REPORT
OF THE
STEERING GROUP
ON
HEALTH, FAMILY PLANNING & NUTRITION
FOR THE FIFTH FIVE YEAR PLAN

DR. BANWARI LALL, F.A.M.S.
CHIEF(HEALTH)& CONVENOR
STEERING GROUP
ON
HEALTH, FAMILY PLANNING & NUTRITION
PLANNING COMMISSION
GOVERNMENT OF INDIA
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Introduction:

The Steering Group on Health, Family Planning and Nutrition was set up under the Chairmanship of Shri Mohan Dharia, Minister of State for Planning in May 1972 with a view to suggest developmental programmes for the Fifth Five Year Plan after making a comprehensive assessment of the problems and needs of Health, Family Planning and Nutrition Schemes. The list of members is appended at the end.

The Steering Group constituted 6 Task Forces, one for Family Planning, one for Nutrition, and four for Health viz. one each for Health Programmes, Medical Education, Training and Research, Indigenous Systems of Medicine and Homoeopathy and Drugs & Food Adulteration. These Task Forces submitted their reports to the Steering Group which considered them at its meetings held on 17th May, 1972, 3rd June 1972, 28th July, 1972 and 21st/22nd November, 1972. Draft final report was discussed in Steering Group meeting held on 1st March, 1973.

In the preparation of this report, the Steering Group has taken note of the resource position of Fifth Five Year Plan, sectoral outlays, directives and guidelines, approved by National Development Council.

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C O N T E N T S

P A R T I I I

NUTRITION PROGRAMMES

PART I

H E A L T H

Evolution of Health Strategy

1.1 Government of India appointed Bhore Committee in 1943 to survey the then existing health conditions and health organisation and to recommend future developments. The Committee in their report published in 1946, laid down certain principles which have provided the base and foundation to all subsequent health plans. The Bhore Committee suggested short-term as well as long-term programmes for development of health care services in the country. Health programmes in the First and second Five Year Plans were based on the short-term programmes recommended by this Committee.

1.2 In the year 1959 Government of India set up a health survey and planning committee known as Mudaliar Committee to review the past health programmes and to formulate further health plans for the country. This Committee laid down certain objectives which formed the base for the Fourth Plan health programmes. The objectives are i) providing an effective base for health services in rural areas by strengthening the primary health centres, ii) strengthening of sub-divisional and district hospitals to provide effective referral services and iii) expansion of the medical and para-medical education to meet the technical manpower requirements.

1.3 Such programmes resulted in commendable achievements, especially in the control of communicable diseases. The expectation of life at birth has gone up from 32 years in 1951 to 50 years in 1971. The number of hospitals beds is expected to increase from 1,13,000 in 1950-51 to 2,81,600 in 1973-74 and the bed population ratio would go up from 0.32 to 0.49 per 1000 people. The number of medical colleges in the country has also gone up from 30 to 98 during this period with an annual admission capacity of 12000 thus enlarging the stock of doctors available in the country.

1.4 Inspite of all these achievements the position is nowhere near the norms recommended by the Bhore [illegible] and [illegible] Mudaliar Committees. For example, the recommended norm of one bed per 1000 population and one doctor per 3000 population is still not within reach. There are considerable regional disparities in the country in respect of the availability of medical facilities. Though 80% of the population is residing in rural areas only 30% of the hospital beds are [illegible] located in rural areas and 20% of the doctors are working the

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It would appear paradoxical that while the gap in the personnel required to run the nursing services in hospital institutions and the number of nurses actually employed is very wide, there are not enough job opportunities for the number of nurses actually available. The nurse bed ratio varies from the recommended norm of 1:3 in teaching hospitals and 1:5 in non-teaching hospitals in certain areas to as high as 1:24 in others.

1.5 The outlays on public health programme during the plans periods are indicated in Table below.

Table

(Rs. in Crores)

Outlays on Health Programmes

Sl. No.	Plan	Centre	Centrally Sponsored	State/ Union Territory	Total	Percentage of Public Sector Outlays
1.	First Plan	NA	NA	NA	90.50	3.82
2.	Second Plan	NA	NA	NA	146.00	3.18
3.	Third Plan	14.83	45.46	205.57	225.86	2.55
4.	1966-69	16.76	11.14	112.21	140.11	2.03
5.	Fourth Plan	53.50	176.50	204.50	433.50	2.60
6.	Fifth Plan (Tentative)	65.00	315.00	560.00	940.00	2.70

(NA: Not available)

The allocations as would be obvious from the Table, varied from 2.03 to 3.82 per cent of the total public sector outlay. The average central annual allocation of roughly Rs. 45 lcrores for health programmes for the entire country during the Fourth Plan, is rather inadequate considering the vastness of our population and the magnitude of their requirements. Even this small outlay on the health plan is not likely to be fully utilised, and the anticipated expenditure is likely to show a not insignificant shortfall. The reasons for incomplete utilisation of the resources have mainly been attributed

to lack of adequate formulation of plans, preparing project reports, obtaining components etc. Steering Group would like to express its concern over the incomplete utilisation of development funds and recommends that the causes for failure be investigated in detail and adequate remedial action taken to strengthen the planning and executing organisations at the centre and the State levels to ensure successful implementation of health programmes in the Fifth Five Year Plan, which has more than double the outlay for the Fourth Plan.

Objectives in the Fifth Plan

1.6. The primary objective during the Fifth Plan is to provide minimum public health facilities integrated with family planning and nutrition for children. It will be necessary to consolidate the gains so far achieved in the various field of health, such as communicable diseases, medical education and provision of infrastructure in the rural areas. Attempts should be made to remove rural urban imbalance in the provision of medical care facilities and deficiencies in the infrastructure created in the rural areas. The accent during the Fifth Plan should be on i) increasing the accessibility of health services to rural areas and correcting the regional imbalance, ii) further development of referral services by removing deficiencies in district and sub-divisional hospitals, iii) intensification of the control and eradication programmes of communicable diseases especially malaria and smallpox, iv) integration of health, family planning and nutrition programmes v) augmentation of training programmes of multi-purpose worker who would take up integrated programmes of health, family planning and nutrition and vi) The qualitative improvement in the education and training of Health personnel.

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Strategy

1.7. In regard to minimum public health facilities, generalised norms such as improvement in the doctor-population and bed-population ratios or per capita expenditure on health are not enough. Availability of health facilities in rural areas continues to be lopsided. The norm will have to be related to adequate extension of medical and health care to rural areas. The present standard of one public health centre for a block population of 80,000 to 100,000, supported by t 8 to 10 sub-centres, each serving a population of 10,000 has been accepted by the N.D.C. as the minimum norm for the Fifth Plan. The main thrust has to be directed at making up deficiencies in buildings, staff, equipments and drugs and medicines in a coordinated way. In subsequent plans, the coverage of a sub-centre may be reduced to a population of 4000 to 5000. The emphasis on rural health will have to be on preventive medicine, family planning, nutrition and detection of early morbidity with adequate arrangements for referring

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serious cases to an appropriate higher echelon such as the sub-division or the district hospitals.

1.8 The envisaged comprehensive multi-tier system cannot be built on the basis of the present expensive system of prolonged medical education. A new approach towards raising suitable medical and para-medical cadres for the lower tiers has to be worked out. A proper role for the indigenous systems of medicine will have to be worked out. Health education should be woven into the general educational systems

1.9 The family planning programme will need continued emphasis. Rapid progress will have to be made in integrating family planning with health and nutrition facilities. It is only in this manner that the concept of small families can be promoted on a durable basis.

1.10 In order to attack the problem of malnutrition at its root, it will be necessary to take care of pregnant women lactating mothers and pre-school children of weaker sections. It is a gigantic problem, requiring colossal resources. Feeding programmes will have to be integrated with health care, immunisation and nutrition education to form a package. There is the added problem of designing an adequate delivery system of nutrition feeding, appropriately integrated with the health and family planning facilities. Substantial progress towards creating nutrition facilities for pregnant women and young children is anticipated during the Fifth Plan period. This should be made possible by the much larger provision of Rs. 300 crores in the Fifth Plan for nutrition programmes alone. A larger programme will have to be launched to deal with nutritional deficiencies such as vitamin 'A' deficiency and nutritional anaemia and pellagra. Production programmes will have to be linked with national nutritional needs. The nutritive value of high yielding varities of cereals and pulses will have to be kept in view in agricultural production programmes. An intensive and well coordinated programme for ensuring production and consumption of green leafy vegetables has to be launched. A major research problem would be to evolve an appropriate technology to enable the rural poor to utilise locally grown inexpensive foods.

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Targets

1.11 The targets on health care programme during the Fifth Plan have been based on the guidelines given in the Approach Paper approved by the National Development Council. The emphasis is to provide for the minimum needs of our people, specially in the rural and backward areas, which form the bulk of our population. For calculation of targets the rural population of India in 1971 Census, which was 43.87 crores, may be taken as the working base.

Minimum Needs Programme

1.12 National Development Council's approach paper lays down the following minimum norm for the Fifth Plan :

(i) one primary health centre for a block population of 80,000 to 1,00,000.

(ii) One sub-centre each serving a population of 10,000 viz., 8-10 sub-centres under each primary health centre.

1.13 The target for establishing primary health centres in Fourth Plan was 5400 but only about 5250 primary health centres will be in physical existence. There will, therefore, be a likely deficiency or backlog of 150 primary health centres which is to be made up in the Fifth Plan.

1.14 33,000 sub-centres would be in existence, by the end of Fourth Plan against 43,870 required (1971 Census) as per the accepted norm. The immediate concern should be to make up the deficiency of 10,870 sub-centres during the Fifth Plan.

1.15 Deficneices in building staff, equipment and drugs in the present primary health centres and sub-centres to be removed in a co-ordinated manner.

1.16 While 1971 Census rural population has been recommended to be the work base for minimum needs programme targets, Steering Group feels that, if funds permit, adequate provision in the Plans be made to expand the primary health centres complex to cater to the increase in population anticipated in the Fifth Plan period. For this purpose an additional 6500 sub-centres may be needed.

1.17 The Approach Paper lays down the ultimate target of 5,000 rural population for one sub-centre to cover. In terms of numbers, it would mean roughly and additional 44,000 sub-centres needing an outlay of roughly Rs.160 crores at the present day

prevalent norms. This suggestion may be considered as a serious alternative to the scheme for upgradation of primary health centres into 30 bedded rural hospitals.

Upgraded primary health centres

1.18 It is proposed to upgrade about 1,500 primary health centres on selective basis by the end of the Fifth Plan period, to the status of 30 bed rural hospitals. The Steering Group was informed of the contemplated action that upto 200 primary health centres may be upgraded to rural hospitals of 30 beds each in 1973-74 as an advance action. The hospitals are expected to provide routine common specialised services in addition to the preventive and promotional health programmes. By the end of the Fifth Plan, one out of every four primary health centres will have been upgraded. It will mean a net addition of 36,000 beds in rural institutions entirely for the use of rural population (1500 X 24 (30-6 existing).

1.19 Strengthening of sub-division/district hospitals to provide adequate referral services for primary health centre complex is one of the important objectives of the Plan. Endeavour should be made to provide at least one referral hospital below the district hospital level in each sub-division/District. Locations of such referral hospitals should be central within its area of operations, and as far as possible within easy accessibility of the development of primary health centres. Care should be taken to avoid duplication/overlapping of services of upgraded primary health centres with other hospital institutions that may presently be located in the area of coverage. In such a situation, the existing institution should be brought upto the desired functional level by suitably augmenting the staff and equipment etc., where necessary and should serve the purpose of rural hospitals instead of upgrading a primary health centre into a new rural hospital.

1.20 The following priorities may be observed in implementation of the programme :

(i) Minimum needs programme : This should be the first charge of the Health Sector outlays of Rs.940 crores.

(ii) Selective upgradation of primary health centres to 30 bed hospitals.

(iii) Provision/strengthening of referral hospitals at district/sub-division levels.

1.21 During the Fifth Plan, the communicable diseases programmes should aim at the following minimum achievement of targets :-

(i) National Malaria Eradication Programme) should be completed.

(ii) National Smallpox Eradication Programme) should be completed.

(iii) National Filaria Control Programme should cover at least 50% of the population at risk.

(iv) Leprosy Control Programme should cover all hyper endemic and at least 50% of the moderately endemic areas.

(v) Under T.B. programme, 50% of the total infectious cases should be diagonised and facilities for adequate treatment provided.

(vi) Cholera) Programmes should effectively cover the entire country.

(vii) Trachoma) Programmes should effectively cover the entire country.

(viii) Goitre) Programmes should effectively cover the entire country.

1.22 Family planning must aim at reducing the population growth rate to 15 per 1000 by the end of Fifth Plan.

1.23 The preventive health measures are crucial for sustained improvement and must be intensified :

(i) to attain a total coverage of the entire population with good portable drinking water supply;

(ii) to provide adequate sewerage and sanitation schemes in rural areas, and

(iii) give high priority to environmental sanitation.

1.24 Nutrition status of the population must be improved and all the vulnerable sections of population viz., pregnant women, lactating mothers and children of 0-6 years of age to be provided adequate nutrition and protected by comprehensive immunisation.

1.25 Total prevention of drugs and food adulteration is to be aimed at.

HEALTH CARE

Minimum Needs Programme

1.26 The basic requirement of the Fifth Plan Health programmes is to provide for minimum needs of our population. This is to be accomplished as per programmes detailed in the paragraphs following.

Primary Health Centres

1.27 The Fourth Plan target is to establish 508 additional primary health centres so that by the end of the Plan period there would be at least one primary health centre in each block. As per Ministry of Health and Family Planning's estimates the target of 5400 primary health centres in 5224 Blocks is not likely to be achieved and there would be a backlog of 150 primary health centres which has to be made up in Fifth Plan. The Steering Group recognises the fact that the primary health centres complex is the main structure through which the integrated health, family planning and nutrition programmes would be implemented in rural areas in the Fifth and future Plan periods where 80% of the population of the country resides. It has given a serious thought to the Task Force recommendations of providing a primary health centre for 30,000 population but has come to the conclusion that in physical terms the target is too high to be attempted with any measure of successful implementation during the Fifth Plan. Further, in view of the limitations of finance and manpower also, this target cannot be recommended for the Fifth Plan period. Considering the present position when there is one primary health centre in a Block consisting of a population of 80,000 to 1,00,000, the Steering Group suggests that the realistic target for the Fifth Plan period would be to establish the primary health centres in the Blocks which do not have a primary health centre now and to establish additional primary health centres in the more populous Blocks or for lesser population in isolated/difficult terrains. Besides the filling up of the deficiencies in the construction of buildings of the primary health centres and their staff quarters, provision of drugs, equipments, transport and personnel may also receive higher priority. Provision of rural electricity, safe drinking water and road communication should be given due consideration in locating new primary health centres. In this way there would be less reluctance on the part of the technical personnel to go to rural areas as they would have water, electricity, approach roads, adequate drugs to do professional

justice to the patients. Criteria and guidelines for location of new primary health centres should not be too rigid and the State Governments should have some flexibility in framing these schemes to ensure effective utilisation.

1.28 Regarding the present inadequate provision of drugs in the primary health centres and sub-centres, the Steering Group is of the opinion that whatever amenities might be provided through the primary health centres complex, these would always be incomplete unless adequate provision is made for drugs for the patients. This situation must be remedied immediately and it is suggested that an annual provision of at least Rs.12,000/- for a primary health centre and Rs.2,000/- for a sub-centre is made for drugs for day-to-day work and this amount should be specifically earmarked for this purpose. It is also suggested that provision for drugs at sub-centres, primary health centres and upgraded rural hospitals should be provided from the funds earmarked for minimum needs health programmes for the Fifth Five Year Plan. Some commonly used drugs of proven effectiveness from ISM may also be stocked at primary health centres/sub-centres for use of the patients. The Steering Group also suggests that the beds in the upgraded 30 bedded primary health centres should be hospital dieted to improve the occupancy and utilisation. It may be necessary that a high level committee goes into the working of the primary health centres and sub-centres, identifies problems leading to non-utilisation of the existing bed capacity and failure of the sub-centres to provide effective services.

Sub-centres

1.29 Approach Document lays down the norm of one sub-centre for a rural population of 10,000. On the basis of rural population of 43,87 crores (1971 Census) the country should have 43,870 sub-centres. It is estimated that only 33,000 sub-centres will be functioning by the end of the Fourth Plan. A deficiency of 10,870 (43870 - 33000) sub-centres will, therefore, have to be made up under the minimum needs programme during the Fifth Plan. Besides, there is bound to be deficiencies of staff, equipment, drugs and buildings in the existing sub-centres and which must be overcome to make the sub-centres truly functional from efficiency angle. It will be from these sub-centres that integrated health care service can purposefully be extended to rural India. The Steering Group, therefore, emphasise that the sub-centres must be made more functional and more workable by provision of adequate staff and proper supervision.

1.30 The present staffing pattern of a sub-centre is one auxiliary nurse mid-wife, often without any drug component in the budget. Under the scheme of integrated health care, the staff is bound to be increased to ensure a better coverage and the extent to which such augmentation in staff should take place can only be gauged if the work is entrusted to an expert group or groups. It may not be possible to meet the additional fund requirements on this score from health outlay only. As the multipurpose health worker/medical auxiliary will be rendering a package of health care services inclusive of family welfare and nutrition, it is but right and proper that the fund allocations for the family planning and nutrition programmes should undertake an adequate share of expenses.

pgradation f primary ealth entres

1.31 The referral hospital services are generally inadequate in rural areas. The Steering Group, therefore, approves the suggestion that 1500 primary health centres should be upgraded into 30 bed rural hospitals by the end of the Fifth Plan period. Adequate provisions should be made in these hospitals to take care of likely emergencies and care for acutely ill-patients from the neighbouring three primary health centres. This would help in providing relief to the district and other referral hospitals which are overcrowded, and make available expert medical care facilities nearer to the people residing in rural areas. The Steering Group stresses the need to lay down rigid criteria for selection of location of primary health centres to be upgraded to avoid/counter-balance political pressures and vested interests. Selection of primary health centres by the States for upgradation should preferably be done in consultation with Central Government.

uildings or primary ealth entres and pgraded ural ospitals

1.32 A large component of this programme is expenditure on buildings. The Steering Group recommends that utmost economy be observed in the matter of buildings which should be more functional than ostentatious. As far as possible, use of local materials be encouraged to keep down the cost.

ub-divi- ional and istrict ospitals

1.33 The Steering Group has considered the desirability of having a hospital in each sub-division/taluka with an Obstetrician, Surgeon, Physician and Anaesthetist and a sufficiently large District Hospital with General, Medical, Surgical, Orthopaedic, ENT, Dental, Eye, Obstetric, Gynaecological, Dermotology and Psychiatric facilities with X-Ray, Bio-Chemistry, Bacteriological Laboratories and Blood Bank Organisation to provide

efficient referral services to the primary health centres and to provide beds for family planning and medical termination of pregnancy schemes. The limiting factors, however, are the insufficient funds for the health sector as a whole and reducing the existing inadequacyy of medical facilities in rural areas must have a higher priority during the Fifth Five Year Plan. In order to provide adequate referral services, at least one hospital below the District level should be available for this purpose. As such the Steering Group suggests adequate funds should be provided for hospitals at the level of sub-divisions, which are without hospitals at present and to fill up deficiencies in respect of diagnostic and specialists services at District Hospitals.

National Health Scheme for Rural Areas

1.34 The original and the revised version of National Health Schemes for rural areas have been considered by the Steering Group. The original proposal was for employing 3,00,000 registered practitioners at a cost of Rs.152 crores. The revised proposal envisages 29 pilot projects at an estimated cost of Rs.184 clakhs in the year 1973-74. The rural scheme has been made flexible by providing the States, a choice of Registered Medical Practitioners qualified in either allopathy, ayurved, homoeopathy or unani systems of medicine. Administrative control to remain with the doctor-incharge of primary health centres. It has further been suggested that the scheme should be Centrally financed.

1.35 The Steering Group has given careful consideration to this scheme and taken note of the divergent views of the Members. The revised version still suffers from some of the drawbacks of the original scheme e.g., the training of I.S.M. Practitioners in systems other than his own (allopathy or homoeopathy) is likely to lead to certain amount of confusion. In actual practice it is not likely to contribute to the efficiency of the practitioners and then there is the added risk of the practitioner failing to recognise a severe condition and delaying referral to primary health centres/hospitals with adverse consequences to the patient. Such a scheme would prove deterrent to the interest and promotion of I.S.M.

1.36 A further revised version has been brought to the notice of Steering Group. The main points of the new version are:(i)

(i) The scheme is purely a curative one - the sole objective of which is to extend medical care to peripheral areas and does not interfere in any way with the proposed health care scheme of the Fifth Plan.

(ii) The scheme is to be tried as a pilot project in a small unit of 10,000 rural population confined to one or two areas in each State.

(iii) Under the new version, it is intended to utilise the services of only qualified practitioners in ISM and Homoeopathy.

(iv) No further training of practitioners in systems other than their own is contemplated.

(v) Concurrent evaluation will be carried out during the trial; and

(vi) If found successful - the Scheme will be taken under the States Sector during the Fifth Plan.

It is obvious that the revised version has hardly anything in common with the earlier schemes. The Steering Group recommends that the scheme be given a fair trial as an advance action during 1973-74. The cost of the pilot project, estimated to be approximately Rs.9 lakhs, may be met by the Centre.

1.37 Programmes under Health, Family Planning and Nutrition have been in operation for a long time. These programmes are mostly vertically conceived and are being implemented at the field level by the staff deployed to implement these programmes individually, with little co-ordination or integration of the services. The Steering Group feels that the proper integration of Health, Family Planning and Nutrition programmes is highly desirable as it would be more economical and effective. It may be appreciated that the multi-purpose health worker (who may be designated health auxiliary for convenience of reference) would be entrusted with the carrying out integrated functions and would have greater rapport with the people in rural areas who would naturally look to him for all their needs in field of mutually reinforcing

components of Health, Family Planning & Nutrition. The Steering Group accepts the general principles enunciated and would suggest that Health auxiliaries may consist of three categories i.e., Basic Health Worker at the lowest level, Health Visitor/Health Insoectpr at intermediary level and Health Assistants/Health Supervisors at the higher levels. Further, Steering Group would suggest that, with a view to arrive at an effective pattern of integration of the services from operational and training angle, two Working Groups of experts be appointed immediately to go into the details in respect of (i) defining functional role of the Health auxiliary in integrated health programmes, conditions of service, salary structure, avenues for promotion etc., and (ii) defining objectives of training programmes, construction of curriculum in terms of knowledge and skills required to achieve the objectives, identifying training institutions etc., and give the integration programme a concrete shape. This should be done expeditiously as an advance action in 1973-74. In regard to nutrition schemes, the experience gained by the Department of Community Development, Ministry of Agriculture and Department of Social Welfare, Ministry of Education & Social Welfare, should not be lost in effecting integration of Health, Family Planning and Nutrition. Suitable job charts and training programmes tailored to local needs should be proposed for the personnel of Department of Health, Family Planning, Social Welfare, Community Development and others engaged in nutrition programmes. Nutrition feeding programmes will have to be integrated with other Health and welfare programmes to form a composite package which will include apart from feeding, minimum health care, immunisation and improvement in environmental sanitation. Integration of personnel from nutrition programmes will have to be viewed from this angle.

1.38 The Steering Group lays great importance to the integration of Health, Family Planning and Nutrition programmes and suggest that funds should be provided by the Centre under the Centrally Sponsored Sector during the Fifth Five Year Plan for training of (i) the para-medical workers into multipurpose basic health workers; and (ii) other workers especially engaged in nutrition feeding and nutrition education programmes and who would take up the integration work.

1.39 Integration has three components (i) integration of buildings, (ii) integration of drugs & equipments, and (iii) integration of personnel.

1.40 Since the Health, Family Planning and Nutrition programmes are proposed to be delivered through health auxiliaries and other workes based at primary health centres and sub-centres, the buildings will serve a common purpose. Under the existing pattern, separate family planning unit buildings have been provided at all the primary health centres and approximately 50% of the sub-centres in each block. Under an integrated arrangement, it is not necessary to have separate buildings or separate funding for the same. It is, therefore, suggested that the buildings for the integrated services should be funded from a single source and separate outlays for buildings under various programmes is not to be called for. Funds to be provided under health and family planning sector for buildings of primary health centres and sub-centres should ordinarly be pooled together and used for making up the deficiencies in the existing building component and for the expansion of the services. The tentative outlay for buildings in question will be, it is understood Rs.100 crores (Rs.60 crores under the minimum health programmes and Rs.40 crores under the family planning programmes).

Drugs and Equipment

1.41 The drugs and equipment component will be common to all the three services and hence should not be earmarked separately to all the three services for the expansion programme or taking up special programmes under any of the heads. It should be a charge to Central funds to ensure proper implementation of the integrated programme. On the lines suggested for buildings, the merging of funds under drugs and equipment for all the three services should be carried out and no distinction made at the time of procurement and supplies.

Cancer

1.42 Improved diagnostic facilities leading to greater case finding and increased life expectancy has revealed a higher incidence of cancer and a larger number of patients suffering from this disease now come forward to seek help. The two components of tackling the problem are (i) treatment, and (ii) research. While the treatment can be provided at each major hospital, research can only be confined to certain chosen institutions. The Task Force recommended that the treatment aspect can be strengthened by provision of a radiotherapy unit with cobalt beam in a medical institution to cater for every 5 million of population. These treatment centres can be located in a medical college hospital or a district hospital to ensure fair distribution among the population.

1.43 For research the existing 7 Cancer institutes need to be upgraded for purposes of taking up research of higher order. The Steering Group is of the opinion that the transport aspect should be the responsibility of the States but the research institutes should be assisted by the Centre to the maximum extent possible. A specific provision should, therefore, be made in the outlays under the Central or Centrally Sponsored programmes. A tentative provision of over a crore is considered to be the minimum requirement for the research during the Fifth Plan.

Rehabilitation Centres and Psychiatric Clinics

1.44 It is felt that the requirements of the vast majority of handicapped persons among the population have not been adequately met and in view of higher industrial and road accidents, the scheme of establishing more rehabilitation centres has assured higher urgency to deserve sufficient funds in the Fifth Plan. Similarly the incidence of mental illness in the country has shown an upward trend, while the growth of mental care facilities has not sufficiently kept pace with it. The Steering Group feels adequate provision should be made in the Fifth Plan to establish sufficient number of rehabilitation centres and psychiatric units with full complement of staff, equipment and institutional treatment to meet the growing demands.

Medical Records

1.45 Except in a few bigger hospitals, medical record departments in the real sense of the term do not exist. In most of the hospitals the functions are carried out by a clerk who has to do this job in addition to his own routine duty and as such very little attention is paid to the work relating to medical record. There is, therefore, a great need for organising the medical record and hospital statistics department in hospitals on proper lines as it would greatly facilitate research and studies in the medical field as well as help in the matter of cost accounting and uniform system of accounting of the existing services so as to assess the utilisation of the existing facilities for planning for better utilisation. It is suggested that this should be taken up on a phased manner, during the Fifth Five Year Plan. The Steering Group understands that the medical record section at Christian Medical Coll ege, Vellore is a model one and can be followed with advantage in every medical institutions.

Levy of Cess for augmentation of resources

1.46 Steering Group accepts the suggestion for levy of cess to augment resources. It recommends that a token charge of 25 Paise for each out-patient for first visit and 50 Paise per day for an in-patient entitled to free diets be levied in all Government run institutions. This levy need not be rigidly applied and the doctor incharge should be given enough discretionary powers to waive off charges in case of indigent and very poor patients. The Steering Group while making this recommendation is aware of the fact that collection of this cess may have its own administrative problems, which, it is hoped, will be anticipated and settled before hand. It is understood that some States are already levying some such small charge. Proceeds from such a levy should be utilised for improving facilities in the hospitals.

Dieting in-door patients in hospitals

1.47 The necessity of providing proper diet to indoor patients in the hospitals is recognised. The Steering Group feels that this is an important aspect which should be taken into account in formulation of health schemes.

Mobile Hospitals

1.48 The experience of the scheme brought to the notice of the Steering Group, as well as report of the Task Force on its working, it would appear that the scheme has not been able to live upto its declared goals. The performance has been rather deficient. The Steering Group, therefore, does not favour extension of this scheme in its present form. Mobile Hospitals concept should be modified to function as mobile-cum-service units and to provide a linkage of the teaching institutions with a district or part of the district with its totality of health structure. This would also provide opportunity to the teaching hospital staff to work at the periphery.

Control/-eradication of communicable diseases

1.49 Communicable diseases programmes have been categorised as Centrally Sponsored Schemes and accorded the highest priority in the Fourth Plan. Unfortunately, the progress considerably falls short of the desired level. It is, therefore, of utmost importance to identify the main bottlenecks to the progress in each control/eradication programme and take timely remedial action in the Fifth Plan. It is suggested that Groups and Panels of Scientists be established to identify the gaps in the knowledge and strategy in this field so that further research can be carried out purposefully.

1.50 Except for National Malaria Eradication and National Filaria Control programmes, no other communicable diseases have been subjected to studies in depth. The two available scientific evaluation reports on Malaria and Filaria need to be critically examined with a view to find out whether these reports are adequate from the point of view of action or need further examination by another group.

1.51 To ensure steady progress of the communicable diseases programmes the system of performance budgeting be instituted. Further, for speedy effective implementation, a regular and continuous monitoring of these programmes is essential and the necessary machinery for this purpose be provided at the State and Centre level.

National Malaria Eradication Programme

1.52 This programme was taken up in 1958 and even after 14 years of operation, only 59% of the country has gone into maintenance phase. There has been focal outbreaks since 1964 resulting in some reversions. It has been reported that there has been persistent transmission from the contiguous areas comprising of Gujarat, Madhya Pradesh, Maharashtra and Rajasthan. This is partly due to vector mosquitoes having developed resistence to D.D.T. and partly due to the ineffective supervisory services. There have been delays in the supply of insecticides, anti-malaria drugs and replacement of transport vehicles. Besides inadequate basic health services in maintenance phase areas have also contributed towards these reversions. The programme was evaluated in depth by an international team in 1970. This team has observed that eradication is possible in areas having 91 per cent of the population and the remaining 9 per cent population/would continue in /area attack phase for all times. This means that a change in strategy for these areas is called for and intensive research organised to evolve better tools and a technically and administratively sound plan to completely eradicate this menace.

1.53 In view of interlinkage between rural and urban malaria, malaria programme in urban areas taken up in 1971-72 should be vigorously pursued in the Fifth Five Year Plan. The Steering Group notes with concern that the time schedule for malaria eradication has been revised three times since the inception of programme in 1958 and the goal does not appear to be in sight. Steering Group would suggest a scientific study in depth and a denovo appraisal of the programme at the higher level with a view to put up a clear picture before the country, highlight the drawbacks and deficiencies, and

suggest suitable remedies to put the whole gamut of malaria operation on a technically and administratively sound footing. This is absolutely necessary to save continuously high expenditure which could be diverted to more productive venture.

National Filaria Control Programme

1.54 It was launched in 1955-56 and there would be 135 filaria control units, 7 headquarters units and 4 research-cum-training centres functioning in the country by the end of the Fourth Five Year Plan. So far the programme has been confined to the urban areas and one of the reasons for this was that the strategy to tackle the disease in rural areas was yet to be developed. Due to limited finances for the Fifth Five Year Plan, the filaria control programme may have to be mainly restricted to the urban areas.

National Smallpox Eradication Programme

1.55 This programme was launched in 1962 and has made considerable progress since then. The lowest incidence of smallpox was recorded in 1969-70. A high majority of the cases reported during 1972-73 pertains to only three States in the country. Nevertheless, there is a backlog of primary vaccination and in the Fourth Plan additional staff has been sanctioned to vaccinate all the new borns, to remove the backlog and to undertake revaccination of the selected vulnerable groups of population. The major bottlenecks which hamper the progress of the programme are reported to be the deficiencies in the surveillance, outbreak containment, and delay in identifying problem areas. It is envisaged that during the Fifth Five Year Plan smallpox eradication programme would be completed. Further, the country is expected to achieve self-sufficiency in the production of smallpox freeze dried vaccine during the Fourth Plan itself.

National Leprosy Control Programme

1.56 This programme was launched in 1955. Out of 300 million people endemic to leprosy, two million have been covered so far. One million patients have also been registered out of the estimated number of 2.5 million. The leprosy control units have been established in areas where the prevalence rate is one per cent and above and S.E.T. Centres in areas with 0.5 to 1 per cent prevalence rate. So far 227 control units and 1422 SET Centres have been established. In addition, 32 voluntary organisations engaged in the leprosy work were also assisted by the Central Government. The main bottlenecks are reported to be lack of full complement of staff including supervisory staff, and delay in the procurement of drugs. The Steering Group has taken note that the Indian Council of Medical Research has been entrusted with

assessment of the current state of the leprosy control programme and it suggests that their terms of reference may be enlarged to make recommendation for the future programme for the areas inhabited by Scheduled Tribes and hilly areas.

National Trachoma Control Programme

1.57 This programme was taken up in 1963. The target for the Fourth Plan is to cover a population of 141 million. The programme was reviewed in 1969 and afterwards it has been integrated with the basic health services wherein position. The UNICEF assistance for anti-biotic ointment for the programme available earlier has ceased since 1970. The Steering Group feels that the programme is effective in checking eye disabilities amongst population and should continue during the Fifth Plan with the same tempo.

National Cholera Control Programme

1.58 This programme is being implemented in 8 cholera endemic States during the Fourth Plan. Special staff has been sanctioned for these States to look after the cholera work but still the programme did not make much progress. Like other gestro intestinal diseases cholera is intimately connected with clean, hygienic drinking water supply and adequate drainage. Steering Group suggests that for effectige control of this disease higher priority should be given to supply of clean potable water to the cholera endemic States in the country and for anti-disatory precautionary measures for areas known for drought and floods.

National V.D. Control Programme

1.59 The programme did not make much headway during the first three Five Year Plans. The progress during the Fourth Plan has also not been rapid though 284 V.D. Clinics have so far been established in the country. For the Fifth Plan, preference may be given to the tribal areas, hill areas and industrial towns known for higher incidence. Moreover, yaws programme may also be linked with this programme.

National T.B. Control Programme

1.60 It is a major disease in the country. The main methods by which the problem is being tackled are (i) detection of active cases at an early stage and treating them with anti-TB drugs; and (ii) preventing infection in healthy persons by BCG vaccinations. Under the programme a fully equipped and staffed District T.B. Centre in each District is to be established to undertake T.B. case finding, treatment and BCG vaccination activities in collaboration with the existing health and medical institutions.

There are now 246 District T.B. Centres, 17 Training-cum-Research Centres, and 36,500 T.B. beds in the country. It is expected that by the end of the Fourth Plan period, above 300 districts would be provided with District T.B.Centres and the remaining districts would be provided with District T.B.Centres during the Fifth Five Year Plan.

1.61 The Steering Group in general contributes to the view that all the communicable diseases programmes should be properly integrated with all the other health care programmes and be administered through the medical auxiliary. The integration should not take place only at the lowest level but also at the intermediary and higher supervisory levels. For this purpose rerientation of the concerned staff would be necessary.

OTHER PROGRAMMES

Child Welfare: 1.62 Children are the wealth of the Nationa. Thus health and welfare therefore should be uppermost in out plans. Recent studies indicate that children in the age-group 0-6 suffer from mal-nutrition and diseases consequent upon it. In spite of expansion of medical facilities, infant mortality in rural areas, urban slums and drouhgt prone areas continues to be very high. At present there are a number of programmes administered by various agencies for the welfare of under-privileged children. These efforts will have to be coordinated for minimising the programmes effect on the recipient and also for minimising the overhead administrative costs. Therefore, for the welfare of children during the Fifth Plan period, Integrated Child Care Services with emphasis on immunisation, health check-up and supplemtary nutrition would have to be launched for drastically reducing mortality among infants and children of the vulnerable segments of population. It will also be necessary to undertake these programmes on a sizeable scale for making an impact in urral ar

School Health 1.63 Despite the importance of school health programmes, its development in our country has been very rudimentary. Governmen of India had appointed in 1960 a School Health Committee to assess the State of health and nutrition of school children and suggest ways and means to improve them. This Committee highlighted especially, the deficiency existing in the system of medical inspection of school children. The Steering Group suggest that health measures under the school health services programme which include detection as well as treatment of defects of school children should form an integral part of general services. As such, these services should be made availa in rural areas through PHCs and in the urban areas through medical staff appointed at the hospitals run by the Municipl Corporations, Municipal Bodies and the State Governemnts etc.

The Steering Group would emphasize that if the disabilities are spotted at an early age among the children through school health programme, it would help in reducing not only the incidence of various diseases in the country but also in improving the health of people at lesser cost. The Steering Group recommends this to be an important part of State Health Schemes for which adequate provision should be made by the States.

Health Education

1.64 The Steering Group is well aware of the part played by the health education in the preventive aspects of health programmes and in the successful implementation of family planning and nutrition programmes. The health education can play a very effective role in cutting down the expenses on medical care in the country, minimise human misery and sufference due to ill-health, ill-based superstitions and beliefs of the people. It is suggested that health education should be woven into the general educational system of the country and health education material should be brought out in different languages for distribution among the public. In addition other mass medias may also be utilised for promoting the elements of health edudation among the masses.

Participation by Voluntary Agencies.

1.65 It has been recognised that voluntary non-governmental institutidons can usefully participate in providing medical care to the people. The Central Government as well as the State Governments have been providing grants to the voluntary agencies of all-India nature. The intention behind this scheme has been to encourage people to participate in the Governmental efforts to expand the health care facilities in the country as well as to create a sense of partnership with the government among the people. The Steering Grouu feels that during the Fifth Five Year Plan, greater participation and cooperation of such voluntary agencies should be forth-coming and if necessary more funds should be provided for this purpose as many of these private organisations are doing useful work in the country in providing medical care facilities to the people.

Special employment schemes for doctors and para-medical personnel.

1.66 During the last tow decades of planning, special emphasis was laid on creating adequate training facilities for doctors and para-medical personnel to ensure that the manpower requirements are fully met and the programmes do not suffer for lack of trained personnel. Some States have reported a degree of unemployment among doctors and nurses especially, which is a distressing feature in view of the fact that their services should be useful utilised in the rural areas.

One of the limiting factor in not providing government employm~ to them is the lack of resources with the State Govts. It is also a recognised fact that the rural communities with the limited earning capacity are not in a position to provide a reasonable level of livelihood to the doctors, if they decide to set up by their own private practice in the rural areas.

1.67 During 1972-73 some States like Kerala and Mysore came up with special schemes with the twin objectives of providing employment opportunities to the doctors and para-medical personnel and to create medical facilities in the rural areas. In this regard mention may be made of the schemes of establishing rural dispensaries in panchayat areas and cooperative dispensaries for unemployed doctors by the Kerala State Government. The Steering Group suggests that these schemes may be evaluated after one or two years so that other States could also benefit from the experience gained by the Kerala State Government and be in a better position to handle the unpleasant situation, if and when arises, of unemployment among doctors, nurses and other para-medical personnel.

III. MEDICAL EDUCATION, TRAINING & RESEARCH

Medical Manpower:-

1.68 The admission estimates presented by various Working Groups and Task Forces and Health Division of the Planning Commission have been considered by the Steering Group. In the light of the basic minimum needs programme the estimates for doctors manpower prepared by the Health Division, Planning Commission appear to be more realistic. The present annual outturn of the medical colleges is nearly 12500 during the Fifth Plan. About 35000 doctors would be needed to man the Fifth Five Year Plan health, family planning and nutrition schemes. The output by the existing medical colleges would, therefore, be sufficient to meet the demands and the Steering Group feels that no additional medical college institutions appear to be necessary at this stage of development except in those areas where there may be some shortage in the availability of doctors or their reluctance to work there.

Three Year Diploma Course

1.69 The Approach Document (Approved by NDC) recommends examination of the scheme for revival of the Three-Year Medical Diploma Course, for purpose of raising suitable medical and para-medical cadres for the lower tiers of the health services. The Task Force has examined this problem exhaustively and the Steering Group had also considered this suggestion in detail,

in their last meeting. The scheme has many drawbacks. The technical education in medical and health disciplines has made rapid strides in the last decade or two and the old diploma curriculum will have to be drastically revised and the licentiate doctor, therefore, may need four or five years of training after higher secondary or inter-Science and the cost of such training will not be appreciably lower than, what has been spent on training an undergraduate doctor, at present. Further the introduction of a new cadre of licentiates will raise its own problems, of the salary structure, ladder of promotion, competition with allopathic undergraduates and future outlook of this new service. It is also not certain that the licentiates will be motivated enough to settle down in rural areas and for all practical purposes the situation may remain unchaged.

1.70 The manpower estimates in respect of doctors, for the minimum need programme, can adequately be met by the output of the present medical teaching institutions. In the light of these considerations, the revival of the three year diploma course cannot therefore be sustained. Besides such a move will throw up many technical and administrative problems with serious repurcussions at a subsequent stage.

1.71 For adequate delivery of health services, the Steering Group favours the alternative scheme of training multi-purpose medical auxiliaries who would render integrated health, family planning and nutrition services in the rural areas as contemplated under the proposed health strategy to be followed during the Fifth Five Year Plan.

Shortage of Doctors

1.72 The non-availability of sufficient number of doctor to man the rural health services is not due to any shortage of manpower but is a problem of mal-distribution between the rural and urban areas. The Steering Group is of the opinion that medical education should be reoriented towards the needs of the country and emphasis should be on community care rather than hospital care. Further the inadequacies of the basic facilities in rural health care schemes such as lack of funds for drugs, equipments, inadequate transport facilities lack of adequate accommodation, absence of good supporting hospitals etc. must be effectively overcome if good results are to be achieved.

Under-Graudate Medical Education

1.73 The Steering Group would like to repeat their emphasis that in the plans for under-graduate medical education in the Fifth Five Year Plan, the stock of doctors which would be available by 1973-74 should be kept in view. Unplanned schemes to augmatt the doctor-manpower may lead to undesirable situation of unemployment for them. In fact, the problem of unemployment has already arised and many States are now faced with awkward situation of agitation and strikes etc.

by fresh medical graduates.

1.74 Teaching in medical colleges needs a radical change; Institutions must focus their attention more to the community problems than pure curative medicine in the hospitals. For this purpose the district hospitals and PHCs and sub-centres need to be functionally integrated with the activities of medical colleges and large hospitals. It must be impressed that "Rural Medicine" is not something inferior or infradig and the medical students, internees and residents must open their minds to the knowledge of practical training in the problem of rural health. The medical colleges must therefore breakup the shackles of wrong practices and principles which are now outmoded and out-dated. The medical educators, therefore, must change their outlook as well as the medical curriculum of training in force, at the moment.

1.75. To improve the medical under-graduate education, the tendency to go on increasing the number of admission year after year, mainly to accommodate extreme pressures, must be curbed if the quality of the medical education is to be improved. The Steering Group feels that the number of admissions in any medical college should be restricted to 100 per annum unless the increased admissions are accompanied by providing additional teaching facilities such as beds, equipment, staff etc. The Steering Group would recommend that admission to the medical colleges should be on a uniformally competitive basis and a national examination system introduced on an all India basis, to ensure uniformity in admissions. It is understood that Medical Council of India has accepted the principle of "Need Based Education" and have made certain recommendations for training of internees etc. Apparently these recommendations have so far remained on paper only. The present system of medical examination would appear to require drastic changes. The system of internal assessment of semester basis may be considered with more emphasis on oral and practical part of the examination. In order to bring uniformity in the examination standards the Steering Group suggests cretion of a national panel of examiners on All-India basis, for different subjects. An Inter-University Board of Examination could also be set up.

1.76 In view of the importance of family planning, students should be initiated towards this programme also which may form an integral part of education. In some colleges, a department of reproductive biology should be created to which students should be specifically assigned for a period of time during their clinical training. Thus if a change is brought about in this way in the under-graduate medical education system, it is honed, this might also help in curbing the brain-drain of doctors from the country.

1.77 The Steering Group does not favour the reported practice of charging capitation fees at the time of admission by some private ~~examination~~ medical colleges and feels that it calls for serious action by authorities concerned.

1.78 The Steering Group accepts in general, the new conception in medical education visualised in the preceding paragraphs and recommends that a Working Group may be appointed to suggest practical measures to translate them into operative schemes.

Post-Graduate Medical Education.

1.79 Reviewing the post-graduate medical education programme, the Steering Group feels that this programme lacks direction. There are no blue prints for requirements in different specialities or guidelines for different institutions. The absence of an effective machinery to define such requirements or arrange for proper utilisation of trained manpower is also noted. As a result, there are now surplus qualified post-graduates in medicine, surgery and other clinical subjects. So as not to fitter away meagre resources, a rational, well thought out pattern of post graduate education is absolutely necessary. The involvement of post-graduate students in community medicine is also negligible. It is suggested that these points may be kept in view while considering further upgradation of post-graduate departments during the Fifth Five Year Plan period.

Dental Education.

1.80 Fifteen dental colleges with annual admission of 680 are functioning in the country. Some element of unemployment among the dental graduates has also been brought to the notice of the Steering Group. The employment channels for the dental graduates are also not very many. Keeping all these factors in view, the Steering Group suggests that expansion schemes on dental education during the Fifth Five Year Plan period should take into view employment opportunities a and job potentialities.

Medical Research.

1.81 The greatest possible emphasis in the field of research in the Fifth Plan should be in the field of operational research and community oriented research to study the most effective forms of delivery of health services to the rural population within the constratints of resources. The problems that are now in the way of more widespread application of family planning, nutrition and national control programmes against communicable diseases should receive the highest priority. It should be emphasized that basic research and good teaching of high quality should not be neglected.

Brain Drain.

1.82 Emigration of doctors and nurses from the country is a serious situation. The reported causes are lack of employment opportunities, problem of inadequate remuneration, insufficient equipment and supplies for effective functioning in the community, professional isolation and rigid administrative procedures. To remedy the situation, the Steering Group favours the following suggestions:-

by fresh medical graduates.

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i) The objectives of the Scientists pool scheme of the CSIR may be reviewed and ways be found to transform it in to some sort of central agency for identifying high level talents abroad and suitable jobs for them at home.

ii) The Scheme of supernumerary cadre has not been properly implemented in the field of health. It is suggested that the Government may issue instructions to all the Govt agencies and national institutions dealing with health for creating sufficient number of supernumerary posts for them.

iii) To recruitment procedures in the case of health personnel in the national institutions, State medical colleges and research institutions are considered to be outdated. These procedures may be streamlined.

iv) There is great need to enlarge the employment opportunities for physicians and specialists, particularly at the district and sub-divisonal levels.

v) The nurse-bed-ratio in the teaching hospitals as well as general hospitals is very low from the recommended norm, The State Governments should be asked to create more posts. This would help not only in providing better medical care to the patients, but also give employment to larger number of Nurses being trained in the country-

Training Para-Medical Personnel

1.83 The greatest need in the area of training of para-medical personnel is improvement in the quality of training, proper delineation of functions for each category of para medical personnel, the preparation of appropriate learning materials and the provision of a suitable career structure for them.

1.84 The Steering Group is fully conscious of the fact that the training of the para-medical personnel vary from one State to another and is being carried out on the traditional lines. The change suggested above is of medical nature and it may not be easy for the organisers to replace the old system. It would be worthwhile, however, to try the new training pattern in selected areas for selected institutions and assessments made on the feasibility of introducing a wider scale.

Appointment of Expert Working Group/Panels/ Committees/Commissions.

1.85 In their report the Steering Group have recommended appointment of expert groups, committees and panels for study in depth of various programmes which are current in the Fourth Plan or proposed for the Fifth Plan. For ease of reference the recommendations are summed up as follows:-

Committees.	Subject for Evaluation/Study.
1. Internal Committee for Ministry of Health. (para 1.5)	To study in depth the causes for incomplete utilisation of funds under the Health Sector in the Fourth Plan with a view to suggest remedial action.
2. High Level Committee. (para 1.28)	To go into the Working of PHC's and sub-centres, idenfity problems leading to non-utilisation of existing capacity and failure of the sub-centres to provide effective services.
3(a) Expert group of technical personnel in clinical medicines, sociologists and administrators. (1.37)	To define functional role of the health auxiliary in the integrated health programme, conditions of service, salary structure, avenues of promotion and to give the integration programme a concrete shape.
(b) Committee of Medical Educationists. (1.37)	Defining objectives of training programmes, construction of curriculum in terms of knowledge and skills required to achieve the objectives, identifying training institutions etc.
4. Commission consisting of Medical Educationists, other Educationists and Sociologists.	To study the present pattern of medical education (under-graduate) and to suggest ways and means to reorient and reorganise the present medical education system based on hospital training rather than community care and rural medicine. This applies to undergraduate as well as post-graduate medical education.

5. Control of Communicable Diseases

While much progress has been made in the control of Communicable diseases, achievements have fallen short of targets. The reasons for these failures need to be gone into in depth and corrective measures taken. Indeed with the powerful technologies now available for the control of most of the communicable diseases, it is essential that an overall view is taken on the problems and perspectives in this field for the country as a whole. An expert committee should be appointed for this purpose with the following terms of reference.

1) What is the normal distribution of important communicable diseases in India (x See appendix for the list of commubicable diseases).

2) What was their incidence in 1970,71 and 1972.

3) What is the present state of knowledge of their epidemiology.

4) What is the availability of effective(a) Therapy, (b)Prophylaxis and (c) other control measures.

5) What is the current status of control programmes to combat these diseases.

6) In order to make the control programmes more effective what are (a) the research needs, and (b) the organisational and administrative deficiencies.

IMPORTANT COMMUNICABLE DISEASES

	Protozoan	Helminthic	Bacterial	Vital	Other
A. Of National Importance	Malaria	Filariasis Hookworm	Tuberculosis Leprosy Cholera Tetanus Whoop Cough Diptheria Typhoid V.D. Anthrax	Smallpox Measles Polio Hepatitis A Hepatitis B Chickenpox Rabies Rubella Dengue Trachoma Influenza C.Cold Mumps	
B. Of local Regional or limited importance	Kalaazar Dermal Leshmaniasis Amoebiasis Toxoplasmosis	Guineaworm Roundworm Pinworm Tapeworm Schistoso=miasis	Brucellosis Leptospirosis Relapsing Fvrs. PU Sepsis Strep.Infactns Yaws Meningtis	KDD Jap.Enceph Chikungunya Sandfly Fvr. Enetero Viruses Aseptic mening Ornithosis Adeno and resp viruses	Typhuses Scrub Epid Tick Q.Fvr. Scabies
C.Possible threat of occurrence			Plague	Yellow fever	

IV. DRUGS AND FOOD ADULTERATION.

1.86 The drugs & Cosmetics Act has been in force since 1947. The Act regulates the import, manufacture, distribution and sale of drugs in the country. Under the Act, the Central Drugs Standard Control Organisation is responsible for controlling the quality of imported drugs, coordinating the activities of the States and advising them on relevant matters, laying down standards of drugs and regulatory measures. It is reported that so far, the major drug manufacturing States of Maharashtra, Gujarat, and West Bengal have made significant progress, in the enforcement of the Act.

1.87 The Central Food Control Act came into force in June, 1955 with the objective to bring about uniform provisions and standards throughout the country. The Act was amended in 1964 providing more deterrent punishment to the offenders. Effective implementation of provision of the Act is still lacking in many States.

1.88 The Steering Group considers that the essential ingredients of the approach to tackle the problem would be to have well equipped and well organised combined food and drug testing laboratories and adequate training facilities for drug and food inspectors and analysts. It would be therefore necessary to establish and expand the testing analytical facilities in a substantial way throughout the country. The Task Force's recommendations to have 10 such laboratories in addition to a larger number of regional food laboratories in various States may be accepted. These schemes may also be categorised as either centrally sponsored or centrally assisted to ensure proper implementation by States.

1.89 The Steering Group suggests that the feasibility of combining the Food and Drugs Administration both at the Central and the State level may be explored as the problems facing the food and drug control administration are more or less the same. It is understood that Maharashtra State has already taken steps in this direction which may be followed by other States.

1.90. The Steering Group recommends that while the Central Government should continue to provide facilities for training of food and drug inspectors and analysts, the States should also have their own arrangments for training of food and drug inspectors.

1.91 It suggests that the enlistment of cooperation of public members of the medical profession and other bodies such as consumers' councils should be sought to check these malpracties.

1.92 The Steering Group considers that for effective implementation of the Acts, the enforcement staff in the States should be suitably augmented for which adequate provision should be made.

1.93. Regarding the provision of the existing Drug Control and Prevention of Food Adulteration Acts, the Steering Group asks the Central Government to enlarge them to come with the problem of Inter-State offences also.

1.94. Certain commodities of food like ghee, butter, spices, ice-cream, food colours, babyfood etc., should be sold under Government Specification Scheme. Facilities offered by ISI laboratories may be utilised for this purpose.

1.95 Steering Group is aware of inadequate supply of drugs in hospitals, institutions partly due to high prevaling prices in the market and partly to under-budgeting. The prices of drugs could considerably be reduced if the manufacture of essential drugs could be undertaking in the public sector and /or overall bulk purchases made without sophisticated packaging from big pharmaceutical companies and by strict control over industries in drug manufacturing business which cannot be relied upon for production of quality drugs.

1.96. The Task Force has recommended certain measures alongwith the outlays needed to enforce them. The total outlays for the Fifth Plan amount to over Rs.135 crores. The Steering Group supports all other proposals excepting the items concerning assistance to States to tighten food adulteration measures by appointing wholetime Food Inspectors involving an outlays of Rs.134 crores. The Steering Group considers other proposals involving an outlay of Rs.21 crores as very reasonable and recommends their acceptance.

V. INDIGENOUS SYSTEMS OF MEDICINE AND HOMOEOPATHY

ISM

1.97 During the last two decades, steps have been taken by the State Governments for standardising under-graduate education in Ayurveda, Sidha and Unani systems of medicine. Several committees were appointed both by the Central Government and the State Govts. which have gone into the problem in greater details. Financial assistance was extended towards construction of buildings for Ayurveda and unani colleges run by State Governments as well as voluntary organisations during the Second Plan period. With the setting up of the Central Council of Indian Medicine which is to lay down standards of staff, equipment, accommodation, training and other facilities in the undergraduate colleges, it is how honed that a uniform standard of education would be evolved. The Steering Groupsuggested that necessary financial assistance should continue to be provided to the undergraduate colleges.

It further suggests that the proposals of the State Governments and voluntary organisations to start new undergraduate colleges during the Fifth Five Year Plan should have lower priority, instead, efforts should be intensified to fill up the deficiencies in the existing colleges. Financial assistance may also be given to those States which have high concentration of ISM Colleges in their territories, for setting up ISM Universities. In this way it is hoped that the undergraduate colleges which are now finding it difficult to get university affiliation and thus raise their standard of education could suitably be assisted. The Steering Group notes that the Gujarat State Government has already affiliated all the ayurvedic colleges in the State with the Ayurvedic University established by it and Kerala and UP States are also understood to be considering a similar move to establish ayurvedic universities in their respective areas. As regards opening of post-graduate departments, the Steering Group suggests that these should be opened only in the institutions which have an undergraduate course.

1.98. The Steering Group suggests that standardisation of drugs of indigenous system of medicine be given the highest priority during the Fifth Five Year Plan, and the manufacture of such standardised drugs be entrusted to public sector pharmacies. It needs no emphasis that the effeciency of ISM practitioners in the field can be greately improved only when standardised ISM drugs at reasonable prices, like the allopathic drugs are available in the market in adequate quantities. The Steering Group suggests that financial assistance may be extended by the Government for strengthening existing pharmacies as well as for establishment of new pharmacies. Funds may also be provided for establishment of herb farms at suitable places in the country, as this would help in the procurement of adequate quantity of raw materials for the manufacture of drugs. The national formularies for ayurveda and unani systems should also be brought out as early as possible so that the production of drugs by the private and public sector pharmacies could be standardised.

1.99. At present 9000 dispensaries are operating in the country. The Steering Group suggests that more dispensaries should be opened during the Fifth Five Year Plan especially in hilly and difficult areas and some beds may also be reserved at the district and taluks hospitals for ISM treatment. Steps may also be taken to popularise medical aid through ISM in Government controlled bodies such as LIC, Air-India, Indian-Airlines, Employees State Insurance Corporation, Railways, Public Sector Undertakings etc. The Steering Group recommends that not only more dispensaries be opened in Delhi under the CGHS but some ISM dispensaries should also be opened at other places where CGHS has been extended.

1.100 The Steering Group recognises the need for scientific approach and scientific study in ISM and is of the view that research in ISM is absolutely necessary. It does notes with satisfaction that the Indian Council of Ayurvedic Research has already been established which is incharge of the overall research activities of these systems

and it has thus helped in streamlining as well as accelerating the research work being carried out by the various research units in the Country.

Homoeopathy.

1.101 There are at present 70 homoeopathic colleges in the country out of which only 3 colleges are run by the State Governments and the remaining 67 by the private bodies. During the Fourth Five Year Plan the scheme of extending financial assistance to the private colleges has been formulated and grants are being sanctioned to them according to an approved pattern. The Steering Group may like to point out that the private colleges are still not well equipped and they need funds for their development. As such it is suggested that this scheme of extending central assistance to the under-graduate homoeopathic colleges should be continued during the Fifth Five Year Plan. The Steering Group is aware of the unemployment problem amongst practitioners of ISM and Homoeopathy. The problem is likely to accentuate as more trained graduates turn out of the existing institutions and further if the number of training institutions is increased, unless commensurate employment opportunities are created for them. The Steering Group therefore feels that until such time schemes for unemployment are given a definite shape no effort should be wasted towards expanding undergraduate homoeopathic education. Priority should, however, be given to bring uniformity in the standard of under-graduate homoeopathic education in the country and to fill up the deficiencies in the existing homoeopathic colleges during the Fifth Five Year Plan.

1.102 The running of a homoeopathic dispensary is comparatively more economical. In addition there are lesser risks of serious side effect of the homoeopathic drugs. The Steering Group suggests that funds should be provided to open more dispensaries in the country on the model of CGHS Homoeopathic Dispensaries in Delhi.

1.103 There is great need for the exploitation of the herbal wealth of our country by discovering their potentials, through proving for the preparation of homoeopathic medicines and to cultivate foreign plants under Indian conditions. The Steering Group suggests that a Public Sector Pharmacy for manufacture of homoeopathic drugs may also be taken up during the Fifth Five Year Plan in addition to trials of cultivation of foreign plants under Indian conditions. The work relating to the Pharmacopoeial standardisation of homoeopathic drugs may also be taken up during the Fifth Five Year Plan.

Establishment of All India Institute of Indian Medicine and National Institute of Homoeopathy.

1.104 The Task Force has strongly recommended establishment of All India Institute of Indian Medicine and National Institute of Homoeopathy on the same lines as All India Institute of Medical Sciences at New Delhi. While the necessity for such institutes can be visualised the Steering Group considers it is rather premature to establish such highly sophisticated institutes for reasons, amongst others that it may be difficult to find teachers of such high calibre in the various disciplines of ISM and Homoeopathy to carryout work of the nature intended. The outlays proposed are Rs.1530 crores for All India Institute of Indian Medicine and Rs.2.67 crores for National Institute of Homoeopathy for the Fifth Plan.

1.105 The Steering Group has considered in detail the main recommendations of the Task Force, needing an outlay of Rs.185 crores on ISM and Homoeopathy, during the Fifth Plan. While recognising the necessity of high input in the schemes, the Steering Group is also aware of the severe financial constraints and therefore recommends that establishment of ISM pharmacies including herbal farms in public sector and standardisation of drugs may be given the highest priority and should be as far as possible made a centrally sponsored scheme.

Funding.

1.106 Various criteria were adopted by the National Development Council for categorising Centrally Sponsored schemes during the Fourth Five Year Plan. It is considered that the same criteria may hold good for the Fifth Five Year Plan though final decision in this regard will still rest with the National Development Council.

1.107 The Steering Group suggests that the Centre should not provide 100% Central assistance for Centrally Sponsored Schemes during the Fifth Five Year Plan. It will help in elimination of misuse of the funds if the States could be made to share the expenditure.

1.108 There is need for introducing flexibility in the framing of individual schemes under health, family Planning and nutrition programme. The present approach of prescribing a rigid pattern of schemes to the States for implementation may not produce the expected results. For achieving better results the Central Government may only lay down the broad guidelines and the States may be given the freedom to modify even the broad framework taking into account the objective of the schemes and the situation prevailing in each State in consultation of Ministry of Health and Family Planning.

Health. 1.109 During the Fourth Five Year Plan the Centrally Sponsored Health Programmes consisted of programmes pertaining to control/eradication of communicable diseases, post-graduate medical education, ISM higher education, pilot project for mental health, strengthening of PHCs with basic health services and training of occupational therapists etc. These programmes carried out 100 per cent Central assistance by the Centre and a Fourth Plan provision of Rs.176.50 crores was provided for that. Further these programmes satisfy the criteria laid down by the National Development Council for categorising a scheme as Centrally Sponsored Scheme.

1.110 Keeping in view the criteria laid down by the National Development Council for categorisation of schemes as Centrally Sponsored Scheme during the Fourth Five Year Plan and the strategy adopted for the Fifth plan, the Steering Group recommends the following schemes to be taken up as Centrally Sponsored Schemes during the Fifth Plan period.

	Fifth Plan outlay (Rs. in crores)
A.Control of Communicable diseases Programme.	
a) National Malaria Eradication Programme.	84.92
b) (Attack and consolidation phase) Urban Malaria (M&E)	11.79
c) National smallpox eradication programme.	17.50
d)TB (Drugs and BCG vaccine)	8.25
e) VD (Drugs)	0.25
f) Cholera (Vaccine,M&E)	1.50
g) Leprosy (Drugs)	2.50
h) Trachoma (Drugs)	2.50
i)Filaria (oil,equipment and drugs)	5.00
Total (A)	134.21
B.Medical Education,Training & Research,	
a) Training of multipurpose medical auxiliaries.	8.00
b) Training of physio-therapists etc.	2.00
c) Cancer research.	1.50
d) Post-graduate education in general practice.	1.00
Total (B)	12.50
C.I.S.M. Establishment of ISM pharmacies including herbal farms in public sector and standardisation of drugs.	4.50
Total.(C)	4.50

D.Other programmes.

a) School health.	1.00
b) Combined Food & Drug Laboratories. (Buildings, equipment)	3.50
c) Regional Food Laboratories (building, equipments)	0.75
d) Establishment of psychiatric clinics.	1.00
Total (D)	6.25
Grand total.:-	157.46

1.111 Minimum needs programme

Under the minimum needs programme the primary health centres and sub-centres which serve as focal points for providing preventive, curative and promotive health care in the rural areas would be strengthened. Deficiencies in the construction of buildings, equipment, provision of staff and drugs etc., would be filled up in a coordinated way. Additional sub-centres would be opened to provide one sub-centre for a rural population of 10,000 as per 1971 Census. In addition, one out of every 4 primary health centres would be upgraded to a 30 bedded rural hospital. As may be seen from below, it is estimated that the minimum needs programme would involve an outlay of Rs.330 crores.

	(Rs.in crores)
1.Additional 150 PHCs.	4.80
2.Additional drugs for existing PHCs	15.75
3. Deficiencies of the buildings etc at PHCs.	48.12
4.Additional sub-centres 10870	38.05
5. Drugs at sub-centres.	53.00
6. Deficiencies of buildings etc at existing sub-centres.	28.28
7. Upgradation of 1500 PHCs to 30 bedded rural hospitals.	152.00
Total.	330.00

1.112. The Steering Group notes that the pattern of financing the minimum needs programme during the Fifth Five Year Plan is still under consideration. Since the requirements of the minimum needs programme would be the first charge on the plan outlay, the Steering Group recommends that some suitable ways and means may be devised to ensure that the funds provided under the minimum needs programme are not diverted to other programmes during the Fifth Five Year Plan.

1.113 The proposed outlays for the Fifth Plan for health sector may be distributed as under:-

1.Central Scheme.	Rs. 65. crores.
2.Centrally Sponsored Schemes.	Rs.157 crores.
3. Minimum Needs Programme.	Rs.330 crores.
4. States/Union Territories.	Rs.388 crores.
Total.	Rs.940 crores.

1.114. The Steering Group would like to point out here that during the Fifth Five Year Plan an integrated approach to health, family planning and nutrition programme under Health which has been recommended. Under the minimum needs programme under Health which would need Rs.330 crores, the primary health centres and sub-centres are being strengthened. These centres are the main organisational and administrative set up in the rural areas through which the health, family planning and nutrition services would radiate. As such it is quite justifiable if some reasonable amount of funds from the Fifth plan outlays being provided for family planning and nutrition programmes could be utilised for schemes pertaining to strengthening of primary health centres and sub-centres. It may be noted that the Steering Group has already made a recommendation to appoint a Working Group to go into the details of the workload of the integrated services regarding health, family planning and nutrition programmes at periphery and to recommend suitable staff to handle these programmes effectively. The Steering Group suggests that the funds needed to meet the expenditure regarding the salary as well as staff quarters in respect of the additional medical auxiliaries to be appointed at the sub-centres should be borne from the outlays earmarked for nutrition and family planning in the Fifth Five Year Plan.

Family Planning.

1.115 The family planning programme will continue to remain the Centrally Sponsored Programme during the fifth Five Year Plan. A separate identity of family planning programme in the matter of funding may be ensured so that this programme which has been accorded high priority should not be neglected and funds provided for this programme should be utilised only for this specific purpose.

1.116 The present system under which Central assistance is released to the States through ways and means advances is without any reference to the progress of expenditure and requirement of funds overall achievement of physical targets. The release of funds should, therefore, be made conditional on furnishing of progress of expenditure report. It will also ensure that funds meant for family planning and other centrally sponsored /aided programmes are not diverted for other schemes by the State Governments, which irregularity has been commented upon by the Estimates Committee.

Nutrition Programmes

1.117 (i) It is tentatively suggested that the cost of food for supplemental feeding programmes should be treated as part of Centrally Sponsored Programme for a period of 10 years (during the period of Fifth and Sixth Five Year Plan.)

(ii) The pattern of funding of transport and administrative cost for feeding programme will have to be determined for the Fifth Five Year Plan. The Tentative view of the Working Group on Supplementing Feeding Programme is that the cost of transport and administration for supplemental feeding programmes including those for pre-school age children, school age children, pregnant women and lactating mothers should be borne by State Governments inthe Fifth Plan. In the case of Mid-day Meals programmes this is the current pattern.

(iii) Today there are a multiplicity of agencies implementing the feeding programme at the Central and State level. It has been suggested that a Central autonomous agency may be set up vested with the responsibility of implementing all the feeding programme now undertaken by the different Departments at the Central level. This matter requires further processing on a view is taken on the principle involved.

(iv) In the Fourth Plan, the health-based nutrition programmes have been included in the Central Sector of the Plan. The delivery of the nutrients is, however, done by State Health agencies. It is for consideration whether in the Fifth Plan cost involved is delivery items such as iron, folic acid and Vitamin A etc., such be borne by the State Governments and the cost of the material by the Centre.

(v) The production, processing and supply schemes have been the responsibility of the Department of Food at the Centre. It is suggested that the existing pattern of funding may be continued in the Fifth Plan for these programmes.

(vi) It is necessary that provision for evaluation, progress reporting and research should continue to be the responsibility of the Central Government and may be included as part of the Central Sector of the Fifth Plan.

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PART II

FAMILY PLANNING

2.1. The Planning Commission vide order No.HLH-1(3)/71 dated 3.5.72 constituted a Steering Group on Health, Family Planning and Nutrition under the Chairmanship of Shri Mohan Dharia, Minister of State for Planning to make a perspective assessment of the problems and needs of health including medical care, family planning, nutrition, medical education and training upto 1981 and to suggest concrete programmes for the Fifth Five Year Plan. The Steering Group constituted five Task Forces out of which one was on family Planning. The Planning Commission vide order No.HLH-1(4)/71 dated 14.6.72 issued orders constituting the Task Force on Family Planning under the Chairmanship of the Commissioner of Family Planning, Dr.(Miss) L.V. Phatak with the following terms of reference.

i) To review the past development and the existing programmes in the field of family planning.

ii) Identify bottlenecks in the existing programmes and suggest methods for an effective implementation of the Family Planning Programme.

iii) Formulate the main strategy for the Fifth Five Year Plan in such a manner as to ensure an accelerated progress towards the desired goal.

The report of the Steering Group on Family Planning was prepared after a full consideration of the recommendations made by the Task Force on Family Planning submitted, to the Steering Group in September, 1972. The Steering Group report hasbeen divided into 4 chapters as given below:-

i) A review of the Family Planning Programme.

ii) Bottlenecks and deficiencies in the implementation of the programme.

iii) Strategy and programme in the Fifth Five Year Plan.

iv) Concluding remarks.

A review

Outlay and expenditure on the Programme:

2.2. An outlay of Rs.315 crores has been made for this programme for the Fourth Five Year Plan period (1969-74).

The outlay and expenditure on the Family Planning Programme since the First Five Year Plan have been as follows:-

(Rs. in lakhs)

Plan	Outlay	Expenditure	
1st Plan	65.00	14.51	
2nd Plan	497.00	215.58	
3rd Plan	2697.57	2485.95	
1966-67	1495.00	1342.61	(Provisional)
1967-68	3100.00	2652.29	-do-
1968-69	3700.00	3051.45	-do-
Fourth Plan provisions: Rs. 33,000 lakhs*			
1969-70	4200.00	3718.10	(provisional)
1970-71	5200.00	4773.80	-do-
1971-72	6060.46	5924.22	(Estimated)
1972-73	6316.18		

2.3 For the three years of the Fourth Plan, namely, 1969-70, 1970-71 and 1971-72 the allocation to the Central and State sectors and the corresponding expenditure figures are given below:-

	Central Sector		State/U.T. Sector		Total	
	Budget	Expenditure*	Budget	Expenditure*	Budget	Expenditure*
1969-70	720.00	461.75	3480.00	3256.35	4200.00	3718.10
1970-71	581.29	426.85	4618.71	4346.93	5200.00	4773.78
1971-72	578.24	480.83	5482.22	5443.39	6060.46	5924.22@ (Estimated)
				Total:	15460.46	14416.10

*Estimated. @Include unspent balance of Rs.201.73 lakhs lying with the States from past years.

Physical Achievements and significant developments: Performance under various methods.

2.4. Three methods, namely, sterilisation(both for males and females), IUCD insertions and Conventional Contraceptives are the major components of the services provided under the "cafeteria" approach of the Family Planning Programme. For the older couples who have build' up their families, sterilisation is the method of choice. For the younger couples conventional contraceptives of IUCD is the best way for spacing children. Since there can be no compulsion about or insistence on any particular method or device out of the various available methods in view of the local conditions and the individual needs and preferences varying from place to place (though guidance is provided by the medical and para-medical staff) what is material is the total picture in relation to the acceptance of contraceptive practices that emerges over a period of time. It is important to note that though there have been variations in regard to acceptance of particular methods, the total number of acceptors of Family Planning methods has been rising from year to year. During 1966-67 when the Programme was made target oriented, there were 2.26 million acceptors which went upto 2.99 million in 1967-68, 3.10 million in 1968-69, 3.40 million in 1969-70, 3.89 million in 1970-71 and 4.87 million in 1971-72. The following table shows the performance in various years as compared to the year 1966-67.

Method	1966-67		1967-68		1968-69		1969-70		1970-71		1971-72	
	No. in millions	Index of achievement.	No. in millions	Index achievement based on 1966-67 =100	No. in million	Index of achievement based on 1966-67 =100	No. in millions	Index of achievement based on 1966-67 =100	No. in millions	Index of achievement based on 1966-67 =100	No. in millions	Index of achievement based on 1966-67 =100
Sterilisation	0.89	100	1.84	207	1.66	187	1.42	160	1.32	148	2.16	243
IUCD	0.91	100	0.57	74	0.48	53	0.46	51	0.47	52	0.48	53
C.C. Users	0.46	100	0.48	101	0.96	209	1.52	330	2.10	457	2.23	485
Total acceptors	2.26	100	2.99	132	3.10	137	2.40	150	3.89	172	4.87	

2.5. During the current year 1971-72, the number of total acceptors is 4.87 as against 3.89 million during the last year. The break up is:-

	(in million)
Sterilisation	2.16
IUCD	0.48
C.C.Users	2.23
Total:	4.87

Performance during 1971-72 has been the best so far.

2.6. It is encouraging to note that the programme has gone up in all the three methods, i.e., sterilisation by 63.9%, IUCD insertions by 1.6% and C.C. users by 6.4 % during the year 1971-72 as compared to the last year. The performance since inception of the programme till June, 1972 has been as follows:-

		Rate per thousand of population.
Sterilisation	- 11.0 million	19.6
IUCD insertions	- 4.4 "	7.8
C.C. Users	- 2.1 million*	3.8

*They are treated as being effective for the year of use.

2.7. A significant feature of the programme during 1971-72 has been organisation of large scale Vasectomy camps on experimental basis. The conspicious success of the Mass Vasectomy campaign in Eranakulam District in November-Dec.1970 and again in July 1971 was a break through in the revival of Vasectomy following these campaigns about 25 camps were organised in different parts of the country at which 7-4 lakh vasectomy operations were performed.

Couples protected.

2.8. As a result of the efforts so far made about 10.7 million couples (about 10.6 per cent of 100.9 million

couples in the re-productive age group with 15 to 44 years for females in 1971) have been protected by sterilisation and IUCD insertions upto June 1972. Another 2.0 per cent have been protected by the Conventional Contraceptives during the year 1972-73 (April 72 - June 72). Thus the total percentage of couples protected is about 12.7 per cent.

Estimated number of births prevented.

2.9 It is estimated, on the basis of certain accepted assumptions, that the total number of births prevented due to work done under the official Family Planning Programme has been 10.0 million by the end of 1971-72 The number of births which will be prevented eventually as a result of the work done upto 1971-72 shall be as follows:-

Upto 1993-94 .....32 million

The birth rate in 1971-72 based on the births averted has been put as 37.1 per 1000 population. This is quite close to the estimated birth rate for all India in 1970 as 37 per 1000 population as given by the Sample Registration Scheme of the Registrar General of India.

2.10. The objective in the Fourth Plan is to bring down the birth rate to 32 per thousand by the end of 1973-74. In the wake of Family Planning Programme since 1966, the birth rate in Kerala, Tamil Nadu and Maharashtra has already declined below 32 per thousand and that in Mysore, Punjab, Andhra Pradesh and Orissa is likely to reach 32 per thousand by 1973-74. There are also sign of acceleration of acceptance in Uttar Pradesh and Bihar where progress has been comparatively slow.

Conventional Contraceptives.

2.11 The Conventional Contraceptives are being provided through three schemes, namely:-

i) Free distribution through the Family Planning clinics, centres, workers, etc.

ii) Depot Holder Scheme through the Post Offices under which supplies of Nirodh are made at a highly subsidized price of 5Paisa for 3 pieces. The sale proceeds are also allowed to be retained by the person who sells them as his commission and

iii) Commercial Distribution Scheme through the sales outlet of 6 big Commercial Companies operating in the country, at a subsidised price of 15 paisa for 3 pieces. This scheme has been making a satisfactory progress, the outlet having increased from 45,000 to 2,00,000 and the sales having gone up from 15.74 million/ /pieces in 1968-69 to 29.59 million pieces in 1969-70, 52.71 million pieces in 1970-71 and 65.55 million pieces in 1971-72. A large scale publicity programme (radio, newspapers, posters, etc.) has accompanied this scheme. The total supplies of Nirodh during the period 1967-68 to 1972-73 (April'72) were as follows:-

(in millions of pieces)

Year	Commercial	Free	Total
1967-68	-	24.49	24.49
1968-69	15.7 (from Oct. 1968)	43.40	59.14
1969-70	29.59	69.28	98.87
1970-71	52.71	90.21	142.92
1971-72	66.65	107.01	173.56
1972-73 (April-June)	14.50	23.48	37.98

Services and supplies.

2.12. The Family Planning services are provided through Static Units in both the rural and urban areas as well as through Mobile Service Units. At the peripheral level, according to the reports upto April, 1972 there were in all 1908 Urabn Family Planning Centres out of which 1213 were run by the Government. At the rural level, there were 5204 Family Planning centres and 32157 Sub-centres which provided Family Planning Services. In addition there were 2333 institutions in urban areas and 5780 institutions in rural areas which also did Family Planning work. There were 857 mobile service units attached to the District Bureaux for rendering services through camps and in areas not covered by Static Units.

Manpower and Training

2.13. The total manpower requirements of the Family Planning Programme number around 1,50,000 for various categories. The posts sanctioned and persons in position under certain important categories in the States only are as given below:-

Categories	Sanctioned (as on 1.4.72)	In position (as on 1.4.72)
Rural Family Planning Centres:		
1. Doctors	7506	5124
2. Extension Educators	5145	4331
3. Lady Health Visitors	8305	5062
4. Auxiliary Nurse Midwives	34852	27956
5. Family Planning Health Asstts.	14172	13250
Urban Family Planning Centres	(Run by State Governments)	
1. Doctors	1635	1111
2. Extension Educators	1054	845
3. Family Planning Workers	1183	993

Training Institutions.

2.14 There are five Central Training Institutes to provide training to the key trainers. There are also 44 Regional Family Planning Training Centres located in various States. Besides, training is also imparted through 16 Central Family Planning Field Units. The total number of persons trained by various institutions is over one lakh. There is, however, still a back-log of about 29,000 Family Planning personnel at various levels to be filled. When the sanctioned posts are filled up another 13,000 persons will have to be trained.

For training Auxiliary Nurse Midwives and Lady Health Visitors, there are 305 Auxiliary Nurse Midwives

schools and 18 Lady Health Visitors schools. Training is also imparted to private medical practitioners (though the Indian Medical Association). Training is also arranged for practitioners of Homoeopathy and Indian Systems of Medicine with a view to involving them in Family Planning efforts.

Demographic and Communication Action Research

2.15. In the field of Demography and Communication Action Research Government of India give grants to nine Demographic Centres and eight Family Planning Communication Research Centres. Research in these fields is carried out on the recommendations of the Demographic and Communication Action Research Committee. In the field of demography the leading institutions in the country is the International I Institute for Population Studies, Bombay, which also provides training to candidates from the ECAFE region. Considerable research work in demography and studies in various other allied subjects like mortality, migration, urbanisation, population projections, age of marriage, age at widowhood, etc., have been undertaken.

2.16. The K.A.P. (Knowledge-Attitude-Practice) studies have shown that there is no organised religious or community objection to Family Planning in India. They also indicate that the rural masses want an average of four children, whereas the urban population desire to restrict their families to three children. These studies also suggest that 90 per cent of the rural couples with four or more children do not wish to have any more additions.

Studies and Evaluation

2.17 Concurrent evaluation is undertaken in the Department of Family Planning with the help of monthly statistics obtained from the States. In the States Demographic and Evaluation cells have been provided to undertake specialised evaluation studies in connection with the various inputs of the Programme as well as deficiencies in certain areas of the Programme.

Special Social Measures.

2.18. A measure for raising the minimum age at marraige for boys and girls from 18 and 15 years to 21 and 18 years, respectively is being considered. Desirability of compulsory sterilisation of certain categories of persons suffering from congenial diseases and other unfit persons has been advocated and the mater is being examined.

Social Schemes and Efforts.

2.19. A number of new schemes for specialised selective and intensive efforts for quicker results have been started. Amongst them are:-

i) Intensive Districts and selected areas Programme.

51 populous district in the country cover about 1/3rd of the population. Intensive efforts in such areas are likely to give quicker results. 17 Districts have already been taken up under this programme.

ii) Post Partum Programme

Women during pre-natal, natal and post-natal stages are psychologically in the most receptive phase for advice and adoption of family planning methods. A large scale hospital post-partum programme has, therefore, been started for institutions attached to all medical colleges and also in those non-teaching hospitals where more than 3,000 deliveries take place annually. So far the scheme has been approved for 122 institutions. The results have been quite encouraging. During 1971-72, the achievement of targets in the case of direct acceptors was 75.8 % and in the case of indirect acceptors was 77.8%. It is hoped that as the staff strength increases and all approved facilities become available, the performance will improve.

iii) Immunisation and Prophylaxis Schemes.

There is a widely held belief, particularly in the context of high infant and maternal mortality rates in the not too distant past, that the family planning meassage would register better if the health of the new born could be assured through some positive action. Immunisation and prophylaxis schemes for the pregnant and lactating mothers and for children have, therefore, been introduced as a part of Family Planning Programme. Briefly

the schemes their coverage are:-

Scheme	No. of beneficieries (Figures in lakhs)		Financial allocation (Rs. in lakhs)
	Total	Annual	
i) Immunisation of infants and pre-school age children against D.P.T.	26	5	30
ii) Immunisation of expectant mothers against Tetanus.	10	2	5
iii) Prophylaxis against nutritional anaemia for mothers and children.	150	30	200
iv) Prophylaxis against blindness/caused by Vitamin 'A' deficiency in children.	120	24	40
v) Training of dais.	0.5	0.1	50

iv) Increased Mobility:

For increasing the mobility of the existing doctors and other staff as well as for better supervision of the work, vehicles have been provided for the State Family Planning Bureau, District Family Planning Bureau and also planned at the rate of one for each Rural Family Planning Centre. Over 2000 vehicles have already been supplied or are on the way. For proper maintenance of the vehicles, State Health Transport Organisations are being set up.

v) Construction Programme for Rural Family Planning Centres.

Provision of working and residential accommodation for the Rural Centres and Sub-centres has been accorded high priority. All the funds needed for the purpose are being released. Social staff has been appointed in some States

to step up the work. By 1st January, 1973, 870 main centres and 4095 sub-centres buildings had been completed and 1394 main Centres and 4461 Sub-Centres buildings were in progress. For 1972-73 additional targets of 1145 main centres and 4137 sub-centres have been proposed by the States.

BOTTLENECKS AND DEFICIENCIES IN THE IMPLEMENTATION OF PROGRAMME IN THE PRESENT CIRCUMSTANCES.

2.20. A number of difficulties and problems have been encountered in the course of implementation of the programme which have contributed in holding back the pace of the programme. These could be enlisted as below:-

i) LACK OF SUPPORT FROM REPRESENTATIVES OF THE PUBLIC.

Family Planning as a high priority socio-economic programme for the country should enjoy universal political support of the leaders of all partieis. This is far from being so. There is in fact a noticeable lack of their obvious interest in this crucial field all along. It is observed that this does not form a part of the political manifesto of many parties.

ii) CONDITIONS OF SERVICE

A. Permanency: Family Planning has, as mentioned earlier, been adopted as a Centrally Sponsored Scheme with full central financial assistance assured to the States for ten years from 1969-70. As is obvious, the programme will have to continue for a much larger period than a mere ten years from now, becuase apart from achieving the immediate objective of reducing the annual birth rate to 25, maintenance of this level and provisioning of adequate contraceptive services and supplies, therefore, will be a continuing process. Therefore, the necessity of giving permanancy to Family Planning Programme and the services, has been recognished, so that proper personnel may be attracted to its ranks and find the stakes worthwhile.

B. Creation of posts:

i) For a dynamic programme like this, it is necessary that within approved patterns, implementing authorities in the

States should not be fettered by financial delays, routine and redtape in the Central State Finance Departments, particularly where the schemes have already been approved in details by the Central Government in consultation with State Government representatives and which also provide full financial backing.

ii) In the background of the Central assistance being assured for ten years only, some of the State and Union Territory Governments are found to delay considerably the sanctioning of some of the important posts apprehending that after that period, they will have to take over the financial liability which they may not be able to afford.

iii) It has also been noticed that the programme implementation is hampered by inadequate delegation of financial and administrative powers at all levels. During the past few years, lot of time has been consumed by such delays, with obvious detriment to the programme's progress. Exhortations to the State Ministers by the Union Minister for Health and Family Planning have so far borne fruit in the States of Guajarat, Assam, Mysore, Madhya Pradesh, Bihar, Punjab, West Bengal, Orissa and Uttar Pradesh. It is hoped that some other States will follow suit.

C. +Selection and appointment: For the programme to be useful, it is necessary that those involved in it are of the proper acmpetence and have had training in this field. This is difficult to achieve at present.

i) The type of persons required for the programme implementation vary in their importance, field of speciality, station and basic education. To be able to lead the programme initially at least the key posts should be filled on the basis of merit alone and no other criteria and by a careful scrutiny and without prejudice to person and service.

ii) Changes and transfers are not infrequent and adversely affect the programme's tempo. Besides the proper selection organisation of pre and inservice training programme have not fully developed; even where they are developed they are not sufficiently utilised.

iii) Besides the limitation arising from frequent changes and transfers, it is observed that inter-State utilisation of trained persons has not been satisfactorily achieved. This leads to the closing and opening of a large number of training institutions involving delays and unnecessary expenditure.

(iii) THE IDEAL CONTRACEPTIVE

Absence of an altogether safe, simple, inexpensive, effective and readily acceptable method or device has been significant handicap in India, as elsewhere, in expeditiously spreading the programme. The existing contraceptive methods and devices suffer from one or the other drawback in becoming universally acceptable. Sterilisation has restricted application to those with three or more children. Loop and Pills with their effects and other handicap find limited continued acceptance. Nirddh (Condom) is effective and cheap but requires, continuous motivation for its use and poses problems of easy disposal in modest homes, particularly in rural areas. Other conventional contraceptives of equal effectiveness, are not yet easily available and are far from being ideal. Fresh leads needs to be given organised help to avoid delays in their evaluation.

iv) APPLICATION OF RESEARCH

Finding of various researches and evaluation studies are not at present always fed into the programme timely.

v) MOTIVATIONAL EFFORTS

It is observed that the educational and motivational efforts under the Family Planning Programme has been inadequate and not commensurate with the needs of the programme. There has not been an intensive and sustained effort in this field which has resulted in a lower rate of acceptance among different groups of population.

vi) DIFFICULTIES IN LOGISTICS

For a successful implementation, two essential factors are often lacking. These are (a) supervision and (b) mobility. Both these have been partly tackled in the items above, but this is listed separately to highlight the importance of training and available transport once again. Both these will lead to a better supervision and, therefore, a better implementation of the programme.

vii) LACK OF INTEGRATION

Though the policy of integration between health and family planning has been accepted and emphasised, the implementation of this policy has not been satisfactory except in a few States. Efforts are lacking in most of the States in achieving this objective.

viii) VITAL STATISTICS

The system of vital statistics leaves an important gap of information during the intercensal period which militate against quick assessment of the reduction in fertility. The National Sample Survey and Sample Registration Scheme fill the bill only to a limited extent.

2.21. STRATEGY AND PROGRAMME IN THE FIFTH FIVE YEAR PLAN.

The strategy to be adopted in the Fifth Plan could be grouped under the following:-

a) To approach the people through various media methods and through the community leaders so that target couples accept individually suitable methods of family planning.

b) To prepard the community to accept and practise family planning and avail the services available for the purpose under the auspices of Governmental and non-Governmental organisations.

c) To make all the information and services readily available and within easy reach of the people.

d) To make the contraceptive services under the Family Planning Programme an integral part of medical, public health and nutrition services with particular emphasis on maternity and child health services including immunisation of children.

To be able to promote the above following suggestions are made for consideration:-

1. As in the Fourth Plan the Family Planning Programme should find its place also as programme of the highest priority.

2. The Family Planning Programme should continue to be centrally sponsored and central assistance on cent per cent basis for all approved schemes should continue to be provided to the States. This would ensure that the Governmental and non-Governmental organisations put in their best efforts.

3. The Family Planning Programme will have to continue as per the present indications of population growth, for a very long time to come in the country. The programme may have to continue even after the goal of zero population growth rate is achieved. In view of this, it is felt that there should be a commensurate financial commitment to the family planning programme.

3(A) Under the existing schemes of devolution of Central assistance to States, 60 per cent weightage is given to the population criterion. The Steering Group is of the view that with an active implementation of the Family Planning Programme, the weightage given to the population criterion, will create certain anamolous situations. Under this arrangement, it is possible that States which implement the programme effectively and bring down the population growth will be adversely effected in the matter of receipt of central assistance. Therefore, the Steering Group is of the considered view that it is necessary to adopt a base year for the population criterion, upon which Central assistance could be released. This would remove the possibility of unintermation financial gains accruing to certain States which perform poorly under the Family Planning Programme. It is recommended, therefore, that the population figures given in the 1971 Census report may be adopted the base year population for purposes of release of central assistance.

3(B) The Family Planning Programme can be implemented effectively only in an atmosphere wherein positive evidence is available regarding better health care and proper nutrition status for the pregnant women and children in the vulnerable age group of 0 to 5. It has been estimated that even today 20 per cent of the total deaths in the country are accounted for by children in the age group of 0-5. The high infant mortality rate is one of the major handicaps in promoting the large scale acceptance of the small family norm. Therefore, the Steering Group is of the view that the maternal and child health programme along with the nutrition programmes for pregnant women and the pre-school children upto the age of 0-5 should form a comprehensive package and should be implemented through one agency viz., the Ministry of Health & Family Planning. The Nutrition programmes at present are implemented in complete dissociation from the Health & Family Planning programmes. This requires to be modified with immediate effect and the primary health centres and the sub-centres under both health and family planning programmes should be directly associated with the nutrition programmes in addition to the existing immunisation work. The existing channels of distribution which have been set up by the Department of Social Welfare may also continue to be used for the implementation of the Nutrition Programmes along with health and family planning centres and sub-centres. The necessary infra-structure for the delivery of maternal and child health services as also the nutrition services at the primary health centres and sub-centres levels requires to be built up expeditiously.

4. Proper extension education is of primary importance in the field of family planning, for bringing about a change in the attitude of people. Extension education methods should continue to be given full emphasis and the programme should not be treated as synonymous with sterilisation. It should be possible to bring about a behavioural change among the people favour of the small family norm through continuous and intensive extension education.

5. The practice of providing compensation amounts to the acceptors may continue so that the large numbers that are eligible for sterilisation and require special attention are speedily dealt with. In this connection it may be pointed out that in future the term " allowance" should invariably replace the term " incentive" which has gained wide currency.

6. Intensive studies are necessary to be carried out into the motivations for having large families and steps need to be taken to effect these. Ways and means have to be devised to promote appreciation of acceptors of family planning methods.

Schemes could be evolved for individual appreciation and group appreciation. Under the schemes for individual appreciation it is necessary to consider the acceptor, motivator and also the medical and para-medical personnel.

a) Appreciation of the individual acceptor may have to be in the form of personnel incentives, educational benefits or even insurance plans. This scheme will have to be devised in an imaginative manner and should take into account the various factors which stand in the way of non-acceptance of family planning methods.

   The primary aim of individual appreciation should be to offset the motivations which contribute to non-acceptance of family planning. A scheme of no-pregnancy bonus which is being experimented within certain industrial establishments in the country is worth our attention.

b) As far as group appreciation is concerned, popularisation and wider acceptance of the Gram Gaurav Scheme implemented successfully in Maharashtra may be recommended.

c) Allowance in the case of Tubectomies should be restricted to women up to the age of 35 and in the case of Vasectomy to men upto the age of 45.

7. The augmentation of services and the production of necessary contraceptive supplies should keep pace with the priorities and targets laid down. In recent years there has been an increasing demand for sterilisation of women. Therefore, it is necessary to provide necessary facilities to meet this demand.

8. There should be special stress on the work to be done in the socially backward communities and extra efforts should be directed to the groups who are not favourably inclined towards due programme. This may need provision of specially organised efforts.

9. The established pattern of staff and supply of equipment in the District Bureau and in each district are at present unrelated to the area as well as population. This needs immediate revision. Strengthening of the supervisory staff and revision of approved patterns will thus necessarily follow. This principle will also apply to the staff pattern in the State Family Planning Bureau.

10. Special cells should be set up in each State for speeding up construction work. States should be allowed to undertake construction of buildings at the same rates as in the States sector.

11. In view of the accepted policy under the Family Planning Programme to have family welfare as its key objective, it has been recognised that the success of the programme would depend upon the health and survival rate of the children born. Thus the integration of family planning with maternal and child health programme as a part of general health services is obligatory. This principle has been successfully proved by the post-partum programme. The concept may, therefore, be further developed not only by extending the Post-Partum Programme to the district hospitals but also by strengthening the maternal and child health components.

12. Since the relative disinclination of the medical profession in being associated with the programme, is one of the major difficulties, it is felt that a detailed study should be made to identify the reasons for such a disinclination aso as to determine suitable remedies.

13. The Family Planning Programme has reached a stage of development when selectivity in approach is necessary to obtain optimum results from the point of view of its demographic impact and cost of effectiveness.To attain this objective the following priorities in programme implementation which are governed by demographic, motivational and method criteria may be suggested.

a) Population education before a marriage.

b) Intensive motivation of high priority couples in the age group of 25 to 35 and recently married couples.

c) Personal approach to every eligible couple for adopting one family planning method or the other.

d) Terminal methods for men and women who have 2 or more children with special emphasis in the case of women between the ages 25 to 35.

e) The promotion of the use of spacing methods like Conventional Contraceptives both for males and females and IUCD by females until the right family norm is reached or the woman is atleast 25 years old.

14. <u>Personnel Management, Training & Manpower needs.</u>

Considerable emphasis on the adoption of efficient and purposeful personnel management policy in the Fifth Plan which is crucial to the success of the integrated health, family planning and nutrition programme. Such policy should ensure the right type of personnel are attracted and inducted into the programmes for better implementation. It is also necessary to motivate them to a high standard of performance and to retain them in the organisation for a considerable length of time. The personnel policy should take into account the changes taking place in the organisational framework of the programme and the extended nature of its activity.

It has to be recognised that deficiencies in personnel policies have an adverse effect on programme performance. As an important step to remove the existing deficiencies, it is necessary that the placement of officers in senior posts should be made on the basis of commitment to the programme, suitability for the job, past experience and merit-cum-seniority. As a corollary to this point, it is also necessary to lay down that proper training is imparted to the incumbents and that certain objective criteria are drawn up for the assessment of performance in the field of family planning within the integrated framework. The importance of coverting the temporary posts under the programme into the permanent posts and merging them under the integrated pattern has also to be emphasised. To start with, at least these posts which have been in existence for 5 years or more could be made permanent with immediate effect.

For a proper administration of the personnel policies career development plans and the estimation of manpower estimates, the establishment of personnel management and manpower planning cell, at the Central level as well as at the State level is recommended.

It is accepted that the success of integrated delivery of work depends to a large extent on the development of well qualified, trained and competent personnel and, therefore, training needs to be given greater administrative support. To streamline the entire training organisation there should be an overall personnel requirement plan, which should form the basis for having the requisite training centres. The need for compulsory pre-service training before personnel are posted under the programme is to be emphasised. The establishment of management and training courses at Post-Graduate level for persons being recruited for the integrated programme is also considered essential.

Details of proposed integration of Health, Family Planning and Nutrition may be seen on page 12 - 14 under Part I of the Report.

15. Social Legislation - The time is ripe for introduction of certain radical measures through legislation or other-wise. These measures should be centred around the fact that each child born has a right to be assured full opportunities, which would also him or her to grow into useful member of society. A full recognisation should be given to the Declaration of the Rights of the Child adopted in 1959 by the United National General Assembly, to which India is also signatory. It is necessary to grant constitutional recognition to the rights of the child by including this provision under the Fundamental Rights.

The following are some of the steps recommended.

i) Raising the age of marriage from 15 to 18 for girls and from 18 to 21 for boys.

ii) Compulsory registration of marriage applicable to all communities.

iii) Sterilisation of those suffering from incurable communicable or hereditary diseases. These are medical indications for sterilisation and these should be enforced in a more rigorous manner.

15.B. The Steering Group is of the view that in the context of our present stage of demographic growth and development it is necessary to explore methods by which social measures could be introduced which would influence fertility reduction within a short period of time. It is necessary to give thought to this problem without further delay and examine proposals by which social compulsion could be built up in favour of the small family norm. This recommendation has been made by the Steering Group, fully aware of the fact that a large family size for individual couples, is a concept which the country can ill afford at this juncture of economic development.

16. Voluntary agencies: A. The continued involvement of voluntary organisations in the Family Planning Programme in the Fifth Five Year Plan needs emphasis. These organisations form an organic link between the Government and the people. For ensuring a better and more efficient einvolvement of such organisations in the programme the following steps are recommended:-

a) Voluntary organisations should be allowed flexibility in their operational programmes and encouraged to undertake pilot programmes.

b) Voluntary organisations should be categorised according to their capacity to undertake one or more aspects of the programme such as education, services, research etc.

c) There should be an expeditious release of grants to these organisations.

d) Rigidity with regard to the setting of targets for voluntary organisations and the summary stoppage of grants for non-fulfilment of targets have to be avoided.

e) Proper guidance and assistance should be given to the voluntary organisations for improving their performance.

f) State Governments should not deviate from the basic policies of the Central Government in providing encouragement and assistance to voluntary organisations.

B. Organised Sectors: With regard to the involvement of the organised sector in the Family Planning Programme, the Federation of Indian Chambers of Commerce and Industry and the Employers' Federation of India may be encourage to take an active part in getting the programme implemented in a more effective manner in the private industrial sector. Appropriate financial assistance as also supply of educational aids to these agencies by the Government should also be made. Seminars and conferences of industrial management should also be conducted for discussing the implementation of Family Planning programme. The assistance of voluntary agencies in organising Family Planning programme in the industrial sector should also be sought by the private industrial management.

C. There are over 2 million elected office bearers in the rural panchayats in the country and, therefore, it will be valuable to enlist their services for the Family Planning Programme through proper training and suitable motivation. The cooperation of voluntary agencies should be sought for educating the village leaders and motivating them in favour of the programme. The All India Panchayat Parishad would play an important role to energise the panchayats in rural areas. The elected representatives in the panchayats could also be exposed to the idea of family planning during their training. Direct financial assistance to selected panchayats could also be considered for the success of the programme.

D. Labour Unions and Labour Leaders could play an important role in implementing the programme. It will be useful if the Tripartite Labour Conference, which has now come into the existence, expresses its moral support to the Family Planning Programme.

E. It is necessary to involve the ISM practitioners in the rural areas in the programme. Those practitioners who are qualified and registered may be allowed to conduct sterilisation operations and IUCD insertions after proper training. Research being done by the ISM practitioners to discover an ideal contraceptive should be encouraged in the Fifth Five Year Plan also. Along with the other indigenous practitioners the utilisation of the Graduates of the integrated courses will also have to be considered.

17. Research : For a successful implementation of the Family Welfare Planning Programme it is of vital importance that there should be suitable and easily acceptable methods of contraception available. Greater efforts are, therefore, called for in perfecting the present techniques and, therefore, it is necessary to carry out more intensive research to discover new, simple and better methods of fertility regulation. Factors like lack of trained personnel, lack of proper equipment, rigidity of financial control often hampers the research programme. In the Fifth Five Year Plan an attempt should be made to remove these difficulties. In the next Plan greater emphasis should be placed on goal - oriented research rather than on basic research even though the latter is also an important component of research work. The existing research units and centres should be expanded, and better facilities and better career prospects offered to research workers. It is also necessary to provide incentives for attracting Indian research workers inside the country as well as abroad.

18. Targets : The question of target setting has a close link with the population policy of the country. To arrive at meaningful targets there is, therefore, an immediate need to adopt a population policy so that a clear picture is obtained about the objective before us. The target of reducing the growth rate of population to one per cent by 1978-79 is too ambitious. The States should be allowed greater flexibility in determining the optimum mix of family planning methods like sterilisation, IUCD and Conventional Contraceptives.

For a proper assessment and continuous improvement in programme performance the need for a systematised concurrent evaluation of all the activities under the programme cannot be over-emphasised. The establishment of an effective evaluation machinery for carrying out the work is necessary. This is vital area and proper evaluation would only be in the short and long term interests of the programme.

19. Mass Media: The Family Planning Mass Education and motivation programme has to be addressed to different categories of population and for this to be effective different strategies may have to be adopted depending on the composition of the target audience. While the general motivational strategy may highlight the benefits of family planning to individual and his family in terms of health benefits and better standards of living it is also necessary to bring home to all people especially the influential members of society, the social and economic implications of population explosion. There is also an urgent need to coordinate the activities of various agencies and organisations involved in promoting family planning in different sections of the society. During the Fifth Plan the approach to target couples has to be mainly through the following family planning agencies:-

a) Field workers at various levels.

b) Institutions like primary health centres.

c) Official and volurtary organisations.

d) Community and opinion leaders.

It is necessary to equip these agencies, institutions and organisations with the essential educational and audiovisual materials which will impart up -date and necessary information regarding developments in the programme. Under mass media it is also necessary to keep in view the values, attitudes and social contacts within which the idea of family planning has to be propagated. Media units like radio and films should take into account the specific requirement of all Groups and areas. The media methods like a printed publicity and live entertainment are better organised under the auspices of district authorities. For better results a more integrated use of personnel and facilities available with various agencies and departments especially in the districts is necessary.

With the spread of Television network in the country the Family Planning Programme should make an intensive effort to make use of this highly effective medium. This medium with its visual appeal could make a decisive impact on target couples.

20. Population Education: Sustained efforts to continue and strengthen the steps already taken to introduce population education in school curricula are necessary. Arrangements are also needed for educating out of school youth.In the adult literacy programme family planning

could be included as one of the items. The specific roles, responsibilities and functions of agencies involved in these programmes - MCEW, CHED and States - need to be clearly laid down and coordinated.

21. Outlay in the Fifth Plan: The Family Planning Programme in the Fifth Plan will have to be carried out in a much more integrated and expanded form. To reach out to the maximum number of couples through an integrated approach towards family welfare would mean a considerable increase in expenditure. Though the Task Force has recommended Rs.700 crores for the Family Planning Programme the Steering Group is aware of the financial limitations and it recommends that the programme may be accommodated within the tentatively specified outlay of Rs.560 crores. It should be possible as the Family Planning Programme is integrated with and complementary to General Health and Nutrition Programmes.

Concluding Remarks

2.22. The aim of bringing down the growth rate can be only achieved as a part of the Population Policy. Motivation for a small family norm cannot be oriented only on the basis of health assurances. Even if this argument is to be fully utilised long-term policies for ensuring the health of children to come will have to be adopted if needs be by enforcing certain laws. If the programme is to be truly a National Programme of utmost priority, our population policy needs to be enunciated in no uncertain terms encompassing not only its health aspect but also those concerning of economics, ecology, sociology, cultural outlook etc. etc.

We have so far concentrated only on the health aspects of fertility control. It is obligatory to state that this should be adopted as a measure for positive health and thus its integration with MCH and Nutrition at the service points at the periphery becomes logical. It would be necessary, however, to compulsorily orientate the Medical and para-medical personnel of all categories to accept this concept. On the weak platform of a mere health measure, incentives or allowances alone cannot take the programme very far. In fact these can only serve as a stop over measure only until extensive education is made effective. In the latter lies our weakest link of the programme.

This time bound target oriented programme is at present only a part activity of one Ministry. It is necessary that special organisationl structure, imaginative leadership, flexible regulations supported by by simultaneous evaluation are vital. Only then is there a chance to make this a peoples programme with full participation of voluntary workers.

The ultimate success of the programme would depend on not only reducing the population growth but also creating conditions which will improve the quality of the Indian of the future generation.

PART III

" Nutrition Programmes"

1. Approach to the Fifth Plan

Mal-nutrition and its impact on national development

3.1 Care of pregnant women, lactating mothers and pre-school children is included as an essential part of Minimum Needs Programme. Mal-nutrition is, undoubtedly, the biggest problem affecting public health in our country. The worst affected are children below the age of 5 years and women in the re-productive period. Apart from causing ill health, mal-nutrition imposes serious economic burden on the country due to child wastage and decreased productivity. Investments in preventing mal-nutrition will yield rich dividends in terms of overall economic progress in the country. Hence, nutrition may be considered as a priority determinant of economic development.

Nutritional orientation to our agricultural policy

3.2 The nutritional needs of our population cannot be assessed merely in terms of per capita availability of foods as there is serious mal-distribution of foods due to a variety of reasons. Even so, as a first step, augmentation of food production to meet the national needs is important. While cereal production has increased considerably in recent years, the production of other foods like pulses, oilseeds, green leafy vegetable and milk which form part of a balanced diet still require considerable augmentation. These should receive priority in any agricultural plan for increasing the nutrition of our population.

Food conservation and food processing

3.3 Food conservation and food processing should be looked upon as important additional efforts to augment food supply. Technology in respect of the following should be developed :

(a) food storage under rural conditions,

(b) improved milling of rice and pulses,

(c) simple field methods for reducing or eliminating fungal contamination of foodgrains

(d) methods of food processing and food preservation as village or cottage industry so that these processes can be used in large scale feeding programmes.

(e) fortification of common salt with iron for combating anaemia.

(f) solvent extraction technology for augmenting oil yield and for preparing edible protein-rich flours from oilseeds.

Feeding Programmes

3.4 Augmenting food production and economic uplift of the population are two major steps that will improve nutritional status. This must be considered as a long-term objective, but immediate steps should be taken to ameliorate existing mal-nutrition. This can be achieved by specific nutrition intervention programmes. Since the entire population cannot be covered by such a programme, some sort of selection of population among whom mal-nutrition is most widespread are the obvious choices for such a programme. The three important nutritional deficiencies which need to be immediately combated are : (a) calorie-protein deficiency; (b) iron deficiency and (c) Vitamin 'A' deficiency. Calorie-protein deficiency can be combated by providing food supplements so that this deficit in calorie intake is bridged. The case for feeding programmes rests on this main argument.

(a) Case for Feeding Programmes

For obvious practical reasons, it will be necessary to ensure that :-

(a) feeding programmes cover on a priority basis the most vulnerable sections of the population;

(b) Priorities in feeding

(b) the food ingredients necessary for these programmes are locally available so that overheads in transport and storage are reduced to a minimum and eventual continuation of the programme through the community's own efforts will become possible;

(c) the operational costs are reduced to the absolute minimum and there is a maximal community participation.

(c) Recipes — Recipes should be suited to the local dietary habits, tastes and availability of foodstuffs.

(d) Variety of feeding programmes — Feeding programmes may be considered under five broad heads :

(a) Emergencies;

(b) Feeding programmes among tribals, slum dwellers and socially depressed sections;

(c) Feeding programmes among other rural communities;

(d) Feeding programmes for urban situation; and industrial establishments; and

(e) School lunch programmes.

(e) Average calorie-protein deficit for pre-school children — On the basis of carefully gathered data it is now evident that the average calorie deficit in the diet of pre-school children in our poor community is of the order of 300 calories per day. The minimum quantity of supplement needed to meet this calorie gap would be about 75 grams. At this level of intake, a protein content of 12-15 grams in supplement would be more than sufficient to meet the protein requirement. It should be ensured that these supplements do not become replacement of home diets and the necessary education for this purpose must form part of any supplementary feeding programmes.

(f) Integrated approach to feeding programmes — Feeding programmes have to be integrated with other health and welfare programmes to form a composite package programme, which include, apart from feeding, minimum health care, immunisation and improvement in environmental sanitation. The mutually re-inforcing effect of each of the components of these packages will ensure an impressive total effect on the community.

Public Health nutrition programme — 3.5 The problem of anaemia in pregnant women and that of Vitamin 'A' deficiency in children can be combated by a suitable public health programme which provides specific nutrients to the target groups. Anaemia is one of the most common complications of pregnancy, particularly, in low income groups and contributes greatly to maternal morbidity and mortality. Iron deficiency is the major cause and deficiency of folic acid is also involved. Supplementation of iron tablets may be the simplest, easiest and cheapest

(a) Supplementation of iorn and folic acid

way of ensuring adequate intake or iron. Studies on the prophlaxis of anaemia during pregnancy have shown that supplementation of 60 mg. of elemental iron per day during the last 100 days of pregnancy can prevent haemoglobin from falling below 10.5 grams (the 'anaemic' level) in almost all pregnant women. It is, therefore, possible to make a significant impact on anaemia situation for pregnant women by the distribution of iron and folic acid tablets during the last 100 days of pregnancy.

(b) Fortification of foods

Apart from pregnant women, iron defieiency anaemia is also widespread among pre-school children. The possibility of fortification of suitable foods with iron has hence to be considered.

(c) Vitamin 'A' deficiency

Vitamin 'A' deficiency is more spread, specially in the southern and eastern parts of the country. The peak incidence is in the age group of 1-5 years. Prevention of Vitamin 'A' deficiency must receive top priority in any programme designed to improve the health of the children.

(d) other nutritional disorders

Attempts should be made to combat the nutritional disorders created by goitre, pellagra and lathyrism.

Monitoring and Evaluation

3.6 A national nutrition plan implies the availability of a machinery or organisation which can firstly provide relevant basic data, and secondly, undertake objective evaluation of the programmes, so as to facilitate such mid-course corrections as may be needed from time to time.

Nutrition trends in the country should be continuously monitored and major on-going national programmes should be evaluated. Proper organisational set up and the methodology of evaluation need to be developed.

Evaluation, Training & Research

3.7 Proper techniques and materials for imparting nutrition education to different segments of population should be developed.

A number of research organisations and laboratories are currently engaged in research in nutrition and food technology. Problems of national importance can be profitably investigated by collaborative studies by these laboratories.

Present Status - Review of the Nutrition Programmes in the Fourth Five Year Plan

utrition rogrammes n the urth Plan

3.8 Nutrition programmes undertaken in the Fourth Five Year Plan may be classified under the following heads :

(a) Production, Processing and Supply;

(b) Feeding and special programmes for meeting deficiency diseases; and

(c) Training, Education and Extention and Research.

A list of nutrition programmes of Fourth Five Year Plan is appended at Annexure I (Page 80)

Production, Processing nd Supply

General Approach Improvement in Agricultural Production

3.9 The most important programme in the Fourth Plan in nutrition is the overall effort to increase production of cereals and pulses in agricultural sector. Programmes of high yielding varieties of multiple cropping continue to give the thrust to improvement of nutrition situation. Coarse grain, wheat and rice will continue to be the main source of calorie and protein for a long time to come.

Supply of Nutritious Foods

Modern Bread and Balahar

3.10(i) Production, processing and supply programmes in Fourth Five Year Plan, besides covering agriculture, animal husbandry and fisheries sectors also involve processing and supply of nutritious foods. Programmes of development and modernisation of rice milling industry, pulse milling industry and processing of soya have been included in the Fourth Plan. In the list of programmes for supply of nutritious foods, specially for supplemental feeding programmes, plan support for expansion of activities of Modern Bakeries, public sector undertaking, has to be mentioned. So far, nine units of Modern Bakeries have been set up in the country with an annual production capacity of about 100 million standard loaves. Another important scheme for production of nutritious foods for supplemental feeding programmes is the production of Balahar. The revised Fourth Plan includes a provision of Rs.6.45 crores for the production of 1.65 tonnes of Balahar. Till the end of 1971-72 about 18,000 tonnes of Balahar have been produced for various supplemental feeding programmes.

Protein-Isolate Toned Milk

3.10(ii) Attempts have been made in the Fourth Plan for production of protein isolate toned milk in the form of miltone. One million unit is already under production in Bangalore with a capacity of about 1,000 litres per day.

Two more units are expected to go into production at Hyderabad and Ernakulam with a capacity of 2,500 - 3,000 litres per day before the end of the Fourth Plan.

Fortification of Wheat Atta

3.10(iii) Fortification on a pilot scale in regard to wheat flour in selected urban areas has been taken up in the Fourth Plan. So far, about 43,000 tonnes of fortified atta has been manufactured under the scheme.

Feeding and Special Programmes for meeting deficiency diseases

3.11(i) At present, apart from minor supplementary feeding programmes, there are four major feeding programmes in the country. These are :

(i) Mid-day meals programme for school children and pre-school children;

a) Major Feeding Programme.

(ii) Special Nutrition Feeding Programme for pre-school children, expectant women and lactating mothers;

(iii) Applied Nutrition Programmes; and

(iv) Composite Nutrition Programme.

b) No. of beneficiaries reached

3.11(ii) The number of beneficiaries covered under the Special Nutrition Feeding Programme as at the end of October, 1972 was 51.78 lakhs. The number of beneficiaries under the Mid-day Meals Programme is estimated at 12 million for 1971-72. According to information made available by State Governments demonstration feeding was conducted to the extent of 570.75 lakh child days and 70.30 lakh women days for 1970-71 under the Applied Nutrition Programme.

c) Integrated Approach to Feeding recommended by Committee of Planning Commission

3.11(iii) Departments of Education, Social Welfare and Community Development of the Government of India and the States are involved in these programmes. If we take into account the value of food materials used in these programmes and expenses on administration and transport of material and other items, outlays on these programmes would be of the order of Rs.300 crores in the Fourth Five Year Plan. Recently, the Committee for Pre-School Feeding Programmes of Planning Commission has gone into various aspects of supplemental feeding programmes. One of the suggestions made by the Committee is that in organising feeding programmes for vulnerable sections of the population, a package approach is advisable. Such an approach may provide services such as health care and immunisation.

Programmes of the Ministry of Health and Family Planning

3.11(iv) The Ministry of Health and Family Planning of Government of India is at present operating two programmes which have a target of meeting specific nutritional deficiencies in vulnerable groups. They are (i) prophylaxis against nutritional anaemia in mothers and children; and (ii) control of blindness in children caused by Vitamin 'A' deficiency. The progress of these schemes has been rather slow. Upto the end of 1971-72 about [illegible] lakh beneficiaries have been covered in the scheme for distribution of iron and folic supplementation for nutritional anaemia among mothers and children as against 200 lakh beneficiaries to be covered by the end of the Fourth Plan. 120 lakh beneficiaries are to be covered under the latter scheme by the end of the Fourth Plan. About 52 lakh of doses [illegible] of Vitamin 'A' have been supplied to over [illegible] beneficiaries under the scheme - Control of Blindness in Children caused by Vitamin 'A' Deficiency till the end of 1971-72. ✓ 15.5

Training, Education, Extension and Research

3.12 Training, education & extension and research activities are being undertaken by Departments of Community Development, Food, Health & Family Planning in Government of India and also by State Governments. The most important programme in the field of Nutrition Education included in the Fourth Plan is the Applied Nutrition Programme. The target number of additional applied nutrition blocks to be taken up during the Fourth Plan is 450. Achievement for the first three years for which figures are available, are given below :-

Year	Achievement (No. of Blocks)
1969-70	94
1970-71	91
1971-72	100

Working Groups for the Preparation of the Fifth Plan

3.13 The Task Force on Nutrition set up four Working Groups as mentioned below :-

(i) Working Group on Supplemental Feeding Programmes.

(ii) Working Group on Production of Subsidiary and Processed Foods on Supplemental Feeding Programmes.

(iii) Working Group on Nutrition Education, Extension and Mass Media.

(iv) Working Group on Evaluation of Nutrition Programmes.

Targets and outlays

5.14 It is anticipated that during the Fifth Plan, the coverage under the mid-day meals programme will go up from 12 million at the end of the Fourth Plan to 16.3 million by the end of the Fifth Plan and special nutrition programme from 3.2 million at the end of the Fourth Plan to about 9.7 millions at the end of Fifth Plan. It is proposed to provide an outlay of Rs.500 crores in the Fifth Plan for nutrition programmes in the Central Sector. In addition, a provision of Rs. 5 crores is expected to be provided in the Family Planning Sector for Health based nutrition programmes. A provision of Rs.100 crores is also expected to be made for mid-day meals in the Education Sector.

It is proposed to distribute the outlays as follows:-

(Rs.in crores)

S.No.	Name of Programme	Sector	Anticipated achievement at the end of Fourth Plan	Physical targets proposed for the Fifth Plan	Estimated outlays
(1)	(2)	(3)	(4)	(5)	(6)
1.	Programmes of the Department of Food (Pilot projects, food production and processing, research etc.,)	Central			50.00
2.	Programmes of the Department of Community Development (Nutrition Education and Integrated Child Care Services)	Centrally sponsored.			20.00*
3.	Programmes of the Department of Health and Family Planning (Supplementation of Vitamin 'A' iron and folic acid)	Central or Centrally Sponsored.			5.00

Distribution of outlays.

* This is clear of provisions for programmes of Department of Education and Social Welfare.

(1)	(2)	(3)	(4)	(5)	(6)
4.	Programmes of the Department of Education (Mid-day meals programme for school children)	Centrally Sponsored	12 million	4.3 million	222.00 *
5.	Programmes of the Department of Social Welfare (Supplementary feeding programme for children of 0-6 age group, pregnant women, lactating mothers in tribal areas, urban slums and chronically drought prone areas)	Centrally Sponsored	3.2 million	6.5 million	202.06 **
	Total :-				604.66
				Say :	605.00

Funding

The assumptions that form the basis for the programme-wise outlays given above are as follows :-

(i) The cost of food for supplemental feeding programmes should be treated as part of Centrally Sponsored programmes (during the period of Fifth Plan).

(ii) The cost of transport and administration for supplemental feeding programmes including those for pre-school children, school age children, pregnant women and lactating mothers should be borne by State Governments in the Fifth Plan. In the case of Mid-day Meals Programmes, this is the current pattern.

(iii) In the Fourth Plan, the health based nutrition programmes have been included in the Central Sector of the Plan. The delivery of the nutrients is, however, done by State Health agencies. In the Fifth Plan, cost involved in delivery items such as iron, folic acid and Vitamin 'A' etc., should be borne by the State Governments and the cost of the material by the Centre.

** Excluding transport and administration costs.

(iv) The production, processing and supply schemes have been the responsibility of the Department of Food at the Centre. It is suggested that the existing pattern of funding may be continued in the Fifth Plan for those programmes.

(v) It is necessary that provision for evaluation, progress reporting and research should continue to be the responsibility of the Central Government and may be included as part of the Central Sector of the Fifth Plan.

Self-Reliance

3.15 An important issue in regard to supplemental feeding is the attainment of self-reliance, eliminating, as far as possible, commodity gifts from abroad for such programmes. The commodity aid for supplemental feeding programmes are proposed to be phased out with effect from March 1974. The approach to the Fifth Plan has been worked out largely on this basis.

Summary in following paragraphs.

3.16 A summary of the main suggestions made by the various Working Groups has been attempted in the subsequent paragraphs.

Supplemental Feeding Programmes

3.17 The priority areas suggested for supplemental feeding programmes are as given below :-

(i) Slum areas of cities/towns having a minimum total population of one lakh. Within a town or city, slum areas may include those which have been declared as such by the Local Bodies and those pockets where conditions are akin to slums.

(ii) Areas covered by Tribal Development Blocks and pockets outside T.D. Blocks having concentration of tribal population.

(iii) Pockets in rural areas where mal-nutrition and under-nutrition are widespread due to prevalence of drought and famine conditions.

3.18 State intervention through supplemental feeding should be restricted to families belonging to low income groups and socially depressed sections. The following criteria has been suggested for determining low income groups :-

Urban Slums — First priority for families having a monthly income below Rs.150.

Second priority for families having a monthly income between Rs.150 and Rs.250.

Tribal areas — First priority for families having a monthly income below Rs.75.

Second priority for families having a monthly income between Rs.75 and Rs.150.

Rural Areas — First priority for families having a monthly income below Rs.100.

Second priority for families having a monthly income between Rs.100 and Rs.200.

3.19 Supplemental feeding may be undertaken for 300 days in the case of special nutrition programme and 200 days in the case of mid-day meals programme.

3.20 Experience of the feeding programme has shown that generally food is consumed by the beneficiaries on the spot only where cooked food is used for feeding. Where processed foods are used, the tendency is to carry them home where they are often shared by the members of the family. Invariably, thus, they tend to be replacements of the normal family diet, the beneficiaries largely getting only a very small portion of the food. It has, therefore, been suggested that feeding should be done under supervision at the feeding centres for children between 2 - 6 years and carry home methods may be used for expecting and nursing mothers and children below 2 years.

Nutrition Education — 3.21 Nutrition Education should form an important aspect of all supplemental feeding programmes.

Integrated Approach — 3.22 The approach to Fifth Five Year Plan should be to provide an essential package programme for the children which would include apart from supplemental feeding programmes, immunisation, deworming and a minimum of health care.

Production Programmes of Subsidiary Foods for supplemental Feeding Programmes. — 3.23 In the given situation in our country which is characterised by varied requirement in different regions and areas and different categories of beneficiaries, no single approach will meet requirements of the situation and it will be necessary to press into service all the three categories of feeding materials, (processed foods, semi-processed foods and locally available foods) but increased reliance will have to be placed

on foods which satisfy the following requirements :-

(i) Foods which lend themselves to easy distribution involving least amount of cooking.

(ii) Foods which can be standardised to ensure that they have the required quantity of protein and calories.

(iii) Those that are capable of being distributed in a limited amount of time.

(iv) Foods which would not involve the use of scarce commodities like rice, sugar, oil etc. In other words, preference should be given to the utilisation of wheat, maize, tapioca, sweet potato, groundnut flour and soyabean.

(v) They should be of simple formulations without unnecessary enlarging the type of preparation for different groups of beneficiaries.

Nutritional Guidelines

3.24 The following nutritional guidelines have been adopted for working out different patterns of production in the Fifth Plan :-

(a) Six months to one year : 200 - 300 calories and protein 10 gms.

(b) 1 to 6 years : 250 - 350 calories and 10 gms. of protein.

(c) 6 to 11 years : 400 to 500 calories and 12 - 20 gms. of protein.

(d) Expectant mothers during the last trimester and nursing mothers upto 6 months : 300 to 400 calories and 20 - 25 gms. of protein.

(e) Vitamin and mineral nutrients :-

Vitamin 'A' 200 gms.
Riboflavin 0-5 gms.
Iron (Ferrous sulphate) 10 gms.
Vitamin 'B' 12
Folic Acid
Thiamine
Calcium.

No. of days of feeding

3.25 Number of days of feeding have been calculated as given below.

200 days for school feeding and 300 days for pre-school children and for pregnant and lactating mothers during the last three months of pregnancy and first 6 months of lactation.

Allocation of Different kinds of Foods

3.26 Keeping in view the large quantities required to be produced and the fact that the existing production of these various types of foods will have to be expanded before total supply can be arranged from country's own resources, the allocations of different types of foods may be broadly on the following basis :

(i) For the entire 12 million school children the food material will consist of local varieties of Balahar.

(ii) For the programme comprising pregnant and lactating mothers and pre-school children, the arrangement visualised is as follows :-

(a) For the urban areas, the supply of food material would be in the shape of modern bread and miltone.

(b) For the tribal areas processed extruded food as well as local foods depending upon local conditions.

Balahar

3.27 The production of balahar may have to be raised from the present level of about 30,000 tonnes per annum to 2½ lakh tones per year during the Fifth Plan. The total outlay required for balahar is estimated to be about Rs.30 crores per year at Rs. 1200 per tonne. For this purpose, it will be necessary to streamline the procedure for production of balahar and also to decentralise the production in different areas.

Miltone

3.28 Considering the limitations both administrative and financial, about 50 units for production of miltone may be set up in the Fifth Plan in cooperation with the existing dairies in different parts of the country. The capacity of each unit may be of the order of about 2500 to 3000 litres per day. The total quantity of miltone that would be ava ilable would then be 310 lakh litres per year.

Bread

3.29 On the existing basis, the total quantity of bread required for 2 million beneficiaries in supplemental feeding programmes at the beginning of the Fifth Plan would

75 million standard loaves which is expected to increase to about 170 million standard loaves at the end of the Fifth Plan. In addition to the existing nine nunits of Modern Bakeries, three more units are being set up at Ranchi, Srinagar and Chandigarh with a total capacity of 7.5 million standard loaves per annum. Department of Social Welfare in colloboration with the Modern Bakeries may work out a detailed plan for setting up a chain of Modern Bakeries to cater to different areas and to meet the total quantity required to the maximum extent possible.

Extruded Food

3.30 Extruded food is already being produced in the country and feasibility studies will determine their adoption during the Fifth Plan.

Nutrition Education Extension and Mass Media

3.31 The goal of nutrition education should be to create an awareness about hygienic practices. Nutrition education has to be directed towards the whole family rather than only to the women. To greatest motivating force is the betterment of the child for both father and mother.

Target Groups

3.32 Although for nutrition feeding the target group should be pregnant women and pre-school children belonging to families living below the poverty line for nutrition education purposes it may not be possible to launch programmes only for these groups. The large population of middle classes have also to be kept in view while designing programmes of nutrition education.

Strategy

3.33 The main need of target groups is adequate quantity of diet. The strategy of nutrition education should be to improve the existing diets in the homes apart from providing supplemental feeding programmes. It is necessary that the knowledge to be given to the target group population should be of extremely simple in nature.

Agencies for Nutrition Education

3.34 Nutrition education i.e., communication of very elementary ideas on nutrition health and hygiene should be a regular routine activity at the primary health centre, family clinics and camps, Balwadis, meetings of Mahila Mandals and Yough groups, Village Panchayat meetings, primary schools and feeding centres. The para-medical staff should also communicate these elementary ideas to the people whenever they visit the houses. Cooking demonstration should be arranged at the Balwadi feeding centres and the premises of Mahila Mandals.

Integral part of Education System

3.35 Nutrition education should be an integral part of the education system of the country. This is particularly necessary at the school level. Efforts in this direction are already under way.

3.36 Nutrition education should also be an integral part of various disciplines such as agriculture, animal husbandry, social economics, social welfare, medical service etc. Nutrition education should form part of the college curriculum.

Financial Requirements

3.37 The following schemes have been suggested for inclusion in the Fifth Plan :-

(i) Integrated Child Care Services in Rural India

(ii) Nutrition Education through Mass Media Extension

(iii) Encouragement of Mahila and Yuvak Mandals for undertaking nutrition education programmes in the villages.

(iv) Organisation of Nutrition Education Assemblies in villages, blocks and districts.

(v) Imparting training in Nutrition and Hygiene to food hawkers and vendors.

(vi) Provision for Nutrition Education Cell in NCERT.

Evaluation of Nutrition Programmes

3.38 The need for evaluation has been highlighted by Dr. Ramalingaswamy Committee in their Report on Nutrition Programmes for the Annual Plan 1972-73. The Committee has observed "One of the features of nutrition programmes which impressed us is the absence of concurrent evaluation studies to find their impact. In many instances, base line studies are not available making the task of evaluation of Nutrition programmes difficult. There is need for undertaking such concurrent evaluation, both internal and external, with reference to original objectives of these schemes so that mid-Plan corrections could be carried out in time. In any case, to review these programmes meaningfully over a Plan period, such evaluation studies are urgently required".

Approach

3.39 Evaluation must not be demoralising in its approach and content. Evaluation studies should ensure objectivity, quality and depth.

Base line Surveys

3.40 Base line studies should be undertaken immediately for supplemental feeding programmes where they are not available and in all cases where such programmes are extended. This should be an essential feature of evaluation activity in the remaining period of Fourth and Fifth Five Year Plans.

Evaluation - Two types

3.41 For the Fifth Five Year Plan, there should be a provision for (a) internal evaluation and (b) external evaluation.

Provision for Built-in Evaluation

3.42 All aspects of internal evaluation should be entrusted to a group consisting of a representative of the Department implementing the programme and three other experts representing nutrition statistics and social sciences to enrich the built-in evaluation studies with the right content and focus. Such a Group should take over designing and guidance of evaluation studies from the very conceptualisation of the programme. Funds should be earmarked in the Plan programme for all major nutrition programmes in the Fifth Five Year Plan for undertaking such an internal evaluation.

External Evaluation

3.43 There should also be a machinery for external evaluation of on-going programmes for nutrition in the Fifth Plan. This machinery should have adequate support in the field. The question of selection of a suitable external agency which could take up the evaluation of nutrition programmes in the Fifth Five Year Plan was discussed. It was pointed out that the National Nutrition Monitoring Bureau of the National Institute of Nutrition, Hyderabad, could be fully utilised for the purpose.

Follow-up Action

3.44 Follow-up action in regard to evaluation reports should be undertaken on a regular basis.

ANNEXURE I

FOURTH FIVE YEAR PLAN

Schemewise outlay for the Nutrition Programme in the Fourth Five Year Plan.

S.No.	Scheme	Original outlay (Rs. in lakhs)	Revised outlay (Rs. in lakhs)	Remarks
(1)	(2)	(3)	(4)	(5)
1.	department of health and family planning	513	243	
2.	feasibility tests of vitamin and mineral fortification of staple foods	3	3	central scheme (new)
3.	pilot project for nutrition education through State Nutrition Bureaux	3	3	central scheme (new)
4.	prophylaxis against nutritional anaemia in mothers and children.	405	200	central scheme (new) (this represents rupee outlay domestically available components mainly ferrous sulphate)
5.	control of blindness in children caused by vitain 'A' ddficiency	102	40	central scheme (new)
6.	department of community development	1600	1500	central scheme (new)
7.	applied nutrition programme	1000	1000	centrally sponsored (continuing scheme)
8.	composite programme	600	500	new scheme
9.	nutrition education through mahila mandals	163	163	provision for component (9) and (10) of the scheme is expected to be in the state plan.
10.	strengthening supervisory machinery for women's programme	47	47	

(1)	(2)	(3)	(4)	(5)
11.	demonstration feeding	316		provision for parts (11), (12) and (13) is proposed to be made in the central sector.
12.	encouragement of economic activities by mahila mandals	50	290	
13.	training of associate women workers	24		
14.	department of food	1305	1301	
15.	production of groundnut flour and soyabean products	92	92	central scheme (continuing)
16.	production of balahar and low cost protein foods	670.57	645	central scheme (continuing)
17.	production of weaning food	20	20	central scheme (continuing)
18.	pilot plant for protein isolate and protein isolate toned milk.	40	30	central scheme (continuing)
19.	cotton seed flour	15	3	central scheme (new)
20.	fortification of wheat products	50	50	central scheme (new)
21.	fortification of salt	32	4	central scheme (new)
22.	fortification of bread	1	1	central scheme (continuing)
23.	audio-visual aids and publicity	30	22	central scheme (continuing)
24.	extension work through voluntary agency			

(1)	(2)	(3)	(4)	(5)
25.	mobile food and nutrition extension units	80	80	central scheme (continuing)
26.	nutrition and dietary syrveys			
27.	studies in acceptability of nutritious foods			
28.	formulation of low cost diet through linear techniques			central scheme (new)
29.	drying of groundnut and control of aflatoxin	20	1.80	central scheme (new)
30.	community canning and fruit preservation centres.	45.2	42.07	central scheme (continuing)
31.	production of peanut-butter	1	1	central scheme (continuing)
32.	institutes of catering technology and applied nutrition	62.8	75	central scheme (continuing)
33.	research scheme	10	5	central scheme (new)
34.	maize, pulses and millets processing *	8	*	central scheme (new)
35.	food technology training centre	39	47	central scheme (continuing)
36.	fruit products and cold storage scheme	57	15	central scheme (new)
37.	education through modern bakeries	15	15	
38.	upgrading of laboratories and directional expenditure	16.45	16.43	

* This scheme is now shown in the Agriculture Sector.

(1)	(2)	(3)	(4)	(5)
39.	department of education	500	500	
40.	school feeding	500	500	state sector
41.	department of social welfare	600	500	
42.	nutrition feeding pre-school children through balwadis	600	500	central sector
. .	Total (1+6+14+39+41)	4518	4047 **	

** addition, the Department of Social Welfare is lementing the special nutrition programme with ct from 1970-71. The total provision in the h Plan for this scheme is expected to be of rder of Rs.60 crores.

Appendix I

Names of the Members of the Steering Group on Health, Family Planning and Nutrition for the Fifth Five Year Plan

Shri Mohan Dharia, Minister of State for Planning	- Chairman
Prof. S. Chakravarty, Member, Planning Commission	Vice-Chairman
Shri Asok Mitra,	Member
Shri P. P. Agarwal	Member
Shri M.K.K. Nayar, Jt.Secretary, Planning Commission	Member
Shri K. V. Natarajan,	Member
Shri C. S. Ramachandran, Secretary, Ministry of Health & FP	Member
Dr. J. B. Srivastav, Director-General of Health Services	Member
Dr. P. Diesh Commissioner Rural Health	Member
Dr. Miss L. V. Phatak, Ex-Commissioner(FP)	Member
Dr. Rafiq Zakaria, Health Minister, Maharashtra	Member
Thiru K. Anbazhagan, Health Minister, Tamil Nadu	Member
Dr. V. Ramalingaswami, Director, All India Institute of Medical Sciences, New Delhi	Member

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Dr. P. N. Wahi, Director-General, ICMR	Member
Dr. C. Gopalan, Director, National Institute of Nutrition Hyderabad	Member
Lt. Gen. Ved Prakash, AFMC	Member
Dr. C. Satyanarayana Madras	Member
Dr. J. S. Raman, Mysore	Member
Pt. Shiv Sharma, President, Central Council of Indian Medicine & Chairman, Scientific Advisory Board, Ayurveda	Member
Dr. Shantilal C. Sheth, Bombay	Member
Dr. Banwari Lall, Chief(Health)	Convenor