

KARTAR SINGH

Committee

Report

REPORT OF THE COMMITTEE ON MULTIPURPOSE WORKERS UNDER HEALTH & FAMILY PLANNING PROGRAMMS

CHAPTER I

INTRODUCTION

1.1 National programmes in the field of Health, Family Planning and Nutrition have been in operation in the country for many years. In general, these programmes are being run almost independently of each other by staff recruited under each programme. There is little or no coordination between the field workers of these programmes and even at the supervisory level there are separate and independent functionaries. Though the majority of these programmes, a Primary Health Centre forms the apex of a pyramid, yet till recently even the two doctors working at the primary health centre, had separate spheres of activities, one working for family planning and the other for health. This situation has however, been somewhat rectified by Government of India letter No.23-10/69-Ply, dated 5.7.71 and now in most places the two doctors work both for family planning and health services. According to the duties assigned to them the doctors at a PHC are supposed to be in-charge of all health and family planning programmes in the area covered by each PHC,, but in actual, practice they confine themselves almost entirely to running an out-patient clinic either in the PHC headquarters or at sub-centre apart from looking after a limited No. of patients admitted in the PHC. At the District and State headquarter levels too there is a separate staff for family planning, public health and curative health services.

1.2 In West Bengal, the PHC complex developed in a different manner but now the pattern is being gradually changed to" the all India one. Though minor modification in the pattern given above exists in some States in general the pattern is the same. Not only is there a horizontal division between the staff engaged in the programmes of health and family planning, but in most of the States there is also a vertical division in the staff engaged in different health programmes, like Malaria, Smallpox, Tuberculosis, Leprosy, Cholera, etc.

1.3 This state of affairs has come into existence because various health programmes and later on family planning programme were launched at different times and each was conceived to run vertical with its own staff. Whereas this has resulted in proliferation of staff, it has also yielded some results. For example, 59% of the country is now in Malaria maintenance phase while a few years ago malaria claimed millions of lives in this country. The same is true of small-pox. It is true that both malaria and smallpox have not been eradicated, nevertheless, the progress has been encouraging and it is expected that before long these two diseases along, with some of the other communicable diseases would be things of

the past. Similarly, according to Sample Registration. Survey of 1971 there is a definite trend in the lowering of the birth rate which can substantially be attributed to the efforts of the staff recruited for the family planning programme.

1.4 Admittedly there has been success, although of varying degree in each programme. It is, however, disquietening to note a growing demand for increase of staff under each programme. The justification offered for this demand is the need to reduce population/area covered by each worker.

The demand; being logical, a question is however, raised in many quarters whether the same objective cannot be achieved by coordinating these programmes and pooling the personnel. Could not such an integration reduce the population/area of each worker, thus making his coverage smaller and consequently more effective. This has resulted in the following recommendation made at the first meeting of the Executive Committee of the Central Family Planning Council held on 20th September, 1972.

"Steps should be taken for the integration of medical, public health and family planning services at the peripheral level. A Committee should be set up to examine and make detailed recommendations on:

- i) the structure of integrated services at the peripheral and supervisory levels;
- ii) feasibility of having multi-purpose/bi-purpose workers in the field;
- iii) training requirements for such workers; and
- iv) utilization of mobile service units set up under family planning for integrated medical, public health and family planning services operating from tensile level. "

The membership of the Committee recommended was as follows:-

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| 1. | Addl. Secretary, Ministry of Health & Family Planning | Chairman |
| 2. | Director General, | Health Services |
| 3. | Health Secretary, | Uttar Pradesh |
| 4. | Health Secretary, | Tamil Nadu |
| 5. | Health Secretary, | Maharashtra |

Deputy Commissioner (P), Department of Member Family Planning, Secretary

It is further recommended that the Committee may visit some States to study the actual working at the district and peripheral level and should submit its report within 4 months.

1.5 In pursuance of the above recommendations, the Government of India issued an order Kb. 2-76/72-piy, dated the 28th/30th October, 1972, constituting the Committee (Annexure I).

The terms of reference of the Committee were to study and make recommendations on;

- i) The structure for integrated services at the peripheral and supervisory levels.
- ii) The feasibility of having multi-purpose/bi-purpose workers in the field.
- iii) The training requirements for such workers.
- iv) The utilization of mobile service units set up under family planning programme for integrated medical, public health and family planning Services operating from tehsil/taluq level."

The Committee was asked to visit 'some States to study the actual working at the district and peripheral levels, and to furnish its report by the end of February,. 19.7.3.

1.6 Two further modifications of this order were issued. The first was dated 30th of November, 1972 (Annexure II) in which the membership was increased by the addition of Chief (Health) planning Commission, Director, NIHAEE, Director, Health Services, Haryana, and. Director, Health Services, Gujarat, The Director- General of Health Services was made vice-Chairman of the Committee. The second modification was dated 23rd February, 1973 (Annexure III, in which Deputy Commissioner (T & R) was made the Member-Secretary of the Committee in place of Deputy Commissioner (p). The date of submission of the report was first extended to 30th April, 1973 then to 15th August, 1973; and subsequently to 15th Sept., 1973 vide Government "of India order dated the 22nd May, 1973 and at 25th, August, 1973 (Annexure IV).

1.7 The Planning Commission is also seized of the problem and in the Report of the Steering Group on Health, Family Planning and Nutrition plans for Fifth Five Year Plan, the following observations were made:-

Integration of Health & Family Planning Programmes under Health, Family Planning and Nutrition have been in operation for a long time. These programmes are mostly vertically conceived and are being implemented at the field level by the staff deployed to implement these programmes individually, with little co-ordination or integration of the services. The Steering Group feels that the proper integration of Health, Family Planning and Nutrition programmes is highly desirable as it would be more economical and effective. It may be appreciated that the multi-purpose health worker (who may be designated health auxiliary for convenience of reference) would be entrusted with the carrying out integrated functions and would have greater rapport with the people in rural areas who would naturally look to him for all their needs in the field of naturally reinforcing components of Health, Family Planning & Nutrition. The Steering Group accepts the general principles enunciated and would suggest that Health auxiliaries may consist of three categories i.e., Basic Health Worker at the "lowest level, Health Visitor/Health Inspector at intermediary level and Health Assistance/Health Supervisor at the higher levels. Further Steering Group would suggest that, with a view to arriving at an effective pattern of integration of the services from operational and training angle, two working groups of experts be appointed immediately to go into the details in respect of : (i) defining functional role of the Health auxiliary in integrated health programmes, conditions of service, salary structure, avenues for promotion, etc., and (ii) defining objectives of training programmes, construction of curriculum in terms of knowledge and skills required to achieve the objectives, identifying training institutions, etc., and give the integration programme a concrete shape. This should be done expeditiously as an advance action in 1973-74. In regard to nutrition schemes, the experience gained by the Department of Community Development, Ministry of Agriculture and Department of Social Welfare, Ministry of Education and Social Welfare, should not be lost in effecting integration of Health, Family Planning and Nutrition. Suitable job charts and training programmes tailored to local needs should be proposed for the personnel of Departments of Health, Family Planning, Social Welfare, Community Development, and others engaged in nutrition programmes. Nutrition feeding programmes will have to be integrated with other Health, and Welfare programmes to form a composite package which will include apart from feeding, minimum health care, immunisation and improvement in environmental sanitation. Integration of personnel from nutrition programme will have to be viewed from this angle.

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

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

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

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

1.8 PROGRAMME OF THE COMMITTEE

1. The Committee held its first meeting at Delhi on 15th March, 1973.

It was decided to co-opt Dr. P. Diesh, Commissioner, Rural Health, as a Member of the Committee.

At this meeting, it was unanimously agreed that the concept of the multi-purpose workers at the periphery was both feasible and desirable. It was left for further discussion whether such multi-purpose workers could be introduced throughout the country or only in those areas where malaria was in maintenance phase and smallpox was under control. Some members felt that if multi-purpose workers were put into operation in areas where malaria was in attack or consolidation phase, it would be difficult to control malaria.

It was decided that the Committee would obtain more information by paying visits to some of the States, talking to the workers and gathering first-hand knowledge before coming to definite conclusions on its terms of reference.

2. The Committee three field visits:
 - A. To Punjab, Haryana and Himachal Pradesh on 20th to 22nd April, 1973.
 - B. To Mysore and Tamil Nadu on 21st to 24th June, 1973.
 - C. To Bihar, West Bengal and Orissa on 19th to 22nd July, 1973.

On each visit, the members visited a primary health centre and a sub-centre in each State and interviewed various field workers like an ANM, Family planning Basic Health Worker, Vaccinator etc. The supervisory staff like LHV, Sanitary Inspector, Vaccination-Inspector, Health Inspector were also interviewed. While on visit to Mysore & Tamil Nadu the Committee also met the field workers and Senior Health administrators of Kerala. Opinions were elicited from field workers, their supervisors and health administrators etc., about their reactions to the tasks before the Committee. The doctors working in the primary health centres were also questioned about their views on having multi-purpose workers. An attempt was made to assess the attitude of the PHC doctors vis-a-vis their role as leaders of the health team in the entire area covered by a primary health centre. The response of the village community to the existing health service was also elicited by talking to the villagers, school teachers, panchayat leaders, etc. Discussions were held with the State Health authorities and their views were also sought about the concept of multi-purpose workers and the problems that would have to be overcome to execute the programme. The Committee had also the benefit of discussing the subject with some of the State Health Ministers.

1.9 During the very first visit, it was decided that the Committee should confine itself to the question of multipurpose workers for the rural areas only. This was done for the following reasons:-i) The main area of operation for the multi-purpose workers both in health and the family planning programmes was in the rural sectors.

ii) There was a fair degree of uniformity of the staffing pattern of services for rural population in different States.

iii) On the other hand, there are multiple authorities in the urban-sector like municipalities, large hospitals, medical colleges, etc., which also participate in health and family planning programmes.

For these reasons workers engaged in health and family planning programmes in urban areas have been excluded for the purpose of this Committee's report.

3. The last meeting of the Committee was held on 27th & 28th August, 1973 at Delhi where the draft report was discussed and finalised.

1.10 ACKNOWLEDGEMENT;

The Committee wishes to acknowledge its gratitude to the State Health Authorities of Punjab, Haryana, Himachal Pradesh, Mysore, Tamil Nadu, Bihar, West Bengal and Orissa, for the courtesy extended to its members during", their visits to the respective States. The Committee wishes to express its sincere thanks for all that these States did to make the field visits really fruitful.

The Committee is also grateful to the officers of the Ministry of Health & Family Planning and the DGHS for their valuable hel' .The Committee wishes to express its sincere thanks to its Member-Secretary, Dr. D.N. Gupta, who prepared the draft of this report. Thanks, are also due to Dr. B.N. Haider, Assistant Commissioner(FP), for assisting the Committee.

CHAPTER II
EXISTING FACILITIES

I. STAFF

2.1 NOMENCLATURE

In general there exists a certain degree of uniformity in the staffing pattern at the primary health centre, level in diff States. Minor modifications, however, are in evidence in some States & the gaps between the sanctioned staff and the staff positioned in different States, widely vary. Whereas some States have recruited almost the entire sanctioned staff, there are others in which there are wide disparities. This is particularly so in the case of categories like ANMs and LHVs.

According to the figures available, there are 5197 PHCs functioning at present in the country catering to the rural population of 435.8 million (1971 Census). In general, a PHC caters to a population of 80,000 to 1,50,000 or even more. However, in certain parts like the tribal, hilly, and desert areas a PHC covers a much smaller population. The area covered by a PHC also varies. Usually there are six to eight sub-centres in a PHC, each sub-centre catering to a population of 10 to 15 thousand. The staff sanctioned for each PHC is generally as follows:-

1. Doctors	2
2. Block Extension	1 Educator
3. Family Planning Health Assistants	4
4. Vaccinators	3 to 4 (one for 30,000 pop.)
5. Basic Health Workers Malaria Surveillance Workers	8 (one for 10,000 population)
6. Health Inspectors	2 Malaria Surveillance Inspectors
7. ANMS	10
8. Lady Health Visitors	2
9. Sanitary Inspector	1

Some States have introduced functionaries with different designations like Junior Health Inspectors, Health Inspectors, Senior Sanitary Inspectors, Health Assistants, Enumerators, etc.

This multiplicity of names, varying job responsibilities and different categories of functionaries have come about because of historical reasons and the provision of promotional avenues to the staff recruited.

The existing staff position as supplied by the different States is given in Annexure V.

2.2. JOB RESPONSIBILITIES

Almost all the States have printed manuals of the job responsibilities of different functionaries. A few representative samples are given in Annexure VI.

2.3. EDUCATIONAL QUALIFICATIONS

There are variations in the educational qualifications of different functionaries in different States and also within each State. Generally the old entrants were non-matriculantes who were recruited and then given in-service training. The subsequent recruits have been mostly Matriculantes who have either had pre-service training of variable duration or service training.

2.4 PAY SCALES

There are fairly wide variations in the pay-scales existing in different States. For example the pay-scale of a Vaccinator in Mysore is Rs.80-145, in Punjab it is Rs.100-160, and in Tamil Nadu it is a fixed pay of Rs.120/- with Dearness pay of Rs. 118/-(a total of Rs.238/-). Similarly, in the case of ANMs, Tamil Nadu's pay scale is Rs.170-225, in Mysore it is Rs.90-200, in Punjab it is Rs.110-200 and in West Bengal it is Rs.180-350.

2.5 TRAINING FACILITIES

The training facilities under Family Planning Programme are well organised in established training centres spread all over the country. These centres are being run with 100% Central assistance. The training facilities under Health Programmes are available in the State run Sanitary Inspector schools while advantage is also being taken of the training facilities at the District Hospitals and in some cases, Medical College Hospitals. The following recognised training programmes centres are available in the country

2.5.1 UNDER FAMILY PLANNING PROGRAMME

(a) Central Institutes (Five)

1. National Institute of Family Planning, New Delhi (Under the Department of Family Planning, Government of India). This Institute runs training programmes for the trainers. An Annual Calendar of activities is prepared by the Institute and approved by the Department of Family Planning.

2. Central Health Education Bureau, New Delhi (Under the control of Director-General of Health Services).

This Institute runs training programmes for both health and family Planning programmes. For the latter, it receives aid from the Department of Family Planning. Under the Family planning Programme, the training programmes are for the trainers. It also runs a Diploma Course in Health Education recognised by the University of Delhi. It prepares an Annual Calendar of its activities which is approved by the Director General of Health Services for health training programmes and by the Department of Family Planning for family planning training programmes.

3. All India Institute of Hygiene and Public Health, Calcutta (under the control of Ministry of Health and Family Planning).

This Institute runs training programmes both for health and Family Planning. For the latter, it receives aid from the Department of Family Planning. Family planning training programmes are run for the trainers, mostly District Family "Planning Officers. In the field" of health, it has instituted Diploma Courses in Health Education, Public Health and Nutrition.

4. Family Planning Training & Research Centre, Bombay (under the Department of Family Planning, Government of India).

It conducts courses for the training of trainers in family planning like District Extension Educators. Recently, it has run along course of three months for Block Extension educators.

5. Gandhigram Institute of Rural Health & Family Planning (run by a voluntary agency and aided by the Department of Family Planning).

This Institute runs training courses for trainers like District Extension Educators and has conducted long courses for Block Extension Educators. This Institute also gives a Diploma in Health Education.

(b) Regional Family Planning Training Centres.

These centres provide orientation and short-term training to PHC doctors, Block Extension Educators, ANMs, FPHAS and to other personnel engaged in family planning programmes. 46 such centres have been sanctioned and 44 are in existence in different parts of the country. Each has a staff of 26, consisting of 1 Principal, 1 Medical Lecturer-cum-Demonstrator, 1 Health Education Instructor, 1 Statistician, 1 P.H. Nurse Instructor, and 4 Health Education Extension Officers plus a Projectionist, a Draughtsman and some office staff.

(c) 16 Family Planning Field Units.

These are peripatetic training teams which provide on the job orientation training in family planning to ANMs, Family Planning Health Assistants school teachers and others engaged in family planning programmes. Each has the following staff:

Family planning Officer	1
Asstt. Surgeon	1
Health Educator, Gazetted	1
Junior Health Educator	1
Social Worker	1
Projectionist	1
Mechanic	1
Driver	1
Upper Division Clerk	1
Lower Division Clerk	1
Peon	1
Chowkidar	1
Sweeper (Part-time)	1

2.5.2 UNDER HEALTH

1. Sanitary Inspector Training Centres

There are about 40 Sanitary Inspector Training centres run mostly by State Governments and a few by private agencies. The duration of the course used to vary from 5 months to 1 year, but has since been fixed at one year by the Government of India.

2. Rural Training Centres - one at Najafgarh and the other at Singur under Government of India and sixteen others under different States.

3. As mentioned above, advantage is also taken of district hospitals and medical college hospitals for providing short-term training to health workers like Vaccinators, Malaria workers, etc.

2.5.3 ANMs and LHVs receive pre-service training in recognized ANM and LHV schools. There are 320 ANM schools and 23 LHV schools in different parts of the country.

a) Majority of ANM schools (223) are run by State Governments and of these 60 are Centrally aided by Department of Family Planning. The remaining 97 are run by voluntary agencies and 62 of these are aided by the Department of Family Planning. Though the admission capacity of all these schools is 8169 per year, yet for want of adequate hostel facilities the number admitted each year is lower, viz., about 6500. The course is of two years duration and the minimum educational qualification for entry is VII class pass. Of late, a large number of girls who have passed Matriculation have been coming up for admission.

b) Lady Health Visitors' Course is of 2 1/2 years duration and Matriculation is the minimum educational qualification for admission. The annual in-take of all the schools is 1043, but the number admitted each year is about 800 only.

c) Public Health Nursing: Facilities for this course are available at nursing Colleges and at some of the Nursing schools.

2.6. MOBILE UNITS

Mobile Sterilisation Units have been in position since August 1964. In 1966 the Mukherjee Committee recommended the introduction of IUD units to provide a greater coverage for this programme. The Committee, after weighing the pros and cons of attaching IUD units either to P.H.C. or to District Bureau, was in favour of the latter alternative. It also recommended that the staff of Primary Health Centre will be interchangeable with the staff of the mobile units. The Government accented the recommendations of this Committee and sanctioned establishment of one mobile sterilisation unit and one V mobile IUD unit for a population of 5.5 to 7.5 lakhs in each district. In order to make the visits of these units more profitable for rural areas, it was decided in September, 1967 that each of the units will carry general medicine for emergency medical relief.

Since the performance under IUD programme fell and these unit were unable to achieve targets set for them it was decided that both units would provide all the services and will be termed as mobile service units.

A review of the performance of the units in February, 1971 showed that the average performance per unit per month was on the low side. It was, therefore, decided in October 1971, that such mobile service units as were not being put to optimum use and there service facilities were available at other places like hospitals, urban centres and primary health centres, these be closed and spare vehicles utilised elsewhere.

According to the information available, there were 399 sterilisation units and 456 IUCD units in March 1973 throughout the country. The State-wise distribution of these units is given in Annexure VII.

Each sterilisation unit has a staff consisting of Medical Officer and an operation theatre nurse and an attendant. Each IUD unit has for its staff, a lady Assistant Surgeon, an ANM and an attendant.

The Performance of these units has been further examined in July, 1973 and it has been decided to retain only one mobile service unit in each district. The pattern of mobile service units in intensive districts would, however, continue.

For each intensive district, of which there are 17, it was decided in 1969 that in addition to the number of mobile units on population basis there would be three more multipurpose mobile units for each district.

CHAPTER III

FINDINGS OF THE COMMITTEE

3.1. Background many health administrators have felt that the present staff of the primary health centres and sub-centres 'cannot adequately deal with the health and family planning, requirements of the population involved. The population given to each worker is too large to be adequately covered and frequently visited. For example, an ANM has a population of 10 to 15 thousand in which she is expected to provide maternity services along with anti-natal and post-natal care, child health care and also do family planning extension work. This population may be concentrated in a radius of 2 to 3 miles from her headquarters or scattered over a 1 area of 10 to 15 miles radius or even more. The same is the case with the malaria workers and the position is much worse for vaccinators.

3.2 While ascertaining the views of the community leaders about the existing health and family planning services, it was clearly brought out that the people are not happy with so many workers con to their homes and making enquiries for individual programmes. The community leaders were of the opinion that a single worker delivering both health and family planning services would be more welcome.

It was also mentioned that the present health and family planning workers were not able to provide remedies even for simple ailments like head-aches, cuts and burns and the rural community had to take the help of either the village quack or trudge long distances to get relief at the PHC. When the ANMs and the Malaria and Smallpox workers were asked about it, they too endorsed these views and further added that their acceptability to the community would also be increased if they were in a position to provide a rudimentary treatment for minor ailments.

From time to time, studies have been undertaken to ascertain if by increasing the number of health/family planning workers their efficiency would increase. In Naurangwal (Punjab) the number of ANMs per block was increased to find out the optimum population which could be effectively covered by each. The Institute of Rural Health and Family Planning at Gandhi gram compared the performance in two blocks, keeping 5,000 population per ANM in one block and 10,000 in the other.

Limited experiments on similar lines for male workers have also been tried in Maharashtra.

In Wardha an integrated scheme of malaria eradication and smallpox programmes was started in 1966 with the final aim of having a basic health worker for all health programmes. More recently this experiment has been introduced in Kolhapur district also by an integrated malaria and smallpox project in one section of each of the 52 sectors in the district. This integrated project covers 1% of the rural and urban population of the district.

Since the above mentioned experimental projects have been few and far between and covered only a small number of workers, an apprehension has been expressed whether the project of the multi purpose workers would at all be feasible. During the visits of the Committee, similar fears were expressed by some of the State Health authorities. To-date, we have only one experimental study conducted by NIHAE, (a WHO/UNICEF assisted research project), in Kilo block of Rohtak district, Haryana State, where male workers engaged under malaria, smallpox and family planning programme have been grouped together; given a short orientation training of one week and put into the field as multi-purpose workers. This project has been in operation for just over a year. The performance of workers in various health & family planning programmes prior to the introduction of multipurpose workers scheme vis-à-vis their performance as multipurpose workers is given in Annexure VIII. It shows that there is a definite improvement in the malaria programme (both active surveillance and passive surveillance) by way of increased number of slides collected and the number of positive cases detected; increased number of both primary vaccinations and revaccinations and in the family planning programme. The results so far obtained are extremely encouraging.

3.3 The Maharashtra Government has also instituted a project similar to the NIHAE Project at Miraj Medical Centre. In this project they intend giving intensive training of about 10 weeks to the future multi-purpose workers. Their supervisors will go through the same programme plus two weeks more for supervisory duties. It is proposed that the ANMs should also undergo a short training to acquaint themselves with the activities of the multipurpose workers. The sponsoring institute of this project is the Miraj Medical Centre.

3.4 FINDINGS

3.41 Feasibility: In the light of experience obtained in the various studies and consequent upon the discussions with the State Health authorities and District Medical Officers of Health the views expressed by the peripheral workers themselves and the reactions of the community, the members of the Committee felt

vinc that the concept of having multi-purpose workers was both desirable and feasible. The field workers were quite enthusiastic about this concept and they felt that it would enhance their acceptance and effectiveness. The Committee felt that the results of the Kiloj projects have been sufficiently encouraging to dispel any apprehensions in this matter.

3.4.2 Number of workers involved;- The number of male workers engaged in malaria, smallpox and trachoma and family planning programmes is sufficiently large and after integration each male worker will have 6 to 7 thousand population to cater to. The position regarding the ANMs is, however, not satisfactory. Their number is only about half that of the male workers. It Was ascertained from some of the male workers engaged in malaria, smallpox and family planning programmes, that it would not be possible for them to undertake maternity work for would they be acceptable to the community in this role. On the other hand some of the ANMs felt confident that they could do malaria and smallpox work in addition to their own.

3.4.3 Phasing;- On the question of phasing of the programme, some members of the Committee felt that multi-purpose workers should be introduced only in those areas where malaria was in the maintenance phase and smallpox has been controlled. Others were of the opinion that the programme could be introduced all over, irrespective of the stage of control of these diseases. After mature consideration, the Committee feels that since the number of workers to be trained is so very large, a practical way out would be as follows:-

To begin with, the training of the workers as multi-purpose functionaries could be started in those areas where small-pox is controlled and malaria is in the maintenance phase. Since such areas constitute 59% of the country, the number of workers to be trained, though still large, would be more manageable. After a few years when these workers have been trained and, other areas have been brought into maintenance phase, the programme could be extended to cover the entire country.

It was felt that a start with, workers of only four programmes i.e., malaria, smallpox, trachoma and family planning including M.C.H. be included in the multi-purpose concept. Since filaria, cholera and leprosy are of regional or zonal importance and since the number of workers engaged under these programmes is comparatively small, these programmes may continue to run as vertical programme for the time being and the workers in these programmes could continue as uni-purpose workers. Trachoma is also zonal in distribution, but since the number of workers involved in this programme is small and their job is

very specific, it was decided that these workers may be included from the start. It was also felt that the same applied to B.C.G workers. This, however, should only be a temporary phase and eventually, the Committee felt that all the workers should be brought under this programme

3.4.4 Supervisors:- Time and again it was brought home to the Committee that lack of proper supervision was an important factor in the unsatisfactory functioning of the peripheral workers. The Committee, therefore, is strongly of the opinion that equal attention needs to be paid both to the multi-purpose workers and- their supervisors.

It was felt that in an ideal situation, there should be one female workers (ANM) for a population of 3000 to 3500 or in an area of not more than 5 kilometres radius from her place of work. A male worker could also effectively cater to the same population. Taking into consideration the number of available workers both male and female, it was felt that a male worker according to the existing number would have to cover a population of 6 to 7 thousand, although this coverage will not be totally effective. An A.N.M. on the other hand will have to work for a population of about 10 to 15 thousand. Till such time as the number of ANMs can be increased, it was considered that the population for an ANM may be divided into two zones, one intensive zone of 3 to 4 thousand within a radius of 5 k.m. and the other, a 'twilight' zone consisting of the remaining population. In the intensive zone she should be fully responsible for the MCH and family planning services while in the 'twilight' zone her service would be available only on request.

3.4.5 Now designations:- The question of nomenclature for the multi-purpose workers was also discussed. Some members felt that now nomenclature might create difficulties while others felt that with new job responsibilities a new designation would be more useful. The consensus was in favour of the latter and the Committee suggests the new designations for multi-purpose workers as Health Worker (Male) and Health Worker (female). The latter would be the present day ANM. The new designations proposed for the supervisors are Health Supervisor (male) and Health Supervisor (female) respectively.

In each sub-centre, there will be a team of two workers, one male and one female, for effective supervision, it was felt that there will have to be a separate male and a separate female supervisor.

3.4.6. The Committee felt that when adequate facilities of men material and money are available, the No. of P.H.Cs_ should be increased. It is felt that for a proper coverage there should be a PHC for 50,000 population. Each PHC would have at least two doctors, one of them should be a female.

3.4.6. (a) The population in each PHC would be divided into 16 sub-centres, each having a population of about 3100.

3.4.6. (b) Each sub-centre would have a team of one female junior community health worker.

3.5. The Committee recommends that for real effectiveness and enhanced acceptability in the community each multi-purpose worker (male and female) should be provided with a few simple medicines for minor ailments costing up to Rs.2000/- per annum per sub-centre. These medicines should be replenished at regular intervals. The workers must be taught when to refer cases beyond their competence the PHC doctor.

3.6. The Committee was convinced that if integration is to succeed it should not only be confined to sub-centre, sector or PHC, but the concept must also extend to the Tehsil and District levels and also to the State head-quarters. For the multipurpose and integrate outlook to develop fully in the district and at lower levels, it is necessary that the district should be under the over-all charge of the Chief Medical Officer who will be fully responsible for the entire medical, health, family planning and nutrition programme in that district. He will be assisted by Deputy Chief Medical Officers, who will assist him in the execution of all programmes listed above. These Deputy Chiefs may also be entrusted with the work of coordination of specific programmes but they should be given peripheral responsibility in respect of field implementation of all the programmes on an area basis.

It will be necessary to give the Chief Medical Officer technical and administrative assistance. Such assistance is available from the existing staff. The Administrative Officer and the District Mass Information and Education Officer and the District Extension Educators could be attached directly to the C.M.O. so that the Administrative Officer provides him assistance in administration, establishment and organisation at the headquarters and the DMETO and DEE become Public Relations Officers for all programmes.

At the State headquarters level the total authority for medical, health, family planning and nutrition, would rest with the Director of Medical and Health Services. He would be assisted by Addl./Joint/Deputy Directors.

CHAPTER—IV

JOB FUNCTIONS OF THE MULTIPURPOSE WORKERS HEALTH WORKERS- (FEMALE)

According to the information made available to the Committee; there are 40,225 ANMS employed in the country. They include all these who are working in sub-centres, PHCs, urban centres, and in district and other hospitals. In general, 2 ANMs are stationed at each PHC, one provides nursing care to the immediate neighbourhood of the PHC. Thus the number of ANMS working in the sub-centres only would be about 20 to 25 thousand.

As mentioned earlier, there is a far greater shortage of ANMs than of their male counter-parts. The Committee felt that a concerted effort should be made to increase the number of ANMs even for the minimum needs programme of health and family planning. Since the existing training programme for an ANM is of two years duration, it will take a fairly long time to make up the shortage. A partial solution of this problem could be to post all ANMs to sub-centres and take them out of all other places. For the nursing care of the in-patients of PHCs and in district and other hospitals, her place could with advantage be taken by trained nurse-midwives. The latter, the Committee was informed, are available and will be more suited for the nursing care of the in-patients and would also relieve ANMs for the community work for which they are primarily trained.

4.1.1 JOB RESPONSIBILITIES RECOMMENDED:

She should provide 100% ante-natal and post-natal coverage to a population of 3 to 4 thousand and about 50% coverage for intranatal care. For the additional population in the "twilight" Zone her services should be available on request only.

The following will be her job responsibilities:

i) Ante-natal care:

1. Registration of pregnant women from three months pregnancy onwards.
2. Looking after pregnant women throughout the period of pregnancy.
3. Urine examination of pregnant women wherever possible.
4. Distribution of iron and folic acids tablets to antenatal and nursing mothers.
5. Referral of cases of abnormal pregnancy.
6. Immunisation of expectant mothers-with Tetanus Toxoid.

ii) Intra-natal care:

1. As stated above she will conduct about 50\$ of deliveries in her intensive area and whenever called in the twilight area.
2. To supervise deliveries conducted by dais whenever called in.
3. Referral of cases of difficult labour

iii) Post-natal and infant care:

1. She will pay at least, three post-delivery visits for each delivery case and render advice regarding feeding of the new born.
2. She will do primary small-pox vaccination and BCG vaccination to all the new born infants.

iv) Family Planning:

1. Maintenance of a copy of eligible couple registers.
2. Spreading the message of family planning to the women in her area and distribute conventional contraceptives amongst them.
3. Follow-up of IUD and sterilisation cases,

v) Nutrition:

1. She will give advice on nutrition to pregnant women, nursing mother and infants, in-arms (0-1 year age), but she will not be responsible for storage, preparation and distribution of food.
2. As stated above, distribution of iron and folic acid tablet to pregnant and nursing mothers. If required, she will distribute Vitamin 'A' to children of 0 to 1 year age.

vi) Training:

She will help in the training programmes of Dais.

vii) Health Education:

She will take part in health education programmes during home visits and also when mothers come to the centre.

viii) Health Care:

1. She will render health care for minor ailments and provide first aid in case of emergencies.
2. She will refer cases beyond her competence to the P.H.C. or to the nearest dispensary.

4.2. Health Worker (Male)

1. According to the figures available, the following are the number of different categories of workers which can be made male multi-purpose workers:-

1. Basic Health Workers	
2. Malaria surveillance Workers	21,190
3. Vaccinators	20,314
4. Family Planning Health Asstts.	12,500
5. Health education assistants (Trachoma)	374
	Total
	<u>76,378</u>

As mentioned earlier, workers engaged in cholera and leprosy control and for BCG vaccination may be allowed to continue as uni-purpose workers for some time. Their number is as follows:-

1. BCG technicians	1,752
2. Cholera Workers	1,461
3. Para-medical Assistant (Leprosy)	<u>1,448</u>
	Total
	<u>4,661</u>

The Health Worker (male) will require training before he can be put on the Job whereas his female counter-part has had a pre-service training of 12 years, the existing workers in health and family planning programmes who will be converted into multipurpose workers have had training in only one field of activity and that too for a comparatively short duration. The duration of the training and the place where it is to be imparted are discussed in another chapter.

This worker, after receiving training in all the programmes, will be able to look after a population of 6 to 7 thousand at present. He will work in collaboration with his female counterpart, i.e. Health Worker (female). Both of them can stay in the same sub-centre village. The Committee feels that if these workers function as a team, their effectiveness will be the minimum. 4.2.1.

During visits to the sub-centre, it was brought to the notice of the Committee that male workers engaged in health and family planning programmes do not have adequate opportunities to come in contact with the male members of the

rural community. This is because the majority of the people, are working, in the field or have to go out to work during day time and hence are not available to the male workers during their home visit, The question of change of working hours of these male workers was" therefore discussed. A suggestion was made that these workers should have different working hours, starting later in the day and continuing till late evening. During discussions, however, it was brought out that by adopting this method a number of administrative problems would arise and at the same time the team work between the male and female field workers would be disturbed. It was, therefore, decided that the male workers may have the usual working hours but they should not confine their attention only to the home visits but should contact the male members of the rural community wherever they can find them.

4.2.2. JOB RESPONSIBILITIES RECOMMENDED

i) Health Programme

1. Will help in the control of communicable diseases including malaria. For this he will pay regular visits to each house-hold once immediately any outbreak of infectious diseases such as cholera, 'typhoid, polio, small-pox etc.
2. Immunisation of children of over one year for small-pox (revaccination) diphtheria, tetanus and whooping cough. He will also re- vaccinate all adults above 15 years of age after every three years.
3. He will assist the supervisor in the school immunisation programme.

ii) Family Planning

1. He will be responsible for the preparation, up-dating and maintenance of eligible couple registers. He will also supply a copy of these to the Health Workers (Female).
2. He will distribute Nirodh to the population in his area.
3. He will spread the message of family planning amongst males of his area and follow up the acceptors.

iii) Health Education

1. He will help in the health education programme during his visits to the homes and at other areas of contact with the males of the population.

2. He will be responsible for maintenance of birth and death registers and other vital statistics.

3. He will identify community leaders and with their help educate and involve the community in health, family planning & nutrition programmes.

iv) Nutrition;

He will help in the nutrition programme of the pre-school going children by way of spotting cases of malnutrition and refer them to Balvadis of PHC for necessary nutrition supplement or treatment. He will, however, not be responsible for maintenance of stock and preparation and distribution of food.

V) Health Care;

1. He will provide medical aid for minor ailments and render first aid.

2. He will refer cases beyond his competence to the PHC to the nearest dispensary.

CHAPTER V

JOB FUNCTIONS OF SUPERVISORS

Health Supervisor (female)

5.1 The supervision of ANMs, in most places, is done by LHVs. This functionary is a Matriculate who has had 2.5 years' pre-service training. According to the course content of her curriculum, this training is community oriented. For the last decade or so, the Nursing Council of India has not been in favour of continuing the LHV course. Some of the State Nursing Councils have accepted this suggestion and have discontinued the LHV training. Instead they have instituted one to three months community health orientation course for nurse midwives who have undergone 3.5 years course and put two continued the LHV training in spite of the Nursing Council's objection.

In all, there are at present 23 LHV schools with an annual admission capacity of 1043. Of these, eight schools are centrally aided and 15 are State-run.

The members of the Committee had opportunities to talk to LHVs, public health nurses and nurse-midwives who had received additional community health training and were working as supervisors of ANMs. The general impression gathered was that the present day LHV was not proving an effective supervisor. This could be partly attributed to the fact that they are much fewer than the number required and hence have proportionately larger area to cover. Secondly, they are unable to provide technical help and guidance to the ANMs in maternity work because after training they get out of touch with this work.

The experience of Maharashtra State Health Authorities, on the other hand, is that nurse-midwives with community health training, when put as Supervisors of ANMs are not keen to stay on, but want to go back to the hospitals as staff nurses. This is understandable since it is common experience that a person wishes to return to the environment in which he/she was trained.

5.1.1

The general consensus in the Committee was that for the effective supervision of the work of Health Worker (female), a functionary was needed who is primarily trained in community health she should have maternity practice as a major component of her training and should continue to practice in this field in order to render expert advice and help. Her training should be more community oriented than hospital based. It is, therefore, apparent that LHV training needs modifications.

5.1.2 The total number of LHVs and public health nurses employed at present is 7462. This no includes those who are attached to primary health centres and others posted in urban centres at the district and State headquarters as well as district public health nurses. According to the existing pattern, only 2 LHVs PHNs are sanctioned for each PHC. Although both are expected to go into the periphery, they have duties at the PHC itself to attend to.

From the total figures of ANMs and LHVs available, it is obvious that if all ANMs are to be put in sub-centres and all LHVs are to work only as their supervisors, the ratio will work out at one LHV for six ANMs.' The Committee is of the view that effective supervision can only be exercised if one LHV supervises the work of not more than 4 ANMs. The need for having more LHVs is therefore obvious.

5.2 JOB RESPONSIBILITIES RECOMMENDED

1. She will reinforce the skills in Health Worker (female) in MCH, Family Planning and nutrition components of her pre-service training.
2. She will supervise and guide the H.W. (female) in giving MCH and Family Planning services to the public in her sector.
3. She will observe and supervise the work of H.W. (female- trained dais. For this purpose, it is necessary for her to observe them conduct one or two domiciliary deliveries.
4. She will help them improve technical and human relationship skills.
5. She will respond to urgent calls from the H.W. (female) and trained dais and render the required help.
6. In abnormal cases she will arrange for transport to take the expectant mothers to the PHC or the nearest hospital.
7. She will visit at least once a week, on fixed days, each sub-centre in her jurisdiction. During these visits she will conduct ante-natal and well-baby clinic. During her visits to the sub-centres she will carry out home visits and during these visits in addition to giving advice about maternity and child health. She will demonstrate simple procedures to relieve conditions such as sore eyes, scabies and common boils, etc.

8. She will arrange to give group talks to expectant mothers laying stress on personal hygiene, nutrition education and environmental sanitation.
9. She will contact the mothers during her clinic visits and distribute educational materials to them.
10. She will also help in educating the women in control of communicable diseases.
11. She will held staff conferences once a month with the H.W. (female) and trained dais working within her area
12. She will give an evaluation report of the work done in the field of maternal and child health in her sector.
13. She will be responsible for maintenance of records, preparation and submission of reports and returns. A separate record is to be maintained for domiciliary confinements.
14. She will undertake the training of dais with the help of H.W. (female).
15. She will personally motivate resistant cases for family planning.

HEALTH SUPERVISOR (MALE)

5.3.1 In most of the States the present Supervisor is one who worked in a particular programme for a number of years and was promoted to the higher grade. In some of the eastern States like Orissa, Bihar, and West Bengal, however, there is another class of worker the health assistant. These persons are matriculates who were given two years training in medical colleges. They are bracketed with sanitary inspectors, malaria inspectors, etc., as far as their salary is concerned, but by virtue of their training, they are comparable to Bare Foot Doctors of China. This training programme was however given up some years ago and the number of health assistants is therefore gradually coming down.

5.3.2 According to the figures available in the Directorate General of Health Services, following is the number and categories of Workers who, after suitable training, can perform supervisory tasks for the male health worker

i) Health Inspectors/Sanitary Inspectors	3200
ii) Malaria Surveillance Inspectors	5207
iii) Vaccinator/Supervisors	4649
Total	13156

Of these, the number available for the rural areas will be about half, i.e., 22000.

As the number of male health workers available should be a little over, 76,000, and if, the work of 4 peripheral workers can be supervised by one supervisor, the total number of male supervisors required would be about 19,000 only. This means that there is a surplus of about 3,000 of male supervisory workers.

The number of male health supervisors being over three times the number of female supervisory workers, there is an urgent need to concentrate on increasing the number of female supervisory workers during the Fifth Five Year Plan period. To get round this problem of mal-distribution of numbers, the Committee considered the possibility of giving the task of supervision of female multi-purpose workers to male supervisors. However, the existing functionaries when asked about it were reluctant and lacked confidence. The Committee also feels that the work of the female multi-purpose workers cannot be effectively supervised by the male supervisors.

According to the existing number of supervisors, there will be one male supervisor over three to four male health workers as contrasted to one female supervisor for six female workers for the time being.

5.4 In addition to the Categories mentioned above in some States there are supervisors in still higher grades. These are senior sanitary inspectors, senior malaria and health inspectors and senior vaccination inspectors. The Committee considered this problem and suggests that since this is not an all India pattern, and the number involved is not very large, the only solution is to abolish such posts for future. During the interim period, one senior inspector of health, malaria or smallpox can be posted at the P.H.C.

5.5 The position of the Block Extension Educator is peculiar. He is generally a graduate in social sciences who has had a short orientation training in family planning work but has no knowledge of medical or health programmes. In some States, BEEs are matriculates. His scale of pay is the highest of all the workers engaged in health and family planning programmes. At present, he is in charge of extension education for the entire block and he stays at the P.H.C headquarters. Whereas his higher academic qualification is an or set the lack of training and knowledge of health and medical programmes is his handicap.

The Committee was therefore faced with the problem of fitting this functionary in the proposed set up. It considered placing him in the category of male Health Supervisor along with Sanitary Inspectors/Health Inspectors but the KILOI experiment was discouraging. According to the report, he proved to be recalcitrant to an integrated approach. He was apprehensive that if converted into the role of a health supervisor his area of influence would be reduced resulting in loss of prestige. Moreover, if he is to be made a male health supervisor his training would be longer and more intensive as compared to the health inspector/sanitary inspector, etc.

The Committee therefore felt that as an interim measure, they should be posted at the PHC and should serve as a consistent to the Medical Officers. He would render the medical officers assistance in arranging meetings and camps and all public relations work. He would also help the PHC doctors in-office work and record keeping. It is suggested that his designation be changed to "Block Health Assistant".

He would, however, not be in a position to exercise any technical supervision over health supervisors.

It was felt that in all probability such functionaries may be needed in future. Their promotion to the district level as District Health Assistants could be considered where they would work as Assistants to the CM.Os for extension work.

Training to be imparted to the so-far-single-purpose senior community health Workers is of crucial importance. This aspect is discussed in a subsequent chapter.

5.6 JOB RESPONSIBILITIES RECOMMENDED FOR HEALTH SUPERVISORS(MALE)

1. To supervise the work of male health workers, and provide adequate guidance to them by making frequent visits to each worker in his jurisdiction.
2. To arrange small group meetings with the help of community leaders for spreading the message of family planning to the males and answering any of their queries on the subject.
3. To check vaccination of all school-going children.
4. To check and supervise the malaria maintenance work and the small-pox vaccination work of the male health workers.
5. To supervise the records maintained by the male health workers.

6. To keep a close watch on the sudden outbreak of epidemics like cholera, small-pox, etc.
7. To treat all cases whose blood smears are positive for malaria.
8. To supervise spraying of insecticides.
9. To supervise the work of male health workers regarding environmental sanitation, disinfection of wells, etc.

10. To periodically check the registers and records maintained by male health workers by actual physical verification.
11. To be responsible to the primary health centre doctors for delivery of health, family Planning and nutrition services to the community.
12. To maintain adequate supplies of Nirodh and other contraceptives for distribution.

CHAPTER VI

INTEGRATION AT DIFFERENT LEVELS

6.1 The organisation of the present day health and family planning and nutrition services in any State bears a close resemblance to an hour glass. The constriction in the middle can be compared to a PHC with widened areas above and below. Above the PHC there is a broad division of health services into preventive medicine there are individual officers responsible for different programmes like malaria, smallpox, cholera, tuberculosis, etc. Below the PHC level there are again different workers engaged in individual and separate programmes like malaria smallpox, leprosy, cholera, family planning, etc.

6.2 The Committee feels convinced that having multi-purpose workers at the periphery and their immediate supervisors at the sectoral level, without integration of the entire range of curative and preventive health services and family planning, from the State headquarters down-wards, would be only a partial solution of the complex problem.

6.3 A strong plea was made to the Committee that Preventive and promotive health activities could only be built around a pillar of curative medicine. Any worker engaged in health and family planning activities must be able to provide curative measures for simple ailments if he/she is to be effective and acceptable to the community. The same is applicable to the doctors. Only that doctor will prove effective for motivating people for family planning or accepting inoculations who can treat them for their ailments.

6.4 PRESENT SCENE

6.4.1 P.H.C. Level

1. The PHC doctor to-day has a large number of responsibilities, at least on paper. In most of the cases he is a fresh graduate and has not been given any training to discharge these responsibilities during his under-graduate days. He therefore finds it convenient to confine himself to doing the out-patient clinics at the PHC or at the sub-centres during his visits. A small portion of his time is also spent in the care of in patients at the PHC. In the Kiloi study, it was brought out that about 60% of the time of the PHC doctor is unaccounted for. This is obviously a serious situation.

2. In addition to the PHC, there are a variety of dispensaries in many blocks. Some of the dispensaries are run by local bodies, voluntary agencies and some by Government. These dispensaries are either manned by Allopathic doctors or by Ayurvedic, Unani or Homoeopathic practitioners. There is no inter-link between these dispensaries and the PHC.

3. The distance between a PHC and the next larger hospital where greater expertise is available, varies from 5 to 100 miles. In general there are no graded hospitals in-between the medical college hospitals where specialists and a wide array of investigative services are available and the PHC where neither is available. There are however, some well equipped District Hospitals where adequate facilities for investigations and treatment are available.

4. The administrative hierarchy, too, is both diffuse and confusing. For the preventive services the PHC doctor is responsible to the district health officer and for the curative medicine he has to make referrals to the district hospital. In some States, family planning and health services are combined in one functionary, i.e. the district medical officer of health and family planning while in others, two separate functionaries exist.

6.4.1.1 The doctors of PHC during their visits to sub-centres will not only render health care to the population but will also check the work of the health workers and their supervisors.

6.4.1.2 All the dispensaries in the jurisdiction of a primary health centre should be linked with the PHC and each dispensary doctor should render referral services to the cases referred by the health workers.

6.4.1.3 The doctors at the PHC should divide the population on a geographical basis for their field visits. While one doctor attends to the out-patients and in-patients at the PHC, the other doctor should go out on field visits and extend integrated health, family planning and nutrition services to the population. Thus each doctor will be at the PHC for three days and will be away on field visits for the other three days of the week.

Wherever there is one lady doctor at the PHC, she should render specialist services for maternity and child health to the entire PHC population.

Wherever tehsil/taluq hospitals are in existence, specialist services and investigative facilities are, in general, poor. Wherever such hospitals do exist medical officers working in these hospitals are responsible for the health care of only the in-patients of the hospital. They are not responsible for the public health activities of that area.

At the district level, there is a Civil Surgeon who is usually in charge of the district hospital. In many district hospitals there are junior specialists in surgery, medicine and obst. and gynae. X-ray and laboratory facilities are available to a limited degree. In addition to the Civil Surgeon, there are two, three or more district medical officers of health, In some States, district medical officers have combined responsibilities for health and family planning while in others the two are separate- In most of the States, the Chief Medical Officer-has an overall charge of both the civil hospital and the public health services of the district. In general the promotional avenues tend to gravitate towards the Civil Surgeon and not from the Civil Surgeon to medical officers of the health and family planning.

In many States there is only one man at the top, Director of Health Services, for all the health and family planning programmes including education and training. He is assisted by a number of Deputy Directors and Assistant Directors. In other States, medical education is taken away from the purview of the Director of Health Services and a separate Directorate has been set up to look after medical education. Usually an officer of the rank of an Assistant Director posted at the State headquarters looks after the nursing and MCH services. There is hardly a State in which training of the paper medical staff is entrusted to a single officer in the Directorate.

In the vast sea of health and family planning services of the States, Medical Colleges and the attached hospitals are islands in themselves. Their responsibility starts and ends with under-graduate and post-graduate medical education and rendering of medical care to those who seek help either as out-patients or are admitted into the wards. Their specialist services and the sophisticated investigative techniques are hardly ever extended to the community at large. Whatever liaison exists between the staff of the medical colleges and the doctors working in the district hospitals or in PHCs, is on personal basis.

Although each medical college is supposed to have, and many do have, a rural and urban field practice area, it is more of a show-piece and hardly ever caters to the health needs of the community within this area.

6.5 Comments:

With such a diverse, diffuse and at times conflicting array of medical facilities available in the country, it is not surprising that there is a constant cry of neglect and of inadequacies particularly for the under-privileged sections of the society which constitute the vast majority. Even though we may have a poorer, doctors-population ratio, as compared to the developed societies, it is an inescapable fact that a proper harnessing of the available resources and reorganisation of the entire system can go a long way in solving the health problems of the country.

If proper bridges, could be built between the medical college hospitals on one side and the primary health centres at the other, with taluq and district hospitals in between, a much closer liaison can be established between all workers engaged in the health and family planning programmes. Graded facilities of specialist skills and investigative techniques can then be made available at different levels.

The existing practice of separating curative and preventive medicine, also needs to be reviewed. The old departments of hygiene in medical colleges and their more recent prestigious replacements (Departments of preventive and Social Medicine) have to be evaluated. Whereas some divisions in the field of medicine like general medicine surgery, obst. ophthalmology, etc. have to be there, it is questionable if divisions between preventive medicine, curative medicine and family planning need to be continued.

It seems that the time is ripe for a reappraisal of the whole organisation of medical services in the country. The existing divisions both in account of historical developments and of borrowed ideas from the West need to be reviewed and the entire system over-hauled.

6.6 RECOMMENDATIONS:

At present we have a little over 100 medical colleges in the country and in all there are about 370 districts. It is suggested that a medical college with its attached hospital be made responsible for the entire health, family planning and nutrition programmes of say three districts. Of course, the

Medical Colleges will have to work in close coordination with 1 District Health and Medical Officers of the concerned Districts for which proper guidelines will have to be laid down. Each district should have a 100 to 150 bedded hospital with specialist services in medicine, surgery, obst., ophthalmology and well developed X-ray and laboratory services. Under the district hospital could be placed four or Five, 50 to 75 bedded taluq/tehsil hospitals with general medicine, general surgery and obstetrics' provisions and limited X-ray and laboratory facilities. The last link in this chain would be the PHC with 5 to 10 beds. A referral system can be in-built in such an organisation whereby patients can be referred from a PHC to the taluq, to the district and to the medical college hospital. The Medical College will also organise in consultation with the District Health and Medical Officer the training programmes for the doctors, nurses and para-medical staff within their jurisdiction. This will make training more relevant to the day-to-day needs of the community. The follow up services, the records of the patients and vital statistics would also improve.

In addition to the involvement of Medical College Hospitals with rural health institutions specialising in certain fields like cardiology, neurology, orthopaedics, ophthalmology, etc., will have to be created on zonal basis. The extra medical colleges in the large cities of India, i.e., Bombay, Calcutta, Madras and Delhi could be converted into such specialist institutions. The Committee recommends that this concept may be further examined and seriously considered.

Whatever may be the final decision on this concept, the Committee was unanimously of the view that there has to be an integration net only at the level of the peripheral workers but right up to the State headquarters.

A separate note on this point by Dr. D.N. Gupta, Member-Secretary of the Committee, can be seen at page No. 47 at the end of the report.

CHAPTER VII

PROBLEMS TO BE FACED

For a successful implementation of the programme of having multi-purpose workers for health, family planning and nutrition services, a number of problems are to be faced. Broadly speaking, these can be grouped under Administrative and Training.

7.1 Administrative Problems

It has been brought put in an earlier chapter that in different States there is a wide variation in the educational qualifications, training background and pay--scales of workers. In general the vaccinators have the lowest pay scales and education background.

To put all these workers into one category of male health workers, is therefore going to raise some administrative problems. The Committee recommends that for the future entrants, a minimum qualification of matriculation in science subjects should be insisted upon. The existing functionaries after suitable training, may be grouped together in one pay scale with marginal adjustments of their existing scales and protection of the individuals present pay.

7.1.1. Promotional avenues

For a successful implementation of any programme it is essential that the workers involved should have suitable avenues of promotion. The Committee, therefore, recommends that two-thirds of the posts in the higher cadre of the health supervisors be reserved for those who successfully completed at least three years of service as health workers. This period may be extended to five years for those who are not matriculates. The Committee recommends that the new entrants in the health supervisor's cadre should have passed Inter Science or Higher Secondary with science subjects.

A suggestion made by West Bengal Government was to have two or three grades for all types of para-medical staff and a fixed percentage of promotions from a lower to a higher grade. The Committee however, feels that it would be more advantageous to have only two categories with two grades, one for the junior and the other for the senior health workers.

7.1.2. Another problem faced by the Committee was whether to have the same pay scale for the male and the female workers. This is relevant as ANM has a two years pre-service training whereas the malaria or small-pox worker of today has only 1 to 3 months in-service training. Moreover, ANMs are in short supply as compared to the male workers. Conversely it was also felt that

for a proper teamwork, no discrepancies between the two workers should exist.

Taking into consideration all this, it is recommended that there should be a uniform grade for both male and female health workers. It is also recommended that fixation of the grade for the time being should be left to an individual State which as far as possible should be the highest that exists in that State for these workers. All the grades, however, should be made uniform in due course.

7.1.3. The Committee also considered the question of the existing Class 7 employees like attendants, disinfectors, etc. It was felt that such functionaries may continue wherever they exist and perform the prescribed duties. For future, however, there was no need to have any Class IV." employees at the sub-centre or sectoral level, except for sweepers.

7.1.4. The question of trained dais is, however, different. In some States, trained dais are regular employees getting a fixed amount of Rs.50 to 100A per month. They help AIMS in their day-to-day work and also undertake home deliveries. The Government of India had recently appointed a Committee to go into the question of training of indigenous dais. The report has been submitted and this Committee has brought out that suitable incentives have to be offered to the indigenous dais to undergo training. It has also highlighted that in the next 5 to 10 years training of indigenous dais shall have to be stepped up to fill the gap of ANMs shortage. Amongst other suggestions, this Committee has recommended that in order to attract indigenous dais for the training programmes, posts of ANM attendants may be created on the existing pattern of Haryana giving them a suitable salary of pay Rs.100/- a month or so. An alternative suggested is to give them fees on a prorata basis on the number of cases delivered each month. This Committee endorses the view that creation of posts of suitably trained indigenous dais would be appropriate till such time as the ANM shortage is made good.

7.2 Problems in Training

In recent years, greater and greater emphasis is being placed on training for better job performance. Although the concept of training for improved job functions is of recent origin derived mainly from the experience in American industry, the concept is old as antiquity. The older method of a son following the trade of his father or of a young apprentice attached to a master craftsman are examples of the same. All the same, there are a number of problems in the sphere of training in the field of health. These problems may be considered as general and specific.

7.2.1

GENERAL

By and large, training of the workers engaged in health programmes, doctors, "nurses or para-medical staff, is undertaken in specified training institutes. These institutes impart training in an atmosphere which is usually devoid of the knowledge of the actual needs of the workers. It is commonly patterned on similar trailing courses run in other places mostly in USA and U.K. Not only the main features of these courses are borrowed, but in several instances even the terminology used is the same. Since many of the trainers have had their own training in training institutes abroad, the terms and phrases used by them are foreign and many a time unintelligible to the trainees. During the last few years many terms have been introduced in this field which are not in common usage in this country and poorly understood by all others except those who use them. This has resulted in training for training's sake, devoid of any relevance to the actual needs and the job requirements of the trainees. The trainers hardly move out of their training centres, are not in touch with the field workers and have very vague ideas of the problems faced by the trainees in their jobs.

The trainees are sent to the training institutes less on their own initiative and more on administrative orders. Promotion is not linked with training. Historically the pattern of our education and training in this country is based on the English model. An individual expects to add some letters of alphabet to his name following formalized training, be it a certificate, a diploma or a degree course. Since no such addition is possible after the present day training courses, and since promotion or even increments in pay are not linked with a satisfactory training, there is reluctance on the part of trainees to come for training. Moreover, the stipend paid to the trainees is low and since he has to run two establishments during this period, he is reluctant to add to his already heavy financial load. All this results in under-utilisation of the training facilities. Then again, frequent transfers from one job to another add to the backlog of training load. The administrator on the other hand feels concerned when he finds that the expenditure on training does not yield commensurate results. This vicious cycle of training un-related to job performance, under-utilisation of woefully inadequate training facilities, high expenditure and poor results, needs to be broken. Those, who are responsible for the delivery of the health care services, must have a say in the training programmes and the trainers must be intimately aware of the requirements of the trainees.

Another problem common to most of the training programmes is the tendency of the trainers to introduce into the training programme as much factual knowledge as possible. There seems to be an apprehension that the trainee may never come again and therefore he should be taught as much as possible. This not only lengthens the course but also makes it less relevant to the prevailing situation. On his return from the course the trainee finds a great deal of what he learnt of no relevance to his job requirements. It is felt that it is better to keep the training courses short and more frequent rather than long and infrequent.

7.2.2. SPECIFIC

7.2.2.1 Doctors

After the prescribed 4.5 years' under-graduate course an undergraduate undergoes one year of pre-registration internship programme. In-service orientation training in family planning, of one week to one month duration, is given in different States. Short training courses of a few days are also given to doctors engaged in special programmes like malaria, smallpox, B.C.G., etc., but such programmes are neither standardised nor are available in all the States.

It is indeed ironical that whereas a doctor is said to be a leader of the team consisting of nursing and para-medical staff, no training is imparted to him to enable him to discharge such a function. Throughout his undergraduate career not a single hour is devoted to develop managerial skills, checking of accounts supervision of his juniors or for other duties expected of a leader. Little wonder therefore that a young medico at the PHC is a leader of his team only in name. Being inexperienced, not only does he have a feeling of technical insecurity but he also feels shaky, in all the administrative duties required to be performed to him. Some of the members of this Committee felt these deficiencies in his training were more responsible for his disinclination to work in villages rather than lack of physical and social amenities.

It was also felt that the medical education that he receives has hardly any relationship to the conditions in which he would be required to work either in the State run health programme or even in private practice. The place where he feels most comfortable is a large hospital with all available specialist backing and the help of sophisticated investigative techniques. Since medical Education in this country is based almost entirely on the Western model, he is more suitable for the conditions that prevail in Western model, he is more suitable for the conditions that prevail in Western countries than in his own.

Till such time as the existing pattern of medical education. is changed, the Committee recommends that a pre-service training of 6 to 8 weeks may be given to each PHC doctor to make him familiar with the role that he would be expected to perform as the leader of his team. This would include training in managerial, administrative and financial aspects of his job.

7.2.2.2 Nurses. In the nursing field the training is either pre service or in-service. The former includes ANM, LHV and B.Sc. nursing courses and the latter the nurse midwife course.

a) ANMs: The existing course of ANM training is of two years duration after an educational qualification of 7th class pass. The training is imparted in ANM schools, most of which are attached to district hospitals or other hospitals. During the course, practical training is imparted in general, medical and surgical nursing and maternity training forms an essential component, Community training is prescribed but not always strictly followed. In general many of the ANM schools are deficient in staff, accommodation (both teaching and hotel) and equipment. In some ANM schools, the existing facilities can only be termed as deplorable.

Government of India recently appointed a committee to go into the curriculum of the ANM training. Its report has been submitted and is under the consideration of the Department of Family Planning. This Committee is of the view that for future entrants, matriculation should be the minimum educational qualification and the training should be modified giving emphasis on midwifery, public health and nursing in that order. It is also our view that the duration of the course could be reduced to 18 months. This can be conveniently done by reducing the period spent by the trainees in the medical and surgical wards.

The Committee is also of the view that an ANM during her training should stay at a PHC for a period of at least three months. From the Primary Health Centre she can be taken to a sub-Centre by her tutor to learn the conditions at first hand. Such an exposure would prepare her better for the job that she would be required to perform after her training.

The urgent need of having more ANMs particularly in States like UP and Bihar where their number is extremely small has been emphasised in an earlier chapter.

c) L.HV.; The controversy involving L.H.V. and nurse-" midwife with community health training has been referred to. The Committee is of the view that there has to be a female supervisor for the female Health Workers said that such a supervisor should receive training with a greater community bias rather than hospital

oriented training. The Committee is also of the view-that after some years it may be possible to have common courses for all the nurses but for the next 10 to 15 years, it will be profitable to have separate categories of hospitals biased nurses and community oriented nurses.

The Committee also feels that the present day L.H.V. is not a very effective worker. She does not provide technical guidance to A.N.Ms nor is she a competent supervisor. The Committee is of the view that her training needs modification. It is recommended that the duration of the L.H.V. course could be reduced from 2½ years to 2 years and emphasis placed on equipping her to become a suitable supervisor and technical expert in the field of maternity and child health for the female Health Workers.

7.2.2.3 Para-Medical

Apart from a course for Sanitary Inspectors, there are no regular training courses for the para-medical workers engaged in the field of Health. In the Family Planning, however, 1 to 3 months courses for extension educators and family planning health assistants are run in regional family planning training centres. The Sanitary Inspectors course used to vary from 5 to 10 months. This has now been made uniform and its duration is 12 months. There are at present 40 Sanitary Inspector schools in different States.

It was painful to observe that whereas the duration of the course for Sanitary Inspectors is one year, their job is mostly confined to supervision of disinfection of wells, looking after sanitation and almost nothing else. One seriously wonders if it is essential to have one year's training for performing the task which the Sanitary Inspector does at present.

7.3 RECOMMENDATIONS

Since the number of persons who would require training to equip them for duties of multi-purpose health workers and their supervisors is very large, the Committee attaches a lot of importance to the training programmes.

7.3.1 It strongly feels that all training facilities should be pooled together "and training imparted in an integrated manner. It was not possible for the Committee to go into the details of the curricula, content and the duration of the training. The Committee feels that it requires a detailed study and some experimentation. Borrowing from the experience of Kiloi experiment, it is suggested that the male health worker may be given one to two weeks initial orientation training, preferably at the

PHC followed by 6 to 8 weeks training at selected training centres. Such a training will be for all the national health programmes and in family Planning and nutrition.

7.3.2 There are at present 16 field units in different parts of the country. The Department of Family Planning has recently taken a decision to disband the field units as it was felt that there was no longer any need for their continuance in view of the establishment of the regional training centres. The Committee is of the view that since there is going to be a tremendous training load and existing training facilities are meagre, it will be worthwhile to reconsider this decision. The field units are mobile and functioning and can be utilised for providing to the community health workers on the job initial orientation training.

7.3.3 For the new entrants, it is recommended that a one year pre-service training may be insisted upon. The Health Supervisors may be given one to two weeks orientation training at PHC followed by similar training imparted to the health workers plus two weeks training in supervisory duties. The new entrants should be given 18 months pre-service training. As suggested above, two-thirds of the posts in the supervisory scale should be filled on promotion from the health workers both male and female.

7.3.4 The Committee also recommends that a group consisting of Health Administrators, trainers and technical experts may be appointed to go into this question in depth and suggest training methods and the course contents of the training courses.

7.3.5 For the proper integration of training activities, planning of courses and bringing out training manuals, etc., the Committee recommends that a Training Division be set up at the Ministry of Health and Family Planning. This Division would look after all training requirements for health and Family Planning.

CHAPTER VIII

MOBILE UNITS

8.1 There are 399 mobile sterilisation units and 456 IUD unit in position in different States. The staff in position in these centres varies. The performance of these units has steadily declined over the last three years. At the same time the number of sterilisation beds has increased in both large and small hospitals. The Committee considered the question of continuing the mobile units in view of the changed conditions and was of the view that there was no need to continue these units. During discussions with the State Health authorities this view of the Committee in general was shared by them. However, many State Health Authorities felt that for propagating the use of IUD, the retention of IUD mobile units may be necessary since each unit has a lady Assistant Surgeon. Though the declining performance of the units was admitted by all, some State Health Authorities felt that till such time that more lady doctors were available at PHCs it may be necessary to continue the mobile IUD units.

8.2 In a recent communication, Government of India have asked the States to disband mobile service units except one for each district with effect from 1st August, 1973. The pattern of mobile units in the intensive districts would however continue. The vehicles and staff, which will become surplus, consequent upon the disbanding of these units, are to be utilized elsewhere. In case of two States, extension of time limit for disbanding of units beyond 1st August, 1973 has been agreed to.

8.3 The Committee recommends that the mobile service unit in each district may be manned by a lady doctor and used primarily as IUD unit. If the lady doctor in such a unit has adequate training and experience in performing tubectomies, her services could also be made available for assisting the PHCs having adequate facilities to undertake such operations. The continuance of these units, the Committee recommends, should be linked with completion of fixed targets with proper follow-up action.

CHAPTER IX

SUMMARY OF RECOMMENDATIONS

1. Multi-purpose workers for the delivery of health, family planning and nutrition services to the rural communities are both feasible and desirable. (3.4.1).

2. A new designation is proposed for the multi-purpose worker Health Worker (Male/female).

The newly designated female Health Workers will be the present ANMs and the newly designated male Health Workers will be the present day Basic Health Workers, Malaria Surveillance Workers, Vaccinators Health Education Assistants (Trachoma) and the Family Planning Health assistants. (3.4.5)

3. The programme of having multi-purpose workers should be introduced, in the first phase, in areas where malaria is in main tenance phase and small-pox has been controlled. The programme can be extended to other areas as malaria passes into maintenance phase or where small-pox is controlled. This will be the second phase.

The workers engaged in cholera control, filaria, and leprosy programme may continue as such for the time being, Similarly, BCG vaccinators may also continue as such. However, all these workers will be made multi-purpose workers in the third phase of the programme. (3.4.3)

4. There should be a team of two health workers, one male and one female, at the sub-centre level. (3.4.5)

5. There should be a team of two health workers, one male and one female, at the sub-centre level. (3.4.5))

After training in all programmes each health workers, male and female, should be given a first-aid kit and also some medicines for minor ailments, costing up to Rs. 2,000 per annum for each sub-centre. These medicines should be replenished at regular intervals (3.5)

6. The field visits of the male health workers should not be limited to the homes of the villagers but they should also go to the places of work of the villagers. (4.2.1)

7. In order to reduce the existing shortage of the female health workers, ANMs whose job is confined to the PHC headquarters, and others posted at the district hospitals and at other places should be withdrawn and posted at sub-centres. The posts vacated by the A.NMs should be filled by nurse-midwives. (4.1)

Jurisdiction, for each health workers:

8.1.1. As an ultimate objective it is recommended that when adequate facilities of men, material and money are made available the number of PHCs should be increased. It is felt that for a proper coverage there should be a PHC for 50,000 population. Each PHC would have at least two doctors one of them should be a female. (3.4.6)

8.1.2. The population in each PHC would be divided into 16 sub centres, each having a population of about 3000 - 3500 depending on topography and means of communications. (3.4.6)

8.1.3. Each sub-centre would have a team of one male and one female health worker. (3.4.6)

8.b. Taking into consideration the existing number of male and female health workers, it is recommended that;

8.b.1. A male health worker would have for the present to look after a population of 6 to 7 thousand. (4.2)

8.b.2. A female health worker (ANM) would have a population of to 12 thousand This population be divided in two zones - one intensive-area of 3 to 4 thousand or an area of no more than 5 K.M in radius from her place of stay, where she will be responsible for Maternity and Child Health and Family Planning services and the other 'twilight' areas where her services will be available for partial coverage on request only. (3.4.4)

8.b.3. During the interim period, it is suggested that the services of trained dais be increasingly used particularly in 1 'twilight' areas. In order to make the trained dais reliable assistants of the female Health Workers, they may be given a suitable remuneration. (7.1.4)

10. Emphasis should be placed in the 5th Five Year Plan on increasing the training facilities of female health workers. The number of ANM schools should be increased particularly in the States that have an acute shortage. (7.2.2.2)

10. Jurisdiction for each health supervisor:

10a.1 with an ultimate objective of a PHC for 50,000 population centres, the work of eight health workers (4 males and 4 group of two health supervisors, having 16 females) would be supervised by a one male and one female. (3.4.5)

10.a.2 These supervisors should preferably stay in the area of the four sub-centres they have to supervise. (3.4.5)

10.b With the existing situation of having a much larger number of male health supervisors as compared to the female health supervisors, it is recommended that for the time being one male health supervisor may supervise the work of 3 - 4 male health workers and the female health supervisor (LHV) may supervise the work of 4 female health workers. (5.3.2)

10.c. The present day lady health visitors now designated as female Health Supervisor should be withdrawn from all posts other than those of ANM supervisors. For example, lady health visitors at PHC headquarters, or at urban centres or in district headquarters etc., should be withdrawn and posted for field work of the sector allotted. Nurse-midwives may be posted in their place in urban centres and the District for static duties. (5.3.2)

10.d Nurse-midwives with community health training or qualify public health nurses should be recruited to make up the deficiency in the number of female Health Supervisors. (5.3.2)

11. Two-thirds of the posts of the Health Supervisors both male and female should be reserved for promotion from the Health workers cadres. The remaining one-third should be filled by direct recruitment. (7.1.1)

12. Training:

It is recommended that a small group consisting of health administrators, trainers and technical experts be constituted to go into the details of the training that is to be imparted to the future multipurpose workers and their supervisors. Such a group would also devise manuals, "and" prescribe curricula for the training of the present day uni-purpose workers in order to make them multipurpose workers. The course content and the duration of training for those who are to be recruited in future as multipurpose workers will also be indicated by this group along with the places where such a training can be imparted.

12.a The same group should examine the existing, curricula of ANMs and LHVs and suggest ways and means to make the training of these functionaries more practical and job-oriented} C7.3.4)

12.b Pending the recommendations of the proposed group the Committee recommends:

12.b.1 The existing uni-purpose peripheral male workers may be given 1-2 weeks orientation training followed by 6 to 8 weeks intensive training. (7.3.1)

12.b.2 The supervisory workers should receive 1 to 2 weeks orientation training followed by 6-8 weeks common training with the junior health workers plus 2 weeks of supervisory training. (7.3.3)

12.b.3 The duration of ANM and LHV training can be conveniently reduced by six months in each case. (7.2.2.2.)

12.c The minimum educational qualifications for the new entrant; as Health Workers (females) should be preferably matriculation or equivalent with science and biology and for the male Health Workers, Matriculation with Science and Biology. For the Health Supervisors (male and female) Higher Secondary with Science should be the minimum qualification.

- 12.d Training for all the workers—engaged in the field of the family planning and nutrition should be integrated. (7.3.1)
- 12.e A training division should be established at the centre (7.3.5)
13. The job responsibilities of the proposed Health Workers and their supervisors (male and female) are given in Chapters IV and V.
14. The pay scales of the health workers and their supervisors should as far as possible, be made uniform in all States. (7.1.2)
15. The doctor-in-charge of a PHC should have the overall charge of all the supervisors and health workers in his area. He be assisted by the Block Health Assistant for his headquarters' work. (5.5)
16. The doctors of PHC during their visits to sub-centres not only render health care to the population but will also check the work of the health workers and their supervisors. (6.4.1.1)
17. All the dispensaries in the jurisdiction of a primary centre should be linked with the PHC and each dispensary doctor should render referral services to the cases referred by the health workers. (6.4.1.2)
18. The doctors at the PHC should divide the population on geographical basis for their field visits. While one doctor attends to the out-patients and in-patients at the PHC, the other doctors should go out on field visits and extend integrated health family planning and nutrition services to the population. Thus, each doctor will be at the PHC for three days and will be away on field visits for the other three days of the week. Wherever there is one lady doctor at the PHC, she should render specialist services for maternity and child health to the entire PHC population. (6.4.1.3)
19. In order to bring about an effective integration of workers engaged in vertical programmes of health and family planning, the concept should be extended to the district and the State Level. The division of work amongst the district medical officer should be on a geographical basis rather than on a programme basis (3.6)
20. The concept of medical colleges integrating all health, family planning, nutrition, and training programmes, has been put forward. (6.6)
21. It is suggested that there is no valid need for mobile sterilisation units. For IUD work there may be justification for maintenance of some units but their continuation should be made subject to fulfilment of specified targets. (8.3)

NOTE BY DR.. D.N. GUPTA MEMBER-SECRETARY OF THE COMMITTEE

At present there are a little over 100 medical colleges in the country, of these, there are four colleges each in the four major towns Delhi, Calcutta, Bombay and Madras. Six other towns, i.e., Hyderabad, Ahmedabad, Poona, Nagpur, Bangalore and Ludhiana have two medical colleges each. The rest about 71 medical colleges are located in different States either at State headquarters or in large district towns.

Apart from under-graduate medical education which is imparted in each medical college, more than half also impart postgraduate medical education. In many, the attached hospitals impart training to the nurses. A few also undertake training for para-medical staff like laboratory technicians, X-ray technicians. Some also participate in the training of some categories of health staff. As such, medical colleges are important training centres for doctors, nurses and para-medical workers.

Though the medical colleges provide a large nucleus for the training of health workers, it is common knowledge that their role in the health delivery system of the country is meagre. The trainers hardly know the job requirements for which they impart training and those who have to utilize the services have very little say in the training programmes. The producer and the consumer therefore work almost in isolation of each other.

The medical profession in India to-day is caste ridden. There are generalists and specialists, preventive and curative health-workers, administrators and non-administrators and teachers and non-teachers. In the latter there is again a distinction between clinical and non-clinical teachers. Each group has its own vested interests and there are group rivalries. There are several reasons for this, some historical, some due to influence of rapidly advancing science, but mostly on account of a lack of an over-view by a central body or authority. This has resulted in a situation where both the profession and the public are dissatisfied.

It is felt that if the medical colleges could be made responsible for the health delivery services of a section of population this trend can be reversed. *The* recommendation in the report of only coordinating the existing patterns is considered a mere patch work -and the situation will not change materially. It is felt that direct and unequivocal responsibility for training and health care must be given to a single authority. The country be divided on population basis or the existing districts could be

taken as units, three or four being entrusted to each medical col] for training and comprehensive health care including family planning and nutrition programmes. In such a set-up there will be graded facilities for health care, investigative, facilities, and specialist services. The health staff working in all the institutions in the area from sub-centre to the medical college hospital will be the staff of the medical college. There will be no division between preventive and curative medicine and teachers and non-teachers. Facilities of all the centres, PHC, Taluk, District or the medical college would be utilized for training. The staff would not be static but could be moved from one to the other central Those who dispense curative medicine, be it in paediatrics, ophthalmology, maternity or general medicine would also look after its preventive side.

Such a re-organisation would also result in a better referral system whereby patients can be referred from one level to the other and their records can be complete and traceable when ever needed, A greater cohesion in the staff whether of the PHC or of the district would also result, since all will belong to one department. The training imparted would become meaningful since it would be related to the actual requirements. The much desired shift in the outlook of health staff of all categories from the hospital bias to the community would be brought about as all would| be required to work in the community for their training. The young medicos will develop greater self-confidence as they would get a feeling of belonging to a team though working at different levels. A great deal of team spirit is also likely to develop between the doctors, nurses and para-medical staff as they would have common training places.

It is thus visualised that a medical college (if preferrance it may be redesignated Health Institute) will become a miniature directorate where the only division is of various branches of medicine. The Civil Surgeon, District Medical Officers of Health, Family Planning Officers, etc., would merge in the larger unit each member engaged both in health delivery and training.

It is suggested that this concept may be tried on expert mental basis in some medical colleges of some States. Alternative]? a Commission may be set up to examine this concept in depth.