Comprehensive Health Services and Non-Government Organisation
Chapter - 6

COMPREHENSIVE HEALTH SERVICES AND NON-GOVERNMENT ORGANISATIONS

Comprehensive health service means providing Public Health services to all the people with the help of Government and non Governmental organizations to create a healthy society. For that, the government took a series of measures not only through various schemes but also with the five year plans. Accordingly, rural health services were evolved in every nation within the framework of global trends. Excellent design for the development of rural health was given by the Bhore Committee. It gave emphasis to comprehensive rural health service which was to be tackled. Primary Health Centres were created to provide integrated preventive and creative devices to the rural population. Following Bhore and Mudaliar committees, enormous network of primary health centres were set up to provide basic health services to the rural population. Since independence health network in India riveted to institution of Primary health centre envisaged as service point for preventive and curative health for each development block.

The welfare commitments incorporated in the Indian constitution envisaged the ensuring of good health of the people. The Community Development Programme launched in 1952 as a part of first five year plan aimed at tracking triple enemies of progress: poverty, ignorance and ill health through comprehensive and integrated approach.

Government was responsible in bringing primary health care to semi-urban and rural areas in an effective manner through hospitals and dispensaries. Under postwar reconstruction scheme, 30 primary health centres were opened in 1947. The introduction of Primary Health Centres with subsidiary centers in
1952 changed position in rural areas. Though primary health centre were started there was no expected progress in the already opened centres. It was established in Community development blocks in 1953 with the aim of basic health services to the people. The rural medical wing scheme was inaugurated by K. Kamaraj in 1956. In the villages, primary health centres were selected for rural dispensary and were opened in North Arcot, Coimbatore, Malabar and Guntur. To serve in the primary health centres, the post of medical officers was sanctioned.

The effective implementation of the government depended on supervision and control of district officers. The peripheral health organization were set up at three levels namely villages, units and block levels. Within district, each block had a community health centre (CHC) with 30 bedded hospitals. Within each block, 3 PHCs were established for a population of 30000. In the health sub-centre, there was one male and one female health workers. The female health worker was the auxiliary nurse midwife. In village Anganwadi workers provide health and nutrition to women and children. The public sector of the health care system in India is a three tier structure comprising of public health centres, sub centres and community health centres serving the semi-urban and rural areas. In modern medicine general trend was to emphasis on preventive medicine to improve general health standards. For this, community minded and preventive approaches were required to meet the needs of our state. To deal with the public health problem and medical needs of the rural areas, Primary Health Centers were opened to provide integrated preventive and curative services.

In Tamilnadu, thirteen district health officers and two district health and family welfare officers functioned. At the village level, Gram Panchayat, an agency for planning and development in villages, covered the entire administration, sanitation, public health, social and economic development. With the establishment of primary health centre and the sub centres health personnel like basic health workers,
vaccinators and paramedical staff were involved with the task to improve the situation. For the betterment of health, staff were employed in PHC and their pay scale was revised.6

There was scarcity of trained male nurse, hence auxiliary nurse cum midwives were appointed in Primary Health Centres. In all 374 blocks in rural areas a PHC was opened for each block which brought the number of PHC to 125 with FP centres. Problems of rural medical relief were felt as 75% doctors in were urban areas. There were 428 rural dispensaries of modern medicine established by 1950 and 85 of them were closed due to lack of rural medical practitioners.7 Post war plans were organized on twenty years basis.

Plan period allotment
Health services –Rs.140 crores –I plan
Health services –Rs.274 crores –II plan

Each province was authorized to select its own sanitary commissioner later called as the Director of Public Health. The allocation of health officers at district and municipal level was to be decided by provinces and its implementation was prevented partially by the outbreak of the Second World War. Primary Health Centre is a multipurpose unit established at peripheral level to form the nucleus for the general social and economic development of community. It differs from place to place depending upon type of diseases, availability of qualified personnel, priorities set up in health field, need and extent of active community participation. The absence of PHC and medical attention rendered people to the risk. Since dawn of independence, both Union and State Government decided to provide health and medical services to rural population. In the early 50’s, PHCs were established for each development blocks and government laid emphasis on the people’s participation in its establishment.

Progress through people’s participation has been observed by the First Five Year plans. Both Union and State Government had put-forth its efforts to provide
medical and health services to the rural population of the country. Concentration on hospitals was expensive and cooperation schemes between government hospitals and Municipal Corporation at Madurai were started for the treatment of TB patients. More beds were required, because at time artificial treatment were only available. A cooperative plan for treatment of TB evolved in 1950 in Madras.

Community welfare was not a part of interest of the citizen of India since 1947. Seven D’s bedevil the implementation of primary health care and they were:-

Diet → people eat what they like.

Diarrhoea → protective water supply

Disease → community was not aware of serious diseases.

Distance → doorstep and hospital.

Doctors → no proper trained medical men of health – need of qualititive change in training and out look and not quantitative increase doctors.

Drugs → importance of graduates on PHC – doctors clear about basic drugs was needed.

Democracy → UK has socialized medicine – provide primary medical care as general practitioners delivered primary care. Under the second five year plan expansion of existing medical institution and opening of new institution were carried out. Opening of primary health centres were initiated in the places like South Arcot, Salem and Coimbatore where no medical facilities was available. From 1963 the supervision of PHC were entrusted to District Health officers in the Public Health Department. Under the Director of Public Health, the planning and development in various departments the progress of health schemes were laid.
During the Second Five year Plan (1956-61) the government of India made an agreement with WHO and UNICEF for the development of rural health services. The master plan operation was formulated for the development of health services in community development areas. The Community Development Programme from 1958 was revised. The programme of opening primary health centre under community development programme and under health ministry programme were clubbed together. Fifty four centres were opened between 1956 and 1959 under Community Development Programme and twenty eight more were opened by 1959-60. Minimum health programme for each development block was the opening of PHC.

Before the primary reporting agency was village head man for cases in rural areas. In urban areas municipal health authorities rectified the cases. There were defects in notification like delay and in accuracy in reporting cases. The defects were only noted after damage and miss reporting of small pox as of chickenpox and Cholera as of diarrhoea had occurred. In 1965, ESI Corporation took beds in mission hospital and cost was reduced to Rs. 7 per bed a day. The central government of health meeting convened in October 1967 studied the above process and recommended present system of reporting through health workers. The PHC health workers responsible for reporting outbreak of epidemic diseases in main areas and Medical Officers of PHC must coordinate the report at block level.

By the end of the Third Five year Plan, 220 primary health centres were to be established. For each Community Development Block, there was one PHC under Third Five year plans. 31 PHC's were sanctioned but implementation was deferred due to lack of finance. One of the major problems confronting the PHC was the absence of doctors. Problem of medical relief in rural areas was difficult due to paucity of doctors willing to take up appointments in rural areas. A number of dispensaries of modern medicine remained closed during 1953. Another step of Madras Government was provision of mobile dispensary to limited extent.
UNICEF offered assistance to PHC’s in the form of jeep and equipments. Under Government of India Health Ministry Scheme, eighty primary health centres were opened. Each PHC will have Medical Officer, one health visitor, one health inspector, four maternity assistants, one pharmacist and other auxiliary staff. Additional PHCs setup in the National Extensive Service Blocks extended facilities for integrated form of medical and health services in rural areas.

**Health publicity**

Health Education is one of the important planks in fighting public health problems among illiterates. Staff attached to health propaganda and publicity scheme for execution of various work were reorganized as health Education bureau. For these works, health officers, lower division clerk, steno typist, attenders, peons and cinema operators were appointed. Activities were published through pamphlets, posters and radio talks, films and leaflets on health subjects. Pamphlets in English, Tamil, Telugu and Malayalam on control of epidemics were also circulated to the people. Hoardings and leaflets prepared by health authorities sensitised people on methods to prevent diseases. Do's and Don't's to be followed by the public to prevent contact of diseases from affected person were informed.

In 1949, propaganda on health was broadcast in the All India Radio with the talks given by the health minister. As a part of health propaganda a documentary on leprosy produced by film division, Ministry of Information and Broadcasting, Government of India were screened in all cinema theatres. Health Exhibitions were conducted at Madras, South Kanara, Madurai and Tiruparankundram. Public Health bulletin was a journal to keep officers of the health department informed of the development of Public Health. Central Public Human Resource organization brought leaflets pamphlets, folders, bookmarks and picture posters. The Heads of the schools and Teachers were requested to display health slogans like Beware of fly to draw attention of students as a matter of health.
Maternal and child welfare, control of communicable disease and food nutrition were made available for public. From first five year plan health education and publicity was undertaken to create health consciousness among the people. Health publicity item was designed, printed and supplied to local bodies and Block Development Officers. Disney cartoons, sound films, and copies of film on TB were printed. The Publicity Campaign organization in 1957 carried out health publicity for leprosy. Due to the vastness of rural areas, economic distress and over population there was need of voluntary efforts to support and supplement government action.

**Non Government Organization**

Tamilnadu has a strong tradition of voluntary non government organization. The most important aspect of voluntary effort is that it provides a set of action research models for community care. These agencies operate alongside the governmental system. There are a number of nongovernment organisations which are engaged in primary health care. Voluntary health services were the first non government organization to introduce concept of prepayment (health insurance). Health had direct effort on economic growth with the community infrastructure on economically viable society.

There are countries in which the government takes the responsibilities of health care of the people as in USSR, UK and New Zealand. In USA health services are organized at federal level with Surgeon General as head and the states are autonomous. In UK health ministry is centralized. Local authorities are responsible for medical and health matters in Italy. The Union Ministry of Health centrally administers public health in USSR. The above systems are selected and tried to be incorporated to suit the Indian condition. The heavy mortality caused by the outbreak of epidemics awakened the government to the need for more state participation. Madras state had gone through many incidences of diseases since independence. It was in the hands of the government to bring about effective measures in the form of policies and programmes at national and state level. During the
Second Five Year Plan (1956-61) an agreement was made between the Government of India, WHO and UNICEF with masterplan operations for the development of rural health services in community development areas.²⁴

Community health and Education development combines input for community health

![Diagram](attachment:diagram.png)

Single uniform delivery channel for rural or urban rich or poor.

**GREEN TRIANGLE OF PHC**

- **A** Govt (central & state) community, health Education and bureaucracy
- **B** Local bodies, political will and participation
- **C** Professionals doctors, drugs village health guide, paramedical workers

The above Triangle indicate that community must go ahead with concern for the health.
International Agencies

After the establishment of United Nations Organization in 1945, the World Health Organization was created as an international agency with its activities like prevention and control of disease, strengthening health service, collection of health statistics, health information and co operation with other agencies. The WHO and other international bodies highlight the threat posed by vector borne diseases to India. The Government of India is an active member of WHO, UNICEF, Colombo Plan, CARE and other agencies that found within the framework of national health services.

World Health Organization

WHO assisted projects were planned for the development of health and sanitation services. Research supported by WHO was directed to the solution of problem in developing countries. Vector control, communicable diseases and nutrition were given high priority in the research. Distribution of informational and educational material on the epidemiology, bacteriology, treatment and control of diseases were prepared by WHO. Attention was paid to the organization of rural health services and to the integration of mass campaign against communicable diseases. In the general health services, international cooperation in health matters had found recognition in the constitution of WHO with governments of the world and medical associations of different countries. WHO helped in preparation of the BCG vaccine and on training our doctors in the technique of its administration.

Nursing and midwifery training played an important role in the WHO programmes. Extension of small pox eradication activities in a number of countries under the intensified world programme and development of epidemiological surveillance were some of its activities. The World Health Organization rendered help to India for the eradication of malaria, tuberculosis, venereal diseases, cholera,
plague, and improvement of maternal and child health. The activities of various state government and the international agencies as mentioned above were coordinated by the Indian government.

The constitution of the World Health Organization came into force on 7th April 1948, and the seventh April was celebrated every year as world health day. Throughout India, the world health day was celebrated and widest publicity was made by state with the theme “know your own health services”. Health section of the League of Nations, contributed to enhancing education of health personnel. WHO considered education and training as fundamental functions from its very first day. Rajkumari Amrit Kaur was the First Women President of the WHO who had involved with social activities and guided the health authorities in health aspects. During the World Health Assembly held in 1954, Dr. Lakshamanaswamy Mudaliar had pointed out that wars had caused loss of lives and the main aim of WHO was to remove sufferings and promote health. Agencies like UNICEF, WHO, CARE, humanity association provided milk supplement and carried out school feeding programme.

UNICEF

With the assistance of UNICEF, developing countries had met the needs of children and youth health activities, immunization, rural water supply and sanitation. In India, UNICEF assistance was received in the form of milk powder, production of vaccines and sera, health equipments, education and publicity materials. For the immunization programme, vehicles, syringes, needles, health education publicity materials and vaccine were supplied. Milk medicine programme to combat malnutrition was initiated by UNICEF. It supplied about 24000 tons of milk powder and 4155 short tons of rice to 10 lakh children and mothers all over the state. Multivitamin, shark liver oil and yeast tablets were supplied during 1950 and free gift
of skimmed milk powder was supplied to malnourished children under 12 years. Nursing and expectant mothers had taken advantage such programmes. The United States Agency for international development helped India in malaria eradication programme, medical education, health education, family planning and environment sanitation. There was an active famine in the state in 1951. Milk powder, multivitamin tablets, food packets butter, cheese, wheat, and beans were distributed to poor and under nourished children and nursing mothers throughout the state. The donor countries were Canada, Australia and Sweden. Private medical institutions were given maintenance grant.

History of UNICEF Programmes in India: Milestones – 1949-59

1. Milk feeding programme to refugee children by UNICEF assistance.

2. India’s first Penicillin plant established at Pimpri at 1949.

3. First DDT plant to supply for National Malaria Eradication Programme by the Government of India.

4. Massive campaign on vaccination promotion. The first Governor General of India backs the campaign and programme assisted by the UNICEF together with United Nations.

5. In 1951, five anti TB centres were established and Madras was one among them.

6. Maternal and child health activities were intensified from 1952-54 when the government of India adopted the National Eradication Programme for rural areas, later termed as Community Development Programme.

7. In 1963 Water supply schemes in India were introduced with UNICEF entry. Applied Nutrition Programme was introduced in 1963. India signs with UNICEF and its sister agencies WHO and FAO.
Non-Government Organisation

Health was considered as a personal responsibility and thus the involvement of the voluntary agencies in promoting health practices and medical care services remained active. These services received impetus when community medicine was established by Gautama Buddha and his son Rahul by a network of hospitals. In due course of time the system of community medicine was revived on modern lines. During the British rule it was the voluntary bodies that organized charitable dispensary to provide medical care to rural people.

Voluntary organization included voluntary agencies, private voluntary organization, private non-profit sector, voluntary development, people organization and non-governmental organization. About 135 voluntary health services were started to provide medical help to low income groups. It is a non profit society run by doctors and leading citizens with the aid of the government and community task supplying facilities for medical relief, medical research and education.

The Indian Red Cross Society

The society, established by the Act of 1920, looked after the welfare services, teaching of occupation, relief of distress and rehabilitation of maimed and infirm. The Madras State branch of Indian Red Cross Society gave grants to maternal and child welfare centres, anti venereal works, supply of food, milk powder and medicine tablets. Free maternal and child health centres were manned by the society. Urgent problem of the day were covered in addition to distribution of nutritional aids, medicaments, hospital comforts to various organization and institutions. Training of the public in medical, social and allied public health work were also undertaken.
Activities of Voluntary Organization

Voluntary system played an important role in India’s social history with its root in social reform movement. Gandhi’s call for voluntary work during 1920 for betterment of poor gained momentum in 1930 and 1940’s. In the following years response were created to crisis such as drought, flood famine to provide relief and rehabilitation. This led to rise of philanthropic and charity oriented organization on religious stream and non-governmental organization. Non Government Organizations in Tamilnadu were registered under Societies of Registration Act 1860.

Voluntary organization like Red Cross, Nurse Association and Private charities had their coordinator and administrator as local health officer trained in medical and public health. It sustained interest in the work of maternal and child health schemes which deserved financial contributions from funds of government and local bodies.

Leprosy Relief

Leprosy relief in Madras state started with the establishment of colonies by the various Christian missionaries who took the leading part in the work. The District TB Association undertook construction of TB Sanatorium at Capper Hills, Cuddalore. By 1950, there were 17 leprosy institutions housing about 3226 cases. Though no mass leprosy control work was undertaken before 1955, the following sanatoria were in existence:-

Central Leprosy Teaching at the Research Institute, Thirumani, Chingleput (Central Government)

Government Children’s Leprosy Sanatorium Ethapur, Salem district

Government Gandhi Memorial Leprosium Tholurpatti, Tiruchirappalli district.

Sacred Heart Leprosy Hospital, Sakkottai, Kumbakonam.
Debendranath Mallie Leprosorium, Vedathorasalur, South Arcot district, Schieflichin
Leprosy Research Sanatorium, Karigiri, North Arcot district.
St. Joseph's Leprosy Home, Arokiapuram, Tuticorin, Tirunelveli district
Holy Family Hansenorium, Fatimanagar, Tiruchirappalli district
Dayapuram Leprosy Hospital, Manamadurai, Ramanathapuram district
C.P. Memorial Leprosy Hospital, Colachel, Kanyakumari district.

**National Health Association of South India**

This association carried out health education campaigns and was responsible for bringing a home called Daya Sadan at Perambur where diseased destitutes were accommodated. A leprosy home was organized by Daya Sadan at Villivakkam, Madras for hundred persons. Leprosy patients from slum areas were admitted, treated and provided shelter. The Guild of Service took responsibility in the field of social work in the cities and districts. The members of the guild visited the Beggar Home at Melappakam. The Government of India gave grants to participate in the control programme and about 37 voluntary organizations throughout India received such grants. By the fourth plan, 40 more voluntary agencies were given grant.

**British Empire Leprosy Relief Association (BELRA)**

It was the only voluntary organization and religious institution that undertook leper work. Christian missionary societies first started leprosy asylums to shelter wandering lepers in large numbers. The provincial committee for leprosy relief constituted in 1925 dealt with anti leprosy campaign. The Madras branch of Belra organized the lady Wellington leprosy settlement at Tirumani and it was handed over to the Scottish Mission. The inpatient institution for lepers belonged to the private organization started by the Christian Mission. The church of Scottish mission, Chingleput, had six homes for lepers and a home at Kumbakonam. The government
took over the Lady Wellington Sanatorium and children’s clinic from Saidapet and Ettapur. The Government Lady Willingdon Leprosy Sanatorium was regarded by the Government of India as the best and most organized sanatorium.47

In 1950, the Madras Provincial Branch of British Leprosy Relief Association was dissolved and Hindu Kusht Nivaran Singh was constituted.48 The Bethesda Hospital, Ambur had foreign doctors to serve. Schieffin Leprosy Sanatorium, Karigai and Cheshire Home, Katpadi were opened for Leprosy control. The Danish Mission opened Debendra Mullick Leper Home.49 The Omalur taluk leprosy clinic was run by the Catholic missionary. There were twenty special leprosy clinics in the state owned by voluntary agencies. The presence of more leprosy clinics arrested the spread of leprosy in the province.

Rehabilitation services

Leprosy relief centres acted as rehabilitation centres giving surgical treatments for the reconstitution of hands, feet and face. Polambakkam Leprosy centre was operated by Belgian social workers. It was taken over by the government in 1960. The Belgian Leprosy centre had well equipped facilities for physiotherapy, laboratory investigations, temporary hospitalization and reconstructive surgery. It carried dynamic programme of treatment in Madurantakam taluk and neighbouring areas.50 In the department of surgery and physiotherapy, operations were carried out. In Madras state a good number of voluntary organizations were engaged in control work with the close cooperation of the government. With the change in the conception about leprosy and its control, the voluntary agencies had also undergone a radical change in their methods.

In 1961 new hope was given to the leprosy patients by the training scheme at the Christian Medical College, Vellore organized by Dr. Paul Brand. During the Vellore scheme, it was revealed that the claw-like hands and feet and paralysed eyelids which throughout the ages had been the part of the mutilations resulting from
leprosy were restored by replacing the damaged muscles and tendons with healthy ones transplanted from other parts of the body. Doctors and surgeons from many parts of the Commonwealth had attended the special courses at Vellore and were able to repair the ravages caused by leprosy. Thus an important step had been taken towards the rehabilitation of leprosy sufferers who could thereafter take a proper place in the society. Besides the Christian Medical College and Hospital at Vellore, the Kasturba Kushta Nivaran Nilayam at Malavanthangal, Madras received aid from BELRA.

**Tuberculosis Hospitals and Clinics**

Tuberculosis Association of India, a philanthropic organization, conducted eye camps. Privately organized health insurance scheme were in operation at Madras named Asoka Bihar. Arrangements for total health care for their clients were given. National Health Association of South India gave effective aid to sickly destitute in the city through Anand Seva Sangam, Madras. Voluntary bodies involved in anti-tuberculosis work which included TB Sanatorium in India the highest in TB sanatorium. Three private sanatorium at Arogyavaram, Perundurai and Tiruchirappalli and Wellesley Sanatorium Jail, Bellary were taken over by the government.

**TB Hospital, Nellore**

The Madras Provincial Welfare Fund was started by Lady Nye on the 30th January 1947. On October 2nd 1950, the foundation for the Welfare Fund TB Hospital was laid by T.S.S.Rajan, and in 1952 was handed over to the Government. It was the TB Hospital with 30 beds equipped with modern X-ray plant. At that time TB was on increase and affected poor people found it difficult to get accommodation in sanatoria at Madras and other places. It was expected by the Government to raise it as a 200 bed hospital. Gandhi Memorial Leprosy Foundation under the auspices of Gandhi Smarak Nidhi came out for the first time in India with a scheme for treatment of leprosy patients in the villages. In the endemic states leprosy control centres were started.
Blind Relief

Blindness for the most part was preventable when the people were sufficiently educated to adopt simple precautions and availed of early and proper treatment for the injuries and diseases of the eye. Eye camps were opened by Blind relief mission, Nagpur at Vijayawada and Rameshwaram. Tuberculosis Association of India a philanthropic organization conducted eye camps. The All India Blind Relief Society opened an Eye Relief Camp in Dalmiapuram in the Tiruchirappalli district in April 1947 and carried on relief work. Though facilities were available in the government ophthalmic hospital and in the eye clinics in the district headquarters hospitals private clinics of eye specialists were also founded. Moses Gnanambaram Eye hospital, Coimbatore provided good eye care services. Great mass of poor people could not avail of the services of qualified ophthalmologists. Hence All India Conference for Blind held at Bombay in 1947 recommended mobile ophthalmic units to be provided in every district to carry medical relief to villages. Eye camp in rural areas performed large number of operations with trained assistants. Dr. R.E.S. Muthaiyya, an eye Surgeon started the first Eye Bank in India in 1948 to combat corneal opacity.

Voluntary Health Services

With the aid of the government and community task supplying facilities for medical relief, research and education the voluntary health services were started to provide medical help to low income groups. Many types of voluntary organisations participate on health activities with or without the aid of the government. The Christian missionary charitable institutions run medical colleges with concurrent hospitals and outpatient complex in places such as Vellore where medical care services, education and manpower was undertaken. Christian Medical College, Vellore run by the Protestant American Arcot Mission has updated equipment and
eminent doctors. Various functions pertaining to women welfare guild of services, midday meals to under nourished were performed by the organisation. Activities of the foreign missionaries were a great gift to the state.

A number of voluntary agencies had been running full fledged charitable institutions. With the necessities for providing medical care services for the poor and needy institutions of various dimensions were found on charitable basis. The Indian Council of Child Welfare established in 1952 extended its activities for research in various branches of medicine and gave grants to voluntary agencies. For the opening of hospitals Rs.102 lakhs amount was given to voluntary health services, Mylapore.

Numerous voluntary agencies were interested in the problems of social welfare, public and private institutions activities were continuously intermingled. In 1958 Dr. K.S. Sanjivi, a professor of Madras Medical College founded a non profit society known as voluntary health services to provide medical education and research facilities in rural areas around Madras.

Some missionary bodies and voluntary organisations took active part in items of public health work like tuberculosis, leprosy and maternity and child welfare work. The St. Barthalomeo hospital constructed in 1874 later expanded in the treatment was taken over by the government in 1920. This hospital situated in Ooty was known as the Sait Memorial hospital which performed only maternal services. The early missionaries build up confidence in their very limited medical abilities. The tribal people often sought bandaging, medicines and even inoculations from the German and Swiss missionaries. By the early twentieth century Roman Catholic nuns were also making medicines available and medical work became a regular missionary strategy. Dr. K.I. Simon, a Malayi christian trained in scientific medicine, set up the Ketti Medical Mission in the Nilgiris which remained very active in 1955.
Mission Hospitals were of considerable value during the war years and even today they maintain professional excellence. Till 1966, they were manned by foreign doctors who drew their salaries from abroad.

With the exodus of overseas missionaries these hospitals functioned in India situated in Kotagiri town in the Nilgiri district. The Kotagiri Medical Fellowship hospital was one such hospital where medical works were begun by two English missionaries Miss Vera Noveli and Monica Sutton in 1937 in response to needs of the tribals. In 1941, Dr. Jaffrey, an American Missionary ophthalmologist enlarged the work and now the hospital was referred to as Jaffrey Hospital. From 1942 several buildings were added to the hospitals with the support of the above said medical fellowship hospital. In 1976, the Kotagiri Medical Foundation was formed as a charitable trust serving the tribal population.

Mobile Dispensary

Skipp Van Hospital Committee, Kodaikanal Swedish Mission Hospital, Tirupattur, Ramanathapuram district provided medical aid to people of rural areas. Leprosy Missionary bodies Hindu Kust Nivaran Sangh, Thakkar Bapa Kusht Nivaran, Kasturbai Gandhi Memorial were some of the non governmental organization. Arcot mission, Wandiwash initiated rural medical service of Christian College, Tambaram. Madras Medical College and Stanley rural squads were agencies for voluntary leprosy control. Sri Ramakrishnamath dispensary private medical institution, Mylapore, Madras was given maintenance grant from state for the first time.

During 1954 there was a demand for many dispensaries, as rural dispensaries remained closed. Hence there was ample scope for private and voluntary organization. About fourteen State Insurance dispensaries were established. Some of
them were the Pankaja Mills Dispensary, Coimbatore, Buckingham Dispensary and Carnatic Mills Dispensary, Madras. For the medical benefits of the employees 43 panel doctors were selected and their services were utilized.60

Maternity and Child Health

Health services for care of mother and child should have the top priority in the national health. In 1931 Maternity and Child Welfare services on 80 centers were run by voluntary agencies taken over and run by the state. Maternity and Child Welfare organization has 445 mother and child centres with maternity homes. Madras is the only state in India, which has a Public Health Act under which provision for Maternal and Child Welfare care exists. In 1949 Family Planning Association of India was established by Dhanvantri Rao. In 1950, she along with Margaret Singer started the international Planned Parenthood federation in Bombay. India was the first country in the world to officially adopt Family Planning as government policy in 1951.61

Population policy in India was combined with birth control measure before 1960, for improving quality of life with the help of PH services, especially with mother and child health programme. One of the early supporters of Family Planning in India was R.D. Karve of Bombay who started the birth control movement.62 The Government of India during the first plan period undertook the prevention, control and eradication of disease.

Throughout the state foreign agencies like UNICEF, WHO, CARE, IRCS, humanity association provided milk supplement and carried out school feeding programme. Government sanctioned the free supply of whooping cough vaccine for the inmates of Avvai Home, Madras a charitable institution of Mrs.Muthulakshmi
Reddy from the Kings Institute, Guindy free of cost. Industrial concerns had their own medical care services. With the communicable diseases causing high mortality, people needed immediate medical relief. As the government could not fully satisfy medical care services to the poor and needy especially in rural areas, medical institution on charitable basis has emerged. To fulfill the increased demand of maternity service, maternity home were established.

The UNICEF supplied milk powder, rice to 10 lakh children and for nursing mothers multi vitamin tablets shark liver oil and yeast tablets were given. The Madras Presidency Child Welfare and Maternity Relief Association was a purely voluntary health association with the aim of training health visitors and maternity supervisors and rendering of financial assistance in the employment of trained personnel. Voluntary and philanthropic organization provided finance for maternity and child welfare schemes.

Due to increased welfare services there was fall in the infant and maternal mortality. This is one of the fields of public health services where tangible results were achieved by the provision of skill aid to expectant and nursing Mothers. Population of small farmers, landless labourers and slum dwellers in urban and peri urban areas were reached.

Mahatma Gandhi had remarked that increase in the number of hospitals and medical man is no sign of true civilization. The attention of health ministers was confined to establishment of facilities for curing disease and they should believe that constitution of hospital, sanatoria, clinic and dispensary were the first requirement. "Prevention is better than cure" was forgotten and the defects in the policy of health officials must be realized.
Reference

2. Taylor Carl.C, A Critical Analysis – India’s community development programme, CPA.
3. GO (MS) No.4204, Health. 28-11-49.
4. GO (MS) No.3579, Health. 07-12-1957.
8. Sanjivi K.S., Planning India’s Health updated, 1988, Voluntary Health Services, Medical
   Center. Madras.
9. GO(MS)No.321. Health. 15-02-1965
10. GO (MS) No.2149, Health. 1-7-1959.
12. First Five Year Plan. op. cit., p-54.
17. GO (MS) No.1500, Public Health, 26-4-1949.
18. GO (MS) No.2852, Health, 13-08-1959.
21. GO (MS) No.3400, Health, 16 Sep 1953.
22. GO (MS) No.3434, Health.01-11-1952.
24. GO (MS), No. 3187, E & PHI, 28-10-1959.
32 GO (MS) No. 2542, Health July 6, 1953.
33 GO (MS) No. 3555, Health, 28-09-1953.
34 GO (MS) No. 424, Health, 06-02-1956.
38 Health, Journal, Volume XXXVII, No. 12, December 1954, p. 34.
42 Madras Information, Volume XVV, Number 3, March 1964, p. 16.
43 Madras Information, Volume XIX, Number 7, July 1965, p. 11.
46 GO (MS) No. 3025, Public Health, 03-09-1948.
47 Madras Information, Volume IV, No. 8, August 1950, p. 29.
48 Madras Information, Volume X, No. 6, June 1956, p. 12.
50 Madras Information, Volume XVV, op. cit., p. 21.
51 Madras Information, Volume XVI, Number 9, September 1962, p. 32.


56 Francis W, op. cit, p-255.

57 GO (MS) No.1358, Public Health, 17-04-1951.


60 GO (MS) No.2610, Health, Education & Local Admn, 01-09-1956.


62 Shruti Choudhary, Population health literacy concept content and communication, Northern Book Centre, New Delhi, 2001, p-19.

63 GO (MS) No.3949, Health, 17-11-1953.