

**MUKERJI
COMMITTEE
REPORT**

(PART II)

- 1968 -

REPORT OF THE BASIC HEALTH SERVICES

INTRODUCTION

1.1 In 1963, a Special Committee was appointed by the Government of India under the Chairmanship of the then Director General of Health Services to study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme. This Committee, popularly known as the Chadha Committee, recommended a certain measure of strengthening of the rural health services which, apart from providing certain other basic health services to the rural population, could also take care of the maintenance phase of the National Malaria Eradication Programme and gradually also of the other mass campaigns, such as smallpox eradication, when these entered the maintenance phase. The pattern of the basic health service recommended by this Committee was accepted by Government. The 1963 Reorganised Family Planning Programme and the staff added on its account were to function in an integrated manner with the rest of the basic health service.

1.2 With the increasing importance of the Family Planning Programme and the necessity to implement this programme as a crash programme all over the country as speedily as possible, the need became apparent for reviewing the 1963 Reorganised Family Planning Programme and its strategy. The Central Council of Health at its meeting held on the 31st December, 1965, in Madras appointed a Committee under the Chairmanship of the Union Health Secretary to undertake this review. This Committee, popularly known as the Mukerji Committee, while recommending the strengthening of the administrative set up at different levels from the Primary Health Centre upto the State Headquarters, also recommended some extent of delinking of malaria maintenance activities from Family Planning in order that the latter could receive, undivided attention of its staff and could be carried through as a crash mass programme. Since at the present stage, in the blocks that are or soon will be in the malaria maintenance phase, the activities connected with malaria maintenance form the principal items of work of the basic health service, the recommendations of the Mukerji Committee pointed also to the need for a further review of the basic health service so as to ensure that it would be in a position or develop to be in a position to take the additional maintenance responsibilities and when other mass programmes such as malaria eradication, smallpox eradication, control of T.B., Leprosy, Filariasis, Trachoma, reached the maintenance stage or could be otherwise integrated in the basic health service. The general question that still seemed to require detailed consideration was how in these mass programmes which have to be provided with special staff and inputs for the attack and consolidation phase, the transition can be made from these to the maintenance phase. This question came up in the 13th meeting of the Central Council of Health held in Bangalore on the 25th June where it was also revealed that under the pattern of financial assistance given by the Central Government to the State Governments, a burden was being thrown on the latter in the maintenance phase of malaria which they were finding extremely difficult to carry and was endangering the stability of the malaria maintenance programme and, therefore, a review of the position was also necessary. It was also revealed in this meeting of the Council that under the present system, the mass programmes, particularly the malaria and Smallpox Eradication Programmes, were not being assured of adequate attention during the maintenance phase in the urban areas of the country which also may endanger the continued success of these programmes even in the rural areas. The council, therefore, recommended that these questions may be examined by a Committee consisting of the Health Secretaries of Assam, Andhra Pradesh, West Bengal, U.P. and Punjab with the Union Health Secretary as the Chairman. The order of the Government constituting this Committee is shown in Appendix I.

1.3 The Committee had its first meeting in Delhi on the 11th July, 1966, and its second meeting in Calcutta on the 25th and 26th July, 1965. The list of persons who participated in these meetings is shown in Appendix 2. In the first meeting, the Committee discussed and formulated the general approach, and principles which, in their opinion, should be followed in building up the basic health service in the country. In its second meeting, the Committee worked out the details of the basic health service which should be provided at the block level and some consequential strengthening at higher levels. It also discussed and formulated its views as to how the urban areas of the country could be duly taken care of and what should be the pattern of Central Assistance to the States for supporting the basic health service. Thereafter a draft report was prepared by the Chairman and circulated among the members of the Committee. The Committee had its third meeting at Delhi on 20th September and considered the comments given by the Department of Family Planning expressing certain doubts regarding some of the suggestions made in the draft report for the integration of the family planning programme with the general health programme. The Committee also considered the comments of the Additional Director General of Health Services and of the Health Secretary of Assam and of the Health Secretary of West Bengal (conveyed on the trunk telephone to the Union Secretary of Health), who could not attend the meeting. The persons who attended this meeting are also shown in Appendix 2. The Chairman was authorised to finalise the report after making the necessary changes in accordance with the decisions taken in this meeting. In the sections that follow the recommendations of the Committee have been set out somewhat briefly not at any attempt to elaborate their viewpoints more than is necessary to justify them, to avoid the report becoming unduly long.

1.4 The Committee take this opportunity of recording their appreciation of the work of Dr. P.R. Dutt who functioned as the Secretary of the Committee and gave it considerable assistance by collecting the necessary material and preparing a record of the deliberations of the Committee.

SECTION I

General approach and Principles

2.1 After careful consideration, the Committee decided that in proceeding to work out the details of the basic health services for the rural areas, they should be governed by the following approach and general principles,

2.1.1. The approach should be entirely practical, taking into account the very tight financial position that has come to exist today and is likely to continue for quite some time. Due consideration should also be given to the inadequacy of manpower resources and the administrative limitations which exist today and which can be surmounted only over a period of time. But in formulating their recommendations the Committee should, aim at suggesting a framework and pattern of development by adhering to which a comprehensive Basic Health Service could be gradually developed for the whole country, providing for an integrated approach to the problems of public health and medical care, a growing programme of service to the people gradually extending to the whole field of health, and a developing instrument of service on well-conceived lines.

2.1.2 While the objective of gradually building up a comprehensive Basic Health Service in the entire country is important and must be steadily pursued, it would be quite impractical to attempt to do this all at once, both because of inadequacy of resources and also because

it would not be desirable to have a bigger instrument of service at any stage than would be warranted by the programmes under active implementation with necessary financial and other input supports assured for them. It may be stressed at the very outset that the concept of the Basic Health Service should be primarily related to the service rendered in the health field to individuals and the community and only secondarily to the instrument or the organization needed for rendering that service. Any staff that is put in position should have specific and concrete items of work to do, which should be related to clear objectives aimed at under the different, programmes under active implementation, and, in respect of which the performance would be capable of being tested, with reference to the results produced. If this is not assured, there can be both infructuous work as well as frustration among workers and the people alike. Even the programmes of health education and health intelligence must generally fulfil these requirements, It is important in health programmes and more so in health education, that there, should be growing people's participation. In the circumstances of our country, such participation can only be promoted around active programmes undertaken by Government or with their assistance. We should guard against creation of more demands by the people on Government which the latter may not immediately be in a position to fulfill on account of financial and other limitations. Keeping these considerations in view, in the Committee's opinion, the principal programmes that at present should be taken care of by the basic health services are maintenance phase of malaria eradication and smallpox eradication, family planning, health intelligence including vital statistics and health education, the latter two to be limited largely to the requirements of the programmes in hand or in immediate contemplation.

2.1.3 The concept and technique of the domiciliary service has to be promoted and increasingly applied in the development of the basic health services so that through these the health needs of the people can be increasingly met; and this can be done only gradually with growing people's education and participation and improvement in their socio-economic status. In the stage in which we are at present, periodical visits to each family by the basic health worker will still be necessary, but it can be only for the limited purposes related to the programme actively under implementation at present. Even so, these visits and the work to be done through them will take the bulk of the time and will account for the bulk of the work that the Basic Health Worker will be performing now and will, not leave him much time for other items of work which will have taken up in increasing numbers in future, too. Develop a comprehensive Basic Health Service for the rural people. But it would be futile to provide for spare capacity in the basic health services today for taking *care* of these other items of work since the programme support for these would not. Just now be available. In the opinion of the Committee, it is possible that in due course the pattern of work of the basic health services will change. This would be so as people's education and participation, will grow and their socio-economic condition will improve Health Education can and should promote this development. Methods of work will also improve and so also transport facilities. As the health conditions in the rural areas improve, the actual work-load connected with many of the functions of the basic health services will tend to diminish. Later in this report (paragraph 3.39) we have suggested how some of the additional, auxiliary health staff which, is or will be taken for certain programmes, such as trachoma, cholera and leprosy can be integrated in the basic health service.

2.1.4 The Committee would like importance be attached to an integrated approach in the entire health fields programmes of public, health and medical care should be integrated to the maximum extent possible and so also the programmes within each field. An integrated organization should be developed, at every level of operation

and supervision, for the entire health programme. Health workers at the lower levels should become increasingly multipurpose workers. In certain phases of any large national programme it may be necessary to have for it separate staff and other inputs, at the maintenance stage the activities under the programme should get integrated more and more with the basic health services and to the extent possible should be taken care of through the domiciliary service, which, as has been stated earlier, should gradually be developed into an important method for taking care of the health of the rural population in our country. In this integration, however, there has to be ensured adequate attention to different programmes, and avoidance of neglect to any. This objective can be secured by proper organisation, allocation of work, system of supervision and by balanced planning. With the considerable experience that has been gathered and well documented in the course of implementing so very successfully the gigantic programme of malaria eradication, this task should not be difficult to perform. Since the Family Planning Programme has yet to become in actual operation a crash mass programme, for the present it should continue to function somewhat separate in identity from the basic health services, in accordance with the recommendations of the Mukerji Committee. This Committee, however, does recommend that at a later stage, not long from now, there can and should be a much greater integration between the Family Planning and Maternity and Child Health Programme and the basic health services, than is being necessary for the present in this report. Even at this stage the Family Planning/M.C.H. programme does include the primary smallpox vaccination of the new borns delivered by or under the supervision of the Auxiliary Nurse Midwife. The Committee are aware that this view had been questioned to some extent by the Department of Family Planning. The anxiety is that at the stage in which the Family Planning Programme is at present, it has to be a single purpose programme for a large number of workers and any hasty integration of this programme with the rest of the health programmes may impede the rapid expansion of the Family Planning Programme that is so vitally necessary for the country. The Committee considered this view carefully at its last meeting and came to the conclusion that none of the specific recommendations that have been given in this report for integration between Family Planning and the rest of the basic health services is likely to have any adverse effect on the progress of the Family Planning Programme. On the contrary, many of these recommendations point to the practical ways of securing greater collaboration between the workers on the health and family planning sides which will be to the mutual advantage of the programmes on the two sides. It has been admitted, by all that Family Planning has to be an integral part of the health programme. None of the recommendations of the Mukerji Committee questioned this basic position nor did that Committee recommend any general approach of separation between the family planning and the rest of the health programme. It only recommended a certain measure of strengthening of the necessary on by addition of personnel and changes in the functions of some of them at the Primary Health Centre level and at higher levels to ensure adequate support for the Family Planning programme to bring about a closer relationship and interdependence between the two sides of the overall health programme as soon as possible. It is with this objective in view that the specific recommendations for the integration of the two programmes or collaboration between the workers on the two sides have been made in this report,

2,1,5 Importance must be given to due strengthening of the supervisory levels to correspond to the strengthening of the base necessary on. This is particularly necessary for the basic health services since the quality of the performance of the functionaries at the base level, who have to be comparatively more numerous but cannot be so well paid nor of very high caliber nor technically so well equipped, will determine greatly the quality of the whole service and the benefits derived therefrom by the rural people. Supervision of their work has, therefore, to be particularly strong and continuous. This supervision must be both administrative and technical, must be adequate both in degree and quality and must not be confined only to exercise of control but must extend also to providing help and guidance.

2.1.6 Equally important it is to ensure that the staff at all levels are provided proper facilities of work are given office and residential accommodation, and supplied necessary equipment, transport etc., so that we can get the best out of the staff.

2.1.7 Even today it is necessary and should be considered a matter of some importance to bring in other existing governmental staff and the institution and local leaders to lend a helping hand to the basic health services and this would be more necessary in future which when the work load on the basic health service will increase on new items or work being entrusted to them as and when other mass programmes enter the maintenance phase. It should be possible for the community development staff, school teachers, panchayat secretaries, leaders in the Panchayati Raj Institutions, workers of mahila mandals and other people's institutions to give assistance to the Basic Health Workers in various ways, such as, in educating the people, creating favourable public opinion, and in organizational work of various kinds. The possibility of this has not been as actively investigated and pursued so far as should be our objective. It would, indeed be a mistake to try to build up the basic health services in isolation of the rest of the administrative machinery functioning at the base level or to fail to take advantage of the people's institutions that are being actively promoted in pursuance of the objective of democratisation of the rural countryside and promoting people's participation in developmental activities.

2.2 It may be made clear that the basic health services will be generally responsible only for the maintenance phase of the mass programmes of disease eradication or control. This will mean that as each programme gradually passes into the maintenance phase, residual or continuing work connected with it will devolve on the basic health services. This will present the problem of transition from the attack and consolidation phases to the maintenance phase. That will have its bearing on the programme of activities and mode of their implementation on the organisation, its strength, composition and method of functioning, and on questions of planning and financing, particularly of Central assistance for the States. Although all mass programmes of eradication or control of communicable diseases will not have the exact parallels to the "attack", "consolidation" and "maintenance" phases of the malaria eradication programmes most of them will in the course of their implementation, some sooner than others, reach a stage analogous to the maintenance phase of malaria when they can and should be integrated with the basic health services, both organisationally and programatically. At what stage and in what manner which integration can and should be made in the case of each programme should be carefully determined; it will have to be governed both by technical and administrative considerations. The integration may be made at different levels and in different areas within the same state at different stages. The technical and administrative factors will vary with different programmes. It may be mentioned that for the control of leprosy, tuberculosis and trachoma an integration at certain levels has already been effected. The leprosy control work visualises specially trained non-medical staff posted at the primary health centre for case finding, case recording and other work. The methodology for trachoma and cholera control programmes envisages strengthening the basic health services in the malaria maintenance areas with an additional basic health worker. Similarly, the tuberculosis control programme has also been partially integrated with the basic health service since the Primary Health Centre staff is being used, for case detection, treatment and contact investigation. Experts should work out the kind, and degree of maintenance services that will have to be performed in the maintenance phase of the different mass programmes, the work load in each case, staff coverage needed, training needs, requirements of supervision, laboratory facilities, transport etc. This will need, a considerable amount of forward planning of which some mention has been made in later paragraphs. Some technical criteria, as in the case of malaria, will have to be worked out to determine when any mass programme reaches the stage in any area ripe for integration in the basic health services.

2.3 Keeping in view the general principles mentioned above, the development that should take place in future, and the existing limitations of finance and administration, the committee have aimed at recommending for the present a minimum nucleus service which should be capable of handling the present actual load of work connected with programmes actively under implementation, but taking care that structurally and in composition this nucleus should be capable of expansion as work expands and more resources become available. This Committee, therefore, recommends that there should be a periodical review of the basic health services for the purpose of seeing how it should be strengthened and further developed from time to time. Lest this recommendation of a periodical review gives rise to any apprehension of uncertainty regarding the future development of the basic health services, we add that the concept and pattern of this service recommended by us would not be changed by the reviews. In fact, as has already been said, an important objective which the Committee has had in mind has been to recommend a concept, pattern and methodology for promoting the long term development of the basic health services.

SECTION - 2

Composition and organisation of the Basic Health Service

Primary Health Centre Level

3.1 Keeping in view the general approach and principles explained in the previous section, the Committee considered in great details what should be the strength and composition of the Basic Health Service at the present stage. Due account was taken of the need for ensuring a high degree of vigilance that is essential for guaranteeing that the substantial achievements that have been registered in the eradication of malaria in these areas that have entered the maintenance phase will be preserved. The Committee went through very carefully the details of the task that must be performed in pursuance of this objective and the work load that will be thrown on the basic health worker. In this connection the views expressed and recommendations made by the W.H.O, Expert Committee on Malaria in their twelfth report were duly considered by the Committee and fully accepted, that a high degree of vigilance should be maintained in the maintenance phase of malaria. The Committee recognised the need to give this work first priority and that domiciliary visits to every family once a month was necessary if this work was to be properly performed. In the consolidation phase, the basic health worker is required to visit every family twice a month. There was considerable discussion as to whether by being required to visit every family only once a month instead of twice, the work load of the basic health worker will not be halved to enable us to reduce substantially the number of basic health workers per block. Some took the view that one visit per month may not be adequate for the purpose of malaria vigilance; but it was recognised that if the visits were to be made more frequent, the basic health worker will be left with little time for any other work unless his population coverage was greatly reduced thus requiring many more basic health workers per block. The consensus of opinion was that the, calculated risk could be taken of only one visit a month provided, at the same time, the supervision on the work is improved and the laboratory and epidemiological services strengthened. The Committee accepted this view and came to the conclusion that it should be possible for the basic health worker, to take due care of malaria vigilance by paying one visit a month to every family within his jurisdiction and this should leave him some spare time to attend to the other tasks that, at the present stage, he should be required to attend to. These other tasks would be attention to smallpox work in those areas where the programme has reached a stage analogous to that of the maintenance phase, and to health education and health intelligence including vital statistics. And lastly, the basic health worker should carry the message of and some information about family planning to the families he visits, but without being made specifically responsible for such work as organising camps, distributing contraceptives, taking motivated persons to camps or static centres for receiving the needed service. The reason why at this stage in the implementation of the family planning programme, some separate staff is needed has been mentioned earlier. The same purpose cannot be served by requiring the basic health worker to participate more fully in the family planning programme than what the Committee recommend as would be served by having some separate staff as has been recommended by the Mukerji Committee. Any attempt to give the basic health worker more work under the family planning programme would either endanger malaria vigilance work or there would need a larger number of basic health workers per block than what the Committee have recommended. The latter course will add to the cost and will still remain inadequate for the purposes of the family planning programme in its present stage of implementation. The Committee do, however, as has already been mentioned earlier, visualise the possibility of greater integration after some time of the family planning programme with the programme of the basic health service at the block level.

3.2 The Committee recommend that there should be one basic health worker for a population of 10000 in normal areas but in areas with difficult terrain or very sparse population, the population coverage per basic health worker should be suitably reduced. In making this recommendation, the Committee have taken into account the recommendation of the earlier Committee, the Mukerji Committee, that there should be one basic health worker for a population. In suggesting an increase in population coverage, the Committee took into account the great need for economy as also more fully and in a much more detailed way the actual work load that will have to be carried by the basic health worker at this stage. It would be necessary to lay down in details the job chart of the basic health worker. The job chart should consist of specific and concrete items of work which should be related to clear objectives aimed under the different programmes under active implementation and it should ensure adequate attention to the different fields of work. The Committee wish to emphasise this latter condition, but are satisfied that it is capable of being fulfilled in terms of the total work load that will fall on the basic health worker under the Committee's recommendations. It could also be taken care of through supervision of the work of the basic health worker.

3.3 The Committee recommend that a leave and training reserve of 5% of the total number of basic health workers should be provided. This is particularly necessary because the reduction in the total number of basic health workers now suggested, and the work, is bound to suffer to an extent as can endanger the malaria vigilance work if there is no leave and training reserve to provide for substitutes when persons go on leave or are withdrawn from active duty for purposes of training. About the importance of training, mention has been made later. In fact, the Committee were of the opinion that a 5% leave and training reserve was very much on the low side but again for the compelling need for economy they have suggested this somewhat low percentage to begin with. The position should be reviewed after some experience has been gathered

3.4 The Committee recommend that for every four Basic Health workers, there should be a health inspector who should provide close supervision and guidance to the Basic Health Workers. He should be in addition to the existing Sanitary Inspector already provided in the staffing pattern of the Primary Health Centre. About the importance of supervision and of what nature it should be, mention has already been made earlier; supervision becomes more important because the number of basic health workers recommended by this Committee will be smaller than would have been under the recommendations of the Mukerji Committee. The existing Sanitary Inspector provided for the Primary Health Centre should concentrate on environmental sanitation.

3.5 A clerk should be provided for the Primary Health Centre. He should relieve the Medical Officer of all clerical work, such as preparation of a large number of reports and returns required by the State Governments, writing the daily out-patient attendance register, the names and addresses on prescription etc.

3.6 The Committee would like to make the general recommendation that the technical staff, particularly the medical staff at all levels should be relieved, as much as possible, of administrative, routine and clerical work by providing non-technical workers for taking over such work. The Committee would suggest that a detailed study may be made of this subject,

3.7 The staff recommended above will be in addition to the ^ normal staffing pattern of the Primary Health Centre and sub-centres and the staff sanctioned under the Family Planning Programme. All the staff should work under the overall control of the Medical Officer of the Primary

Health Centre, and there should be as much co-ordination and collaboration in their working as possible. In particular, there should be one single office for the Primary Health Centre for all the staff including that for Family Planning. The following services should be common for both the health and family planning sides:

Health Education, Health Intelligence and
Statistics, Laboratory Services and Training.

3.8 The Medical Officer of the Primary Health Centre should devote sufficient attention to supervising the work of the Basic Health Workers and the Health Inspectors, which is generally not the case at present,

3.9 The Committee feel that wherever in a block there is also a Medical Officer for Family Planning, it should be possible, without detriment to the Family Planning, work, for the Medical Officer of the Primary Health Centre and the Medical Officer for Family Planning to so distribute the total work among themselves that both of them can attend to some medical care work at the Primary Health Centre, some work of family planning and some work connected with supervision of the Basic Health Workers and the Sanitary Inspectors, During tours the Primary Health Centre doctor can supervise the work of the Family Planning Health Assistants, Lady Health Visitor and Auxiliary Nurse Midwives and the Family Planning doctor can supervise the work of the Basic Health workers and Health Inspectors. At the final meeting of the Committee some doubt was expressed by the representatives of the Department of Family Planning of the Ministry of Health that the proposed arrangement may work to the disadvantage of the family planning programme and may even be used as an argument by some State Governments to have only one doctor in the Primary Health Centre to attend to all work. After fully discussing this point the Committee still remained of the view that the arrangement suggested by them could be easily worked in a manner as would be to the advantage of both, the family planning and general health programmes. It will give greater job satisfaction to both the doctors, reduce the monotony of work of the family planning doctor and get greater outturn of work from both during their tours of the villages. It will be altogether a more rational arrangement. The Mukerji Committee had also recommended periodical interchange of duties of the Primary Health Centre staff with these of the staff of the mobile units (see paragraph 2.15 of the report). All the same, we will emphasise the need for ensuring that the Family Planning Programme does not suffer in any way.

3.10 The Committee recommend that if for a block a Lady Medical Officer or a male doctor to take her place is not available, the posts may be filled on a temporary basis by a Public Health Nurse or a nurse with public health training or by just a nurse or a Lady Health Visitor. If none of these are available then a Sanitary Inspector could be appointed until a Lady Medical Officer is available. If there is only single doctor at a Primary Health Centre his burden will be very heavy and any of the substitutes for a Lady Medical Officer will be able to render some help to the male medical officer in matters connected with family planning, maternity and child health, school healthy immunisation programme etc.

District Health Organisation

3.11 A mention has already been made of the need and importance of adequate supervision, help and guidance that should be given to the basic health service at the peripheral level. From this point of view, the District Health Organisation has to play the most important role. Apart from general field supervision of the work of the basic health services functioning at the Primary Health Centre level, the organisation

at the district level has particularly to give support to the peripheral staff in conducting epidemiological investigations and ensure that remedial measures are quickly taken in the laboratory work at the Primary Health Centre level, and by providing the necessary consultative and referral service in all the principal fields of medical and health care, namely, maternity and child health" including family planning and nursing, health education, laboratory work, environmental sanitation, epidemiological intelligence and communicable diseases control, health intelligence and statistical service.

3.12 For adequately discharging these responsibilities, the District Health Organisation, including the hospital and other ancillary services, has to be gradually strengthened by being adequately staffed ii including specialists in various branches, by being adequately equipped with X-ray, laboratory and other diagnostic facilities, and by being provided with adequate ambulance and transport facilities, dental unit, blood transfusion facilities, facilities for treatment of mental cases etc. The Committee recognise that with the limitations of finance, shortage of personnel and other limitations, the strengthening of the District Health Organization can only be promoted gradually. But it does need, to be stressed that the gradual strengthening of the District, Health Organisation and its coming closer to and giving increasing support to the peripheral organisation and a growing integration of public health and medical care must be regarded as very important aspects of the development of the Basic Health Service,' It has already boon amply demonstrated that the public health activities including the mass disease control programmes, increase rather than reduce the pressure on the medical care services,

3.13 Recognising the limitations, at the present juncture and having indicated the general lines of development that should continue to take place, the Committee wish to make the following recommendations In regards to the District Health Organisation for early implementation.

3.13.1 The Head of the Organisation should be a Chief Medical Officer of Health who should be a whole time non-practising medical officer with training and experience in community organisation, in health administration and planning and preferably also in hospital administration. But he should not be given any clinical responsibility in the District Hospital, He should have two deputy chief Medical Officers to assist him, one for Family Planning and the other for Health, The District Family Planning Officer should be redesignated as the Deputy Chief Medical Officer (F,P.). Although his primary responsibility would be for Family Planning, as we have recommended earlier, it should be possible to have some coordination and sharing of work between him and the Deputy Chief Medical Officer (Health), without detriment to the work of family planning. Both officers would work under the overall control and supervision of the Chief Medical Officers of Health. The Mukerji Committee had also recommended (vide para 2.16) that there should be some administrative arrangement at the District level whereby proper coordination would be established between the District Civil Surgeon, the District Health Officer and District Family Planning Officer. If necessary, the senior most among them could be put in overall charge of the entire health and family planning programme in the District, but only for the purpose of effecting the necessary co-ordination. The present suggestion that it should be possible to have some co-ordination and sharing of work between the Deputy Chief (Health), both working under the overall supervision of the Chief Medical Officer of Health, is in this Committee's opinion; only taking the process of coordination a little farther than what was suggested by the Mukerji Committee and it should help the programmes of both. The recommendations of the Mukerji Committee that the District Family Planning Officer (now proposed to be called the Deputy Chief Medical Officer (F,P.) should be a Class I Officer, should be given a special pay and 'Should have the authority to correspond directly with the officers

at the State Headquarters (vide paras 2.14) are not to be affected by the recommendations of this Committee.

3.13.2 The Committee would wish to emphasise again that at the District level there should be as much integration of the general health programme with the family planning programme as possible, ensuring at the same time, however, that the family planning programme continues to receive adequate attention, and profits from such integration. In particular the Committee recommend that there should be only one office under the Chief Medical Officer of Health which should serve as the office for both the Health and Family Planning sides and that the following services should be common for both sides:

Health Education, Health Intelligence and
Statistics, Laboratory Services and Training,

3.13.3 This arrangement has also been suggested at the Primary Health Centre level. This is not to suggest that individual functionaries sanctioned for the units that will provide these services cannot still have separate and primary responsibility for the family planning or the health programme as the case may be. For example, the Health Education and Information Officer at the District level or the Extension Education (F.P.) at the Block level will still have Family Planning as their primary responsibility. What is suggested is that there should be only one unified unit for Health Education in the Primary Health Centre and District Organisation and all the staff equipment etc., need not be duplicated. There is obviously great need for coordination in the entire field of health education extending both to the fields of family planning and general health programmes. The same observations will apply to Health Intelligence and Statistics etc. The Mukerji Committee had pointed to the need for supplementing the effort of the Health Education Officer for family planning at the State level by that of the State Publicity/Public Relations/information Department and so also of the Statistical Division of Family Planning by that of the State's statistical Bureau (vide Paras 2.10 and 2.12). That this Committee is suggesting is a further application or extension of the same principle or coordination and collaboration.

3.13.4 Following from the general principle mentioned earlier, to which the Committee would wish considerable importance to be attached, that medical and technical officers should be relieved as soon as possible and to the maximum extent possible of administrative and non-technical work which non-technical persons can easily and often better perform, the Committee recommend that there should be an Administrative officer in the office of the Chief Medical Officer of Health who should relieve him and the Deputy Chief Medical officers of all non-technical and routine, duties connected with administration, accounts work etc. He should be a gazetted officer of appropriate status. The Mukerji Committee too had recommended that there should be an Administrative Officer of the rank of Sub-Deputy Collector/Tehsildar of the State Service who should look after general administration, stores and accounts, we would suggest now that the administrative section should be a combined section both for the Health and the Family Planning sides and with suitable upgrading in the rank of the Administrative Officer and with necessary supporting assistance given to him, it should be possible for a combined administrative section under one Administrative Officer to adequately look after the administrative, accounts and other work on both sides. The Administrative Officer may be of the rank of a Junior State Civil Service Officer and to the staff suggested by the Mukerji Committee for the District Family Planning Bureau may be added one more U.D, Clark, one Assistant Accountant and another cashier. We wish to make it clear that this staff should be in addition to the staff that may be

already sanctioned for the District Health Office. For accounts work, it might be advisable to have two separate units under the Accounts Officer, one for the Health side and the other for the Family Planning side, since the budget provisions for the two sides would be separate and separate accounts would, therefore, have to be kept. Also the accounting work on the family planning side will be heavy and somewhat complicated.

3.1315 The Administrative Officer should have experience in General Administration, and it would be an advantage if he is given some special training of a short duration in Health Administration.

3.1316 The Chief Medical Officer of Health should plan all health activities in the District, co-ordinate the basic health services with hospital referral and consultation services, so that a comprehensive Basic Health Service gradually develops in the whole district. With due relief from administrative and routine work, the Chief Medical Officer and the Deputy Chief Medical Officers must devote considerable time to supervising the field activities under the different programmes. The Chief Medical Officer should have some specific functions of his own (the distribution of functions between him and the Deputy C.M.O.s. may be arranged between them) and he should not function only as a higher tier of supervision and authority above that of his Deputy C.M.O.s. Although he will also have to perform some supervisory functions in regard to the work of the two Deputy Chief Medical Officers C.M.O.s of Health should also be in charge of Drugs Control and Prevention of Food Adulteration. Increasing attention should be given to these two fields of work and they should come to be regarded as essential public health activities. To give the C.M.O. Health necessary assistance in this work, which will be quite considerable, some staff will have to be specially sanctioned according to the need of each district. The Deputy C.M.O.(F.P.) should concentrate on the family planning work, The Deputy C.M.O., of Health should, be primarily responsible for communicable disease control, particularly malaria and smallpox at the present stage, and the other general health work of the district. Between the Chief Medical Officer and the Deputy- Chief Medical Officer (Health) should be distributed the work of adequate supervision of the hospitals and dispensaries and the Primary Health Centre, other than the District Hospital, (The role of the C.M.O. vis-a-vis the District Hospital has been mentioned in paragraph 3.22). Till such time as the Public Engineering Service is not strengthened at the District level, (as recommended in paragraph 3.21) the Deputy C.M.O. (Health) should look after environmental sanitation,

3.15.7 For a more detailed supervision of the work of the Basic Health Workers and the Sanitary Inspectors working at the Primary Health Centre level, the Deputy C.M.O.(Health) should be assisted by one Health Supervisor for every 10 Primary Health Centres. Where there are less than 10 Primary Health Centres in any district, there should be at least one Health Supervisor, He should be a graduate with trainings and experience in Public Health work. For the present, the post should be filled from among non-medical Unit and Assistant Unit Officers (H.M.E.) or by a Health Inspector who is a graduate and has done a year's adv: course in Sanitary Engineering. Later on, the post should be filled graduate in Public Health or Sanitation.

3.13.8 Since a large number of Auxiliary Nurse Midwives or nurse will be employed in Maternity and Child Health and Family Planning, there is a need for a Nursing Supervisor at the district level who will supervise the M.C.H. *and* Family Planning work and the nursing and immunisation services in the district, including these in the Primary Health Centre but excluding the District Hospital Nursing Service. This post of Supervisor should be included in the family planning programme although she should naturally co-ordinate her work with the rest of the health programme.

3.14 The Committee considered that it is necessary to strengthen the Public Health Engineering Service at the district level. This is a basic preventive service, yet adequate technical guidance is generally not available in this field at the district level. The protected water supply and sanitation schemes have been given high priority in our plans and are going to receive further impetus in the Fourth Five Year Plan. There is, therefore, great need for strengthening the Public Health Engineering Service at the most vital level of implementation i.e. the district level, recognising however, the fact that qualified Public Health Engineers may not be available in adequate numbers to provide one for each district, which, in any case, will also be a costly arrangement, and recognising also the possibility that the existing workload may not justify a whole time Engineer for every district, the Committee recommend that one qualified Public Health Engineer of district rank may be employed for two to three districts suitably grouped. These Engineers should be assisted by a Sanitary Supervisor i.e. a senior Sanitary Inspector's Course. The Unit under the Public Health Engineer should also co-ordinate and guide the work of the engineering establishment under the Panchayati Raj institutions and ensure that the water supply and sanitation programmes of the different agencies are implemented in a co-ordinated manner over the entire district.

District Hospital

3.15 The Committee recommends that the district hospital should be under a Medical Superintendent who in most cases can be selected from among the Specialists in the Hospital. He should discharge the functions of the Superintendent in addition to his clinical duties. Although the Chief Medical Officer of Health of the district will exercise overall supervision on the working of the District Hospital, he should have very little to do with its day-to-day management, nor should he have any clinical responsibilities in the hospital. The C.H.O.'s role of supervision and coordination will come in particularly in those matters where the District Hospital will have a role to play in the basic health services as for example, diagnostic and referral service which the hospital can perform for the Primary Health Centres. The passive surveillance work which it should do in the Malaria Eradication Programme. Particular importance should be attached to providing the -clinical services for family planning and the C.H.O. assisted by the Deputy C.M.O. (Health) should take special interest in this matter and ensure that all the hospital and other medical institutions in the, district make their maximum-contribution to family planning.

3.16 In the case of the District Hospitals also, the Committee would strongly recommend that except in the case of very small district hospitals, the Medical Superintendent should be assisted by a non-medical hospital administrator who will relieve him of all administrative and routine duties which should not be allowed to come in the way of discharging his professional responsibilities. The hospital administrator should be of suitable rank depending on the size of the hospital.

State and Central-Organisation

3.17 The Committee did not attempt to work out any details of the organisation that would be needed above the District level, i.e. at the Zonal, the State..and the Central levels, for giving, the necessary support and guidance to the basic health service of the concept and pattern and having the objectives that the Committee have recommended. The strength and composition of the organisation and other arrangements existing in the different States vary considerably, The extent to which the basic health service of the kind being recommended in this report can be developed immediately in the different States will also vary

considerably. Any attempt, therefore, on the part of the Committee to make detailed recommendations of the additions or changes in the organisation and methods of working that should be introduced at the Zonal and State levels would have required very detailed study of the existing organisation and the scope for developing the recommended pattern of basic health service in each State. The Committee, therefore, refrained from going into this subject. They also felt that the State Government could themselves work out better the strength and pattern and method of functioning of the health organisation at the Zonal and State levels which would fulfill the present needs of the basic health service as is being recommended by the Committee and the needs for its future development. However it would be useful to repeat in this context some of the general principles that must also apply to organisation at the Zonal and State levels. As at the lower level so also at the Zonal and State levels, Public Health and Medical Care should be integrated both in terms of programmes as well as organization. From the practical point of view, it may be necessary in some States where such integration has not yet taken place to promote this process gradually so as to prevent any administrative or other complications from arising. The strategy to be followed and the stages through which the process of integration should pass can be best decided by each State Government. But the Committee would wish to urge that this process should be speeded up as much as possible, for without the integration of Public Health and Medical Care the development of the Basic Health Service will remain incomplete and deficient in many ways. In the planning and implementation of the health programme also, there should be as much integration as possible. The integration must be fully reflected in the planning to make it possible for an integrated programme to be pursued at the district and the block levels as an important aspect of the development of the concept of a basic health service that we have attempted to bring out in this report.

3.18 During the attack or consolidation phase of any mass disease control programme, separate, staff of adequate strength will have to be provided at the state level and sometimes also at the Zonal level. Although this staff will have to work in close co-ordination with the rest of the organisation. As these programmes reach the maintenance phase in a sufficiently large position of the State, the special staff could gradually merge with the general organisation at the State level as it would at the district, Zonal and block levels,

3.19 Just as we have recommended that at the district level some of the service units should be common for all the programmes including the family planning programme, so should be the position at the State level. These units will be those dealing with administration and accounts, the epidemiological and laboratory services, health education and health intelligence including statistics and maintenance services for transport, equipment etc. How this arrangement will work has been explained in paragraph 3.15.1. It may be necessary during some stages in the intensive operation of some of the mass programmes that separate service limits may have to be provided for these programmes even for the fields for which normally there should be units common for all programmes. But as the necessity for this ceases, these units should cease to have their separate identity and should merge with their larger counterpart units to provide common service to all programmes. These units will have to be strengthened from time to time as their responsibility increases on account of the integration of the mass programmes with one general health services, particularly would this be the case with the units providing the epidemiological and laboratory services,

3.20 For some time even after the malaria maintenance phase has been reached in almost an entire State, it may be advisable to make some special arrangement at the State level to ensure adequate vigilance in the malaria maintenance programme.

3.21 It may also be necessary to have some special arrangement, partly, to be provided by some special staff but more by having proper arrangements for coordination between the different units in the health organisation at the State level, that will ensure adequate attention being paid to the development of the Primary Health Council complex in the manner recommended in this report, you are suggesting this because we realise that it is going to be no easy task, that of developing the Primary Health Centre complex both administratively i.e. finding all the staffs medical and para-medical, training them, providing them with the necessary equipment, medicines, office and residential accommodation, transport etc, and programmatically i.e. integrating more and more programmes with the basic health service as these ripen for such integration, and ensuring due performance of the growing responsibilities of the basic health service.

3.22 Another important task that should be taken, care of at the State level is that of coordination of the work and efforts in the promotion of the basic health services with these of other Governmental and non-governmental agencies, particularly the community development workers, educational workers, Panchayati Raj institutions and their "employees and other voluntary agencies to get for the basic health service necessary support in the manner mentioned earlier in the report. Unless the programme and efforts of these agencies are coordinated, both in planning and implementation at the State level, it would be futile to expect coordination at the lower levels.

3.25 Some of the general considerations that we have recommended should apply to the organisation at the Zonal and State level will also apply to the organisation at the Central Government's level. The Committee did not consider it necessary to go into the details of the Central Organization,

Laboratory Service

3.24 A developing laboratory service is a vital necessity for a developing basic health service. Even for the somewhat rudimentary scheme of basic health service that has been recommended for the present in the foregoing paragraphs, it is very important that proper laboratory service should be organised. At the Primary Health Centre level there should be facilities for simple laboratory examination. This would need a laboratory technician with a microscope. The microscope would be available from the UNICEF under one of their schemes and all Primary Health Centres should endeavour to qualify for getting this assistance from the 'UNICEF,

3.25 There should be a properly developed laboratory at the district level which may be based in the District Hospital and connected with the Pathology Department, but should be strengthened whichever necessary in order to serve also as a laboratory for the basic health service for the whole district. In the latter capacity, it would function as a referral service, and should be in a position to give some guidance to the laboratories at the P.H.C. level. The laboratory service both at the P.H.G. and District levels should be common for the Health and Family Planning Programmes, The Committee were happy to learn that a detailed programme for providing a comprehensive laboratory service at all levels is being worked out by the Directorate General of Health Services, They would urge that speedy action be taken to implement such a programme in coordination with the expansion of the basic health service to be able to fully meet the growing need for the latter.

Buildings

3.26 The committee wish to emphasise the need for providing proper office and residential buildings for the Primary Health Centres, sub-centres and their staff. Although this has been recognised by everyone this recognition has not yet been reflected in the actual implementation of the programme. Detailed studies have already been made to work out the minimum cost of providing these buildings, having reasonably good specifications and using annual-maintenance. But even on these estimates the total cost of buildings for all the Primary Health Centres and sub-centres works out to a very high figure which in the present period of acute, financial stringency, cannot be found unless it is spread over a considerably long period, say over the entire Fourth Five Year Plan and, perhaps even longer. To phase the programme over such a long period will certainly impede the development of the Primary Health Centre, complex and of the basic health services in the manner we have recommended. Therefore, unless there will be the assurance that funds will be found for completing the building programme within the Fourth Plan period. We suggest that a concerted effort should be made to bring down the cost of buildings by further lowering of the specifications the life of the buildings may have to be reduced to an average of 10 to 12 years and the annual maintenance cost may have to be increased. The Committee feel that even this may be preferable to taking the risk of the whole programme of development of the basic health services, centre round the Primary Health Centre complex being seriously retarded, the indirect consequence of which would be considerable wasteful expenditure and even increased expenditure on some of the health programmes. There would be the risk of inadequately built up basic health services taking over the maintenance services of the mass disease control programmes, particularly malaria, resulting in the neglect of these services and the tragic recrudescence of these communicable diseases without proper residential accommodation, we will continue to face the situation of P.H.C.'s and sub-centres being without doctors and para-medical personnel or will get poor quality of work from them. If these arguments prove effective in actually and definitely securing larger allocation of funds for providing all the P.H.C.'s and sub-centres with office and residential buildings within the next 4 to 5 years, the Committee would not recommend any substantial scaling down of the specifications of the buildings of the P.H.C.'s and sub-centres. But this does not seem to be a promising possibility. Even with funds allocated now, there can be no guarantee that on our present financial difficulties increasing in the coming years, the allocation will not be reduced or that there will not be difficulties in the implementation of the programme due to scarcity of building materials required for the higher specifications, or due to greater involvement of the Engineering staff of the P.W.D. on works of higher priority. Taking all these possibilities into account, it may still be the wiser course to scale down the specifications and, to the extent possible, get the cheaper types of buildings constructed with local materials and by departmental agencies, without having to rely too much on the staff, of the C.P.W.D.

3.27 Wherever the needs can be met by taking rented accommodation, they should be so met. But where this can at best be only a temporary arrangement, the construction of Government accommodation should be included in the phased programme for construction of P.H.C. and sub-centre buildings. State Governments should be given the authority to hire accommodation and the cost of this should be shared by the centre and the State Governments. In these matters, the Committee would like to make the same recommendations as the Mukerji Committee have made.

3.28 The Committee wish to emphasise the great need for taking a quick and clear decision on this most vital matter of providing buildings for the proper development of the P.H.C. complex, communicating

this to the State Governments and requiring of them to prepare a phased programme and implementing it with vigour. No decision has yet been conveyed to the State Governments on their requests for increasing the ceiling for buildings necessitated by increase in costs and in the number of buildings. For this and other reasons few States have so far attached adequate importance to this part of the programme. One difficulty they have had has been that of accommodating within a tight Plan ceiling adequate provision for P.H.C. and sub-centre buildings. There seems to be a strong case for including this programme among the centrally sponsored schemes and increasing the share of central assistance.

Training

3.29 The Committee wish to emphasise the need for giving increasing Importance to the training of all the staff, medical and para-medical, who would be working in the basic health services at any level. It seems to be necessary and would definitely be an advantage if the entire programme of training of all categories of health personnel is visualised and planned keeping in view the requirements of the developing basic health services of the conception recommended by the Committee. Already some studies have been made in the direction. The Mukerji Committee have, in their report, referred to the workshop on Training of Family Planning Personnel which was organised in New Delhi from the 10th March to the 12th March, 1966. The report of this workshop should provide much material on training of staff who would work in the basic health services. Earlier, we have recommended the provision of 5% leave and training reserve of basic health workers. Special attention should be given to the training of this class of workers. But training, whether institutional or through study groups, orientation camps and seminars not only initial but also refresher training from time to time, will be needed for almost all classes of workers of the basic health services. This is particularly necessary because a new concept, which has many facets and will have growing application, has to be promoted in the country and accepted and understood by an increasingly large number of workers of various kinds and calibers and they have to be equipped to work it. The training, therefore, of these workers has to be both orientation training and job training. The Committee did not wish to go beyond stating these general points, because they understood that detailed studies have already been made or are in progress on this subject. They would wish to urge that speedy action may be taken to complete the training arrangements to meet adequately the growing requirements of a developing basic health services,

5.29 Related to the broad question of training is the administrative problem of planning for the absorption of different categories of staff which will be specially appointed to separate programmes or will become redundant from time to time on the different mass disease control programmes getting integrated gradually with the basic health services. Regarding the first category of staff reference was made in paragraph 2.1.2. In regard to the second category of staff redundancy will arise in different numbers and at different times in the different States. The difficulties involved in this administrative problem can be well visualised. The problem has already arisen in regard to same malaria, workers in some States with a general shortage of trained and experienced staff, we can ill-afford to retrench such staff. There has to be careful forward planning to facilitate their absorption in the growing basic health service corresponding to the plan for implementation, through their different phases, of the mass programmes of disease control and eradication and their integration with the basic health, services. Training also will have an important role to play in this process, not only training to be given on the eve of such absorption but also training given in advance to prepare for the duties that will have to be performed in the subsequent role. In fact, it may be necessary and worthwhile to review from time to time the entire staffing pattern, recruitment policies, system of training

etc. connected with the mass disease control programmes to mould these to the maximum extent possible, though necessarily gradually, to facilitate as much as possible, the eventual absorption of the staff in the basic health service. It would be desirable and should be possible that with the basic health service getting gradually strengthened, some of the future control programmes, such as of diphtheria and tetanus, and also perhaps measles and whooping cough, utilise the basic health services to moot their needs and do not entertain any separate staff. This objective be promoted also by proper training of personnel to be used for these programmes. It will help in the ultimate integration of these programmes at the maintenance or equivalent state if the basic health worker and the Auxiliary Nurse Midwife are used in these programmes rather than we train new classes of workers. Similarly, it would be desirable to review the training schemes under these programmes which now use special trained workers e.g. the leprosy, T.B., cholera, trachoma control programmes to see if they can be co-ordinated with the scheme of training of the Basic Health Workers so that the latter can meet also the needs of the leprosy, T.B., Cholera and trachoma control programmes. To facilitate this kind of planning it is necessary and it is desirable even, otherwise, to adopt a standardised nomenclature in the basic health services throughout the country and follow a uniform structure for the service. The Committee's suggestions are contained in Appendix 3.

SECTION III

Arrangement for Urban Areas

4.1 The expectations on which the Chadha Committee's recommendation for dealing with the urban areas were based have not materialised. The Committee had laid emphasis on passive vigilance through hospitals and dispensaries supplemented by domiciliary case detection in slum and fringe areas which are more vulnerable than the others. It was also envisaged at the time that large scale anti-mosquito measures would be taken up in the urban areas under the National Filariasis Control Programme. Experience, however, has shown that the vigilance services and screening of cases through hospitals and dispensaries has been very inadequate. The incidence of malaria and its transmission had been significant in some urban areas particularly on account of the problem created by the *A. Stephensi* species becoming resistant to insecticides in a very short time. The expansion of the filaria control programme has not taken place to the extent needed or desired, and at the same time the problem from filaria and its danger has been increasing. Similarly, there has been a lack in the vaccination programme in urban areas, and smallpox continues to prevail in many of these areas.

4.2 On a full examination of this whole question the Committee came to the conclusion that although conditions in urban areas are not comparable to those existing in the rural areas to continue to treat the urban areas very differently from the rural areas for purposes of providing a basic health service and giving it central financial assistance would be taking a grave risk of allowing a very unsatisfactory position to continue in the urban areas both in regard to malaria and smallpox. Efforts should, no doubt continue to be made to ensure that the existing medical and health institutions, and, agencies under the State Governments, local authorities and voluntary organisations systematic screening of fever cases in furtherance of the Malaria Eradication Programme and undertake systematically the vaccination of the new borns as well as revaccination of the others. But the Committee are convinced that the objectives in these two major fields of public health, malaria and smallpox eradication, will not be achieved unless a minimum basic health service is assured for the urban areas. For the present, the Committee would emphasise only these two fields of public health that must be immediately and effectively taken care of in the urban areas by a basic health structure.

4.3 The technique of the domiciliary service should be fully applied also in the urban areas and adequate arrangements made for good supervision of the work of the Basic Health Workers. Special attention has to be given to all the vulnerable localities and sections of the people in any urban area, such, as slum areas, immigrant labour concentrations engaged on construction work, colonies of Harijans and other depressed classes. The work of the basic health services should be supplemented to the maximum extent possible by the passive vigilance work of the hospital and dispensaries; in this there is need and scope for considerable improvement,

4.4 Almost in every urban area, there is already some health staff of Government, local authorities and voluntary agencies. Use should be made of this staff to the extent possible and in a coordinated manner to serve the purposes of a basic health services. Since the Committee found during the discussions that there is very great difference in the situation obtaining in different metropolitan areas, large cities, cities of medium size and small towns in the different States, they are not in a position to make any detailed recommendations regarding the organisation of the basic health services for the urban areas. They can only make the general recommendation that in urban areas there

should be one Basic Health Worker for every 15,000 of population, as against one per 10,000 population recommended for the rural areas, the higher population coverage in the urban areas being possible because of the greater density of population and compactness of the area.

4.4.1 There should be one Inspector for every five Basic Health Workers for supervising the work of the latter.

4.5 State Governments should prepare detailed plans for each urban area in the State. The, plan should show both the organisation and the services to be rendered. It would provide for full coordination in the working of the agencies of the State Government, local authorities and voluntary agencies and in also their respective programmes. These plans should achieve the objective recommended by us of having at least one Basic Health Worker for every 15,000 of the population for looking after the malaria and smallpox eradication programmes duly supported by a supervisory staff of functionaries and proper hospital and laboratory facilities in the same manner as has been recommended for the rural areas. It would be possible in most cases to provide for supervision laboratory facilities and the necessary specialist and hospital referral service through the existing staff and facilities of the State Government and/or local authorities.

4.6 The additional expenditure on the staff that may have to be employed over and above the existing staff should be share between the State and Central Governments on the same pattern as we are recommending for the rural areas in a lower section. It should not, however, be permissible for the State Government or local authorities to exchange any of their existing staff for the Basic Health Workers that we are recommending and thus ask for an existing financial liability of theirs to be shared by the Central Government or by the State and Central Governments.

4.7 The Committee wish to point but that the institution of a basic health service for the urban areas of the pattern suggested above would not in any way reduce the importance of anti-larval work which should continue to be done by municipalities and other local, authorities as a long term measure for dealing with all mosquito-borne diseases. Nor would the importance be reduced of improving the drainage conditions in the urban areas, so necessary for the improvement of the general health conditions of these areas. But it should be recognised that the local authorities also have their genuine difficulties, financial and otherwise some of which are not of their making. This subject itself merits more detailed examination.

SECTION IV.

Financial assistance for State Governments

5.1 As stated in the introduction to this Report, it was revealed in the discussions that took place in the meeting of the Central Council of Health in Bangalore on the 25th June that under the present pattern of financial assistance given by the Central Government to the State Governments the financial burden thrown on the State Government on malaria maintenance, when the programme reached the maintenance phase was more than what the States found themselves able to bear. The pattern of assistance for the Malaria Eradication Programme seems to have been worked out on the basis of the principle which had come to be applied to schemes sponsored or aided by the Central Government under the Plans, namely that the continuing recurring expenditure should become the 'committed expenditure' of the State Government, to be met from its own revenues. One justification given in support of this principle is that in the reviews of the finances of the Central and State Governments for purposes of recommending allocation of financial resources between the two, which reviews take place on the eve of every new Plan the Finance Commission takes into account, inter alia, the increased burden thrown on the state government as a result of such committed expenditure. we need not to go into the details of this argument. It has been represented on behalf of State Governments that the assistance which they got as a result of a Finance Commission's recommendations do not wholly neutralise the additional burden of a continuing nature thrown on them or undertaken by them during the previous five year period. It has been seen that very often State Governments have been hesitant towards the end of a Plan period to undertake increased financial responsibilities on account of schemes that they had already been implementing, in the earlier years of the Plan because of the fear that they may have difficulty in finding, the additional funds for meeting the committed expenditure on these schemes from the commencement of the next Plan period. Partly in recognition of this difficulty of the State Governments, and partly because of its national importance and very high priority in the Family Planning programme the pattern of financial assistance given by the Centre to the States has been radically altered and State Governments have been freed from the burden, for the next 10 years of committed expenditure on schemes and institutions started under the programme from the inception of the Five Year Plans.

5.2 On the representation of some. States that they were finding it difficult to meet the expenditure on the maintenance phase of malaria eradication because all their resources had already been tied up with the Plan that was in operation the Central Government agreed to give to the States in the last two years of the III Plan financial assistance equal to 50% of the expenditure on the additional staff engaged from the block level up to the district level on account of the Malaria Eradication Programme entering the maintenance phase. Although this decision was taken to help the State Governments to tide over during the remaining part of the Third Plan the financial difficulties arising from the malaria maintenance phase, it has become apparent that the difficulty was not only temporary but is of a permanent character. It arises from the fact that the increase in the resources of State Governments, even taking account; of the increased allocations, they receive as a result of the recommendations of the recommendations of the Finance Commission, are inadequate for meeting the increased liabilities on account of both the committed expenditure of a previous Plan and the new expenditure on the new plan. The Committee feels that unless something is done to help solve this real difficulty of the State Governments, it is likely to have only one of the two consequences. Either further development in the medical and health fields in the coming years would be increasingly affected as the burden of the

developing basic health services increases on more and more mass disease control programmes getting integrated with it, or the gains made under the mass disease eradication and control programme would be put in jeopardy. The greater likelihood is that under the pressure of circumstances, some of which will arise also from the taking up of successive now Plans even to the neglect of *the* maintenance services required for preserving the gains made under the various communicable disease, control and eradication programmes. The Committee would wish to respectfully and earnestly urge that the realities of the situation should primarily dictate policy in this matter.

5.5 Another way of looking at the issue would be to appreciate the far-reaching significance of the Basic Health Service of the conception and character that is being recommended for development by us. If any task in the health field can be regarded as pre-eminently one of national importance and significance, this task of developing such a basic health service can be so regarded. Its successful accomplishment alone would give real significance and the needed to the programmes of eradication' and control of communicable diseases. By themselves this could but be regarded only as a preliminary, though an essential stop, in the task of building up a comprehensive Basic Health Service for the whole country which will be able to promote more positively the health and well being of the nation, as one by one the principal health hazards, the communicable diseases, are surmounted. In this task there has to be long term partnership between the Central and State Governments, local authorities and voluntary agencies, extending over all the fields - administrative, technical and financial. Naturally, such partnership to extend over a long period of time must have bases that are not temporary'- nor changing from time to time. It is only such a partnerships that can ensure that there will be a truly national plan for the development of the Basic Health Service with the needed uniformity in objectives and planning and sustained implementation all over the country over a long period. It is this point that the Committee would wish to strongly urge, and therefore, to recommend that there should be continued assistance given by the Central Government financially, as also administratively and technically, to the State Governments for building up the basic health services. Financially, the assistance should be 50% of the expenditure on the additional staff taken into the developing basic health service from time to time from the Primary Health Centre and sub-centre level up to the District level. For the present, the decision may be taken to give this assistance for a period of ten years as in the case of Family Planning, but from the beginning of the Fifth Five Year Plan the share of the Central assistance can be gradually scaled down so as to cease by the end of that plan period. The assistance need not be extended to staff that may be taken at the State level and it need not extend to the staff needed for strengthening the laboratory service except what has been specifically suggested in this report.

5.4 The Committee would also wish to recommend that if any State Government finds it difficult to meet its own share of the 50% expenditure on the additional staff taken into the basic health service, the Central Government may help that State Government with a loan on the same term as was given as an interim arrangement during the last two years of the Third Five Year Plan,

5.5 The expenditure on the additional staff on which the 50% assistance should be provided by the Central Government should include the salary and allowance of the staff rent for accommodation or house rent allowance that may be payable, the expenditure incurred on the maintenance of vehicles provided for the staff for discharging their duties, and provision of 5% of the budget on account of general contingencies. The Committee recommends that the T.A., D.A. and cycle allowance to the staff working in the basic health service should be fixed on the same basis, as has been recommended by the Mukerji

Committee for the corresponding staff who will work on the family planning programme. Similarly, the budget provision for the maintenance of vehicles may be made on the lines recommended by the Mukerji Committee,

5.6 The additional staff recommended in this Report for the P.H.C. level and the District level is shown in Appendix 4. Appendix 5 shows the full staffing pattern of the P.H.C. complex as it will be if the recommendations of this Committee and the Mukerji Committee on Family Planning are fully accepted. Appendix 6 shows what should be the District Organisation.

From

Shri R.N. Sinha,
Under Secretary to the Government of India,
Ministry of Health,
New Delhi.

To

The Director General of Health Services,
New Delhi.

Subject: 13th Meeting of the Central Council of Health held at Bangalore in June, 1966 – Implementation of the Resolution No. 7 – Constitution of a Committee to recommend the staffing pattern of the Primary Health Centre Complex.

Sir,

With reference to your U.O. No. F.28-10/66-PHC dated the 4.7.1966 on the subject noted above and in continuation of resolution No.7 passed at the 13th meeting of the Central Council of Health held at Bangalore in June, 1966, I am directed to convey the approval of the Government of India to the constitution of a Committee composed of the following members to review the staffing pattern of the primary health centre complex and to recommend the minimum staff of various categories required at different level within the district so as to provide an integrated health service capable of fully catering to the needs of the vigilance services in the maintenance chase of National Malaria Eradication Programme, smallpox eradication, tuberculosis, leprosy and trachoma control, etc. and to recommend the pattern of Central assistance for the States,

Composition

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|---|----------|
| 5. Union Health Secretary,
New Delhi. | Chairman |
| 2. Shri K.S. Lall
Secretary to the Government of
Andhra Pradesh,
Health, Housing and Municipal
Administration Department,
Hyderabad. | Member |
| 3. Shri G.C. Phukan
Secretary to the Government of Assam,
Health Department,
Shillong. | -do- |
| 4. Mrs, Sarla Grewal
Secretary to the Govt. of Puniab,
Medical and Health Department,
Chandigarh. | Member |
| 5. Shri B.R. Gupta,
Secretary to the Government of
West Bengal, Health Department,
Calcutta. | -do- |

6. Shri Uma Shankar -do-
Secretary to the Government of Uttar
Pradesh, Medical, Public Health and
Excise Deptt. Lucknow.
7. Dr. P,R. Dutt Secretary
Assistant Director General (Instt)
Directorate General of Health Services,
New Delhi.

2. The Committee will held its meetings as frequently as deemed necessary to finalise its report by the end of July, 1966.

3. The Committee may lay down procedure for its working and may coopt members as deemed necessary.

4. The expenditure Involved on T.A. and D.A. of the officers may be met from the source from which their pay is drawn.

Yours faithfully,

sd/- R.N. Sinha

NO.F.28-10/66PHC.

Copy forwarded to the;-

1. A.G.C.R., New Delhi.
2. A.Gs. in the States of Andhra Pradesh, Assam, Punjab, West Bengal and Uttar Pradesh.

sd/- R.N. Sinha

Copy forwarded for information to all members of the Committee.

Copy to P.S. to Union Health Secretary.

Copv to Dr. P.R. Dutt, Dte. G.H.S.

Copy to D.S. (PH)

sd/- R.N. Sinha

List of participants

Meeting held on 11th July 1966

1. Shri B. Mukerji, Union Health Secretary, Chairman
2. Shri B.R. Gupta, Health Secretary, West Bengal
3. Shri K.B. Lall, Health Secretary, Andhra Pradesh
4. Shri G.C. Phukan, Health Secretary, Assam
5. Shri S.K. Chaudhri, Secretary (Family Planning) and Special Secretary, Medical and public Health, Uttar Pradesh.

Special invitees:

6. Shri Govind Narain, Union Secretary for Family Planning
7. Shri D.J. Madan, Joint Secretary, Ministry of Finance
8. Dr. K.N. Rao, Director General of Health Services.
9. Lt. Genl. S.P. Bhatia, Commissioner, Family Planning.
10. Dr, C.L. Mukerji, Director of Health Services, West Bengal
11. Dr. Ghulam Ahmed, Director of Public Health, Andhra Pradesh
12. Sh. R.C. Bhargava, Deputy Secretary, Planning, Uttar Pradesh
13. Dr. K.K. Govil, Joint Director of Medical and Health Services, U.P. Lucknow.
14. Dr, K.M. Lal, Adviser Health, Planning Commission.
15. Dr. T.R. Tewari. Deputy Director General of Health Service
16. Dr. A.P. Ray, Director, National Malaria Eradication Programme, Delhi.
17. Dr. B.L. Raina, Director, Central Family Planning Institute New Delhi,
18. Dr. A.S. Sen, Deputy Director General of Health Services (Smallpox),

Observers:

19. Sh. M.K. Kutty, Deputy Secretary, Ministry of Health.
20. Sh. K.P. Soni. Deputy Financial Adviser. Ministry of Finance (Health Division).
21. Dr. M.V, Singh, Deputy Director, Malaria, U.P.
22. Dr. N,L, Bordia, T.B, Adviser, Directorate General of Health Services.
23. Dr. G.P. Sen Gupta, Deputy Director, National Malaria Eradication Programme.
24. Dr. B.G. Misra, Assistant Director, N.M.E.P.
25. Dr. H, Bannerjee, Assistant Commissioner, Family Planning.
26. Dr. M.I.D. Sharma, Deputy Director, National Malaria Eradication Programme, Lucknow.
27. Dr. I.N, Khoshoo, Director, National Leprosy Control Programme, Ghaziabad.
28. Sh. R,N, Singha, Under Secretary, Ministry of Health.

Secretariat

29. Dr. P.R. Dutt, Asstt, Director General of Health Services Member-Secretary 30
30. Sh. R.R. Bagga, Deputy Assistant Director, N.M.E.P.
31. Sh.P.N. Chawla, Assistant, P.H.C. Cell.

Participants at the meeting held on 25th and 26th July, 1966 at Calcutta

1. Sh. B. Mukerji, Secretary, Ministry of Health Chairman
2. Sh. B.R. Gupta, Secretary, Health, West Bengal.
3. Sh. G.C. Phukan, Secretary Health, Assam.
4. Sh. S.K. Chaudhri, Secretary (Family Planning) and special Secretary Medical and Public Health, U.P.

Special Invitees:

5. Sh. Govind Narain, Union Secretary for Family Planning
6. Sh. D.J. Madan. Joint Secretary, Ministry of Finance
7. Dr. K.K. Rao, Director General of Health Services
8. Dr. C.L. Mukerji, Director of Health Services, West Bengal
9. Dr. Ghulam Ahmed, Director of Public Health, Andhra Pradesh
10. Sh. R.C. Bhargava, Deputy Secretary, Planning, U.P.
11. Dr. K.K. Govil Jt. Director of Medical & Health Services, U.P.
12. Dr. A.P. Ray, Director, N.M.E.P.
13. Dr. A.S. Sen, Deputy Director General of Health Services
(Smallpox)

Observers:

14. Sh. A.K. Sen, Additional Secretary, Finance Dept, W. Bengal.
15. Sh. S.K. Chakravarti, Deputy Secretary, Health, West Bengal.
16. Sh. N.M. Chaughuri, Assistant Secretary, Health West Bengal.
17. Sh. B.C. Bhattachary, Officer on Special Duty, Deptt. of
Health, West Bengal.
18. Dr. S.D. Basu, Jt. Director of Health Services, West Bengal.
19. Dr. P. Bose, Deputy Director of Health Services (Health) W.B.
20. Dr. S. Das Gupta, Deputy Director of Health Services
(Family Planning), West Bengal.
21. Dr. S. Mullick, Deputy Director of Health Services
(Administration), West Bengal.
22. Dr. N. Ganguli, Deputy Director of Health Services
(Infectious Borne Diseases), West Bengal.
23. Dr. B. Bannerji, Asst. Director of Health Services, W. Bengal.
24. Dr. A.C. Roy || Z.S.M.O., N.M.E.P., West Bengal.
25. Dr. S. Dutta Roy ||
26. Dr. N.K. Dutta, Epidemiologist, Health Directorate, W. Bengal.
27. Dr. S.K. De, Assistant Malariologist, West Bengal.
28. Dr. (Mrs.) M. Sen, Director, All India Institute of Hygiene
and Public Health, Calcutta.
29. Dr. N.K. Basu, Regional Director (F.P.), Calcutta.
30. Dr. A.M. Roy, Central Family Planning Officer, Calcutta.

Secretariat:

31. Dr. I.R. Dutt, Asst. Director General of H.S. Member Secretar
32. Sh. R.R. Bagga, D.A.D., N. M. E. P., Delhi
33. Sh. P.N. Chawla, Assistant, P.H.C. Cell

Participants at the meeting held on 20th September 1966.

1. Sh. B. Mukerji Union Health Secretary, Chairman
2. Sh. K.B. Lal, Health Secretary, Andhra Pradesh
3. Sh. S.K. Ghauthri, Secretary (F.P.) and Special Secretary
Medical and health U.P.

Special Invitees

4. Dr. K.N. Rao, Director General of Health Services
5. Dr. N. Jungalwalla, Additional Director General of Health
Services
6. Sh. K.P. Soni, Deputy Financial Adviser (Health Division)
7. Dr. H. Bannerjee, Asstt. Commissioner, Family Planning.

Observers:

8. Dr. S. Krishhaswamy Rao, NIHAE
9. Dr. L. Ramachandran, Officer in Charge, Rural Health
Training Centre, Najafgarh

Secretariat:

10. Dr. P.R. Dutt, A.D.G.H.S., Member Secretary
11. Sh. R.R. Bagga, D.A.D., N.M.E.P.
12. Sh. R.N. Chawla, Assistant, P.H.C. Cell.

LEVEL	NOMENCLATURE	EDUCATION REQUIREMENTS (Years of schooling)	PERIOD OF TRAINING	EXPERIENCE	REMARKS
SUB-CENTRE	Basic Health Worker.	8-10 years	4 months training and 2-6 weeks programme orientation.	Experience in one or other mass control programme would make eligible, after suitable short-term orientation to serve as a basic health worker.	a) Short courses for 2-6 weeks may be necessary on an ad hoc basis when workers from one programme e.g., malaria, filaria etc., are required to undertake bi-reader responsibilities the basic health worker. b) The period of training will be gradually extended to equate the training period with that of the auxiliary nurse midwife in a phased manner. Will serve as a Supervisor of Basic Health Workers.
INTER-MEDIATE LEVELS:	Health Assistant Sanitary Inspector	8-10 years	About 9 months' training or orientation of 3 months for experienced Basic Health Workers.	About 2 years of experience as Basic Health Worker or Sanitary Inspector.	
I.H. CENTRE.	Senior Health Assistant Sanitary Inspector.	8-10 years	Should have taken basic training for Sanitary Inspector or Health Assistant.	About 3 years as Health Assistant or Sanitary Inspector.	

LEVEL	NOMENCLATURE	EDUCATION REQUIREMENTS (Years of schooling)	PERIOD OF TRAINING	EXPERIENCE	REMARKS
INTER-MEDIATE LEVELS	Health/Sanitary Supervisor.	8-10 years/Graduate.	Basic Training of Sanitary Inspector/Health Assistant with Special Supervisors Orientation Course. OR Graduate (B.Sc.) in sanitary science.	3-4 years as sanitary inspector at PHC or in specialized programmes.	a) The course at Gandhigram is for Senior Sanitary Inspectors and trains them for supervisory duties. b) Warangal Medical College trains for B.Sc. (Sanitation) c) Short orientation courses given at Singur, Najafgarh etc., for Sanitary Inspectors.
DISTRICT LEVEL	i) Senior Sanitary Health Supervisor.	8-10 years or Graduate.		5 years as Senior Sanitary Inspector OR 2 years for a graduate.	
	ii) Junior Health Officer of small Municipalities.	As for Graduate	Graduate	4-5 years experience at Taluk/Tehsil or District level.	
		Officer of small Municipalities.			at Taluk/Tehsil District level

Additional staff recommended for Basic Health Service

(a) At Primary Health Centre

- | | |
|--------------------------|---|
| 1. Basic Health Worker | - 1 for 10,000 population
(plain area) |
| 2. Health Inspector | - 1 for every 4 basic health
workers. |
| 3. Clerk | - 1 |
| 4. Laboratory Technician | - 1 |

(b) District Health Organization

- | | |
|---|---|
| 1. Upgrading of the post of A.O.
sanctioned under Family Planning Programme. | |
| 2. Health Supervisor | - 1 for every 10 primary Health
Centres subject to the minimum
of 1 per district. |
| 3. Public Health Engineer | - 1 for 2 or 3 districts |
| 4. Sanitary Supervisor | - 1 |

(c) District Hospital

- | | |
|--|-----|
| 1. Administrative Officer
(Non-medical) | - 1 |
|--|-----|

(d) Urban Areas

- | | |
|-------------------------|--------------------------------|
| *1. Basic Health Worker | - 1 for 15,000 population |
| *2. Health Inspector | - 1 for 5 basic health workers |

*only to the extent that these cannot be found from the existing staff of the State Government, Local authority for voluntary agencies.

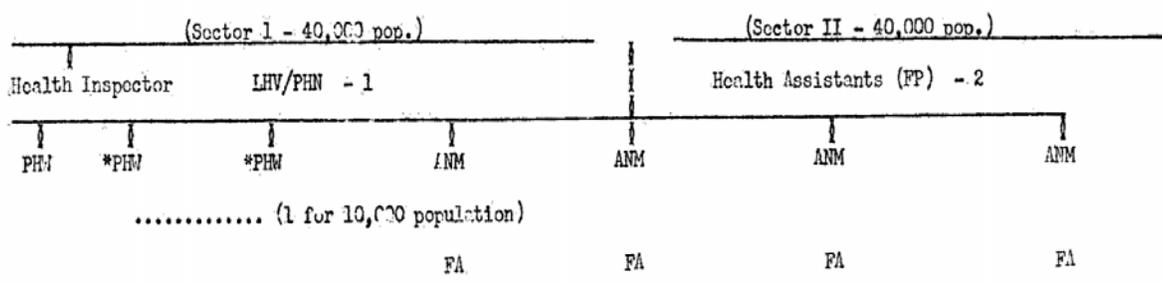
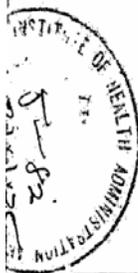
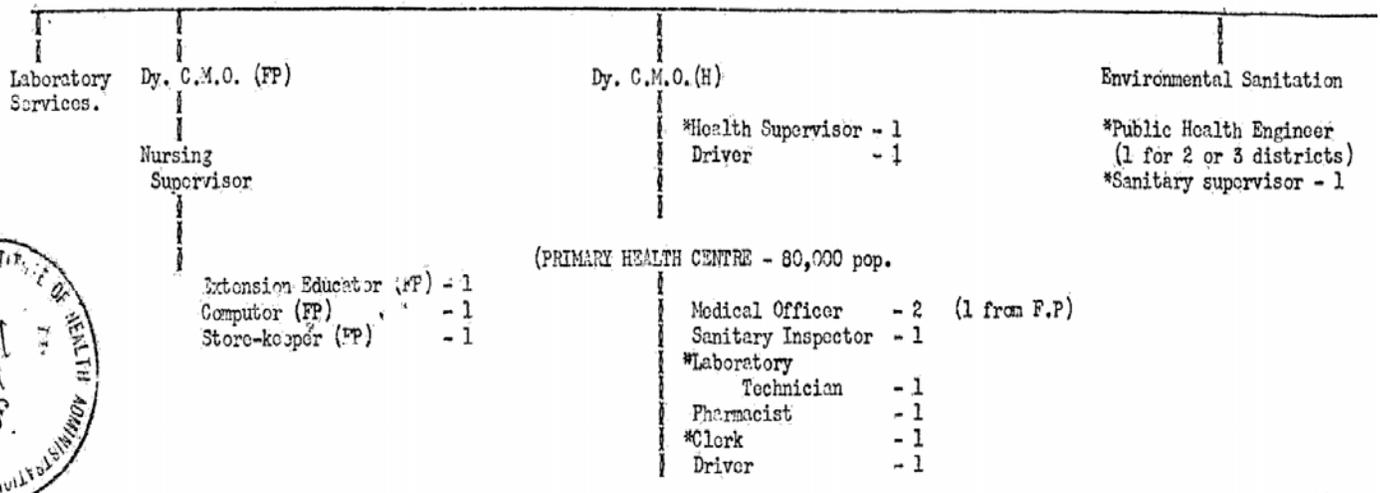
ADDITIONAL STAFF RECOMMENDED AT P.H.C. LEVEL

	Staff committed (as per initial pattern)	Under Family Planning.	Under Basic Health Services.	Total Staff
Medical Officer	1	1	-	2
Compounder	1	-	-	-
Sanitary Inspector Senior	1	-	-	1
Health Inspector/ Health Assistant	-	4	2	6
PHN/LHV	1	1	-	2
A.N.M.	4	6	-	10*
Basic Health Worker	-	-	8	8
Lab. Technician	-	-	1	1
Extension Educator	-	1	-	1
Computer	-	1	-	1
Clerk	-	-	1	1
Storekeeper	-	1	-	1
Driver	1	-	-	1
Ancillary	2	-	-	2

*Of the total of the 10 A.N.Ms. 2 will be posted at the PHC and 7 at the sub-centres. 6 A.N.Ms. will be provided by the F.P. and 4 by the Health side.

ORGANISATION OF PUBLIC HEALTH SERVICE

C.M.O.(H)



..... (1 for 10,000 population)

(FA = Female Attendant)

*Personnel for basic Health Services

SEPARATE STAFF FOR SPECIAL PROGRAMMES.