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

Government of India
Ministry of Health and Family Planning
(Department of Family Planning)

New Delhi
September 15, 1973
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**NOTE BY DR. D N GUPTA**

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#### PART II

ANNEXURES

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MEMBERSHIP OF THE COMMITTEE

1. Shri Kartar Singh, Additional Secretary
   Ministry of Health & Family Planning
   Government of India.
   Chairman

2. Dr. J B Shrivastav, Director General of Health Services, Government of India
   Vice-Chairman

3. Shri K N Srivastava, Commissioner, Health & Family Planning
   Government of India
   Member

4. Shri S E Sukthankar, Secretary, Health Department
   Government of Maharashtra
   Member

5. Shri. H M Singh Secretary, Department of Health & Family Planning
   Government of Tamil Nadu.
   Member

6. Dr. R P Sondhi, Director of Health Services
   Government of Haryana
   Member

7. Dr. V H Thakore, Director of Health Services
   Director General of Health Services,
   Government of India
   Member

8. Dr. A Timmapaya, Director, National Institute of Health
   Administration & Education,
   New Delhi
   Member

9. Shri A Prasad Deputy Secretary
   Planning Commission
   Government of India, New Delhi
   Member

10. Dr. P Diesh Commissioner, Rural Health & Mobile Hospitals,
    Government of India.
    Co-opted Member

11. Dr. D N Gupta, Deputy Commissioner,
    Department of Health & Family Planning
    Government of India.
    Member-Secretary
CHAPTER - I

INTRODUCTION

1.1 National programmes in the field of Health, family planning and Nutrition have been in operation in the country for many years. In general, these programmes are being run almost independently of each other by staff recruited under each programme. There is little or no coordination between the filed workers of these programmes and even at the supervisory level there are separate and independent functionaries. Though in the majority of these programmes, a Primary Health Centre forms the apex of a pyramid, yet till recently even the two doctors working at the primary health centre, had separate spheres of activities one working for family planning and the other for health. This situation has however, been somewhat rectified by Government of India letter No. 2310/69 ply dated 5.7.71 and now in most places the two doctors work both for family planning and health services. According to the duties assigned to them the doctors at a PHC are supposed to be in-charge of all health and family planning programmes in the area covered by each PHC, but in actual practice they confine themselves almost entirely to running an out-patient clinic either at the PHC headquarters or at sub-centre apart from looking after a limited No. of patients admitted in the PHC. At the District and State headquarter levels too there is a separate staff for family planning, public health and curative health services.

1.2 In West Bengal, the PHC complex developed in a different manner but now the pattern is being gradually changed to the all India one. Though miner modifications in the pattern given above exist in some States, in general the pattern is the same. Not only is there a broad division between the staff engaged in the programmes of health and Family Planning, but in most of the States there is also a vertical division in the staff engaged in different health programmes, like malaria, Smallpox, Tuberculosis, Leprosy, Cholera, Etc.

1.3 This state of affairs has come into existence because various health programmes and later on family planning programme were launched at different tires and each was conceived to run vertically with its own staff. Whereas this has resulted in proliferation of staff, it has also yielded some results. For example, 59% of the country is now in Malaria maintenance phase while a few years ago malaria claimed millions of lives in this country. The same is true of smallpox. It is true that both malaria and smallpox have not been eradicated, nevertheless, the progress has been encouraging and it is expected that before long these two diseases along with some of the other communicable diseases would be things of the past. Similarly, according to sample registration Survey of 1971 there is a definite trend in the lowering of the birth rate which can substantially be attributed to the efforts of the staff recruited for the family planning programme.

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

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

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

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

The membership of the Committee recommended was as follows:-

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

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

1.5 In pursuance of the above recommendations, the Government of India issued an order No. 2-76/72-ply, dated the 28th/30th October, 1972, constituting the Committee (Annexure I).

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

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

The Committee was asked to visit some States to study the actual/working at the district and peripheral levels, and to furnish its report by the end of February, 1973.

1.6 Two further modifications of this order were issued. The first was dated 30th of November, 972 (annexure II) in which the membership was increased by the addition of Chief (Health) Planning commission, Director, NIHAE, Director, Health Services, Haryana, and Directors, Health Services, Gujarat. The Director-General of Health Services was made Vice-Chairman of the Committee. The second modification was dated 23rd February, 1973 (Annexure III) in which Deputy Commissioner (T&R) was made the Member-Secretary of the Committee in place of Deputy Commissionery (3). The date of
The Planning Commission is also seized of the problem and in the Report of the Steering Group on Health, Family Planning and Nutrition Plans for Fifth Five Year Plan, the following observations were made:

1.37 Integration of Health, Family Planning & Nutrition: Programme under Health, Family Planning and Nutrition have been in operation for a long time. These programmes are mostly vertically conceived and are being implemented at the field level by the staff deployed to implement these programmes individually, with little co-ordination or integration of the services. The Steering Group feels that the proper integration of Health, Family Planning and Nutrition programme is highly appreciated that the multi-purpose health worker (who may be designated health auxiliary for convenience of reference) would be entrusted with the carrying out integrated functions and would have greater rapport with the people in rural areas who would naturally look to him for all their needs in the field of naturally reinforcing components of Health, Family Planning, Nutrition. The Steering Group accepts the general principles enunciated and would suggest that Health auxiliaries may consist of three categories i.e., Basic Health Worker at the lowest level, Health Visitor/Health Inspector at intermediary level and Health Assistants/Health Supervisors at the higher levels. Further, Steering Group would suggest that, with a view to arriving at an effective pattern of integration of the services from operational and training angle, two working groups of experts be appointed immediately to go into the details in respect of: (i) defining functional role of the Health auxiliary in integrated health programmes, conditions of service, salary structure, avenue for promotion, etc. and (ii) defining objectives of training programmes, construction of curriculum in terms of knowledge and skills required to achieve the objectives, identifying training institutions, etc., and give the integration programme concrete shape. This should be done expeditiously as an advance action in 1973-1974. In regard to nutrition schemes, the experience gained by the Department of Community Development, Ministry of Agriculture and Department of Social Welfare, Ministry of Education and Social Welfare, should not be loss in effecting integration of Health, Family Planning and Nutrition, Suitable job charts and training programmes tailored to local needs should be proposed for the personnel of Department and others engaged in nutrition programmes. Nutrition feeding programmes will have to be integrated with other Health and welfare programmes to form a composite package which will include apart from feeding minimum health case, immunization and improvement in environmental sanitation. Integration of personnel from nutrition programme will have to be viewed from this angle.

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

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

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

1.8 Progress of the Committee

1. The Committee held its first meeting at Delhi on 15th March, 1973. It was decided to co-opt Mr. P. Diesh, Commissioner, Rural Health, as Member of the Committee.

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

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

2. The Committee paid three field visits
3. To Punjab, Haryana and Himachal Pradesh on 20th to 23rd April, 73
5. To Bihar, West Bengal and Orissa on 19th to 22nd July, 1973.

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

1.9 During the very first visit, it was decided that the committee should confine itself to the question of multipurpose workers for the rural areas only. This was done for the following reasons :-

i) The main area of operation for the multi-purpose workers both in health and the family planning programmes was in the rural sectors.

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

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

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

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

1.10 ACKNOWLEDGEMENTS:-

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

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

I. STAFF

2.1 NOMENCLATURE

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

According to the figures available, there are 5197 PHCs functioning at present in the country catering to the rural population of 435.8 million (1971 census). In general, a PHC caters to a population of 80,000 to 110,000 or even more. However, in certain parts like the tribal, hilly and desert areas, a PHC covers a much smaller population. The areas covered by a PHC also varies usually there are six to eight.

Sub-centers: A PHC each sub-centre catering to a population of 10 to 15 thousand. The staff sanctioned for each PHC is generally as follows:

1. Doctors 2
2. Block extension Educator 1
3. Family planning Health Assistants 4
4. Vaccinators 3 to 4 (one)
5. Basic Heath worker, malaria Surveillance worker For 30,000 population) 3 (one for 10,000 pop.)
6. Heath inspector / Malaria Surveillance Inspector 2
7. ANMs 10
8. Lady Health Visitors 2
9. Sanitary Inspector 1

Some States have introduced functionaries with different designations like junior Health Inspector, Health Inspectors, Senior sanitary Inspector, Health Assistants etc. This multiplicity of names, varying job responsibilities and different categories of functionaries have come about because of historical reasons and the provision or promotional avenues to the staff recruited. The exiting staff position as supplied by the different States is given in Annexure V.

2.2 JOB RESPONSIBILITIES

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

2.3 Educational Qualification

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

2.4 PAY SCALES

There are fairly wide variations in the pay-scales existing in different States. For example the pay scale of a vaccinations in Mysore is Rs. 8045, in Punjab it is R. 100-160, and in Tamil Nadu it is a fixed pay of Rs. 120/- with dearness pay of Rs. 118/- (a total of Rs. 236/-). Similarly, in the case of ANMs, Tamil Nadu’s pay scale is Rs. 170-225, in Mysore it is Rs. 90-800, in Punjab it is Rs. 10-200 and in West Bengal it is Rs. 180-360.

2.5 TRAINING FACILITIES

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

2.5.1 Under Family Planning Programme
(a) Central Institutes (Five)

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

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

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

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

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

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

It conducts courses for the training of trainers in family planning like District Extension Educators. Recently, it has run a long course of three months for Block Extension Educators.
5. Gandhigram Institute of Rural Health and Family Planning (run by a voluntary agency and aided by the Department of Family Planning).

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

(b) Regional Family Planning Training Centres

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

(c) 16 Family Planning Field Units

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

- Family Planning Officer 2
- Asstt. Surgeon 2
- Health Educator, Gazatted 2
- Junior Health Educator 2
- Social Worker 2
- Projectionist 2
- Mechanic 2
- Driver 2
- Upper Division Clerk 2
- Lower Division Clerk 2
- Peon 2
- Chowkidar 2
- Sweeper part-time 1

2.5.2 Under Health

1. Sanitary Inspector Training Centres

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

2. Rural Training Centres: - One at Najafgarh and the other at Singur under Government of India and sixteen others under different States.
3. As mentioned above, advantage is also taken of district hospitals and medical college hospitals for providing short-term training to health workers like Vaccinators, Malaria workers, etc.

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

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

b) Lady Health Visitor’ Course is of 2 ½ years duration and Matriculation is the minimum educational qualification for admission. The annual in-take of all the schools is 1043, but the number admitted each year is about 800 only.

c) Public Health Nursing’ Facilities for this course are available at Nursing Colleges and at Home of the Nursing Schools.

2.6 MOBILE UNITS

Mobile Sterilization Units have been in position since August, 1964. In 1966 the Mukherjee Committee recommended the introduction of IUD units to provide a greater coverage for this programme. The Committee, after weighing the pros and cons of attaching IUD units either to P.U.C. or to District Bureau, was in favour of the latter alternative. It also recommended that the staff of Primary Health Centre will be interchangeable with the staff of the mobile units. The Government accepted the recommendations of this Committee and sanctioned establishment of one mobile sterilization unit and one mobile IUD unit for a population of 5 to 7.5 lakhs in each district. In order to make the visits of these units more profitable for rural areas, it was decided in September, 1967 that each of the units will carry general medicine for emergency medical relief.

Since the performance under IUD programs fell and these units were unable to achieve targets set for then it was decided that both units would all the services and will be turned as mobile service units.

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

A review of the performance of the units in February, 1971 showed that the average performance per unit per month was on the low side. It was, therefore, decided in October 97, that such mobile service units as were not being put to optimum use and where service facilities were available at other places like
hospitals, urban centres and primary health centres, these be closed and spare vehicles utilized elsewhere.

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

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

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

FINDINGS OF THE COMMITTEE

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

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

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

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

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

In Wardha an integrated scheme of malaria eradication and smallpox programmes was started in 96 with the final aim of having a basic health worker for all health programmes. More recently this experiment has been introduced in Kolhapur district also by an integrated malaria and smallpox project in one section of each of the 5 sectors in the district. This integrated project covers 15 of the rural and urban population of the district.

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

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

3.4 Findings

3.4.1 Feasibility: In the light of experience obtained in the various studies and consequent upon the discussions with the State Health authorities and District Medical Officers of Health; the views expressed by the Peripheral workers themselves and the reactions of the community, the members of the Committee felt convinced that the concept of having multipurpose workers was both desirable and feasible. The field workers were quite enthusiastic about this concept and they felt that it would enhance their acceptances and effectiveness. The Committee felt that the results of the Kiloi projects have been sufficiently encouraging to dispel any apprehensions in this matter.

3.4.2 Number of workers involved: The number of male workers engaged in malaria, smallpox and trachoma and family planning programmes is sufficiently large and after integration each male worker will have 6 to 7 thousand population to cater to. The position regarding the NAMs is, however, not satisfactory. Their number is only about half that of the male workers. It was ascertained from some of the male workers engaged in malaria, smallpox and family planning programmes, that it would not be possible for then to undertake maternity work nor would they, be acceptable to the community in this role. On the other hand some of the ANMs felt confident that they could do malaria and smallpox work in addition to their own.

3.4.3 Phasing: One the question of phasing of the programme, some members of the Committee felt that multi-purpose workers should be introduced only in those areas where malaria was in the maintenance phase and smallpox has been controlled. Others were of the opinion that the programme could be introduced all over, irrespective of the stage of control of these diseases. After nature consideration, the Committee feels that since the number of workers to be trained is so very large, a practical way out would be as follows:
To begin with, the training of the workers as multi-purpose functionaries could be
started in those areas where smallpox is controlled and malaria is in the maintenance
phase. Since such areas constitute 59% of the country, the number of workers to be
trained, though still large, would be more manageable. After a few years when
these workers have been trained and, other areas have been brought into
maintenance phase, the programme could be extended to cover the entire country.

It was felt that to start with, workers of only four programme i.e. malaria, smallpox,
trachoma and family planning including M.C.S. be included in the multi-purpose concept.
Since filarial, cholera and leprosy are of regional or zonal importance and since the number
of workers engaged under these programmes is comparatively small, these programmes
may continue to run as vertical programmes for the time being and the workers in these
programmes could continue as uni-purpose workers. Trachoma is also zonal in distribution,
but since the number of workers involved in this programme is small and their job is very
specific, it was decided that these workers may be included from the start. It was also felt
that the same applied to B.C.G. workers. This however, should only be a temporary phase
and eventually, the Committee felt that all the workers should be brought under this
programme.

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

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

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

In each sub-centre, there will be a team of two workers, one male and one female.
For effective supervision, it was felt that there will have to be a separate male and a
separate female supervisor.
3.4.6 The Committee felt that when adequate facilities of man, material and money are available, the No. of P.H.Cs. should be increased. It is felt that for a proper coverage there should be a PHC for 50,000 populations. Each PHC would have at least two doctors; one of them should be a female.

3.4.6(a) The population in each PHC would be divided into 6 sub-centres, each having a population of about 3100.

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

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

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

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

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

JOB FUNCTIONS OF THE MULTI-PURPOSES WORKERS

HEALTH WORKERS (FEMALE)

4.1 According to the information made available to the Committee, there are 40,225 ANMs employed in the Country. They include all those who are working in sub-centres, PHCs, urban centres, and in district and other hospitals. In general, 2 ANMs are stationed at each PHCC, one provides nursing care to the in-patients of PHC and the other looks after the area in the immediate neighborhood of the PHC. Thus the number of ANMs working in the sub-centres only would be about 20 to 25 thousand.

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

4.1.1 JOB RESPONSIBILITIES RECOMMENDED:
She should provide 100% ante-natal and post-natal coverage to a population of 3 to 4 thousand and about 50% coverage for intra-natal care. For the additional population in the “twilight” zone her services should be available request only.

The following will be her job responsibilities:

i) Ante-natal care:

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

ii) Intra-natal care

1. As stated above she will conduct about *(text missing)* of deliveries in her intensive area and whenever called in the ‘twilight’ area.
2. To supervise delivering conducted by dais whenever called in.
3. Referral of cases of difficult labors.

iii) Post-natal and infant care:
1. She will pay at learnt three post-delivery visits for each delivery case and render advice regarding feeding of the new born.

2. She will do primary small-pos vaccination and ECG Vaccination to all the new born infants.

iv) Family Planning:
1. Maintenance of a copy of eligible couple registers.
2. Spreading the message of family planning to the women in her are and distribute convention and contraceptives amongst them.
3. Follow up of IUD and sterilization cases.

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

vi) Training:
She will help in the training programmes of Dais

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

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

1. According to the figures available the following are the number of different categories of workers which can be made multipurpose workers:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic health workers</td>
<td>22,000</td>
</tr>
<tr>
<td>Malaria surveillance workers</td>
<td>21,100</td>
</tr>
<tr>
<td>Vaccinators</td>
<td>20,314</td>
</tr>
<tr>
<td>Family Planning Health Assistants</td>
<td>12,000</td>
</tr>
<tr>
<td>Health education assistant (Trachoma)</td>
<td>371</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76,378</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECG technicians</td>
<td>1,752</td>
</tr>
<tr>
<td>Cholera workers</td>
<td>1,461</td>
</tr>
<tr>
<td>Para-medical Assistants (Leprosy)</td>
<td>1,418</td>
</tr>
</tbody>
</table>
4.631

The Health Worker (male) will require training before he can be put on the job. Whereas his female counterpart has had a pre-service training of 2 years, the existing workers in health and family planning programme who will be converted into multipurpose workers have had training in only one field of activity and that too for a comparatively short duration. The duration of the training and the place where it is to be imparted are discussed in another chapter.

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

4.2.1 During visits to the sub-centre, it was brought to the notice of the Committee that male workers engaged in health and family planning programme do not have adequate opportunities to come in contact with the male members of the rural community. This is because the majority of the people are working in the field or have to go out to work during day time and hence are not available to the male workers during their home visits. The question of change of working hours of these male workers was therefore discussed. A suggestion was made that these workers should have different working hours, starting later in the day and continuing till into evening. During discussions, however it was brought out that by adopting this method a number of administrative problem would arise and at the same time the team work between the male and female field workers would be disturbed. It was therefore, decided that male workers may have the usual working hours but they should not continue their attention only to the home visits but should contact the male members of the rural community wherever they can find them.

4.3.3. JOB RESPONSIBILITIES RECOMMENDED:

i) Health Programme

1. Will help in the control of communicable diseases including malaria. For this he will pay regale visits to each household once every 2 – 3 weeks and contact all cases of fever. He will report immediately any outbreak of infected diseases such as cholera, typhoid, smallpox etc.
2. Immunization of children of over one year for smallpox (revaccination), diphtheria, tetanus and whooping cough. Will also revaccinate all adults above 15 years of age after every three years.
3. He will assist the supervisor in the school immunization programme.

ii) Family Planning

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

1. He will help in the health education programme during his visits to the homes and at other area of contact with the males of the population.
2. He will be responsible for maintenance of birth and death registers and other vital statistics.
3. He will identify community leaders and with their help educate and involve the community in health, family planning & nutrition programmes.

iv) Nutrition:

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

v) Health Care:

1. He will provide medical aid for minor ailments and render first aid.
2. He will refer cases beyond his competence to the PHC or to the nearest dispensary.
JOB FUNCTIONS OF SUPERVISORS

Health Supervisor (Female)

5.1 The supervision of ANMs, in most places, is done by LHV's. This functionary is a Matriculate who has had 2.5 years, pre-service training. According to the course content of her curriculum, this training is community oriented. For the last decade or so, the LHV course. Some of the state Nursing Councils have accepted this suggestion and have discontinued months community health orientation course for nurse midwives who have undergone 3.5 years course and put them as supervisor of ANMs. Maharashtra and West Bengal are two such states majority of the other States have, however, continue the LHV training in spite of the Nursing Councils objection.

In all, there are at present 23 LHV schools with as annual admission capacity of 1045. Of these eight schools are Centrally aided and 15 are State run.

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

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

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

5.1.2 The total number of LHV's and public health nurses employed at present is 7462. This no. includes those who are attached to primary health centres and others posted in urban centres at the districts and state headquarters as well as district public health nurses. According to the existing pattern, only 2 LHV's/PHNs are sanctioned for each PHC.

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

1. She will reinforce the skills in Health Worker (female) in Family Planning and nutrition components of her preservice training.
2. She will supervise and guide the H.W.(females) in giving MCH and Family Planning services to the public in her sector.
3. She will observe and supervise the work of H.W. (female) trained dais. For this purpose, it is necessary for her to observe them conduct one or two domiciliary deliveries.
4. She will help them to improve technical and human relationship skills.
5. She will respond in urgent calls from the H.W. (female) and trained dais and render the required help.
6. In abnormal cases she will arrange for transport to take the expectant mothers to the PHC or the nearest hospital.
7. She will visit at least once a week, on fixed days each sub-centres in her jurisdictions. During these visits she will conduct ante-natal and well baby clinics. During her visits, to the sub-centres she will carry out home visits and during these in addition to giving advice about maternity and child health. She will demonstrate simple procedures to relieve conditions such as sore eyes, scables and common boils, etc.
8. She will arrange to give group talks to expectant mothers laying stress on personal hygiene, nutrition’s education and environment sanitation.
9. She will contact the mothers during her clinic visits and distribute educational materials to them.
10. She will also help in educating the women in control of communicable diseases.
11. She will hold staff conference once a month with the H.W.(female) and trained dais working within her area.
12. She will give an evaluation report of the work done in the field of maternal and child health in her sector.
13. She will be responsible for maintenance of records preparation and submission of reports and returns. A separate record is to be maintained for domiciliary confinements.
14. She will undertake the training of dais with the help of H.W. (female)
15. She will personally motivate resistant cases for family planning.

5.3 HEALTH SUPERVISOR (MALE)

5.3.1 In most of the States the present supervisor is one who worked in a particular programme for a number of years and was promoted to higher grade. In some of the eastern states like Orissa, Bihar, and West Bengal, however there is another class of worker the worker the health assistant. These persons are matriculates who were given two years training in medical colleges. They are bracketed with sanitary inspectors, malaria inspectors, etc., as far as their salary is concerned, but by virtue of their training, they are comparable to Bare Foot Doctors of China. This training programme was however given up some years ago and the number of health assistants is therefore gradually coming down.
5.3.2  According to the figures available in the Directorate General of Health Service, following is the number and categories of workers who, after suitable training, can perform supervisory tasks for the male health workers.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Inspectors/Sanitary Inspectors</td>
<td>32000</td>
</tr>
<tr>
<td>Malaria Surveillance Inspectors</td>
<td>5207</td>
</tr>
<tr>
<td>Vaccinators/Supervisors</td>
<td>4649</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41856</strong></td>
</tr>
</tbody>
</table>

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

As the number of male health workers available would be a little over 76,000, and if the work of 4 peripheral workers can be supervised by one supervisor, the total number of male supervisors required would be about 19,000 of male supervisory workers.

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

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

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

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

The Committee was therefore faced with the problem of fitting this functionary in the proposed set up. It considered placing him in the category of male Health Supervisor along with sanitary Inspectors/Health Inspectors but the KILOI experiment was discouraging. According to the report, he proved to be recalcitrant to an integrated approach. He was apprehensive that if converted into the role of a health supervisor his area of influence would be reduced resulting in loss of prestige. Moreover, if he is to be made a male health supervisor his training would
be longer and no more intensive as compared to the health inspector/sanitary inspector, etc.

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

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

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

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

5.6 JOB RESPONSIBILITIES RECOMMENDED FOR HEALTH SUPERVISORS (MALE)

1. To supervise the work of male health workers, and provide adequate guidance to them by making frequent visiting to each worker in his jurisdictions.

2. To arrange small group meetings with the help of community leaders for spreading the message of family planning to the males and answering any of their queries on the subject.

3. To check vaccination of all school going children.

4. To check and supervise the malaria maintenance work and the small pox vaccination work of the male health workers.

5. To supervise the records maintained by the male health workers.

6. To keep a close which on the sudden outbreak of epidemics like cholera, smallpox etc.

7. To treat all cases whose blood smears are positive for malaria.

8. To supervise spraying of insecticides.

9. To supervise the work of male health workers regarding environmental sanitation, disinfection of wells, etc.

10. To periodically check the registers and records maintained by male health workers by actual physical verification.

11. To be responsible to the primary health centre doctors for delivery of health, family planning and nutrition services to the community.
12. To maintain adequate supplies of Nirodh and other contraceptive for distribution.
CHAPTER VI
INTEGRATION AT DIFFERENT LEVELS

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

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

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

6.4 PRESENT SCENE

6.4.1 P.H.C. LEVEL

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

2. In addition to the PHC, there are a variety of dispensaries in many blocks. Some of the dispensaries are run by local bodies, voluntary agencies and some by Government. These dispensaries are other manned by Allopathic doctors or by Ayurvedic, Unani or Homeopathic parishioners. There is no interlink between these dispensaries and the PHC.

3. The distance between a PHC and the next large hospital where greater expertise is available varies from 5 to 100 miles. In general, there are no graded hospitals in between the medical college hospitals where specialists and wide array of investigative services are available and the PHC where neither is available. There are, however some well equipped District Hospitals where adequate facilities for investigations and treatment are available.
4. The administrative hierarchy, to is both diffuse and confusing. For the preventive services the PHC doctor is responsible to the District health officer and for the curative medicine he has to make referrals to the district hospital. In some states, family planning and health services are combined one functionary, i.e., the district medical officer of health and family planning while in others, two separate functions exist.

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

6.4.1.2. All the dispensary in the jurisdiction of a primary health centre should be liked with the P.H.C and each dispensary doctor should render referral services to the cases referred by the health worker.

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

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

6.4.2. Taluq/Tahsil level:-
Wherever tahsil / taluq hospitals are in existence specialist services and investigative facilities are in general poor. Wherever such hospitals do exist medical officer working in these hospitals are responsible for the health cares of only the in-patients of the hospital. They are not responsible for the public health activities of that area.

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

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

7.1 Administrative Problems

It has been brought out in an earlier chapter that in different States there is a wide variation in the educational qualifications, training background and pay scale of workers who could be grouped together to form multipurpose workers. In general, the vaccinators have the lowest pay scales and educational background.

To put all these workers into one category of male health workers is therefore going to raise some administrative problems. The Committee recommends that for the future entrants, a minimum qualification of matriculation in Science subjects should be insisted upon. The existing scales and protection of the individual’s present pay.

7.1.1 Promotional avenues

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

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

7.1.2 Another problem faced by the Committee was whether to have the same pay-scale for the male and the female workers. The is relevant as an ANM has a two years pre service training whereas the malaria or smallpox worker of today has only 1 to 3 months in service training. Moreover, ANMs are in short supply as compared to the male workers. Conversely it was also felt that functionaries after suitable training, may be grouped together in one pay scale with marginal adjustment of their existing for a proper teamwork, no discrepancies between the two workers should exist.

Taking into consideration all this it is recommended that there should be a uniform grade for both male and female health workers. It is also recommended that fixation of the grave for the time being should be left to an individual state which as far as possible should be the highest that exists in that state for these workers. All the grades, however, should be made uniform in due cost.
7.1.2.1 The Committee also considered the question of the existing class IV employee like attendants, disinfectors, etc. It was felt that such functionaries may continue wherever they exist and performed the prescribed duties. For future, however, there was no need to have any class IV employees at the sub-centre or sectoral level, except for sweepers.

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

7.2 Problems in Training

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

7.2.1 GENERAL

By and large, training of the workers engaged in health programmes, doctors, nurses, para-medical staff, is undertaken in specified training institutes. These institutes import training in an atmosphere which is usually devoid of the knowledge of the actual needs of the workers. It is commonly patterned on similar training courses run in other places mostly in USA and U.K. Not only the main features of these courses are borrowed, but in several instances even the terminology used is the same. Since many of the trainers have had their own training institutions abroad, the term, all phrases used by them are foreign and many a time unintelligible to the trainees. During the last few years many terms have been introduced in this field which are not in common usage in this country and poorly understood by all other except those who use them. This has resulted in training for training’s sake, devoid of any relevance to the actual needs and the job requirements of the trainees. The trainers hardly move out of their training centres, are not in touch with the field workers and have very vague ideas of the problems faced the trainees in their jobs.
The trainees are sent to the training institutes less on their own initiatives and more on administrative orders. Promotion is not linked with training. Historically the pattern of our education and training in this country is based on the English model. An individual expects to add some letters of alphabet to his name following formalized training, be it a certificate, a diploma or a degree course. Since no such addition is possible after he present day training courses, and since promotion or even increments in pay are not linked with satisfactory training, there is reluctance on the part of trainees to come for training. Moreover, the stipend paid to the trainees is low and since he has to run two establishments during this period, he is reluctant to add to his already heavy financial load. All this results in underutilizations of the training facilities. Then again frequent transfers from one job to another add to the backlog of training load. The administration on the other hand feels concerned when he finds that the expenditure on training does not yield commensurate results. This vicious cycle of training unrelated to job performance, under-utilization of woeful inadequate training facilities, high expenditure and poor results, need to be broken. Those who are responsible for the delivery of health care services, must have a say in the training programmes and the trainers must be intimately aware of the requirements of the trainees.

Another problem common to most of the training programme is the tendency of the training to introduce into the training programme as much factual knowledge as possible. There seems to be an apprehension hat the trainee may never come again and therefore he should be taught as much as possible. This no only lengthens the course but also makes it less relevant to the prevailing situation. On his return from he course the training finds a great deal of what he learnt of no relevance to his requirements. It is felt that it is better to keep the training courses short and more frequent rather than long and frequent.

7.2.2 SPECIFIC

7.2.2.1 Doctors

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

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

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

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

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

a) ANMs: The existing course of ANM training is of two years duration after an educational qualification of 7th class pass. The training is imparted in ANM schools, most of which are attached to district hospitals or other hospitals. During the course, practical training is imparted in general, medical and surgical nursing and maternity forms an essential component. Community training is prescribed but not always strictly followed. In general many of the schools are deficient in student accommodation (both teaching and hotel) and equipment. In some ANM school, the existing facilities can only be termed in deplorable. Government of India ***text missing*** into the curriculum of the ANM training. Its report has been submitted and is under the consideration of the Department of Family Planning. This Committee is of the view that for further entrants, matriculation should be minimum qualification and the training should be modified giving emphasized on midwifery, public health and nursing in that order, it is also our view that the duration of the courses could be reduced to 18 months. This can be conveniently done by reducing the period spent by the training in the medical and surgical wards.

The Committee is also of the view that an ANM her training should stay at a PHC for a period of at least three months. From the Primary Health Centre he can be taken to a Sub-Centre by her tutor to learn the conditions at first hand, such in exposure would be perform after her training.

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

b) L.H.V: The controversy involving LHV and nurse-midwife with community health training has been referred to. The Committee in of the view that there has to be a female supervisor for the training Health Workers and that such a supervisor should receive training with a greater community bias rather than hospital oriented training. The Committee is also of the view that after some years it may be possible to have common courses for all the
nurses but for the next 10 to 15 years, it will be profitable to have separate categories of hospitals biased nurses and community oriented course.

The Committee also feels that the present L.H.V. is not a very effective worker. She does not provide technical guidance to A.N.Ms nor is she a competent supervisor. The Committee is of the view that her training needs modifications. It is recommended that the duration of the L.H.V. course could be reduced from 2.5 years to 2 years and emphasis placed on equipped her to become a suitable supervisor and technical expert in the field of maternity and child health for the females Health Workers.

7.2.2.2 Para-Medical
Apart from a course for Sanitary there are no regular training courses for the paramedical workers engaged in the field of Health. In the Family Planning, however, 1 to 3 months courses for extension educators and family planning health assistants are run in regional family planning training centres. The Sanitary Inspectors course used to vary from 5 to 10 months. This has now been made uniform and its duration is 112 months. There are at present 40 Sanitary Inspector schools in different States.

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

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

7.3.1.1 It strongly feels that all training facilities should be pooled together and training imparted in an integration manner. It was not possible for the Committee to go into the details of the Curriculum, content and the duration of the training. The Committee feels that it requires a detailed study and some experimentations. Borrowing from the experience of kilo experiment, it is suggested that the male health worker may be given one to two weeks initial orientation training, preferably at the PHC followed by 6 to 8 weeks training, at selected training centres. Such a training and I family planning and nutrition.

7.3.1.2 There are at present 16 field units in different parts of the country. The Department of Family Planning has recently taken a decision to disband the field units as it was felt that there was no longer any need for their continuance in view of the establishment of the regional training centres. The Committee is of the view that since there is going to be a tremendous training load and existing training facilities are meager, It will be worthwhile to reconsider this decision. The field units are noble and functions and can be utilized for providing to the community health workers on the job initial orientation training.
7.3.3 For the new entrants, it is recommended that a one year pre-service training may be insisted upon. The Health Supervisors may be given one to two weeks orientation training at P.H.C followed by a similar training imparted to the health workers plus two weeks training supervisory duties. The new entrants should be given 18 months pre service training. As suggested above, two-thirds of the posts in the supervisory scale should be filled on promotion from the health workers both male and female.

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

7.3.5 For the proper integration of training activities, planning of course, and bringing out training manuals etc., the committee recommends that a Training Division would look after all training requirements for Health and Family Planning.
CHAPTER VIII

MOBILE UNITS

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

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

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

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

2. A new designation in proposed for the multi-purpose worker Health Worker (male/female)
   The newly designated female Health Workers will be present ANMs and the newly designated male health workers will be the present day Basic Health Workers, Malaria Surveillance Workers, Vaccinators, Health education Assistants (Trachoma) and the Family Planning Health Assistants. (3.4.5)

3. The programme of having multi-purpose workers should be introduced, in the first phase, in areas where malaria is in maintenance phase and small pox has been controlled. The programme can be extended to either areas as malaria in phases into maintenance phase or where small-pox is controlled. This will be the second phase.
   The workers engaged in cholera control, filarial and leprosy programme may continue as such for the time being. Similarly BCG vaccinators may also continue as such. However as those workers will be made multi-purpose workers in the third phase of the programme (3.4.5)

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

5. After training in all programmes each health worker male and female should be given a first aid kit and also some medicine for minor ailments, costing upto Rs.2000 per annum. For each sub centre. These medicines should be replenished at regular intervals (3.5)

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

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

8. Jurisdictions for each health worker:
   8.1.1 As an ultimate objective it is recommended that when adequate facilities of men, material and money are made available the number of PHCs should be increased. It is felt that for a proper coverage there should be a PHC for 50000 population. Each PHC would have at least two doctors one of them should be a female. (3.4.6)
   8.1.2 The population in each PHC would be divided into 16 sub-centres, each having a population of about 2000-3500 depending on topography and means of communications. (3.4.6)
   8.1.3 Each sub centres would have a team of one male and one female health worker (3.4.6)
   8. b Taking into consideration the existing number of male and female health workers, it is recommended that:
     8. b. 1 A male health worker would have for the present to look after a population of 6-7 thousand (4.2)
     8. b. 2 A female health worker (ANM) would have a population of 10 to 12 thousand. This population be divided into two zones- one intensive area of 3
to 4 thousands or area of not more than 5 k.M. in radius from her place of stay, where she will be responsible for maternity and Child Health and Family Planning Services and the other “twilight” areas where services will be for partial coverage on request only.(3.4.4)

8. b.3 During the interim period, it is suggested that the services of trained dais be increasingly used particularly in the “twilight” areas. In order to make the trained dais reliable assistance of the female health workers. They may be given a suitable remuneration.(7.1.4)

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

10. Jurisdiction for each health supervisor.

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

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

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

10. c The present day lady health visitors no designated as female Health Supervisors should be withdrawn from all post other than those of ANM supervisors. For example, lady health visitors at PHC headquarters or at urban centres or in districts headquarters, etc., should be withdrawing and posted for field work of the sector allotted. Nurse, Midwives may be posted in their place in urban centres and the District for State duties. (5.3.2)

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

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

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

12. a. The same group should examine the existing curriculum of the ANMs and LHVs and suggest ways and means to make the training of these functionaries more practical and job-oriented. (7.3.4)
12. b. Pending the recommendations of the proposed group the Committee recommends:

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

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

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

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

12. d Training for all the workers engaged in the field of health, family planning and nutrition should be integrated. (7.3.1)

12. e A training division should be established at the Centre. (7.3.5)

13. The job responsibilities of the proposed Health Workers and their supervisors (male and female) are given in Chapters IV and V.

14. The pay scales of the health workers and their supervisors should as far as possible, be made uniform in all states. (7.1.2)

15. The doctor in charge of a PHC should have the overall charge of all the supervisors and health workers in his areas. He will be assisted by the Block Health Assistant for his headquarters work. (5.5)

16. The doctors of PHC during their visits to sub centres will not only render health care to the population but will also supervisors. (6.4.1.1)

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

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

Wherever there is one lady doctor at the PHC she would render specialist services for maternity and child health to the entire PHC population (6.4.1.3)

19. In order to bring about an effective integration of workers engaged in vertical programmes of health and family planning, the concept should be extended to the district and the state level. The division of work amongst the district medical officers should be on a geographical basis rather than on a programme basis. (3.6)

20. The concept of medical colleges integrating all health, family planning, nutrition, and training programmes, has been put forward. (6.6)

21. It is suggested that there is no valid need for mobile sterilization units. For IUD work there may be a justification for maintenance of some units but their continuation should be made subject to fulfillment of specified targets. (8.3)
NOTE BY Dr. D. N. GUPTA MEMBER SECRETARY OF THE COMMITTEE

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

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

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

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

It is felt that if the medical colleges could be made responsible for the health delivery services of a section of population this trend can be reversed. The recommendation in the report of only coordinating the existing patterns is considered a more patch work and the situation will not change materially, it is felt that direct and unequiuocal responsibility for training and health care must be given to a single authority. The country be divided on population basis or the existing districts could be taken as units three or four being entrusted to each medical college for training and comprehensive health care including family planning and nutrition programme. In such a set up there will be graded facilities for health care, investigative facilities, and specialist services, The health staff working in all the institutions in the area from sub-centre to the medical college hospital will be the staff of the medical college. There will be no division between preventive and curative medicine and teachers and non-teachers. Facilities of all the centres, PHC, Taluk, District or the medical college would be utilized for training. The staff would not be static but could be moved from one to the other centre. Those who dispense curative medicines, be it in pediatrics, ophthalmology, maternity of general medicine would also look after its preventive side.

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

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

It is suggested that this concept may be tried on experimental basis in some medical colleges of some States. Alternatively, a Commission may be set up to examine this concept in depth.
ANNETTURE-I

No. 2-76/72-Ply
Government of India
Ministry of Health and Family Planning
(Department of Family Planning)

New Delhi, dated the 28th /30th October, 1972

O R D E R

In pursuance of the recommendation of the Executive Committee of the central Family Planning Council made at its first meeting held on the 28th September, 1972, the Govt.of India is pleased to constitute a committee to study the question of feasibility of having multipurpose workers in the field under the Heath and Family Planning Programme and to make suitable recommendations in that connection.

2. The composition of the committee shall be as follows:-
   1. Additional Secretary, Ministry of Health and Family Planning, Government of India : Chairman
   2. D.G.H.S. : Member
   3. Commissioner of Health & F.P., Utter Pradesh. : Member
   4. Secretary, Department of Tamil Nadu. : Member
   5. Secretary, Health Deptt., Maharashtra. : Member
   6. Deputy Commissioner (P) Department of Family Planning : Member-Secretary

3. The Committee shall have power to co-opt other experts as member.
4. The terms of reference of the committee shall be to study and make recommendation on:
   1. The structure for integrated services at the peripheral and supervisor v level,
   2. The feasibility having multi-purpose/pursuance workers in the field,
   3. The training requirement for such workers and the utilization of mobile service units set up under family planning programme for integrated medical public health and family planning services operating from Tehsil/Taluk level
5. The committee may visit some states to study the actual working at district and peripheral level.
6. The committee should furnish its report latest by the end of February, 1973

Sd/-D.N. CHAUDHRI
Director

Copy forwarded for information to:-
   1. All Member of the committee
   2. All Members of the Executive committee of the central
   3. A.P.Council etc.
ANNEXURE-II

No. 2-76/72-ply
Government of India
Ministry of Health and Family Planning
(Deprtment of Family Planning)

New Delhi, dated the 30th November, 1972

ORDER

In continuation of Ministry of Health and Family Planning (Department of Family Planning) order No.2-76/72-Ply dated the 30th October, 1972, constituting a committee to study the question of feasibility of having multi-purpose workers in the field under the Health and Family Planning Programmes and to make suitable recommendation in that connection, the government of India is pleased to decide that the following shall also be member of that committee

1. Chief (Health), Planning Commission.
2. Director, N.I.H.A.E.
3. Director, of Health Services, Haryana.
4. Director of Health Service, Gujarat.

2. Director General of Health Service shall be Vice-Chairman of the Committee

Sd/-D, N.CHAUDHRI
DIRECTOR

Copy forwarded for information to:-

1. All members of the Committee (with a copy of order No.2-76/72-Ply, dated 30/10/1972 to new member).
2. All members of the Executive Committee of Central Family Planning Council.
3. Planning Commission (Health Division), etc. etc.
ANNEXURE-III

No.2-76/72-Ply
Government of India
Ministry of Health and family planning
(Department of family Planning)

New Delhi, date the 23rd February; 1973

ORDER

In partial modification of department of family planning order No 2-76/72-Ply dated the 28th/30 October, 1973, it has been decided that in place of Deputy Commissioner (P), Department of family planning, Deputy Commissioner (T&R) will be Member Secretary of the committee constituted. To study the question of the feasibility of having multi purpose workers in the field under the health and family planning programmed and to make suitable recommendations in that connection.

It has also been decided that the Committee may submit its report to the Ministry of Health and Family Planning (Department of Family Planning) latest by the 30th April, 1973 instead of by the end of February, 1973.

Sd/- D.N. CHAUDHRI
Director

Copy forwarded for information to:-

1. All Members of the Committee.
2. All Members of the Executive Committee of the Central Family Planning Council.
3. Planning Commission (Health Branch)
4. Ministry of Finance (Health Branch)
5. Director, NIFP, New Delhi.
6. All Officers /Sections of the Department Of Family Planning.
7. DPIO ( Shri M.M.Lal)

Sd /-A.P. Atri
UNDER SECRETARY
ORDER

In continuation of the Department of Family Planning Order No.2-76 /72-Ply, dated the 2nd February, 1973, it has been decided that the Committee appointed under the Ministry Of Health and Family Planning (Department of Family Planning) Order No.2-76 /72 –Ply dated the 28 /30 October, 1972 to Study the question of feasibility of having multi –purpose worker in the field under the Health and Family Planning programmes And to make suitable recommendations in that connection, May submit its report by the 15th August, 1973.

Sd / - D.N. CHAUDHRI
Director

Copy forwarded for information to:-
1. All Members of the Committee
2. Planning Commission (Health Division).
3. Ministry of Finance (Health Branch).
5. All Officers in the Department of Family Planning.
6. D. P.I.O. ( Shri M.M. Lal )

Sd/- R.P. Marwaha
Under secretary
No.2-76/78-Ply
Government of India
Ministry of Health and Family Planning
(Department of Family Planning)

New Delhi, dated the 27th August, 1973

ORDER

In continuation of the department of Family Planning Order No.2-76/72-Ply, dated the end of May, 1973, it has further been decided that the committee appointed under the Ministry of Health and Family Planning (Department of Family Planning) Order No.2-76/72-Ply dated the 28/30th October, 1972, to study the question of feasibility of having multi-purpose workers in the field under the Health recommendations in that connection, may submit its report by the September, 1973.

Sd/- D.N. Chaudhri
Director.

No.2-76/72-Ply
Copy forwarded for information to:-

1. All members of the Committee
2. Planning Commission (Health Division)
3. Ministry of Finance (Health Branch)
5. All Officers in the Department of Family Planning.
6. D.P.I.O. (Shri M.M. Lal)

Sd/- R.P. Marwaha
Under Secretary
### Junior Community Health Workers Female (A.N.M)

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Total A.N.Ms in 14 States & 2 Union Territories.  
26493* 33698

*No. of sanctioned posts in TamilNadu is not available.
# LADY HEALTH VISITORS

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| Total No. of L.H.Vs in 14 states & 2 Union Territories | 6485 | 3668 |

Total no. of L.H.Vs. in 14 States & 2 Union Territories.

Annexure-V (Contd.)
## JUNIOR COMMUNITY HEALTH WORKERS (MALE)

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H.I. = Health Inspector  
B.E.E. = Block Extension Educator  
M.I. = Malaria Surveillance Inspector  
S.I. = Sanitary Inspector  
V.I. = Vaccination Supervisor/ Inspector  
B.H.W. = Basic Health Worker  
M.S.W. = Malaria Surveillance Worker  
F.P.H.A. = Family Planning Health Assistant
JOB RESPONSIBILITIES

EXTENSION EDUCATOR:

1. Established effective working relations with the health staff of primary health centre, sub-centre, and representatives of other Government departments, voluntary organizations, local bodies and community leader at the block /primary health centre headquarters, sub-centres and villages.

2. Plan educational meetings with the staff of the Primary Health Centre so that all health workers are equipped with the health education aspects of various programmes specially family planning.

3. Guide and supervise health education work in the block by working with all the health personnel at primary health Centre and sub-Centres.

4. Help in the organization of vasectomy and IUCD camps within the block and ensure that preparatory and follow-up services are given by F.P.F.W. and ANMs for IUCD and vasectomy camps.

5. Organize group meetings with officials and non-officials for educational activities in connection with health programmes specially family planning and discuss individually with those subscribing to and reading newspaper.

6. Supervise and guide the computer in the maintenance of correct vital statistics and keep in touch with village registers direct and through the F.P.F.Ws.

7. Will be responsible for complication of all the reports and returns connected with family planning work.

8. Get the Educational material and ensure its distribution and also be the responsible for A.V. equipment and its use in the block.

9. Will assist in training of personnel and in the field studies.

10. Will ensure good stock and ready supplies of contraceptives.

11. Know the radio sets both community and private in each village and work with the radio rural forums.

12. Arrange and utilize the occasion offered by big and small conferences by Public Relations, Panchayat and Development and Co-Operative Deptts., for the promotion of family planning education.

13. Be on tour for about 20 days a month, supervising and guising family planning field workers and coordinating the work with lady Health Visitors and Health Inspectors.

14. Work out schedule for family planning field workers month wise keeping in view the loop and the vasectomy camps to be held in the next month.

15. Depict the family planning targets and achievements in the block in abstractors, charts, bar diagrams etc., and keep them up to date.

16. Feed the family planning bulletin periodically with local success stories and send press-worthy news items on family planning officer for release from the district bureau.
HEALTH INSPECTOR/MALARIA INSPECTOR

1. Control of communicable diseases:
   
   (a) Malaria
      1. Supervision of Basic Health Workers.
      2. Administration of radical treatment to malaria positive cases.
      3. Assisting the block health officer, in charge of the P.H.C. in locating malaria positive case and taking of remedial measures.
   
   (b) Small-pox
      1. Notification of cases.
      2. Adoption of control measure
   
   Cholera
      3. Supervision of work of vaccinations and trachoma workers

1. Environmental Sanitation:
   
   (i) Be responsible to the block health officer in improving the water supply, disposable of wastes by helping construction of latrines, manure pits, drains and smokeless chulas, etc., control of fly and mosquito breedings, and improvement in school sanitation.
   
   (ii) Supervise and guide the basic health workers in all the activities and work.
   
   (iii) Health education for health programmes in the homes of the people and in other places of work, in the school and other institutions.
   
   (iv) Help the Lady Health Visitor and auxiliary nurse midwife to recruit dais for training through the panchayats.
   
   (v) Supervise the work of sanitary beldars.

2. Vital statistics
   
   Check unregistered birth and deaths and rectify mistake by checking 10-20 household every month.
JOB RESPONSIBILITIES

BASIC HEALTH WORKERS/SURVEILANCE WORKER

1. Control of communicable diseases:
   a) Malaria:-
      1) Domiciliary visit to every house in every village once a month and the work load would be about 100 houses a day.
      2) Enquiry about history of fever cases, duration, nature and number of episodes without chill or rigor, etc.
      3) Prepare the blood slides both thick and thin of those persons who had fever due to rigor and shivering, fever of long, continued and unexplained nature, intermittent fever.
      4) Prepare a list of local medical practitioners and visit them to enquire about the cases treated by them with anti-malaria drugs and contact such cases and prepare their blood slides.
      5) Administer presumptive treatment to persons from whom blood slides and collected.
      6) He will make a list of nomads and temporary labour population take their blood slides and give them presumptive treatment.
      7) Notification of smallpox and cholera (acute diarrhoea and vomiting) and cases and cough for one month or more to the Medical Officer Incharge of the Primary health Centre through his supervisor or directly, if needs.

2. Family Planning:
   a) Familiarise himself with the married people and know their ideas about the ideal size of family, their desire to space the children and limiting their number by asking specific question.
   b) Services and Supplies:- To give specific information of the supplies and services available for spacing of children at the sub-centres, primary health centre and depots.
   c) To give exact dates and places for loop and vasectomy camps being held and also facilities for vasectomy and loopin the primary health centres and other medical information’s.

3. Health Statistics
   To keep a record of the population, births and deaths.

4. Health Education:
   For promotion of malaria maintenance, family planning notification about smallpox and cholera and the registration of vital statistics by:
   a) Establishing report with leaders of the village, dais, chowkidars and married couples and informing them about health programmes mentioned above.
   b) Contacting and knowing village level workers, panchayat members, patwaries, teachers, secretaries of farmers clubs, youth clubs, etc., for spreading message of family planning and securing their assistance for promoting health programmes.
   c) Participation in group meetings and discussions.
   d) Individual family discussions specially with married men at the time of home visits for advising about spacing of children and limiting their numbers.
   e) Distribution of educational materials.
f) To report the misconceptions and fears about use of contraceptives and vasectomy operations that come to his attention to his superiors.
SANITARY INSPECTOR

1. Improvement of sanitation protection of water sources, disinfections of water supply during epidemics, floods, etc., installation and maintenance of sanitary latrines particularly at PHC, sub-centre, dispensary and schools; arrangements for refuse disposal and cleaning of streets in selected villages.

2. To form sanitation committee at P.H.C. and sub-centre levels, with the help official leadership.

3. Responsible for general sanitation and incineration of septic dressings, etc., at P.H.C., sub-centre, dispensary and tehsil hospital premises.

4. Prompt notifications, surveillance and containment measures for smallpox, cholera and epidemics, and also to assist in immunization work.

5. To supervise and help in the work of vaccinators, swasthya sahayaka, smallpox supervisors and trachoma supervisors.

6. To motivate eligible couples for accepting family planning services.

7. To undertake health education and publicity work in support of various health programmes, special attention will be given to mothers, school children and youth groups. To collect and distribute departmental publicity material and utilize local ideas and resources for health education.

8. To maintain maps, charts and other records up-to-date, and submit reports and daily diary to the Medical Officer Incharge on the last day of the month.

9. TO perform any other duties as may be assigned to him by the Medical Officer Incharge.
AUXILIARY NURSE MIDWIVES

I. Maternity and Child Health
   a) Providing maternity and child health services, clinic and domiciliary, consisting of prenatal, natal, post-natal, infant and pre-school child care.
   b) Training of indigenous dais and their supervision.
   c) Refer cases of abnormal presentations, deliveries and other, when needed, to the primary health centre.

II. Family Planning:
   a) Create acceptance for small-family norms.
   b) Provide advice and information (specially regarding loop and vasectomy camp) to the married ladies/couple on child spacing and child limitation through contraception and sterilisation, in general and IUCD in particular. She will particularly visit all the post natal mothers to advise them to use contraceptives. She will provide contraceptives to all married ladies/couples, who accept her advice for spacing of children. She will start working with the mothers for acceptance of family planning when they come for parental check up so that after delivery they will be more prepared to accept.
   c) Refer cases for loop insertion and vasectomy to the doctor and assist in the loop clinic and loop and vasectomy camps and help in follow-up of such cases.
   d) Arrange for women with 3 or more children to have their husband for undergoing vasectomy to limit the size of their families.
   e) Establish women depot holders after helping in their training and supply them conventional contraceptives once a month or as indicated.

III. Communicable diseases control:
    Notifications of smallpox, cholera cases and cases having fever and cough for one month or more to the primary health centre through the supervisor or directly as rapidly as possible.

IV. Vital Statistics:
    Make an initial family-wise survey of the resident population and prepare an abstract as advised.

    Registration of all births and deaths occurring in the intensive areas specifying still-births, infant and maternal deaths.

V. Record of migrations and marriages:
    Health education for maternal and child health, family planning registration of vital events, control of communicable diseases, nutrition, environmental sanitation and personal hygiene in the homes and schools by:
i. Providing information and guidance to mothers on the possibility of achieving and necessary of having small size families.

ii. Contacting and knowing local leading women such as wives of panchayat members, lambarders, teachers Gram Sevikas, secretaries of mahila mandals, etc., and educating them about the advantage of having small size families.

iii. Distributing educational material to the literates.

iv. Holding group discussions for educating mothers in a family planning and other health problems as indicated.

VI. Medical relief for minor ailments:
   Distribution of prophylactic drugs for avoiding deficiency diseases like anemia, rickets, etc.

   Distribution of UNICEF milk.

   Distribution of any other drugs as desired by the doctor.
JOB RESPONSIBILITIES

Family planning Field Workers:

1. To provide or prepare a map of the area showing:
   i) Location and name of villages, approach distance
   ii) Location of medical and health institutions
   iii) Populations of such villages
   iv) Schools in villages
   v) Panchayats.
   vi) Headquarter of village level workers and auxiliary nurse midwives, basic health workers and vaccinator etc.

2. Conduct a Family Planning survey of such village giving details in the prescribed proforma and prepare a summary of population surveys.

3. Learn of and list leaders in each village and know them by person and place of residence especially the panchayat members and other influential persons.

4. Know members of other departments and voluntary bodies working in his area and establish working relationship with them.
   i) Development and Panchayats
   ii) Education
   iii) Public Relations
   iv) Revenue
   v) Veterinary
   vi) Co-operative
   vii) Public Health
   viii) Youth clubs and other associations and organizatons

5. Determine needs for and make recommendations on and help in organization of loop and vasectomy camps.

6. Give family planning education through individual contacts and group discussions and distribute family planning literature to the literates in each village.

7. Organize family planning education seminars of local leaders at least once a month.

8. Register loop/vasectomy cases and wanting other contraceptive, arrange for follow up of loop and vasectomy cases securing the help of family planning and child health staff for loop cases in their areas of intensive work.

9. Keep daily diary of works and copy of tour programme with them and make appropriate daily notes in his diary.

10. Maintain village-wise records regarding
    i) Users of conventional contraceptives
    ii) Cases who have got loop insertion.
    iii) Vasacanised cases.
    iv) Births, deaths and birth and death rates for each village.
    v) Targets for loops and vasectomises and other contraceptives for his area.

11. Submit family planning progress reports on prescribes proformas.

12. Discuss with primary health centre staff at monthly meetings the difficulties, rumours, misconceptions and fears of people in implementations of family planning programme in his area.

13. Establish depot holders for stocking and issuing conventional contraceptive safer educating them on the subject and replenishing their stocks once a month or as needed.
ANNEXURE-VI

(Haryana)

JOB RESPONSIBILITIES

VACCINATOR

1. Map of area preparation of
2. Follow the schedule of works
3. Vaccinate the entire population allotted to him; primary vaccination and revaccinations 100%.
4. Reporting of cases/deaths of smallpox and prompt action.
5. Co-ordination of his activities with B.H.W of his area.
6. Sending reports of work done to necessary quarters.
7. Keeping the necessary records of works.
ANNEXURE-VI

(West Bengal)

JOB RESPONSIBILITIES

BASIC HEALTH WORKERS:

He will be allotted an area with definite boundary comprising of 6500 population (i.e. 1300 families) that is Section.

He will visit approximately 65 houses daily as that he finishes visiting all the houses allotted to them in the course of 20 working days (i.e. one month) and start once again. Thus he will visit every house each month:

(I) to carry out enumeration of the population in the village/areas assigned initially and again in the last two months of each calendar year and recording the particulars in the House Register.

(II) To carry out number of each house in his area if nor already done and stenciling or fixing House cards as provided.

(III) Detection of fever cases (present fever, history of fever in between visits) and recording in House Register.

(IV) Drawal of blood smears from selected fever (e.g., long continued fever; those having irregular fever off and on, all fever cases with chill) and recording in M.F.1 and M.F.2A registers and their dispatch with M.F.2 form.

(V) Administration of presumptive treatment to such of these fever cases from which blood smears have been drawn and their entry into the House Register (M.F.1);

(VI) Enquiry regarding new-comers in the areas;

(VII) Whether there is illness of any kind specially of epidemic diseases like smallpox and cholera amongst any of the members nor or had been during the intervention period, and to report such cases in Red and White cards as indicated in the Health Directorate circular No.HIB-M-521-05/3405, dated 6.4.

(VIII) Recording of births, deaths (indicating sex and date and marriage in the House Register (M.F.1) and with details in a separate register, a report of which to be submitted to S.I. of the block every month;

(IX) To carry out vaccinations and inoculations and recording of vaccinations work carried out an transmission of replicates of records to the Health Inspector of the area; also inspection of all Primary Vaccinations done by him and recording the same in proper form;

(X) Assistance in family planning activation; distributions of educational materials to households; direct person to proper places for informations about Family planning through village deputy; inform public in advance about special events (e.g., F.U.C.D. services, vasectomy camps in health centres, exhibition, film shows, mass meetings, melas, etc.);

(XI) Besides above, during emergencies like epidemics, natural calamities faire and festivals, etc.; he will carry out any other …duties that may be assigned to him by superior authorities;

(XII) He will carry out elementary health education on prevention of cholera, smallpox, T.B., general cleanliness and hygiene and nutrition’s;

(XIII) He will maintain a record of information of P.H. importance in his area as follows;

(a) No. of tube wells in his area village-wise showing tube wells in working order or in derelict condition;
(b) List of important melas or fairs in his area;
(c) List of dispensaries.
(d) List of private practitioners (Registered or non-registered);
(e) List of schools (Primary, M.E. etc)
(xiv) He will submit his weekly report and returns to his Health Inspector on every Saturday
HEALTH INSPECTOR

To carry out:-

1. (a) Concurrent supervision and consecutive inspection of the work of Basic Health Workers assigned to him as per fixed day programme in every month.
   (b) Handled treatment of malaria positive cases.
   (c) Verification of-(1) primary vaccination, (ii) births and deaths, (iii) bloodsmear collection from fever cases and (iv) incidence of epidemic diseases.

2. (a) He will be in charge of about 32,500 population comprised of certain of certain well defined boundaries, that is, “Sector”
   (b) He will have generally 5 Basic Health Workers working under him,

3. In one day he will supervise the work of the Basic Health Workers assigned to him in rotation, that is

<table>
<thead>
<tr>
<th>Day</th>
<th>Basic Health Worker</th>
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<tr>
<td>1st day</td>
<td>B.H.W. 1</td>
</tr>
<tr>
<td>2nd day</td>
<td>B.H.W. 2</td>
</tr>
<tr>
<td>3rd day</td>
<td>B.H.W. 3</td>
</tr>
<tr>
<td>4th day</td>
<td>B.H.W. 4</td>
</tr>
<tr>
<td>5th day</td>
<td>B.H.W. 5</td>
</tr>
<tr>
<td>6th day</td>
<td>B.H.W. 1 and so on</td>
</tr>
</tbody>
</table>

The Inspector will check up the work of each Health Workers every 5th day so that he will inspect the work of each workers, 4 times a month in course of his 20 workers strictly by Health Inspector.

4. He will have to check daily at least 20% of the houses of the last 2 days work of Basic Health Workers under him according to the programme and to cover all the villages/areas in his area within a course of 2 months.

5. Concurrent supervision of work of a particular basics Health Worker should be carried out at the beginning if his day’s work when he will collect from the Basic Health Workers records of his past 2 day’s work. Defect detected in the current work of Basic Worker in respect of the under mentioned aspects should be entered in the Note Book of Basic Health Worker.

<table>
<thead>
<tr>
<th>(a)</th>
<th>late arrival and early departure of the Basic Health Worker;</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b)</td>
<td>questionnaires put by the basic health workers to the inmates of the houses.</td>
</tr>
<tr>
<td>(c)</td>
<td>Primary vaccination carried out in the unprotected children of the houses.</td>
</tr>
<tr>
<td>(d)</td>
<td>Enquiries regarding new birth or death in the houses.</td>
</tr>
<tr>
<td>(e)</td>
<td>Administration of presumptive treatment to those from whom blood smear was collected.</td>
</tr>
<tr>
<td>(f)</td>
<td>Recording of particulars in the house register (SFI);</td>
</tr>
<tr>
<td>(g)</td>
<td>Initiation the wall stencil/house card;</td>
</tr>
</tbody>
</table>

6. In the course of the consecutive inspection he will check 20% of the Houses visited by the basic health workers and for this the Health Inspector must across the villages/ towns/areas in a zig zag manner covering every street, the lane and bye-lane of the villages/towns/areas.
7. Enquiries made by Health Inspector during the consecutive inspection should pertain mainly to:

(I) regularity of visit of basic Health Worker;
(II) the questionnaires put by the Basic Health Worker to the inmates of the house to be verified by asking the family members;
(III) omission of primary vaccination amongst unprotected children in the house;
(IV) omission of recording of vital events;
(V) Whether blood smear were taken from suspected fever cases and presumptive treatment given to them by Basic Health Worker.

8. In course of consecutive and concurrent supervision if the Health Inspector comes across any undetected malaria suspected fever cases, he should immediately collect blood smear and administer presumptive treatment and particulars of such case be recorded in N.F.2A. Similarly, if he come across with any unprotected children he will carry out primary vaccination and same should be recorded in the register.

9. Health Inspector should arrange to send blood smears collected from Basic Health Workers immediately to the malaria Eradication Laboratory/Primary Health Centre Laboratory.

** Concurrent supervision be in one village or area of the particular basic Health Worker and the consecutive inspection in 2 villages or areas representing the past 2 days work of the same basic Worker.

10. He should carry out radical treatment of parasite positive cases by domiciliary visit as per instruction of MO PHC/SDHO/ADHO with 4 and 3 aminoquinolines. The drugs are to be administered personally as per dosage schedule in his presence for consecutive five days.

11. He will verify and inspect all primary vaccinations carried out by basic health worker under him on the day fixed for particular basic health worker. He will thus visit the areas of each basic health worker twice in a month as per fixed day programme for this purpose. The observation of such inspection will be recorded by him in respective family vaccination register.

12. He will maintain a office at a suitable place in is jurisdiction.

13. Every Saturday he will collect relevant report and returns in proper profoma from basic Health Workers, scrutinize and consolidate them for onward transmission to Sanitary Inspector of the primary Health Centre (Block).

14. He will maintain sufficient stock of lymph, HCV, disinfectants, anti-malarials in his office for distribution to Basic Health Workers under him and will be responsible to replenish his stores as and when necessary.

15. He will assist the Sanitary Inspector (Block) in carrying out investigations and control operations of epidemics and any other duties allotted to him from time to time by appropriate authorities.

16. He will also assist the Sanitary Inspector (Block) to organize and participate in anti epidemic operations to Fairs and Festivals.
SANITARY INSPECTORS

He will perform the duties impose upon him in respect of any matter affecting public health. He shall execute and enforce regulations, rules and orders relating to public health which may be an acted, made or issued by competent authority.

He shall supervise work of Health Inspector and Basic Health Workers within his block according to advice of Medical Officer, Primary Health Centre and according to a fixed calendar programme to the drawn up for the purpose. He shall tour for at least 20 days in a month and cover over 125 miles (200 KM). As far as practicable he shall keep himself informed of all matters affecting or likely to affect injuriously the public health.

He shall under the guidance and supervision of Medical Officer Primary Health Centre, carry out:-

(a) epidemiological survey of outbreak of communicable diseases, analyse data and take control measures;
(b) implement approved sanitation programme;
(c) carry on continuous health education campaign;
(d) verify vital events and keep records;
(e) keep records and submit progress reports in respect of all public health programmes, as may be required from time to time;
(f) carry out all statutory obligations in respect of smallpox vaccination under the rules of Bengal Vaccination Act, 1880 and the Bengal Vaccination (Amendment) Act, 1911.

Notification of epidemic outbreaks:-

He shall give immediate information to the Medical Officer Primary Health Centre/Sub-divisional Health Officer/district Health Officer of the occurrence of any infections or epidemic disease within his jurisdiction.

Epidemic management:-

On the event of outbreak of any dangerous or epidemic diseases within his jurisdiction, he shall visit, without delay, the locality where the outbreak has occurred and enquire into the cause of such outbreaks and take control measures. In case he is not satisfied that all due precautions are being taken, he shall report to the Medical Officer, Primary Health Centre/Sub-divisional Health Officer/Health Officer, as to the measures which appear to him to be required to prevent the spread of the disease and shall take such measures for the prevention of the disease as he may be authorized to do so.

He shall, when possible, remove or superintend the removal of patients suffering from infectious diseases to infectious disease hospital or ward and shall perform or superintend the work of disinfection after the occurrence of cases of infectious diseases.

He shall pay particular attention to the water supply for the area under his jurisdiction, especially if it is approved for public wells, tubewells or reserved tanks. He shall report to the Medical Officer, PHIC/SDHO/Distt. Health Officer, If the Public wells and tubewells are not in good condition, if the reserved tanks are not properly fenced and kept free from contamination and he shall render every assistance to ensure the purity of the water supply.
He shall personally attend, with the subordinate public health staff, all important fairs and religious festivals, agricultural and industrial exhibitions and other large gatherings held in his jurisdiction and arrange for the erection of the temporary latrine accommodation and the protection of the water supply, in order to guard against the occurrence of water-borne diseases.

He shall report to the Medical Officer, Primary Health Centre/Sub divisional Health officer/District Health Officer any noxious or offensive trade, business or manufactory establishment within his jurisdiction, and the breach or non-observance or any by-law or regulation made in respect there of.

If he is of opinion that any trade occupation of the keeping of any goods or merchandise, by reason of its being injurious to the public health, should be suppressed or removed or prohibited, or that action should be taken regarding any public nuisance, he shall report the matter to the Medical Officer/District Health Officer so that action may be taken under Section 133 of the Code of Criminal Procedure, 1898, or any other provision of law.

Whenever necessary or advisable, or whenever directed to do so by competent authority, he shall inspect the sanitary condition of railway stations and steamer ghats within his jurisdiction, and shall report the result of his inspection to the Medical Officer, Primary Health Centre/Sub-divisional Health Officer/District Health Officer.

Every Saturday he shall forward to the District Health Officer by post, at such an hour as in the ordinary course of post will ensure its delivery to the District Health Officer on the following Monday morning, a return in such form as the Health Department may from time to time require showing the number of cases of infectious diseases notified to him during the week.

As soon as practicable after the 31st day of December in each year he shall make, in a form prescribed by competent authority, an annual report to the District Health Officer up to the end of December on sanitary circumstances and public health administration of the areas under his jurisdiction along with a tabular statement containing the following particulars:

a) The number and nature of the inflections made by him during the year;

b) The number of notices served during the year, distinguishing stationary from informal notice; and

c) The result of the service of such notices.

He will maintain good relationship with the public.

He will maintain stock-ledger concerning stores and equipment of his section.
Job description of different categories of Public Health Workers.


Surveillance worker: - Malaria Surveillance-Home visits-Detection of Fever cases-Collection of Blood Smears, Treatment, etc.

Vaccinator/Health worker - Small pox vaccination, Detection and steps for hospitalization, Home Visits, Submission of Report and Returns, Maintenance of Case cards, etc.

Health Asstt./ Sanitary Asstt - Duties like Basic Health workers covering bigger areas- Duties in Health Centres and R.P.H.Cs. under supervision of Sanitary Inspectors and other duties as assigned to him.

Sanitary Inspector: - Responsible for execution of regulations, rules and orders relating to P.H., Supervision of work of Health Asstt P.H.W., Epidemiological survey of outbreak of communicable diseases, food Inspection power (if so delegated), Implementation of Sanitation programme, Health Education, Recording of vital events, Submission of progress reports, Statutory obligations in respect of small pox vaccination, Epidemic management, water supply arrangement, and other duties as assigned to him.

Health Supervisor: - Supervision of ant malaria work in 5-6 Blocks, supervision of work of Basic Health Workers, etc.

Malaria Inspector: - Supervision of work of malaria field staff, responsible for proper storage and distribution of insecticides, medicines, spray equipment, etc., submission of reports and returns, house to house check-up, etc.

Surveillance Inspector: - Supervision of work of surveillance workers, detection of fever cases, collection of blood slides, and dispatch to laboratory for examination, treatment of cases etc.
1. The family planning Health Inspector must maintain a list of eligible centres (village-wise). For this he must visit house to house in the villages total population that is allotted to him is about 30,000)and prepare the eligible couple register. He will work for 5 days a week going round the villages and on the 6th day will consolidate the work done in the week. He will visit a village of about 1000 population a day with the book pertaining to the village and will cover 40 to 50 houses. Thus he will cover the entire population of 20,000 every 2 months.  
2. He must supply contraceptive to the village Depot Holders (males) and review the stock position periodically and replenish the stock.  
3. He must also distribute contraceptive himself in case there is a request for it from the people.  
4. He will visit ten contraceptive depot in a week.  
5. He will canvass at least two eligible fathers every month for Vasectomy operation.  
6. He should attend to complaints brought to his notice by father after Vasectomy operation and arrange for their check-up and treatment in the nearest Primary health Centre or Government hospital.  
7. He must select enthusiastic leaders and conduct a quarterly meeting of these leaders presided over by the Medical Officer of the Primary Health Centre to popularize Family planning  
8. He will be responsible for arranging for preparation and publicity on Family Planning n his jurisdiction. This will include conduct of exhibitions, film shows on Family Planning, Villupattu dramas, etc., on Family Planning.  
9. He should submit the various periodicals to the Medical Officer regularly and punctually as per the instructions of the Directorate.
HEALTH VISITORS:-

1. She will assist the medical Officer Incharge of Primary Health Centre organizing Matenity, child health and Family Planning Services in the area.
2. She will supervise and guide the Auxiliary Nurse Midwives and trained dais in giving Maternity, Child Health and Family Planning services to the public.
3. She will undertake training of dais through Auxiliary Nurse Midwives.
4. She will assist the medical officer incharge of the Primary Health Centre in school health work, as and when needed.
5. She will guide the Auxiliary Nurse Midwives to establish women depot holders for contraceptives.
6. She will conduct ante-natal, well baby, post-natal and family planning clinics and also do supervisory home visiting in the intensive area of the Primary Health Centre. She will be responsible for registration of births and deaths in the intensive area.
7. She will visit of the six sub-centres at least once in two weeks if there is only one Lady Health Visitors, they will divide sub-centres among themselves and each wick visit her three sub-centres once in a week.
8. She will educate the mothers in the clinics and distribute educational material and educate the Auxiliary Nurse Midwives in Maternity, Child Health, Family planning, nutrition and control of communicable diseases.
9. She will notify cases of smallpox, Cholera, Malaria, fever and cough of one month or more duration and other communicable diseases to the block health officer when such cases come to her notice.
10. She will contact and know the Block Development Officer, Lady Social Education Organizer, wives of Panchayat members, Lady School Teachers, Secretary of the Mahila Mandal, etc., at the block level.
11. She will be responsible for preparation and submission of reports of Maternity Child Health Work.
12. She will work in close co-operation with the Block Extension Educator and the Health Inspector for mutual help on technical matters and to coordinate the working of staff at lower levels.

**************************
AUXILIARY NURSE MIDWIVES

1. The Auxiliary Nurse Midwives will pursue functions she has already been performing in rural areas, particularly contacting ante-natal mothers to provide them with advice regarding Nutrition sans Hygiene. Mothers may be referred to the Sub-centres for Ante-natal clinical examination. As Midwife, she will primarily conduct deliveries and give post natal care. The objective is to provide as soon as practicable Auxiliary Nurse Midwives for each 10,000 of the population. With the augmented staffing now visualised. It will now be possible for the Auxiliary Nurse Midwife to expand the scope of her work, especially in the direction of concern for child care. This work inclusive more interest in nutrition, house-hold sanitation and immunization for children.

2. The proportion of Auxiliary Nurse Midwife to population will still not be high enough, for a long time, to expect that they can handle all deliveries. Actually it will become more important even than before that the Auxiliary Nurse Midwives contact indigenous midwives, establish useful and fundamental improvements in their own techniques of delivery. The indigenous midwives should become more active friends and agents of the health programme in this way.

3. Family Planning will become a major function of the Auxiliary Nurse Midwives; they will provide advice, information and contraceptive supplies in the course of their work. They will help group of village mothers to agree on appropriate depot holders for contraceptive supplies, and check to see that the depot holders is active. In this work, the attendant assigned with the Auxiliary Nurse Midwife can also be of considerable assistance.

4. An important function of the Auxiliary Nurse Midwives will be to keep in touch with village registrars for vital statistics and to ensure that the record of all births (and such deaths) s shown to her are entered in these registers. She should also furnish information to the Computer for his vital statistics and Family Planning record.
ANNEXURE VI

JOB RESPONSIBILITIES

BLOCK EXTENSION EDUCATOR:

1. He shall organize at least one training camp per month for about five leaders from each panchayat covering three to five panchayats every month. Each training camp will consist of about 15 leaders and this will cover 180 leaders per annum.

2. He shall attend the monthly meetings of the villages panchayats to enlist cooperation five the elected members of the Panchayats. He shall attend at least five such meetings every month.

3. He shall organize health committees in each village with the specific object of the furtherance of the Family Planning Programme and the general object of participation in all health programmes. The village leaders identified and selected by him may be involved in such committees. He shall attend at least five such health committee meetings every month. He shall see that the concerned Family Planning Health Inspectors attend similar meetings in the other villages.

4. He shall contact the Depot Holders in each village and find out their needs and arrange to meet these needs.

5. He shall meet as many eligible couples as he can, in any case not less than five, in every village he visits for the health committee and the Panchayat meetings.

6. He shall organize staff meetings at Primary Health Centre head-quarters twice a month to review the progress of the programme and to educate all the members about the goals and the methods to achieve them.

7. He shall attend the Panchayat Union Council meetings as and when they are convened.

8. He shall assist the Medical Officer, Primary Health Centre in the organization of Vasectomy Camps as and when they are conducted in the block.

9. He shall contact individuals who have undergone the operation in the village he visits and enquire about their welfare and health.

10. He shall conduct surveys of Family Planning and General Health along with the village leaders. At least one such survey shall be done every month.

11. He shall evaluate the impact of the Programme in the villages utility of leaders camps, the impact of ideas of vasectomy, loop and contraceptive, etc. This can be done during the leaders...

12. He shall study the birth and death data in full in at least one village per month with particular reference to order of births in the community, the number of births and completeness of registration of births and deaths, etc. to assess the impact ***text missing*** on the birth rate.

13. Establish effective working relations with the health staff of Primary Health Centre, Sub-centres and representative of other Government departments, Voluntary Organizations, Local bodies and Community leaders at the block-Primary Health Centre headquarters sub-centres and villages.

14. Plan educational meetings with the staff of the Primary Health Centre, so that all health workers are equipped with the health education aspects of various programmes, specially family planning.

15. Guide and supervise health education work in the block by working with all the health personnel at the Primary Health Centre and Sub-centres.
16. Help in the organization of vasectomy and IUCD camps within the block and ensure that preparatory and follow-up services are given by Family Planning Field Workers and Auxiliary Nurse Midwives and IUCD and Vasectomy camps.

17. Organise group meetings with officials and non-officials for educational activities in connection with health programme, specially family planning and discuss individually with those subscribing to and reading newspapers.

18. Supervise and guide the Computer in the maintenance of correct vital statistics and keep in touch with village registrars direct and through the Family Planning Field Workers

19. Will be responsible for compilation of all the reports and returns connected with Family Planning work.

20. Get the educational materials and its distribution and also be responsible for Audio-Visual equipment and its use in the block.

21. Will assist in training of personnel and in field studies.

22. Will ensure good stock and reach supplies of contraceptives.

23. Know the radio sets both community and private …village and work with the radio rural forums.

24. Arrange and utilize the occasion offered by big and small conference by Public Relations, Panchayat and Development and Co-operative Departments for the promotion or Family Planning Education.

25. Be on tour for about 20 days a month, supervising and guiding Family Planning field workers and co-ordinating the work with Lady Health Visitors and Health Inspectors.

26. Work out schedule for Family Planning field workers month-wise keeping in view the loop and the vasectomy camps to be held in the next month.

27. Depict the Family Planning targets and achievements in the block in abstract, chart, bar diagrams, etc., and keep them up to date.

28. Feed the Family Planning bulletin periodically with local success stories and send pres worthy news items on Family Planning to District Family Planning Officer for release from the District Bureau and through State Family Planning Bureau.
<table>
<thead>
<tr>
<th>Sr. No</th>
<th>States</th>
<th>Mobile required</th>
<th>Units in position</th>
<th>Staff doctor</th>
<th>Position O.T. Nurse</th>
<th>Performance 1970-71</th>
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<td>41</td>
<td>41</td>
<td>1933 (of 36 units)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Maharashtra</td>
<td>25</td>
<td>25</td>
<td>18</td>
<td>16</td>
<td>19530</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Mysore</td>
<td>19</td>
<td>19</td>
<td>18</td>
<td>19</td>
<td>N.A</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Orissa</td>
<td>14</td>
<td>14</td>
<td>12</td>
<td>18</td>
<td>3397</td>
<td>2034</td>
</tr>
<tr>
<td>12</td>
<td>Punjab</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>12278 (Oct.71 to march 72)</td>
<td>5232</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Rajasthan</td>
<td>26</td>
<td>26</td>
<td>22</td>
<td>32</td>
<td>2472</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Tamil Nadu</td>
<td>13</td>
<td>18</td>
<td>13</td>
<td>13</td>
<td>N.A</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Uttar Pradesh</td>
<td>84</td>
<td>84</td>
<td>29</td>
<td>29</td>
<td>529(of 16 units for 3 months)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>West Bengal</td>
<td>27</td>
<td>20</td>
<td>17</td>
<td>16</td>
<td>N.A</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Tripura</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>766</td>
<td>334(upto Sept.71)</td>
</tr>
<tr>
<td>18</td>
<td>Himachal Pradesh</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Delhi</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>14</td>
<td>83 (upto Dec.71)</td>
</tr>
<tr>
<td>20</td>
<td>Manipur</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>N.A</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Chandigarh</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Total:</td>
<td></td>
<td>373</td>
<td>399</td>
<td>298</td>
<td>319</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*These units have been integrated with IUCD units and named as Sterilisation cum IUCD units.
# ANNEXURE-VIII (cont.)

## STATEMENT OF MOBILE IUCD UNITS

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>States</th>
<th>Mobile required</th>
<th>Units in position</th>
<th>Staff doctor</th>
<th>Position O.T. Nurse</th>
<th>Performance 1970-71</th>
<th>Performance 1971-72</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Andhra Pradesh</td>
<td>67</td>
<td>21</td>
<td>19</td>
<td>21</td>
<td>1090 (of 20 units)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Assam</td>
<td>23</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Bihar</td>
<td>46</td>
<td>46</td>
<td>46</td>
<td>46</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Gujarat</td>
<td>36</td>
<td>27</td>
<td>7</td>
<td>10</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Haryana</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>695</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Jammu Kashmir</td>
<td>18</td>
<td>8</td>
<td>6</td>
<td>6</td>
<td>563</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Kerala</td>
<td>20</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Madhya Pradesh</td>
<td>50</td>
<td>50</td>
<td>41</td>
<td>43</td>
<td>1785 (of 34 units)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Maharashtra</td>
<td>61</td>
<td>61</td>
<td>45</td>
<td>31</td>
<td>140</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Mysore</td>
<td>88</td>
<td>19</td>
<td>19</td>
<td>-</td>
<td>-</td>
<td>1040</td>
</tr>
<tr>
<td>11</td>
<td>Orissa</td>
<td>21</td>
<td>19</td>
<td>10</td>
<td>20</td>
<td>9469</td>
<td>5228</td>
</tr>
<tr>
<td>12</td>
<td>Punjab</td>
<td>23</td>
<td>23</td>
<td>20</td>
<td>23</td>
<td>226</td>
<td>183 (Oct71 to March72)</td>
</tr>
<tr>
<td>13</td>
<td>Rajasthan</td>
<td>50</td>
<td>26</td>
<td>25</td>
<td>28</td>
<td>1810* (15 units)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Tamil Nadu</td>
<td>28</td>
<td>13</td>
<td>18</td>
<td>13</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Uttar Pradesh</td>
<td>84</td>
<td>84</td>
<td>27</td>
<td>36</td>
<td>3816 (Ist…qtly only)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>West Bengal</td>
<td>36</td>
<td>18</td>
<td>6</td>
<td>14</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Himachal Pradesh</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Tripura</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Delhi</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Manipur</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Chandigarh</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total:-</strong></td>
<td><strong>621</strong></td>
<td><strong>456</strong></td>
<td><strong>324</strong></td>
<td><strong>330</strong></td>
<td></td>
<td></td>
</tr>
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</table>

*Merged with sterilization units*
1. Medical Care

**STATEMENT OF AMBULATORY AND INSTITUTIONAL CARE PROVIDED IN PHC, KILOI, BEFORE AND AFTER PHASE II**

<table>
<thead>
<tr>
<th>Month of 1972 and 1973</th>
<th>New cases</th>
<th>Old cases</th>
<th>Total</th>
<th>Indoor Admission (includes Sterilisation admission too)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January’72</td>
<td>623</td>
<td>740</td>
<td>1363</td>
<td>5</td>
</tr>
<tr>
<td>February’72</td>
<td>651</td>
<td>1150</td>
<td>1801</td>
<td>2</td>
</tr>
<tr>
<td>March’72</td>
<td>625</td>
<td>1182</td>
<td>2017</td>
<td>1</td>
</tr>
<tr>
<td>April’72</td>
<td>996</td>
<td>1589</td>
<td>2685</td>
<td>8</td>
</tr>
<tr>
<td>May’72</td>
<td>1564</td>
<td>1992</td>
<td>3556</td>
<td>21</td>
</tr>
<tr>
<td>June’72</td>
<td>2163</td>
<td>1979</td>
<td>4142</td>
<td>12</td>
</tr>
<tr>
<td>July’72</td>
<td>1950</td>
<td>1771</td>
<td>3727</td>
<td>7</td>
</tr>
<tr>
<td>August’72</td>
<td>1664</td>
<td>1512</td>
<td>3176</td>
<td>1</td>
</tr>
<tr>
<td>Sept., 1972</td>
<td>1932</td>
<td>1787</td>
<td>3719</td>
<td>6</td>
</tr>
<tr>
<td>October, 1972</td>
<td>1383</td>
<td>1148</td>
<td>2531</td>
<td>7</td>
</tr>
<tr>
<td>November, 1972</td>
<td>1030</td>
<td>903</td>
<td>1933</td>
<td>9</td>
</tr>
<tr>
<td>December, 1972</td>
<td>1215</td>
<td>980</td>
<td>2195</td>
<td>8</td>
</tr>
<tr>
<td>January, 1973</td>
<td>865</td>
<td>1145</td>
<td>2010</td>
<td>6</td>
</tr>
<tr>
<td>February, 1973</td>
<td>1087</td>
<td>1008</td>
<td>2095</td>
<td>5</td>
</tr>
<tr>
<td>March, 1973</td>
<td>1221</td>
<td>1338</td>
<td>2559</td>
<td>4</td>
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<tr>
<td>April, 1973</td>
<td>1446</td>
<td>1595</td>
<td>3041</td>
<td>3</td>
</tr>
<tr>
<td>May, 1973</td>
<td>1650</td>
<td>1993</td>
<td>3823</td>
<td>11</td>
</tr>
<tr>
<td>June, 1973</td>
<td>2111</td>
<td>1334</td>
<td>4445</td>
<td>10</td>
</tr>
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</table>

**NOTE:**

1. The months and figures underlined indicate the work under Phase II of the Research Project.

2. Figures in respect of Minor Ailment provided in domiciliary visit and OPD attendance at sub-centres are under compilation. Therefore, the figures shown above pertain to P.H.C. work only.
FEVER SURVEILLENCE
STATEMENT SHOWING ACTIVE AND PASSIVE SURVEILLANCE WORK DONE
UNDER NMEP IN PHC BEFORE AND AFTER PHASE II

<table>
<thead>
<tr>
<th>Months of 1972-73</th>
<th>Active</th>
<th>Surveillance</th>
<th>Passive</th>
<th>Surveillance</th>
<th>Details of Treatment of radical treatment</th>
<th>E.T. completed</th>
<th>Untr…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of slide collected</td>
<td>No. of positive cases detected</td>
<td>No. of slides collected</td>
<td>No. of positive cases detected</td>
<td>Total positive cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January’72</td>
<td>870</td>
<td>2</td>
<td>24</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>February’72</td>
<td>1187</td>
<td>4</td>
<td>66</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>March’72</td>
<td>1089</td>
<td>20</td>
<td>141</td>
<td>1</td>
<td>21</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>April’72</td>
<td>1005</td>
<td>52</td>
<td>142</td>
<td>2</td>
<td>54</td>
<td>54</td>
<td>-</td>
</tr>
<tr>
<td>May’72</td>
<td>934</td>
<td>81</td>
<td>253</td>
<td>7</td>
<td>88</td>
<td>81</td>
<td>7</td>
</tr>
<tr>
<td>June’72</td>
<td>1213</td>
<td>85</td>
<td>491</td>
<td>17</td>
<td>102</td>
<td>86</td>
<td>16</td>
</tr>
<tr>
<td>July’72</td>
<td>1229</td>
<td>57</td>
<td>398</td>
<td>17</td>
<td>74</td>
<td>57</td>
<td>17</td>
</tr>
<tr>
<td>August,1972</td>
<td>650</td>
<td>41</td>
<td>282</td>
<td>25</td>
<td>66</td>
<td>45</td>
<td>21</td>
</tr>
<tr>
<td>Sept.’1972</td>
<td>2306</td>
<td>500</td>
<td>648</td>
<td>69</td>
<td>578</td>
<td>234</td>
<td>344</td>
</tr>
<tr>
<td>October,1972</td>
<td>1826</td>
<td>515</td>
<td>418</td>
<td>57</td>
<td>572</td>
<td>175</td>
<td>397</td>
</tr>
<tr>
<td>November,1972</td>
<td>1410</td>
<td>71</td>
<td>237</td>
<td>-</td>
<td>71</td>
<td>2</td>
<td>69</td>
</tr>
<tr>
<td>December,1972</td>
<td>1240</td>
<td>10</td>
<td>173</td>
<td>1</td>
<td>11</td>
<td>Nil</td>
<td>11</td>
</tr>
<tr>
<td>January,1973</td>
<td>688</td>
<td>11</td>
<td>83</td>
<td>1</td>
<td>12</td>
<td>Nil</td>
<td>12</td>
</tr>
<tr>
<td>February,1973</td>
<td>706</td>
<td>5</td>
<td>115</td>
<td>1</td>
<td>6</td>
<td>Nil</td>
<td>6</td>
</tr>
<tr>
<td>March,1973</td>
<td>918</td>
<td>14</td>
<td>161</td>
<td>3</td>
<td>17</td>
<td>24</td>
<td>17+7 (old cases)</td>
</tr>
<tr>
<td>April,1973</td>
<td>1164</td>
<td>36</td>
<td>196</td>
<td>6</td>
<td>42</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>May,1973</td>
<td>1108</td>
<td>162</td>
<td>269</td>
<td>49</td>
<td>211</td>
<td>128</td>
<td>83</td>
</tr>
<tr>
<td>June,1973</td>
<td>1564</td>
<td>264</td>
<td>391</td>
<td>67</td>
<td>321</td>
<td>274</td>
<td>47</td>
</tr>
</tbody>
</table>

Note: 1. The months and figure underlined indicted the work under Case II of the Research Project.

The marked decline in the No. of slides collected under active surveillance during the months of January and February, 1973 is due the mass vasectomy campaign in the district as well as in the experimental area. As a result of the campaign, the CHWS were performing their domiciliary visits regularly. The supervisory machinery was once again geared up in the month of march, 1973 and improvement is evident from the figures of the subsequent months. The number of untreated positive cases is on the higher side which is not permissible under the NMEP directives. However such a backlog has not been accumulated due to non-availability of the drug period for R.T. The drugs required for presumptive as well as medical treatment were constantly in short supply.
The targets of the slides required to be collected under active surveillance roughly works out to 1377 slides per month.
ANNEXURE-VIII

III. SMALL POX VACCINATION

STATEMENT SHOWING MONTHLY PROGRESS OF PRIMARY AND PRIMARY AND RE-VACCINATION OF PHC KILOI, BEFORE AND AFTER PHASE II.

<table>
<thead>
<tr>
<th>Month of 1972-73</th>
<th>No. of P.V done</th>
<th>No. of R.V. done</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>January’1972</td>
<td>741</td>
<td>1415</td>
<td></td>
</tr>
<tr>
<td>February’1972</td>
<td>667</td>
<td>1220</td>
<td></td>
</tr>
<tr>
<td>March’1972</td>
<td>794</td>
<td>1385</td>
<td></td>
</tr>
<tr>
<td>April’1972</td>
<td>669</td>
<td>1210</td>
<td></td>
</tr>
<tr>
<td>May’1972</td>
<td>462</td>
<td>1668</td>
<td></td>
</tr>
<tr>
<td>June’1972</td>
<td>316</td>
<td>667</td>
<td></td>
</tr>
<tr>
<td>July’1972</td>
<td>622</td>
<td>1802</td>
<td></td>
</tr>
<tr>
<td>August,1972</td>
<td>387</td>
<td>627</td>
<td></td>
</tr>
<tr>
<td>Sept.’1972</td>
<td>475</td>
<td>246</td>
<td></td>
</tr>
<tr>
<td>October,1972</td>
<td>229</td>
<td>615</td>
<td></td>
</tr>
<tr>
<td>November,1972</td>
<td>747</td>
<td>6211</td>
<td>Smallpox fortnight in selected villages</td>
</tr>
<tr>
<td>December,1972</td>
<td>239</td>
<td>541</td>
<td></td>
</tr>
<tr>
<td>January,1973</td>
<td>19</td>
<td>10</td>
<td>Data in respect of male CHV is under compilation because some bonus entries have been found; therefore, data is under scrutiny. The figures given represent work done by the female CHVs only.</td>
</tr>
<tr>
<td>February,1973</td>
<td>124</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>March,1973</td>
<td>596</td>
<td>524</td>
<td></td>
</tr>
<tr>
<td>April,1973</td>
<td>302</td>
<td>355</td>
<td>Vaccine is short supply</td>
</tr>
<tr>
<td>May,1973</td>
<td>404</td>
<td>565</td>
<td></td>
</tr>
<tr>
<td>June,1973</td>
<td>325</td>
<td>816</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: 1. The months and figures underlined indicate the work under Phase-II of the Research Project.
2. The figures of P.V. and R.V. before Phase-II of the research Project are arbitrary because no record is available to verify their authority. In Phase-II, the figures can not verified from the record; therefore, more representative of actual work done.
ANNEXURE-VIII

IV. FAMILY PLANNING

STATEMENT SHOWING FAMILY PLANNING ACHIEVEMENTS OF PHC KILOI, BEFORE AND AFTER PHASE II

<table>
<thead>
<tr>
<th>Month of 1972-73</th>
<th>No.of E.C contacted</th>
<th>No. sterilizations vasectomy</th>
<th>Tubectomy</th>
<th>IUCD Insertion</th>
<th>C.C. Distribution</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>January’1972</td>
<td>16220</td>
<td>155</td>
<td>20</td>
<td>1</td>
<td>1630</td>
<td>Special FP campaign</td>
</tr>
<tr>
<td>February’1972</td>
<td>16023</td>
<td>-</td>
<td>11</td>
<td>82</td>
<td>8846</td>
<td>Special IUCD campaign</td>
</tr>
<tr>
<td>March’1972</td>
<td>13806</td>
<td>1</td>
<td>4</td>
<td>288</td>
<td>5401</td>
<td></td>
</tr>
<tr>
<td>April’1972</td>
<td>15449</td>
<td>-</td>
<td>1</td>
<td>13</td>
<td>2304</td>
<td></td>
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NOTE:

1. The months and figures underlined indicate the work under phase II of the Research Project.

2. The figures in respect of E.C. contact in 1973 are under compilation.

3. During special F.P. campaign in 1973 the existing strength of all the peripheral field workers irrespective of their unipurpose organization was by and large, deployed in F.P.Programme. This would mean that the achievements whatsoever are, the result of collective efforts including the active part taken by other departments such as Revenue, Social Welfare etc. Thus the figures are not representative of work performance of only F.P.staff. Likewise, in Phase II of the Research Project all the CHWs were asked by the district authorities to concentrate on special campaign rather than on other programmes. As a result the output
performance of other programme suffered considerably. The figures for January and February, 1973 includes work done for the special campaign by other department.