HEALTH CARE DELIVERY SERVICES IN RURAL AND URBAN AREAS

POLICIES AND PERSPECTIVES

VIII FIVE YEAR PLAN (1990-95)

WORKING GROUP REPORT OF THE PLANNING COMMISSION

JUNE, 1989

HEALTH CARE DELIVERY SERVICES

IN

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C O N T E N T S

ANNEXURES — PAGE(S)

BACKGROUND

WORKING GROUP ON HEALTH CARE DELIVERY SYSTEM IN RURAL AND URBAN AREAS FOR VIII FIVE YEAR PLAN (1990-95)

A Working Group was constituted by the Planning Commission vide order No.2(3)/88-H&FW, Government of India, Planning Commission, dated the 3rd November, 1988 with the following Terms of Reference:

1. To review the present position/progress/problems of Health Care Delivery Services in rural and urban areas in the country and to suggest changes/modifications in the programmes and priorities, keeping in view the directions of the Steering Committee in this line and the goal of achieving Health for All by the year 2000 A.D.
2. To review the present Man-power position engaged in this field in the country and project its requirement/training needs for development during the 8th Five Year Plan.
3. To project Financial/Physical requirements (i.e., targets etc.,) for implementation of these programmes during the 8th Five Year Plan.
4. The Working Group may appoint any Sub-Group or co-opt any member under intimation to theChairman of Steering Committee.
5. To identify the extent to which the policies and Strategies adopted in the 7th Plan need to be further improved in the context of National Health Policy and goal to achieve "Health for All by 2000 A.D."
6. To review the present procedure of Monitoring and Evaluation and suggest suitable modifications for further improvement.

7. To identify the priority areas of research in the field.

II. COMPOSITION OF THE WORKING GROUP IS AS UNDER:

1. Dr.Harcharan Singh Adviser (H), Planning Commission New Delhi.	Chairman
2. Sh.M.S.Dayal, Additional Secretary (Health), Ministry of Health & FW, New Delhi	Co-chairman
3. Shri P.K.Mehrotra, Joint Secretary, Ministry of Health& FW, New Delhi.	Convenor
4. Dr.R.S.Arole, Director, Comprehensive Rural Health Project, P.O. JAMKHED, Dist. Ahmednagar, Maharastra, Pin.413201	Member
5. Dr.M.D.Sehgal, 289, Gulmohar Enclave, New Delhi 110049	--do--
6. Mr.Alok Mukhopadhaya, Director, Voluntary Health Association of India, 40, Institutional Area, South of IIT, New Delhi -110016	--do--
7. Dr.(Mrs)V.K.Bhasin, Deputy Director General (RH) Dte.General of Health Services, Nirman Bhavan, New Delhi110011.	Co-convenor
8. Drug Controller of India, C/o Dte.General of Health Services, Nirman Bhavan, New Delhi-110011	Member
9. Shri G.Kumaraswamy Reddy, Secretary (Health), Govt. of Andhra Pradesh, Hyderabad.	--do--
10. Dr.C.L.Malhotra, Director of Health Services, Govt. of Himachal Pradesh, SHIMLA	--do--

11.	Dr.S.Chatterjee, Medical Officer (Health) New Delhi Municipal Committee, New Delhi	**Member**
12.	Dr.R.P.Bhagi, Medical Officer (Health), Municipal Corporation of Delhi, Delhi	--do--
13.	Dr.L.M.Murry, Director of Health & Family Welfare, Govt. of Nagaland, KOHIMA	--do--
14.	Director of Health Services, Govt. of Assam, GUWAHATI,	--do--
15.	Shri Darshan Kumar, Secretary (Health) Govt. of Punjab, CHANDIGARH	--do--
16.	Mrs. Vinita Rai, Joint Secretary, Ministry of Health & FW, Nirman Bhavan, New Delhi	--do--
17.	Shri Palat Mohandas, Health Secretary, Govt. of Kerala, TRIVANDRUM, Kerala,	--do--
18.	Director of Health Services, Govt. of West Bengal, Writers Bldg, Calcutta,	--do--
19.	Prof.S.Dewan, Preventive & Social Medicine Dept., Maulana Azad Medical College Bahadur Shah Zaffar Marg, New Delhi -110001	--do--
20.	Prof.R.D.Bansal, Preventive & Social Medicine Deptt, Smt.Sucheta Kripalani Hospital, Bhagat Singh Marg, New Delhi	--do--
21.	Dr.Rameswar Sharma, Director, Indian Instt. of Health Management Research, C.105, Lal Kothi Scheme, Jaipur-302015	--do--
22.	Rakesh Mohan, Adviser (W.S.) Planning Commission,	--do--
24.	Director General, AFMS, New Delhi	--do--

24. Dr. Sneh Bhargava, Director, A.I.I.M.S, Ansari Road, New Delhi-29	Member
25. Dr. Musul Bhattacharjee, Medical Supdt., Fatima Hospital, LUCKNOW, UP,	--do--
26. Dr.K.J.Nath, Prof. Environmental Health, All India Instt. of Hygiene & Public Health, 110, Chittaranjan Avenue, Calcutta-700073	--do--
27. Dr.D.Baneerjee, C/o Centre for the Study of Social Medicine and Community Health, Jawahar Lal Nehru University, New Mehrauli Road, New Delhi 110067	--do--
28. Dr.N.K.Sinha, Ex.Dy.Adviser, PlanningCommission A.II, Hauz Khas, New Delhi -110016	--do--
29. Secretary (Medical), Delhi Administration, 5, Shyam Nath Marg, Delhi-110054	--do--
30. Director of Health Services, Delhi Administration, Saraswati Bhavan, E.Block, Connaught Place, New Delhi-110001.	--do--

III. Co-opted Members:-

The Working Group was empowered by the Planning Commission to co-opt any member it felt necessary, vide item 4 of the Terms of Reference. In exercise of the above, the Working Group co-opted the following as members:-

1. Dr.P.N.Ghei,
   Deputy Commissioner (PE)
2. Shri R.Sethuraman,
   DeputySecretary (AP)

3. Dr.Gopa Kothari,
   L.T.M.Medical College,
   Bombay,

4. Dr.T.P.Sharma, Director,
   (PH&FW), Madhya Pradesh,
   Bhopal

5. Dr.D.K.Jagdev,Director,
   (M&H Services),Rajasthan,
   Jaipur,

6. Dr.J.S.Nagra,
   Director of Health Services,
   A&N Islands,
   Port Blair

7. Dr.L.Tenzing,
   Director Health Services,
   Sikkim, Gangtok,

8. Dr.P.V.Gulati,
   G.B.Pant Hospital,
   New Delhi,

9. Dr.Mehta, Retd. from MAMC,
   Social & Preventive Medicine,
   New Delhi

10. Dr.Vasudevan, I.C.D.S

11. Dr.(Mrs) Shanti Ghosh,
    A-1/18, Panchasheel Enclave,
    New Delhi

12. Dr.K.P.M.Prabhu,
    A.C.(ORT)

13. Dr.Jothna Sokhey,
    AC(I)

14. Dr.K.K.Sen, DDG (ME)

The following officers of the Ministry of Health & FW also participated in the discussions while formulating the draft recommendations of the VIII Plan:-

1. Dr.(Miss) A.Bhardwaj, Asstt. Commissioner(T)

2. Dr.(Mrs) T.Bhasin, Asstt.Commissioner (RHS)
3. Dr.S.C.Sharma, ADG (HA),
4. Dr.(Mrs) K.Khar, CMO,
5. Dr.V.N.Sardana , DADG (CH),
6. Shri R.K.Wasan, DeputyDirector,
7. Mr.T.Dilip Kumar, DNA
8. Dr. (Mrs) D.Lahiri, Director, CBHI.

IV. The Working Group concluded its discussions over four meetings held on 28th December, 1988, 16th January, 22nd February and 5th and 6th April, 1989. Another meeting of selective members was held on 15-16th May, 1989 to discuss the structure of the Working Group Report and rural health programmes to formulate the tentative recommendations.

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HEALTH CARE DELIVERY SERVICES IN INDIA COMPRISE OF

A. HEALTH CARE SERVICES IN RURAL AREAS,

B. HEALTH CARE SERVICES IN URBAN AREAS.

THE DETAILS OF THE ABOVE ARE DISCUSSED IN THE FOLLOWING CHAPTERS.

CHAPTER.I

A. HEALTH CARE SERVICES IN RURAL AREAS:

INTRODUCTION

1.1. Delivery of primary health care is the foundation of rural health care system which forms integral part of the National Health Care system. For developing the country's vast human resources and for the acceleration and speeding of socio-economic development for attaining improved quality of life, primary health care is accepted as one of the main instrument of action. In the rural areas services are provided through a network of integrated health and family welfare delivery system. Health care programme has been restructured and reoriented from time to time for obtaining the objectives of the National Health Policy and for attaining Health for All by the year 2000 A.D. by providing comprehensive health services i.e. promotive, preventive, curative and rehabilitative services. Priority has been accorded to extension, expansion and consolidation of the rural health infrastructure viz. sub-centre, primary health centre, community health centre and with placement of trained village health guides and trained dais at village level.

Primary health care pays particular attention to the point of initial contact between members of the community and the health services. Sophisticated and specialised needs are referred to secondary and tertiary levels. For rural and urban health services following dimensions are taken into consideration viz., i) appropriate technology, ii)affordability, iii)availability, iv) accessibility, and v)acceptability.

Appropriate technology calls for scientifically sound materials and methods that

are socially acceptable and directed against relevant health problems e.g. Oral Rehydration Therapy in the control of diarrhoeal diseases and domiciliary treatment for treatment of tuberculosis.

For making services available, accessible and acceptable, all possible efforts are being made to involve other cadres of functionaries i.e., Village Health Guide (VHG), Traditional Birth Attendants/ Dais (TBAs) and Multi-purpose Workers (MPW) and Social Workers (SW) by providing them training and support. Medical Officer, along with these categories of workers at various health institutions, forms the leader of the 'Health Team'. Care is being taken that the health services are made available as near people's homes as possible and at work places with good referral system. In this regard, mobility needs to be looked after. Various systems of medicine including ISM and homoeopathic systems are being provided depending upon the local acceptability of the people. Besides these, community participation, multi-sectoral coordination and strong political will, are other basic principles on which these services are based.

Community Participation

Besides the overall responsibility of the Central and the State Governments, the involvement of individuals, families and communities in promotion of their own health and welfare including self-care is an essential ingredient of primary health care. Community's participation in planning, implementation, maintenance, monitoring and evaluation of health services is essential.

Multi-sectoral approach

Health Sector alone can not attain the goal of Health for All by 200 A.D. Therefore, other related sectors i.e., Education, Food and Agriculture, Science and Technology, Social Welfare, Animal Husbandry, Housing and Public Works, Urban Development and Rural Reconstruction including Panchayati Raj involvement are essential.

Translation of values into action requires two further elements; 'Political Will' and 'Economic Resources."

Political commitment has been created by revitalising and strengthening Panchayati Raj system which may bring policy, economic and other support to the primary health care.

1.2. STRATEGY

The approaches and strategy adopted for develping Health Care Delivery Services in the rural areas, as enunciated in the 7th Plan Document, are quite sound and feasible in the context of philosophy of National Health Policy and the goals set for attaining "Health for All" by the year 2000 A.D., However, to optimise and further improve the efficiency of the available health infrastructure programmes would be identified on the basis of priority and some may require modifications for effective and concerted interventions in the critical areas, especially in health manpower development and other health problems. According to the latest available reports received, the likely position of infrastructure as on 31.12.88 and 31.3.90 would be as follows:

Category	Total units required by 31.3.1990	Units set up till 31.12.1988
Sub-Centres	1,30,000	1,10,370
Primary Health Centres	21,666	16,652
Community Health Centres	2,708	1,456
No. of Health Guides trained	5,00,000	3,90,000
No. of Dais trained	5,72,000	5,60,000

Apparently with these achievements, the proposed targets set for the 7th Plan Period would, by and large, be achieved excepting for the village health guides, for they (scheme) had been frozen since July,'86. This would mean that 100% of the requirement of the sub-centres and Primary Health Centres and 50% of the Community Health Centres would be in position in the beginning of the 8th Plan Period.

Though quantitatively these achievements are impressive (in terms of establishment), it has been observed that they are not operationalised properly/adequately to the desired extent and the services provided at these centres have to be improved to bring in the credibility required for efficient working of the Health System.

It was, therefore, suggested that there should be minimal further expansion of the rural infrastructure and bulk of the resources may be spent for consolidation i.e., providing medicines, equipment and buildings where necessary.

It was agreed in principle that there should be no expansion. However, there was scope for

relaxation of norms for sub-centres in difficult, hilly and remote areas where the workers can not effectively cover a population of 3,000. The travel time and distance should be taken into account for setting up sub-centres.

It was also crucial for the programme that the knowledge and skill of the Health Workers match their job requirements. Therefore, the basic training, in-service training and continuing education should receive the highest priority during the 8th Plan Period.

It was suggested that advance planning should be done both at the State and District level to ensure that the required equipment, trained personnel and other physical facilities are available not only for the new infrastructure to be created but also making up the deficiencies in the existing infrastructure.

The State should include in their 8th Plan the necessary programmes and activities towards this and provide adequate resources for the same. The modalities of these should be worked out well in advance.

There are a larger number of dispensaries of Allopathic, ISM and Homoeopathic in rural areas which are providing only curative services. All these institutions may be oriented to the Primary Health Care concept and given additional inputs, wherever necessary to make them capable of providing comprehensive health care services within a well defined geographical area.

It was further recommended that promotive and preventive services particularly ante-natal care, post-natal care, immunization, Oral Rehydration Therapy (ORT), nutrition and health education should be appropriately strengthened. Care must be taken so that these programmes are not developed on vertical basis but are synthesised particularly at that level.

Setting up of new dispensaries and mobile service teams which are curative-oriented should be discouraged except in exceptional cases in remote areas as interim phase. Eventually, they may be absorbed in the 3-tier structure of Rural Health Services.

It was also stressed that holistic view of the health programmes should be taken for the delivery of the services in rural areas as distortions creep in because of the pressures of targets of immunization and family planning. The primary health care structure should be accountable for the total health status of the community in the catchment area.

Infrastructure, physical targets for the Eighth Plan is appended at Annexure.I.

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CHAPTER.II

RURAL INFRASTRUCTURE

As mentioned earlier, a chain of referral system right from the village level to the Community Health Centre (CHC) level has been developed in the 7th Plan Period which will be strengthened and revamped in the 8th Plan Period.

2.1. COMMUNITY LEVEL SERVICES

This is the most crucial area specially for primary health care as community involvement is of utmost importance for bringing about behavioural changes for accepting promotive and preventive services and the concept of positive health. Strong community involvement can only prepare the community to accept the change of the medical infrastructure from being only curative centres to that of health education and disease prevention institutions. Community groups like Mahila Mandals, Village Health Committees, Youth Organizations need to be strengthened and made aware of the primary health care concept. Two important allies i.e., the village health guides and traditional birth attendants are existing in almost all villages in India and can act as catalyst for community action, besides Anganwadi Workers, village level workers, school teachers, extension and agricultural workers etc.,

2.2.VILLAGE HEALTH GUIDE SCHEME

2.2.1. There are almost 3.9 lakhs Village Health Guides trained since its inception. Additional one lakh village health guides shall have to be trained in the 8th Plan Period to fulfil the goal

of providing a village health guide for one village/one thousand population.

2.2.2. According to the information received from the State Governments, male village health guides have been discontinued in some states

2.2.3. Certain draw-backs have been identified in the optimum operationalisation of the Village Health Guide (VHG) scheme, like raising of the honorarium and amount for medicines and demand for recognition as Govt. employees etc.,

2.2.4. The scheme has not been functioning well in some States because of lack of superivision and their accountability either to the health system or to the community.

2.2.5. Lack of funds for implementing the scheme in the 7th Plan Period lead to the improper implementation of the scheme. The scheme is subjudice because of the VHG Associations having gone to the courts against the proposed modification of the Ministry of Health from male village health guides to female village health guides for 100 % Central assistance.

2.2.6. The group, therefore, strongly recommends as follows:-

a) Village health guide scheme has a good potential and is well accepted by the community. Hence, the scheme should continue in the 8th Plan Period.

b) The accountability of the village health guides and the payment of honorarium and money for the medicines must be totally handed over to the institutions of Panchayati Raj system at the village level.

c) All State Health Departments should, however, continue to train and retrain village health guides for proper functioning. The orientation training should be promotive and preventive rather than curative. Care and emphasis should be on health education.

d) Though preference should be given to female village health guides but the decision for selection should be left entirely to the State Governments/village Panchayats.

e) Effective publicity need be given in the area about the availability of the village health guides and the work expected of him/her by the community and the health functionaries. The work of the village health guides need to be properly coordinated with other developmental functionaries specially with the Anganwadi workers and adult education workers and teachers. The scheme of village health guide and ICDS may be suitably dovetailed and there should be no overlapping of functions.

f) Scheme of Awards and Rewards for the best performing village health guides may be introduced by the Panchayats.

2.3. SCHEME OF TRAINING OF DAIS/TRAIDITIONAL BIRTH ATTENDANTS

2.3.1. Traditional Birth Attendants (TBAs) are another important resource in the community. Linkages of a mutually helpful rapport between the Health Worker (female) at the sub-centre and the TBAs needs to be developed urgently for a good Maternal and Child Health (MCH) Programme, which can form the basis of the entry point for the acceptance of family planning methods. At present about 5.7 lakh dais have been trained all over the country.

Since 80 % of the deliveries in rural areas are still being conducted by dais, the training and retraining of the TBAs need to be taken up on priority basis for betterment of MCH services.

2.3.2. The group, therefore, strongly recommends as follows:-

a) The State Governments need to review the programme urgently and all untrained practising dais need to be trained and, if already trained, need to be retrained.

b) Expanded role should include

- Early registration of pregnancies
- Identification of high risk pregnancies and referral to the health workers
- Conducting asceptic and hygienic delivery
- Detection of low birth weight babies
- Getting mothers and children immunised

c) The dais should be provided presterilised disposable delivery kits, weighing scales and good pictorial educational material.

d) To create a regular contact with the sub-centres, a monthly meeting of dais should be arranged at the sub-centre, where all births conducted by them should be reported.

e) The reporting fee should be raised from Rs.3/ to Rs.10/ for making it worthwhile for the dai to travel to the sub-centre.

f) The payment of Rs.10/ may be made conditional to the early registration of pregnancies at the sub-centres, three ante-natal check-ups, two doses of tetanus toxoid and conduction of asceptic and hygienic deliveries. The TBAs could provide a very good contact point in the villages for the Health Worker (F) to work with the community.

g) Dais' training programme needs to be intensified in the 8th Plan Period and the States should accord priority to improve MCH services in the rural areas and effectively bring down the maternal and infant mortality rates.

h) The group also took note of the decreasing number of dais in some of the States. It is, therefore, recommended that the younger generation may be inducted into the midwifery training programme of longer duration to bring in a new cadre of functionaries necessary for providing MCH services. To begin with, this training programme can be introduced in the States where indigenous dais are scarce. It should, however, be made very clear that these women will be self-employed and will be licensed to practise midwifery.

2.4.SUB-CENTRE

2.4.1. Sub-centre is the most peripheral governmental institution providing primary health care services to 5000-3000 rural population. All promotive and preventive aspects of health care emanate from this centre. About 70-80 per cent of the health problems can be tackled at this level by effective functioning of sub-centres. It is, therefore, of utmost importance that top priority be attached for proper operationalisation of the sub-centre.

2.4.2.Population norm:

A sub-centre has been established on a population norm basis for 5000 population in plain areas and for 3000 in difficult, hilly and tribal areas. The total number of sub-centres expected to be in position at the end of the 7th Plan Period is 1,30,000. As on 31.12.88, 1,10,370 have already been established.

2.4.3. Staff

A sub-centre is manned by a male and a female health worker. The number of female health workers has kept pace with the establishment of sub-centres. Adequate number of female health workers is available for manning the sub-centres. There is however a shortage of male health workers. The ideal team to work at a sub-centre is a male and a female health worker so that the total health needs of the population are taken care of. There is a voluntary worker also provided at the sub-centre.

2.4.4. Drugs, equipment and furniture:

There is a standard list of drugs, equipment and furniture to be provided to a sub-centre. However, the sub-centres are lacking in all these items and it is, therefore, very essential that for effective functioning, equipment, drugs and furniture must be provided on uniform basis to all the sub-centres.

2.4.5. Buildings:

At present, about 30-40 percent of the sub-centres are having independent buildings. The remaining are functioning from the MPW Female's residence or rented buildings with inadequate space for proper delivery of services. At present, there is a provision of only Rs.1000/ per annum for renting a sub-centre. This needs to be suitably augmented. In the 8th Plan Period, buildings should be provided for all sub-centres. Blue print for sub-centre buildings should be adhered to, to provide adequate space for proper functioning. The states should, however, be encouraged to use the locally available material to keep down the cost of construction which should not exceed the ceiling limit of Rs.1.25 lakhs (approximate).

2.4.7. Mobility:

Though the population covered by a sub-centre is 5000-3000, it does not take into account the distance and travel time. Some workers are covering a radius of 10-15 kms. To improve the efficiency and the frequency of the visits to the far off villages, cycles/mopeds may be provided to the health functionaries. State Governments may consider giving soft loans or advances for purchase of vehicles. A fixed travel allowance may be paid to the workers as per State Government's rules so that they don't have to prepare bills for reimbursement of travel expenses.

2.4.8.Training:

Male and Female Health Workers are the actual implementors of all programmes at the grass-root level. They should be exposed to in-service training programmes at an interval of 2-3 years. The basic training of these workers and the Institutions imparting the training also need the priority attention of the Governments.

2.4.9. The group recommends as mentioned below:-

a) While establishing new sub-centres, due consideration must be given to the locational strategy in terms of population concentration in addition to communication and other facilities. There may not be any deliberate attempt to relax norm on a large scale but in very difficult, hilly, desert and remote areas, the travel time or distance may be taken into account for establishing new sub-centres.

b) The districts which have a high maternal mortality, infant mortality and low couple protection rate may be provided with two female health workers and one male health

c) The voluntary worker at the sub-centre may preferrably be a trained dai of the area.

d) The shortage of male workers was viewed seriously. It was strongly recommended that male and female health workers should form a health team for effective coverage of the population. The states should be urged to take up the training of the male health workers seriously in the 8th Plan Period. In order to overcome the shortage, short term training programmes of 4 months to be followed up later by further training may be thought of. This is being suggested on the pattern of sandwich courses adopted by Maharashtra for female health workers.

e) Since employment of the male health worker is in the State Sector, the training programme of the male health worker has not been taken up by the State Governments. Hundred per cent of the central assistance may be made available only for those sub-centres which have, both the male and female health workers in position. Alternatively, 50% of the funding of both the male and the female health workers may be considered to ensure the presence of both workers at the sub-centre.

f) UNICEF equipment for sub-centres which includes midwifery kit and male and female health worker kit needs to be resumed and all sub-centres should be properly equipped.

g) The sub-centres need to be properly equipped for providing the services for IUD and the pill and should be provided adequate drugs for follow up of post tubectomy cases.

h) The amount of Rs.2,000/- per year for medicine is inadequate and needs to be increased to Rs.5,000/- per sub-centre. Money for purchase of furniture and equipment needs to be enhanced from Rs.3,200/- to Rs.5,000/-

i) Mobility must be ensured for all workers and there should be adequate provision of travel allowance.

The group felt that the role of the female health workers in the sub-centre is crucial. Therefore her working conditions should be made more conducive. Hence following are the recommendations for improving the working of the ANMs:-

a) She should have adequate medicines to give to the people to build her credibility amongst the population in which she works.

b) Female health worker should be made responsible for the total health care including MCH, immunization and family planning in the population in which she works. She should not be subjected to the pressures of vertical programmes as it has been seen that undue stress and achievements of family planning targets affects her work in other spheres.

c) There should be a work plan developed at the sub-centre which should be publicised so that people know her functions and roles and presence in the villages on scheduled dates.

d) Eligible couple and child registers should be supplied to her.

e) She should coordinate her work with that of the health guides, trained dais and Anganwadi workers. Her safety may be ensured by constructing residences for her/hiring residences in the heart of the village.

f) Promotional avenues should be opened up for good performing female health workers.

All the recommendations which are made for female health workers hold good for the male health workers also.

Financial Implications of the Changes Suggested

A.Sub-Centre Unit

	Existing pattern of assistance	Proposed changes
	(In Rupees per annum)	
1. Salary of the HW(F) & Allowances	15,000/	18,000/
2. Helper	600/	1,200/
3. Contingency	600/	1,200/
4. Drugs	2,000/	5,000/
5. Rent	1,000/	1,200/
	19,200	26,600/

Salary of the female health assistants would increase from Rs.15,000/- to Rs.18,000/- because of additional allowances i.e., an additionality of Rs.3,000/- per post per annum of female health assistant.

The female health assistants' posts will be one for six sub-centres. The salient features are:

1. One male and one female health worker should be available at a sub-centre.
2. The expenditure for drugs to be enhanced from Rs.2,000/ to Rs.5,000/
3. Contingency expenses to be doubled (i.e, from Rs.600/ to Rs.1,200/)
4. Buildings to be constructed for all sub-centres.

2.5. PRIMARY HEALTH CENTRE

2.5.1. Primary Health Centre is a very important governmental health institution. This is the point where the community comes in direct contact with the Medical Officer (MO) for getting the health services. About 80% to 90% of the health problems of rural population can be tackled, if primary health centre functions effectively. Hence, there is a need to provide top priority to qualitative services at the primary health centre level. Out of a total of 21,666 PHCs required by 1990 i.e., by the end of 7th Fiver Year Plan, 16,650 PHCs are functioning as on 31.12.1988. More stress may be given on consolidation for effective functioning of already established PHCs. New PHCs may be established in remote, hilly, tribal and difficult area according to the requirement.

2.5.2. Population norm:

The population norm for establishment of primary health centre should remain the same as in the 7th Five Year Plan Period i.e., one PHC for every 30,000 population, in plain and one for every 20,000 population, in hilly, tribal, backward and difficult areas. However, in difficult areas travel time/distance need to be taken into account for establishing a primary health centre.

2.5.3. Staff:

a) Staffing position in PHC needs improvement. The vacant posts may be filled up urgently. There sheuld be a minimum of one doctor in each PHC. Those States who have attained the norm of one doctor, permitting finances and availability of doctors, two medical officers may be posted. Out of the two medical officers, one may be a lady doctor.

b) The modalities of recruitment may be suitably modified for recruitment and posting of Community Health Officer (CHO) at PHCs. This could be done on selection basis, where eligible candidates can apply. Keeping in view the thrust on MCH & Family Welfare Services, in looking after the high risk mothers and children and to provide supervision to the health workers, the group recommended that one Public Health Nurse may be considered in approved staffing pattern of PHC.

2.5.4. Drugs, Equipment & Furniture

Drugs, equipment and furniture may be made available in all the PHCs according to the standard list. Graded financial assistance commensurating with number of OPD patients attendance may be considered. The amount of Rs.12,000/- per annum may have to be enhanced from Rs.20,000/- to Rs.60,000/- per annum. Essential drugs should be always made available in the PHCs. Essential equipment is also equally important for providing good quality of health services.

2.5.5. Building

The building should be functional one and located at the central place with adequate accommodation for effective functioning of PHCs. By the end of 7th Five Year Plan, it is expected that 50% of the PHCs will be in governmental buildings. It is suggested that the blue-print for PHC building may be adhered to, to provide adequate space for proper functioning of PHCs. States may, however, be encouraged to use the locally available material so as to keep the cost of construction within the financial norms as approved by the Planning Commission. To gear up

MCH & Family Welfare Services there is a need to have a labour room at PHC, space for IUD insertion, MTP facilities and to perform vasectomy, etc., besides conducting aseptic deliveries.

2.5.6. Health Management Information System:

To improve the 'Health Management Information System' (HMIS) at the PHC level a record clerk or a clerk with training in the statistics may also be posted.

In order to improve the health management information system printed registers and reporting formats need to be made available to the health personnel of the PHCs. The PHC staff should be trained and instructed to fill and maintain these records so that they can be utilised to improve their day to day performance. Records can be used for health management purposes.

2.5.7. Mobility

Endeavour may be made to provide atleast one vehicle in running condition, with adequate POL. To improve the quality of extension services/domiciliary visits vehicle may be provided to health functionaries. Soft loans/advances for purchasing cycles/mopeds may be given to the health functionaries. They may be paid fixed travelling allowance according to theState Government rules, so that staff's botheration of preparing travel allowance bills for reimbursement can be avoided. Proper and adequate mobility will improve the supportive supervision also.

2.5.8. Training:

At PHC, in the "Health Team" Medical Officer is the leader of the team. To improve the quality of health care delivery services, it is crucial that the Medical Officer should be imparted train-

ing in leadership qualities, management, behaviour, communication and pedagogic skills and in the latest clinical knowledge. Similarly, it is essential that all categories of health functionaries may be imparted in-service training after 3 to 5 years. The group suggested that the community bias training with adequate public health component may be started at the under-gradudate training of doctors. "Reorientation of the Medical Education" (ROME) scheme may be revitalised/strengthened.

2.5.9. Recommendations:

a) Primary Health Centre may be located at a central and approachable point i.e., connected with roads, so that patients referred from sub-centres may have easy access to the PHC.

b) Vacant staff position may be filled up as soon as possible with additionalities as recommended earlier.

c) Medical Officer Incharge of PHC may be given sufficient administrative and financial powers for effective functioning of primary health centre involving decentralisation of powers from States to district, CHC to PHC, to sub-centres.

d) It was observed by the group that medical education at under-graduate level needs to be improved in primary health care approach which would go a long way in filling up of the posts in the periphery.

e) The post of Medical Officer at PHC should be made a non-practising one, and states may be persuaded to take a policy decision in this matter as early as possible.

f) The following incentives are recommended for the staff working at the Primary Health Centre:

- Significantly attractive rural allowance;
- higher house rent allowance to Government residential accommodation;
- children education allowance;
- choice posting after two rural postings of three years each;
- seats may be reserved for admission to post-graduate courses for the staff working in the rural areas;
- extra-monetary incentives when posted in difficult areas;
- soft loans/advances for purchasing cycle/moped/ car.

g) Drugs, equipments and furniture may be made available. Essential medicines and equipment for emergency must always be available.

h) To gear up family welfare work, the State Government may ensure continuous availability of Nirodh, Oral Pills, Intra-Uterine Devices (IUD)/Copper-T facilities. Similarly, to boost up other National Health Programmes, including various Nutritional Programmes, to prevent and treat diseases like Malaria, Filaria, Tuberculosis, Leprosy, Blindness, Diarrhoeal diseases and nutritional deficiencies, drugs supplied under Centrally Sponsored Programmes etc., Oral Rehydration Salt (ORS) packets and other nutritional supplements like Vitamin 'A', Iron & Folic Acid tablets may be made available. This is a well known fact, that it is through curative services, by providing medicines to the patients, that the credibility of the health functionaries is established.

i) Entire "Health Team" right from Medical Officer to health worker may be motivated to see that community is involved in making potable water available and in proper disposal

of waste and sewage. For these the community is constantly and properly informed about the advantages so that demands are generated by the community to avail these facilities including health services. Thus, the people will enjoy the real benefits of healthy life and improve their socio-economic conditions.

j) The importance of health education may be stressed as a part of the job responsibility of the health functionaries. Each member of the "Health Team" needs to become health educator, realsing that health education will not only build up the cost effective measures, but will also reduce the morbidity and mortality due to preventable diseases like diarrhoea, dreadful diseases e.g., tetanus, diphtheria, whooping-cough, poliomyelitis, measles, tuberculosis and many other nutritional diseases.

k) Lot of printed health education material is being produced by various health and other health related agencies. States & district level health administrators may like to see and pursue that printed material reaches right upto the PHC, sub-centre and village Panchayats, so that health functionaries get the latest knowledge not only about the communicable diseases but also the other emerging diseases due to changing life styles like hypertension, diabetes, heart diseases, psychosomatic problems e.g., smoking alcoholism, drug addiction and AIDS, etc., If people are educated about these diseases timely they may be able to prevent these diseases.

l) Laboratory facilities are being provided by Government of India. States may ensure that well-equpped laboratory is set up at each

PHC, this will not only help in early diagnosis of diseases like malaria, filaria, tuberculosis, leprosy and many others, but will also be useful for Medical Officers and other health personnel to treat the patients more scientifically. Besides laboratory facilities, some amount is earmarked per PHC for purchasing latest equipment to ensure the professional satisfaction and competence of the Medical Officer. Utilisation of this amount may be ensured wherever it is available.

m) PHC Medical Officer, who commands great respect in a definite small area with known community, needs to involve other health related sectors that is Ministry of Education through school teachers, Ministry of Food and Agriculture through agriculture extension officers and workers and functionaries of other rural developmental schemes so that health education and other developmental activities/facilities of PHC are improved. For this, Orientation Training Camps (OTC), organised by Family Welfare can be made use of by informing the community regarding health programmes by coordinating with local folk media.

n) PHC staff members may be encouraged rather sponsored by State authorities to attend various meetings on health programmes including national and international This practice will definitely motivate them to work more and efficiently. Some reward system may be considered in the form of just giving them certificate in view of recognition of their good work at the PHC or village level or for doing some developmental/innovative work of research. This will go a long way in improving the quality of rural health serivces as PHC is a nodal/vital point for providing health care delivery services.

PROPOSED UNIT COST FOR A PHC.

Recurring		Nenrecurring	
Salary	Rs.3.20 lakhs	Equipment	Rs.10,000/-
Medicines	Rs.20,000/-	Building with residential eccommodation	Rs.10 lakhs
Contingency	Rs. 6,000/-		
POL	Rs.30,000/-		

Salient features of PHCs are given below

SALIENT FEATURES

1. Priority should be given for establishment of PHCs in difficult areas.
2. Second Medical Officer to be posted wherever resources permit.
3. Creation of post of Public Health Nurse at Primary Health Centre.
4. Enhancement of Budget for drugs from the present Rs.12,000/- to Rs.20,000/- upto Rs.60,000/- as per OPD attendance.
5. Creation of functional buildings by using locally available material.
6. Posting of Record Clerk or trained Clerk in Statistics for HMIS.
7. Provision of vehicle with adequate POL.
8. Decentralisation of Administrative and Financial powers.
9. Health Education component to be strengthened in Training Programmes.
10. Reward system to be established for encouraging good work.

2.6. COMMUNITY HEALTH CENTRE

2.6.1. Scope of Community Health Centre:

As per the present pattern, a community Health Centre is to be established for every one lakh population. There will be 4 specialities namely Medicine, Surgery, Paediatrics and Gynaecology along with 30 Indoor Beds and facilities for good laboratory and X-Ray. It is expected that this Community Centre will perform the function of a Rural Referral Hospital which will not only provide curative services but also coordinate with the PHCs, the preventive and promotive services in the area including implementation of National Health & Family Welfare Programmes.

2.6.2. Building:

At present there are about 1,456 CHCs as on 31.12.88 in the country but a large percentage of them are not having any proper building of their own, as a result the work is suffering. During the 8th Plan it is recommended that State Governments should take urgent steps for construction of Institutional buildings as well as residential accommodation for the essential staff so that the work does not suffer.

2.6.3. Staff:

As per the present pattern, there is provision of specialities in the field of Medicine, Surgery, Paediatrics and Gynaecology but there is no provision of Community Health Man who will look after the preventive and promotive aspect and coordinate the National health Programmes in the jurisdiction of CHC. Therefore, it is stongly recommended that during the 8th Plan there should be a provision of one Senior Public Health Specialist in every Community Health Centre.

2.6.4.Equipment:

Most of the Community Health Centres are today not properly equipped. There should be provision of ECG Machine, a good laboratory facility, X-Ray facility besides the usual equipments needed in a 30 bedded hospital as per the specialities mentioned above.

2.6.5.Vehicle:

In every Community Health Centre there should be provision of atleast three vehicles, one Ambulance and two vehicles for staff so that one vehicle could be utilised for Specialist services/visits in the areas where needed and another vehicle should be for preventive and promotive activities including supervision/implementation of National Health & Family Welfare Programmes.

2.6.6.Management Information System:

At least, at the CHC level, relevant informations should be available from the 4 PHCs which are under its jurisdiction i.e., there should be flow of information from the PHCs to the CHCs and from the CHCs to the District hospital so that it helps in planning, programming, implementation and evaluation of various health programmees.

2.6.7.Cost:

At present, though there is a National norm for construction of the CHC, there is wide variation from state to state. The minimum capital expenditure for the establishment of a New CHC need to be limited within Rs.25-30 lakhs and where only some conversion of the existing centre to CHC is needed the cost may be limited within Rs.10 to 15 lakhs and the local material and manpower are needed to be utilised to keep the cost under limit.

2.6.8. Referral system:

At present there is lack of proper referral system between the PHCs and the CHCs and CHCs to the Sub-District/District Hospitals. During the 8th Plan this referral system should be improved.

2.6.9. Points for consideration:

(a) PUBLIC HEALTH SPECIALITY IS TO BE INTRODUCED.

(b) IN MOST OF THE CHCS RECOMMENDED SPECIALITIES ARE NOT AVAILABLE. IN MOST OF THE PLACES ONLY ONE OF THE SPECIALISTS IS AVAILABLE AND SOMEWHERE THIS IS MANNED BY GENERAL DUTY OFFICERS. DURING THE 8TH PLAN ALL SPECIALITIES NEED TO BE AVAILABLE IN EVERY CHC.

(c) BUILDING, EQUIPMENTS AND VEHICLES NEED TO BE ENSURED FOR PROPER FUNCTIONING OF A CHC.

(d) A WELL DEVELOPED REFERRAL SYSTEM FROM PHCS TO CHC AND FROM CHC TO SUB-DISTRICT / DISTRICT HOSPITAL IS NEEDED TO BE DEVELOPED.

2.7. SUB-DISTRICT AND DISTRICT HOSPITALS

2.7.1. Creating facilities at the sub-centre, Primary Health Centre and the Community Health Centre will only be effective if the cases referred from these centres are taken care of immediately at the sub-district and thedistrict level. The linkage of health services from CHC to the sub-district level and from the sub-district to the district level are deficient. In most of the States this tier of medical care do not exist even with the result that there is a big lacuna in the delivery of health services from the CHC to the sub-district and district hospitals. Creation of these two levels of hospitals and provision of specialists services, diagnostic facilities and Operation Theatre facilities will go a long way to cater the health needs of the population at large and will also reduce the pressure on the teaching institutions which should be made only as referral centres for the highly specialised and complicated cases so that the bulk of the patients pressure is reduced and quality of services can be created at these institutions.

2.7.2. The sub-district hospitals should have indoor facilities. The hospitals should have specialists in the field of General Medicine, General Surgery, Obstetrics & Gynaecology, Ophthalmology, anaesthesiology and Dental Surgery. In addition, diagnostic facilities like X-Ray, E.C.G. and laboratory facilities should also be created at the sub-district level. These diagnostic facilities should be manned by trained technicians under the guidance of specialists in these fields. A well equipped labour room and an operation theatre are the other requirements at the sub-district level.

2.7.3. The district hospital with an indoor facility for 500 beds may have the additional specialities of Clinical Pathology, Psychiatrist,

Paediatrics, E.N.T., Intensive Baby Care Unit and at least two Operation theatres and a Labour Room. District hospital should also have a well organised Medical Record Section headed by a trained Medical Record Officer. A school of nursing attached to the hospital will take care of the requirements of the nursing staff for the district.

2.7.4. The district centre, being the administrative unit for the whole of the district, should be strengthened in the undermentioned areas:

a) Administrative & Financial Powers:
The Chief Medical Officer should be given sufficient powers so that he can administer the whole of the district efficiently.

b) Planning & Organisation:
The Chief Medical Officer should be involved intimately in the planning and organisation of the health set-up for the whole of the district. He may be made responsible to coordinate the health delivery system from the village to the District level. He should be made responsible to see that the policies laid down are implemented for the whole of the District and all records and returns are sent in time. For all this it is essential that he/she should have experience and expertise in public health.

c) Epidemiological surveillance:
An Epidemiological team should be stationed at the district level to take immediate action for investigation and control of any disease, incidence of which is more than normal in a geographical area of the district.

2.7.5.The CHC, Sub-district and district centres should be intimately involved in the training of Medical Officers, the training in Medical Record and training of workers for the national Programmes.

2.7.6.<u>Points for consideration:</u>

I	STRENGTHENING OF SUB-DISTRICTS AND DISTRICT HOSPITALS
II	MEDICAL [redacted] RECORD SECTION AT DISTRICT LEVEL
III	SCHOOL OF NURSING AT DISTRICT LEVEL
IV	ADMINISTRATIVE AND FINANCIAL POWERS TO CHIEF MEDICAL OFFICER
V	EPIDEMIOLOGICAL SURVEILLANCE UNITS

CHAPTER.III

HEALTH MAN-POWER DEVELOPMENT AND TRAINING FOR RURAL SERVICES

3.1. As already mentioned, 8th Plan will be directed towards operationalisation and consolidation of the infrastructure created in the 7th Plan Period. Training assumes the highest priority so that adequate number of health functionaries are available to work in the rural areas. The training will take care of both the basic training programmes and the in-service training of the personnel at the district and below levels to bring about the attitudinal changes and improvement of skills and knowledge of all health workers to perform their duties well.

Since health personnel have to provide an integrated health cover, it is essential that holistic view of training is taken rather than the fragmented approach which has been the practice so far. All training institutions in the country need to be reviewed specially those which are providing basic and in-service training programmes for the peripheral workers as they are the implementors of the programme. In order to give boost to training in future all training programmes should be under 100 % Centrally Sponsored Schemes.

3.2.Training of Medical Officers

Basic Training Programme

There is enough capacity in the country to produce adequate doctors to meet the demands of the health system. In order to correct the present inverted pyramid of Health Manpower trained it is suggested that no new Medical College need be established and training capacity of medical personnel need not be augmented. However, the qua-

lity specially regarding the National Health Programmes needs to be included in the curriculum of the MBBS courses and the internship period should be utilised to acquaint them with the rural situation in the country by placing them at the district head-quarters, primary health centres and sub-centres.

3.2.1. Induction Training Programme

Before entry into the Government Health system, a fresh MBBS doctor finds himself alien in rural set up. The PHCs have very meagre equipment and the people are culturally different from cities with different beliefs, customs and superstitions. There is an urgent need for an induction training programme for all doctors who join the Government Health System. The training programme should be geared to the problems like management, administration logistics and personnel problems at the Primary Health Centre. The programme should be like the probation training programme for people entering civil services. Each state should have special training institutions to conduct this sort of programme.

3.2.2. Inservice Training Programme:

In-service training programme of the doctors is conducted at Health & Family Welfare Training Centres (H&FWTCs) which are 47 in number established all over the country. Because of the increasing load of the activities, it is time that new centres covering not more than 6-10 districts should be set up. The total number of requirement would be 23. In the 8th Plan, at least the establishment of ten new institutions can take place in the states of Madhya Pradesh, Uttar Pradesh, Bihar and Rajasthan.

The existing institutions need to be upgraded and their hostel capacity need to be increased. POL and contingency money has to be enhanced. Good libraries have to be provided and modern AV Aids may be made available to improve the quality of training. The provision of guest lecturers on specialised subjects may be made.

Apart from the reorientation on management logistics and National Health Programmes, there is a need for the medical officers to be updated in the clinical knowledge specially for tubectomy, vasectomy, paediatrics and obstetrics emergencies. There is, therefore, a need of placement of medical officers at district hospital and other big hospitals for clinical training of atleast one month duration at an interval of 3-5 years.

3.3. Male & Female Health Assistants Training Programme:

3.3.1. Basic Training Programme:

Basic training programme needs to be evaluated as supervision is very important aspect of the implementation of the primary health care and is seemed to be lacking. The erstwhile two years training programme of lady health visitors should be reintroduced in view of the priority being attached to the maternal and child survival programmes which is the back-bone of family planning acceptance. For male health assistants, six months promotional training be introduced to meeting the demand of training 4,000 health assistants during 8th Plan.

3.3.2. Inservice Training Programme:

In-service training programme of both male and female health assistants of two week's after every 3 years should be taken up at the district level. The training should be directed towards the skill development on primary health care and should be problem solving.

3.4. Male & Female Health Workers Training Programme:

3.4.1. Basic Training Programme:

a) Basic training programme of these two categories of workers need to be evaluated urgently and it is proposed that two years training programme should be introduced for the female health workers so that they develop good skills in conducting deliveries managing new borns, training the dais and organising the community. Since adequate number of female health workers would be in position by the end of 8th Plan, it will be beneficial to improve the basic training programme by improving the physical facilities of the training institutions like buildings, hostels, vehicles and qualified teachers, POL, contingency money also need to be increased. Good libraries and AV aids for modern method of teaching must be introduced in these schools.

Male health workers are short by 50,000. Hence, utmost importance should be attached to the training of male health workers. At present, 97 schools are imparting training to these workers. There will, however, be need to establish 85 new schools to meet the demand of providng one male worker at each sub-centre. The physical facilities required as mentioned for the female health workers schools also applies to the male health workers' schools.

b) In order to increase the availability of Health Worker (M) in the field, it is suggested innovative sandwich type of courses may be tried. Basic training programme may be revised from time to time and mechanism be developed so that the elements of continuing education programme are integrated.

3.4.2.In-service Training Programme:

In-service training programme for both male and female health workers can be taken up at district level by establishing the district training centres.

3.5.Key Trainers

In order to bring about the qualitative improvement in the training programmes at all levels, it is absolutely essential that the teachers of health workers (F) training schools, promotional schools, teachers of MPW(Male) schools have to be trained every 3-5 years. It is proposed that the training of the teachers of these schools be conducted at the Regional Health& Family Welfare Training Centres. The faculty of H&FWTCs should be reoriented at the national level institutes every 3-5 years.

Apart from the health functionaries of the PHCs and sub-centres, district level officers and state level officers also need to undergo training in management and logistics. These training programmes can be organised at suitable training institutions like National Institute of Health & Family Welfare, Management Institute at Ahmedabad, Calcutta, Bangalore, etc., and at places where there are state training institutions. Health Management Courses may be introduced to train health administrators.

Because of the large number of health functionaries available in each district, training may be decentralised and should become a part of the district set up. District training centres may be established from the existing staff available in the district to take up the training of peripheral health functionaries. The trainers may be given incentives like better career development, better postings and teaching allowance.

Physical facilities i.e., a big lecture hall, a store room, two rooms for faculty members need to be constructed at the district head-quarters. The existing female health worker training schools should be provided with additional accommodation to provide hostel facilities for in-service candidates. These districts core groups should take up integrated training programme so that workers get proper instructions to carry out their activities.

District hospitals and other bigger hospitals in the States should be assigned the responsibility for taking up clinical training programmes for medical officers, female health assistants and female health workers. Post-partum units can be effectively used for this training programme. Bigger maternity hospitals in the districts can also be used for the purpose.

3.6. Recommendations

a) The training policy needs to be defined in the 8th Plan Period so that training is given top priority for improvement of health care. Regular rosters of all health personnel will have to be maintained so that everybody is deputed for training on regular basis and keeps himself/herself ready to go for the training programmes. Roster should be circulated to all concerned persons.

b) The training courses undergone should be reflected in the annual confidential reports of the personnel.

c) All categories of health personnel should be made to undergo training before taking on promotions/new assignments.

d) Institutions taking up basic and in-service training programmes should be strengthened and all modern audio-visual aids may be made available to training centres and modern teaching methods need to be adopted.

e) Training programmes may be periodically evaluated. The training curriculum and duration of training programmes need to be changed according to the needs.

f) Distance training by sending out professional journals, hand-outs, etc., may be taken up on regular basis.

g) There is a need for proper networking of all the training institutions working in the States. Each Health & FW Training Centre should assume the responsibility of 6-10 districts and should also provide guidance to the female and male health worker schools. One of the H&FWTCs in a State should be upgraded and assume the coordinating role for all training activities in the State.

h) A system of board of examinations must be evolved to maintain the quality and standardization of the training programmes.

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CHAPTER.IV

REVIEW & MODIFICATIONS OF THE ONGOING TRAINING SCHEMES

4.1.Village Health Guide Scheme

The training of the Village Health Guides will remain the responsibility of the Health Departments. A well-designed retraining programme to maintain a liaison with the sub-centre and primary health centre will be developed in the 8th Plan Period. Payment of honorarium and medicines to village health guides may have to be handed over to Panchayati Raj System.

4.2.Dais Training Programme

The dais training programme will continue in the 8th Plan Period with the objective of training all the practising dais in the 8th Plan. An innovative retraining programme with monthly contacts with the sub-centre will be taken up in the 8th Plan period. The role of the dai will be expanded from conducting hygienic and safe delivery to that of disseminating information on tetanus toxoid injections, weighing of the new borns, use of presterilized dai kits, breast feeding, Oral Rehydration Therapy and motivating to adopt family planning methods. She will also promote safe motherhood concept and identification of high risk pregnancies. The programme should cover the entire country in a phased manner.

4.3.Female Health Workers & Female Health Assistants, Training and Regional Teachers Training

Female health workers training, female health assistants training and regional teachers training will continue in the 8th Plan Period. These schools will however be strengthened by providing trained teachers, buildings, where possible, increase the contingency and POL expenses.

The schools will also be provided with AV aids and vehicles for effective training programmes.

4.4. Male Health Workers Training Programme:

The training programme will continue in the 97 schools already set up for the purpose. In addition, 85 new schools will be set up in a phased manner in the 8th Plan. These schools will also need strengthening. In order to make the programme more rural oriented, it is proposed to give a vehicle to each of the training institute for field training, provide additional contingency money as well as provide some funds for AV aids. They would be imparted rural field training at already existing PHC annexes built for the female multipurpose workers.

4.5. Male Health Assistants Training Programme

So far we had adequate number of male health assistants. However some of the States will need more health assistants. So provision of 15 male health asstts' schools is being made in the 8th Plan to train about 4,000 male health assistants.

4.6. Maintenance & Strengthening of Health& FW Training Centres:

There are 47 Health & Family Welfare Training Centres (H&FWTCs) functioning all over the country. These centres were established in the period between 1956 to 1965. They are in a dillapidated condition and need repair and proper maintenance. The furniture and equipment needs to be replaced. The contingency money and POL charges also may be enhanced. Out of the 47 H&FWTCs, 10 are still running in rented buildings which do not have sufficient accommodation for running the training programmes. H&FWTCs have also been given the additional responsibility of running the male health workers training programme which has further lead to shortage of the space specially the hostel accommodation. These training institutions need

more hostel accommodation and lecture halls. The 47 H&FWTCs, therefore, need upgradation and strengthening to perform their functions better.

Because of the vast expansion of the infrastructure and increase in health manpower, these 47 H&FWTCs are not sufficient to take on the load of in-service training programmes. It is, therefore, suggested that 23 new H&FWTCs need to be established in the country to take on the responsibility of training needs of six districts each. In the 8th Plan Period, it is suggested that ten of these H&FWTCs should be established in the States with high infant and maternal mortality rates.

Vehicles will also need to be replaced and new vehicles to be given to new H&FWTCs.

Library facilities will also have to be strengthened in all the schools and recurring grant for journals, new books, etc., will have to be provided.

4.7. Scheme of continuing Education for the Primary Health Centre Staff:

The objective of the scheme was to strengthen institutes like medical colleges, promotional schools, health workers (F) schools for taking up the inservice training programme of health functionaries working at PHCs and sub-centres at an interval of 5 years. Because of an enormous expansion of the health man-power it is now being suggested that the training be decentralised to the district, where a calendar of activities of training programmes for all categories of workers is worked out and training takes place at the district level. Hence, a new scheme of the establishment of district training centres is being suggested in the 8th Plan instead of the erstwhile scheme of continuing education of PHC staff.

The district level set up would require one lecture hall with furniture for the participants and other physical facilities, two rooms for faculty and one room for the store. The trainers of the district training team will however be picked up from the existing officers/health personnel working in the district. The trainers are recommended incentives like training allowance, promotional avenues, postings at a place of choice after three years and career development i.e., admission in post-graduate courses on priority basis against the reserved posts for in-service candidates. The district training teams should also be provided with a vehicle so that they are deeply involved in the training need assessment, evaluation of training programmes and problem solving mechanism at the field level.

4.8. Community Health Officer Scheme

The States have not accepted the CHO scheme in a big way. Only states which have sponsored candidates are Andhra Pradesh, Meghalaya, Mizoram and Manipur. This scheme has run into problems because of the various schemes to be amalgamated for promotion purposes. It is, therefore, suggested that CHO be made a selection post and after the candidates are selected, an in-service training programme of six months can be arranged at the 10 institutions. A tentative provision of 3,000 candidates is suggested for the 8th Plan Period.

4.9. Scheme of training of specialists & Para-Medical Personnel:

This scheme has been proposed in the 8th Plan in State sector by NDC Committee. This scheme has not been accepted by States at all. Only 3 states responded to the training of laboratory technicians i.e, Himachal Pradesh, Uttar Pradesh and Kerala. There is no report received from Uttar Pradesh regarding the training of laboratory technicians.

Himachalpradesh has already stopped the training and Kerala never asked for funds. As per NDC's proposed decision, this scheme has been passed on to the State sector in the 8th Plan Period. So the States will take action to train the various categories, if they so desire, and funds may be earmarked by Planning Commission directly to the State Governments for taking up the programme. It should be a 100% centrally sponsored scheme.

4.10. MPW Scheme (50:50)

This scheme was for reorientation training of all the personnel employed to provide primary health care right from the district to sub-centre level. The objective of the scheme was to reorient the unipurpose into multipurpose concepts. It also provided for rationalisation of the pay-scales of the health workers. The scheme is stagnated at the grass-root level and is not functioning beyond district, state and national level. There is need to have holistic approach to all programme resulting in coordination of all programmes. The scheme is being wound up in the 7th Plan Period.

4.11. Setting up of laboratories

All the Primary Health Centres being established for 30,000 population will be provided financial assistance for setting up of a laboratory. For the diagnosis of the ailments at the Primary Health Centres and for professional satisfaction of the Medical Officers, it is absolutely essential that this scheme is carried in the 8th Plan Period and all the 22,000 PHCs should have a laboratory set up.

The details of the schemes are annexed. at annexure.2 to 15.

CHAPTER.V

SPECIAL ISSUES OF HEALTH CARE DELIVERY SERVICES

5.1. REFERRAL SYSTEM

The primary health care approach has to be backed by an efficient referral system covering the basic specialised services. The curative services that can be provided at the peripheral level through grass-root workers i.e., Health Guides, Dais, ANMs at the sub-centres would be of a restricted nature covering simple common ailments. Some cases will be needing attention of the qualified doctors which can be tackled at the PHC level. PHCs can then refer cases for specialists consultation to the CHCs (Taluq hospital and sub-divisional hospital) as also district hospitals. The district hospitals will function as the referral institution within the first tier and will serve as the referral hospital for CHC/upgraded PHC. After successful treatment, the patients will be sent to the original CHC/PHC from where the referral came for further follow up as necessary.

The hospital in the State capitals may be equipped with more modern facilities for routine use and some of the super specialities. These hospitals will be the second tier of the referral system.

The third tier will be a few hospitals spread over the country with the latest current techniques alongwith Research & Development facilities. They will deal with the patients referred by the second tier hospitals. In this context, the recommendations made are:-

(a) Referral hospital may fix at least one day in a week exclusively for attending to oases referred from the PHCs and other rural institutions.

(b) Certain percentage of beds may be reserved in these hospitals for the cases referred from the PHCs.

(c) In order to implement the referral system effectively it has been suggested in the 7th Plan also, that in these hospitals, the referral cases should be free while the cases coming direct should be made to pay for the services. The specialist facilities and expertise available in Government hospitals for diagnosis and treatment should also be available on payment to the cases referred from hospital run by voluntary organisations and private practitioners. Referral system will only succeed if there is a provision of ambulance service. For this the possibility of reimbursing the cost of private transport to poor patients should be considered.

Additional staff and vehicle have been provided in the medical college hospitals and district hospital under the ROME and Post-Partum programme. There is a need to review the functioning of these two schemes and to revamp them to ensure that the specialist services are provided under these schemes. The specialists provided under these schemes also visit the PHCs at regular intervals.

5.2.COMMUNITY INVOLVEMENT

The Health Guide Scheme has sought to initiate community involvement through village health committees in every village which should select him or her. Community should be involved for effe-

ctive health care delivery services and for health education. Community should be involved right from the planning to implementation of the programmes eventually. Through Health Education, demand should be generated by the community to utilise health services provided by the Government. Keeping this in view, the following recommendations are made to encourage community participation:-

a) Community in the village should form village health committees with women organisations, SC/STs and other associations and known leaders.

b) Now that the village Panchayats are being given responsibilities, they should be involved in the concept of village health guide scheme through village health committees.

c) Seventh Five Year Plan document stated that the Block and District level Panchayats should be fully involved in planning, organising and delivering the health services on the pattern of Maharashtra and Gujarat, the same should be put into practice in other states/UTs.

5.3. ROLE OF VOLUNTARY ORGANISATIONS

Voluntary organisations contribute singnificantly in providing primary health care in large towns, semi-urban areas and rural areas. They provide health care services including health education through various audio-visual aids. Their coverage is limited at present due to financial and other constraints.

Besides they run on parallel lines along with the public health delivery system without coordination or integration.

There is a need now to integrate the two systems i.e., Governmental and non-governmental so that the knowledge and valuable experience can be shared by both.

Recommendations:

The Voluntary organisations, therefore,

a) may be encouraged to extend their activities for establishing sub-centres and PHCs.

b) need to be given facilities to train their staff in the Government training institutions.

c) There may be two-way flow of referral between the voluntary organisations hospitals and government hospitals. Government hospital facilities should be made available to the cases referred by the voluntary organisations.

d) The diagnostic and treatment facilities and expertise available in the Government hospital should be made available to the voluntary organisations on nominal payments.

5.4. INVOLVEMENT OF PRIVATE PRACTITIONERS

There are a large number of private practitioners in urban and rural areas. Only 25% of the qualified Medical Manpower are in service employed by Central and State Governments, semi-Government and Industrial Sector, etc., and 75% of the doctors are providing these services as private practitioners. The private practitioners can be actively involved in providing primary health care. The group, therefore, recommends the following:-

a) Involving them in the National Health Programmes by organising refresher training courses for private medical practitioners particularly in respect of Family Welfare and MCH, Immunization, control of communicable diseases etc., This can be done through I.M.A. and its branches.

b) These practitioners could be involved by providing them for National Programmes free of cost (drugs - contraceptives) on the same lines as being done under Family Welfare and MCH programmes. The only condition that should be attached to this should be that they distribute them free of cost to their clients and report the number of beneficiaries to the Government organisation.

c) The patients referred by the private practitioners to the government institution may get free diagnostic facilities.

d) They may be encouraged to participate in the National Health Policy in the programme of Immunisation according to the local needs. Government may provide them the required vaccines, some equipment and drugs depending on the population of the villages they cover.

e) Giving them encouragements and financial incentives in the form of easy available bank loans to establish themselves in semi-urban, rural and medically backward areas.

f) All facilities which are available to an unemployed graduate for self-employment be given to qualified graduates of medicine.

g) In the medically backward areas, medical practitioners may be given these facilities in the form of providing land at subsidised rates, soft loans under long-term repayment scheme, capital grant for building and equipment, water and electricity at concessional rates, exemption from income-tax and other benefits.

h) There should be a provision for conditional grant-in-aid with the following:-

- To improve diagnostic facilities

- To strengthen operation theatre/labour room
- To give theraputic treatment to the poor patients
- For operational research in the field of health

5.5. INVOLVEMENT OF ISM & HOMEOPATHY

There are a large number of dispensaries of ISM and Homeopathy in the rural areas. There are nearly 4-5 lakhs medical practitioners in the rural areas. These practitioners command respect in the rural areas. In view of the integrated approach envisaged in the National Health Policy, it is desirable that the infrastructure of trained health manpower available in this system is fully utilised in the delivery of primary health care services. Keeping in view the policy, a suitable package of preventive, promotive and crative training may be arranged for doctors of ISM and Homeopathy. It will be more cost-effective if instead of supporting curative institutions under these systems, facilities for treatment under this system are introduced in the existing sub-centres and PHCs and CHCs wherever required. These ISM and Homeopathy doctors may be given a short orientation course and they can make a significant contribution in the preventive, promotive aspects, family welfare and health education activities, etc.,

5.6. MULTI-SECTORAL COORDINATION

It is well known that Health Sector alone can not achieve the goal of Health for All. Health related sectors must be partners in health field. Many other Ministries, voluntary institutions (Non-governmental organisations) and all levels of administration down to the community must become involved in Health. The goal can be achieved only by concerted inter-action of all relevant sectors

namely Agriculture, Food and Nutrition, Education, Information and Broadcasting, water Supply and Sanitation, Industry and Labour Organisations. The ICDS is coordinating the efforts of Ministry of Social Welfare, Education and Health and Family Welfare for running an integrated package programme of child health. This needs to be strenthened as well as the School Health education programme. For this integration committees should be formed at various levels at the Centre, State, district and block level.

5.7. RESOURCE MOBILISATION

5.7.1. Considering the national commitment for the implementation of the National Health Policy and to achieve the objectives given therein, Plan allocations for Health will need appreciable augmentation. The public expenditure has increased to a great extent both at Central and State levels. With a commitment to provide health care for all, there is a limit to which public finances can meet all the costs of health care. Since, Government alone can not meet the total resources required for health services, semi-government, autonomous agencies, voluntary organisations and private efforts have to be geared side by side to achieve the objectives.

Community resources may supplement public sector investment for expansion of the health delivery system. Additional resources so generated need to be utilised for expansion of health delivery services according to the needs of the area. There is a need for well-considered Health Insurance Scheme for mobilisation of additional resources for health promotion and for ensuring that community shares the cost of services in keeping with its paying capacity. Keeping this in

view, a scheme may be evolved for this purpose that only those who are able to pay are made to contribute.

5.7.2. The Working Group, therefore, recommends:

a) The individuals who seek specialist services directly without being referred from a peripheral health institution should be made to pay for such services. These charges may be in the form of consultation fee and charges for the various diagnostic services rendered.

b) All patients attending the out-patient department for curative health services at hospitals, PHCs and dispensaries should be normally charged at the time of initial registration. This charge may be waived off in case of poor persons.

c) Provision of paying-wards in the district hospitals may be made. This will ensure that the individuals with paying capacity do not avail of free services. All services provided in the paying wards should be charged.

d) There should be a standard list of medicines of which medicines may be provided free-of-cost by the institutions at various levels. Medicines required outside this list should be purchased by individuals. However, all medicines required for emergency cases must be available from the hospitals, irrespective of their cost and paying capacity of the patients.

5.8. MONITORING AND EVALUATION SYSTEM

5.8.1. Under the existing system only numerical achievement in respect of health man power trained and institutions established is collected from States and UTs through a structured questionnaire on

quarterly basis. The evaluation of the achievement is made vis-a-vis the targets assigned to the States/UTs for various programmes. Whenever any shortfalls or gaps are noticed in the performance, the States are accordingly urged to step up their efforts to achieve the assigned targets. Since these programmes are target-oriented and time-bound, the States make endeavours to achieve the numberical targets caring less for the qualitative aspects of these programmes. This had been voiced by the participants during the discussions held for formulation of Eighth Plan. As a matter of fact, the country has set before itself certain goals and targets to be ultimately achieved which have been enshrined in the National Health Policy.

5.8.2. The Group, therefore, recommends:

a) The effective and efficient way of making real evaluation of achievement of various health programmes by the States/UTs is to see in the perspective of these goals and targets for attaining Health for All by 2000 A.D.

b) The mere establishment of infrastructure with cursorily trained personnel is not going to ultimately help achieve the goals for Health for All. Therefore, goals set for various indicators of Health and Family Welfare Programme may be evaluated periodically at a reasonable interval, so that the States/UTs would know whether they are moving in a right direction and if not, which are the weaker areas which need to be revamped or suitably modified so as to ultimately lead to the achievement of these goals for various indicators,

c) This exercise can be undertaken by conducting field surveys or taking advantage of the services and of other organisations/agencies. For instance, annual birth rate, death rate and infant mortality rate are worked out by the Registrar General of India;

d) This further requires establishment of Health Management Information System on a sounder footing at all levels in the field; and

e) There is a need for intensive training programmes for Health Workers and sensitisation programmes for middle level and senior level supervisors which needs to be organised and may be repeated at reasonable intervals.

5.9. RESEARCH

5.9.1. Research and Health Care Delivery services in the rural and urban areas is very crucial for improving the quality and out-reach of the programme. There is a need to conduct research on various facets of the different schemes/projects and to utilise these research findings in order to improve the schemes.

5.9.2. The following recommendations are made:

a) Several research centres/institutions are existing in the country which may be strengthened by increasing the number of functionaries and finances;

b) There is a need to look into the training aspects so as to improve their skill in performing, coordinating, compiling and dissemination of research findings;

c) Behavioural studies/surveys conducted by various institutions, i.e., by governmental and voluntary organisations, may be utilised; and

d) high priority needs to be given to Operational Research on health care delivery services to identify cost effective strategies of health schemes.

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CHAPTER.VI.

B. HEALTH CARE DELIVERY SERVICES IN URBAN AREAS

INTRODUCTION

6.1. As per WHO estimates about 50% of the world population would be living in urban slums by the year 2000 A.D. In 1981 census, urban population in India was 167 millions and by the year 2000 A.D. it would be approximately 367 million i.e., 45% of the total population. This means that urban population is growing faster (4.6%) than the national rate (2.3%). It is well known that though good health service facilities are available in cities and towns, yet the major portion of the population of cities and towns are not able to avail the same for various reasons. Moreoever, the preventive and promotional health care facilities which were particularly recommended for the slum population of the urban areas have not yet been developed, though the same had been recommended by the Krishnan Committee during the Sixth Plan Period.

6.2. Recommendations

The Group felt that the recommendations of the Seventh Plan Working Group were well prepared but proper efforts have not yet been made to implement these. Keeping in view the guidelines provided by the National Health Policy and the Seventh Five Year Plan document regarding greater involvement of community and voluntary organisations and re-orientation of medical education, it is recommended that:-

a) There should be a Health Centre/Health Post for every 50,000 population preferably located in slum areas or at least nearer to the slum area. This Centre should cater to areas having at least 40% of the slum population and/or poorer sections of the community. These health

centres should give primary health care, maternity and child health care including immunization and FW services. They should also give extensive health education to the community so that whatever facilities are provided are optimally used.

b) The organisational aspects of urban Health Services need to be looked into and necessary reforms made to make the most efficient use of trained manpower already available and avoid duplication and overlapping of functions. The present wasteful practice of patients moving from one institution to another on their own should be effectively tackled.

c) Voluntary organisations and local bodies should be encouraged to undertake family welfare and primary health care services under the above scheme (as per Krishnan Committee's recommendations) with clearly defined functions and territorial jurisdiction.

d) It must be ensured that the technical staff required for re-organisation of the services in urban areas is trained properly and in no case such staff be diverted from the rural areas to urban area thereby adversely affecting the health care delivery system in rural areas.

e) All institutions providing services, super specialities should be declared as referral institutions so that they attend only to cases referred from the first and second level of referral services.

f) It is further recommended that any individual seeking services from specialised institutions directly should be made to pay for the services sought.

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CHAPTER.VII

SPECIFIC RECOMMENDATIONS OF RURAL & URBAN AREAS

1) It has been observed that though the achievements are impressive in terms of establishment, they are not operationalised properly and the services provided at these Centres have to be improved to bring in credibility required for efficient working of health services. It is, therefore, decided that there may be minimal expansion of the rural infrastructure and all the resources must be spent for consolidation i.e, providing medicine and equipment and buildings wherever necessary.

2) It is also crucial for the programme that the knowledge and skills of the Health Workers match the needs of their job requirement. Therefore, the basic training and continued education should receive the highest priority during the 8th Plan.

3) Involvement of other systems of medicine in institutions of Primary Health Care was also recommended.

4) It was recommended that other related health sectors may also ' involved that is education, food and agriculture, science and technology, social welfare, animal husbandry, housing, urban development and rural reconstruction. Integration with other health related sectors is of vital importance. This area has not been given its rightful due. There is a need for integration with other sectors and in particular with ICDS Programme which is a sort of parallel health programme. The mechanism for integration of ICDS and health activities shall be worked out in consultation with the Ministry of Social Welfare.

5) It was recommended that community should be involved in planning, implementation, maintenance, monitoring and evaluation of the health care. The community may provide manpower and material and time whenever needed. It was considered that there was a need to look at all the functionaries of different departments working at the village level and to use them effectively for promotion of health activities like sanitation, water supply, sewerage and health education purposes.

6) It was agreed upon that there should be flexibility in approach and freedom for action in some of the difficult and remote areas.

7) The demand of the villagers and the authority to improve their demands should be vested at the village level.

8) There is a need to have a greater flow of funds through village level, which may be by Panchayati Raj System.

9) It is recommended that mobility must be ensured at the primary health centres.

10) Adequate stock of medicines and drugs must be made available even at village level or at still smaller places, at health centres so as to establish credibility of the system as curative services are the entry point for availing these services.

11) Some NGOs are successfully functioning in the field of health. However, they are charging a little money towards cost of medicine. Their involvement on a larger scale needs to be rationalised and backed by a political will.

12) Management of public health should be accorded priority. This discipline has to be inculcated from the top level health manager to down-the-line. Community Health (Public Health) needs to be given greater attention.

13) There is a need to redefine the role of VHG, TBA and Anganwari worker when all the three functionaries are working in the same area, that is, a village.

14) It would be beneficial depending upon the local situation to establish sanitary-cum-epidemiological stations at the primary health centre. The district health organistion should have as an integral part of a set up a well developed epidemiological unit to coordinate and supervise the functioning of the field stations. These stations would participate in the integrated action plans to eradicate and control diseases besides tackling specific local environmental health problems.

15) The decentralisation of services would require the establishment of well worked out referral system to provide adequate expertise at the various levels of organistional set up nearest to the community, depending upon the actual needs and problems of the area and thus ensure against the continuation of the existing rush towards curative centres in the urban areas. This may be done through ration card, health card or identity card.

16) A sub-centre be considered functional only if male and female multi-purpose workers are in position. Funds to be released by the Govt. of India only for the functional sub-centres and not for all sub-centres as is the practice at present.

17) One model sub-centre per PHC and one model PHC per district should be identified and these institutions should be utilized for training under special scheme.

18) Efforts should be made to achieve the objective of one bed for every 1,000 population taking into account the hospital facilities available through voluntary organisations and other private institutions.

19) The allocation of beds should be 20% for primary health care, 30% for the first referral i.e., in Community Health Centres/ CHC and other hospital below the district level, 40% at the second referral i.e., district level and 10% for medical college hospitals, regional hospitals and specialised hospital and super specialities.

20) Considering the need of the most vulnerable population, it is recommended that at least 40% of all beds should be earmarked for women and children.

21) In order to take effective measures to contain the spread of communicable diseases in the rural areas and urban slums there is an urgent need to organise epidemiological services at district and CHC level to provide back up support to the peripheral health services at the village and slums which are riddled with communicable diseases and other health problems. The working group, therefore, recommends that at the district headquarter/ CHC there should be a medical officer suitably trained in public health/epidemiology supported by a Public Health Laboratory and a Public Health team who will immediately investigate/survey the area in the event of any outbreak/impending epidemic of any communicable disease.

22) Health Management Information system should form an integral component of the syllabus of the training of the health workers (F) and MPWs(M) for health functionaries' future training programme to be conducted under various programmes. Inservice training in the proper maintenance of the records/registers, preparation/compilation of the Monthly Reports, its use for monitoring and evaluation may be organised for existing multipurpose workers (Male & Female), Supervisors, Computors of PHCs, MOs of PHCs and District level staff.

23) To ensure proper maintenance of records and reporting, it is recommended that specific funds for printing of records/registers and reporting formats be provided for each level.

24) Health Management Information System may be included in the 8th Five Year Plan as a 100 % Centrally sponsored scheme to be established in all the States/UTs in the country.

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Annexure.I

INFRASTRUCTURE PHYSICAL TARGETS FOR VIII PLAN

Unit		Total requirement	Likely available as on 1.4.90	Additional recommended No.	% of total requirement.
1.Trained Dais		5.8 lakhs	5.8 lakhs	1.16lakhs	100
2.Health Guides		5.8 lakhs	3.9 lakhs	2.5 lakhs	100
3.a)Sub-centres	(R)	1.35 lakhs	1.35 lakhs	Nil	100
b)Training of MPW (M)		1.35 lakhs	1.33 lakhs	0.22 lakhs	100
c)Training & employment of MPW (M)		1.35 lakhs	86,383	61,574	100
d)Training & employment of F.H.A.		22,500	20,758	4,856	100
e)Training & employment of male H.A.		22,500	23,441	2,575	100
f)Construction of sub-centres		1,35,000	43,320	91,680	100
g)Additional medicines		Rs. 5,000 PA	Rs. 3,000 PA		
4.PHC's/SHCs(new)	(R)	22,500	19,970	2,530	100
5.CHCs	(R)	5,625	1,927	3,698	100

(R) = Revised figures.

ANNEXURE.2

FINANCIAL REQUIREMENTS FOR V.H.G. SCHEME

		(Rupees in lakhs)
1. Honorarium for 3.45 lakh V.H.G. @ Rs.1200/ per annum	-	4140.00
2. T.A. for attending monthly meeting at PHC for 3.45 lakhs @ Rs.120/ per annum	-	414.00
3. Drug kits for 3.45 lakh VHGs @ Rs.600/ per annum	-	2070.00
4. Salary of 3,159 Third Medical Officers @ Rs.18,000/ per annum	-	--
5. Drugs for 4,227 PHCs @ Rs.6,000/ per annum	-	--
6. Contingency for 4,227 PHCs @ Rs.2,500/per annum/PHC	-	--
		6624.00
		x 5
Total	-	33120.00

Training for additional new 2 lakhs VHGs in VIII Plan

1. Stipend for 2 lakh @ Rs.600/ per VHG	-	1200.00
2. Manual and VHG kit for 2 lakh VHGs @ Rs.150/ per VHG	-	300.00
3. Honorarium, TA & Drugs (40,000 trained annually)		11520.00
		13020.00

Total requirement in VIII Plan = Rs.33120 lakhs + Rs.13020 lakhs =

46140.00

Annexure.3

DETAILS OF RECURRING (R) AND NONRECURRING (NR) COST - TRAINING OF DAIS

Component	Unit cost				Units to be created	Total cost annual				Total plan costs 1990-1995			
	Existing pattern		Proposed pattern			Existing pattern		Proposed pattern		Existing pattern		Proposed pattern	
	NR	R	NR	R		NR	R	NR	R	NR	R	NR	R
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
						(Rupees in lakhs)							
1.Training Dais	--Rs.300/ dai		--	--	1 lakh dais to be trained	--	60.00	--	--	--	300.00	--	--
2.(a)Reporting fee (apprx. 25 deliveries/Dai)	--Rs.75/ dai Rs,3/delivery		--	Rs.250/ @ Rs. 10/ delivery	For 4 lakh dais								
(b)Manual	--Rs. 20/		--	Rs. 20/									
(c)Pre-sterilised disposable delivery kit	--		--	Rs.75/ (Rs.5/kit)									
(d)Continuing education	--		--	Rs.300/ (@Rs.25/day for 12 days in a year)									
(e)Weighing scale & other eqpmt.	--		--	Rs. 50									
				Rs.695		--	78.40	--	556.00	--	392.00	--	2780.00

Annexure.3 contd.

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
3.Training material for ANMs & LHVs	--	--	--	Rs.50/sub-centre	--	--	--	--	-13.00	--	--		-65.00
4.Honorarium for ANMs & LHVs	--	--	--	--Rs.250/LHV/PA Rs.250/ANM/PA	--	--	--	--	76.20	--	--	--	381.00
				Total		138.40			645.2		692.0		3226.00

Annexure.4

DETAILS OF RECURRING (R) AND NONRECURRING (NR) COST - SUB-CENTRE PROGRAMME

Component	Unit cost existing NR	Unit cost existing R	Unit cost proposed NR	Unit cost proposed R	Units to be created	Total cost annual existing pattern NR	Total cost annual existing pattern R	Total cost annual proposed pattern NR	Total cost annual proposed pattern R	Total plan cost existing pattern NR	Total plan cost existing pattern R	Total plan cost proposed pattern. NR	Total plan cost proposed pattern. R
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1.a) Salary of ANM & allowance	--	Rs.10,800	--	Rs.12,000									
b) Helper	--	Rs. 600	--	Rs. 1,200									
c) Contingency	--	Rs. 600	--	Rs. 1,200									
d) Drugs	--	Rs. 2,000	--	Rs. 5,000	For 1.35 lakh sub-centre maintenance cost								
e) Rent	--	Rs. 1,000	--	Rs. 1,200									
	--	Rs.15,000	--	Rs.21,400		--	Rs.20,250	--	Rs.27,820	--	Rs.1,01,250	--	Rs.1,39,100
2.Salary of LHV		Rs.15,000		Rs.18,000	For 21600 LHV posts	--	Rs. 3,390	--	Rs. 3,888	--	Rs. 16,950	--	Rs. 19,440

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Annexure.4
Contd.:.

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
3.Construction of sub-centre	1 lakh	--	1 lakh	--	67,000	67,000	--	--	--	67,000	--	--	--
4.Strengthening of sub-centres supply of equipment	2,200	--	15,000	--	For 80,000 sub-centres	--	--	12,000	--	--	--	12,000	--
						67,000		12,000		67,000		1,18,200	
			Total				23,640		31,708		12,000		1,58,540

Annexure.5

DETAILS OF COST - PRIMARY HEALTH CENTRE

Programme	Carri.. over liabi..ty of 7t. Plan	Expansion proposed	Additional allocation proposed	Total	Sector-wise allocation			REMARKS
					Health	Family	State	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.Consolidation of infrastructure (PHCs)	Rs.16 .23.25 ..khs	Rs. 2,579,5 lakhs	--	Rs.19,102.75 lakhs	--	--	Rs.19,102.75 lakhs	
2.Construction of PHCs	Rs. 3,..29.0 l.. hs	Rs.90,209.0 lakhs	--	Rs.93,338.0 lakhs	--	--	Rs.93,338.0 lakhs	

Annexure.6

DETAILS OF COSTS - COMMUNITY HEALTH CENTRES

RECURRING COSTS			NONRECURRING COSTS		
PER CHC UNIT					
Salary	=	Rs. 5,65,000	a) Rural Clinics (New) 2598 @ Rs.25 lakhs each	= Rs.	64,950 lakhs
Medicines	=	Rs. 75,000			
Contingency	=	Rs. 20,000	b) Repair and addition 1100 @ Rs.5 lakhs each	= Rs.	5,500.5 lakhs
POL	=	Rs. 45,000			
Total	=	Rs. 7,05,000	Total cost for 3698 CHCs		70,450.5 lakhs
Total CHCs required by the end of VIII Year Plan	=	5,625	Vehicles for 3698 CHCs @ Rs.3.5 lakhs each	=Rs.	12,943.5 lakhs
TOTAL RECURRING COST =			TOTAL NONRECURRING COST	=Rs.	83,393.5 lakhs
7.05 x 5,625 lakhs					
	=	Rs.1,982.21 crores			

TOTAL COSTS = Rs. 2,81,675.00 lakhs

Annexure.7

FINANCIAL REQUIREMENTS FOR THE 8TH FIVE YEAR PLAN FOR TRAINING SCHEMES

Programme	Carry over liability of VII Plan	Expansion proposed	Additional allocation proposed	Total	Sector-wise allocations			REMARKS
					Health	F.W.	State	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
				(Rupees in lakhs)				
1) Basic training of MPW(M)	2,57 00	To establish 85 new schools	3,424.00 including modifications	5,994 that is 6,000.00	--	6,000	--	--
2) Training of HA(Male)	To tr n 4000 HA(M)	At 5 new schools at existing HFWTCs	198.00	198.00	--	198.00	--	--
3) Training of CHOs	--	To train 3000 at 10 institutions	442.00	442.00	442.00	--	--	--
4) Dist.Training Centres	Nil	Estb. of 440 centres	Rs.8,702.00	8,702.00	--	8,702.00	--	--

Annexure.7 contd.

	Unit Cost		Units to be created	Total cost	
	Non-recurring	Recurring		Nonrecurring	Recurring
(1)	(2)	(3)	(4)	(5)	(6)
				(Rupees in Lakhs)	
I.Basic training of MPW(M) at					
i) existing 47 HFWTCs	Nil	3.60	-	Nil	845.00
ii) 50 new schools(existing)	Nil	6.90	-	Nil	1,725.00
iii) 85 new schools (opening)	1.65	6.90	85 new schools	140.00	3.692.00
				140.00	5,261.00
**Expenditure on proposed modifications, vehicle and AV aids for each of the 182 above institutions	2.50 at HFWTC Rs.20,000 at 3.00 at new schools Rs.34,000 at all HFWTC		Purchase of 182 vehicles and AV Aids	522.00	71.00
				662.00	5,332.00
GRAND TOTAL :Rs.5,994.00 lakhs i.e.,Rs.6,000 lakhs.					
II.Training of HA(M)					
i)15 schools proposed	Nil	3.60	15 proposed at HFWTCs	Nil	198.00
III.Training of CHO	14.04	6.03	*10 institutions proposed	140.50	301.50
GRAND TOTAL: Rs.442.00 lakhs					

P.T.O.

Annexure.7 contd.

(1)	(2)	(3)	(4)	(5)	(6)
IV. Establishment of District Training Centres	10.08	4.25	440 trg.centres	4,435.00	4,147.30

GRANT TOTAL : Rs.8,702.00 lakhs for 440 centres

* Due to the slow uptake of the scheme it is proposed to train only 3,000 candidates against a requirement of approximately 25,000 during VIII Plan. This training is proposed to be undertaken at 10 training institutions which would need to be identified, In case the scheme finds favour with the States, the target would be accordingly revised.

Annexure.7 contd.

Name of the scheme	Carried over liability of VII Plan	Expansion proposed	Additional allocation proposed	Total	Sector-wise allocations			REMARKS
					Health	F.W.	State	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
5. Orientation training of medioal and paramedical personnel	800	Not known	1500	2300	--	2300	2000	50% to be allocated during the 1st year to enable the states to initiate action
6. Training of Specialists & Paramedical Workers	25	Nil	2575	2600	2600	--	2596	20% targets are set for each year of tha Plan
7. Health and Family Welfare Training Centres	1985	10 new HFWTCs	785	2770	--	2770	2770	--

Annexure.7 contd.

ORIENTATION TRAINING OF MEDICAL AND PARAMEDICAL PERSONNEL

(Rupees in lakhs)

Sl.No.	Item	Unit cost		Units to be created (Not known - only VII Plan liability)		Total cost	
		Non-recurring	Recurring			Non-recurring	Recurring
1.	Hostel for 20 trainees alongwith lecture and demonstration room	5.00	--	266	schools	1,330	--
2.	Furniture for hostel and class-room, kitchen articles	0.30	--	266	"	79.80	--
3.	Training equipments and Aids	0.10	--	266	"	26.60	--
4.	Rent for hostel till the bldg is completed	--	0.36	266	"	--	404.30
5.	Stipend - As per rates admissible for each category		2.56 lakhs to be trained				
	- Average per trainne		Rs.400/				1.80
6.	Contingency	--	0.10	266	"	--	133.00
7.	Additional staff a) ANM & KHV Schools	--	0.30	112	"	--	183.00
	b) RHTCs (Regienal Teachers Training Schools)	--	0.50	30	"	--	75.00
8.	Consumable training	--	0.05	266	"	--	66.50
			TOTAL				2,300.00

Annexure.7 contd

FINANCIAL REQUIREMENT FOR VIII PLAN FOR TRAINING OF FEMALE HEALTH WORKERS (ANM) AND FEMALE HEALTH ASSISTANTS (LHV)

(Rupees in Lakhs)

Programme	Carried over liability of VII Plan	Expansion proposed	Addl. allocation proposed	TOTAL	Sector-wise allocation			REMARKS
					Health	FW	State	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Training of Female Health Worker (ANM) and Female Health Asstt. (LHV)	5750.00	a) Inspection of schools by Inspectors (6) b) Continuing Education of Nursing Teachers c) Construction of 100 schools d) Strengthening of schools by providing vehicle and A.V. equipment e) Training midwives (new scheme) 50 schools f) Opening of 50 schools	3730.00	9605.00	--	9605.00	--	(of 9605 lakhs a sum of Rs.2000.00 lakhs towards capital)

ANNEXURE.8

LABORATORY FACILITIES AT PRIMARY HEALTH CENTRES

(Rupees in lakhs)

Name of the scheme	Carried over liability of VII Plan	Expansion proposed	Addl allocation proposed	TOTAL	Sector-wise allocation			REMARKS
					Health	F.W.	State	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Laboratory facilities at Primary Health Centres	156.00	Not known	728.00	884.00	884.00	--	884.00	20% target is set for each year of the Plan.

Annexure. 9

HEALTH MANAGEMENT INFORMATION SYSTEM (NEW SCHEME) (VIII PLAN PERIOD)

	Activity	Cost per district Rs.in lakhs	Total cost Rs.in lakhs
1.	Training of Health functionaries, Computors and other statistical personnel	0.43	189.2
2.	Printing of records/registers, reporting formats	4.30	1,892.0
	TOTAL	4.73	2,081.2

Annexure.10

MAN-POWER TO BE TRAINED IN THE DISTRICT

(Population 10 lakhs)

Village Health Guides	1,000
Dais	1,000
Male MPWs	200
Female MPWs	200
HA (Male)	35
HA (Female)	35
BEE	10
Medical Officer at PHC	40
PHN	30

Annexure.11

TRAINING PLAN FOR DISTRICT (POPULATION - 10 LAKHS)

Category	Type of training	Institution/Venue	Duration & interval	Teachers
1.Village Health Guide	a)Initial training	Block H.Qrs.	3 months	BEE/HA(Male)/MO
	b)Retraining	PHC (30,000)	1 day every month	HA(Male)/HA(FEmale)
2.Dais	a)Initial training	PHC (30,000)	1 month	/HA(F)/MPW(F)
	b)Retraining	Sub-centre	1 day every month	HA(F)/MPW(F)
3.MPW (Female)	a)Basic training	Female Health Workers'school	1½ years	ANM School teachers
	b)Inservice training	Distt.Training Centre	2 weeks every e years	Nursing personnel
	c)On the job trg.	DTT at PHC	2 days	DTT Members
4.MPW (Male)	a)Basic training	Male Health Workers'school	1 year	Staff sanctioned for schools
	b)Inservice trg.	As for Female Health Workers	-	As for female Health Workers
	c)On the job. trg.	As for Female Health Workers	-	As for female health workers

.....CONTD...

Annexure.11 contd.

Category	Type of training	Institution/Venue	Duration & interval	Teachers
5. Health Asstt.(F)	a) Basic training	Promotions sohools	6 months	Sanctioned staff
	b) Inservice Trg.	DTC	2 weeks every 3 years	DTT Members
	c) On the job Trg.	DTT at PHC	2 days	DTT members
6. Health Asstt.(M)	a) Basic Training	Not needed at present	6 months	Sanctioned staff
	b) Inservice Trg.	As for female health asstts	-	As for female health asstts
	c) On the job trg.	As for female health asstts	-	As for female health asstts
7. MO (PHC)	a) Basic training	Med.Colleges	4½ years	Faculty of Med.College
	b) Inservice trg.	HFWTCs	2 weeks every 3 years	Faculty of HFWTCs
	c) Clinical Trg.	Distt.Hospital/ Private hospi-tal PP Units	Once in 3 years	Staff of PP Units.
8.BEEs	Inservice Trg.	HFWTCs	2 weeks every 3 yrs	Faculty of HFWTCs
9.Teachers of ANM Schools, promotional schools, MPW Male Sohools, DTT	Inservice Trg.	HFWTCs	2 weeks every 3 yrs	Faculty of HFWTCs

Annexure.12

UTILISATION OF HEALTH & FAMILY WELFARE TRAINING CENTRES
(10 Districts per HFWTC)

Category	Total No.	1/3 No.	Duration of Trg.	Interval	No. of batches	Utilisation
MO (PHC)	350	120	3 weeks	3 years	6 x 20	6 months
BEE	100	35	2 weeks	3 years	2 x 20	1½ months
ANM Schools	80		2 weeks	1 year	4 x 20	3 months
Male MPW Schools	10		2 weeks	1 year	1 x 10	
LHV Schools	10		2 weeks	1 year	1 x 10	
DTT Members	50		1 week	1 year	10 x 5	

Annexure.13

LOAD ON DISTRICT TRAINING CENTRES AND UTILISATION

Category	Total No.	1/3 No.	Duration	Interval	Batches	Utilisation of DTC.
MPW Female	200	67	2 weeks	3 years	3 x 25	4 months
MPW Male	200	67	2 weeks	3 years	3 x 25	
Health Asstts. (M)	35	12	2 weeks	3 years	1 x 12	1½ months
Health Asstts. (F)	35	12	2 weeks	3 years	1 x 12	
	35	12	2 weeks	3 years	1x 12	1 month
On the job training of 2 days at PHC						5½ months
Any other course						

Annexure.14

SEVENTH FIVE YEAR PLAN (1985-90) - OUTLAY AND LIKELY EXPENDITURE ON HEALTH PROGRAMMES.

(Rupees in lakhs)

S.No.	State	7th Plan approved outlay		Likely expenditure during 7th Plan								
			MNP	Hosp & Disp	Med. Ed. Research	Trg. programmes	Control of communicable diseases	ISM & Homoeopathy	ESI	States share of CSS	Other programmes	Total Col.4 to 12
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
1)	Andhra Pradesh	16420	5372	4797	+	-	-	809	37	2782	707	14524
2)	Arunachal Pr.	1450	788	393	68	27	48	29	-	8	72	1428
3)	Assam	7555	4770	1909	1827	67	-	223	14	2525	407	11742
4)	Bihar	14640	7568	809	7398	148	-	387	33	2999	1178	20520
5)	Goa	# 2444	280	143	1420	77	47	1	9	-	11	1988
6)	Gujarat	10314	4300	664	927	69	25	223	24	3737	295	10266
7)	Haryana	7877	2335	1013	1185	-	-	164	38	2000	204	6939
8)	Himachal Pradesh	2625	1566	776	685	37	-	442	22	425	181	4134
9)	Jammu & Kashmir	6306	3138	1036	4694	61	172	61	2	204	413	9781
10)	Karnataka	11800	5491	3554	4	40	40	282	75	2164	+	11646
11)	Kerala	5200	1317	550	1870	140	90	830	114	139	655	5705
12)	Madhya Pradesh	15733	6470	3346	997	280	492	767	55	4995	1694	19096
13)	Maharashtra	37400	15401	2359	2997	$	281	$	54	7160	749	29001
14)	Manipur	1300	607	361	12	14	15	7	-	298	124	1438
15)	Meghalaya	1600	1014	237	48	$	-	2	-	279	95	1675
16)	Mizoram	1400	685	498	26	$	-	6	-	110	218	1543

Annexure.14 contd.

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
17)	Nagaland	1500	647	570	110	$	52	4	-	257	193	1833
18)	Orissa	5450	2803	1535	1215	112	358	684	79	644	288	7718
19)	Punjab	10350	1889	840	1796	13	$	192	36	1822	536	7124
20)	Rajasthan	8257	3715	864	2870	55	--	1216	54	3283	161	12218
21)	Sikkim	581	274	112	-	6	-	8	-	124	267	791
22)	Tamilnadu	15000	4075	2944	1500	78	-	1054	-	960	3624	14235
23)	Tripura	1300	756	460	295	$	4	38	-	516,	55	2124
24)	Uttar Pradesh	30080	14880	5800	14550	50	70	2080	80	5934	1529	44973
25)	West Bengal	12800	5403	2532	1546	45	205	630	64	1685	279	12389
	TOTAL	229327	95564	38102	48036	1319	1899	10139	790	45052	13935	254831

Annexure.14 contd

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
UNION TERRITORIES												
1)	A&N Islands	400	453	208	-	11	-	-	-	-	35	707
2)	Chandigarh	900	97	368	-	-	-	-	18	-	481	884
3)	Dadra & Nagar Haveli	142	77	57	-	-	-	6	-	-	33	173
4)	Daman & Diu	@	40	110	-	-	40	1	-	-	55	246
5)	Delhi	18086	-	15840	730	-	2350	630	-	-	372	19922
6)	Lakshadweep	100	81	6	-	-	3	24	-	-	22	136
7)	Pondicherry	600	167	678	-	22	74	41	15	-	64	1061
	TOTAL OF UTS	20228	915	17267	730	33	2467	702	33	-	982	23129
GRAND TOTAL (All States & UTs)		249555	96479	55369	48766	1352	4366	10836	823	450052	14917	277960

\# Including figures for Daman & Diu

@ Included in figures for Goa

\+ Included under hospitals &Dispensaries

$ Included under Medical Education & Research

¶ Included under other Programmes.

VIII FIVE YEAR PLAN (1990-1995) FOR RURAL HEALTH SERVICES FINANCES RECOMMENDED

(Rupees in Crores)

SCHEMES	Amount required
1. VILLAGE HEALTH GUIDE SCHEME	461.40
2. DAIS PROGRAMME	32.26
3. SUB-CENTRE PROGRAMME	1585.40
4. PHCs	1124.41
5. CHCs	2816.75
6. TRAINING PROGRAMME	
a. Basic Training of MPW (M)	59.94
b. Training of HA(M)	1.98
c. Training of HW(F) & HA (F)	96.05
d. Training of CHOs	4.42
e. District Training Centres (new scheme)	87.02
f. Orientation Training of Medical & Para-medical personnel (if continued)	23.00
g. Training of Specialists and para-medical workers	26.00
h. Health & FW Training Centres	27.70
i. Laboratory facilities at PHCs	8.84
7. H.M.I.S.	20.81
8. Grants to Voluntary Organisations	10.00
9. Involvement of Private Practitioners	10.00
10. Research	5.00
11. Employment of MHW & HA (M)	832.50
GRAND TOTAL	7233.48

Construction Cost:-1)Per entire CHC Rs.25-30 lakhs for addiotionality only Rs.10-15 lakhs
2)Primary Health Centre Rs.5-7 lakhs (with residential Qrs. Rs.10 lakhs)
3)Sub-Centre - Rs. 1 lakh.