of accounting & aid of computer

Chap 19
Minimum Needs Progt (MNP) was a 1st year of Fifth Five Year Plan (1975–78) to introduce network of basic services / facilities of social consumption in specified time frame — to raise living stds + ↓ regional disparities.

Sixth Plan - it had larger outlays — 1980-85

Alloc° — Rs 5,807 crores of which Rs 4924 cr in State sector + Rs 883 cr in Central sector.
est. expenditure - " 6,547.05 " " " " 5265.33 " " " 1281.72 " "
XS expenditure over outlay — is not a lack of utilis°.

MNP - Sixth Plan Outlay & Expenditure (Rs - crores)

Progr.	Outlay 1980-85	Expenditure 1980-81	'81-82	'83-84	84-85	1984-85 anticipated outlay	1984-85 anticipated expenditure
Rural Health	408.00 +169.00	40.05 +19.57	62.84 +24.30	67.53 +32.87	91.68 +44.65	109.76 +63.43	113.19 +61.78
Rural water Supply	1407.00 +600.00	211.91* +99.00	259.54* +100.00	307.79* +151.45	360.51 +265.71	366.08 +292.50	358.15 +292.50
Housing for landless workers	354.00	54.54	76.54	92.31	110.51	119.71	92.64
Improv° of urban slums	151.80	21.69	25.52	27.15	35.23 +12.00	42.33 +10.00	41.34 +10.00
Nutrition	219.00	28.58	35.37	68.41	117.79	139.72	146.98
Total: State Sector	4924	718.75	861.10	974.99	1293.06	1312.99	1417.43
" : Central "	+ 883	+ 129.45	+ 150.66	+ 208.06	+ 362.09	+ 428.54	+ 431.46
Grand Total	5807	848.20	1011.76	1183.05	1655.15	1741.53	1848.89

Elementary edu°: 851.00 + 54.00
Adult edu°: 68.00 + 60.00
Rural electrific°: 301.00
Rural Roads 1165.00

4698.11 + 1848.89
6547

Rajiv Gandhi's - high achievement phase

Rural Health - under MNP - Estab. of rural subcentres - high priority
Against target of 40000 SC's likely achievement is 35509. Shortfalls in H.P, Karnataka + M.P. Against 6th plan target of 1600 PHC's (incl Subsidiary health centres) achiev^{n} is 3702, i.e. is > twofold. This is largely d/o Maharashtra augmenting its PHC facilities in a no. of rural dispensaries during 84-85. Karnataka, UP & WB not able to fulfil targets (does it have to do i States i Opposition Govts)
Under CHC scheme likely achievement^{n} at end 1984-85 reported to be 400 against a target of 174. All States could to accord high priority to setting up CHC's.
(NIP to respond to dev^{t} of CHC's / Rural hosp's etc — + not by reducing them to 'PHI' status)
Despite extensive infrastructure, the States have not been able to provide adequate no. of drs, nurses + other paramedical staff in the health care units set up under the programme - mainly d/o the fact that trained staff has not been available. Accordingly financial assistance has been ensured to the States to train paramedical staff in the categories where shortages persist.
Under UHG scheme, 3.72 L health guides were trained + positioned in 4170 PHC's (against a target of 4810 PHC's) under the Progr. till end '84-85. (Emphasis on quantity vs quality)
* But the tie-up of unipurpose health workers for converting them to MPW's led a setback :: States were unable to resolve issues rel. to unific^{n} of cadres + rationalis^{n} of pay scales of MPW's
(emphasis needs to be given to mgt + both + unintellectual so called non-technical aspects of policy implementn).

Role of personalities

29/8/97

Ref: NTI lib

23/6/96

SIXTH FIVE YEAR PLAN 1980-85, Planning Commission, GOI

Chairman — Indira Gandhi

Dpty Chairman — Narayan Dutt Tiwari

Member — R. Venkataraman

" — M.S. Swaminathan

" — Mohd. Fazal

Member-Sec — Manmohan Singh

Preface of framework "The formulation + execution of the 5 year Plan is a responsibility both of the centre + the States" - State Govts have also the resp. to prepare progs in agri, irrig, power, educ, health, industry, infl, village + small industry + resource mobilisation. "pass. decentralisation - giving dist/block authorities scope for mobilising local resources for local dev".

Foreword (by Indira Gandhi)

Progress in a country of India's size + diversity depends on the participation + full involvement of all sections of the people. This is possible only in democracy. But for democracy to have meaning in our circumstances, it must be supported by freedom + economic justice + freedom gives social equality - This is the frame of our planning.

Special difficulties faced —

(a) plan exp + (b) budget exp when the whole world + India more than others was hard hit by inflation, & could use of petroleum prices, while price of our raw materials remained static

+ (c) other political & economic factors +

(d) unprecedented expenditure

Severe financial constraints + political expectations.

Planning is more than putting together a no. of central + State Govt projects. It is a direction. Once the nation is clear about the path to be followed, the details can be adjusted as we go along.

"The measure of a plan is not intention but achievement, not allocation, but benefit."

Preface - N D Tiwari

Planning Com: reconstituted in April 1980

Working grps formed. Consult's held: Ministerial + Consultative Committee of MP's on Planning

"6th 5 yr plan - a framework" presented to NDC in Aug '80

NDC - directed Pl. Com to prepare final draft

Wide-ranging consultation & experts

3rd Pl - J. Nehru "Planning is a continuous movement towards desired goals" 'process'

Essential goals of Indian planning have been growth, removal of poverty & achievement of self-reliance.

Concern has been to give practical shape to the national collective will for using all human resources & energies of the nation for an effective attack on poverty, unemployment & inequalities.

Final size of public sector outlay - Rs 97,500 cr. of 79-80 prices (97500 97 thousand million (How many million make a billion)

In real terms 80% higher than 5th Pl. outlay

Share of States + UT's in the Plan is Rs 50,250 crores i.e. 51.54% of total outlay

In Non Plan - it is all State Sector.

Need to create conds for resource mobilisation in a non-inflationary manner. Inflation is the most regressive form of taxation.

[Indo-China war - '62, Indo Pak war '65, Indo Pak war '71 - Story] (1948 - Indo Pak war.)

Acute inflationary pressures e prevailed in 1979-80 have shown some signs of abatement in 80-81. But economy extremely vulnerable to rise in oil prices & to deterioration in terms of trade generally.

Need to reduce energy imports, promote exports & increase earnings.

30 yr. secrecy of official documents - lack of analytical, historical analysis of post Independence Indian History Assn. - also has not brought out glaring unnecessary dependance on American versions of planned economy!

Need - import substitution + export rate 9-10%
+ growth rate of 5.25% + direct means of ↓ poverty in rural areas
thru - transfer of assets, provision of inputs, credit, kg + services
wage employ^n. thru NREP, provision of social services thru MNP/Other
Raise at least 3000 poorest households above poverty line in each
Block during Plan. ✱

Outline of impl^n for Chap 2

Necessary changes in extension + delivery services will be given high priority
The success of the Plan depends crucially on the efficiency, quality
+ venture of implementation - all round improvement in production
+ efficiency, not merely in the functioning of the infrastructure or the
public sector, but in all segments of national life.
Special responsibility devolves on that segment of the pop^n which has benefited
disproportionately from planned dev^n so far + also on those who have
been fortunate enough to enjoy superior access to education +
professional skills.

Chap 1 - Develop^n Performance

Basic objectives of Planning - 4 heads - (a) growth (b) Modernisation (c) self reliance
(d) social justice.
Growth - Prolonged period of stagnation preceded Independence
Expert estimations of national income of undivided India showed the
trend growth rate between 1900-01 + 1945-46 was 1.2% for
national income, abt 0.3% for agricultural prod^n + 2% for industrial
production. One of the most significant achievements of post-Independence
dev^n policy - This handicap of stagnation was overcome + process
of growth initiated

Chap

Between 1950-51 + 78-79 underlying trend rate of growth of
national income was 3.5%, of agri. prod^n 2.7% + of industrial prod^n
6.1%. In per capita terms, income grew at a trend rate of 1.3%, ∈
after allowing for rising share of investment in national income, means a
modest 1.1% per annum rise in per capita consumption

Targeted & Actual growth Rates (percentages)

Plan	Target	Actuals	Growth rate for
1. First Plan	2·1	3·6	national income ex SEV + Cal 61
2. 2nd "	4·5	4·0	national income decline for 64-65 just when 3rd Pl was formulated
3. 3rd "	5·6	2·2	national income
4. 4th "	5·7	3·3	net domestic product
5. 5th "	4·4	5·2	gross domestic product

[NB: Targets were generally specified in terms of net national income / product upto the 5th Pl. in & for the first time targets were specified in terms of GDP]

Grth of nat. income depends on a complex interaction of a large no. of variables, not all of ē are amenable to govt. control. Quantum of investment & productivity of this investment as measured in a simplified model by the capital/output ratio, exercise an imp. influence on overall grth. rate.

Approx. & first order explan^n for gap bet. Target & actual levels of income grth found in comparison of trends in income & investment. — Shortfalls (or excesses) in income grth are larger than wd would follow from shortfalls (or excesses) in investment. Realised capital output ratios post. during 3rd & 4th Pl. periods have been much higher than anticipated. Total investment Targets have by & large been met or exceeded in recent plans. 7/11 Plan period - excess was due largely to higher levels of private sector investment & stock accumul^n in public sector. Link bet. invest^t & income is not simple & operates thro' not merely capital output ratios, but also in reverse dir^n - ie shortfalls in income grth & their impact on domestic savings can lead to a shortfall in investment.

Deficiency in investment & higher capital output ratio's are only the immediate, arithmetical explanations for shortfalls in growth targets.

Further analysis necessary to identify factors accounting for departures from forecasts / targets.

Some portion of the difference is attributable to a degree of unrealism in the forecasts. (also occurred in NTP — need to consider trend in pop. growth, income growth + std of living, wars/refugees, external financial constraints); but in the case of investment + capital productivity, the explanation lies to a considerable extent in deficiencies in effective implementation of plans.

Data on rates of gross savings + investment show very substantial rise in rate of gross investment, a rise ē came in 2 spurts — 1st - during 1st decade of planning + 2nd bet 1972-73 + '78-79 by ē time rate rose to 23.2%. Bet 60-61 + 72-73 rate fluctuated around 17%. in this period shortfalls rel. to rates in various plan perspectives are most substantial.

High current rate of capital form. financed largely by domestic savings. - savings of household sector most buoyant; public sector + corporate savings have grown much more slowly than anticipated (mangt. + admin. failure)

Level of public investment det. largely by plan expenditure ē has generally exceeded plan provision in nominal terms but fallen short in real terms. Main reason for this is the fact that there is no built in mechanism to protect public sector resources + investment against inflation.

A high level of public investment in infrastr + key industries is a precond. for dev of pvt. sector.

Problems

a) inefficiency in utilisation of assets - avoidable
b) declining efficiency in power + railways since mid 60's
c) declining capacity utilis. rates in industry
d) yearly variations in agriculture d/o drought + regional disparity in land / pace of agri. + stagnation in prod of pulses + oilseeds
Despite fast tempo of agri. advance maintained.

• At Independance we inherited an industrial structure restricted to textiles + sugar. 1st steel plant had been set up + limited dev. of engineering in railway workshops + assembly plants.

Drive for diversific. / self reliance → new sectors of chemicals + engineering substantially ↑. Dev. of dominant pos. of public sector i.e. steel, non-ferrous metals, petroleum, fertilizer, petrochemicals, heavy engineering

Emp of private sector recog. by Govt + relevant of restrictions estab. to support + regulate it - eg develop. banks for finance. gave 5000 Cr Rs till Mar 79 @ 10% i.e. low rate + provision of refresh, raw material, supply, marketing + technology. Small scale industries / artisans protected thru' product reservation + concession

Regulatory framework - early Industries (Dev. + Regn.) Act
later: Monopolies + Restrictive Trade Practices Act - ie
- by no means perfect

Agri - Zamindari / other intermediary tenures almost eliminated
- Technology change - high yielding varieties, irrig., fertilizers, pesticides, agri. research + extension services
- sys. of support prices, procurement, public distri
- Sig. progress in prod of major foodgrains, horticulture, animal products like egg, milk, fish. - but yields still below what is expected (who benefits more
role of entrepreneurs
- coop credit sys spread ↓ dependance of cultivator on moneylending / trader
- dev of Land Dev. Banks, Regional Rural Banks, Agri Refinance + Dev. Corpn.
- FCI i.e. ~~marketing~~ foodgrain stock + marketing / processing
unequal rel. bet farmer + trader allowed
- Human skill wastage.

- rapid expansion of technical educ / I.T.I's
Scientists, div's, agri graduates - 3rd layer tech + sc manpow.
But capacity of sys to absorb them into productive employment inadeq.
1) pure/applied research limited - except: agri research, atomic energy + space.

Human skill - a formidable asset - if used effectively will turn out to be one of the most fruitful results of planning.

- Mobilis" of savings
- innovations like development banks for industry & agri + sys of cooperative credit.
- major change in functioning of capital markets effected thru nationalis" of banks in 1969 after which a substantial ↑ occurred in bank lending to agriculturists, artisans, small industrialists, transport operators + those whose access to bank credit was hitherto severely limited.
- At Independence we inherited policy admin" oriented to maintenance of law & order + revenue admin".
Later an elaborate dev" admin" built up from village, thru block, dist to secretariat + intro of panchayati raj has a role in dev" admin".

Sectors in health an unfinished dev. - it has to improve qualitatively - better diagnostics, drug supply, transport + living cond" will all & quickly.
Eg. for PHCMO's + SrHA's on - dev", P.R.
Though there are deficiencies in terms of motivation, probity + efficiency it provides a point of contact between govt + household/enterprise.
The major problems at present lie not in lack of institutions or persons for tasks at hand but in their effectiveness + in some parts of the institutional framework there is a mismatch between form + function which needs correction.

Self-reliance dimensions → reduced dependance on foreign & diversified domestic prod: & imports in certain critical commodities, & export to enable payment for imports from own resources

1st Pl recog. that in early stages of dev:, deficit in BOP inevitable in need for finance for imports of machinery & other goods & could not be met from domestic supplies

This BOP to be met by

a) use of reserves → 1st 2 plans by drawing down sterling balances accumulated in pre-independence period

b) inflows of external finance → external aid & in 2-4th Pl.

c) in long run → adjustment for trade & import substitution & export promotion.

% of imports financed by net aid was 4.9% in 1st Plan, but it rose to 26.9% in 2nd Pl. V. rapid ↓ in reserves led to foreign exchange crisis in 57-58 after dependance on external assistance. Thereafter sharply ↓ in % of imports financed by net aid & to 37.5% in 3rd Pl. + Annual Plan. (61-66 + 66-67; 68-69). Thereafter steady ↓ in 5th Pl net aid financed 12.8% of imports.

Net Aid as % of Plan expenditure →

Gross & Net Aid by Plan Periods (Rs in crores)

Period	Utilisation of external assistance	Amortisation + interest payment	Net Aid	Net Aid as % of Plan expenditure	Net Aid as % of imports
1. First Plan, 51-52 - 55-56	201.7	23.8	177.9	9.1	4.9
2. 2nd Pl - 56-57 to 60-61	1430.4	119.4	1311.0	28.1	26.9
3. 3rd Pl - 61-62 to 65-66.	2867.7	542.6	2325.1	27.2	37.5
4. Annual Plans 66-67 - 68-69	3229.6	982.5	2247.1	33.9	37.5
5. 4th Pl 69-70 - 73-74	4183.7	2445.0	1738.7	11.2	17.6
6. 5th Pl 74-75 to 78-79	7309.5	3770.4	3539.1	8.9 *	12.8

* on actual expend. for 1st 4 yrs + anticipated exp for 78-79.

Ext. Aid carries debt service obligⁿ in subsequent years to be discharged from foreign exchange earnings. Debt service burden as % of exports from less than 1% in 1st Plan to peak of 27% in 4th Plan — Thereafter rapid rise in export earnings % ↓ to 15.4% in 78-79.

(International Financial Institutions benefit from this — as also their major stakeholders — in recession/inflation in West — there will be ↑ pressure on us to resort to this — as it is a way of income power for them)

? % of net aid derived from donor countries vs bilat + multilat aid.

Need to ↓ ext. aid dependence just as it was initiated in 3rd Pl — I. Gandhi's 4th Pl — Exp. Obj — to ↓ net aid by ½ over pl. period, foll. by speedy elimin thereafter.

Also stop ↑ in import prices of petroleum products + other commodities, in absolute terms question of debt aid ↑ in 1st 2 yrs of 5th Pl but ↓ once again to roughly that prevailed in 4th Pl. by 78-79.

Import subst — dev of machinery, manufacture + capability in project consultancy, design engineering, project implementation dev to a level that we can export those services

(but we need to keep moving the selling edge)

Obj Need to ensure more equitable world economy. ↑ ↓ vulnerability to internal pressures + disturbances.

a) dev ↑ ability to cope with food grain prod shortfalls of
- Drought - mid 60's - Substantial food grain import or concessional
- " - early 70's - imports from open market - with food aid reserve
- " 1979 - managed with food grain import.

b) Fifth Pl — ↑ BoP burden ∵ of oil price ↑ — foreign exchange earnings in critical sectors like power maintained ∵ of limited dependence on imports for equip supplies.

P

c) Rapid deterioration in international environment - mid 70's onwards : ↑ price for imports of petroleum products, fertilisers, machinery & other products. Bet 74-75 & 78-79 net loss abt Rs 5000-5500 cr. - as % of national income, loss of abt 1.5 % per annum. However, GDP & export earnings & remittances helped accumulate a substantial volume of foreign exchange reserves.

Other problems

a) Sudden shortages in availability of critical items

b) growing protectionism in developed countries

(The economic imperative of dev. planning / financial stringency has been yet to impress on policy makers / planners that investing in basic health & educ. is also in ec. interest. However, it would challenge the hold of the small upper minority groups in asset holding & decision making)

Social Justice - 2 dimensions - a) Improved living standards of poorest (b) reduce inequalities in asset distribution.

Variety of instruments used over the years

c) Direct attacks on poverty & asset inequality - what was the impact on poverty.

b) More indirect fiscal measures.

Bet 1950-51 & 1978-79 - per capita private consumption grew by 43 %

But ? distribution.

* Share of poorest 30% in consumer expenditure (%)

Sector	1958-59	1977-79
Rural	13.1	15.0
Urban	13.2	13.6

% of pop: below poverty line

	1972-73	'77-'78
Rural	54%	51%
Urban	41%	38%

Various analyses of movement of poverty % over a longer time period do not show a significant upward or downward trend. Broad picture is of an increase in mid sixties when consumption standards were badly affected by 2 severe drought + a declining thereafter.

Distribution of Assets in Rural Areas %

% share in assets of	1961	1971
1. Lowest 10%	0.1	0.1
2. Lower 30%	2.5%	2.0%
3. Top 30%	79.0	81.9
4 Top 10%	51.4	51.0

This is based on an All India Debt + Investment Survey - highlights very low land & asset holding of poorest 30% in rural areas - where bulk of pop lives. (b) There has not been any major change in structure of asset ownership in rural areas during the 60's. Of 'poor' households are defined as those with less than Rs 1000 of assets in 1961 or to allow for inflation Rs 2,500 in 1971, the % of such households increased from 30% in 1961 to 35% in 1971. Bulk of assets of these 'poor' households consist only of their huts, some household goods + some livestock.

Principal productive asset in rural areas is land which in 1976-77 was distributed as follows -

Distribution of land (%).

Operational holdings of	No.	Area operated
1. less than 2 hectares	72.6	23.5
2 2-10 hectares	24.4	50.2
3. Over 10 hectares	3.0	26.3

Small & marginal farmers, constituting over 70% of land holders operate barely 24% of land. ↑ agri productivity - irrig - new seeds - fertilizers - technology directly improve earning power of agricultural land, & only indirectly that of agri. labour. ↑ agri gth itself may not solve poverty problem - Need mix of two measures - employment generation diversifi of occupations, land reforms, revision of credit system massive public investment in rural infrastructure - for equitable distn of fruits of economic progr.

Benefits would be skewed towards the 3+24 %, who could avail of the new schemes.

- a potentially volatile situation.

Land reforms - 1st phase - Abolition of Zamindari / intermediary tenures to a large extent successfully implemented. later phase dominated - Tenancy reforms, protection of share croppers, land ceiling & land consolidation. Impl of these poor. land ceiling legislation slow & full of loopholes ∴ impact on structure of land holdings is minimal.

Poors obtain income from ownership of assets & from employment. Limited impact of Plans on the well being of poor sections of the pop is a consequence of our inability to restructure asset distn & to provide sufficient employment for a growing work force

Poverty % are based on the definition of a norm that takes nutritional requirements into account & all persons below the norm are classified as poor. A more direct estimate of nutritional inadequacy for 71-72 based on calorie norms of 2300 cals + protein norm of 57 gms shows that the % of pop suffering from either cal. or protein deficiency or both — 28.5% in rural areas & 32.6% in urban areas

life expectancy at birth:	1951	1971
men	32	46
women	32	45

d/o Comds combined c&s spex + malaria + extension of health facilities

Enrollment in elementary educ. ↑ from 32% in 50-51 to 68% in 79-80%, yet illiteracy rate high → 65.5% in 1971 excl. 0-4 age gp.

Scholarships for weaker sections + better geographical spread of fac. for sec + higher educ.

+ public expenditure for water supply; housing, suppl. nutr.

Urban Assets - ownership less fully known. Dir. direct measure Urban Land Ceiling Act faced major difficulties in implementation. ↑ in public sector + nationalisation of financial system helped reduce no. of people at top of income distribution.

The Principal instrument for asset distn other than land are fiscal — progressive taxation of income + wealth + preferential treatment of poorer sections in provision of credit. — has been limited by tax evasion & creates further problem of black money + ostentatious consumption.

(not v. successful; negligible; splashy; rhetoric)

- Growth of employment has lagged behind growth of labour force. Rural Labour Enquiry showed that between 1964-65 + 74-75 no. of days for which employment was available for rural labourers declined by 10% for men, 7.5% for women, 5% for children. Data on average earnings from these enquiries when corrected for inflation also show a decline.

Urban Employment Exchange - live register ↑ from 1.6 million in 1960 to 12.7 mill. in 1978 — ↑ partly d/o coverage. but also ↓ availability

NSS - direct data: Rates of Unemployment by daily status (% of labour force)

	Rural	Urban
male	7.1	9.4
female	9.2	14.6

- Rapid expansion of pop^n + labour force approx 2%
- Regional imbalances → At Indep^{ce} Industry was mainly in Bhavy, Calcutta + Ahmedabad + agri in pockets
∴ - deliberate policy of industrial dispersal.

In 1971 — 27.5% of employ^t in manufacturing was - 9 states
77-78 → value of agri. output per head of rural pop ranged from Rs 888 in Rajasthan → Rs 3361 in Punjab — ∴ large diff bet states in % of pop below poverty line.

"Evidence suggests that the most that can be claimed (reg. social justice) is that there has been no perverse movement, no worsening of inequalities or incidence of poverty. In some respects a degree of progress has been achieved.

Conclusion → Advs in economy of
a high savings rate, developed skill base + substantial degree of self-reliance provides a valuable cushion to absorb ext'nal shocks.

% of pop. below the poverty line by States 77-78.

	Rural	Urban	Combined
1. AP	43.89	35.68	42.18.
2 Assam	52.65	37.37	51.10.
3. Bihar	58.91	46.07	57.49.
4. Gujarat.	43.20	29.02.	39.04
5 Haryana	23.25	31.74	24.84.
6. H.P.	28.12.	16.56	27.23.
7. J+K	32.75	39.33	34.06.
8. Karnataka	49.88	43.97	48.34
9. Kerala	46.00	51.44	46.75.
10. M.P.	59.82.	48.09	57.73.
11. Maharashtra	55.85	31.62	47.71
12. Manipur	30.54	25.48	29.71
13. Meghalaya	53.87	18.16	48.03
14. Nagaland.	NA	4.11	4.11
15. Orissa	68.97	42.19	66.40
16. Punjab.	11.87	24.66	15.13.
17. Rajasthan	33.75	33.80	33.76.
18. TN	55.68	44.78	52.12.
19. Tripura	64.28	26.34	59.73
20 UP	50.23	49.24	50.09
21 WB	58.94	34.71	52.54
22. All UT's.	34.32	17.96	21.69
All India (weighted)	50.82	38.19	48.13

Above estimates derived using all India poverty line of Rs 65 per capita per month at 77-78 prices. Corresponds to min. daily calorie yield of Rs 2400 per person in rural areas + poverty line of Rs 75 per month corresponds to cal. yield of 2100 in urban areas. → provisional results of a special 32nd round July 77 - June 78

Continuing burden of poverty

affects TB prevalence.

affects amt of money available for health budgets

purchasing power of people + health spending

? for 1st Plan Document.

Ref: SIXTH FIVE YEAR PLAN 1980-85, Planning Com., GOI

"The day will dawn. Hold thy faith firm" Tagore. -taken

SECOND FIVE YEAR PLAN, 1956, PLANNING COMMISION, GOI

(1). After Partition relief + rehab. of displaced persons from west + East Pakistan was a major national task. 1st 5 yr plan gave high priority to rehab. of 8.53 mill. displaced persons (12.6) (8.6) ; outlay of Rs 136 crores on urban loans, rural loans, Rehab. finance admin loans (12.90) industrial loans (3.0), housing (66.9), educ + vocational trg (21.7) 2.3 mill from W. Pakistan settled on land, 1.2 mill in evacuee houses, 1 mill in 200,000 newly constructed tenements. (TOTAL 4.5 mill) Total 12.36 mill + ongoing.

3.83 mill disp. persons from E. Pakistan - bulk in W. Bengal, Tripura, Bihar, Orissa, UP, Assam. Continuing influx in the East.

Medical facilities - expenditure mostly confined to giving relief assistance to displaced TB pts. No. of beds reserved for displ. TB pts in sanatoria/hosps ↑ to 500 in Eastern Rep. in view of high incl of TB among displaced persons. Also agreed to provide free medicines + maintenance allowances to displaced TB pts + walking escorts to hosps. + for 3 mths after discharge. Maintenance allowance raised from Rs 50 to 65/mth + proposals invited from State Govts to ↑ no. of segregation wards, providing added facilities for clin Rx, X-ray exam + for setting up colonies for discharged TB pts. As existing facilities are inadeq. new hosps will be opened in urban areas + disp. cum mal-nut centres in rural areas specially for benefit of displaced persons - facilities in Eastern zone. + ↑ total no of beds to 1000. Total provision of 2.82 Rs cr. in 2nd plan for expanding medical facilities. Rehab progs increasingly being coordinated in general progs of economic + social dev.

Kept for social security even when displaced person is a ? and political refugee from there

(2) J. Nehru Chairman, VT Krishnamachari, Dy Chairman, Gulzarilal Nanda Member, CD Deshmukh member, KC Neogy - member, TC Ghosh - member, YN Sukthankar - Sec, Tarlok Singh - Jr Sec.

3. Neogi stressed That dlo magnitude of plan it will be diff. to implement it in 5yrs, deficit financing on a large scale may be dangerous, need for balanced dev of transport & prod".

4. HEALTH Aims - a) to expand existing health services (disparity existed + was implicitly stood)
b) to bring them increasingly within reach of all people
c) to promote progressive improvement in level of national health

Specific Objectives

a) estab. institutional facilities
b) dev. technical manpower + employ trained people
c) 1st step in improved public health - institute measures to control widely prevalent com. dis.
d) active campaign for environ. hygiene
e) F.P. + other supporting progs to raise std of health

Hosp. services ✱ Key point - quantity, distn, integn, quality
✱ Required sys - teaching hosp, district hosp, tehsil hosp, rural medical centre & health unit

✱ In view of high cost of these services - create more hospls + dev. existing ones - & efficiency, economy ↓, staffing, accomod", equip & supplies - need sp. attention.

✱ Long range progr (i) integrate working (ii) link & clinics, dispensary + pub. hlth services (iii) better use of available beds & ↓ turnover interval ↓ dur of stay (iv) separate accom for acute communicable dis as these presently occupy great deal of bed space (v) cheaper accom & less elaborate medical/nursing care for ch diseases (vi) in view of recent advances of chemth / prev. measures make clinic based/dom. services more effective, conc. on exp" of such services in preference to ↑ of hosp. accom".

Statement before TRC silently results

Rural focus, domiciliary care + integr'n were already part of national thinking before NTP

- 1951 - estimated 8,600 medical inst'n's & 113,000 beds

'55-56 - " 10,000 " " 125,000 "

TG 16% in " " + 10% in "

Plan provides Rs 43 crores (430 million) for augmenting + improving hosp. services incl. staff, accom'n, equip't + supplies.

- HEALTH UNITS - "Provision of adequate health protection to the rural pop'n by for the most urgent need to be met in the second 5 year plan." & progr for NES (national extension service) for rural pop'n est. of prim. hlth units in as many dev't blocks as possible, is a necessary step towards providing integrated prev. + curative med. services in rural areas, essential services of (1) institutional + domiciliary medical care, & adequate emphasis on prev. aspects - MCH, school hlth, control of communic. dis. (2) envr. sanit'n (3) health educ'n (4) impr'n of nutrition & hlth status (5) FP. In the early stages certain services such as the control of malaria, filaria, TB, VD + leprosy, may have to be rendered by special staff, but after adeq. control has been attained such services shd form part of + be integr'd with the normal activities of a hlth unit. Integr'n will be greatly facilitated if during 2nd FP coordinated activities can be estab. for specialised services + health units. Staff employed shd alternately be able to provide basic + specialised services. Provision of transport & considerable practical ings. Existing disp. to be converted into health units & new disp's shd not be started on old lines.

Integr'n not in NTP in current

Diff in obtaining Dr's + HIK personnel in rural areas is less due to lack of trained personnel esp. Dr's as do not. having facilities for educ'n of children + other amenities ∴ essential to make conditions of services more attractive.

725 Health Units set up in 1st Plan. Proposed to estab. 7300 Hlth Units in NES. States gov'ts propose to convert 131 existing disp. into PHU's. + set up. See 4V. Rs 23 Cr. provided in 2nd FP for them. (230 million)

before NTP

incremental policy development.

MEDICAL EDUC

No. of med. coll ↑ from 30 in 1950-51 to 34 in 1954-55 + 42 in '55-56
Annual admissions ↑ from 2,500 in '50-51 to abt 3,500 by '55. Present facilities provide for annual outturn of abt 2,5000 drs during 2nd PP.
Presently there are 70,000 qualified drs in India. Abt 12,500 will qualify during 2nd PP. Drs rqd 30,000 ∴ more trg facilities rqd to fill gaps.
GHS, trg of Dr's + AHP were only picking up when NTP was formulated.
Paucity of teaching staff. + lack of infrastr', facilities, amenities in rural areas.
? Multiplic'n of bands if DTO's identify / combat GP's / put Hosp's in area + formally enlist their participn in NTP — def. needs 2 DTO's ē clinical + pub. health skills.
Priority to expansion of existing colleges — Rs 20 cr. (200 million) allotted for this ie for exp' of med. coll, attached hosp, Estt. of Prev Med + Psych. Depts, completion of AIIMS, + upgrading certain depts for PG trg + res.
This will ↑ annual admissions by 400. — to cover part shortfall of Dr.
∴ need to estab. / start new med. coll. — Rs 6·5 Cr. provided for this
Private practice presently allowed by teachers of med. colls. This concession is one imp. reason for low standards of teaching + small attention to med. res. MCI recom. every dept in have a full time non-practising unit of professor + Dept. 3·5 Cr for 35 colleges in 2nd PP for this — will rq. R2L/yr/coll.
Nursing + other trg progs — at end 1954 no. rqd in diff. categories in the States were 20,793 nurses, 24,290 midwives, 756 HV's, 4468 dais + 946 nurse aids. Norms 1 hosp bed / 1000 pop: 1 nurse, 1 midwife / 5000 pop', 1 HV + 1 San. inspector

950,000 beds
9.5L.

Character of present shortages given below - highlighting need for accelerated, sustained action if even elementary services are to reach the mass of the people.

	1950-51	1955-56	1960-61	No. needed
Drs	59,000	70,000	82,500	80,000
Nurses (incl ANM's)	17,000	23,000	31,000	80,000
Midwives	18,000	26,000	32,000	80,000
HV's	600	800	2,500	20,000
Nurse dais / dais	4000	6000	41,000	80,000
HA's + San. Insp's	3500	4000	7000	20,000

2nd Pl, Rs 6 Cr. available for T'ng of nurses, midwives, pharmacists, SI's in med. colls + large hosp's.
Dev's of all categories belonged to a Single integrated service + nursing cadre.

- Rs 4 cr provision for medical research.
- Rs 2.5 cr for setting up/expanding labs in the States.
- dearth of qualified Statistic cadre
- Indigenous sys — Rs 37.5 L in 1st Pl.
  2nd Pl — 1 Cr at Centre, Rs 5.5 Cr in States

Control of Communicable Dis:- 22 Cr in 1st Pl, Rs 58 crores in 2nd Plan.
Includes - Malaria (28 cr), filaria (9 cr), TB (14 cr), leprosy (4 cr) + VD

TB A progm of TB control based on foll. practices & primary emphasis on prev" was enunciated during 1st 5 Yr Plan.

(i) BCG (ii) clinics & dom. service (iii) Tuy + Domic. Control
(iv) Beds for isol" + Rx (v) after care + rehab. Proposed to expand TB control measures during 2nd Plan as a national progm.

To ensure that mass BCG-vaccin: campaign is completed acc to schedule during 2nd Plan period, States have been requested to draw up definite schemes taking into consider: size of pop. to be covered / no. of teams needed for purpose + cost involved.

- Good institutional / infrastructural foundation laid
- need to build on it — enforcing tb, maintaining quality, linkage to consumer agencies / progs, research

As BCG vaccin: is to be carried out as a part of the public health progr in the States, even after the termin: of the present mass campaign, it is necessary that a certain no of persons employed in BCG work shd be retained by the States on the permanent strength of the pub. hlth dept. By the end of the 1st Plan > 70 mill. persons will be tuberculin tested & abt 24·5 mill vacc. in BCG. 2nd Pl. target to complete 1st round of campaign by covering the entire susceptible pop: < 25 yr of age.

As new antibiotics make it poss. to have a large no of TB pts treated at home, clinics have gained in imp & intended to function as diagnostic, advisory, + prevention units + be able to offer some specific Rx. Cannot serve these purposes effectively unless they are sufficient in no. + of adequate min. std. Most existing clinics are of poor std — few are equipped or staffed adequately for preventive work or for effective domiciliary service.

Quality

2nd Pl. to establish / expand abt 200 clinics as against 166 set up during 1st plan. Object to provide at least 1 clinic / dist, preferably at its HQ. - of full time Dr's, HV's + ancillary personnel + few beds directly attached or in nearby instn.

Govt. of India Central TB Institute, useful for teaching + demonstration, has considerable imp: of shortage of personnel for running TB services. Shd preferably be attached to med. colleges & be equipped with 4 Sections (1) epidem. section for mass x-ray survey + BCG, (2) clinical section for Dgns + Rx, (3) bacteriological section & (4) domiciliary service under dir of PH Nurse. Coordinated work in employee & prev: aspects. Presently 3 centres at New Delhi, Patna + Tuticorin, + 2 more in near future at Madras + Nagpur. 10 more proposed in 2nd Pl.

Stress to be laid on providing simply designed cheaply constructed units for use of infective pts, esp where isol: or Rx at home is impossible. These shd be in or near

crowded areas where TB is most prevalent. Those needing advanced surgical Rx will be moved to institutions where necessary facilities exist. Abt 400 beds likely to be added in 2nd Plan.

After care, domiciliary + rehab centres for pts in TB needs no emphasis. After care, absence of existence of Hadamapalle for 30 yrs where >40 expts are employed. A few centres estb. during 1st Pl. Proposed to set up 10 during 2nd Pl. d reach handicrafts / cottage industries.

140 million ÷ 5 = 28 mill/yr

Total provision for abt 14 crores made for TB control in 2nd Pl.

— x —

For effective control of all communicable dis it is essential to have a nationwide prgm for all affected areas.

finance — TB specific + dmp + planned activities
Upgradation of
dev of GHS.
Rankings etc - large public sector concerns

Ref PLANNING COMMISSION, GOI, FOURTH FIVE YEAR PLAN, 1969-74

Chairman - Indira Gandhi. * context

Dpty " - D.R. Gadgil.

Member - R Venkataraman.

B. Venkatappaiah.

Piramber Pant.

B.D. Nag. Chaudhuri.

Sec B.D. Pande. Aug 67 - Feb 70

D. Mitra Feb 70 -

Preface (Indira Gandhi) July 1970

Attack on our territory - 1962 (China) + 1965 (Pakistan) forced us to modify the pattern of national expenditure. Before we could recover compelling claims of dev't + defence, drought struck us → near famine. Foreign credits became uncertain. Recession followed. All these severely restricted our freedom of choice. For some time long term planning had to be virtually suspended. But we succeeded in turning adversity to good use.

We concentrated on import substitution + further enlarged our industrial base. This along with the need for more foreign exchange put us on the path of a more fruitful export drive. We maintained investment in dev't work, esp. in those agricultural prog's.

Rural disparity ↑ - partly d/to efforts in ↑ self sufficiency + partly d/to rashness in implementing land reforms. Tho. industrial recession has eased, new industries not coming up fast enough + acute unemployment continued. We have a more articulate pyr.

• Iyr of plan gone by - projected public sector investment stepped up., schemes added to help small farmer esp in unirrigated areas

• nationalis'n of 14 big banks evidence of our determination to bring a greater volume of resources within area of social control. Recog of credit policy in public sector expected more + more to occupy commanding heights of economy.

Goal - prosperous, democratic, modern socialist society

During 3rd Plan national income at 1960-61 prices rose by 20% in 1st 4 yrs + regd a decline 5.6% in last year.
Per capita real income in 65-66 was about the same as it was in 60-61 - meagre gr rate of national income almost completely neutralised by 2.5% rate of gr of pop.

64-65 record harvest
65-66 | severe drought
66-67 |
67-68 record harvest

Slow rate of gr in agri prod, depressed rate of gr of economy & led to alarming ↑ in dependance on imports of foodgrains & other agri. commodities as in Third Plan.

25 mill tonnes foodgrains imported.
3.9 " value of wheat
1.5 " " " pulse - heavy imports in subsequent years

Despite ↑ imports of foodgrains per capita availability was lower than 1961 level except in 1965 + there was severe pressure on prices
1965-66 - Indo-Pak conflict & consequent disruption in flow of foreign aid, gr of industrial prod ↓ to 5.3% - over 8-10% in last 4 yrs of Plan.. Slowed down public investment led to further ↓ in rate of gr of industrial prod in subsequent years.
Unutilised capacity in many industries: low purchasing power: setback on agri front, stagnation in investment, shortage of foreign exchange: need for abnormally high imports of foodgrains & raw mat. & for completion of a no. of projects started earlier.

Several fiscal measures followed :-

Devaluation of rupee in June 1966 followed by import liberalisation, increased decontrol of certain commodities - steel, coal, paper, fertilisers, vehicles, efficiency of use of industries

some ↑ in public sector demand for domestic manufactures

+ some industrial recovery in 1968.

↑ in price level - ↑ in DA to Govt employees & industrial workers & resulting ↑ in non-Plan expenditure adversely affecting Govt's capacity to step up investment. Also cost of prod'n - economy - ↑ for various factors + profitability of enterprises!

+ ↑ in defence expenditure.

BoP worsened - use of buffer stock & stock for assistance.

↑ taxes done, however domestic resources were inadequate

∴ ↑ dependence on foreign aid + ↑ deficit financing

Inflationary pressures generated, affecting domestic savings & making resources for financing dev't.

Temporary suspension of foreign aid : 1965-

growing trade deficit, mainly debt stabilisation

Private sector (banks & dalals) pressures ↑ but → leads balancing forces to ensure accountability → ∴ affects civic society.

Public sector - lack concern for speed, efficiency + economy.

Social justice needs ↓ conc' + wider diffusion of wealth, income & economic power. + better conditions for weaker sections for employ', edu'. eg ↑ expectation of life at birth from 35 yrs in 1950-51 to 52 in 1967-68 ↑ school enrolment from 23.5 mill in '50-'51 to Rs 74.3 million in '68-'69.

Reg. objective of equality - sufficient data are not available to base a definite statement about income inequality. Available info does not indicate any trend towards red' in conc' of income & wealth. Inconsistency indicates ↓ disparity between levels of living of various classes. Complaint is that there is

institutions like coop's, were fashioned to promote SE democracy, propertied classes + rich dominate. Probs of low income, unemployment underemployment remain sizeable. Regional imbalances continue.

- Need for self reliance. To be retained.
- "concern for achieving the desired T in production is the shortness of the necessitates the conc. of effort in areas + on classes of people who already have the capability to respond to growth opportunities. This consideration shaped the strategy of intensive dev. of irrigated agri. Output increases more rapidly in areas where basic infrastructure. Spec. of programmes for assistance related to size of prod. Tends to benefit the large producers in the private sector. A small no of business houses + expansion in resources have been able to take greater advantage of the expansion of opportunities for profitable investment.

Difficulties encountered part to need for firmer policy direction + use of supplementary measures + instruments to carry out necessary adjustments.

Health & FP — Chap 18 — pp 386 - 397

Broad objectives of health progr. during 1961-69 has been to a) control & eradicate communicable diseases (b) provide curative & prev. health services in rural areas thru estab of PHC in each CD Block. & (c) to augment trg progs of medical & para-medical personnel. Progs formulated on basis of report of Health Survey & Planning Committee of 1961

Fourth Plan — efforts will be made to provide an effective base for health services in rural areas by strengthening PHC's.

(imp to Read/Keep track of what is not said in the Plans but is actually done — there seems to be a tendency to underline socially relevant etc) PHC's render prev. & curative health services, take over maintenance phase of control progs like malaria & smpox & become focal points for nation wide FP Prog. Subdiv & dist. hosps will be strengthened to serve as ref. centres. Comprehensive communi. dis will be undertaken. Medical & nursing educ & trg of PHW's will be expanded to meet minimum technical manpower requirements.

Outlay on Pub HIE & Med. Progs (Rs crores)

	Centre	Centrally Sponsored	States	UT's	Total
1. 3rd Plan	14.83	5.46	183.24	12.33	225.86 (2,258 mill.)
2. 1966-69	16.76	11.14	105.24	6.97	140.11
3. 4th Plan	53.50	176.50	184.25	19.28	433.53 (4335 mill.)

biggest chunk in States.

Distri of Outlays for 4th Pl. (Rs cr- outlay)

1. Med. educ & research	— 85.29
2. Trg progs	— 12.93
3. Control of commun. dis.	— 127.01
4. Hosp & disps	88.29
5. PHC's	76.49
6. ISM's	15.83
7. Other progs	27.69
8. Total	433.53

$\frac{127 \times 100}{433.7} = 27\%$

$\frac{127 \times 100}{749} = 17\%$ → incl. FP

The annual ~~plan~~ expenditure on health progs at end of 3rd Plan + annual of 4th 5 yr plan is estimated at Rs 120 crores & Rs 190 crores resp.
(4th Plan does a much shorter / sharper section on Health + fam

NMEP (April 53) made satisfactory progress till 63-64 fd. by setbacks due various causes — mainly administrative, operational + technical. In maintenance phase (208·88 units out of 393·25 units) the programme has been integrated i GHS. Rest: consolidation + attack phases. NMEP scheduled to end: 67-68 expected to be completed by 1975.

Several progs had impl. gaps.

Nat. Smpx Eradic Progr launched 62-63 as a 3 yr prog. Was expected that incidence would be so low that it would be poss. for the progr to be carried as a part of GHS. Expec. not reached. During recession's large susceptible pop. pair is vulnerable age gp 0-14 yrs + migratory, labour pop. remain unprotected.
∴ - Strengthen staff to ↑ primary + recovery at block/district
+ ↑ prod. of freeze dried Smpx vaccine

TB

"As area all of the obsn therapy / prophy in Madras it was discovered that domiciliary Rx for TB was as effective as institutional Rx
∴ The DTC progr then domiciliary Rx, designed to ↓ mobility + mortality has been taken up as continuous progr. By the beginning of the 4th Pl. 502 clinics have been set up of which 185 are well equipped. There are 15 hip + dispensaries one in each State except Assam, Haryana, HP & Nagaland. There are 3 Trg + Res. Institutes. — NTI, TRC, Madanapalle.

Leprosy — NLCP, 182 control units + 1136 SET centres est. before start of 4th Pl
MO + PHNs Trg at Central Leprosy Teaching + Res. Institute, Chingleput + Naggin Hed. all.

Trachoma — survey: ↑ high % of rejection of candidates d/t Trachoma. — undesirable prev. in 11 States. National Trachoma Control Progr — ∈ expansion than PHC's

the story of the milkmaid dreams comes to mind – each progr. builds on the supposedly existing basic health services — & have been in turn completely diverted to FP / MP + various internationally sponsored progr's., Tho' actually States are bearing the major financial burden of running the health services, they have a marginally small role in policy making – internal. dict + feeling – call the shots.

Strat'y : To people

- Rs 2·34 crores for mobile medical units / labs. for Asia, innoc + control of cholera
- Med. Educ" – 57 med. colls at commencement of 3rd Plan (Table to show effect of policy : attitude of V. rapid growth ! new account created + new account increased gradually)
  - 30 new m.c's est. in 3rd Plan + 6 more in foll. 3 yrs, i.e 93 at commencement of 4th Plan.

  focus on prod" of Dr's.

  1968-69 — 11,500 admissions/yr — 10,500 at end of 3rd Plan
  In 4th Pl. — 10 new m.c's likely to open, & annual admissions to 13,000 by 1974
  Dr-pop' Ratio – 1961 – 1 : 6100 1968 – 1 : 5150
  expected in 1974 1 : 4300 – What's the current ratio
  Shortage of teachers has resulted – : Emphasis on PG educ". Presently 4 PG Institutes – Delhi, Pondicherry, Calcutta, Chandigarh
  Nurses – 34,000 added in past 8 yrs. Total stock 61,000 in 1968-69 expected to rise to 88,000 by end of 4th Pl
- Med. Research 4th Pl. outlay of 22 crores – 11 cr. for ICMR, 2 cr. ISM, 2 crores for research institutes & 7 cr. for F.P.
- Hosp. beds past 8 years 70,100 gen. beds in Govt. insts added – i.e Total of 255,700. Target of est. 54,000 beds in 3rd Pl. achieved. Subsequent pace ↓. In '69-'74 intended to add 25,980. Emphasis on better facilities at sub-divisional & district hosp. Thus specialist services (This is still under belief)
- PHC's form the base of the integrated structure of med. services in rural areas. By end 3rd Pl. it was intended to establ 1 PHC/CD Block. By Mar '66 463 centres estab. In 3 successive yrs 288 PHC's established.
  ↑ in no's of PHCs led some political interference – however concern for staffing, drug supply, equipment was less relatively. ∴ quality continues to depend – of water supply, transport.

5 4998. 34000 (6.7)
24988
4012

4998 - 340
340 × 100
4998

4397
261
340
4998 nos. in CD Blocks

∴ at beginning of 4th Pl 4919 PHC's are functioning — 261 CD Blocks have > 1 PHC, 4397 have 1 PHC + 340 have none (6.7%)

At beginning of 4th Pl. abt 50% of PHC's have hospital bldgs + only 25% residential qtrs. Lack of bldgs one of main obstacles in posting Dr's + nurses in rural areas. Suitable bldgs for PHC's, SC's, staff not easily available in rural areas.

∴ 4th Pl. emphasis on estab. of effective machinery for speedy const. of bldgs + improvt. of PHC's by providing staff, drugs, equip. + estab. of 508 PHC's covering 340 Blocks (or PHC's)

PHC's in malaria maintenance phase areas to be strengthened & additional staff to take up vigilance activities in maintenance phase of commun. dis. cont. prog.

(sticking to ideology, if even tho it is right, may have been at the cost of many lives + great suffering. Deft. strategies may be allowed for the translation of the philosophy into action)

Such an approach involving integr. of health & medical care, will ensure optimum use of resources & manpower, preventing duplic. & wasteful expenditure on progs. (1)

∴ if public enthusiasm for participation in health schemes (the reasons for it may be many viz. compulsion, profit making, etc) + to create a sense of partnership & for efforts voluntary contributions shd be encouraged.

F.P. (61-66) Rs 27 cr. provision in 3rd Pl, expenditure — 24.86 Cr. — FP bureaux organised at State level + in 199 distts in all States. By end 3rd Pl. there were 3676 rural FP centres, 7081 rural subcentres + 1381 urban FW + Pcentres. agencies for integration of health services. Few sc's were FP, to provide supplies, services + advice on FP. 28 Trg centres estab to 7641 personnel taking regular courses + 34,484 short term courses.

need for grp for advocacy / lobbying at policy level + a grp of skilled people for implementation.

- Research – in 7 demogr. centres, 7 communication action research centres + 8 on biomed. aspects of FP. Central FP. Institute estab. at Delhi for technical support.

Since April 1966 a seperate Dept of FP constituted at centre to coord. Centre & States – lic quite soon after NTP formulated.

(a) woes + disappointments (b) political power struggles in INC, in centre + States (c) conditional US food Aid – v. rapid ↑ in FP. foams + exhausted. a a new slant appears on the 'health services' – agenda set outside / abroad ∴ concurrence of one political wing / policy makers – US trained demographers – Health Minister + lots of money for the area ∴ total divergence of attention from 'genl health services'. Hegding US world leadership.

End of 3rd Pl. ICMR approved mass utilis of IUCD – Lopp. i equal imp to sterilis., IUCD's condoms. IUCD factory estab. at Kanpur ? & American help. & daily prod capacity of 30,000 loops.

During last yr of 3rd Pl 0.8 mill IUCD inserted mode

States pd. will of State public for camps effect

1.33 mill. sterilis performed in 3rd pl.

Services fees + compensation for out of pocket expenses, conveyance + loss of wages. Transendum public sector Nirodh factory – 144 million pieces / annum. + Mass educ: propr. ?propaganda – 22 FP programme cells in 22 AIR stations, 30 AV Units under Directorate of Field Publicity – films, exhibitions, wall paintings, hoardings.

67-68 – >1.8 mill. voluntary sterilisations >double earlier best performance of 0.8 mill in 66-67 (obviously achievement overstated.

"Mange" approach – interesting acceptance of American pressure despite of vocal radical socialistic rhetoric), exceeded the target of 1.5 mill. for the year loop – 0.47 mill, insertions in 68-69 against 0.67 mill in 67-68. Backlash a/o SE – of bleeding + pain. (on what basis does ICMR approved given!).

On eve of 4th Pl 5 central Institutes, 43 State FP Trg Centres, 4326 Rural FW P centres, 22,826 rural SC's & 1797 urban FWP centres are in operation. Progress in opening subcentres has been unsatisfactory d/o shortage of ANM's & of others for Q workers in rural areas.

At beginning of 4th Pl., 450 F.P. annexes to PHC's have been constructed (190 completed, 360 in progress) + buildings of 2770 subcentres have been taken up (1280 completed + 1490 in progress)

(during Q anda - FP)

Review of Progress & Targets

Item	unit	3rd Pl	1966-69	4th Pl
1. expenditure	Rs crores	24.87	69.48	315
2. Distt FP bureaus	No's	199	303	335
3. Rural FWP Centres (cumulative)	No's	3676	4326	5225
4. Rural S.C's (")	No's	7081	22826	31,752
5. Urban FWP centres (")	No's.	1381	1797	1856
6. F.P. Trg. Centres (incl. central institutes)	No's	30	48	51

(1 = outlay)

F.P. to remain centrally sponsored for next 10 yrs & entire expenditure met by Central Govt. It will be ensured that performance does not lag behind expenditure. (Promissory note by GOI to USAID!) General Health Services will be fully involved in the programme. integr: used from commencement!

Draft Plan Outlay of Rs 300 cr. revised upwards to Rs 315 cr. Org. of services & supplies & compensation for sterilizg & IUCD will constitute an expenditure of Rs 269 crores.

"Efficiency" of these services can be ensured only if a min. network of centres & S.C's all over the country & if attention to despl's in larger no. of maternity cases & to populous distts. Rs 4 crores for trg, res, motivation, eval: - those amounts considered adequate by WHO - Tech. To discuss in Health Mission.

Phases in Health services:

1948 – 62 – Malaria / TB control – WHO/UNICEF.

mid-60's – 77 – FP – USAID / TPPF / IPPF.

78 – – UIP/EPI – UNICEF.

80's – Primary Health Care Layer

– Bilateral agencies

DANIDA – guinea worm, blindness, leprosy.

SIDA – TB – x rays.

ODA – TB (DOTS), Rural Health, malaria (mela)

Basically penetrating one man Delhi.

It is time to 'liberate' Indian Health Policy making from the international straightjacket.

Aim to ↓ BR to 32/1000 pop by 73-74 from present 39 – proposed to step up targets of sterilisations & IUCD insertions, & widen acceptance of oral & injectable contraceptives + conventional contraceptives. Oral pills OKed for use by medical practitioners Health workers inflate figures – ∴ they think that's what people at the top want.

– ∴ they were introduced into the FP. progr in Aug. 1967 as a pilot project. Surgical equipment will be provided in all rural & urban FW Planning centres – nearly 7000 – for sterilisations + > 1000 mobile service units attached to Distr FP bureaux. Salpingectomy becoming popular – estimated that 25% of all sterilisations will be on women. – 3300 beds will be provided for this. – Additional schemes for intensifying family planning programmes – post partum programme, supply of surgical equipments to hospitals, intensive dist + selected area programme, supply of vehicles to all PHC's + strengthening of Central + State Health transport organisations included for implementation – 4th Pl.

FP. is likely to be more effective & acceptable if MCH services are integrated

This has now been done - basic agenda however is FP! - by the gap

clear that

UNICEF may promote the same for diff. reasons.

∴ DPT / TT / anaemia prophylaxis & V.A will be implemented thru FWP. centres.

Health - selected achievements + targets — 4th Pl. annexure I

(numbers)

Item	1960-61	1965-66	1968-69 anticipated	1973-74 Targets
1. Beds	185600	240100	255700	281600
2. PHC's	2800	4631	4919	5427
3. Medical colleges	57	87	93	103
4. Annual admissions	5,800	10,520	11,500	13,000
5. Dental colleges	10	13	15	15
6. Annual admissions	281	506	586	800
Manpower				
7. Doctors'	70,000	86,000	102,520	1,37,930
8 Nurses'	27,000	45,000	61,000	88,000
9. ANM's & midwives	19,900	36,000	48,000	70,000
Control of diseases				
10. NMEP (units)	390.00	393.25	393.25	393.25
11. Attack phase (units)	390.00	80.26	112.985	30.00
12. Consolidation phase (units)	—	170.36	70.385	93.25
13. Maintenance phase (units)	—	142.63	209.85	270.00
* **Tb. control**				
14. Clinics	220	427	502	582
15. Demonst. + Trg Centres	10	15	15	17
16. Isol. beds	20,500	35,000	35,000	37,500

['] = in practice

This table hides the dominance of FP on the health sys.
However it is obvious that TB & malaria have been shipwrecked - also distributional aspects hidden - regional - inter-state - urban-rural.

Health Programmes : Level of Achievement at the beginning of 4th Plan

Annexure II

State/ U.T.	Estimated pop. 1968-69 (mills)	Medical Colleges.	PHC's functioning	No. of PHC's yet to be established	Sub-centres	beds/1000 persons
1. A.P.	41.771	8	409	9	1122	0.61
2. Assam	14.857	3	99	77	300	0.45
3. Bihar	55.427	4	587	—	3523	0.24
4. Gujarat	25.363	5	250	—	1497	0.46
5. Haryana	9.574	1	89	—	482	0.44
6. J+K	3.953	1	69	4	118	1.00
7. Kerala	20.424	4	163	—	1584	0.84
8 M.P.	39.067	6.	428	29	1220	0.32.
9. Maharashtra	47.979	11	382	44	2776	0.50
10. Mysore	28.155	9	265	1	2470	0.52
11. Nagaland	0.448	—	6	11	15	2.25
12. Orissa	20.795	3	309	5	747	0.37
13. Punjab	14.043	4	127	1	659	0.69
14. Rajasthan	25.047	5	232	—	574	0.51
15. T.N.	38.344	9	317	65	1887	0.70
16. U.P.	87.393	8	740	135	2902	0.37
17. W.B.	42.886	6.	225	110	548	0.85
U.T.'s						
18. A+N Island	0.077	—	1	4	1	1.00
19. Chandigarh	0.145	—	—	1	—	5.51
20. Dadra+Nagar Haveli	0.070	—	2	—	2	2.80
21. Delhi	3.894	3	5	1	34	2.40.
22. Goa, Daman+Diu	0.760	1	15	—	—	2.30.
23. Himachal Pradesh	3.456	1	72	6	251	0.60.
24. LMA Islands	0.029	—	7	—	—	3.44
25. Manipur	0.946	—	12	4	38	0.57
26. NEFA	0.408	—	74	—	—	2.80
27. Pondicherry	0.448	1	11	1	—	0.95
28. Tripura	1.385	—	23	—	22	0.33
TOTAL	527.144	93	4919	508.	22,826.	0.49.

WELFARE - low priority - low budget - low utilisation

1st Plan — 1·60 cr.

2nd " — 13·40 cr.

3rd " — 19·40 cr.

1966-69 — 12·08 cr.

4th Pl. — 41·38 cr.

Dist. services for handicapped + destitute — grants to voluntary orgs.

Trg of women, holiday camps for pre-adolescent girls

eg: 3rd Pl — 19 cr. Expenditure outlay of 31 cr.

66-69 — 4/5th ground used.

Probs — absence of counselling

lack of established data

deficiencies in manage't + supervision at field level + absence of proper coordination.

low utilisation.

18/8/87.

Ref:

NTI library 14/6/86.

PLANNING COMMISSION, GOI, Third Five Year Plan 1961-66

Chairman - JNehru, Dpty Chairman - Gulzarilal Nanda.
Members - Morarji R Desai, VK Krishna Menon, CM Tiwedi, Sriman Narayan, TN Singh, AN Khosla, PC Mahalanobis
Sec: Vishnu Sahay. Addl Sec. - Tarlok Singh.

- To give precise content to the social objectives of the constitution.
- work began end '58, detailed studies by working grps at the Centre & States, draft outline published & circulated in July 1960.
- Parliament gave general approval in Aug 1960.
- used as a basis for prep" of plans of States.
considered by CM's of States Oct - Sept - Nov 1960.
Jan'61 - NDC made recommendations - set up Committee on Savings & 5 Parliamentary Committees - studied aspects gave recommends
Multipurpose Committee of MP's chaired by PM + Consultative committee of members + Panel of Economists; Scientists, + Panels on Land Reforms Agri, Educ, Health, Housing, + studied by Progr. Evaln Org", Res. Progr"s Committee, Committee on Plan Projects, CSO, ISI
ie a vast national undertaking
- The 1st phase: a long term 15 yr scheme of dev".
- objectives/targets only a min. & must be assured.
- "the greatest stress in the Plan has to be on implementation, on speed & thoroughness in seeking practical results, on creating conds for max. prod" & employment" & the dev" of human resources; Discipline & national unity basis of SE progr. & achievement of socialism.
- demands dedicated leadership at all levels, & by last standards of devotion & efficiency from public services understanding & participation by people & willingness to bear responsibility & larger burdens for the future

India – traditional society, static economy, petrified to some extent by colonial rule. A set of moral & ethical values have governed Indian life. The people may not have lived upto them
Covered up by widespread, appalling poverty
Political aspects of Independence & social & economic advance
From earliest beginnings Indian nationalism had a large element of economic thinking & social reform.
Dadabhai Naoroji presented a paper on "The poverty of India" in 1876. To Gandhiji freedom was not merely a political objective but the raising of masses of people from poverty & degradation.
Agrarian probs. : imp. Large proportion of membership came from among the peasants.

- A comprehensive economic prog. was adopted in 1931
an agrarian prog in 1936
and 1938 – National Planning Committee constituted – could not work : 2nd world war during which many were imprisoned – considered nearly all aspects of planning, prod. Studies formed basis for post Independence Planning.
- Interim Govt, before Independence, constituted Advisory Planning Board – delayed implementation by politics
- Early 1950 adopt of New Constitution by Constituent Assembly of India. GOI est. Planning Commission To assess the country's material, capital & human resources • to formulate a plan for their most effective & balanced utilisation.
Need to form Bulk land plans – assess of NRs, put, Govt resources & strategies for their working – being bound/kept by our constitution.
- Basic objectives of constitution set forth in "The Directive Principles of State Policy"

- art 38 is "The State shall strive to promote the welfare of the people by securing & protecting, as effectively as it may, a social order in which justice, social, economic & political shall inform all the institutions of national life"
- Gives more precise direction in Dec 1954 when Parliament adopted "the socialist pattern of society as the objective of social & economic policy.
- 2 main aims have guided India's planned dev.:
  a) to build up by democratic means a rapidly expanding & technologically progressive economy &
  b) a social order based on justice & offering equal opportunity to every citizen
- However lack - limited means & inadequate data. & To change a traditional society thru' peaceful & democratic means & to their consent is difficult.
- 5 yr pl.'s always in context of long term 15 yr plans.
- Distribut" of outlay. (Rs - crores)

Head	First Plan expenditure	%	Second Plan expenditure	%
1. Agri. & Com. Dev.	241	15	530	11
2. Major & medium irrig'	310 + (incl flood cntl)	16	420	9
3. Power	260	13	445	10
4. Village & Small industries	43	2	175	4
5. Industries & minerals	74	4	900	20
6. Transport & communic'	523	27	1300	28
7. Social Services & misc.	459	23	830	18
Total.	1960	100	4600	100

1st Pl - greatest stress on progr in Agri. i.e. agri + irrig' = 31% of outlay
2nd Pl - ↑ stress on industrial dev" eg indus' + min ↑ from 4 to 20%
Transport & communic. high priority in both.
Social services & misc. — ↓ from 23 to 18% — this incl. health.

* This is only a % of Central Plan expenditure – if one includes State expenditure Non Plan expenditure the % is v. low 2-3%
But trend from 1st - 2nd plan is interesting.

	1st Plan. actual	%	2nd Plan. est.	%	3rd Plan target
outlay on Plan	1960	100	1600	100	
ext'l resources	1772	90	3510	76	
external assistance	188	(10) *	1090	* (24)	

Some Deficiencies in implementn

Focus on the good elements : Indian society & build on it.

- During the 1st Plan target of % T in agri prod'n, national income T by 18%. against target of 12%
- 2nd Pl T 20% against target of 25%
- Decade as a whole. Shows overall progress. T in national income has been 42% over last decade, but % T in pop'n T in per capita income has been 16%.

"No. of hospitals & dispensaries has significantly T, special measures taken to eradicate malaria, & general improvement in health cond's resulting in substantial T in Survival rate".

- Item — unit — 1950-51 — 1955-56 — 1960-61 — (3rd Plan target) — % T – 60-61 over 50-51

Item	unit	1950-51	1955-56	1960-61	(3rd Plan target)	% T – 60-61 over 50-51
Health						
Hospital beds	000 no's	113	125	186	(240)	65
Dis (practising)	000 no's	56	65	70	(81)	25
Consumption levels	cals per capita per day					
food		1800	1950	2100		17

- Social Services Dev't of human resources thru' provision of facilities for educ', health & social welfare is one of the major objectives of planned dev'.

In 1st & 2nd Plan Rs 1288 Crore spent, Tho' needs are much larger.

Include – educ', scientific research, health, housing, welfare of BC's, Rehab, employment.

Health considerable expansion of health services occurred, large no's of new hospitals, dispensaries, health units, maternity & child welfare centres were opened & special programmes for water supply & sanit'n, control of communicable diseases & expansion of training facilities were undertaken.

GHS

T in health infrastructure

In 1950-51 there were 5,600 medical instit's & abt 113,000 beds.
" 60-61 no. T to 12,600 " " & 185,600 " in addn to 2800 PHC's were opened
No. of medical colleges T from 30 to 57 +
" " dr's in practice/service T. 56,000 to 70,000
Entire pop' covered by malaria eradic' progr.
Resulting from these measures life expectancy at birth T by abt 10 yrs during last decade

Early in 1st Plan prom' of FP was adopted as public policy - by 60-61 there were 549 urban centres, 1100 rural centres in FP service. A no. of non-official org's engaged in FP work were given grants financial & technical assistance. The progr. however is a most difficult one to carry out & raises problems of great complexity. Sustained & intensive efforts are required over a fairly long period before FP can become a popular movement & a part of the accepted attitudes of the people generally. During 1951-61 pop T by 77 millions.

Financial Provisions

The Plan includes outlays not only by the public sector but also by the private sector. Breakups of public/private investment given below. (Rs Crores)

	2nd Plan.				3rd plan.			
	Public	Private	Total	%	Public	Private	Total	%
Agri & CD	210	625	835	12%	660	800	1460	14
Major & medium irrig'	420	mili abne	420	6	650	mil + abne	650	6
Power	445	40	485	7	1012	50	1062	10
Vill. & Small industries	90	175	265	4	150	275	425	4
Organised industry & minerals	870	675	1545	23	1520	1050	2570	25
Transport & communic's	1275	135	1410	21	1486	250	1736	17
Social Service & Misc	340	950	1290	19	622	1075	1697	16
unallocated	—	500	500	8	200	600	800	8
Total	3650	3100	6750	100	6300	4100	10,400	100

* Major public sector outlays in power + transport + commun - i.e. in total infrastr.
+ Ratio of public to private T in 2nd Plan.

Health & Family Planning Chap 32, p 651 - 678.

The broad objective of the H+FP progs in 3rd Pl is to expand health services, bring abt progressive improvement in health of people by ensuring a certain min. physical wellbeing & to create conditions favourable to greater efficiency & productivity. Increased emphasis will be laid on preventive public health services. & accords very high priority to FP

a) Need to take a positive approach in analysis even when using a critical analytical framework. Build on the strengths of the system

b) Interesting to see the way studies are commissioned. Decision on studies taken at a high level.

As against outlays of Rs 140 & Rs 225 crores in 1st & 2nd Pl resp., progs in 3rd Pl. have a total outlay of Rs 342 crores, abt Rs 297 crores being in the States & the rest in the Centre

Distn of outlay. (Rs crores)

Progr.	First Plan	2nd Plan	3rd Plan
Health			
water supply & sanit^{n} (rural & urban)	49.0	76.0	105.3
Primary HH Units, hospitals & disps	25.0	36.0	61.7
Control of Commun. Diseases	23.1	64.0	70.5
Educ., tg. research	21.6	36.0	58.3
ISM's, homeo, nature cure	0.4	4.0	9.8
Other schemes	20.2	6.0	11.2
FP	0.7	3.0	27.0
Total	140.0	225.0	341.8

Much progress has occurred — marked decline in malaria. ∴ in 1958 NMCP changed to NMEP. A basic type of health org: providing integ. prev & curative service has been estr. in 2800 dev. blocks, & popn of 200 mill. At end of 2nd Pl there were 78 univ. teaching ISM's & annual intake of 1375 (raised to 1515 by TB). ISM's have 98 hospitals, 5372 disps, & 2462 beds. Abt 664 schemes of urban water supply & drainage entailing total cost of 112 crores completed / in progress

In addition to schemes of rural water supply implemented under the progs of com. Dev., local dev. works & welfare of backward classes, abt 228 schemes i est. cost of Rs 20 crores have been taken up under health progr.

Birth Rate etc – 1941–61

Period	birth rate	death rate	IMR male	IMR female	Life expectancy at birth male	Life expectancy at birth female
1941–51	39.9	27.4	190.0	175.0	32.45	31.66
1951–56	41.7	25.9	161.4	146.7	37.76	37.49
1956–61	40.7	21.6	142.3	127.9	41.68	42.06

These are rough estimates & subject to several limitations. Tho considerable dev.s have occurred, certain deficiencies are exp. marked a) in rel. to med. institutional facilities were quite inadequate esp. in rural areas. distributional problem.

b) Uneven distn of docs bet urban/rural areas. urban conc., rural shortages, existing instns did not have full complement of personnel. Progr. in some cases continued hampered in several parts of country, due shortages of trained personnel & to some extent of personnel & equip. Despite measure of progress in rural water supply, there were large rural tracts where safe drinking water. In many urban areas drainage prob. accentuated due rapid pop. growth.

Achievements vs Targets

Communicable Dis.	1950–51	55–56	60–61	65–66
Malaria – units	–	133	390	370 *
pop. covered (mills)	—	107	438	497
Filaria – units	—	11	48	48
pop. covered (mill)	—	15.1	24.6	NA
TB BCG teams	15	119	167	167 *
TB Clinics	110	160	220	420
TB diag & typ centres	–	3	10	15
beds	10371	22000	26500	30,000.
TB beds	113,000	125,000	185600	240100

PHU's, Hosps + Displ

Working of PHU's during 2nd Pl shows that among factors affecting progress of the programme were (i) shortage of health personnel (ii) delays in cond'g of lodge + residential qtrs for staff + (iii) inadeq. typ facilities for diff. categories of staff upd for service in rural areas. Need felt to strengthen PHU's + to integrate as early as may be feasible, services such as those for control of malaria, TB etc in normal activities of hlth units. Among other steps to be taken to improve efficiency of PHU's are provision of min. staff upd, orgn if necessary typ facilities + infrastr. of activity of PHU's + other health services available in the area.

Diffl experienced in securing sufficient no of drs. To create necessary climate + cond's for securing personnel for rural areas, foll. measures suggested

a) As in some States, there shd be a single cadre for personnel working in rural as well as urban areas. Service rules may stipulate that each incumbent in the cadre has to put in a certain period of service in rural areas before he can cross the first efficiency bar or join the next grade. Period of service for rural areas shd be taken into consideration for accelerated promotion, advance increments or selection for PG trg.

b) residential accom + other facilities in rural areas + additional expenses on account of children educ

c) Stipends scholarships etc to be given in rural areas for prescribed course

d) Utilisation of part time services of drs in urban/rural areas for

e) Use ISM Dr's - PHU's + SC's in addition.

To maintain stds - link to referral / dist. hospitals. Specialised services at present concentrated in larger cities. Need to increase bed strength of dist + subdiv. hosp. + provide x-ray, path, medical, surgical, obstetrical specialist services. Organise OPD's as polyclinics in groups so that much of Rx is handled here.

Overall target for 3rd Pl. is est of 2000 more hosp. + disp's or 54,000 additional beds

Communicable dis control:

1st Plan - total expenditure 23 cr, 2nd Pl - 64 cr, 3rd Pl. - 70 cr.

T.B - Recent ICMR sample survey - showed total no. of cases of P.T is country ~5 mil. than of c 1.5 mill might be infectious & while mortality from TB is showing signs of decline, incidence has remained more or less the same both in rural & urban areas.

(+ communic. dis, diarrh. Plan priorities, health become longer, + more in priorities)

The pub. hlth sys now a real factor: delay in DS is, mismanag: technically & putting of pts dbs per behaviour ~ (

During 2nd Plan abt 120 mill. persons tested under BCG Vacc Campaign. TB clinics + from 160 in 1956 to 220 in 1961. 10 TB clin + Tup Control estab. No of beds for TB pts + from 22,000 in 1956 to 26,500 in 61 NTI est. in Bihar in 1959.

In Third Plan BCG campaign will be intensified to cover another 100 mill persons. No of clinics will + from 220 to 420. In addition 25 mobile clinics equip: x-ray for mini-mum films + mobile labs for sp. collection / simple exam: will be set up for service in rural areas. 5 more TB tup & demo centres will be est. Abt 3500 more beds for TB pts will be added during which no of beds to 30,000 by '66 Provision also made for setting up 7 Aft. Care & Rehab Centres.

Our TB prob. must be solved by SCC / DOTS. We need a long term integrated strategy & effective base / space for each, compound to play it role.

Med. Educ + Res

18 new med. coll. will be estab. in 3rd Pl bringing total to 75. Separate DSH Depts to be est. AIIMS to be completed Pop Dr ratio remains at 6000:1 if pop gets + will continue like this in 3rd Pl.

Shortage of teachers
Suggested to have Medical Assistants

HE To implement this, CHE Bestt. in 1956 at DGHS + several States have also set up such Bureaux.

HIth Insurance - Health + medical facilities for industrial workers under ESI Scheme + for Central Govt Employees in Delhi under Contributory Health Service Scheme.

MCH At end of 2nd Plan nearly 4500 maternity + child welfare centres exist - 1/3rd in urban areas.

MMR was 20/1000 LB's in 1938 is now estimated to come down to 12.4/1000 LB's.

Drugs: 3rd Plan envisages a large T in drug prod in the country + replacement of imported drugs & raw materials by indigenous manufacture. In past, quality + drug standards were based on imported drugs, but in future stoppage of imports + dev of indigenous prod. Indian Pharmacopoeia + National Formulary will become basis of standards in drugs + dev of industry. Quality of drugs both imported + manufactured is controlled under the Drugs Act 1940. This law in force in all States - but not adequately implemented. partly d/to inadequacy of staff / proper facilities for analysing drug samples from manufacturers & traders. Recent amendments of the legislation - the Central Govt has taken Concurrent Power in the States over the manufacture of drugs. Services of Central Drugs Labs at Calcutta placed at disposal of State Govts, but essential that State Govts shd themselves provide for estabs. of own labs for analysis. Central Govt has appointed a skeleton staff for control of manufacture of drugs concurrently in State Govts., but it will also be necessary for State Govts to take early steps to augment their present personnel for day to day administration of the legislation. At present too few samples are taken + long delays occur in their analysis

Manufacturers + trade associations shd play a responsible role - maintaining standards/quality. Consumer assn's, local bodies, villages shd bring deviations from standards/excessive prices to attention of general public + of authorities concerned.

While prices of many essential drugs are maintained at reasonable levels Those of proprietary brands are often excessive + large profits are made. Indian manufacturers, medical profession + State govts shd follow National Formulary guidelines

Evils of substandard + spurious drugs - : Recent amendment to Drugs Act prescribes 1 yr min imprisonment for manufacture/sale of spurious drugs

Nutrition In 1st 2 Plans no concerted effort to improve nutrition, create awareness i ↑ prod + economic condn i 3rd Pl a systematic approach shd now be feasible

ICMR diet surveys over 2 periods 1935-48 + 1955-58 show that while there has been no appreciable change in consumption of cereals + pulses there may well have been a small reduction in consumption per capita of some non-cereal foods.

At Centre - a National Nutrition Advisory Committee functions

FP Approx Rs 65 Lakhs in 1st Plan, financial provns. for 5 cr reached in 2nd Pl

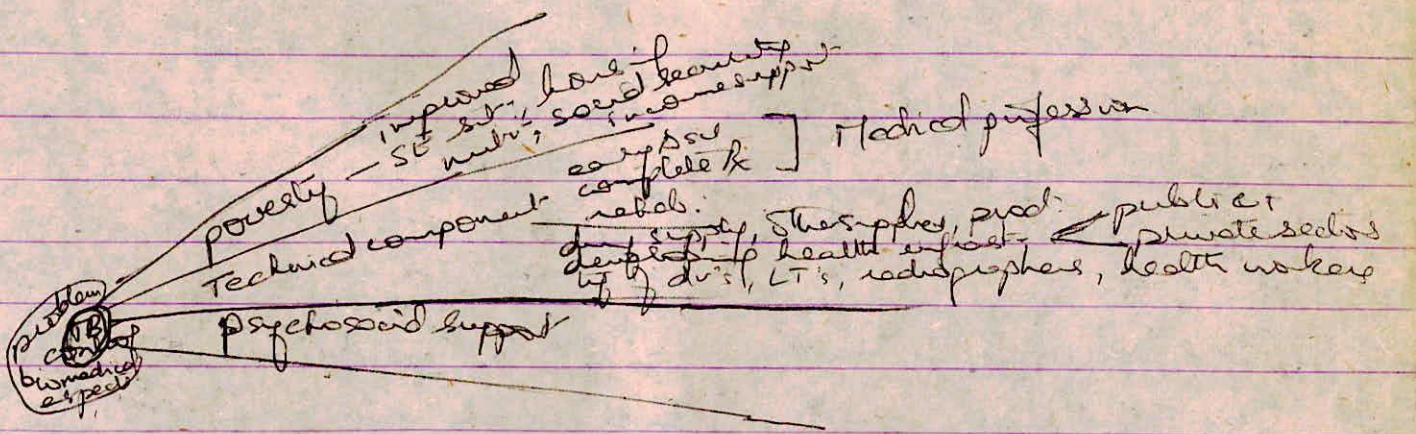
Needs admin arrangements at Centre/States to be greatly strengthened

To equip & train PHC's/SC.D provide FP services is a task whose magnitude/complexity shd not be underestimated

Utilising private prac, indigenous dr's, dais etc is careful planning

Prod of contraceptives is another major undertaking

The days of the logic of IA & take over.


problem
poverty
Technical component
psychosocial support
improved housing
sanitation
income support
rehab.
Medical profession
public
private sectors
health workers

सत्यमेव जयते — Truth Alone Triumphs

15/8/97

Ref NTI lib 31/5/96

THIRD FIVE YEAR PLAN, PLANNING COMMISSION, GOI: 1961-66

Jawaharlal Nehru - Chairman, Gulzarilal Nanda - Dpty Chairman
Members. Morarji R Desai, VK Krishna Menon, CM Trivedi
Sriman Narayan, TN Singh, AN Khosla, PC Mahalanobis
Sec Vishnu Sahay Addl Sec Tarlok Singh

PROCESS of formul.

1st 5 yr Plan - Till Mar 1956.
prep for 2nd - commenced April '54
prep for 3rd - commenced end '58

- draft outline published July '60 - a detailed study by working grps set up at Centre & States.
- Parliament gave general approval to Draft Outline in Aug 1960 discussed Thro' country, served as basis for prep of State Plans considered by CM's of States, Dec Sept & Nov 1960.
- Jan 61 Nat. Dev Council made recommendations concerning overall size & structure of 3rd Pl. Set up Com. on Savings
- May 31 & June 1st NDC considered Draft Report & approved it
- Objectives & priorities considered by 5th Parliamentary Committee in Nov 60 Put to Comm of MP's from all pol. parties presided over by PM. Consultative Committee of MP's ass' with Planning Com: also reviewed Plan.
- Advice from Plan. Commissions Panel of Economists, Scientists, Land Refs - - - Agri. ... Edn. ... Hlth & Housing &
- Studies by Prop Eval. Org', Research Progs Comm Com on Plan. Projects, CSO, ISI etc
  ie a vast national undertaking

First phase of a long term dev' Plan of 15 yrs
Economy to expand, become self reliant, self generating
Objectives & targets - only a minimum that must be achieved.

"The greatest stress in the Plan has to be on implementation, on speed & thoroughness in seeking practical results. Discipline & national unity basis of social & economic progress & achievement of socialism. Each step will demand dedicated leadership at all levels, higher standards of devotion & efficiency from public services, wide spread understanding & participation by people. & willingness on their part to take their full share of responsibility."

Table showing progress of TB in absolute no's over time. A complimentary search to be undertaken.

TB A sample survey conducted recently under auspices of ICMR has shown that total no. of cases of Pul TB in the country may roughly be 5 million of which about 1.5 mill. may be infectious & that mortality from TB is showing signs of decline. The incidence rate has remained more or less the same. both in rural & urban areas. During the 2nd Plan abt 120 mill. persons were tested under BCG vaccination Campaign. No of TB clinics ↑ from 160 in 1956 to 220 in 1961. 10 TB Demonstration & Training Centres were estab. & the no. of beds for TB pts ↑ from 22,000 in 1956 to 26,500 in 1961. NTI est. at Bhopal in 1959.

In the 3rd Plan BCG Campaign will be intensified to cover another 100 mill. persons. No of clinics will be ↑ from 220 to 420. In addition, 25 mobile clinics equipped with x-ray for miniature films & mobile labs for collection of specimens & sample chests will be set up for semi-rural areas. 5 more Training & Demonstration Centres will be estab. Abt 3500 more beds for TB pts will be added bringing the total no of beds to 30,000 by 1966. Provision also been made for the setting up of 7 after care & Rehabilitation Centres

Physical Targets proposed for 3rd Pl along with statistics of progress in 1st & 2nd Plans are given in summary form below

	1950-51	'55-'56	'60-'61	'65-66
Hosp & disp.				
institutional beds	8000 113,000	10,000 125,000	12,600 185,600	14,600 240,100
PHC's	—	725	2800	5200
Med Coll	30	42	57	75
Nurses & adm's	2500	3500	5800	8000
Trg progs.				
dr's @	56,000	65000	70000	81000
nurses @	15,000	18500	27000	45000
ANM's/midwives.	8000	12,780	19,900	48,500
HV's.	521	800	1500	3500
Health Assistants	na	na	42000	48000
TB				
BCG teams	15	119	167	167
TB clinics	110	160	220	420.
TB demon & trg centres	—	3	10	15
beds	10371	22000	26,500	30,000

Working of PHC's during 2nd Plan showed that among factors affecting progress of this programme were (1) shortages of trained personnel (2) delays in construction of bldgs + residential quarters for staff. (3) inadequate facilities for diff. categories of staff. and for service in rural areas. Need to strengthen PHC's + to integrate as early as may be feasible services such as those for control of malaria, TB etc in rural areas of health units

Diff. progs could also become vested interest groups trying to dev. their area's eg malaria, FP.
IMP. to keep national interest + interest of poor first.

1st 3 plans v. explicitly talk of working towards a socialist society & v inequalities., Tho' hampering the prod: process.

Other steps to improve efficiency of PHC's are provision of min. staff org' of lig facilities, integrating PHC activity & other health services available in area.

To attract dr's - suggested (a) As is practice in some States there shd be a single cadre for personnel in rural + urban areas Rural service to be considered for accelerated promotion, advance increments, 'PG-selec'., (b) Residential accom' + other facilities. Due account for addl expenditure for educ' of children

(c) Scholarships & bdg's to work in rural areas
(d) use part time services of pvt practitioners for hosp's/disp + school health services (e) good of indigen. sys of med in PHC's PSC's
Links & Referral / Dist Hosp's
Head & Dist H. & x-ray/path + med/surg/obst specialist services
org. OPD's as polyclinics - so that tech. equip used & OPD.

Overall target of 3rd Pl - establish 2000 more hosps + 54,500 addl beds

Control of Com Dis - Sp. emphasis on eradic' of malaria + spox
1st Pl - 23 cr, 2nd Pl - 64 cr expenditure
3rd Pl - 70 cr outlay.

Period	Birth Rate	Death Rate	IMR ♂	IMR ♀	expect' of life at birth ♂	expect' of life at birth ♀
1941-51	39.9	27.4	190.0	175.0	32.45	31.66
1951-56	41.7	25.9	161.4	146.7	37.76	37.49
1956-61	40.7	21.6	142.3	127.9	41.68	42.06.

Inspite of gains - deficiencies — institutional facilities quite marked esp in rural areas, Dr's not evenly distributed bet urban & rural areas Rural instt'. did not have full complement of staff.

progress of communic. dis hampered in several parts on account of shortages of trained personnel + to some extent also of supplies & equip.

Focus of 3rd Pl on water supply + expansion of institutional facilities Pl. comm. well intentioned — unable to halt social/ec. forces. & worked thru informal channels. → bureaucrats + politicians,

"Progr for eradic" - for malaria will be completed + efforts made to eradicate smpox + to control filaria, cholera, TB, leprosy + other communic dis's.

H&FP Progr

H&FP - Broad objective of 3rd Pl. is to expand H&FP services, bring about progressive improvement in health of people + create conds favourable to greater efficiency + productivity. Increased emphasis will be laid on preventive public health services. 3rd Pl. also accords v. high priority to FP.

As against outlays of Rs 140 + 225 cr in 1st + 2nd Pl 3rd Pl involves a total outlay of abt 342 cr — abt 287 cr being in the states + the rest at the centre. These are distr under diff. heads as follows:-

(Rs & crores)

Progr.	1st Pl	2nd Pl	3rd Pl
Water Supply + Sanit (rural + urban)	49.0	76.0	105.3.
PHC's, hosp's + disp's	25.0	36.0	61.7
Control of commun. dis	23.1	64.0	70.5
Educ", Tg + res.	21.6	36.0	56.3.
Indig sys of med, homeop + rational cure	0.4	4.0	9.8
Other schemes	20.2	6.0	11.2
F.P.	0.7	3.0	27.0
TOTAL	140.0	225.0@	341.8

@ - actual expenditure is expected to be of the order of Rs 216 Cr.

Progress 1 Marked decline in incid of malaria - in 1958 progr changed from control to eradic".

2 Applicable progr in control of: filaria, TB, leprosy, VD

3. No of hosps/disp. ↑

4. Basic H&FP organis' providing public hr. prev + cur. service estab. in 2,800 dev' blocks & pop of 200 mill.

5 At end of 2nd Pl. - 78 inst", reaching 15M's & annual intake 1375 15M faculties in 98 hosp., & 372 disp, & 2462 bed strength.

6 664 schemes of urban water supply + drainage - cost 112 Cr.

7 In addition to schemes of rural water supply implemented under progr for CD, local dev. works + welfare of backward classes abt 228 schemes & est. cost of 20 Cr taken up under Health progr.

(There is still an urban rural divide { quantity (no of inst'/Dr budget) / quality of service / access.

Personnel Requts & Trg. Progs For carrying out 3rd Plan progs health + medical personnel, specially in ancillary categories as nurses, midwives + HV's will fall short of requts. Given below is pos. at end of 2nd Pl & proposals for 3rd Pl.

	1960-61			1965-66		
	Institn.	Intake	Outturn	Institn	Intake	Outturn
Dr's	57	5800	3200	75	8000	4830
Nurses	250	4000	2800	350	6200	4500
ANM/midwife	420	5200	4000	550	9100	7000
HV's	30	650	375	50	850	500
SI	28	2250	2250.	38	2850	2850
Pharmacist	10	550	480	15	1450	1270

A prob is calls both for rapid expansion of PG educ & for various short term measures is the shortage of teachers in med. colls is at present est. at abt 2000 & is likely to go further.

FP essential to provide FP services at PHCs Large nos of women workers have to be recruited & trained. Progs have been drawn up are likely to be undertaken & should considered further

Financial Resources The limit to financial resources is never an absolute one., it is related to the quality of effort that is brought to bear on implementn of projects, on garnering of surpluses & on pres- ther fiscal & other measures into consumption or non-priority investment. Dev. has in due course to become self financing. In choosing projects for implemn Central & State Govts shd keep constantly in mind the need to get results from investments as quickly as possible. Rapid improvements in planning & exec- over a no. of years can yield a larger return in the aggregate. ; ; in attn to these resources can be raised beyond the limits presently envisaged.

Prob. of resources links up with prob. of admin & organis. efficiency

1969-74

Fourth Five Year Plan, Planning Commission, GOI 18/7/30

Planning - vital instr. to realise our social objectives
Attack on our territory in 1962 + again in 1965 forced us to modify the pattern of national expenditure. Before we could reconcile competing claims of defence + dev", drought struck us. Foreign credits became uncertain. Recession followed. All these seriously restricted our freedom of choice. We had to divert energies to fight drought + near famine + their aftermath. For some time long term planning had to be virtually suspended.

We concentrated on import substitution & further enlarged our industrial base. The along with need for more foreign exch. put us on the path of a more fruitful export drive. We maintained our investment in dev" - esp. in irrigation, agricultural progs. Welcome upsurge in economy - nearer to self sufficiency in foodgrains. Probs.

Rural disparities ↑, partly owing to the very efforts we have made to move rapidly towards self-sufficiency in food + partly owing to slackness in implementing land reforms.

Although industrial recession waned some industries were coming up fast enough + unemployment continued to be acute.

Basic aim to ↑ std. of living esp. of less privileged sections of society, need ↑ prod" & rational distn. Overriding imperative must be a burning concern for social justice. Need to reduce / prevent conc. of wealth + economic power. Benefits of dev". shd accrue to weaker sections.

One year of the plan gone by.

Nationalisation of 14 big banks - evidence of determination to bring a greater vol of resources within the ambit of social decision. Has effected a major change in our economic str. Restricted scope for monopolistic operations by private sector. Need to
- enforce land laws + manage of public sector enterprises
- tone up admin. as a whole

CHAPTER 18
HEALTH AND FAMILY WELFARE

Health

18.1 Realizing that achievement of the goal Health for All by 2000 AD which was laid down in the National Health Policy (1983) is unlikely to be achieved within the time specified. The Eighth Plan consciously and consistently focused the attention on promoting the health care to the under-privileged segments of vulnerable population through consolidation and operationalising the Primary Health Care infrastructure and strengthening referral system through District Health Care models. Thrust areas include :

a) Major investment in development and strengthening of primary health care infrastructure aimed at improving the quality and out reach of services.

b) Consolidation and expansion of the secondary health care infrastructure upto and including the district level services.

c) Optimization of the functioning of the tertiary care.

d) Building up of referral and linkage system so that optimal utilization of available facilities at each level is possible.

e) Control of communicable diseases which continue to dominate major public health concerns in the country .

f) Tackling the emerging problem of non-communicable diseases.

g) Improving the utilization of Indian Systems of Medicine and Homoeopathy (ISM&H).

h) Creation of well trained skilled medical and paramedical manpower, adequate in quantity and appropriate in quality, to take care of the health needs of the population.

18.2 Specific efforts have been made to ensure that the ongoing economic restructuring doesn't lead to any adverse effect on provision of essential care to meet the health needs of the most needy segments of the population. Some of the major efforts in this direction include allocation of funds under the Social Safety Net Scheme to improve Maternal and Child Health (MCH) infrasructure in a phased manner, beginning with the 90 poorly performing districts. Specific efforts are also being made to promote Indian Systems of Medicine especially in view of the fact that these are traditionally well accepted by the population, personnel belonging to these systems are available in the remote and rural areas and provide treatment at affordable cost. Involvement of voluntary organisations and improved Information Education and Communication (IEC) activities are supported so that there is adequate community participation and improved utilisation of the available health facilities.

Comprehensive Review of Public Health System

Review of Annual Plan 1994-95

18.3 The major problems facing the Public Health System in the country is need to ensure the outreach of appropriate services at affordable cost and at the same time maintain quality of services. Under the direction of the Prime Minister an Expert Group has been constituted under the Chairmanship of Member (Health) to comprehensively review existing Public Health System in India and suggest measures for improving it. The Committee has the mandate to comprehensively review:

a) Public Health System in general and the quality of epidemic surveillance and control strategies in particular;

b) The effectiveness of existing health schemes, institutional arrangements and the role the State and local authorities play in improving public health system;

c) Status of Primary Health Care infrastructure (Sub-Centre, Primary Health Centres and Community Health Centres) in rural areas especially their role in providing intelligence and alerting the system to respond to the signs of outbreak of disease and the effectiveness of the District level administration for timely, immediate action; and

d) The existing Health Management Information System and its capability to provide up-to-date intelligence for effective

surveillance, prevention and remedial action.

The Committee, while giving the report, is also to recommend short and long term measures to prevent recurrence of epidemics and generally improve the standards of hygiene in the country and inter-alia delineate the financial arrangements to be adopted for achieving the goal set out in their recommendations.

Annual Plan 1995-96

18.4 The Committee had so far held three meetings. In each of the meetings indepth review of specially prepared background document on each of the terms of reference was undertaken and appropriate recommendations were made . The Report of the Committee is expected to be finalised shortly. It is expected that immediate action on some of the recommendations will be initiated as a part of the Annual Plan 1996-97. The Recommendation of the Committee is expected to form the base and basis for formulation of Ninth Plan proposals for the Public Health System in the country.

Rural Health
Review of Annual Plan 1994-95

18.5 Primary Health Care infrastructure provides mechanism for sustained and continuous outreach of all health and family welfare programmes in the country. Earmarked outlay under Minimum Needs Programme (MNP)is provided for consolidation and operationalisation of Primary Health Care infrastructure. The total approved outlay for the Annual Plan 1994-95 for the improvement of three-tier system of rural health services viz. Sub-Centres, Primary Health Centres and Community Health Centres under the Minimum Needs Programme of the States and Union Territories was Rs. 386.2 crore. The target set for 1994-95, 1995-96 along with cumulative achievements by the end of the year (31.03.1995) are given in Table 18.1 below:

18.6 During Working Group discussions with States/UTs on their draft Annual Plans 1994-95 and 1995-96, no targets for additional Sub-Centres were given to the States. All the States and UTs were advised to consolidate and operationalise their primary health care infrastructure so that qualitative improvement in the delivery of primary health services is achieved and made available at the village level. As far the establishment of Primary Health Centres and Community Health Centres, the States of Arunachal Pradesh, Gujarat, Himachal Pradesh, Jammu and Kashmir , Karnataka, Manipur, Meghalaya and Mizoram have been able to achieve their targets both for Primary Health Centres and Community Health Centres for 1994-95. Nagaland was able to only achieve the targets for Community Health Centres and Rajasthan and West Bengal were able to achieve the targets for Primary Health Centres only during Annual Plan 1994-95.

18.7 There has been substantial shortfall in the achievement of targets set for Primary Health Care infrastructure. One of the major reasons for this is the fact that financial norms for construction were drawn up decades ago and the States are unable to achieve physical targets within the sum allocated. The financial norms for construction, as well as recurring cost of running the Primary Health Care institutions need be worked out on the basis of

TABLE 18.1

MNP Targets and Achievements

Programme	No.as on 1.4.92	8th Plan	1992-93		1993-94		1994-95		Likely No. as on 1.4.95	1995-96 Target
			Target	Actual Ach.	Tar.	Ach.	Tar.	Ach.		
1.Sub-Centres	131605	17030	4066	147	18	43	-	-	131795	-
2.Primary Health Centres	20716	4450	759	335	640	421	780	296*	21768	601
3.Community Health Centres	2189	1269	259	84	164	80	157	66*	2419	206

Source : Medical, Public Health and Population Control Working Group discussion 1995-96, Planning Commission.

* Progress Report for 1994-95, Deptt. of Programme Implementation.

current costs in order to prevent these shortfalls.

Annual Plan 1995-96

18.8 The Rural Health Annual Plan 1995-96 has also been formulated keeping in view the assessment made by Planning Commission on quality and quantity of rural health services during Working Group discussions and the strategies envisaged in the Eighth Five Year Plan document. The States have been advised to consolidate the physical facilities by completion of buildings of Sub- Centres, Primary Health Centres and Community Health Centres and their staff quarters that are already underway; ensure provision of essential equipments, drugs and dressings as per the approved standard list; filling up of all the vacant posts and improve in- service and other training of staff.

Health Manpower in Primary health care : Review of Annual Plan 1994-95

18.9 Substantial proportion of the specialist posts in the community health centres are vacant; because of this Community Health Centres (CHCs) will be unable to fulfil their function as first referral units (Table 18.2). In view of the serious implications of this lacunae in the establishment of referral system, as well as effective provision of MCH/FP care, there is an urgent need to rectify this.

18.10 Though the norms require one male and one female multi- purpose worker per 3000 to 5000 population, the number of sanctioned posts of male multi-purpose workers is only half of that of female multi-purpose workers. The vacancies in radiographer lab-technicians and other para-professional posts have serious implications in malaria and TB control programmes.

Table 18.2

Health Manpower in Primary health care

Category	No. in Position (As on 31.03.92)	% Vacant	No.in Position (As on 31.3.95)	%Vacant
i. Surgeons	652	29.4	703	45.4
ii. Obst & Gynaecologists	355	63.1	576	47.5
iii. Physicians	399	23.6	658	42.9
iv. Paediatricians	274	45.2	436	43.7
v. Doctors at PHCs	22013	14.3	28135	15.8
vi. Block Extension Educators	5125	7.3	5658	9.9
vii. Health Assistant (Male)	9726	7.6	15916	13.0
viii. Health Workers (Male)	64008	12.0	62629	12.3
ix. Health Assist- nts (Female)/ LHV	21233	12.0	19045	12.4
x. Health Workers (Female)/ANMs)	121765	7.9	132950	5.4
xi. Pharmacists	16287	12.6	20172	6.7
xii. Lab Technicians	8875	12.7	10715	19.5
xiii. Nurse Mid- wives	12479	16.9	11653	26.7
xiv. Radiographers	565	24.2	1200	19.6

Annual Plan 1995-96

18.11 The Annual Plan 1995-96 discussion focussed on this problem of vacancies in the vital paraprofessional posts and the States were requested to initiate appropriate steps to rectify the above lacunae utilising the 10+2 vocational training courses so that the functioning of primary health care infrastructure is optimised.

18.12 For the Annual Plan 1995-96 target of 601 PHCs and 206 CHCs have been given to the States and UTs especially in remote, tribal and hilly areas.

Areas of concern

- Poor utilisation of funds allocated under MNP especially in poorly performing States.
- Substantial shortfall in the achievement of targets for Primary Health Care infrastructure.
- Financial norms for construction and recurring costs of running Primary Health Infrastructure do not take into account cost escalation.
- Substantial proportion of specialist posts in CHCs are vacant.
- Number of specialists posts and number of sanctioned posts of Male Multipurpose worker is only half of the prescribed norms.

Control of Communicable Diseases

Vector Borne Diseases

National Malaria Eradication Programme

18.13 The National Malaria Eradication Programme (NMEP) is the oldest of the communicable disease programme of the country and was launched by the Government of India in the year 1958. After the initial success of the modified Plan of operation the estimated number of Malaria cases have remained around 2 million during the last few years.

Review of Annual Plan 1994-95

18.14 Resistance to chloroquine and to a variety of insecticides used for spraying operation are increasingly being reported in many States. The country witnessed focal epidemic during 1994 in Rajasthan, Manipur, Nagaland and 3-4 fold increase in malaria deaths. In several States there are major shortfalls in smear collection from fever cases and administration of presumptive treatment as well as delays in smear reading and administration of radical treatment.

Annual Plan 1995-96

18.15 Government of India appointed a Committee of Experts to identify the worst affected malaria areas and to suggest specific remedial measures. The Committee observed that though appropriate technology for control of malaria is available for different epidemiological paradigms of malaria, the organisational weakness and operational problems, in the States had led to periodic epidemics and high mortality. Based on the recommendations of the Expert Committee, the Directorate of NMEP has prepared the revised strategy for the control of malaria in the country which will be adopted to the extent possible during 1995-96. It is envisaged that the State health authorities will re-orient the health organisation conforming with the revised strategy taking into consideration the new epidemiological parameters for accelerating the programme activities in different malaria paradigms especially hard-core tribal areas, epidemic prone areas, development project areas and problematic urban agglomerations. The seven North Eastern States predominantly having tribal population, hilly terrain and high incidence of falciparum malaria were provided with 100 per cent Central assistance for control of malaria, from 1.12.1994. A proposal to intensify malaria control measures in Tribal areas in some States is currently under formulation.

Kala Azar

18.16 Kala-azar is a public health problem in the States of Bihar and West Bengal. Presently, 30 districts of Bihar covering a population of 6.81 Crore (1991 Census) and few districts of West Bengal are at risk of kala-azar. The strategy for kala-azar control broadly includes the following three major activities:

(i) interruption of transmission by reducing vector (Phlebotomus) population contact by undertaking indoor residual insecticidal spraying twice annually during the transmission season;

(ii) early diagnosis and complete treatment of kala- azar cases; and

(iii) health education for community improving awareness and involvement.

Review of Annual Plan 1994-95

18.17 Following resurgence of Kala-azar, a separate budget under Kala-azar Scheme was approved in 1990-91, to intensify control measures. During 1992-93, a total plan expenditure of Rs.20 crore was incurred for kala-azar control of which Rs.19.26 crore was provided to Bihar as assistance in kind and Rs.0.74 crore for West Bengal. During 1993-94, out of Rs.20 crore plan allocation, expenditure of Rs.17.24 crore was incurred by Bihar and Rs.1.40 crore by West Bengal. During 1994-95, a provision of Rs.20 crore was approved and the same amount has been kept for Annual Plan 1995-96.

Annual Plan 1995-96

18.18 It is noteworthy that the incidence of kala-azar cases and deaths due to kala-azar have shown a decreasing trend in the last three years. The activities have to be kept up to ensure that the gains during the last three years are consolidated.

Other Vector borne Diseases
Annual Plan 1995-96

18.19 Filaria Control Programme which is at present in operation in only urban areas is being extended to rural areas by providing drugs to the cases through Primary Health Care system.

18.20 Dengue fever was considered essentially an urban problem; in the last few years, several States have reported Dengue fever in rural areas. Yet another area of concern are the reports of a Dengue haemorrhagic fever and Dengue shock syndrome from some States.

18.21 With increasing development of irrigation projects, the areas from where Japanese encephalitis cases are reported in the country have been progressively increasing.

18.22 Increasing morbidity and mortality due to vector borne diseases can be reduced by appropriate vector control measures aimed at reduction of disease transmission and strengthening of facilities for early diagnosis and treatment of cases in primary and secondary care settings. It is also necessary to intensify the information, education and communication activities with the objective of making the community aware about malaria, filaria, kala-azar and japanese encephalitis control and thereby ensuring their active cooperation.

National Leprosy Eradication Programme

18.23 India has over half of the known leprosy cases in the world. With the availability of multi drug therapy in the 100% CSS National Leprosy Eradication Programme (NLEP), there has been considerable decline in the number of leprosy cases. As against 40 Lakh estimated leprosy patients in 1981, there are about 10 Lakh cases on record now. On an average, about 4-5 lakh cases are being detected every year. The main aim of the programme is early case detection and domiciliary treatment; the ultimate goal is arresting transmission of the disease in the country by 2000 AD. The main strategy during the Eighth Plan is to provide Multi Drug Therapy (MDT) to all the districts with endemicity of two and more per thousand population on modified pattern.

Review of Annual Plan 1994-95

18.24 Currently about 50 per cent of the leprosy patients are getting benefit of MDT in the country. To spread the MDT coverage to as yet uncovered areas and to further intensify the efforts, the Government has taken World Bank assistance for extension of MDT services in the 66 endemic districts on regular vertical pattern and for extension of MDT services in 253 moderate and low endemic districts through primary health care services and a limited number of trained leprosy workers. The health education and training activities of the programme are also being intensified. Disability and ulcer care services are also being strengthened. The Table 18.3 shows targets and achievements for case detection, cases under treatment and cases discharged.

Annual Plan 1995-96

18.25 The following strategy under the programme will continue to be pursued during 1995-96 :

(i) provision of domiciliary Multi Drug Treatment coverage in 201 districts with prevalence of five or more leprosy cases per 1,000 population, by specially trained staff in leprosy;

(ii) provision of Multi Drug Therapy (MDP) services through mobile Leprosy Treatment Units with the help of existing health care services in 77 moderately en-

Table 18.3

Targets and Achievements of various activities under National Leprosy Eradication Programme

(In lakh)

Case	Case Detection		Cases under Treatment		Cases Dis-charged	
	Targets	Achieve-ments	Targets	Achieve-ments	Targets	Ach-ieve-ments
1990-91	3.69	4.82	3.69	4.74	8.81	9.85
1991-92	3.35	5.13	3.35	5.10	6.12	8.26
1992-93	2.89	5.48	2.89	5.41	5.74	10.53
1993-94	2.65	4.94	2.65	4.86	5.25	7.19
1994-95	2.24	4.29	2.24	4.19	4.24	6.26

demic districts and 176 other low endemic districts;

(iii) intensification of health education activities; and

(iv) appropriate rehabilitation.

18.26 A provision of Rs.94 crore was made for the Annual Plan 1994-95 including World Bank assistance and a provision of Rs.80 crore has now been made for Annual Plan 1995-96.

National Tuberculosis Control Programme

18.27 The National Tuberculosis Control Programme (NTCP) is a continuing Centrally Sponsored Scheme with 50:50 cost sharing between the Centre and the States since 1962 and is integrated with the general health services. The programme aims to detect cases early and treat them. The Central share is in the form of material and equipments including X-Ray machines and anti-TB drugs. In the district, the programme is implemented through the District Tuberculosis Centre (DTC) and a number of peripheral health institutions. The DTC organises and coordinates tuberculosis control activities within the district. Out of 460 districts in the country, DTCs have been established in 390 districts. The changing prevalence and incidence of the disease over the last three decades, emergence of multi drug resistant strains and anticipated increases in number of persons with dual infection (Tuberculosis and HIV infection) have been sources of concern. Hence the National TB Control Programme has been accorded a high priority by the Government during the Eighth Plan and the outlays have been increased to Rs.50 crore for 1995-96 so that additional funding for improving diagnostic facilities and providing drugs for short course Chemotherapy for treatment of Tuberculosis.

Review of Annual Plan 1994-95

18.28 The detection of new TB cases has been doubled within the last 2-3 years and now more than 18 lakh cases are being detected annually under the programme. Short Course Chemotherapy containing more effective drugs is being introduced in the country in a phased manner. So far, more than 250 districts have been covered. The targets and achievements of various activities under the programme are given in the Table 18.4 below:

Annual Plan 1995-96

18.29 The targets under the programme for 1995-96 are sputum examination at PHCs - 39.99 lakh and New TB case detection - 12.70 lakh.

18.30 The NTCP has suffered due to poor detection due to acute shortage of Lab technicians and Radiographers at primary health centres. Case holding is also poor and is to some extent attributable to the non availability of male multi purpose workers to follow up the defaulters. A Task Force under DG,ICMR developed revised strategy for control of Tuberculosis with the following features :

(i) Achieving 90 per cent cure rate of infectious cases through supervised Short

TABLE 18.4

Targets and Achievements under National T.B. Control Programme

Year	New case detection		Sputum Examination at PHC level	
	Target	Achievement	Target	Achievement
1990-91	16.50	16.16	34.00	24.21
1991-92	17.00	12.79	34.00	21.56
1992-93	17.50	15.39	34.00	26.56
1993-94	18.00	13.30	34.00	24.44
1994-95	19.00	13.59 (Provisional)	34.00	22.40 (Provisional)

Course Chemotherapy involving peripheral health functionary;

(ii) Augmentation of case finding activities through quality sputum microscopy to detect at least 70 per cent of estimated cases; and

(iii) NGO involvement, Information Education Communication(IEC),improved Management and Information System and operational research.

18.31 The revised strategy was launched with SIDA assistance in three cities viz. Bombay, Delhi and Gujarat and subsequently in Calcutta and Bangalore to cover a population of about 25 lakh. The operational feasibility and implementation of this strategy is being tested in one district each of the five States of Bihar, Himachal Pradesh, Kerala, Gujarat and West Bengal and one area each of the ten cities viz. Bombay, Calcutta, Madras, Delhi, Bangalore, Hyderabad, Jaipur, Lucknow, Bhopal and Pune with assistance from World Bank.

National AIDS Control Programme

18.32 HIV infection has been reported from almost all the States and Union Territories of the country. The common mode of transmission of HIV infection in the country is through heterosexual contact; however, the pattern of transmission in North Eastern States is predominantly due to sharing of infected needles by IV drug users. Realising the gravity of the epidemiological situation of HIV in the country, the Government of India launched a 100 per cent Centrally Sponsored Scheme with an estimated cost of Rs 222.6 crore during the 8th Plan with the World Bank assistance. Under the National AIDS Control Programme (NACP), the following strategies have been intensified during the 8th Plan :

(i) Surveillance of the population with special emphasis on high risk behaviour groups for detection of infection;

(ii) Strengthening of the blood banks and blood safety measures with priorities on special areas and metropolitan and large cities to start with;

(iii) Area specific strategy for control of infection and target specific IEC activities based on epidemiological data;

(iv) Integration of the control programme with the activities of the departments like Social Welfare, Youth & Sports etc. and other Government and non-Governmental organisations;

(v) Strengthening of STD Control Programme; and

(vi) Training of staff.

Review of Annual Plan 1994-95

18.33 According to the figures reported to NACO till March 1995, 24.76 lakh persons have been screened for HIV; 18.02 lakh persons have been found to be sero positive (Sero positivity rate 7.3 per thousand). A total of 1094 AIDS cases have been reported in the country till March, 1995.

Annual Plan 1995-96

18.34 During the year 1995-96, in addition to 516 already modernised blood banks, 92 will be taken up, thus making a total of 608 modernised blood banks in the country. The sanctions for establishment of State AIDS Cell

have already been issued to all 26 States and six Union Territories. 62 Surveillance Centres have also been established in the country. Poor utilisation of funds and tardy progress of AIDS programme in some States has been a cause of concern.

Environmental Health
Review of Annual Plan 1994-95

18.35 The interactive interdependence of health, environment and sustainable development was accepted as the fulcrum of action under Agenda 21 at the Earth Summit in Brazil in 1992. The essence and the essentials of health programmes include control of communicable diseases and reduction of health risks from environmental pollution and its attendant hazards. Population growth and rapid urbanisation have resulted in marked deterioration of sanitation and waste disposal especially in large cities. A High Power Committee on Urban Solid Waste Management in India was constituted by Planning Commission, under the Chairmanship of Member (Health). The terms of reference of the Committee were:

(i) To assess the impact of the present system(s) of Solid Waste Management on community health and suggest remedial measures aimed at minimizing health hazards and adverse health outcomes.

(ii) To identify the potential hazardous wastes in cities and towns including hospital wastes, and the associated health risk.

(iii) To assess the quantum and characteristics of domestic, trade and industrial solid wastes in towns exceeding Ten Lakh inhabitants (1991 census).

(iv) To review the existing technologies for solid waste collection, transportation and disposal and suggest the most appropriate and feasible ecofriendly and cost-effective technology option(s) keeping in view the cost-benefit, the waste characteristics, socioeconomic status and demographic structure of the community.

Annual Plan 1995-96

18.36 The Committee has submitted its report. Waste reduction, reuse and recycling utilising appropriate technology, avoidance of risk transference from one source to other, reduction in the potential risk to human health and environmental degradation, conservation of energy or its generation through non conventional sources are the major thrusts of the recommendations of the Committee. The report of the High Power Committee also emphasises the need for appropriate legislation to regulate industry, hospitals and town planning, need for health impact assessment along the lines of environmental impact assessment for major projects. The report of the High Power Committee was discussed in the Internal Meeting of Planning Commission under the Chairmanship of Deputy Chairman, Planning Commission on 23rd September 1995 and was adopted. It is expected that urgent action will be initiated through allocation of funds for infrastructural development of solid waste mangement under the Centrally Sponsored Megacity project during the remaining period of the Eighth Plan. The implementation of the recommendations would also require major outlay for urban develpment during the Ninth Plan.

Control of Non-Communicable Diseases
National Programme for the Control of Blindness
Review of Annual Plan 1994-95

18.37 The National Programme for the Control of Blindness (NPCB) was launched in 1976. The programme aims to reduce the rate of blindness due to cataract to 0.3 per cent by the year 2000 AD. Reducing disability due to blindness is imperative in view of the increase in longivity. The programme is a 100 per cent Centrally Sponsored Scheme. The assistance provided to the service component under the programme has been stepped up from Rs.25 crore during 1993-94 to Rs.40 crore during 1994-95 and there is a provision of Rs.72 crore during 1995-96. The achievement in cataract operations has gone up. The target in 1993-94 was 24.3 lakh operations and 19.14 lakh operations were performed. A target of 24.5 lakh cataract operations was set for the year 1994-95 and achievement was about 90 per cent. During 1995-96, a target of 25.50 lakh cataract operations has been given to the States. The new dimension in the implementation of the NPCB is : (i) improvement in efficiency levels of existing systems by way of optimum utilisation of existing resources, research, introduction of new technologies and strengthening of monitoring systems; and (ii) additional inputs in terms of infrastructure, manpower, new technologies and equipments. The voluntary organisations are also playing a very significant role in this programme. With the success

achieved and experiences gained through the pilot district projects, District Blindness Control Societies are being established throughout the country. By the end of 1994-95, 40 per cent District Blindness Control Societies were established. The grants to non-governmental organisations are now being released through District Blindness Control Societies to ensure timely payment. The targets and achievements in respect of cataract operations under the programme are given in Table 18.5 below:

Table -18.5

Targets amd Achievements of Cataract Operations under National Programme for Control of Blindness

(In lakh)

Year	Targets	Achievements
1990-91	12.84	11.83
1991-92	19.90	15.05
1992-93	20.00	16.00
1993-94	24.30	19.14
1994-95	24.50	21.64

The approved strategies of the Eighth Plan are:

i) Upgradation of District Hospitals to perform greater number of cataract operations. This is done by appointing an Ophthalmic Surgeon and one P.M.O.A.

ii) Strengthening of Mobile Ophthalmic Units and creating more permanent infrastructure for ophthalmic services.

iii) More and more involvement of voluntary organisation in the National Programme for Control of Blindness.

iv) Establishment of District Blindness Control Societies.

v) Increasing the Targets for cataract operations in successive years with the intention of speedy clearance of cataract backlog.

18.38 A provision of Rs.40 crore was made for various activities under the NPCB for 1994-95 including World Bank assistance. The World Bank project is being implemented in seven States and similar project is implemented in J&K utilising funds provided by Govt. of India.

Annual Plan 1995-96

18.39 Programme will be vigorously implemented through the infrastructure and the machanism created earlier; an amount of Rs.72 crores has been kept under the programme for the year 1995-96.

National Iodine Deficiency Disorders Control Programme

18.40 It is estimated that in India alone, more than 6.3 Crore people are suffering from various iodine deficiency disorders. Realising the magnitude of the problem of iodine deficiency disorders, the Government of India re-named this 100 per cent Centrally Sponsored National Goitre Control Programme which was in operation since 1962 to National Iodine Deficiency Disorders Control Programme (NIDDCP). Sample surveys conducted by the DGHS and other agencies have shown that IDD is confined to sub himalayan region. The survey results indicate that out of 243 districts, IDD is a major public health problem in 200 districts of the country.

Review of Annual Plan 1994-95

18.41 Universal iodisation of salt is the strategy adopted by the Government of India since 1985. To promote the production of iodised salt, 641 private manufacturers have been licensed by the Salt Commissioner. The annual production of iodised salt has been raised from 5 lakh MT in 1985-86 to 50 lakh MT in 1994-95. In order to ensure use of only iodised salt, majority of the States and UTs have issued notification banning the sale of uniodised salt for edible purposes under PFA Act. For ensuring quality control at consumption level i.e. household level, testing kits for on-the-spot qualitative testing have been developed and distributed to all the District Health Officers in endemic States for regular monitoring.

Annual Plan 1995-96

18.42 For effective implementation of National Iodine Deficiency Disorders Control Programme in all the States/UTs, Iodine Deficiency Disorders Control Cells are being set up in all the States and UTs. A reference national lab for monitoring of IDD has been set up at

Bio-chemistry Division of NICD for training of both medical and paramedical personnel and monitoring salt and urinary iodine. Several training programmes are being organised. The IEC activities have been intensified by broadcasting/telecasting on radio/TV spots. Video films have been distributed to States. Posters highlighting the storage technique of iodised salt for use by wholesaler and retailers are being distributed.

National Mental Health Programme
Review of Annual Plan 1994-95

18.43 The National Mental Health Programme (NMHP) was launched as a purely Centrally Sponsored Scheme during 7th Five Year Plan with a view to ensure availability of mental health care services, did not make much of a headway in the Seventh Plan. During Eighth Plan, a fresh thrust is being given to widen the scope of programme. The following specific activities are being undertaken :

(a) implementation of district level mental health programme;

(b) improvement in the mental hospitals with particular reference to the improvement in the rehabilitation units;

(c) training of trainers of PHC personnel;

(d) welfare measures for the chronic mental disabled ensuring gender equity; and

(e) programme for substance use disorders.

For all these activities, a sum of Rs.15 lakh has been allocated under this programme during 1995-96.

18.44 During the Eighth Plan period, there had been some public interest litigation regarding some major mental hospitals in the country; as directed by the Supreme Court, the Central Government has been providing additional funds to improve conditions in these hospitals.

Annual Plan 1995-96

18.45 A comprehensive review of the situation in different States to chalk out methods to improve these institution is under consideration.

National Cancer Control Programme

18.46 India has one of the lowest Cancer rates in the world. It is estimated that incidence of Cancer is 4-6 lakh. The two most common ones are Cancer of cervix in woman and oral Cancer in both sexes. Both these Cancers have easily recognisable symptoms; diagnosis by biopsy is easy. Inspite of all these advantage, most cases are detected in stage III or IV even in States like Kerala, Tamil Nadu, Karnataka and Goa where health infrastructure is fairly well-developed. There is a need to educate the people so that Cancer detection is done at early stages at the peripheral level.

18.47 During the Eighth Plan, emphasis is on prevention, early detection of cancer and augmentation of treatment facilities in the country. The National Cancer Control Programme (NCCP) was started during the year 1975-76 when a pattern of Central assistance for the projects of cobalt therapy units for treatment of cancer patients was laid down. Subsequently, 10 major institutions were recognised as Regional Cancer Centres. These centres received grant-in-aid from the Government under the programme.

Review of Annual Plan 1994-95

18.48 During the year projects at district level for prevention of cancers through health education, early detection and introduction of pain relief measures have been initiated. Under the scheme, assistance is provided to the State Governments for each district project selected under the scheme. Financial assistance for development of Oncology Wings in medical colleges/hospitals for purchase of equipments is also provided which includes Cobalt Wing. So far, financial assistance has been provided to more than 25 medical colleges in the country and also to regional institutions and to the registered voluntary organisations for the purpose of undertaking health education and early detection activities in cancer.

Annual Plan 1995-96

18.49 To implement the programme in a phased manner in the country, a sum of Rs.15 crore has been allocated for this programme during 1995-96.

National Diabetes Control Programme

18.50 The National Diabetes Control Programme was included in the Seventh Five Year Plan as one of the Central health programme; a sum of Rs. 25 lakh was allocated for the programme to initiate district diabetes control programme. A Central Steering group coordinated the programme, monitored the progress

of the work in different districts. The project was initiated in two districts in Tamil Nadu (Salem and South Arcot), one district in J&K (Jammu) during the Seventh Five Year Plan period.

Review of Annual Plan 1994-95

18.51 During the Eighth Plan period, some of the States had initiated District Diabetes Control Programmes as a part of the State Plan Schemes; the State of Karnataka has initiated the programme in two districts and now proposes to expand to three more districts.

Annual Plan 1995-96

18.52 Andhra Pradesh, Rajasthan, Maharashtra, Himachal Pradesh and Punjab have indicated that they intend to initiate district diabetes control programme during 1995-96. Training material and health education material in local languages is available in Tamil Nadu, Maharashtra, Karnataka and J&K. The Deptt. of Health is reconstituting and convening the Steering Committee ; the Committe is expected to provide necessary guidance and help in the preparation of necessary training material and assessment of the requirement of various states to ensure smooth functioning of the programme.

Medical Research

18.53 Indian Council of Medical Research the nodal organisation for biomedical research in India, formulates, conducts, coordinates and reports basic, clinical, applied and operational research studies relevant to major health problems in the country. These studies are carried out in the permanent Institutes of ICMR as well as the ICMR funded research projects in Universities, Medical Colleges and Non-Governmental Organisations. In addition to ICMR, DST, DBT, CSIR fund research studies predominantly basic research-in R&D establishments and universities.

Review of Annual Plan 1994-95

18.54 Major thrust areas of research include existing problems of communicable diseases, emerging problems of non communicable diseases, improvement of health and nutritional status of women and children and increasing contraceptive acceptance and continuation. Indigenous development of immuno-diagnostics, research studies on improved drug regimens to combat emerging drug resistance among several bacteria, alternative strategies for vector control in view of the increasing insecticide resistance among vectors, testing innovative disease control strategies through increased community participation has been the major focus of research in communicable diseases.

18.55 ICMR has recently completed a 10 year study on health consequences of Bhopal Gas Disaster providing data base for planning the infrastructure needed to meet the health care requirements of the population exposed to toxic gas over the next decade. Anti tobacco community education, early detection and prevention of cervical cancers in women and oral cancers in both sexes, life style modification to reduce the rising morbidity due to hypertension and cardiovascular diseases, documenting the health problem associated with life style changes and increasing longivity of life are some of the major research areas in Non Commuicable disease. Evaluation of ongoing Mid day meal programmes in schools, assessment of changes in dietary intake and nutritional status of urban and rural population in different States over the last two decades, investigating the health effects of food contaminants, adulterants and increasing use of pesticides are some of the activities in nutrition research.

18.56 Studies on safety and efficacy of non-surgical methods for inducing abortion in early pregnancy, basic research studies to evolve and test immunodiagnostics, as well as innovative methods for contraception are some of the major areas of research in Reproductive Health. Operational research aimed to improve maternal and child health under existing health infrastructure, and epidemiological studies to estimate the prevalence of STD/RTI in different segments of women have also been initiated in the last year. A case control study has been initiated to evaluate the long term health consequences of vasectomy, in view of the fact that majority of the 1.3 Crore vasectomised men in India are likely to be over fifty years of age during the late nineties.

Annual Plan 1995-96

18.57 Research studies in all these areas will be continued. The Annual Plan outlay for 1995-96 for ICMR is Rs. 7.5 crore from Deptt. of Family Welfare and Rs. 29 crore from Deptt. of Health.

Education in Health Sciences
Review of Annual Plan 1994-95

18.58 There is, at present, no proper central mechanism to interlink the growth and development of health manpower with the needs of health care system, to plan a balanced development of all categories of human resources for health, or to ensure that the quality or competency of such manpower produced are relevant or commensurate with the country's needs. The Health Manpower Planning, Production and Management Committee in its Report submitted in 1987 and the Eighth Plan Working Group on Medical Education, Training and Manpower Planning recommended that the Education Commission for Health Sciences must be established as a Central organisation on the lines of the UGC for professional and para-professional education in health sciences, inter alia, to provide realistic projections for national health manpower requirements and suitable mechanism to continuously review the projections based on felt needs. The Draft National Education Policy for Health Sciences (1988) prepared by a Consultative Group under the Chairmanship of Prof. J.S. Bajaj, now Member (Health), Planning Commission reiterated the urgent need to set up the Education Commission in Health Sciences.

Annual Plan 1995-96

18.59 For the establishment of the Commission through necessary legislation and preparation of implementation details, a token provision of Rs.10 lakh is made for Annual Plan 1995-96.

Medical Education
Review of Annual Plan 1994-95

18.60 The Medical Education should be oriented towards supplying the necessary number of specialists/general duty officer in each category with appropriate training. There is also need to standardise the curriculum both at the undergraduate and postgraduate level; improved teaching methods and effective training in the required areas. Funds have been provided in the State plan for improvement and augmentation of facilities in terms of staff, equipment, libraries, laboratories and buildings in medical colleges and attached teaching hospitals to meet the requirements of the standards laid down by MCI.

Annual Plan 1995-96

18.61 The schemes for strengthening the post-graduate facilities in specialities and certain super-specialities taken up by the various State Governments will continue. The Centre has set up regulatory bodies for monitoring the standards of medical education, promoting training and research activities. This is being done with a view to sustaining the production of medical and para-medical manpower to meet the requirements of the health care delivery system at the primary, secondary and tertiary levels in the country. Special efforts are also underway to improve the dental education facilities so as to be able to cope with the manpower requirements for dental care at primary, secondary and tertiary care levels.Health related vocational courses at 10+2 level of education as part of vocationalisation of secondary education is being done to provide manpower required as per the needs and especially the urgent need for removing the backlog of paramedical manpower and imbalance of medical and para-medical personnel. Funds have been provided for this under the Education sector for 1995-96 also.

Nursing Education

Review of Annual Plan 1994-95

18.62 There is an acute shortage of nurses in the country. The accepted norm is a doctor-nurse ratio of 1:3. In India there are an estimated 4.5 lakh doctors belonging to allopathic system; there are only 2.3 lakh registered nurses. There is thus a shortage of about 6 lakh nurses. Nursing education and nursing services have been given a high priority during the Eighth Plan in order to bridge this gap. There is an increasing need for nurses with specialised training in specialities such as oncology, psychiatry and paediatrics and in wards providing intensive care to patients for improving quality of patient care.

Annual Plan 1995-96

18.63 With the objective of improving the situation regarding nursing training the following schemes are being implemented during 1995-96:

(a) Establishment of 10 new school of nursing with a very substantial intake of SC/ST students.

(b) Strengthening/adding seats to existing schools of nursing.

(c) Training of Nurses under Continuing Education Programme.

(d) Nurses colony in Delhi.

A provision of Rs. 9 crore has been made for above activities during 1995-96.

National Board of Examinations

18.64 The National Board of Examinations (NBE) was established by the Government of India in 1975 and it became an independent autonomous body under the Ministry of Health and Family Welfare with effect from 1st March, 1982. The Board conducts post-graduate and post-doctoral examinations in 39 disciplines of medical sciences and awards its own degrees known as Diplomate of National Board which are equivalent to MD/MS/DM/M.Ch. of other Indian universities. The Board is thus a national level body helping in maintenance of a high and uniform standard of post- graduate medical education and training. About 124 hospitals/institutions with in-take capacity of 550 candidates in various disciplines have been accredited by the Board after inspection.

Review of Annual Plan 1994-95

18.65 The Board has created a well-stocked question bank in various disciplines. A peer-review for appraisal of examination conducted by NBE has been initiated. Research into evaluation methodologies have also been carried out. Several structural reforms have been introduced in the context of theory, practical, clinical and viva voce. The Board is developing linkages for interaction with speciality, professional associations, other national and international academic and examination bodies.

Annual Plan 1995-96

18.66 All the ongoing activities will be continued during 1995- 96.The NBE is now generating substantial resources for its on- going activities. For additional support, a sum of Rs.17 lakh has been allocated during Annual Plan 1995-96.

National Academy of Medical Sciences

18.67 The National Academy of Medical Sciences(NAMS) was established in 1961 as a registered society with the objective of promoting the growth of medical sciences. It recognises talent and merit throughout the country in the form of election of fellows and members of the Academy. The National Academy of Medical Sciences recently has established regional centres for Continuing Medical Education (CME) Programmes and provided seed money to enable the establishment of minimal but relevant infrastructure for the conduct of such programmes.

Review of Annual Plan 1994-95

18.68 The CME Programme is being implemented by NAMS since 1982 as per pattern approved by the Government of India to keep medical professionals abreast with newer current problems of the country and update their knowledge in those fields for the required degree of health care and also helps medical students in preparation for post-graduate examinations of various universities and National Board of Examinations. The CME Programme also covers human resource development by sending junior scientists to centres of excellence providing training in advanced methods and techniques. A Memorandum of Understanding has been signed between the NAMS and the Indira Gandhi National Open University to develop distance education and learning as a critical mode for ensuring expeditious implementation of the long term policies developed by the NAMS.

Annual Plan 1995-96

18.69 Efforts will be made to establish more regional centres during 1995-96 and for its continuing activities, an amount of Rs.23 lakh is allocated during Annual Plan 1995-96.

Hospitals and Dispensaries

Primary Health Care in Urban Areas: Review of Annual Plan 1994-95

18.70 With increasing urban population especially migrant labourers living in poor and unhygienic condition settling near major cities and towns as urban slums, a need for primary health care for this vulnerable and underprivileged population has been felt. In order to provide primary health care to these urban slum population dispensaries and hospitals are being established by the state govt's under state plan. The slum population of the urban areas are also looked after by mobile vans.

Annual Plan 1995-96

18.71 Alternative approaches to provide services to urban slums are also being tried; the feasibility, outreach, and cost quality care in

each of these approaches will be assessed during the year.

Secondary Health Care
Review of Annual Plan 1994-95

18.72 Provision has been made for continuing and further strengthening the schemes for improvement of medical care facilities in the hospitals and dispensaries under the charge of the State Governments/Ministry of Health and Family Welfare in order to take care of referrals from primary health care and to reduce over crowding at tertiary centre.

Annual Plan 1995-96

18.73 Many of the States e.g. Himachal Pradesh, Karnataka, Punjab, West Bengal etc. have formulated project proposals for development of secondary level hospitals with the assistance of bilateral funding agencies. Adequate provision has also been made for augmentation and consolidation of the facilities already available and opening of additional dispensaries and hospitals, depending upon the local needs of the people. The network of hospitals would be strengthened gradually towards achieving the objective of one hospital bed for every 1000 population.

District Health Care Model

18.74 Development of District Health Care model has been initiated by the Planning Commission during Working Group discussions with State Governments on their Annual Plan proposals. The primary objective behind these models is to link the primary health care system with secondary care level centres so that referral for management of communicable and non-communicable diseases and health problem of women and children could be achieved. The secondary care centres, will inturn establish linkages with tertiary care centres for referral of cases requiring specialised facilities not available at secondary level.

Review of Annual Plan 1994-95

18.75 To begin with, in the Eighth Plan attempt has been made to develop district health models in some districts with distinctive features. The ongoing project in Nagpur district explores the feasibility of establishing the linkage at all levels in a district where over 50% of the population is urban. The project at Visakhapatnam looks at establishment of similar linkages in a coastal district.

Annual Plan 1995-96

18.76 A proposal for an operationalising district care model in two border, desert districts in Rajasthan is under consideration. It is expected that the experience gained through these will be of use in formulating the district health care proposals in the Ninth Plan.

Indian Systems of Medicine and Homoeopathy
Review of Annual Plan 1994-95

18.77 Indian systems of Medicine and Homoeopathy (ISM & H) are widely accepted in the country specially in the rural, remote and difficult areas. There are 5.65 lakh practitioners belonging to these systems who are available and provide health care at affordable cost in remote rural areas. Measures for popularisation and development of Indian systems of medicines and homoeopathy are being vigorously pursued during Eighth Plan. Efforts will be continued to integrate Indian Systems of Medicine and Homoeopathy with the mainstream of primary health care delivery network has been given a thrust.

Annual Plan 1995-96

18.78 For a proper direction and accelerating the promotion of ISM&H at the national level, a separate department for Indian system of medicines and homoeopathy including a directorate for Ayurveda has been set up vide notification dated 8.3.95. Emphasis has been given to the programme by propagating and promoting the development of medicinal plants; strengthening of ISM&H research institutes. An amount of Rs.23.82 crore is allocated for the further development of ISM&H in the country during Annual Plan 1995-96.

Recent Health Legislations
Review of Annual Plan 1994-95

18.79 The legislation on 'Transplantation of Human Organs' was enacted to regulate the removal, storage and transplantation of human organs for therapeutic purposes and for the prevention of commercial dealings in human organs. The Act and the Rules thereunder were enforced from 4th February, 1995 in all Union Territories and States of Goa, Himachal Pradesh and Maharashtra. Other States have been requested to adopt the legislation.

Voluntary Organisation

Review of Annual Plan 1994-95

18.80 Voluntary Organisations are being encouraged to supplement and complement the Govt.'s efforts in providing Health & Family Welfare services to the community and by educating and motivating them to utilise health & Family Welfare services. The financial assistance is provided to voluntary agencies for providing medical care to rural and high density urban slum population. The Voluntary Organisations which are running hospitals in rural areas or in urban areas (high density slums) are eligible to get financial assistance for expansion and improvement of existing hospital facilities. Financial assistance is provided for the purpose of purchase of costly essential equipments. The financial assistance is also given for setting up of new hospitals, dispensaries in rural areas with a maximum bed strength of thirty. The voluntary organisations are also being provided with necessary assistance under several programmes such as Blindness Control Programme, Leprosy Eradication Programme, AIDS Control Programme and under several schemes of Department of Health & Family Welfare.

Annual Plan 1995-96

18.81 To provide further encouragement to voluntary organisations to participate in the development of medical care facilities, an outlay of Rs.80 lakh has been proposed for the Annual Plan 1995- 96 under Central Health Sector Programmes.

Funding

18.82 There is an increasing recognition that human health is an essential prerequisite for development and the movement to 'invest' more, not only 'in' but 'for' health is gathering momentum. In India both the State and the Central Governments provide funding for programmes aimed at prevention of diseases, promotion of health, providing curative and rehabilitative services. In addition the private and the voluntary organisations play an important role in providing health care to the population. The outlays for the various Health Sector Programmes are given in Annexure 18.1 and 18.2.

External Assistance

18.83 Over the last few years there has been an increase in the quantum of external assistance for health care projects. The institutions/programmes shown in the Table 18.6 will receive External Assistance during the Annual Plan 1995- 96.

Table 18.6
External Assistance received under Health Sector Programmes during 1995-96

(Rs.in crore)

Name of the Programme	Amount of Assistance
1.National AIDS Control Programme	79.00
2.National Leprosy Eradication Programme	61.50
3.Blindness Control Programme	61.00
4.National TB Control Programme	4.00
5.National Institute of Biologicals (NOIDA)	19.50
	225.00

Plan Outlay for 1995-96

18.84 For the Annual Plan 1995-96, an outlay of Rs.2173.90 crore has been provided for the health sector as compared to the provision of Rs.1819.48 crore and revised estimates of Rs.1709.59 crore in 1994-95 as shown in Table 18.7.

Areas of Concern

- Periodic focal outbreaks of malaria with high morbidity and mortality.
- Increasing prevalence of falciparum malaria, chloroquin resistence in parasite and insecticide resistence in the vector.
- Re-emergence of Kala Azar
- Multidrug resistence in tuberculosis
- Emerging HIV epidemic and secondary epidemic of tuberculosis
- Poor utilisation of funds and tardy progress in AIDS control programme.

TABLE 18.7

Annual Plan Outlay for Health Sector for 1994-95 & 1995-96

(Rs. in crore)

	Centre	States/UT	Total
1994-95			
Approved Outlay	578.00	1241.48	1819.48
Revised Estimates	599.38	1110.21	1709.59
1995-96			
Approved Outlay	670.00	1503.90	2173.90

- Demographic transition, life style changes and increasing prevalence of non-communicable diseases such as diabetes hypertension, cardio-vascular diseases and malignancies.

- Emerging problem of environmental health.

Family Welfare

16.6%

18.85 India with 2.5% of the world's land mass is the home of 1/6th of the world's population.The population of the country was 84.63 Crore in March 1, 1991(1991 census) as against 68.33 Crore in 1981. Technological advances and improved quality and coverage of health care have resulted in rapid fall in mortality rates from 27 in 1951 to 9.3 in 1993. There had been increasing use of contraceptives over the same period, but the fall in birth rate, from over 40 in 1951 to 28.7 per 1000 in 1993 has been less steep; as a result the annual population growth had been over 2 percent in the last three decades. The rapid increase in population has come in the way of improvement of quality of life of citizens in the country. Rightly,therefore, population stabilisation was recognised as one of the six major objectives of the Eighth Plan.The Family Welfare Programme launched in 1951 aims to deliver a package services for Family Planning and Maternal and Child Health through a country wide network of Primary Health Care System supported by secondary and tertiary care institutions linked by appropriate referral system.

NDC Committee on Population

18.86 With a view to give new thrust and dynamism to Family Welfare Programme, a Sub- committee of National Development Council on Population was constituted. The report of the Sub- committee was considered in the meeting of the NDC held on 18th September, 1993 and the recommendations made by the sub-committee were endorsed in the meeting .

Review of Annual Plan 1994-95

18.87 Department of Family Welfare has taken up implementation of the recommendation of the Committee; some of these which involve large financial and policy implications are under consideration. The Department is expected to convene the meeting of the Chief Ministers of the States for wider consultations regarding some of the recommendations of the Committee.

Integration of MCH and FP into Family Welfare Programme

Review of Annual Plan 1994-95

18.88 Recognising the fact that reduction in Infant and Child mortality is essential prerequisite for acceptance of small family norm, Government of India has attempted to integrate MCH and Family Planning as part of Family Welfare services at all levels. The NDC in 1991 approved the Gadgil- Mukherjee formula which for the first time gave equal weightage to performance in MCH sector (IMR reduction) and FP sector (CBR reduction) as part basis for computing central assistance to Non-Special Category states. The central assistance given under Plan allocation to non-special category States under Gadgil-Mukherjee Formula during 1994- 95 is given in Annexure 18.3. At secondary and tertiary care level FP services are closely integrated with obstetric / gynaecology and paediatric care. At the primary health care level the PHC doctor and the ANM provide both MCH and FP services. The integration of these services has been recognised as a key intervention strategy for population stabilisation and is accorded a high priority in the Eighth Plan.

Performance of FW Programme

18.89 The Eighth Plan targetted to achieve the following by 1997, the terminal year of the plan.

Crude Birth Rate 26 per 1000 population

Infant Mortality Rate 70 per 1000 live births

Couple Protection Rate 56%

Review of Annual Plan 1994-95

18.90 The Infant Mortality Rate (IMR) has declined from 80 per 1000 live births in 1991 to 74 in 1993. The target of IMR of 70 per thousand live births by 1997 is certainly achievable. The target of CBR of 26 per thousand and couple protection rate of 56% by 1997 is, however, likely to be more difficult to achieve within the remaining short period of the Eighth Plan in view of the fact that CBR in 1993 is 28.7 and estimated couple protection rate on 31.3.1995 is only 45.4%. Inspite of similar norms under this Centrally Sponsored Programme, there have been substantial differences in the performance between States as assessed by IMR and CBR (Annexure 18.4). At one end of the spectrum is Kerala with mortality and fertility rates similar to those in some of the developed countries. At the other end there are the four large northern States (Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan) with high Infant Mortality Rate and Fertility Rates; even within the States, there are differences in performance between districts. These reinforce the need for expeditious implemetation of the recommendations of the NDC Committee on Population regarding area specific, decentralised micro-planning and involvement of Panchayati Raj institutions in the programmes tailored to meet the local needs.

Annual Plan 1995-96

18.91 The NDC Committee on Population had recommended that a differential area specific approach should be followed while attempting to improve the performance in the Family Welfare services. Based on the existing infrastructure and the performance as assessed by demographic indicators, States can broadly be classified into four broad categories. In the first category are States such as Keraia with good infrastructure and are performing well; these States require only uninterrupted supply of drug and devices. Recognising the fact that these States are performing well Kerala and Tamil Nadu have been exempted from method specific targets during the year. In the second category are the States like Bihar and Uttar Pradesh with poor infrastructure and poor performance; the Deptt. of Family Welfare is making several special provisions to improve the infrastructure so that performance could improve. In between these two extremes are two categories of States. In one group are the States with below average level of infrastructure but average level of performance such as Himachal Pradesh and Andhra Pradesh; attempt to improve infrastructure in these States might result in rapid improvement in performance. The last category are the States like Punjab with above average level of infrastructure and below average performance; in these States specific efforts need be made to identify the factors responsible for the relatively poor performance and correct them.

Additional assistance to poorly performing districts

18.92 Available information indicate that investment in health especially in the primary health care infrastructure is low in many poorly performing States (Annxure 18.4). Recognising the need for special attention and necessity for additional inputs to improve the performance in poorly performing States, one-half of the total funds for Social Safety Net Scheme have been provided to the Department of Health and Family Welfare. On the basis of data from 1981 census, 90 districts with Crude Birth Rates of over 39 per thousand population, high Infant Mortality Rate and low literacy among women have been chosen and interventions aimed at reduction in maternal and infant mortality and increase in institutional delivery have been initiated in 1992-93. The CSSM programme was also initiated first in the poorly performing districts. Besides Area Development Projects aimed at establishing primary health care infrastructure for providing family planning and MCH services have also been taken up in some poorly performing States. A project aimed at revitalising the Family Welfare Programme in Uttar Pradesh was initiated with assistance from USAID in 1993. Effort should be made to optimally utilise the available funds made available through all these projects, avoid duplication of efforts and improve quality of services so that their utilisation increases. There is also a need to assess progress of work in these projects through process and impact indicators.

18.93 To achieve desired demographic goals, Family Welfare has evolved an action plan in consultation with the States and UTs so as to reach a national consensus in support of the family welfare programme.Some of the features of the action plan are as under:-

(i) Improving the quality and outreach of family welfare services;

(ii) Differential strategy for focus on 90 poorly performing districts (birth rate of 39 and above per one thousand population as per 1981 census);

(iii) Increasing the coverage of younger couples;

(iv) Introducing new contraceptives and improving the quality of contraceptives;

(v) Strengthening family welfare schemes in urban slums ;

(vi) Reorientation of information,education and communication system in spreading the message of family welfare programmes;

(vii) Involving voluntary and non-governmental organisations to promote community participation in the programme;

(viii) Evolving high level inter-sectoral coordination mechanism at the national, State and district levels.

Family Planning

Permanent methods of contraception

Review of Annual Plan 1994-95

18.94 Review of the performance regarding sterilisation during 1994-95 reveals that there has been a small decline as compared to the period 1993-94 (Table 18.8). A decline in performance has been reported in Andhra Pradesh, Assam, Bihar, Kerala, Punjab, Jammu & Kashmir, Tamil Nadu and West Bengal and Bihar. Madhya Pradesh and Uttar Pradesh have shown an improvement in performance while in Rajasthan, the performance is stagnant at the level of 1993-94. The decline in the acceptance of sterilisation is a cause of concern, because surgical sterilisation is the safest and most effective method of ensuring freedom from pregnancy for the next two decades or longer in young couples who have completed their family.

Annual Plan 1995-96

18.95 Vasectomy is safer, simpler and easier than tubectomy and the procedure is well-suited to the primary health care services; however over the years there has been a progressive decline in number of couples protected by vasectomy. Efforts to improve the acceptance of vasectomy should receive due attention in 1995-96.

Reversible methods of contraception

Review of Annual Plan 1994-95

18.96 In the year 1994-95, there has been an improvement in acceptance of temporary methods of contraception as compared to 1993-94. The States of Assam , Uttar Pradesh, Orissa and Madhya Pradesh have shown improvement in performance of IUD insertions during 1994-95 as compared to 1993-94, however, Bihar , West Bengal and Rajasthan have shown a decline.

18.97 Reversible methods of contraception like IUD and Oral Contraceptives are needed to achieve appropriate spacing between pregnancies and to prevent unwanted pregnancies. Over the last two years, there has been a progressive improvement in the acceptance of IUD, OC and Condoms. But there has been a fall in the offtake of OC and CC through commercial and social marketing outlets. Continuation rates for these reversible contraceptives in India are low. Counselling, providing information on the contraceptive options, helping the users to choose the method best suited to their needs and providing follow up services are some of the steps that might go a long way in improving both acceptance and continuation rates.

Annual Plan 1995-96

18.98 The expected levels of achievements during 1995-96 under different contraceptive methods are sterilisation 50.6 Lakh, IUD insertion 75.5 Lakh and OC Users 33.1 Lakh. In the year 1995-96, the Department of Family Welfare has exempted two States - Kerala and Tamil Nadu from method specific targets. In addition, one district from each State has also been exempted from method specific targets. Data on acceptance of different methods will be collected and reported in the same manner as the rest of the States. It is expected that in a couple of years information on the impact of removal of method specific targets allocation on acceptance of suitable contraceptive method by eligible couple will become avail-

able. This experiment is in line with the NDC Committee's recommendation that decentralised planning and area specific approaches should be adopted for improving performance in terms of reduction in crude birth rate.

Maternal and Child Health
Review of Annual Plan 1994-95

18.99 As a part of overall strategy for reduction of maternal,infant and child mortality rates, the Child Survival and Safe Motherhood Programme was launched in August, 1992. The programme aims at sustaining the ongoing programmes of immunisation, management of diarrhoeal diseases,prophylaxis and treatment of anaemia in pregnant women and children under five years of age, administration of vitamin A to children under three years of age. The new interventions also include treatment of pneumonia by the peripheral health staff, improvement of essential obstetric and newborn care, and establishment of first referral units for providing emergency obstetric care. This programme was taken up in a phased manner; under the child survival component , 51 districts were covered in 1992-93, 103 districts in 1993-94, 101 districts in 1994-95. As many as 98 new districts will be taken up during 1995-96. Under the Safe Motherhood Programme, 21 districts were covered in 92-93, 32 in 93-94, 51 in 94-95.

Annual Plan 1995-96

18.100 Forty eight districts will be covered in this programme during 95-96. An allocation of Rs. 220 crores has been made in 1995-96 for the programme.

Immunisation
Review of Annual Plan 1994-95

18.101 Under Universal Immunisation Programme, the percentage achievement of target under different methods of immunisation during 1994-95 are given in Table 18.8. There has been a decline in achievement under almost all methods as compared to the achievements in 1993-94; this is a cause of concern. Though there had been significant achievement in terms of overall coverage during the Eighth Plan period , 100% coverage of vaccine preventable diseases before infant becomes one year old is still not achieved. There are occasional slip in the quality of services resulting in morbidity and mortality.

Annual Plan 1995-96

18.102 Though there has been a steep fall in the reported cases of polio over years, majority of States still report polio cases. In an effort to achieve the set goals of eradication of polio by 2000 A. D. Delhi had taken up a pulse polio immunisation from the year 1994-95. The lessons learnt from this effort may be of use to the programme implementors in other metropolitan cities.

Ante-natal Care
Review of Annual Plan 1994-95

18.103 Maternal Tetanus Toxide (TT) coverage and iron and folic acid supplements is given in Table 18.8 . There is an urgent need to improve TT immunisation programme. There has been some improvement in coverage of pregnant women for prophylaxis against anaemia. The impact of this in terms of improvement in the maternal Haemoglobin status or reduction in anaemia in pregnancy need to be assessed. In majority of the States availability and utilisation of ante natal and intra partum care in rural areas continue to be poor. It is also noteworthy that while in some States like Kerala over 90% of women have access to institutional delivery , majority of deliveries in poorly performing States are still conducted at home and by untrained personnel.

Annual Plan 1995-96

18.104 Many States have attempted several innovative strategies to improve ante natal care and intra partum care; the impact of these in terms of reduction in neonatal and maternal morbidity and mortality have to be assessed and appropriate mid-course correction initiated during the 9th Plan.

Child Health
Review of Annual Plan 1994-95

18.105 Available data indicate that there are marked differences between States in both neonatal and infant mortality rates. Efforts to improve neonatal and infant care services are underway in all States. Making ORS available through social marketing and supply of ORS through revamped PDS is being advocated in areas where ready access to health services are not available.

Research and Development

18.106 ICMR is the nodal research agency for carrying out basic, clinical and operation

Table 18.8

Performance in the Family Welfare Programme Annual Plan 1994-95

	Target/ELA (Lakh)	Achievt.	%age achievt. of proportionate targets	%age increase/ decrease over 93-94
Family Planning				
Sterilisation	52.4	42.9	81.7	(-) 3.1
IUD	75.9	62.4	82.3	(+)10.2
CC users	217.5	171.1	78.7	(-) 0.4
OP Users	54.6	47.5	86.8	(+)11.3
MCH				
Immunization				
DPT	242.9	219.2	90.2	(-) 1.7
Polio	242.9	220.8	90.9	(-) 1.6
BCG	242.9	230.8	95.0	(-) 0.9
DT	214.5	106.9	73.3	(+)37.3
TT (10 years)	203.1	84.6	61.1	(+) 8.1
TT (16 years)	181.5	65.1	52.2	(+) 5.7
TT				
(Pregnant Women)	270.0	214.5	79.4	(-) 2.2
Measles	242.9	200.6	82.6	(-) 5.8
Prophylaxis against Nutritional Anaemia				
Pregnant Women	275.0	208.3	85.8	(+)25.2
Children	247.7	162.9	94.4	(+)70.3

*FIGURES PROVISIONAL.

research in contraception/MCH. Some of the other agencies carrying out research in these areas include National Institute of Health & Family Welfare, Central Drug Research Institute, Lucknow, and Central Council for Research in Ayurveda and Siddha.

Review of Annual Plan 1994-95

18.107 Basic research efforts for development of newer technology for contraceptives devices are currently underway; though they are unlikely to lead to availability of newer methods for use in the programme during 90s, these efforts are needed to cater to the requirements of the population in the coming decade.

Annual Plan 1995-96

18.108 For improving the contraceptives coverage during remaining years of the Eighth Plan and during 90s efforts need be directed towards improving the quality of care and assist men and women to choose appropriate contraceptives from those currently available. Therefore, more stress is being laid on operation research for improving the performance of Family Welfare Programme. In order to ensure that quality control in products utilised in the programme, a National Centre for Technological Evaluation of IUDs and Tubal Rings has been set up at IIT, New Delhi.

Monitoring of Family Planning Services
Review of Annual Plan 1994-95

18.109 In order to conduct research on various socio-economic, demographic and communication aspects of population and Family Welfare Programme, 18 Population Research Centres are at present functioning in various parts of the country. These are located in universities and institutions of national repute. The Centres are provided with 100% grant-in-aid by the Centre. For quick

evaluation of the family planning programme, the Deptt. of Family Welfare has constituted regional evaluation teams which carry out regular verification and validate acceptance of various contraceptives. Planning Commission has suggested, that the Department may explore the feasibility whether these evaluation teams can be used to obtain vital data on failure rates, continuation rates and complications associated with different family planning methods.

18.110 The Office of the Registrar General of India works out the annual estimates of crude birth rate, crude death rate and infant mortality rate through their scheme of Sample Registration System. The system provides an independent check / evaluation of the impact of the Family Welfare programme in the country. Besides, the decennial growth rate as estimated by the office of the Registrar General of India on the basis of the census also provides indirect evaluation of impact of the Family Welfare programme.

Involvement of Non-Government Organisations and Voluntary Organisation for Promotion of Family Welfare
Review of Annual Plan 1994-95

18.111 The Ministry of Health & Family Welfare has initiated several programmes involving NGOs in efforts to improve Family Welfare Programme. These include:

(i) revamping of Mini Family Welfare Centre where couple protection rates are below 35%

(ii) involvement of ISM & H practitioners

(iii) area specific IEC activities through NGOs

(iv) establishment of State Standing Committees for Voluntary Action (SCOVA) to fund NGO projects promptly

(v) identification of Govt/ NGO organisations for training of NGOs in project formulation , programme management and monitoring.

Village Health Guide Scheme
Review of Annual Plan 1994-95

18.112 The Village Health Guide Scheme(VHG) was started in 1977 for the purpose of providing primary health care and health education in villages. The Dept of Family Welfare took up the funding of the scheme since 1981. Currently, more than three lakh Village Health Guides are available in the country.

Annual Plan 1995-96

18.113 The scheme is being revamped taking into account the lessons learnt from the past experiences so that VHGs can play an effective role in improving community participation and effective utilisation of the Health and Family Welfare services.

Funding

18.114 Realising the urgent need to build up the primary health care network in order to reach the services to the vulnerable group of women and children underserved rural, remote regions of the country, Family Welfare Programme has been providing funding for establishment of PHCs and CHCs under MNP. The Externally Aided Area Projects also provide funds for establishment of physical infrastructure for primary health care, inservice training and orientation of existing personnel.The Social Safety Net Scheme provided funds for establishment of First Referral Units and delivery rooms in an attempt to improve intrapartum care. In spite of all these efforts, the progress has been tardy in several States and the achievements well below the set targets (Table 18.1)

18.115 There has been a serious concern that funds earmarked under MNP for creating primary health care infrastructure has been underutilised. The utilisation of funds under MNP was worse in the poorly performing States where primary health care infrastructure is weak and require urgent improvement. There had been time and cost overruns in Area Projects as well as bilateral Externally Aided Projects in many States.

18.116 Realising the critical role of ANMS in providing MCH/FP Care the centre has provided funding for creation of this post in all States. As a result the number of ANM Course sanctioned and in position fulfils the norms suggested. However, for the male multipurpose worker, a substantial number of posts are yet to be sanctioned by the States. There are also vacancies in the Specialist posts at CHCs (Table 18.2) which have seriously hampered the establishment of first referral unit to take care of the emergencies especially during intrapartum and neo-natal period.

Table 18.9

Scheme-wise Family Welfare Outlay (1995-96)

(Rs. Crore)

No.	Scheme	Outlay for 1995-96
1.	Services & Supplies	755.55
2.	Training	28.22
3.	Information, Education and Communication	33.50
4.	Research and Evaluation	16.72
5.	Maternal and Child Health	220.10
6.	Organisation	11.61
7.	Village Health Guide Scheme	10.00
8.	Area Projects	250.00
9.	UP Projects	30.00
10.	Other Schemes/ New Initiatives	84.30
11.	Arrears	141.00
	Total	1581.00

18.117 The National Family Welfare Programme is a 100% centrally sponsored programme. Every year the problem of arrear payable to the State Government is an important issue in Annual Plan discussion and invariably substantial funds are earmarked for this purpose. The arrears accumulate because of the increase in maintenance cost of the various health centres as well as cost of delivery of services. The reimbursement has to be made to the States as per the norms fixed. There is an urgent need to revise these norms in order to check the accumulation of arrears payable to the States.

Family Welfare Programme Outlay for 1995-96

18.118 The entire outlay under the Family Welfare Programme continues to be Plan Outlay since the beginning of the programme. For 1995-96 an outlay of Rs.1581 crore has been approved representing an increase of 10.5 % over 1994-95 approved outlay. The scheme-wise breakup of the outlay is given in Table 18.9.

15,810 million

Externally Aided Projects

18.119 Funds are being provided for Family Welfare Programme from United Nations Agencies, bilateral and multilateral donors. A statement of ongoing projects, their cost and budgetary requirement is given in Annexure 18.6.

Areas of concern

- Small but perceptible fall in the total number of sterilisation
- Continued progressive decline in number of vasectomies.
- Fall in offtake of OP and CC through social marketing outlets
- Shortfall in 100% coverage of infants under vaccine preventable diseases.
- Occasional slip-up in the quality of immunization services
- Poor coverage of pregnant women
- Inadequacy of ante-natal, intra-natal and neo-natal services.

Annexure - 18.1

OUTLAY FOR HEALTH IN THE CENTRAL SECTOR

(Rs.in Crore)

PROGRAMME/SCHEME	8th PLAN OUTLAY	1992-93 OUTLAY	1992-93 ACTUAL EXPDR.	1993-94 OUTLAY	1993-94 ACTUAL EXPDR.	1994-95 OUTLAY	1994-95 ANTCIPTD. EXPDR.	1995-96 OUTLAY
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
A.CENTRAL SCHEMES								
I.RURAL HEALTH	1.00	0.40	0.40	0.40	-	0.10	0.10	0.40
II.CONTROL OF COMMUNICABLE DISEASES	14.75	3.82	4.71	7.56	7.00	7.60	9.60	10.45
III.CONTROL/CONTAINMENT OF NON-COMMUNICABLE DISEASES	85.00	11.90	24.91	26.18	20.29	19.10	20.92	17.15
IV.HOSPITALS AND DISPENSARIES	94.00	15.95	34.19	31.70	30.34	26.00	33.08	34.55
V.INDIAN COUNCIL OF MEDICAL RESEARCH @	125.00	20.00	25.55	28.00	29.00	28.00	30.00	28.70
VI.MEDICAL EDUCATION AND RESEARCH (EXCLUDING ICMR)	266.50	38.65	76.31	68.60	81.39	73.25	85.62	91.26
VII.ISM AND HOMOEOPATHY	83.00	10.50	13.58	21.00	16.10	21.00	24.40	23.29
VIII.OTHER PROGRAMMES	74.75	13.28	7.57	19.11	14.67	27.70	25.83	39.20
SUB-TOTAL A(CENTRAL SCHEMES)	744.00	114.50	187.22	202.55	198.79	202.75	229.55	245.00
B. CENTRALLY SPONSORED SCHEMES								
I.CONTROL OF COMMUNICABLE DISEASES								
1.MALARIA CONTROL (INCLUDING KALA AZAR,FILARIA & JE CONTROL)	425.00	65.00	98.03	110.00	110.54	110.00	167.73	139.00
2.T.B.CONTROL	85.00	13.50	27.01	35.00	17.19	46.00	46.00	50.00
3.LEPROSY CONTROL	140.00	24.00	33.99	35.00	50.94	94.00	94.00	80.00
4.CONTROL OF BLINDNESS	100.00	13.50	17.59	25.00	18.81	40.00	40.00	72.00
5.NATIONAL AIDS CONTROL PROGRAMME (INCLUDING STD AND BLOOD SAFETY MEASURES)	280.00	70.00	29.71	73.00	33.06	82.55	71.21	80.00
6.GUINEA WARM ERADICATION	1.00	-	0.72	0.50	0.50	0.50	0.50	0.30
7.PLAGUE CONTROL PROGRAMME	-	-	-	-	-	-	18.00	-
SUB-TOTAL B.I	1031.00	186.00	207.05	278.50	231.04	373.05	437.44	421.30
II.ISM & HOMOEOPATHY	5.00	0.50	-	0.25	-	0.20	0.20	0.20
III.OTHER PROGRAMME	20.00	1.00	1.84	2.00	1.50	2.00	2.00	3.50
SUB-TOTAL B (CENTRALLY SPONSORED SCHEMES)	1056.00	187.50	208.89	280.75	232.54	375.25	439.64	425.00
GRAND TOTAL (A+B)	1800.00	302.00	396.11	483.30	431.33	578.00	669.19	670.00

@ - EXCLUSIVE OF FUNDS PROVIDED UNDER FAMILY WELFARE

Annexure - 18.2

OUTLAY FOR HEALTH IN THE STATES & UNION TERRITORTES

(Rs. Lakh)

	8th PLAN		1992-93		ACTUAL		1993-94	
	OUTLAY		OUTLAY		EXPENDITURE		OUTLAY	
STATES	HEALTH	MNP	HEALTH	MNP	HEALTH	MNP	HEALTH	MNP
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1 ANDHRA PRADESH	18332.00	5360.00	1400.00	700.00	2210.00	753.28	2759.40	800.00
2 ARUNACHAL PRADESH	2802.00	1250.00	595.00	273.00	565.00	259.35	695.00	309.00
3 ASSAM	15949.00	8100.00	3700.00	1620.00	3866.00	1620.00	3920.00	1620.00
4 BIHAR	67687.00	33722.00	11431.00	5715.00	4619.00	2919.00	12014.00	6711.00
5 GOA	5900.00	1222.00	1150.00	232.00	1012.00	160.24	1232.00	232.00
6 GUJARAT	24200.00	11787.00	4093.00	1650.00	4267.00	1492.12	4132.00	1650.00
7 HARYANA	17611.00	6768.00	2431.00	981.00	2061.00	688.47	2591.70	925.00
8 HIMACHAL PRADESH	12100.00	4800.00	2200.00	932.00	2359.00	997.70	2460.00	975.00
9 JAMMU & KASHMIR	17990.00	7500.00	3201.00	1499.00	3242.00	1373.18	3602.00	1560.00
10 KARNATAKA	34200.00	13050.00	5646.00	2280.00	5030.00	2671.55	11242.00	3517.00
11 KERALA	12000.00	2297.00	2200.00	660.00	1491.00	219.74	2450.00	506.00
12 MADHYA PRADESH	30087.00	15000.00	7578.00	3000.00	5348.00	1762.90	7644.00	2808.00
13 MAHARASHTRA	55326.00	28100.00	8367.00	6000.00	7185.00	3627.32	10604.00	4741.00
14 MANIPUR	2100.00	1015.00	415.00	210.00	423.00	135.44	545.00	60.00
15 MEGHALAYA	4000.00	1800.00	790.00	400.00	857.00	554.34	1079.00	483.00
16 MIZORAM	2550.00	1500.00	580.00	300.00	580.00	300.00	720.00	200.00
17 NAGALAND	5000.00	640.00	1140.00	120.00	506.00	70.00	1197.00	100.00
18 ORISSA	22323.00	7800.00	3020.00	1200.00	2297.00	681.38	3040.00	1207.00
19 PUNJAB	25475.00	8000.00	6000.00	1335.00	2511.00	608.47	4600.00	601.00
20 RAJASTHAN	39095.00	15000.00	4457.00	2040.00	4346.00	2040.49	5621.00	2400.00
21 SIKKIM	5220.00	1345.00	1340.00	345.00	629.00	106.10	1375.00	245.00
22 TAMILNADU	26600.00	6500.00	6509.00	402.00	8035.00	1380.00	7158.00	2448.00
23 TRIPURA	5000.00	2000.00	850.00	424.00	703.00	348.00	880.00	450.00
24 UTTAR PRADESH	51757.00	26000.00	9058.00	4035.00	8547.00	4242.71	9833.00	3924.00
25 WEST BENGAL	28100.00	12178.00	4112.50	2245.00	779.00	400.00	2906.00	1292.00
TOTAL STATES	531404.00	222734.00	92263.50	38598.00	73468.00	29556.78	104300.10	39764.00
UNION TERRITORIES								
1 A & N ISLANDS	2251.00	945.00	314.00	216.00	436.23	252.18	574.35	240.00
2 CHANDIGARH	6682.00	75.00	825.00	27.00	600.81	46.75	1072.00	55.00
3 D & N HAVELI	280.00	104.00	57.25	24.15	57.67	12.70	66.00	24.75
4 DAMAN & DIU	240.00	100.00	50.00	25.00	69.13	40.60	63.00	41.00
5 DELHI	35000.00	0.00	6500.00	0.00	6600.82	0.00	7209.00	0.00
6 LAKSHADWEEP	362.00	180.00	70.90	35.00	76.29	24.96	81.94	35.55
7 PONDICHERRY	2000.00	900.00	450.00	178.00	475.18	147.70	550.00	207.00
TOTAL UTs	46815.00	2304.00	8267.15	505.15	8316.13	524.89	9616.29	603.30
GRAND TOTAL (STATES & UTs)	578219.00	225038.00	100530.65	39103.15	81784.13	30081.67	113916.39	40367.30

* Revised approval letter not issued

** Recommended by the Working Group

Annexure 18.2 (Concld.)

OUTLAY FOR HEALTH IN THE STATES & UNION TERRITORTES

(Rs. Lakh)

	1993-94		1994-95						1995-96	
	ACTUAL EXPENDR.		OUTLAY		R.E.		Anticipated.Expdr.		OUTLAY	
STATES	HEALTH	MNP	HEALTH	MNP	HEALTH	MNP	HEALTH	MNP	HEALTH	MNP
(1)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
1 ANDHRA PRADESH	2686.00	761.83	3259.40	800.00	3259.40	750.00	3259.40	750.00	4100.00	1029.00
2 ARUNACHAL PRADESH	626.00	279.14	773.00	346.05	774.00	339.00	776.00	346.05	1069.00	448.00
3 ASSAM	4253.00	1649.00	4520.00	1890.00	4938.00	1890.00	4500.00	1871.00	6550.00	2048.00
4 BIHAR	2370.00	1818.82	12014.00	2700.00	3900.00	996.00	3900.00	996.00	12014.00	2700.00
5 GOA	1151.00	184.60	1253.00	232.00	1152.00	189.00	1152.00	162.00	1309.00	170.00
6 GUJARAT	4402.00	1748.17	4841.00	1718.00	4841.00	1718.00	4841.00	1659.00	6800.00	2160.00 **
7 HARYANA	2224.00	811.47	2547.00	900.00	2446.65	900.00	2446.65	900.00	3020.00	1063.00
8 HIMACHAL PRADESH	2432.00	987.70	2875.00	1257.00	3473.00	1344.00	3185.00	1286.85	3479.00	1400.00
9 JAMMU & KASHMIR	3627.00	1574.97	3876.00	1662.00	4257.44	1662.00	4318.56	1718.85	4964.00	1946.00
10 KARNATAKA	6990.00	3245.00	10771.00	3438.00	8776.00	3438.00	10674.00	3414.49	11472.00	3638.00
11 KERALA	1738.00	461.00	3100.00	506.00	3160.00	0.00	3100.00	466.00	3900.00	675.00
12 MADHYA PRADESH	6261.00	2277.78	8450.00	3350.00	7000.00	3921.13	6760.53	2403.48	7700.00	2919.00
13 MAHARASHTRA	9379.00	4440.99	10140.00	3566.00	10140.00	4884.00	9998.99	4883.85	13939.00	6698.97
14 MANIPUR	441.00	166.49	485.00	225.00	485.00	225.00	485.00	225.00	678.00	231.50
15 MEGHALAYA	759.00	483.00	1079.00	500.00	879.00	535.00	879.00	535.00	1331.00	946.00
16 MIZORAM	770.00	454.68	720.00	328.00	681.00	273.80	681.30	303.82	787.00	400.00
17 NAGALAND	860.00	72.00	1053.00	175.00	465.34	95.00	1053.00	174.68	2023.00	175.00
18 ORISSA	2318.00	804.97	3940.00	1489.47	2912.25	909.57	3122.16	1098.65	3769.00	1293.00
19 PUNJAB	2521.00	717.00	4302.00	1000.00	4009.28	854.08	4302.00	962.50	4600.00	1100.00
20 RAJASTHAN	4900.00	2173.00	7191.00	2950.00	7648.00	3296.00	8361.26	3700.00	14153.00	8296.00
21 SIKKIM	1351.00	111.55	1337.50	250.00	1349.50	101.00	1337.50	101.00	1258.00	170.00
22 TAMILNADU	7259.00	2554.89	8210.00	2679.00	8210.00	2679.00	8843.85	2934.20	9244.00	3014.00
23 TRIPURA	810.00	450.00	900.00	450.00	900.00	450.00	900.00	450.00	1200.00	460.00
24 UTTAR PRADESH	7778.00	3492.23	11095.00	4295.00	10115.00	3976.00	12616.69	5140.06	12998.00	5361.00
25 WEST BENGAL	2749.00	800.00	3163.90	1107.00	2996.90	600.00	3182.90	1325.00	3330.00	995.00
TOTAL STATES	80655.00	32520.28	111895.80	37813.52	98768.76	36025.58	104676.79	37807.48	135687.00	49336.47
UNION TERRITORIES										
1 A & N ISLANDS	557.07	263.77	800.00	372.00	800.00	372.00 *	719.00	325.00	1025.00	330.00
2 CHANDIGARH	1130.41	55.00	1387.50	90.00	1387.50	90.00 *	1387.50	108.00	2043.84	119.56
3 D & N HAVELI	92.67	10.75	88.40	38.00	88.40	38.00 *	88.00	38.10	111.80	45.00
4 DAMAN & DIU	111.02	77.90	70.75	45.00	70.75	45.00 *	109.47	54.97	100.00	50.00
5 DELHI	6687.02	0.00	9120.00	0.00	9120.00	0.00 *	9120.00	0.00	10055.00	0.00
6 LAKSHADWEEP	90.93	43.66	100.00	48.32	100.00	48.32 *	100.00	48.32	122.00	39.35
7 PONDICHERRY	534.00	145.96	686.00	211.00	686.00	175.00	686.00	172.96	1245.00	214.00
TOTAL UTs	9203.12	597.04	12252.65	804.32	12252.65	768.32	12209.97	747.35	14702.64	797.91
GRAND TOTAL (STATES & UTs)	89858.12	33117.32	124148.45	38617.84	111021.41	36793.90	116886.76	38554.83	150389.64	50134.38

Annexure 18.3

1% Allocation of Central Assistance under Gadgil Mukherjee Formula to non-Special Category States

(Rs. Crore)

Non-Special Category States	Annual Plan	
	1994-95	1995-96
1. Andhra Pradesh	3.96	6.50
2. Bihar	5.66	2.03
3. Goa	6.80	8.29
4. Gujarat	4.00	4.15
5. Haryana	6.36	3.61
6. Karnataka	4.11	5.72
7. Kerala	6.80	8.29
8. Madhya Pradesh	2.11	5.85
9. Maharashtra	5.64	7.00
10. Orissa	3.02	5.88
11. Punjab	4.32	6.49
12. Rajasthan	4.09	2.31
13. Tamil Nadu	5.69	8.29
14. Uttar Pradesh	5.50	2.01
15. West Bengal	3.94	7.93
Total :	72.00	84.35

(Source: FR Division, Planning Commission)

Annexure 18.4

Selected Indicators For Major States

States	Outlay 1993-94 (Rs.Crores)		Expenditure (Rs.Crores)		CBR (1993)	IMR (1993)	CPR March'94 (Provisional)	Life Expectancy (1986-90)
	Health	MNP	Health	MNP				
1	2	3	4		6	7	8	9
India	113501.03	40367.70	89858.12	33117.32	28.7	74	45.4	57.70
MAJOR STATES								
Andhra Pradesh	2759.40	800.00	2686.00	761.83	24.3	64	48.2	59.10
Assam	3920.00	1620.00	4253.00	1649.00	29.5	81	23.6	53.60
Bihar	12014.00	6711.00	2370.00	1818.82	32.0	70	24.1	54.90
Gujarat	4132.00	1650.00	4402.00	1748.17	28.0	58	58.2	57.70
Haryana	2591.71	925.00	2224.00	811.47	30.9	66	54.9	62.20
Himachal Pradesh	2460.00	975.00	2432.00	987.70	26.7	63	56.5	62.80
Karnataka	11242.00	3517.00	6990.00	3245.00	25.5	67	50.3	61.10
Kerala	2450.00	506.00	1738.00	461.00	17.4	13	51.5	69.50
Madhya Pradesh	7644.00	2808.00	6261.00	2277.78	34.9	106	43.1	53.10
Maharashtra	10604.00	4741.00	9379.00	4440.79	25.2	50	54.0	62.60
Orissa	3040.00	1207.00	2318.00	804.97	27.2	110	39.0	54.40
Punjab	4600.00	601.00	2521.00	717.00	26.3	55	77.4	65.20
Rajasthan	5621.00	2400.00	4900.00	2173.00	35.1	82	30.3	55.20
Tamil Nadu	7158.00	2448.00	7259.00	2554.89	19.5	56	54.9	60.50
Uttar Pradesh	9833.00	3924.00	7778.00	3492.23	36.2	94	36.5	53.40
West Bengal	2906.00	1292.00	2749.00	800.00	25.7	58	34.9	60.80

** Relate to the year 1990

Annexure 18.5

STATE WISE OUTLAY AND EXPENDITURE UNDER FAMILY WELFARE PROGRAMME

(Rs. Lakh)

	STATES	1992-93		1993-94		1994-95	1995-96	
		OUTLAY	EXPENDITURE	OUTLAY	EXPENDITURE	OUTLAY	OUTLAY	
1	ANDHRA PRADESH	5445.33	7316.54	5550.30	9139.67	6412.87	5686.59	
2	ARUNACHAL PRADESH	147.48	58.09	157.16	67.90	153.17	138.76	
3	ASSAM	2251.73	1754.64	2127.81	2299.50	2036.79	4169.49	
4	BIHAR	4800.15	6914.11	5188.59	7435.86	6999.29	6890.98	
5	GOA	125.19	94.77	122.84	100.06	125.66	133.91	
6	GUJARAT	3386.66	4942.94	3740.57	6057.38	4090.20	3477.35	
7	HARYANA	1520.05	2322.01	1531.18	2800.81	1729.21	1375.84	
8	HIMACHAL PRADESH	993.11	1364.48	1409.82	2188.34	881.67	922.25	
9	JAMMU & KASHMIR	1137.92	1222.58	1003.36	1295.31	2788.68	992.62	
10	KARNATAKA	3094.07	4158.06	3333.15	4515.54	3624.74	6482.55	
11	KERALA	2493.69	3100.44	2347.72	3815.43	2231.23	2402.52	
12	MADHYA PRADESH	5201.07	6325.25	6575.01	8155.46	5745.48	5356.93	
13	MAHARASHTRA	6491.20	8367.25	6824.49	9510.43	5979.41	6048.42	
14	MANIPUR	373.48	478.49	368.69	347.96	351.80	390.08	
15	MEGHALAYA	254.10	234.41	257.31	275.38	248.97	265.28	
16	MIZORAM	152.01	159.91	166.88	167.35	170.90	187.99	
17	NAGALAND	217.48	229.21	213.89	256.58	217.94	209.65	
18	ORISSA	3196.64	3486.35	2824.57	2465.07	4521.42	2900.31	
19	PUNJAB	1841.37	3247.65	1915.42	3553.01	2619.43	1785.82	
20	RAJASTHAN	3762.22	5002.37	5037.44	5439.35	3716.58	6294.46	
21	SIKKIM	131.41	190.37	173.59	266.25	203.08	236.86	
22	TAMILNADU	4441.96	7221.54	4530.30	4790.10	5125.47	3976.78	
23	TRIPURA	299.30	556.94	316.83	340.21	302.66	326.65	
23	UTTAR PRADESH	12838.90	14526.10	16506.92	19945.65	16228.41	13721.94	
25	WEST BENGAL	4895.05	5841.06	5349.45	6317.42	4761.27	6561.74	
	UNION TERRITORIES							
1	ANDAMAN & NICOBAR I	70.15	72.94	65.10	77.14	70.90	76.41	
2	CHANDIGARH	103.25	102.15	115.75	122.62	138.25	155.75	
3	DADRA & NAGAR HAVEL	20.10	14.01	21.80	18.73	24.00	24.72	
4	DAMAN & DIU	13.30	13.71	18.52	37.53	21.25	25.51	
5	DELHI	619.10	299.68	675.10	816.55	1173.00	1518.07	
6	LAKSHADWEEP	7.35	3.00	8.22	5.67	9.30	10.65	
7	PONDICHERRY	63.10	61.33	68.00	78.80	80.00	88.01	
	TOTAL	70387.92	89682.38	78545.78	102703.06	82783.03	82834.89	
	OTHERS(CENT. SECT./ COST OF SUPPLIES)	29612.08	19357.62	48546.22	28559.22	60227.00	61165.11	*
	ARREARS PAID TO STATES		10000.00		21000.00		14100.00	**
	GRAND TOTAL	100000.00	119040.00	127092.00	152262.28	143010.03	158100.00	
		(104100.00)		(142357.00)		(153800.00)		

FIGURES IN BRACKETS ARE REVISED ESTIMATE

** PROVISION MADE FOR ARREARS

Annexure 18.6

Foreign Assistance Routed Through Budget: ANNUAL PLAN (1995-96)

(Rs. in Crore)

Sl. No.	Name of the Project	Foreign Aid Sources	Total Foreign Aid	Eighth Plan			1992-93 (Actual)		
				Foreign Compo-nent	Local Cost	Total	Foreign Compo-nent	Local Cost	Total
1.	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	Provision of Recanalisation	UNFPA	6.22	6.70	0.00	6.70	0.78	0.00	0.78
2.	Family Welfare Prog. through Ministry of Labour	UNFPA	7.22	8.00	0.00	8.00	1.20	0.00	1.20
3.	Child Survival & Safe Motherhood Project	World Bank/ UNICEF	1125.58	506.70	126.60	633.30	85.00	15.00	100.00
4.	Monitoring and Surveillance	UNFPA	81.84	0.80	0.00	0.80	0.00	0.00	0.00
5.	Area Projects	World Bank/ UNFPA/ODA/ DANIDA/FRG/ European Community	1409.97	320.00	80.00	400.00	58.16	15.50	73.66
6.	Innovations in family planning services project for Uttar Pradesh	USAID	$325m	0.00	0.00	0.00	1.00	0.00	1.00
7.	New ICOMP Project	ICOMP/ UNFPA	$199,980 0.59	0.80	0.00	0.80	0.00	0.00	0.00
	NEW SCHEMES								
8.	Training of No-Scalpel Vasectomy	UNFPA	4.46	0.00	0.00	0.00	0.00	0.00	0.00
9.	New Organised Sector Project	UNFPA	15.50	0.00	0.00	0.00	0.00	0.00	0.00
	Total			843.00	206.60	1049.60	146.14	30.50	176.64

Annexure 18.6 (Concld.)

Foreign Assistance Routed Through Budget: ANNUAL PLAN (1995-96)

(Rs. in Crore)

Sl. No.	Name of the Project	Foreign Aid Sources	1993-94 (Actual)			1994-95 (Anticipated)			1995-96 (Anticipated)		
			Foreign Compo-nent	Local Cost	Total	Foreign Compo-nent	Local Cost	Total	Foreign Compo-nent	Local Cost	Total
1.	(2)	(3)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
1.	Provision of Recanalisation	UNFPA	0.05	0.00	0.05	0.14	0.00	0.14	0.50	0.00	0.50
2.	Family Welfare Prog. through Ministry of Labour	UNFPA	1.10	0.00	1.10	1.20	0.00	1.20	1.20	0.00	1.20
3.	Child Survival & Safe Motherhood Project	World Bank/ UNICEF	115.82	26.95	142.77	210.00	40.00	250.00	180.00	40.00	220.00
4.	Monitoring and Surveillance	UNFPA	0.00	0.00	0.00	0.00	0.00	0.00	0.10	0.00	0.10
5.	Area Projects	World Bank/ UNFPA/CDA/ DANIDA/FRG/ European Community	119.08	30.00	149.08	200.00	50.00	250.00	200.00	50.00	250.00
6.	Innovations in family planning services project for Uttar Pradesh	USAID	6.00	0.00	6.00	30.00	0.00	30.00	30.00	0.00	30.00
7.	New ICOMP Project	ICOMP/ UNFPA	0.00	0.00	0.00	0.05	0.00	0.05	0.20	0.00	0.20
	NEW SCHEMES										
8.	Training of No-Scalpel Vasectomy	UNFPA	0.00	0.00	0.00	0.00	0.00	0.00	0.45	0.00	0.45
9.	New Organised Sector Project	UNFPA	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.00	0.50
	Total		242.05	56.95	299.00	441.39	90.00	531.39	412.95	90.00	502.95

From: 8th Plan Document (1992-97)
Sent by Dr Prema Ramachandran Adviser (Health) Planning Commission
on 4/3/96

29/8/97

There is no magic wand

CHAPTER 12

HEALTH AND FAMILY WELFARE

12.1.1 Health of the people is not only a desirable goal but is also an essential investment in human resources. The National Health Policy (1983) reiterated India's commitment to attain "Health for All (HFA) by 2000 A.D". Primary health care has been accepted as the main instrument for achieving this goal. Accordingly, a vast network of institutions at primary, secondary and tertiary levels have been established. Control of communicable diseases through national programmes and development of trained health manpower have received special attention.

12.1.2 Many spectacular successes have been achieved in the country in the area of health. Small-pox stands eradicated and plague is no longer a problem. Morbidity and mortality on account of malaria, cholera and various other diseases have declined. The Crude Birth Rate and Infant Mortality Rate (IMR) have declined to 29.9 and 80 (1990 SRS data) as compared to 37 and 129 respectively in 1971. Life expectancy has risen from a mere 32 years in 1947 to 58 years in 1990. However, HFA is a long way off. Disease, disability and deaths on account of several communicable diseases are still unacceptably high. Meanwhile, several non-communicable diseases have emerged as new public health problems. Rural health services for delivery of primary health care are still not fully operationalised. Urban health services, particularly for urban slums, require urgent attention due to changing urban morphology.

Programme Thrusts in the Eighth Plan

12.2.1 It is towards human development that health and population control are listed as two of the six priority objectives of this Plan. Health facilities must reach the entire population by the end of the Eighth Plan. The Health for All (HFA) paradigm must take into account not only high risk vulnerable groups, i.e., mothers and children, but must also focus sharply on the underpriviledged segments within the vulnerable groups. Within the HFA strategy "Health for underpriviledged" will be promoted consciously and consistently. This can only be done through emphasising the community based systems reflected in our planning of infrastructure, with about 30,000 population as the basic unit for primary health care.

Minimum Needs Programme (MNP)

Rural Health Programme

12.2.2 Development and strengthening of rural health infrastructure through a three tier system of Sub-centres, Primary Health Centres (PHCs) and Community Health Centres (CHCs) for delivery of health and family welfare services to the rural community was continued during the Seventh Plan. But, lack of buildings, shortage of manpower and inadequate provision of drugs, supplies and equipments constituted major impediments to full operationalisation of these units.

weakness

12.2.3 The achievements and the present situation for health infrastructure under the MNP and availability of building and manpower are given in Annexures 12.1, 12.2 and 12.3.

12.2.4 The approach and strategy for rural health during the Eighth Plan would be:-

i) Consolidation and operationalisation, rather than major expansion, of the network of Sub-centres, PHCs and CHCs so that their performance is optimised. This would be achieved through -

(a) strengthening of physical facilities including completion of building of the centres and staff quarters;

(b) provision of essential equipments as per the standard list;

(c) filling up of all vacant posts within a defined time frame and in-service training of staff;

(d) ensuring supply of essential drugs, dressings and other material.

ii) To monitor the progress of implementation of MNP at the District, State and National

could be seen as achievable physical target & coverage

levels, a health information management system will be developed and used.

iii) The targets regarding setting up of Sub-centre, PHC and CHC on the basis of population norm are indicative only. The States will be given flexibility in establishing these units as per the local needs depending on geographical and population considerations, resources, manpower availability, etc. In opening new centres the needs of tribal population and communities living in difficult and inaccessible areas will be given first priority.

iv) The rural hospitals and dispensaries will be suitably modified, equipped and staffed to convert them into Sub-centres, PHC, CHC as the case may be, thereby integrating them into primary health care system.

v) The backlog of Sub-centres, PHCs and CHCs in many States is staggering and the resources required to meet the targets are astronomical and as such unachievable in near future. In view of this the entire policy of establishment of Sub-centre, PHC and CHC with the present norms will be reviewed and new policy options developed to make the primary health care accessible, acceptable and affordable to all. Re-organisation of the Indian Systems of Medicine and Homoeopathy (ISM&H) dispensaries/hospitals in rural areas to create ISM&H health centres is one such option. This would be in line with the Government's accepted policy of promoting ISM&H. Reorientation of existing personnel of these dispensaries/hospitals, provision of additional facilities and/or staff, redefining the roles and responsibilities would be some of the pre-requisites to put the concept of ISM&H Primary Health Centres and Sub-centres in an operational mode.

vi) Mechanism will be developed to make the rural health services responsive to the needs of the rural masses and accountable to the community. Panchayati Raj system would become an effective instrument for eliciting community participation in the health programme and providing supervision and support to primary health care infrastructure.

vii) Linkages will be developed with the sub-divisional and district hospital to provide referral back-up.

Urban Health Services

12.2.5 More than one quarter of the population in the country now lives in urban areas. In metropolitan and large cities about 40-50% of the urban dwellers are estimated to be living in slum areas where the health status of the people is as bad as, if not worse than, in rural areas. But infrastructure for primary health care in urban areas hardly exists. Serious attempts will be made to develop urban health services as per the recommendations of Krishnan Committee. Organic linkages will be forged with the urban development schemes including Urban Basic Services for a comprehensive development of health and welfare services. Local hospitals will be made responsible to run these centres and treat them as their extension counters for providing health services to the community. Voluntary organisations and local bodies would be encouraged to develop partnership and ultimately taking full responsibility for carrying out these programmes. Health system research to develop a model of urban primary health care services will be undertaken.

Secondary and Tertiary Care Services

12.2.6 Alongwith the emphasis on consolidation of primary health care, the strengthening of secondary care services and optimisation of tertiary care services would be the key objectives of the Eighth Plan.

12.2.7 The sub-divisional and district hospitals which are the secondary level medical care institutions, lack adequate manpower and facilities, to be able to discharge their responsibilities satisfactorily. In view of the resource constraints, there is need for raising resources to maintain the quality of care and meet rising expectations of the people. It is time that the concept of free medical care is reviewed and people are required to pay, even if partially for the services. The system can be so designed that the truly indigent population are able to get free/highly subsidised medical care. Innovative approaches/practices to this end and a sys-

tem of medical audit will be developed during the Plan. Maximum cost-effective utilisation of existing services will be another item on the agenda.

12.2.8 In accordance with the new policy of the Government to encourage private initiatives, private hospitals/clinics will be supported subject to maintenance of minimum standard and suitable returns for the tax incentives. Norms for minimal facilities and accredition of private hospitals/clinics would be developed to maintain quality of patient care.

12.2.9 The medical college hospitals and specialised hospitals have to be used exclusively as tertiary care centres and for health manpower development. Important pre-requisites for this would be improvement in the facilities and standards of care available at secondary care level and development of strong referral system.

12.2.10 A conscious decision has to be taken to enforce a balanced development of primary, secondary and tertiary care services in the country with priority for primary health care. Otherwise there is a distinct risk of the paradigm of primary health care as a tool for "Health for All" being overrun by the mechanism of "All for a few". This tendency and trend can be halted only with scientific arguments for which sound epidemiological, health management and health financing data is needed and hence the need for health systems research.

Health Man-power Development and Training

12.2.11 As much as approximately two thirds of the total expenditure on health services is spent on personnel. Yet, health manpower planning, production and management, which constitute key elements for effective implementation of health programme, have not received enough attention.

12.2.12 While the States have been more than anxious to [illegible] new medical colleges, their efforts to develop institutions for training of para medical staff have been entirely suboptimal. This has resulted in a considerable mismatch between the requirement and availability of health personnel of different categories. Ideally, the doctor- nurse ratio should be 1 : 3 but currently there are less than 3,00,000 registered nurses against 4,00,000 registered medical graduates. Similarly, there is a shortage of pharmacists, laboratory technicians, radiographers, dental surgeons, etc., in the country.

12.2.13 The National Health Policy affirmed that the effective delivery of health care services would depend very largely on the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel. It is, therefore, of crucial importance that the entire basis and approach towards manpower development in terms of national needs and priorities are reviewed and training programmes restructured accordingly. Besides there is an urgent need to asess appropriate health manpower mix to deliver health services at primary, secondary and tertiary level and for the purpose of training and research.

12.2.14 The approach and strategy for health manpower development during the Eighth Plan would be-

i) A National Policy on Education in Health Sciences which when formulated may form the basis of new initatives in manpower development.

ii) The existing situation regarding health manpower supply, demand and projection and facilities for training of different categories will be reviewed.

iii) Appropriate steps will be taken for bridging the critical gaps in the manpower requirement for primary health care and the higher levels and for training and research needs. Starting vocational courses as part of vocationalisation of general education at the + 2 level of the 10+2 system will be supported to expeditiously bridge the gap in the supply of paramedical personnel.

iv) The distortions created in the past on account of over-emphasis on training of doctors, often at the cost of other categories of personnel, and also the undue emphasis on specialisation/super specialisation will be checked.

v) Continuing education for all categories of staff will be given high priority. For this, district and regional level training institutions will be suitably strengthened. Medical colleges and other institutions including professional bodies like Indian Medical Association (IMA) will continue to play an important role, in coordination with the National Academy of Medical Sciences (NAMS), which has been identified as the nodal agency for this purpose.

vi) The existing facilities for training of medical graduates has outstepped the needs. No new medical college or an increase in the admission capacity of the existing colleges will, therefore, be supported during the Eighth Plan. Instead, resources will be used to strengthen the hospitals, laboratories and libraries of the existing medical colleges so that the standards of training are maintained.

vii) For ensuring uniform standards of medical and paraprofessional education, need for establishment of universities of medical and health sciences at regional level has been recognised. Necessary support will be provided as and when a policy decision in the matter is taken.

viii) Statutory councils will be strengthened and new councils for para-professionals, where they are needed, will be created so that standards of training and education can be laid down and enforced. The proposed Education Commission in Health Sciences will promote and coordinate all educational activities for all categories of health manpower at all levels.

ix) Training facilities for epidemiology and health management, the two disciplines which contribute to the maximum extent to efficient functioning of health services including hospitals, will be augmented in medical colleges and created in specialised institutions where training of teachers can be undertaken.

x) Training of doctors of ISM&H will also be reviewed and re-oriented to make it congruent with the needs of national health programmes and primary health care.

xi) Efforts for re-orientation of medical education, started during the earlier plans, will be pursued vigorously with emphasis on faculty development through workshops for the teachers to make them conversant with the health needs of the country, national policies and programmes, advances in educational technology, and make them appreciate the need for re-direction and retargetting of medical education, relavent to contemporary and futuristic needs.

Programmes for Control of Communicable Diseases

12.2.15 A number of national programmes for eradication/control of communicable diseases have been initiated in the country since the early years of planning. Most of the control/eradication programmes for communicable diseases have been in operation since last several plans at huge financial cost. With a few exceptions, however, no national level comprehensive review/evaluation of these programmes have been undertaken. During the Eighth Plan the following strategies will be followed for control of communicable diseases -

i) National level review of the ongoing control/eradication programme to assess the current strategies and their impact on the disease status..

ii) Ensuring sufficient supplies and logistic support including mobility for carrying out the programmes.

iii) Establishment of epidemiological- cum - surveillance centres at district/regional levels and improvement of health management information system for continuous monitoring of the disease situation and taking appropriate and prompt action .

iv) Intersectoral coordination will be strengthened with departments of public health engineering, local bodies like municipalities, Ministries of Information and Broadcasting, Women and Child Welfare, Water

Resources, etc., for control of vector borne and other diseases.

v) The Information, Education and Communication (IEC) activities within each programme would be given special attention for enlisting community participation, which constitutes one of the weakest links, for carrying out the disease control programmes.

vi) Strategy of training of staff at horizontal level, both within the primary health care and higher level, is essential.

vii) Training in epidemiology is woefully inadequate in the country. Unless this situation is rectified decisions regarding control of communicable diseases and its implementation will be handled by the group of professionals and para-professionals who are not sufficiently equipped to do so with its attendant consequences. Specialised institutions/departments to carry out both pre-service and in-service training in epidemiology for different category of staff will be created and the existing ones strengthened.

Programme-wise strategies are briefly outlined hereunder -

Vector Borne Diseases

Malaria Eradication

12.2.16 As a result of introduction of modified plan of operation in 1976 the incidence of malaria has come down from about 6.5 million cases in 1976 to about 1.89 million cases in 1990. The problem of drug resistance of P. falciparum malaria in several States is a cause for concern. Several operational problems and non-availability of matching funds from States to this 50% Centrally Sponsored Scheme-(CSS) has resulted in shortfalls in spray operations, decline in blood slide collections and incomplete treatment of cases. Irrigation projects without adequate strategies for management of water resources and floating labour population to cities and major project sites has also contributed to the increased incidence of malaria. Since 30% of all malaria cases and 60% of the more dangerous P.falciparum infections are in the tribal areas, a major intensification of efforts would be directed towards these areas.

Kala-azar and Japanese Encephalitis

12.2.17 Kala-azar and Japanese Encephalitis (JE) have emerged as major public health problems in recent years. For control of Kala-azar the twin approach of (i) vector control by insecticide spraying and (ii) case detection and treatment at PHC and referral hospitals was adopted. The reported cases and deaths due to JE in the affected States viz. Andhra Pradesh, West Bengal, U.P. Tamil Nadu and Assam have shown considerable decline during the Seventh Plan with the use of indigenously produced vaccine.

12.2.18 The existing guidelines for Vector-borne disease control include -

(i) Residual indoor spraying with appropriate insecticide in areas with population having API 2 and above in any of the last 3 years.

(ii) Spraying of BHC in districts reporting 100 or more cases of JE in any one of the years during the past decade.

(iii) DDT spraying in PHCs reporting 10 or more cases of Kala-azar in any one of the last three years.

(iv) Continuation of the anti-larval operations; and.

(v) Malathion fogging/ULV spraying to be undertaken as a contingency measure in out-break of JE and Malaria.

These conventional approaches of use of inceticides and chemicals would have to be supplemented or replaced, depending upon the local situation, by newer strategies such as biodegradable inceticides, biocides, bioenvironmental improvement and preventive measures like impregnated bed nets. Finally, the surveillance activities would need to be strenghened so as to improve case detection and case management,

resulting in a break in the chain of infection/ transmission.

Leprosy Eradication

12.2.19 The approach under this 100% Centrally Sponsored Scheme has been early case detection and domiciliary treatment and health education. Multi Drugs Therapy (MDT) has been introduced in all 201 endemic districts and 41 low endemic districts (till March 1991) for case treatment. The programme has shown steady progress in achieving its objectives during the Seventh Plan.

12.2.20 Within the Leprosy Eradication Programme the following activities will be pursued

(i) Creation of additional physical facilities in all the endemic districts.

(ii) Extention of MDT to remaining endemic districts and in low endemic districts in phases.

(iii) Training of the PHC staff in leprosy eradication activities, both in endemic and low endemic districts, with the aim of preparing them to take over the responsibility of leprosy eradication activities following reduction in the prevalance and incidence of the disease.

(iv) Creation of vocational and rehabilitation facilities for the patients declared cured in those districts which have been under MDT for more than 5 years.

Tuberculosis Control

12.2.21 Early case detection and treatment have formed the strategy for control of Tuberculosis (TB) under a CSS with 50% Central funding. A major achievement of the programme during the Seventh Plan was the successful introduction of short course chemo-therapy in 212 districts, thereby reducing the treatment duration from 18-24 months to 6-8 months. However, the programme has suffered from poor case holding leading to treatment default. Problem of drug resistance is yet another cause for concern.

12.2.22 During the Eighth Plan, the TB Control Programme will be further expanded and streagthened by opening District Tuberculosis Centres (DTCs) in those districts where these do not exist. Short course chemo-therapy will also be introduced, and supply of drugs ensured, in all the remaining districts of the country under the Programme. The DTCs will be strengthened by providing necessary equipments like X-ray machines and maintaining essential supplies like drugs, X-ray films etc.

Blindness Control Programme

12.2.23 This programme which was launched in 1976 as a 100% CSS aims at reducing blindness prevalence from 1.4% in 1980-81 to 0.3% by 2000 AD. Cataract is the cause of more than 80% of blindness. Demographic shift leading to larger old age population has increased the prevalence of cataract in recent decades. So far the main strategy has been to provide access to opthalmic services through eye camps and mobile units. While this has suceeded to some extent, it has fallen short of the requirements. Besides the inherent limitation of the camp approach, the magnitude of the problem demands creation of permanent eye care infrastructure, operational throughout the year and within easy reach of the people.

12.2.24 These initiatives will be combined with an intensification of efforts aimed at ophthalmic manpower developmemt with the ultimate objective of improving the outreach and quality of ophthalmic care at primary, intermediate and tertiary levels.

Guinea Worm Eradication

12.2.25 This programme was launched during 1983-84 with the objective of achieving zero incidence of guinea worm by 1990-91. Although the estimated number of cases has come down from 39,790 in 1983-84 to about 20,000 in 1990-91 the objective of "Zero Guinea worm" still remains unachieved. Total eradication of the disease through better surveillance system and improvement of drinking water supply in the endemic areas will be achieved during the Plan.

AIDS Control Programme

12.2.26 Acquired Immuno Deficiency Syndrome (AIDS) has emerged as a new public health problem in the country. The AIDS Control Programme was launched in 1986 as a

Central Sector Scheme. Establishment of surveillance centres, testing of cases for infection, training of personnel and mass health education formed the main activities within the programme. But, the incidence of the disease has shown an increase from 137 seropositives among 41,000 tested up to May 1987 to 7272 seropositives among 13.49 lakhs persons tested by April 1, 1992. Inadequate surveillance system and absence of facilities for examination of blood and blood products and the growing menace of intravenous drug abuse contributed to this upsurge in infection.

12.2.27 For the prevention and the control of AIDS a national programme will be launched during the Eighth Plan. The strategy to be adopted for AIDS control would comprise of -

i) Surveillance of the population with special emphasis on high risk behaviour groups for detection of infection;

ii) Strengthening of the blood banks and blood safety measures with priorities on special areas and metropolitan and large cities to start with;

iii) Area specific strategy for mounting control of infection and target specific IEC activities based on epidemiological data;

iv) Integration of the control programme with the activities of the departments like Social Welfare, Youth & Sports, etc. and other Government and non-government organisations; and

v) Strenghening of STD Programme and training of staff.

Diarrhoeal Disease

12.2.28 Diarrhoeal Disease Control Programme which was initiated during the Sixth Plan was strengthened and included as a part of maternal and child health activities in the Seventh Plan. Under the programme, a large number of professionals and para-professionals were trained for the programme implementation and support besides intensifying IEC efforts. Oral rehydration salt for prevention and treatment of dehydration was made available through the existing health infrastructure. Diarrhoeal diseases control would be continued during Eighth Plan as part of the child survival and safe motherhood programme.

Programme for Non-communicable Diseases Control

12.2.29 The increase in life expectancy and the changing life style of the people, have brought in the problem of non-communicable diseases which have added to the already heavy burden of morbidity and mortality due to communicable diseases in the country. Development of models of care and control programmes for non-communicable diseases, therefore, are no longer a luxury but an essentiality.

12.2.30 The strategies for the control of non-communicable diseases have to be based on sound consideration of epidemiology and demography. They must be integrated with the existing health infrastructure to make them cost-effective. Development of appropriate technology and its transfer to the general health services should be an important component of the strategy. Since the life style and high risk behaviour are important variables associated with the rising incidence of most of these diseases, they lend themselves to prevention by health education. Therefore, mobilising community health action through well structured IEC system including mass media will form an important intervention strategy for the control of non-communicable diseases. Development of appropriate learning resource materials for education and training of manpower will be an essential activity. The strategies for the control of specific non-communicable diseases will be as follows -

Cancer Control

12.2.31 Prevalance of cancer in the country is estimated to be 1.5 to 2.0 millions. The Cancer Control Programme, initiated during 1975-76, was converted into a national programme in 1985 with the objective of i) primary prevention of tobacco- related cancer; ii) secondary prevention of cancer of uterine cervix; and iii) extension and strengthening of treatment facilities on a national scale. The last one was the focus of emphasis during the Seventh Plan.

12.2.32 During the Eighth Plan the diagnostic and treatment facilities for cancer would be further strengthened at the medical colleges and other major hospitals. Primary prevention , par-

ticularly for tobacco related cancer and uterine cervix cancer, will form the sheet anchor of the Cancer Control Programme. It will be carried through IEC activities and early case detection approach, mounted on the primary and secondary health care infrastructure and through mass media.

Iodine Deficiency Disorder

12.2.33 The National Goitre Control Programme which was operated during the Seventh Plan as a "Mission" programme, is a purely Central scheme under the Central health sector. According to the present estimates, about 45 million people suffer from goitre and another 6 to 8 millions from other iodine deficiency disorders. Universal iodization of salt and IEC activities are the main strategies of the programme.

12.2.34 Iodine Deficiency Disorder Control Programme would have continued thrust during the Eighth Plan. The basic approach of the programme being universal iodization of salt, proper coordination with major departments concerned with production and distribution of iodised salt namely, the Department of Industry and Railways, will be brought about . Iodized salt will be made available through the public distribution system. To prevent the losses of iodine in the salt due to long-distance transportation under adverse conditions, iodization of salt on small scales in the States far away from the present production centres will be considered and operationalised. Double fortification of the salt with iodine and iron will also be explored to combat the wide- spread problem of anaemia.

Diabetes Control

12.2.35 The National Diabetes Control Programme was launched in 1987 as a Central Sector health programme in the districts of Salem and South Arcot in Tamil Nadu and Jammu & Kashmir on a pilot basis. The main thrust during the Seventh Plan was to develop an appropriate model for care and control of diabetes mellitus at the district level. The major objectives include (i) prevention of diabetes through identification of high risk subjects and early intervention; and (ii) early diagnosis of disease and institution of management so as to prevent diabetes associated morbidity and mortality.

12.2.36 The programme has been reviewed and would be further extended to cover additional districts in different states during the Eighth Plan. The experience gained in the pilot districts will be used to develop the programme as an integrated model for diabetes, hypertension and heart disease. The learning resource materials, both print and non-print, developed and validated in the pilot districts, will be used for the training of nurses and primary health care workers.

Accidents

12.2.37 For the treatment and rehabilitation of accident victims, accident and trauma services will be started in major cities and also, on pilot scale along some of the high traffic density national highways.

Mental Health Services

12.2.38 The Seventh Plan document had suggested initiation of a National Mental Health Programme with emphasis on community based approaches. However, due to fund constraints the programme has not made satisfactory progress.

12.2.39 During the Eighth Plan mental health services will be given priority. The strategies for mental health programme will be community based utilising the existing primary health care and district hospital services. A psychiatric centre in each of the districts/divisions will be established. Also, every medical college will be encouraged to start a separate Department of Psychiatry so that the required manpower, both medical and para-medical, can be trained.

Other Non-communicable Diseases Control Programmes

12.2.40 The programme for control of other non-communicable diseases will also be taken up on pilot basis. Resource constraints will not be allowed to come in the way of developing experience and appropriate technology for implementation of the control programme at a later date.

Medical Research

12.2.41 The Indian Council of Medical Research (ICMR) is the premier institution which is responsible for carrying out bio-medical and operational research in India. Important achievements of the ICMR during previous plans include: demonstration of improved vec-

tor control using bio-environmental techniques for control of malaria and filaria; establishment of National Cancer Registry; multi drug therapy and short course chemo therapy for leprosy and TB respectively and a national surveillance system for AIDS infection. Various other institutions under the Ministry of Health & Family Welfare and medical colleges have done notable work in the field of medical research.

12.2.42 Research and Development activities by Indian Council of Medical Research and other academic institutions will be pursued during the Eighth Plan through the following strategies -

i) Establishmnet of an integrated Bio-medical Research Complex to strengthen research activities and to optimise the utilisation of the available resources and facilities.

ii) Promotion of excellence by rationalising grants to promising scientists in medical colleges and strengthening of extramural centres for research under eminent scientific leadership.

iii) Establishment of a network of research units in medical colleges for multi-centric studies.

iv) Optimal utilisation of resources through coordination and development of proper linkages with sister agencies, commercial utilisation of research findings, constant review of the status of application of research findings by user agencies, continuing interaction with State authorities to determine area specific research needs, and through providing proper guidance and assistance as well as strengthening of research activities under the State Councils of Medical Research.

v) Development of a Centre for Epidemiological Intelligence.

vi) Augmentation of research activities in specific priority areas viz., integrated Vector Control Programme for Malaria, Filaria and Japanese Encephalitis, integrated control of non-communicable diseases and development of vaccines for communicable diseases as well as fertility regulation.

vii) Enhancement of Research and Development on Family Planning and Maternal & Child Health.

viii) Collaboration with international agencies for transfer of appropriate technology to the Indian scientists.

Indian Systems of Medicine and Homoeopathy

12.2.43 Teaching and training programmes in ISM & H were promoted during the Seventh Plan. Clinical research on drugs of various systems, collection, cultivation and propagation of medicinal plants and standardisation of drugs were encouraged. The Central Councils dealing with these systems of medicine have been strengthened to provide support for training and research in their respective area.

12.2.44 The National Health Policy assigned an important role to ISM&H in the delivery of health services. There are about 5.25 lakhs institutionally trained practitioners of ISM & H. These practitioners are close to the community not only in geographical proximity but also in terms of cultural and social ethos and as such they can play significant role in primary health care delivery. The strategy for utilisation of ISM&H for health care delivery during the Eighth Plan would comprise of the following -

i) There are more than 200 colleges of ISM & H. One of the important tasks during the Eighth Plan would be to provide adequate facilities for training in these colleges so that the graduates emerging from these acquire the desired level of knowledge and skill necessary for patient care. Post-graduate training programmes also require strengthening for the purpose of manpower development for teaching and research in ISM & H.

ii) To integrate the practitioners of ISM & H in the mainstream of health care delivery system, the graduate curriculum of these systems will be suitably oriented to make them conversant with the national health problems, policies and programmes. Refresher courses will also be organised for the inservice practitioners of ISM & H towards the same objective.

iii) There are more than 5000 pharmaceutical units, engaged in the production of drugs of these systems of medicine. Suitable steps will be taken to enforce the provisions of Drugs & Cosmetics Act to maintain the quality of products of ISM & H produced in the country.

iv) Research and Development for the production and standardisation of drugs of ISM & H will be supported during the Plan. The existing research institutions will be strengthened for this purpose.

v) The cultivation, conservation and regeneration of medicinal plants will be supported in State/joint sector farms. There is great potential for internal sale and export of these plants, herbs and formulations.

vi) Separate departments, directorates and drug control organisations at the Central and State Government level will be established, wherever they are not existing currently.

vii) Central Councils for Research in ISM & H would continue to receive support during the Plan so that they can discharge their responsibilities efficiently.

Family Welfare Programme

12.3.1 High growth rate of the population continues to be one of the major problems facing the country. Although the 1991 Census recorded a marginal decline in the annual growth rate of popu' from 2.22% in 1971-81 to 2.11% in 19[illegible]91 this would still mean an addition of 18 million people to the country's population annually.

12.3.2 The fast rate of population growth means that the economy has to grow faster to protect the already low level of per capita availability of food, clothing, housing, employment and social services.

12.3.3 The country is committed to social and economic justice to the millions of people living under conditions of poverty and deprivation. Failure to do so within a reasonable time-frame may generate social tensions and unrest. Besides this, the environmental degradation which is associated with unchecked growth of population carries the inherent risk of natural calamities and disasters.

12.3.4 In this context, population control assumes an overriding importance in the Eighth Plan.

Review of the Performance

12.4.1 The basic premises of the Family Welfare Programme till now have been -

i) Acceptance of the family welfare is voluntary.

ii) The Government's role is to create an environment for the people to adopt small family norm. This is done by spreading awareness, information and education by ensuring easy and convenient availability of family planning aids and services and by giving incentives for adopting family planning.

iii) The programme, which is a 100% Centrally Sponsored Scheme has integrated family planning and Mother and Child Health (MCH) services and is being implemented through countrywide network of primary health centres and supporting institutions.

12.4.2 In spite of massive efforts in the form of budgetary support and infrastructure development, the performance of family welfare programme has not been commensurate with the inputs. Right from the beginning the achievement of the set goals has been unsatisfactory, resulting in the resetting of targets, as indicated in Table 12.1.

Table 12.1

Year	Specified demo-graphic bjective (CBR)*	Year by which the goal was to be achieved	Actual achieve-ment
1962	25	1973	34.6
1966	25	as expeditiously	
1968	23	1978/79	33.3
1969	32	1974/75	34.5
Beginning of Plan	25	1979/81	33.8
1974	30	1979	33.7
Beginning of Plan	25	1984	33.8
April 1976	30	1978/79	33.3
I. Population (reduce the gap)	25	1983/84	33.7
April 1977	30	1978/79	33.3
II. Population Policy	25	1983/84	33.7
January 1978			
Central Coucil of Health	30	1982/83	33.8
National Health Policy	31	1985	32.9
	27	1990	29.9
	21	2000	
Seventh Plan	29.1	1990	29.9
Eighth Plan	26.0	1997	

*CBR: Crude Birth Rate

Seventh Plan Performance

12.4.3 With the long-term objective of achieving the Net Reproduction Rate (NRR) of unity, the Seventh Plan had set the following demographic goals -

	Seventh Plan Target	Current Status
Couple Protection Rate (C.P.R.)	42.0%	44.1 (31.3.91)
Crude Birth Rate (BR)	29.1	29.9 (1990)*
Crude Death Rate (DR)	10.4	9.6 (1990)*
Infant Mortality Rate (IMR)	90	80 (1990)*

* Provisional (SRS Data)

While the Seventh Plan targets of achieving CPR of 42% was achieved, this was not matched by a commensurate decline in the birth rate, possibly because of improper selection of the cases.

12.4.4 The performance in terms of various methods of couple protection were not uniform. While the targets for Intra Uterine Device (IUD) were fully achieved and those for oral contraceptives and conventional contraceptives were exceeded, the targets for sterilisation operations fell short by about a quarter. The targets and performance of the Seventh Plan and the year-wise break up of performance are given in Tables 12.2 and 12.3.

12.4.5 State-wise analysis of performance of the programme reveals that Punjab, Kerala, Ma-

Table 12.2 Target and Performance of the Seventh Plan

(in million)

	Target	Achievement	%Achievement	Remarks
1. Sterilisation	31.00	23.70	76.50	There is a shortfall of 7.30 million sterilisations.
2. I.U.D.	21.25	21.28	100.14	Targets fully achieved.
3. CC & OP Users*	14.50	15.94	109.93	Achievement exceeds the targets

* Indicates terminal year targets and achievement.

Table 12.3 Yearwise Performance of the Seventh Plan

(Nos. in million)

	1985-86	1986-87	1987-88	1988-89	1989-90
Sterilisation	4.9	5.0	4.9	4.7	4.2
	(88)	(84)	(82)	(87)	(76)
IUD	3.3	3.9	4.4	4.8	4.9
	(101)	(105)	(103)	(97)	(93)
CC & OPUsers	10.7	11.6	13.4	14.3	15.9
	(103)	(100)	(104)	(94)	(99)

Note: The figures within brackets indicate percentage achievement.

harastra and Tamil Nadu have performed very well in achieving the targets while Assam, U.P., M.P., Bihar, Rajasthan and some North-Eastern States have performed poorly.

12.4.6 Under the Maternal and Child Health Programme, which is an integral part of family planning programme, targets for reducing Infant Mortality Rate to 90 per thousand live births and for reducing maternal mortality were fixed for the Seventh Plan. The Universal Immunisation Programme (UIP) launched in 1985 with the objective of providing universal coverage of immunisation to pregnant mothers and infants was a major initiative in this direction. Although all the districts in the country have been brought under UIP, the targets for immunisation could not be fully met due to problems of cold chain facilities, inadequate trained manpower, logistic problems, etc. Other programmes aimed at women and children viz., control of diarrhoeal diseases among the children, prophylaxis against anaemia and Vitamin A supplementation for prevention of nutritional blindness achieved varying degrees of success. Nevertheless these efforts were able to achieve a substatial reduction in IMR from 97 per thousand live births in 1985 to 80 in 1990.

Constraints

12.4.7 Containment of population growth is not merely a function of couple protection or contraception but is directly correlated with female literacy, age at marriage of the girls, status of women in the community, IMR, quality and outreach of health and family planning services and other socio-economic parameters. Table 12.4 illustrates this.

12.4.8 The Family Welfare Programme has essentially remained a uni-sector programme of the Ministry of Health and Family Welfare. It has yet to be recognised as a major national concern drawing priority attention and concommitant strong political, social and administrative commitment for the purpose of making it a significant part of our economic development strategy. A national consensus and strong public opinion in its favour, cutting across political, ethnic, religious and geographical boundaries is as yet lacking.

12.4.9 The family welfare programme has also suffered on account of centralised planning and target setting from the top. Regional variations and diversities have not been generally taken into consideration, with the result that similar set of approaches and policies and targets have been applied in States like UP, MP, Bihar and Rajasthan where the health infrastructure is weak and related social inputs are lacking and also for the States like Haryana and Andhra Pradesh where factors other than development of infrastructure contributed to poor performance. Monitoring mechanism under the programme has been reduced to a routine target reporting exercise incapable of identifying roadblocks and applying timely correctives.

12.4.10 Both pre-service and in-service training of programme personnel is poor because of lack of due emphasis at all levels on training pro-

Table 12.4 Selected Indicators

States	CBR (1990)	IMR (1990)	Female literacy rate (1991)	Female age at marriage(1981) in years	People below poverty line (1987-88)%
Bihar	32.9	75	23.1	16.5	40.8
Kerala	19.0	17	86.9	21.8	17.0
M.P.	36.9	111	28.4	16.5	36.7
Maharashtra	27.5	58	50.5	18.8	29.2
Rajasthan	33.1	83	20.8	16.1	24.4
Tamil Nadu	22.4	67	52.3	20.3	32.8
U.P.	35.7	98	26.0	17.8	35.1

grammes for family welfare. Absence of proper training, education and motivation of the programme personnel including supervisory staff has led to an ineffective, insensitive implementation of the programme.

12.4.11 The programme has remained a Government programme, the community's active involvement and participation being marginal. Due to inadequacy of Information, Education and Communication (IEC) activities the knowledge of the community about the contraceptives, their availability, safety, etc. are at a low level. Adoption of the small family norm and use of appropriate measures for birth control are matters of personal choice and decision. The IEC activities have to take this into account. However, till recently, the IEC activities have been directed more to national issues rather than personal issues. Undoubtedly, this incongruity of perception between the people and the providers of services has cost the programe dearly.

12.4.12 Family Planning Programme is being run as a 100% Centrally Sponsored Scheme. The entire outlay is included in the Plan with the result that a major portion (60-70%) of the outlay goes for meeting the expenditure of maintenance nature, leaving very little resources for further expansion, and strengthening of the programme or for any new initiatives. Further, the entire expenditure is borne by the Centre, although the implementing agency is the States Government.

12.4.13 Lot of incentives and awards have been built into the programme. The incentives and awards have not been unequivocally shown to be very effective in the promotion of small family norms. On the other hand , defects such as over-reporting, low quality acceptors and neglect of non-terminal methods of contraception and MCH activities have often been observed to creep into the programme. The element of disincentives is also missing from in programme.

12.4.14 The efforts for the containment of population growth have to be intensified simultaneously on several fronts. This calls for an integrated approach and concerted efforts through both the government and the non- government organisations, besides social and political commitment to make it a national movement.

Strategy for the Eighth Plan

12.5.1 Containing population growth has been accepted by the Government as one of the six most important objectives of the Eighth Plan, with the aim of reducing the birth rate from 29.9 per thousand in 1990 to 26 per thousand by 1997. The IMR will also be brought down from 80 per thousand live births in 1990 to 70 by 1997.

12.5.2 To give a major thrust in this priority area, which constitutes the pivotal point for the success of all developmental efforts, a National

Population Policy needs to be enunciated and adopted by the Parliament. Given the political commitment at all levels, it must generate a cascading effect to become a people's movement. Social determinants such as female literacy, age at marriage, employment opportunities for women, and their status in society are as important as achieving a reduction in infant mortality, improving health and nutrition of pre-school child and providing a comprehensive package of maternal health care services. Such an inter-sectoral interaction, supported by political commitment and a popular mass movement, will constitute the approach to strategic interventions during the plan period. A Committee of the National Development Council(NDC) on Population has been constituted in February, 1992 to consider these issues and based on its report, a concrete plan of action will be worked out.

12.5.3 Within the above mentioned broad guidelines, which have been enunciated in the Eighth Plan Directional Paper already accepted by the NDC the following strategies will be adopted for achieving the goals of family welfare during the Eighth Plan.

i) Convergence of services provided by various social services sectors, e.g., welfare, human resource development, nutrition, etc. Based on a holistic approach to social development and population control, integrated programmes for raising female literacy, female employment, status of women, nutrition and reduction of infant and maternal mortality will be evolved and implemented. The strategy will be (a) to pool the existing resources available for individual and fragmented schemes on these activities and provide additional resources required; (b) to restructure, redesign and integrate these under a common umbrella; and (c) to evolve proper mechanisms for planning, implementing and monitoring these programmes at various levels.

ii) Decentralised planning and implementation will be another strategy. Although there are likely to be commonalities of approach in the general contours of population policy, it is critical that the programme content relates to area-specific planning at the district, the sub-district and the panchayat level based on critical and indepth disseg-regated analysis of a constellation of socio-biological indices and demographic determinants. Area specific strategies would mean flexibility of approach and fund utilisation. Targets, if any, will be determined, fixed and monitoried at the district level and the process will be from below upwards.

iii) As a natural corrolary to decentralised planning and implementation, Panchayati Raj institutions like Gram Panchayat and Zila Parishads, etc., will have to play significant role in planning, implementing and administering the programme. The role of the Centre will be limited to general policy planning and coordination, providing technological inputs where required, safeguarding critical areas and taking innovative leads.

iv) With greater involvement of the people in the population control and family planning programmes through the Panchayati Raj System as envisaged in the Constitution (Seventy-Second Amendment) Bill 1991, the programme will become one of "people's operation with government cooperation". The health planners and administrators must not only become sensitive and responsive to the felt needs of the people but must also adapt to the instrumentality of local self-government.

v) The younger couples, who are reproductively most active will be the focus of attention, with necessarily a greater emphasis on spacing methods, although the terminal methods would continue to remain the important means of birth control. Medical Termination of Pregnancy (MTP) will have to play an important role in the entire scheme of family planning in the Eighth Plan. The coming generation will have to be, therefore, prepared well to accept the small family as a social responsibility. Population education and family life education need to be made a part of general education in which school teachers' role, both as an educator as well as a role

model, becomes of paramount importance.

vi) The targetted reduction in the birth rate will be the basis of designing, implementing and monitoring the programme against the current method of couple protection rate. While broad guidelines may be prepared by the Centre, suitable parameters would be designed by the individual States for this purpose. Identification and registration of eligible couples, enforcement of civil registration scheme, registration of mothers and children for child survival and safe motherhood activities are areas requiring special monitoring.

vii) The outreach and quality of family welfare services will be improved. For this, the health services infrastructure will have to be made fully operational and efficient. This would involve -

(a) completion of infrastructural facilities initiated during the earlier plans like buildings for sub-centres, PHCs, CHCs, etc., and installation of necessary equipments;

(b) ensuring placement of adequate number of welltrained workers specially at the grassroot level;

(c) providing mobility to workers, specially the peripheral ones; and

(d) ensuring adequate drugs and other essential supplies at the Sub-centre and PHC by suitably increasing the funds for this purpose.

viii) The entire chain of CHC, PHC and Subcentres will be equipped to deliver general health and MCH services in an integrated manner with a strong referral suppport and linkage at the District level. For this, facilities for services for mothers and children including reservation of beds for them at different levels will be ensured. Setting up of Regional Maternal and Child Health Institutes will be part of the strengthening process of MCH infrastructure.

ix) Child survival and safe motherhood initiatives will be vigorously pursued. These initiatives will include (a) strengthening of Universal Immunisation Programme, (b) greater emphasis on Diarrhoea Control Programme and effective implementation of ORT programme, (c) Acute Respiratory Infections Control Programme, (d) Anaemia Management Programme and not just Anaemia prophylaxis, (e) Safe Motherhood Programme with high risk pregnancy approach and (f) intensified effort for training of birth attendants.

x) Any system is as good as the people who operate it. Therefore, major emphasis will be laid on health manpower planning along with a review of the education and training programmes of all categories of health care providers. Training will not only aim at providing requisite knowledge and skill, but also ensure development of such behavioural attributes that will be conducive to a closer interaction with the community. The methodology, the logistics and the content of training programme will be continuously reviewed. Special programmes would be chalked out for imparting preservice and inservice training in programme management and IEC activities. To meet the training needs, various training institutions will be strengthened or new ones established, by providing adequate funds, staff, equipments and mobility.

xi) The entire package of incentives and awards will be restructured to make it more purposeful. Individual cash incentives have not made any impact and hence will be phased out. The payment of compensation to the acceptors for the wages lost due to hospitalisation, etc., will be left to the discretion of the States, thus providing flexibility in approach to suit the local requirements. Community incentives in the form of priority consideration under IRDP programmes, e.g., opening of schools, provision of drinking water facilities, linkage by roads, etc., will be built up in the programme. The possibilities of introducing certain disincentives to the non-adoptors of family planning will also

be explored and introduced with due regard to the freedom and the fundamental rights of the people. The performance of the States in this vital sector of human and national concern will be recognised through additional resource allocation as a part of Central Plan assistance to those States which show better performance in terms of pre-determined demographic parameters.

xii) There is an urgent need to secure involvement and commitment of practitioners of all systems of medicine in the Population Control Programme. The practitioners of Indian System of Medicine and Homoeopathy, whose number is estimated to be more than half a million and who are the closest to the community both in terms of place of practice and the socio-cultural milieu of the community will be involved in the programme by -

a) providing well structured educational modules of instructions and training in population dynamics and family planning at the undergraduate level;

b) providing short-term re-orientation courses to the practising doctors;

c) providing incentives and recognition for exhibiting initiative and leadership in population control activities; and

d) promoting a sense of comraderie between these practitioners and the grassroot functionaries of the health and family welfare programme with a view to synergising and potentiating their mutual input. A similar approach is also needed to strengthen and secure deeper involvement of practitioners of modern system of medicine. Organisations such as Indian Medical Association (IMA) will be involved in a greater measure in this national task.

xiii) The role of voluntary organisation in a mass movement such as population control is critical for generation of momentum and accelerating the pace of progress. There is a need to incorporate family planning as a major objective of all voluntary organisations concerned with health and/or education-related activities. Substantially increassed amount of funds will be channelised through these agencies during the Eighth Plan. The establishment of an apex organisation to develop networking between all such voluntary organisations committed to the promotion of national efforts in this important area of human endeavour will be considered.

xiv) As an extrapolation of the concept of voluntary organisations, is the role and place of organised corporate sector which covers approximately 20 million workers and their families. Effective methods will be evolved to get the organised sector involved in the implementation of family welfare programme.

xv) Special efforts will be made to involve the community in the Family Planning Programme. The strategy will be to prepare the community to accept the responsibility, the ownership and the control of the programme fully in the long run. Panchayats, youth clubs, village committees, Nehru Yuvak Kendras, women organisations, etc., can play an important role in community motivation, organisation of camps and contraceptive distribution. Grassroot level functionaries, e.g., village dais, Village Health Guides (VHGs), Auxiliary Nurse Midwives (ANMs), Anganwadi workers, village extension workers, primary school teachers, Gram Panchayat staff etc.will play a facilitatory and supportive role to the community organisations for generating the necessary momentum for population control movement by the people. The village level local functionary will be the kingpin of these new initiatives.

xvi) The village/neighbourhood tea shops, pan shops, public distribution system shops, pharmacies, cooperatives, etc., will be utilised for community based contraceptive sale and distribution.

xvii) The social marketing programme, which was originally launched for Nirodh distri-

bution has demonstrated the significance and importance of involvement of the corporate sector to achieve the family planning objectives. This programme will be extended to the social marketing of oral pills as well as for market research and educational activities for which the Corporate Sector possesses special skill and sensitivity.

xviii) Information, Education and Communication, which are critical inputs will be further strengthened and expanded. The IEC activities of the health and the family welfare sector will be integrated. Greater use of the mass media will be made to disseminate the message of family planning to the remotest corner of the country. The entire system of pricing the media time vis-a-vis its social responsibility has to be given a fresh look, different from the commercial angle. Area specific IEC material will be developed and produced. At the viewers' level, efforts will be made to pool resources of various social sectors and to provide community TV/radio sets, besides maintaining them. The backbone of the IEC efforts will, however, remain the inter-personal communication for which the grass-root level female worker will have to be trained and effectively utilised.

xix) A new thrust in the research and development of methods aimed at regulation of fertility in the male, and of vaccines for fertility regulation, both in the male and female, will be given. Fertility regulation practices such as the use of special herbs by the community particularly in the tribal areas, will also be subjected to research. While intensification of bio-medical research is necessary, research in social and behavioural sciences to explore the human dimensions is vital. Health systems research to optimise operational framework, to improve the efficiency and effectiveness of the service provided and to evolve cost-effective interventions in various areas of family planning operation, will be given high priority.

xx) A continuous monitoring, review and evaluation is an essential component for the successful implementation of the programme. Development and strengthening of health management information system, with district and sub- district data bases of health and demographic parameters and linkages aimed at concurrent evaluation of family planning programme will be developed. This will provide critical inputs at the district and sub- district level and the much needed data for area-specific planning and time-bound implementation.

xxi) The family planning programme has a multi-sectoral dimension. For the purpose of effective intersectoral coordination and to provide the programme appropriate focus and priority, a proper institutional set-up with the backing of the highest political and administrative authority is an essential requirement. The recommendations of the Committee on Population, constituted by the NDC, will be implemented.

12.5.4 To sum up, the base and the basis of the population control programme during the Eighth Plan will be decentralised, area-specific micro-planning, within the general directional framework of a national policy aimed at generating a people's movement with the total and committed involvement of community leaders, irrespective of their denominational affiliations and, linking population control with the programmes of female literacy, women's employment, social security, access to health services and mother and child care.

Outlays

12.5.5 The total outlay for the Central Health Sector is Rs. 1800 crores. The outlays for the Central, States and Union Territories Plans under the Health Sector are shown in Annexures 12.4 and 12.5.

12.5.6 The outlays for the Family Welfare Programme are Rs.6500 crores. Details are given in Annexure 12.6.

Annexure 12.1

Progres of Establishment-Minimum Need Programme

Scheme	No. as on 1.4.85	7th Plan		No. as on 1.4.90	1990-91 Act Ach.	1991-92 Anti.	Likely No. as 1.4.92	8th Plan Target (1992-97)	1992-93 Target
		Target	Achievement			Achievement			
1	2	3	4	5	6	7	8	9	10
1. Sub-Centres	84263	54612	46937	131200	515	5968	137683	17030	4066
2 P.H.Cs*	9134	12392	10115	19249	1315	1241	21805	4450	759
3 C.H.Cs	813	1523	1261	2074	162	313	2549	1269	259

* : Excluding Subsidiary Health Centres, Mini Health Centres etc.

Source : Working Group Discussions for Annual Plan 1992-93, Planning Commission.

Annexure 12.2

Construction of Buildings for Sub-centres, PHCs & CHCs

Sl. No.	Health Institution	Number Functioning	No. of Bldg. constructed / functioning in Govt. / Panchayat Bldg.	No. of Bldg. under construction	No. of Bldg. yet to be constructed	Col. 6 as percentage of Col. 3
1.	2	3	4	5	6	7
1.	Sub-centres	131385	52267	7906	71212	54.2
2.	Primary Health Centres	22328	12685	1371	8272	37.0
3.	Community Health Centres	1955	1206	271	478	24.5

Source : Bulletin on Rural Haelth Statistics in India - December 1991 issued by the Directorate General of Health Services , Ministry of Health and Family Welfare , New Delhi.

Annexure 12.3

Health Manpower Working in Rural Areas

Sl. No.	Category	Sanctioned Posts	Number in position	Vacant Posts	Col.5 as percentage of col.3
1	2	3	4	5	6
1.	Specialists in Rural Areas	3523	2481	1042	29.6
2.	Doctors at Primary Health Centres	25671	22078	3593	14.0
3.	Block Extension Educators	6068	5513	555	9.2
4.	Health Assistants (Male)	24850	23266	1584	6.4
5.	Health Assistants (Female) /LHVs	25726	22999*	2794	10.9
6.	Health Workers (Male)	88182	80701	7481	8.5
7.	Health Workers (Female)/ANMs	130941	119906	11035	8.4
8.	Pharmacists	19225	17702	1523	7.9
9.	Radiographers	667	518	149	22.3
10.	Lab. Technicians	10516	8744	1772	16.9

Source : Bulletin on Rural Health Statistics in India - December 1991 issued by the Directorate General of Health Services , Ministry of Health and Family Welfare , New Delhi.

* Includes 67 posts in position in J & K for which corresponding sanctioned posts are not indicated.

Annexure 12.4

Eighth Plan Outlay - Health Sector

(Rs. Crores)

Sl. No.	Programme	States/UTs	Centrally Sponsored Programmes	Central Schemes	Total
1	2	3	4	5	6
1.	Minimum Needs Programme/Rural Health	2250.38	-	1.00	2251.38
2.	Control of Communicable Diseases		1031.00	14.75	
3.	Hospitals and Dispensaries		-	94.00	
4.	Control/ Containment of Non-communicable Diseases		-	85.00	
5.	Medical Education and Training	3525.54	-	267.00	5324.54
6.	ICMR		-	124.50	
7.	Indian System of Medicine and Homoeopathy		5.00	83.00	
8.	E.S.I.		-	-	
9.	Other Programmes		20.00	74.75	
	Total	5775.92	1056.00	744.00	7575.92

Annexure-12.5

Eighth Plan Outlays-Health Sector-Distribution by States/Union Territories.

(Rs Crores)

Sl. No.	State/UT	Outlay	MNP
	States		
1.	Andhra Pradesh	183.32	53.60
2.	Arunachal Pradesh	28.02	12.50
3.	Assam	159.49	81.00
4.	Bihar	676.87	337.22
5.	Goa	59.00	12.22
6.	Gujarat	242.00	117.87
7.	Haryana	176.11	67.68
8.	Himachal Pradesh	121.00	48.00
9.	Jammu & Kashmir	179.90	75.00
10.	Karnataka	342.00	130.50
11.	Kerala	120.00	22.97
12.	Madhya Pradesh	300.87	150.00
13.	Maharashtra	553.26	281.00
14.	Manipur	21.00	10.15
15.	Meghalaya	33.73	18.00
16.	Mizoram	25.50	15.00
17.	Nagaland	50.00	6.40
18.	Orissa	223.23	78.00
19.	Punjab	254.75	80.00
20.	Rajasthan	390.95	150.00
21.	Sikkim	52.20	13.45
22.	Tamil Nadu	266.00	65.00
23.	Tripura	50.00	20.00
24.	Uttar Pradesh	517.57	260.00
25.	West Bengal	281.00	121.78
	Total : States	5307.77	2227.34
	Union Territories		
1.	Andaman & Nicobar Islands	22.51	9.45
2.	Chandigarh	66.82	0.75
3.	Dadra & Nagar Haveli	2.80	1.04
4.	Daman & Diu	2.40	1.00
5.	Delhi	350.00	-
6.	Lakshadweep	3.62	1.80
7.	Pondicherry	20.00	9.00
	Total :UTs	468.15	23.04
	Grand Total :States & UTs	5775.92	2250.38

Disproportionately high!

2250.38

8026.30

Annexure 12.6

Eighth Plan Outlay - Family Welfare Sector

(Rs. Crores)

Sl. No.	Programme	Outlays
1.	Services and Supplies	3086.00
2.	Training	59.00
3.	Information, Education and Communication	127.00
4.	Research and Evaluation	89.00
5.	Maternirnity and Child Health	1982.00
6.	Organisation	71.00
7.	Village Health Guide Scheme	140.00
8.	Area Projects	400.00
9.	Other Schemes	46.00
10.	Provision for Settlement of arrears payable to States	500.00
	TOTAL	6500.00

65,000 million - FW
80,263 " - Hill
145,263 "
huge