Public Health Administration
Chapter - 4

PUBLIC HEALTH ADMINISTRATION

Government played an important role in the development of health status of the people. Health was measured by death rate (mortality), lower the death rate, healthier is the community. Morbidity (illness) was another measure of the health condition of the people since death rate was falling. Under Article 47 of the constitution of India, the state shall regard raising the level of nutrition and standard of living of the people and improvement in public health among its primary duties.¹

The aim of the government should be the welfare of the people. Health care is next only to security of the nation. Good health is a normal criterion and has been a challenge to mankind. Ill health has been repeatedly causing heavy toll of lives which resulted in seasonal outbreak of epidemics. All over the world many million people had suffered death due to irresistible diseases. Due to the onslaught of water and air borne diseases migrations precipitated in and out of the country.²

There are countries in the world where the governments take the responsibilities of health care of the people as in the USSR, U.K and New Zealand. In the USA health services were organized at federal level with Surgeon General as head and the state were autonomous. In the UK, health ministry was centralized and in Italy local authorities were responsible for medical and health matters. The above systems were selected and tried to be incorporated to suit the Indian condition. In India, health care is given to the state but the centre looks after overall health care.

Evolution of Health Policies

Health policy identifies and discusses the problems of health as nutrition, food adulteration, drugs, environmental protection, maternity and child health, school and occupational health. During the British rule, there was no clear policy for the country.
The British Indian Government in 1944 appointed the Health Survey and Development Committee by which the committees were set up to guide the government to make health policy. Only after independence, the Government of India designed health programmes based on health policies. The Bhore Committee of 1946 constituted under Sir Joseph Bhore, a senior civil servant revealed the health conditions of India prior to independence and provided guideline in framing health care policy. It not only presented the statistics on disease burden and attributed poor state of health in the country but also inadequacies in medical services and health personnel. The prevailing social ills-poverty, illiteracy, poor nutrition and unsanitary conditions were also noticed.

The Second World War caused shortage of funds and materials for public health activities. The Environmental Hygiene Committee in 1949 reported on conditions in Independent India. Water supply had deteriorated in Madras city and the quality nauseating for which remedial measures were the utmost necessity. The Applied Nutritional Programme with the assistance of UNICEF, FAO, WHO aims at increased production of food, fruits, vegetables, fish, poultry, milk and education of villagers. The selection of beneficiaries for free feeding was done by panchayats and associated organization like Youth and Mahila Mandals.

Health System in India

"The Central Health Ministry is the pivot round which all the major schemes for improving the standards of health of nation revolve" said J. L. Nehru

Public health falls within state responsibility and financial support, uniform pattern and policy schemes came from the Centre. Hence the attention of both State and Central Government were needed. Under the Indian Constitution, the states were independent in matters of health care delivery to the people.
At the national level the official organs of health system are:

1) **The Ministry of Health and Family Welfare**

   The Department of Health came into existence in 1945, with the separation of health sector from education department. Only after independence the department was raised to the status of Ministry. In 1966 Family Planning department was added to it and in 1977 the ministry was renamed as Ministry of Health and Family Welfare.

2) **Directorate General of Health Services**

   After 1947, due to the abolition of the post of Director General and Public Health Commissioners, the post of Director General of Health Services was created. He was the principal adviser of the Union Government in medical and public health matters. The functions were surveying, planning, coordination, programming and appraisal of all health matters in the country.

3) **Central Council of Health**

   This council acted for the promotion of coordinated action between the Centre and the State in the implementation of all programmes and measures pertaining to health of the nation. The Union Health Minister was the Chairman and the State Health Ministers were the member of the above council established in 1952. This Council had provided a common forum for deliberation of problems of mutual interest to the various States concerning health matters.

   At the State level, the health administration comprised of the State Ministry of Health and Directorate of Health.

1) **Directorate of State Health**

   The State Ministry of Health had the power to make regulations and sanitary codes that carry out provisions of the state public laws. In Tamilnadu administrative
functions were performed at two levels one at headquarters in the Secretariat and the other in the Directorate at regional, district, taluk, mandal and block levels.

The State Public Health programmes includes preventing disease outbreaks, control of milk and food supply, provision for manufacture of vaccines, vital statistics for the state promotion of maternal and child welfare, school health and family planning recruitment of medical personnel for rural health services, expansion of rural health through public health centre, nutrition and eradication programme and health education.

Two separate departments, medical and public health were functioning in the state, under the head of the Surgeon General and the Inspector General of Civil hospitals and the Director of Public Health. A development in some states of India was the appointment of Director of Medical Education in 1966 in view of increasing number of medical colleges. Teaching, training and research programme in medical field were entrusted to the Directorate. In 1966 the Department of Health services and Family Planning was formed by merging the Directorate of Medical Services and the Directorate of Public Health. In 1976 the Integrated Department was bifurcated into department of Public Health and Preventive Medicine and the Department of Medical Services and Family Welfare.

Public Health and Sanitation, hospital and dispensary were listed under state list in the 7th Schedule of the constitution. After 1947, strenuous efforts were taken to eliminate the scourge of diseases.

Health Committees

The Bhore Committee of 1946 formed the basis for organization of basic health services in India. Health measures were also under consideration during the re-organization of states. The Dave Committee of 1956 set up separate Directorate for
administration of indigenous medicine in Central and State. To survey the progress of health since independence and make proposal for further development and expansion of health services, the A.L. Mudaliar Committee was constituted in 1959. Smt. Jothi Venkatachalam the health minister of Tamilnadu during 1962-63 brought forward a resolution and passed in 1962 for the establishment of a committee to review the medical relief work in the state. In 1963 Chadah Committee was appointed to examine the working of National Malaria Eradication Programme, requirements of Primary Health Centres and other health activities.

To review the strategy related to Family Planning the Government appointed the Mukerjee Committee in 1965 and a similar committee in 1966 to work out details of basic health services. The Mungalawala Committee of 1967 favoured the integrated health services for all problems.

**Preventive Measures**

The pattern of diseases had changed and the aim of preventive measures was to achieve 100% coverage of the entire population in terms of inoculations and vaccination. National programme for the control of malaria, filarial, tuberculosis, leprosy and venereal disease had been undertaken with the aid of WHO and other foreign agencies. They formed the source of information on morbidity and mortality of the population of Madras State programmes. Health programmes were vigourously implemented in this state with munificent grants from UNICEF, WHO and other international organizations.

National Health Programmes were formulated by Government of India to control health problems common to all states.
Table 4.1

<table>
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<tr>
<th>Year of Launching</th>
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<td>NMEP</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>1958</td>
<td></td>
<td>NIDDCP</td>
<td></td>
<td>NTCR</td>
</tr>
<tr>
<td>1962</td>
<td>NSEP</td>
<td></td>
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National Malaria Eradication Programme (NMEP)

With the support of the World Health Organization in 1953 the National Malaria Eradication Programme was launched. With the active participation of the state government, it functioned during the second Five Year Plan period. About 34 million people were benefited by this programme and by 1962 the whole state was covered. The programme of spraying DDT in the rural areas of the entire state, whether endemic or hypo-endemic was followed. In case of urban and semi-urban malarial areas, greater emphasis was laid on anti-larval measures since the vector breed rest mostly in well walls. Anti-larval measures included mineral oil emulsion as larvicide and introduction of larvivorous fish (gambusia) in wells. A second round of spray was carried out in the places with large aggregation of labour and man-made breeding places. The anti-malarial operations in military establishments and cantonment areas were coordinated with those of the state organization. Arrangements made for anti malarial operations in the railway colonies and adjacent state areas were implemented successfully. The National Malaria Eradication Programme in Madras was adjudged as the best in India. For the implementation of
the programme, health inspectors and workers were responsible. The Vigilance Phase Programme was carried out in fifteen unit areas during 1965-66.\textsuperscript{20} The Government of India supplied insecticides, anti-malarial drugs, vehicles and equipments as grant-in-aid for the operation of the programme.

Madras state was the first to implement the surveillance phase, an anti-parasitic operation seeking positive cases of malaria and giving on the spot treatment. For this task, surveillance workers were appointed and were inspected by malaria inspectors. Under the passive surveillance, the medical institutions and private practitioners were requested to report malaria cases treated by them to the concerned units. Voluntary and official agencies cooperated better than the medical institutions and private practitioners.

**National Smallpox Eradication Programme (NSEP)**

In view of the continuous prevalence of smallpox incidence in the city of Madras, the government felt that the measures undertaken by the Madras Corporation were not fully effective and sufficient to cope with the smallpox situation in the city. Under the Madras Public Health Act 1939, the government empowered the Director of Public Health to inspect, control and superintend the operations of the Madras Corporation in the field of smallpox. The Director drew up a scheme for the complete eradication of smallpox by planned, systematic and intensive vaccination. A Crash programme for eradication of smallpox was launched in the districts of North Arcot, Chingleput and Madras city during 1961 as an experimental measure. It was a part of the Public Health scheme under Third Five Year Plan sponsored by the Government of India with the aid of WHO.\textsuperscript{21} The eradication programme was launched in 1962 and in Madras state, it was organized in 1963.

Prior to the launch of the programme, pilot projects were carried out in all states of India.\textsuperscript{22} A pilot project started in Chingleput district was extended to Madras...
Plate 10.18. The smallpox eradication programme was presented in several issues of *World Health*, an illustrated magazine published in many languages by WHO and directed to the general public.
city, North Arcot, Niligiris and Kanyakumari. Later eight development districts namely North Cuddalore, East Thanjavur, South Trichy, North Salem, West Coimbatore, South Madurai, West Ramanathapuram and South Tirunelveli were taken up for vaccination. Preliminary preparations were made by providing comprehensive manual on smallpox and vaccination to the vaccination staff. They were also given field training. Since 1963, every year the National Small Pox Eradication week was observed. Under the National Smallpox Eradication Programme 836087 primary and 11195290 revaccinations were performed on mass scale in 1964. In 1965 eight districts of Madras state were covered and it was extended to other districts for 100% coverage. But in several districts adequate vaccination staff had not been appointed due to dearth of qualified hands. During epidemics temporarily trained staff were appointed.

Intensive mass vaccination work was in progress all over the state covering 3863 lakhs of population during the Third Five Year plan. The maintenance phase of the programme was carried out to vaccinate those who skipped primary vaccination. Fresh vaccine was supplied twice a week from the Kings Institute, Guindy. Revaccination was included in the Third Five Year plan. Government ordered to take up the entire state during 1966-67 under National Smallpox Eradication Programme to maintain community and consolidation phase. It was in progress in all the thirteen districts. A vast international campaign by WHO through the issue of stamps and medals which was held from 1967 to 1979 led to the complete eradication of smallpox.

**National Leprosy Eradication Programme (NLEP)**

National Leprosy Eradication Programme was launched in collaboration with the State Government wherever leprosy was a big public health problem. About 3.1 crores of population was covered under the programme and 3.5 lakh cases were brought
The Government of Madras created a Leprosy department under Surgeon General with the assistance of Honorary Director for Leprosy Campaign as a preliminary work. The Indian Leprosy Control Programme was launched in 1954-55. Prior to 1955 no mass work against leprosy was done. Proposal for leprosy subsidiary centres in endemic areas were made by the government. Leprosy treatment study centre at Tirukoilur is among the centre in India where mass treatment was given and records about the epidemiology of the disease were maintained. The National Leprosy Eradication Programme started its activities by 1955-56. The Indian Council of Medical Research undertook an assessment of the activities of the programme between 1955 and 1974 at Government Leprosy treatment and Study centre in Tirukoilur, South India. This area was highly endemic for leprosy population.

<table>
<thead>
<tr>
<th>Period</th>
<th>No. of Cases Recorded</th>
<th>Prevalence of Leprosy (per thousand)</th>
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<tr>
<td>1955-57</td>
<td>3845</td>
<td>62.7</td>
</tr>
<tr>
<td>1958-60</td>
<td>1019</td>
<td>53.6</td>
</tr>
<tr>
<td>1961-64</td>
<td>1679</td>
<td>45.3</td>
</tr>
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</table>

Other Programmes

Programmes for tuberculosis, filariasis, cholera, smallpox and plague also yielded useful information. Filariasis was a public health problem in the districts of Tanjore, Tiruchirappalli, Chengalpattu, South Arcot, North Arcot and Kanyakumari and control measures were carried by destroying the destruction of mosquitoes. With the assistance of government, four filarial control units continued to function at Kumbakonam, Chidambaram, Chingleput and Vellore.
National Tuberculosis Programme integrated with general health services at both rural and urban level aimed at reducing the problem of tuberculosis in the community. Guinea worm and yaws eradication programmes were also introduced for the control of the disease.27

**Water Supply and Sanitation Programme**

Madras Government Expert Committee on water and sewage purification in 1921 helped the government in solving water supply and drainage problem.28 This Committee suggested measures for the execution of safe water supply and sanitation. The Environmental Hygiene Commission of 1948 planned for supplying protected water to 90% of Indian population.29 Railway water was bad and emanated unpleasant taste and odours and the control of algae growth in water supplies was carried out.

The Water Supply of Madras was quite unsatisfactory. It was insufficient to meet the minimum requirements of an ordinary householder. Some desperate householders have located their services taps in pits below ground level. Pit taps were potentials of grave contamination to the entire water supply. The water has been discoloured due to heavy load of vegetable debris. To make the water safe it was sterilized with large dose of chlorine. Chlorination was the first line of defence in Madras water works. In 1914, an expert committee evolved a method of purifying the Madras Water and utilizing the existing sand filters.

The Planning Commission accorded priority to provide safe drinking water supply. In 1947 the Water Supply and Drainage Committee suggested ways and means to accelerate progress of urban and rural water supply drainage schemes in the province.30 Rural water supply comprehensive scheme was provided to rural areas with pure form of water supply. According to a report, only 2% of the people of Madras had protected water supply.31 The Environmental Hygiene Committee of
1949 reported on the conditions in the newly independent India. Water supply deteriorated in Madras city as mentioned earlier and necessary action was to be made by the government.32

In Madras, the National Water Supply and Sanitation scheme was implemented in selected villages of South Arcot, Tanjore, Tiruchy, Ramanathapuram, Tirunelveli, Madurai, North Arcot, and Chingleput districts. The Second Five Year Plan outlay for the above scheme was 1.20 lakhs and 50% of the expense was borne by the Government of India. Madras State Public Health Board convened at Ooty recommended the establishment of Public Health Engineering Institute for training of personnel to execute national water supply scheme.33 The above recommendations were to be provided under the Third Five Year Plan. The cholera endemic villages of South Arcot, Tanjore, Trichy, Ramanathapuram and Tirunelveli were covered in 1958 under this scheme. The Twelfth World Health Assembly in 1959 stated that safe and adequate supply of water to inhabitants and communities constitute an important measure for the protection and improvement of health which is indispensable for economic and social development.34 In 1961 grants were sanctioned by the government of Madras for rural water supply scheme. Urban water supply and drainage schemes were to be included in the Fourth Five Year Plan.35

National Water Supply and Sanitation (rural) programme was formulated to eradicate waterborne disease such as cholera, typhoid in villages with population of not more than 5000 by providing adequate protected water supply and sanitation facilities. It was beneficial to rural areas which were vulnerable to the attacks of diseases. In districts of South Arcot, Tanjore, Tiruchirappalli, Ramanathapuram, Tirunelveli, Chingleput and Kanyakumari, the programme which was taken up in the Second Five Year Plan was completed. For rural water supply and comprehensive
scheme, the Board of Revenue (Food Production) was the administrative in-charge of the scheme. Maintenance of these works was handed over to local bodies implemented through public engineering departments.

During the Kamaraj ministry propaganda for the rural and urban sanitation programme was enforced wherever necessary. The National Cleanliness Day was observed in the state on the 2nd of October 1960 as cleanliness was a matter near to the heart of Gandhi. The necessity for protected drinking water supply was felt and posters to observe National Cleanliness Day and pamphlets to highlight better living through cleanliness was initiated.

Health message through media

POPULAR SLOGANS

General

1. Be clean; Eat clean and Stay clean
2. Cleanliness is next to Godliness
3. Preserve Health through cleanliness
4. Health through clean hands
5. Dirty hands carry disease
6. Spitting spreads disease
7. Keep public parks clean
8. Prevent fly breeding
9. To protect your health, prevent fly breeding
10. No filth – No flies
11. Fight fly – win health
12. Safe water
13. Boiled water -- Safe water
BCG

BCG as a prophylactic measure was given emphasis in the country’s programme of tuberculosis control. The Central Government introduced BCG in 1948 with the cooperation of WHO and UNICEF with target of 87 million test under first five year plan. In Madras city BCG vaccination was started with the aid of joint enterprise of six foreign teams to work at selected centres in each province. In 1948 the trial venue for vaccination was Madanapalle town. There was a proposal to extend the programme to all districts of the province. Mass vaccination in India since 1951 was the single biggest drive of BCG in the world. In 1953 BCG Euphoria was at its peak with the idea to reduce tuberculosis in the country by its mass use. Emphasis for tuberculosis control was made in the Second Five Year Plan and proposal to complete first round of campaign to cover entire population was made.

The Government policy of BCG vaccination was justified by the British Medical Research Council’s Committee report which showed the substantial value of BCG vaccinated school children. During 1954, health condition of the state was better than previous year. BCG on a mass scale was completed in Coimbatore and its belt areas. The age groups covered under vaccination was one to twenty five years. In 1957, vaccination campaign was completed in rural areas and municipal towns and the administrative unit for the campaign was reorganized. The campaign after its successful administration in South Arcot moved to Tanjore. But the work was hampered by the outbreak of cholera in the delta areas and outpour of heavy north...
east rains during November 1963. Later in North Arcot district, the campaign was
carried in full swing. For the first time house to house vaccination was possible.
Ghosha Muslims who were not covered so far were benefited out of this work. In 1964, BCG campaign was successful in Tiruchirappalli. About 1,93,520 were
vaccinated and intensive educational campaign was organized. The Central Bureau of
Health Intelligence recorded the satisfactory progress of BCG vaccination campaign.
It is to be noted that BCG was administered to patients even in the remotest villages.

School Health Programme

One of the components of the total comprehensive maternal and child health
policy was the school health programme. Backwardness of school child was due to ill
health, contacts with infectious disease, verminous conditions caused by physical and
mental growth. The importance of health of the school child was the prerequisite for
successful implementation of educational programme.

The objectives of the programme were:

→ to detect major diseases and offer medical aid,
→ to maintain record of health
→ to impart health education.

In the prevention and control of communicable disease, balanced diet, personal
and environmental hygiene, celebration of National Cleanliness Day, Anti-Fly week
and smallpox eradication drive were initiated.

The declaration of rights of the child adopted by the United Nations
Organization in 1959 fought for the enhancement of child health and nutrition was to
be given first preference and solutions to be found. Under the CARE assisted
pattern, the school meal programme was started in October 1961. The deficiencies
and diseases noted in the children showed the neglected condition of the school health
programme of 1966. It gained momentum to usher in a new era of health and happiness to every child in Madras State. Central kitchens were opened with the pilot project at Sekkadu in August 1967 with the assistance of CARE.42

On account of the films of mosquito menace and eradication of the enemy received from the Government of India, schemes of school medical inspection for pupils were sanctioned. During the second five year plan period, medical inspection of school children of Kanyakumari district was undertaken.43 The scheme of school medical inspection had been sanctioned by the government for implementation during 1965-66. Further children’s hospitals were also established.44

Immunization of pre-school children with triple vaccine was launched in 1964 to stop children falling victims of whooping cough, tetanus and diphtheria. This work was carried out through the agency of primary health centres. Children below five years were immunized for which a district public health nurse in each district and additional health visitor for each primary health centre were appointed. Every year about 1.75 lakhs of children were administered with *triple antigen*.45 Madras instituted pilot school health programme in selected primary health centers. The medical officers of primary health centres were in charge of school health programme assisted by school health visitors. Health propaganda and education were also carried out by the headmaster and the teachers of the school. The midday meal scheme to substitute calorie deficiency, reconstituted skimmed milk and multivitamin tablets must have shown remarkable effect in the increase of height and width of school children by improving health.

**Occupational Health**

Modern industry creates environment to a host of unknown disease. The Factory Act of 1948 dealt with comprehensive problems of health, welfare and safety. Health Ministers Conference was held in 1949 to discuss the industrial health.46
The Government constituted Environmental Sanitation and Health Education Committee in 1961 for implementing the recommendation of Expert Committee (Hotel Sanitation Committee) to study industrial and occupational hazards and their elimination to deal with the educational aspects. This committee insisted on the importance of the hygiene of the food catering establishments in the spread of foodborne diseases. It also considered cleanliness sanitation in hotels. Nutritional officers drew up proposals for improving hygiene of catering establishment and visited canteens attached to industrial concerns in the state.

The Public Health Act of 1939 was amended in 1959. It provided for the preventive and control of communicable disease and hygienic and sanitary conditions in catering establishments. Hotel sanitation complaint was taken out in hotels and restaurants of Madras. A few cases of tuberculosis infection was detected. In the Royapettah hospital in 1964 out of 591 patients, 27 were workers in Madras Hotels. Health officers in the state inspected the factories very often and their work improved the health of the factory workers.

**Maternity and child welfare measures**

Maternity and child welfare services were recognized as a very important branch of public health work. It included anti-natal, intranatal, post natal services for mothers and nutritional services to infants and children under five years of age. In our country the maternal death rate was high and the World Health Organization had taken it as the foremost problem in health development. An article in an international publication reports stated that 49.6% of births in Madras were in a hospital or nursing home or home deliveries.

By 1947 there were 312 maternity and child welfare centres which rose to 382 by 1948. Local bodies were sanctioned a grant of Rs.1,91,304 to spend for the smooth running of the centres. There were about 100 women medical officers, 112 health
visitors and 814 midwives in 1948. The midwives had conducted 116,609 deliveries with an expense of Rs. 1,508,738.49. Even with the services of the midwives, the infant mortality was recorded as 128. There was utmost necessity of treatment of delivery cases with genuine training and hence untrained midwives were provided training. Women medical officers, health visitors, and midwives had to undergo the maternal and child welfare services of local bodies were under the control of government health officers. Sixty-one maternal and child welfare centres were formed and the posts of seven women medical officers, six health visitors, 73 midwives, and 100 ayahs were sanctioned. In spite of the presence of maternal and child welfare centres and staffs, the maternal mortality rate increased from 5.78 in 1949 to 6.21 in 1950. The infant mortality number rose from 128 to 200. In 1951 there were 71 maternal and child welfare centers in the whole Madras State and 25 centers in Madurai alone. Provision of maternity homes was another step in the development of maternity and child welfare schemes in municipal and district board and general public.

In the whole state by the First Five Year Plan period there were 511 maternity and child welfare and maternity homes with the facilities of 518 beds. In Madras, the infant mortality rate was on the increase as 180.28 per 1000 in 1953 when compared to 163.82 per 1000 in 1952. In 1952, the advisers from the regional office for South East Asia especially WHO experts on maternal and child welfare visited Madras for the development of mother and child care. The assistance of UNICEF was given to formulate the plan for operation emphasizing improvement and extension of training facilities for different types of health workers and development of maternal and child welfare in rural areas. Women were deputed as medical officers in the maternal and child welfare department. Under the second year five plan, 96 maternity and child welfare centers were sanctioned. Gramasevikas, mukyasevikas, and maternal assistants...
were trained. In 1953, 27 maternal and child welfare centers were opened in Tanjore, Coimbatore, Ooty and Madurai. The maternity centres opened benefited about one and a half lakh population.

In 1959, the Charter for maternal and child health embodied in declaration of right of child was adopted by the General Assembly of the United Nations Organization. There were 1945 maternity and child welfare centres including maternity homes in 1960 as against 1759 in 1959. Of the total 1945 maternity homes and centres, 1659 were located in the rural areas and 286 urban areas. As the maternity and child welfare services in rural areas were very inadequate, the government had opened centres in rural areas only.

The distribution of maternity and child welfare staff in rural and urban areas, shows that maternity assistants and health visitors in rural areas are more than in urban areas. On the whole the total number of maternity assistants under both government and non governmental agencies were 2588. UNICEF supplied drugs and diet supplements through the maternity and child welfare centres as free distribution for infants and mothers. Under long range skimmed milk feeding scheme, 40000 malnourished mothers were fed. Health services to mothers were given in 2984 maternity and child welfare centres by 1967. Government drew a phased programme of opening maternity centre by Panchayat Union in the state and thereby additional centres were opened during 1967-68. Due to increase maternal and child welfare services tangible result was achieved. There was a large fall in infant and maternal mortality. But the services had not reached far flung villages in rural areas due to inadequate staff to meet the needs of the state.

Family Planning Programme

Madras state took steps to implement the birth control programme officially known as the Family Planning Programme to create health awareness among the
mothers. Family Planning training institute was opened at Government Hospital for Women and children where women nurses and men instructors were trained. Family Planning Board was set up under family planning scheme to intensify family planning campaign in the state. To facilitate the public, the scheme envisages the opening of family planning clinics in all districts headquarters hospitals. For the second plan 152 rural and 59 urban family planning clinics were targeted to be opened. The Government of India appointed Smt. Mary Clubwala Jadhav as Honorary Family Planning Education leader for Madras State in addition to Dr. Smt. T.S. Soundaram as the Health Education leader for Family Planning in this state.  

Madras gave a lead in the implementation of family planning crash programme to deal with the burning problem of population explosion. To popularize surgical methods of family planning, the government introduced Madras City Public Employees Family Welfare scheme and a scheme for subsidizing private medical practitioners. The achievement of Madras State Family Planning propagation was praiseworthy. Family Planning Day was observed on the 18th of December 1959. Several states were seeking information on various family planning schemes introduced in Madras State so as to implement it in their states. Madras proved that sterilization programme could produce desired results.

The IUCD programme was implemented in major hospitals. Contraceptives were stocked in Family Planning Clinics and free distribution was made to rural areas. The rural family planning clinics opened in primary health centres in 1962-63 was 123. In 1962-63 the state won the National Award for the second time for its outstanding work in family planning. Even then the programme clashed with other programmes causing damage, partly responsible for setback of malaria and smallpox eradication programme in some areas. Crash programme was launched in the state approved by the Planning Commission and Rs. 62 lakhs was provided by the Central Government to meet the cost of the scheme.
Integration of maternity and child health services with Family Planning led to disintegration of health services and maternal and child health work got neglected. The Family Planning Clinic, Poonamallee served the entire population that covered in their unit. Family Planning Manual copies were circulated to the health inspectors, sanitary inspectors, women medical officers, health visitors and maternity assistants in order to educate them on all technical details of the subjects.

Family Planning nurses of the hospitals were introduced to families in municipal areas through house visits to advise the persons to adopt the surgical methods of family planning and to avail the facilities offered by the government. Women medical officers gave talks on family planning in the clinics. About 119 sterilisations were done in some municipalities on the advice of the public health staff. The programme for the Family Planning Day was carried out in several maternity and child welfare centres. A post of social worker was sanctioned in the centre at Seethalakshmi Maternity Home at Coimbatore. In the primary health centres, health inspectors were proposed to be trained in family planning with the approval of the government.

Chart - 1

Family Planning in India

![Chart showing birth rate and death rate percentages from 1901-10 to 1961-70.]

- Birth Rate
- Death Rate
Curative

General health service is the backbone of public health system. As for the rural health scenario interest in rural health dates back to the deliberation of the National Planning Committee appointed by the Indian National Congress in 1938. The framework for the establishment of the infrastructure for rural health services was provided by the Bhore Committee in 1946. For the first time district level health organization was instituted. Under British rule, rural health services were non-existent. Only some taluk level hospitals and dispensaries were in existence. In case of major epidemics, treatment was provided and vaccination against smallpox was the only public health measure available to the people. During the First Five Year Plan only rural health services were set up and progressed during the subsequent Five Year Plans.

Table 4.3

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<td>725</td>
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<tr>
<td>Subcentres</td>
<td>131,118</td>
</tr>
<tr>
<td>CHC’s</td>
<td>2,128</td>
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<tr>
<td>Hospital Beds</td>
<td>125,000</td>
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<td>Medical Colleges</td>
<td>28</td>
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Medical institutions in taluk headquarters were maintained by local bodies. Due to resources crunch efficient maintenance was not possible. Hence it was decided to provincialise taluk headquarters hospital and dispensaries. Government took over the 24 local fund institutions during 1956-59. Provincialisation of medical officers was done in 1959-60 as people were denied medical facilities due to shortage of medical officers in local fund service.
Socialization of Medicine

Cure of a disease is not complete unless patient becomes readjusted soundly and enabled to resume the normal condition or adjust him to rehabilitate. The industrial worker is now protected by social insurance and certain countries had adopted a national health service.59 For the question about the health care coverage of workers in the organized sectors, the answer was that among the many million employed people, the people employed in organized sector were covered by comprehensive social security legislation including social health insurance. The largest of this was the ESI scheme that provided health security to the employed people.60 It covered all employees employed on any work of a factory.

Medical care to insured persons and to their families is the bedrock on which the whole scheme depends. It is available to the worker from the moment he enters insurable employment, and to members of the families. Full medical care was afforded through provision of outdoor treatment, supply of drugs, X-ray examinations, specialist and ambulance services, ante-natal and post-natal care, indoor and emergency treatment.

Employees State Insurance Corporation was regarded as a symbol of social security in India. Rapid industrialization all over the world stressed the need for protection to working members against risks due to accidents, sickness, maternity, old age, death and unemployment. The Workmen’s Compensation Act of 1923 and State Maternity Benefit Acts constituted a beginning in the path towards schemes of social security. The introduction of Health Insurance for industrial workers came into existence based on the Adarkar Report as ESI Act in 1948. The administration of medical benefits became the statutory responsibility of the State Government under the Act.61
The ESI scheme provides five benefits in cash in event of sickness, maternity, disablement and death and in kind in the form of medical care. Since independence, life expectancy had increased from 27 to 32 years. The ESI and contributory health scheme for government servants was a small step towards socialization of medicine. Outdoor medical care was afforded through service system or the panel system. In areas where service system was prevalent, medical care was given through static and mobile dispensaries under Government personnel, while in panel areas private insurance medical practitioners were in charge. Both service and panel system were in practice only in Coimbatore industrial centre and not elsewhere in the country. In Coimbatore, the ESI scheme was inaugurated on the Republic Day of 1955 by Bhakthavatchalam, Labour Minister, Government of Madras. In Madras, ESI scheme was inaugurated by Dr. Rajendra Prasad, President of the Indian Union on the 14th November 1955. In panel areas, the insured persons were looked after by private insurance medical practitioners of their choice.

Employees Provident Fund Scheme of 1952 provided for the constitution of Provident fund for workers in industries and trade concerns. During 1960 for the first time medical benefits under ESI scheme were extended to the families of insured persons in the areas of Rajapalayam, Sivakasi, Tiruchy, Ranipet, and Cauverynagar. An ESI hospital was inaugurated in 1962 at Madras under Kamaraj ministry. Old age pension scheme was introduced in the same year throughout the state. It functioned satisfactorily in all implemented areas.

ESI scheme was extended to workers and family in twelve new centres and already by 1962 there were twenty centres. In August 1963 foundation stone for the ESI hospital at Coimbatore was laid by the Chief Minister of Madras. South Arcot, Dharmapuri and Nilgiris were newly benefited by this scheme. In 1964, the insured persons and their families in Vellore, Nagapattinam, Vedapatti and Othakkalmandapam
(Coimbatore) and Tirunagar (Madurai) came under this scheme. The panel system under this scheme was vogue only in Coimbatore with medical practitioners. A regular ESI hospital at Madras with 175 beds and more hospitals were sanctioned in various parts of the state. In India by 1964 ESI scheme was in force in all states except Gujarat.

**ESI Scheme at a glance**

**Countrywide**

1. ESIC affords five major benefits—Medical, Maternity, Employment Injury. Sickness and Dependents benefit
2. ESIC served 23.25 lakhs insured persons.
3. ESIC served 20.55 lakhs families (insured) for medical care
4. ESI paid 528.22 lakhs towards cash benefits during 1961-63
5. ESIC share of cost of medical benefit during 1962-63 was 472.24 lakhs.
6. ESI scheme was in force in 151 centres extended to 14 states.

**Statewide**

In Madras state the scheme operated at 24 places covering 250000 insured persons. Two hospitals, 60 dispensaries, 90 panel clinics and 6 part time dispensaries were provided with this scheme. 69.85 lakhs paid for the facilitation of this scheme.

**Mid-day Meals Scheme**

The Midday meals scheme was launched as a voluntary measure in July 1956 under the Director of Public Institution, Madras out of public donation. In 1957 with the financial aid of the Government free midday meals were extended for school children. The credit of introducing welfare measures to provide succor to needy young pupils goes to the Justice Party. Socially backward and poor children were attracted towards school.
P. Thiagaraya Chettiar took initiative for the implementation of midday meals. The Madras Scheme of Free school meals were successful in elementary schools.

More and more schools organized free meals centre. From the funds of the Corporation and public funds midday meals were provided in schools run by the Madras Corporation. The expenditure on the provision of the scheme was shared between local community and the Government. The Headmaster of an elementary school of a particular locality was the ex-officio Secretary to the Midday Meals Committee. More schools organized free meals centres and by the end of Second Five Year Plan nearly 10 lakhs of pupils were fed in all types of elementary schools in the state.

About 25% of the children were undernourished and to improve their health standards the Government made provision for midday meals. CARE gave aid to the scheme in schools in the state. Provision of free midday meals to school children was recognized as one of the incentives to regular attendance. Free supply of food had ensured not only regular attendance but also better enrolment. It was expected to benefit about 17 lakhs pupil by the Third Five year Plan. Under the Harijan Welfare Department, this scheme was also extended to children of communities attending the labour schools of the Government. About 1200 schools were benefited and 8000 pupil received midday meals under the Madras Corporation.

Panchayat Unions evinced keen interest in midday meal scheme being administered by the Panchayat President. In 1966-67 about 1735.53 lakhs was spent on midday meal programme. State government managed the largest school and pre-school feeding programmes in the world. Thousands of school children who were kept off the school on account of poverty by parents were brought into school. Poor children of all communities and creed sat together and ate the same meal, thus caste barriers in the young minds broke down. Thus the midday meal scheme benefited to build up a unified and well-integrated society.
Nutritional Measures

Public Health Department in the state had given important place for the nutrition work. Expanded nutrition programme were implemented in seven select development blocks by the state government. Field surveys were conducted in the state to find out food habits of the people. The nutrition programme financed by United Nations Children Emergency Fund with Rs. 13 lakhs grant stimulated production of eggs, milk, vegetables and fish in selected villages. In the distribution of milk, needs of the food deficit and drought affected areas were considered. Large quantities of milk powder were placed at disposal of the Government civil supplies department for distribution through Collectors of affected districts. Five nutritional exhibitions in 1947 were conducted and dietary investigation in 1600 families especially children were examined. In the urban, semi-urban and rural areas about 440 families under low income groups were studied. In South Kanara, nutritional exhibition were organized in 1948. In 1949 four nutritional exhibitions were conducted, pamphlets distributed and the health nutrition officer demonstrated on Food and Nutrition. In the following years too the diet surveys were organized and nutrition propaganda was done.
Frequent exhibitions, publication of articles on current problems, radio talks, educative talks and lectures on nutrition showed the strenuous efforts of the health officials in solving the nutritional problems. Samples of milk were taken for bacteriological analysis at the government milk factory, Teynampet. The UNICEF provided skimmed milk powder which was distributed in 1954-55 to expectant and nursing mothers, infants and children throughout the state. The regional nutritional units at Trichy and Anantapur were shifted to community projects.

In Madras, Panchayats were responsible for implementing the Applied Nutrition Programme. The ANP with the assistance of UNICEF, FAO, WHO aimed at increased production of food, fruits, vegetables, fish, poultry, milk and education of villagers. By the second five year plan, scheme for the employment of dietitians and special diet kitchens in hospitals was proposed. The government proposed to start a separate Food Laboratory at Madras. District Food Analysis Laboratory was set up in Madras, Madurai and Thanjavur under five year plan. About 25000 samples were taken per year under Food and Adulteration Act. For quality control of foodstuffs, regional control laboratory was inaugurated at the Rajaji Hall, Madras on 20th October 1962. Subsidised rice had been given through the Food Corporation of India since 1965. The Chief Minister K.Kamaraj stated that initially quality control measures would be inconvenient to producers and merchants. In the late 1960s, USAID embarked on a survey into the nutritional status of the people of Tamilnadu. It showed that its people had the lowest calorie supply, high intensities of poverty and problematic food behaviour.

**Promotive measures**

Certain measures were adopted to promote health of the society by providing the very essential nutrition for the entire population and thereby combating the evils of ill-health of the people.
Dairy farming

Employment to rural and semi urban population was possible due to the establishment of milk societies. Dairying provided work for number of ex-tappers and ex-addicts. Milk supply societies and unions were formed in certain districts of North Arcot, Tanjore, Tiruchirappalli, Anantapur, Bellary, Malabar, Coimbatore and Chittoor. In the diet surveys conducted in Madras, non-consumption of milk was recorded. To overcome the non-availability of milk and to solve milk problem, milk colonies were set up. About 1500 feeder societies in 600 villages of Chingleput provided tested pasteurized milk and distributed it at a fixed rate.

As a Government venture toned milk scheme was inaugurated in 1955 by the Madras State Agriculture Minister M.Bakthavatchalam and the Chief Minister K.Kamaraj. Madras Milk Colony at Madhavaram was established in 1959 with an expenditure of Rs.108 lakhs during the second five year plan. Dairy development project prepared scheme for setting up two milk powder and butter factories and pasteurization plants in the cities. Toned milk and skimmed milk were made for supply to the government institutions like hospitals, jails and to the public through house delivery. These measures not only supplemented nutritious milk but created awareness towards the consumption of milk for better energy.

With the aid of UNICEF, Madurai milk project was activated in 1967 to produce 5000 litres of low fat milk and sold at subsidized rate. Pasteurization plants were also opened at Tiruchirappalli, Tanjore, Tiruppur and Chidambaram.

Food production

Expansion of agricultural credit and cooperative farming activities were undertaken to increase food production. Khariff crop campaign was started by cultivating paddy, cholam, kambu and ragi. Since independence strides made in
agriculture to be self sufficient in food grains. In rural areas, social inputs like health, sanitation and education were emphasized by the Green Revolution which changed the life of the rural people. On account of food scarcity to prevent epidemic diseases in the state the Director of Public Health proposed a scheme during the first five year plan. Areas with high production of food grains are high in fulfillment of calorie and protein needs. During the famine conditions that prevailed in North Arcot, Salem, Coimbatore and Ramanathapuram districts it is to be noted that paddy crops in deltaic areas had only survived.

Grow More Food campaign launched earlier in 1947 had the notion to increase the area under cultivation and acre yield of grain. It was started to secure self sufficiency in food with huge investment. Accelerated wells subsidy scheme of 1946 followed by new wells subsidy schemes sanctioned for the construction of new wells and repair of old wells. A three year plan (1949-52) was in operation for the renovation of the existing irrigation tanks. Under this plan, 7000 tanks were taken for repair work. Public Works Department had taken up the construction of small irrigation schemes throughout the state. To encourage irrigation, oil engines with pumpsets and electric pumpsets were supplied to agriculturists. Measures were taken to increase the yield on land by improved methods of cultivation. To combat the food problem and to retain the food position of the state the government had putforth certain stringent action. But as a sort of permanent remedy to the food problem and to put an end to the deficiency problem long term measures were also suggested.

In this regard, Dr. M.S. Swaminathan Research Foundation, Taramani, Madras did meritorious services. New discoveries and inventions were made in the sphere of method of agriculture and seeds. The introduction of tractor in agriculture and fertilizers and new manure raised the volume of yield in agriculture sector
Fisheries

Fisheries as an anti-malarial measure and nutrition supplement to the people showed great development. It created employment to youth in rural and semiurban areas. Balanced nutritious food supplied to the people had brought about socio economic equity. Attention was paid to develop fisheries both in land and in deep sea to augment food supplies. The reorganized fisheries department through its pilot scheme and fisheries cooperatives aimed at providing 80000 tones of fish in 1950-1952. Under Grow More Food Programme, scheme for development of Mettur Stanley Reservoir to supply fish to Salem and Dharmapuri was formulated. Development of fisheries was to maximize fish production to supplement the diet of the population of the province.

In 1955, Fisheries Department decided to grow fish in villages. In urban areas, fish supply was planned to be improved through local fisherman cooperatives and initiative for fish marketing was made. Due to natural calamities like cyclone and sea erosion in 1957 fisheries were affected. Under the fishery programme, modernization of fishing industry was done in 1964. Crash programme to increase fisheries in 1965-66 had been undertaken. In Tiruppur and Chidambaram fisheries were developed in 1966. After 60’s rapid strides in the development of this sector were made.

Health Legislation

Public Health laws are as essential as security laws in a welfare state. Health legislation varied from state to state and was passed for the advancement of Public Health in the province. The Madras Public Health Act of 1939, the first act on the statute book empowered the government to inspect, control and superintend the operation of local authorities. A brief description about this act is given already in the first chapter. Since independence a number of acts were passed.
Under the Nursing Council of India and by the Indian Nursing Council Act of 1947, the nursing candidates were registered. The Madras Drug Control Act 1947 controlled the quality of drugs both imported and locally manufactured. In the year 1948 four laws pertaining to health were passed. The Pharmacy Act of 1948 constituted for uniform control and guidance of Pharmaceutical practice. The Employees State Insurance Act 1948 was the first step proposed towards the goal of providing complete health service. The Dentist Act was passed in 1948 under the Dental Council of India for the registration of Dentist. The problems of physical health and safety of workers (industrial health) were dealt with by the Factory Act of 1948. In 1950, Madras Prevention of Adulteration Act was amended and was in force in 95 municipal towns and 141 panchayat boards. As a result, mixing of pulses and flour were prohibited. The Madras Public Health Act was made compulsory. For the health of workers Mines and Quaries Act of 1951 was passed. The Drug and Magic Remedies Act was introduced in 1953 by which advertisements, labels, cartoons relating to the treatment of diseases were scrutinized. Drugs and cosmetic act empowers states to recognize practitioners other than MBBS holders to provide a range of medical care services.

The Central Council of Health tended to enact comprehensive health legislation in the country and recommended to draft a Model Public Health in 1955 to suit the local conditions. The Madras Slum Improvement Act 1954 was passed with the intention of extending government financial assistance depending on merit of individual scheme. Medicinal and Toilet Preparation Act 1955-1964 – Registration of Practitioners of Integrated Medicine in Tamilnadu was legalized by the passing of the Tamilnadu Act No.XXVII of 1956. The Maternity Benefit Act for the year 1958, 1961 benefited the pregnant women. The Panchayat Union was responsible for the establishment and maintenance of dispensaries which was finalized by the Madras Panchayat Act of 1958.
The Madras Public Health Act of 1959 was passed by the first Congress Ministry. This act formed the bedrock of present system of Public Health. Madras Parks Playfield and Open Spaces (Preservation and Regulation) Act of 1959 legislated for preservation of park playground and open spaces in the state to safeguard and promote health of the future citizens. Madras Nurses and Midwives Bill 1960 were brought to extend the Act of 1956 to transferred territory (Kanyakumari district) and Shencottah taluk of Tirunelveli was made. The Drugs and Cosmetic Act 1964 was to regulate the import, manufacture, distribution, and sale of drugs and cosmetics. Legislation has been enacted in 1966 to prohibit quack medical practice.

**Five Year Plans**

The adoption of the First Five Year Plan of Planning Commission by the Union Government was integrated with State five year plan to cover period from 1951-52 to 1955-56. The partition crisis and government concentration in resettlement of refugees forced a delay in the health plans.

### Table 4.4

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<th>Year</th>
<th>No. of Schemes</th>
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<td>1953-54</td>
<td>46</td>
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(1953-54 relates to residuary state (formation of Andhra on 1st October 1953))
Health expenditure by 1962-63 – 20.81 lakhs


The First and the Second Five Year Plans legislated for pilot programme rather than nationwide schemes for rural housing and improvement in sanitation. In the First Five Year Plan, urban water supply and drainage were taken up. Government gave loans to municipalities for taking up such schemes. It was executed by Public Health Engineering Branch. About Rs.141 lakhs were spent on the scheme. Srivilliputhur and Palayamkottai municipalities and Valparai Panchayat, Erode and Tiruppur had been provided with protected water supply system. Funds were also allotted under this plan for community development project in rural areas where adequate medical facilities were not available.

In the Second Plan, increased allotment was made to urban water supply and sanitation and rural water supply schemes. Rupees 600 lakhs were spent on water supply schemes. After the two plans, 16 municipalities and 136 major panchayats had protected water supply. An adequate water supply and drainage were needed for industrial expansion. Improvement of soil sanitation in rural areas has been implemented by inculcating in the minds of villagers the habit of using private latrines under the second five year plan. Also in the second plan provision for medical inspection of one and a half lakh of school children were made. Towards the close of the Second plan, progressing health was assessed by the Health Survey and Planning Committee. Under the leadership of Kamaraj, Madras State had utilized the funds allotted to it and exceeded them in implementing the two five year plans. The Second and Third five year plan legislated for pilot programme rather than nationwide schemes of rural housing and improvement in sanitation.

During the Third Five Year Plan, under the health schemes the Malaria Eradication programme, Smallpox eradication programme, control of guinea worm,
yaws in Coimbatore district and other communicable disease like cholera and tuberculosis were formulated. BCG campaign which was launched in the state switched over from mass vaccination to select vaccination. To promote health of the school children, medical examination in secondary and elementary schools in selected areas were conducted. Immunisation of pre school children and organization and establishment of the Public Health Laboratory and Kings Institute were some of the achievements of the Third Five Year Plan. Under the plan 10 crores were allocated towards water supply in all municipalities.

Among the first three five year plans which attempted to protect the agricultural population from rigours of industrialization the second plan was exemplary. It revised priorities in health and highlighted the importance of monitoring and systematic evaluation.\(^92\)

After Independence, effective programmes for controlling diseases as well as steady improvement in public hygiene and nutritional status of the population led to the substantial control of epidemic diseases.\(^93\) After 1947, the State focused attention on the expansion of basic services, medical personnel, provision of free basic health care, facilities for primary health care and priorities for water supply, sanitation and control of communicable diseases. India’s Five Year plans and National health policies since 1947 lamented the shortage of doctors in rural areas.

The administrative structure had been simplified and streamlined with the aim of integration of promotional, preventive and curative services. But still the health status of the people had not been improved. It is only in the hands of the government to formulate detailed plans, allocate needed resources and implement a time bound programme of action.

The Government of Tamilnadu allocated a substantial amount to provide medical facilities in the rural areas. Reorganisation of medical services cannot be achieved
without the full participation of the state. The medical aid given to the public through charitable and voluntary agencies could not reach the masses without adequate financial support. Inspite of the availability of treatment facilities, in many of the tropical diseases preventive programme have been activated in reducing their incidence. The fact was that most of these drugs were beyond the reach of poor patients. In future, effective and cheap drugs for the treatment of the poor would reduce the death rate as vast majority of sick population consisted of the poor people.

Any amount of public finance spent in the fight against the diseases is bound to pay large dividends by way of better health and greater productive capacity of individual. Government should have found it necessary to postpone their schemes of medical expansion for want of money. Legislative measures alone will not solve the problems unless the public appreciate the value of sanitary measure. Doctors in private practice are contented with their life in towns and cities. Co-operation and mutual understanding between the health workers and the general medical practitioners will provide a way in promoting public health and welfare. Even though the Congress Government did a lot of humanitarian services in health and family welfare schemes, the amount of work could not reach the rural areas where the health and nutrition conditions were poor.
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