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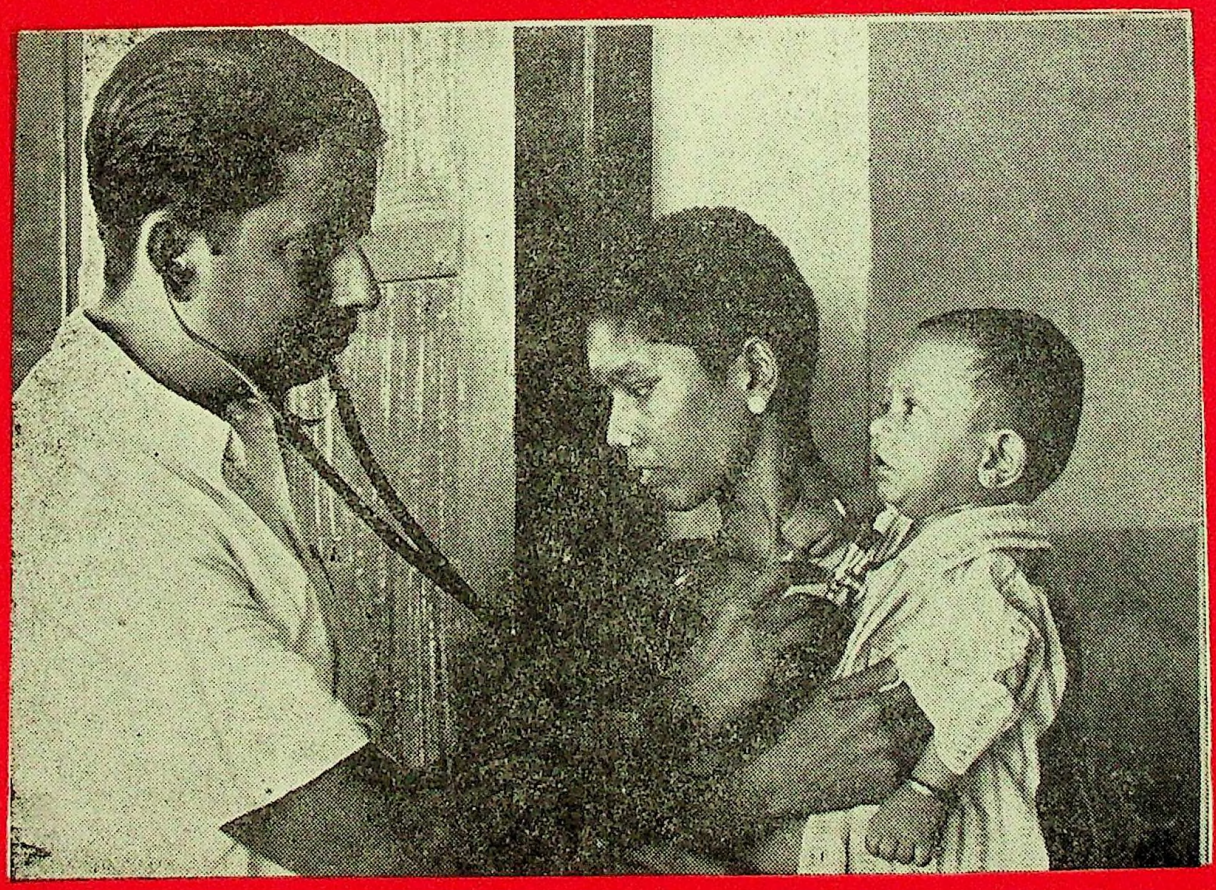

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ASST. EDITOR

D. N. Issar

Sr. SUB-EDITOR

M. S. Dhillon

COVER DESIGN

J. P. Sharma

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In this Issue

SUBSTANTIAL PROGRESS TOWARDS POPULATION STABILISATION

SMT. SERLA GREWAL

PUBLIC health situation remained, by and large, satisfactory in the country during 1984. However, incidence of malaria showed an increase of 18.1% over 1983 and that caused by Plasmodium Falciparum also registered an increase of 12.9%. This was essentially due to the fact that the prescribed three rounds of insecticidal spraying was not done in several States. The attention of the State Governments has time and again been drawn to the need for making adequate budget provision, for timely sanction of schemes as also for timely release of funds to the fields formations so that the three rounds of spraying could be done in the months of May—September with the required concentration of insecticides.

Effective steps were taken to combat the outbreak of dysentery caused by the bacillus known as Shigella Shiga in West Bengal as well as the menace of Viral B Hepatitis in certain parts of Gujarat. The National Institute of Enteric and Diarrhoeal Diseases, Calcutta, helped to identify the Shigella bacillus in West Bengal and the Ministry rushed chlorine tablets, bleaching powder and drugs to the State for controlling the spread of the disease. The National Institute of Virology, Pune, similarly helped the Government of Gujarat in identifying cases of Viral B Hepatitis, and the WHO extended help by procuring vaccines as well as immunoglobulins to protect the public and the medical and para-medical personnel who were particularly exposed to the risk of getting the infection.

Action under the National Programmes for the Eradication of Leprosy and for the Control of T.B. was intensified during 1984-85. All time high financial allocations of Rs. 15 crores Rs. 10.5 crores have been made available for the two programmes. Out of the total estimated number of about 4 million leprosy cases, about 3.2 million have been detected, about 3 million put under treatment and about 1.7 million patients discharged after completion of treatment. In another five years, we should be seeing light at the end of the tunnel. Although Parliament has repealed the Lepers Act, 1898 several States have yet to take similar action with a view to removing the social stigma attaching to the leprosy patients and the disabilities they are put under. Tuberculosis is more easier to detect but more difficult to tackle. Out of an estimated ten million cases (of which 2.5 million are likely to be sputum positive or infectious) a total of 3 million cases have been detected so far. In order to ensure maximum detection of cases, a target of 2 sputum examinations per day per PHC has been prescribed. This would work out to about 600 sputum examinations per annum per PHC or over 3 million sputum examinations in a year for the country as a whole. The progress in this is somewhat impeded by the sizeable number of vacancies in the rank of Laboratory Technicians in the PHCs and the States have been requested to take energetic steps to recruit laboratory technicians. The Central Government has been assisting the States in organising Training Courses for the Laboratory Technicians. The current regimen for the treatment of Tuberculosis extends over 2 years. Case holding becomes a problem since patients tend to start neglecting the treatments as soon as they see improvement in their symptoms. In order to overcome this problems, short-course chemotherapy has been introduced on trial basis which would convert the infectious cases into non-infectious within a short time and reduce the total duration of the treatment to 9-12 months.

Mention must be made of another National Programme, namely, that for the control of Blindness. There is an estimated number of 9 million blind persons, about 55 percent of whom have cataract. The national programme has strengthened the infrastructure at the national, state, district and the PHC level and has been providing financial assistance to Volun-

tary Organisations to carry out cataract operations on a large scale. More than a million cataract operations were performed in 1983-84 alone and at this rate the backlog of cataract cases would be over in the next few years. On the preventive side, the administration of Vitamin 'A' to school going children, as a prophylaxis against blindness, has been taken up in a big way under the Mother and Child Health (MCH) Programme.

Family Planning and MCH constitute the two main ingredients of the Family Welfare Programme. The ultimate aim of the Family Planning Programme is to inhibit the birth rate and thereby the population growth rate and achieve population stabilisation. The figures given below would give an idea of India's position in the Indian Sub-Continent :

Name of the Country	Crude birth rate per 1000 population		Crude death rate per 1000 population		Percentage change in	
	1960	1982	1960	1982	Crude birth rate 1960-82	Crude death rate 1960-82
Bangladesh	47	47	22	17	0.2	—24.7
Nepal	46	43	26	19	—6.5	—27.3
Pakistan	49	42	23	15	—13.6	—34.3
Burma	43	38	21	13	—11.3	—37.9
India	48	34	24	13	—28.3	—46.8
Sri Lanka	36	27	9	6	—25.7	—34.8

(*Source* : World Development Report 1984 published by World Bank).

As a result of further efforts, the Ministry's own assessment is that the Crude Birth Rate (CBR) in India should be around 32.6 per 1,000 population for the year 1984. It may be seen that except for Sri Lanka which had a head start over us, India's performance in bringing about a decline in Fertility Rate and Mortality Rate compares very favourably with those of the other countries of the sub-continent.

The official Family Planning Programme of India comprises broadly two elements namely public involvement through a massive programme of educational campaign publicity and the augmentation of services and supplies in line with the "cafetaria" approach to facilitate the selection of any of the methods that the eligible couples may find suitable or appropriate. The mass media, particularly the Doordarshan and All India Radio are being utilised increasingly for the motivational campaign in view particularly of the fact that the all-too-powerful medium now covers about 70 per cent of the country's population. Spacing methods are encouraged as much as terminal methods and the *two child family* norm is now emphasised. Since child survival is amongst the foremost factors which induce the couple to adopt the two child family norm, MCH programme has been given due importance. Immunisation of pregnant mothers against tetanus and of infants against DPT, Polio and Tuberculosis is the thrust of the MCH Programme. The Infant Mortality Rate (IMR) which was at the level of about 127 or above for a number of years has declined to 114 in 1982.

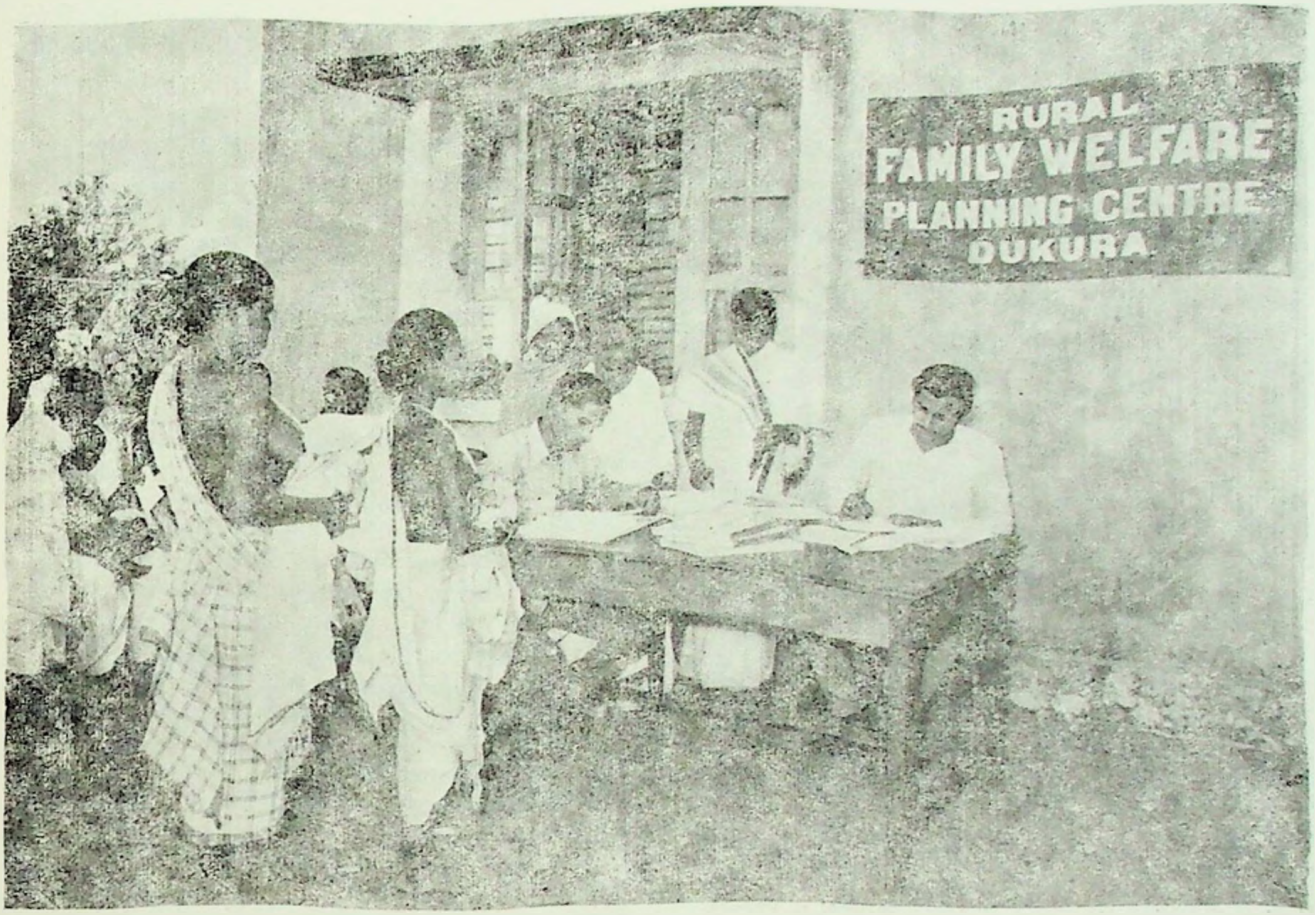
The measure by which the results of the Family Planning Programme is computed is the Effective Couple Protection Rate (CPR). The table would show the vital rates (birth rates and death rates) as reported by the Registrar General and the levels of effective C.P.R. achieved in the different years:

Year	C.P.R. %	Variation in CPR over preceding year (+)(—)		CBR per 1000 population	C.D.R. per 1000 population	Natural growth rate in population
1	2	3		4	5	6
1970-71	10.6	—	(1970)	36.8	15.7	2.11
1971-72	12.4	(+)1.8	(1971)	36.9	14.9	2.20
1972-73	14.6	(+)2.2		36.6	16.9	1.97
1973-74	14.8	(+)0.2		34.6	15.5	1.91
1974-75	14.9	(+)0.1		34.5	14.5	2.00
1975-76	17.0	(+)2.1		35.2	15.9	1.93
1976-77	23.6	( )6.6		34.4	15.0	1.94
1977-78	22.5	(—)1.1		33.0	14.7	1.83
1978-79	22.3	(—)0.2		33.3	14.2	1.91
1979-80	22.2	(—)0.1		33.7	13.0	2.07
1980-81	22.7	(+)0.5		33.7	12.6	2.11
1981-82	23.7	(+)1.0		33.9	12.5	2.14
1982-83	25.9	(+)2.2		33.8	11.9	2.19
1983-84	29.2	(+)3.3	(1983)	33.6	11.9*	2.17
1984-85 (Prov.)	31.6	(+)2.4	(1984)	32.6*		

*This figure is estimated by the E&I Division of the Ministry.

NOTE : *The figure of vital rates (CBR and CDR) upto 1978 do not include those of Bihar and West Bengal, as stated by Registrar General.*

The fact would emerge from the above table that the Birth Rate has no doubt declined but that the Death Rate has declined more steeply than the Birth Rate, what with the better nutrition and health care services as a result of which the life expectancy has risen to early 54 years of age. The Birth Rate would have also registered a sharper decline than it has but for the set-back that the Programme received in the year 1977—80 as would be clear from the table given above. The above table would also bring



Family Planning and MCH constitute the two main ingredients of the family welfare programme. A scene of a Rural Family Welfare Planning Centre.

out the point that the result of the programme efforts of one year in the form of a fall in birth rate becomes visible after a time-lag of one or two years. The National Health Policy lays down the target of 32 births per 1000 population for achievement by 1985. As stated above the Birth Rate, according to the estimation of the Ministry's E & I Division, has come down to 32.6 per 1000 population by 1984. The target of achieving a Birth Rate of 32 per 1000 population by 1985 thus appears to be well within reach.

(Excerpted from the Introduction to the Annual Report of the Ministry of Health and Family Welfare 1984-85)

FAMILY SUPPORT AND THE ELDERLY

The family is the greatest single source of support and the centre of activity for most elderly people. Traditionally, older people are viewed as an integral part of the family, with high esteem and prestige, despite the many forms that the family and its social organization take in different parts of the world. On the one hand, the aging of population has led to the new phenomenon of families spanning four or five generations. On the other hand, the decrease in the number of children, and their dispersion owing to migration and urbanization, means that care for dependent old parents cannot be easily shared by several siblings. Moreover, family care of an elderly person almost always means in effect care by a daughter or daughter-in-law, and the changing role of women and their participation in the labour force further diminishes the chances of family support. This change, seen over the past decades in developed countries, is now occurring at an increasing rate in some developing countries as they undergo social and demographic changes.

From: WHO Technical Report Series, No. 706, 1984 (*The uses of epidemiology in the study of the elderly*), pp. 45—46.

National Malaria Eradication Programme

KEEPING in view the resurgence of malaria the Government of India decided in October, 1976 to undertake a Modified Plan of Operation for NMEP to control the disease and the same has been implemented from April, 1977.

Since the implementation of the Modified Plan of Operation, there has been a gradual downward trend in the cases of malaria in the country as is evident from the following table:—

Year	Blood Slides examined (in million)	Total Incidence	P. falciparum cases
1976	55.98	6467215	753713
1977	57.01	4740900	461484
1978	60.46	4144385	548567
1979	61.42	3064697	558423
1980	66.98	2896000	586438
1981	67.30	2679795	583268
1982	65.03	2182303	551057
1983 (Prov.)	62.20	1932516	549649
1984*	30.97	908096	189495
1983**	31.74	768934	167816

*As per report received upto 30-9-1984.

**Corresponding period.

From the above table it will be seen that there is reduction in both malaria incidence and *P. falciparum* type of malaria which has been achieved in 1983. There is an overall decline of 11.44 per cent and 0.25 per cent in total cases and *P. falciparum* cases respectively during 1983 over the corresponding period of 1982. However, an overall decrease in malaria incidence was noticed in the year 1983 by 70.11 per cent in comparison to the base year 1976.

It is observed from the epidemiological situation of malaria in India during the year 1984 that there is an increase of 18.10 per cent in the total cases over the corresponding period of 1983. Similarly, there is also an increase by 12.90 per cent in *P. falciparum* cases.

Steps to control malaria

To contain the transmission of malaria indoor residual insecticidal spray has been carried out in areas where Annual Parasite Incidence (API) is 2 and above (2 cases or above per 1000 population per year). Stress has been laid for regular fortnightly surveillance in all malarious areas of the country. To deal with vector resistance to insecticides, entomological teams in the zones are engaged to find out alternative solution to the problem. For prompt detection and treatment of malaria cases and to prevent death due to malaria, a large number of drug distribution centres and fever treatment depots are functioning. Surveillance and Spray staff have been are being augmented as per increase in the mid year population. Laboratory services have been decentralised at the PHC level for prompt examination of blood smears and immediate treatment.

Research

Six monitoring teams are working in several parts of the country to identify the *P. falciparum* sensitivity to Chloroquine. One team is working to undertake testing of alternate drug wherever resistance to Chloroquine has been detected in the *P. falciparum* strain. In established *P. Falciparum* Chloroquine resistance areas the drug regimen has been changed and cases are now being treated with alternative drug like combination of Pyremethamine and long acting sulpha.

People's Co-operation

Under the Modified Plan of Operation, Health Education has been made an integral component to seek public cooperation. The Village Health Guides are already involved fully in the anti-malaria work.

Training

To implement the Modified Plan of Operation, training in malariology has got paramount importance.

Laboratory services have been decentralised at the PHC level for prompt examination of blood smears and immediate treatment. A blood smear of a patient is being taken.

The National Institute of Communicable Diseases. Delhi, is conducting malariology and malaria entomology courses for the officers engaged in anti-malaria work in the District and above. In 1984, two courses in Malariology and one in malaria entomology were conducted in which a total of 71 participant received training.

The Budget provision and estimated expenditure under 50 per cent Central share is given in the following table:

Year	Budget Provision	(Rs. in lakhs) Estimated Expenditure
1980-81	4450.00	3350.58
1981-82	5107.31	5460.85
1982-83	5500.00	5511.14
1983-84	5900.00**	6883.33
1984-85	8400.00	—

(An additional amount of Rs. 10 crores has been provided under grant for meeting the expenditure).

Realising the difficulties of the States regarding procurement of costly insecticide malathion, the Government of India has decided to procure and supply malathion on 100 per cent basis to the States.

P. falciparum Containment Programme

At present, 80 districts are under this Programme in various parts of the country covering a population of 96 million.

Provision of US $ 2,97,000 was made during 1984 and 1985 under the WHO regular Biannum budget for various components of the programme which include in materials and equipments as also fellowships.

International Border Coordination Conferences

These conferences between India and the bordering countries, viz., Sri Lanka, Bangladesh, Burma, Nepal and Maldives are held periodically to review these conferences to plan strategy for insecticidal coordination and discuss malaria problem on both sides of the bordering countries. Deliberations are

also held in these conferences to plan strategy for insecticidal spray operations synchronising in the border areas of the concerned countries.

The following International anti-malaria border co-ordination conferences were held during 1984:

VII Burma-India-Bangladesh Anti-malaria Co-ordination Conference at Rangoon (Burma) from 9 to 11 May, 1984.

XIII Indo-Nepal Anti-malaria Co-ordination Conference at Lucknow (India) on 28 and 29 May, 1984.

URBAN MALARIA SCHEME

Urban Malaria Scheme was initiated in 1971-72 under the Directorate of National Malaria Eradication Programme. It was planned to include 132 towns under the ambit of this Scheme by the end of 6th Five Year Plan. The Ministry of Health, Government of India, has sanctioned the Scheme for 131 towns so far, distributed in 17 States and 2 Union Territories. The State Governments/UT have implemented this Scheme in 115 towns till now. Six towns out of 131 towns were sanctioned by the Ministry of Health during 1983 for inclusion under the Scheme. One more town is yet to be sanctioned under the Scheme. The Malaria cases recorded in these urban malaria towns for the last three years are as follows:—

1981	2,75,783
1982	2,39,669
1983	2,48,625

It is evident that there is a marginal increase in the malaria incidence in the urban malaria towns from where the malaria incidence reports are received. Out of 119 towns from where the malaria incidence reports were received during 1983, 70 towns (59 per cent) showed decrease in the malaria incidence during 1983 in comparison to that recorded in 1982. Out of 16 States and 2 Union Territories, only a few States namely Andhra Pradesh, Madhya Pradesh, Maharashtra, Rajasthan and West Bengal recorded high malaria incidence in the urban malaria towns in 1983. The towns which showed higher malaria incidence are Vijayawada (Andhra Pradesh); Ahmedabad, Rajkot and Anand (Gujarat); Bhiwani (Haryana); Jodhpur (Rajasthan); Salem (Tamil Nadu) and Calcutta (West Bengal). The high incidence recorded in Calcutta is due to the accumulation of water owing to deep ditches made for underground railway system. Malaria is still a problem in Madras town. The total number of malaria cases recorded in Madras town for 1983 is 44,817 while it was 44,981 for 1982. The data for 1984 is under compilation.

NATIONAL FILARIA CONTROL PROGRAMME

Filariasis is a major public health problem in India. All States except Jammu and Kashmir, Haryana, Chandigarh, Himachal Pradesh, Punjab, Delhi, Rajasthan, Manipur, Tripura, Nagaland, Arunachal Pradesh, Sikkim and the North-eastern region are endemic for filariasis. To control filariasis, the National Filaria Control Programme was launched in 1955.

During 1984 anti-larval activities and anti-parasitic measures were continued in 184 towns by as many control units. In addition to these, 12 headquarters units, 27 survey units and 107 filaria clinics are functioning. Out of these 4 control units, 1 survey unit and 4 filaria clinics were set up in 1984.

KALA-AZAR

The Kala-azar unit of NMEP is monitoring the Kala-azar situation in India except Bihar. Kala-azar in Bihar is being looked after by the National Institute of Communicable Diseases, Delhi. This unit is regularly collecting the Kala-azar report and is keeping a close vigil over the situation. The Kala-azar incidence in India (including Bihar) since 1981 is given below:—

Years	Cases	Deaths
1981	14611	42
1982	12360	38
1983 (Prov)	14406	135
1984	9573	51 (as per reports received upto 17-10-1984)

Kala-azar is endemic in the States of Bihar and West Bengal which alone account for 90.93 per cent and 9.03 per cent of the total cases respectively. The States have been requested to spray DDT in the affected areas for effective control. A "Brochure on Kala-azar" has been developed for the use of health workers. At present, there is no separate budget for Kala-azar and the insecticides are supplied out of NMEP Budget. However, a plan for 100 per cent central assistance for Kala-azar control submitted by NMEP is under consideration of the Government of India. △

National Tuberculosis Control Programme

NATIONAL TB Programme has been in operation since 1962 and its primary objective is to provide TB case finding and treatment activities on domiciliary basis for TB patient by establishment of an equipped and staffed District TB Centre in each of the Districts of the country to undertake district-wide TB Programme. 359 districts have been provided with District TB Centres which are undertaking District TB Programme in association with the medical and health institutions located in the districts. At all such centres, a team of medical and paramedical personnel duly trained at National TB Institute, Bangalore, is available. In addition, there are about 300 TB Clinics functioning in the country, which are participating in the National TB Programme. There are about 45,500 beds available in the various institutions for the treatment of seriously sick TB patients.

Seventeen TB Training and Demonstration Centres have been estabilshed in major States of the country to undertake the basic training of the paramedical personnel required for the programmes for conducting re-orientation training courses for the medical practitioners, etc. These Centres also provide the necessary technical guidance to the developing District TB Centre in the respective States.

During the Sixth Plan period the schemes of establishment of District TB Centres and TB Beds have been included in the State Plan Sector. The Scheme of supply of Anti-TB drugs/materials and equipments has been classified as a Centrally Sponsored Scheme with 50 : 50 sharing basis between the Centre and the States. The Scheme of supply of Anti-TB Drugs to Voluntary body run TB Clinics and supply of materials and equipments/Anti-TB Drugs to Union Territories is classified as 100 per cent Centrally Sponsored Scheme.

The International Agency like Swedish International Development Agency (SIDA) continues to assist the National TB Programme by way of essential X-ray equipments with Odelca Cameras and miniature X-ray films and stock of latest anti-TB drugs like Rifampicin and Pyrazinamide. A fresh agreement is being entered into with the Swedish International Development Agency for continuation of their assistance to the National TB Programme for another five years.

Primary Health Centres are actively involved in the T. B. case finding activities.

The WHO is also actively assisting the Programme. The two premier TB Institutes, namely National TB Institute, Bangalore, and TB Research Centre, Madras, are provided essential material and equipments required to augment the research and training activities, fellowships and consultants as per the requirements.

During 1984-85, to augment the diagnostic and treatment activities under the Programme, much larger amount of funds have been provided under the Central Sector for supply of material and equipments and anti-TB drugs to the State-run TB Centres and TB Clinics run by voluntary bodies. Standard anti-TB drugs for domiciliary treatment of TB patients to the State-run TB centres and to the TB Clinics run

by voluntary bodies are being continued to be supplied during the year and the budget has been considerably augmented. Anti-TB drugs worth about Rs. 930 lakhs are expected to be supplied to the TB Centres/ TB Clinics run by States/U.Ts./Voluntary bodies. In addition, X-ray equipments, etc., worth about Rs. 120 lakhs as received out of SIDA assistance are expected to be supplied during the year.

Short course Chemotherapy drug regimen has been introduced in eighteen selected districts all over the country on a pilot basis.

With the inclusion of Tuberculosis Programme in the new 20 Point Programme, a thrust has been given for the case finding and treatment activities. Targets laid for detection of new TB cases for the first time during 1982-83 was achieved in full. During 1983-84, a target of 12.50 lakhs new TB Case detection was laid and nearly 12.08 lakh new TB Cases were detected giving 96.5 per cent achievement. During 1984-85 to step up case finding activities the targets of new TB Case detection has been increased to 13.75 lakhs. In addition to involve the Primary Health Centres actively in the TB Case finding activities, targets have also been laid for conduction of 600 sputum examinations of new Chest symptomatics per year per Primary Health Centre since 1983-84.

In order to periodically review the performance of the National TB Programme in the various States/ U.Ts., a Central Coordination Committee consisting of eminent experts in the field, and participants from the States/U.Ts. has been constituted during 1984-85.

BCG Vaccine Laboratory

B.C.G. Vaccine Laboratory, a subordinate Office of the Directorate General of Heatlh Services at Guindy, Madras, has produced and supplied the following biologicals from April to September, 1984—

	Production		Supply	
	Ampoules Doses		Ampoules Doses	
	vials In lakhs	In lakhs	vials In lakhs	In lakhs
Freeze Dried BCG Vaccine 20 doses per ampoule	4.06	81.17	3.83	76.66
Tuberculin 100 doses per vial .	0.097	9.65	0.104	10.37

The Laboratory is also working as a W.H.O. Collaborative Centre for testing BCG Vaccine manufactured by other Laboratories. The Laboratory is provided with $ 1,000 towards expenditure of the tests by the W.H.O. which is being utilized for procuring spares of some imported machineries.

The Laboratory conducts production oriented research. Attempts are being made to manufacture heat-stable BCG Vaccine. One experimental batch was manufactured. The Preliminary results are encouraging. Post-graduate students from Madras University doing M.D. in Microbiology are trained by this Laboratory. △

Sexually Transmitted Diseases Control Programme

SINCE the growing dimension of the disease could not be checked during the past plan periods it was then decided to give a new dimension to the scheme by uplifting the scheme from its very grass root level so as to combat the disease in all aspects. With attention focussed on this aspect, the scheme was entirely restructured to induct the scheme as a purely Central sector scheme with 100 per cent Central assistance during the Sixth Five Year Plan laid importance mainly on teaching, training and research in the field of S.T.D. and with this objective in the forefront the (a) Regional teaching-cum-training centres to impart orientation courses to the in-service medical and para-medical personnel in the discipline of venereology in its various aspects viz. clinical diagnostic therapeutic, laboratory control, etc., of S.T.D. have been/are being established at Calcutta, Nagpur, Hyderabad in addition to the existing teaching and training centres at the Institute for S.T.D., Madras, Medical College, Madras and STD Training and Demonstration Centre, Safdarjang Hospital, New Delhi, (b) Regional S.T.D. Reference Laboratory to provide (i) orientation courses to the Lab Technicians working in the district hospitals/P.H.Cs/Civil Hospitals/ S.T.D. Clinics in the lab. diagnosis of S.T.D., (ii) conduct inter-laboratory evaluation of V.D.R.L. test which all the District hospital laboratories would participate in order to set up a uniform standard of doing the V.D.R.L. test throughout the country and (iii) conduct research orientation work in the field of S.T.D. have been/are being established at Calcutta, Delhi, Hyderabad and Nagpur in addition to the existing Central reference Laboratory at the Institute for the Study of Venereology, Madras, Medical College, Madras; and (c) Regional Survey-cum-Mobile S.T.D. Units to go into the epidemiological aspect of the disease and provide immediate therapy to the patients suffering from STD, have been are being established at Calcutta, Hyderabad, Madras and Nagpur in addition to the existing survey team at N.I.C.D. Delhi.

UNICEF is also assisting the programme by supplying equipments, viz, a shaker, a water bath and a hot air oven to the district hospitals laboratories/ sub taluka hospitals/PHCs for instituting VDRL test in their respective hospitals/centres in order to bring down the infant mortality and morbidity. This test will certainly unearth the hidden forces of syphilis and will eventualiy cause a decline in the disease. UNICEF has so far supplied 61 sets of equipments to the district hospitals in the States and another 100 centres have already been identified for supply of the said equipments by UNICEF. △

Diarrhoeal Diseases Control Programme

DIARRHOEAL Diseases constitute one of the major cause of morbidity and mortality specially in children below 5 years of age. Multiplicity of the organisms, drug resistance, low environmental sanitation, lack of adequate personal hygiene, lack of safe water supply add to the problem. Except cholera, the other diarrhoeal diseases are not notifiable in the country and as such it is difficult to estimate the exact nature of the problem in terms of morbidity and mortality based on available information.

During 1984, outbreaks of dysentery due to Shigella were reported from West Bengal, Tripura, Assam and Orissa.

Government of India has formulated a National plan of action to control diarrhoeal diseases under Primary Health Care. The following activities have been undertaken during the current year:

Supply of ORS

Under the Village Health Guides' Scheme, every Health Guide (more than 3 lakhs) is supplied with 60 packets of Oral Rehydration Salts through the composite drug kits. These are being utilised at the community level to control dehydration in diarrhoea cases.

Health Education

A hand book on Diarrhoea containing all relevant information on diarrhoea and its preventive and control measures is under publication. A total of 11 lakh booklets will be printed all over the country for use by mothers, community members, school teachers, village health guides, etc.

Training Programme

With additional inputs provided by WHO, the following training programmes have been conducted: Training in Laboratory diagnosis from 1 to 10 May; Clinical Management Course for Paediatricians from 2 to 11 July; and the first course of supervisory skill training for district level officers from various States from 27 August to 2 September, 1984 at NICED, Calcutta. The second course on supervisory skill was arranged at NICD, Delhi, from 19 to 24 November, 1984.

In collaboration with the State Governments, 53 National Seminars on O.R.T. have been held so far.

Orientation of Private Practitioners

In association with Indian Medical Association, six Orientation courses for private practitioners on O.R.T. have been held so far at Rohtak, Dehradun, Calcutta, Jabalpur, Nagarcoil and Palghat.

Training for State level Programme Officers

A training programme for the State level officers dealing with diarrhoeal diseases was arranged from 10th to 19th December, 1984.

Review of the Programme

A review of the diarrhoeal diseases programme being implemented by the States and Union Territories, was made in programme officers meeting held at Calcutta on 21 and 22 April, 1984.

400 Primary Health Centres (one from each district) have been identified Sentinal Centres for reporting on morbidity and mortality due to diarrhoeal diseases in children.

A detailed survey on morbidity and mortality due to diarrhoeal diseases among children below 5 years has been planned as under :

A. Urban areas—Delhi, Calcutta, Bombay, Madras and Hyderabad.

B. Rural areas—Himachal Pradesh (Kangra)
Tamil Nadu (Coimbatore)
Andhra Pradesh (Nizamabad)
Manipur (Central district)
Uttar Pradesh (Selected rural districts).

1st survey was carried out in November, 1984. It will be followed by a repeat survey in the summer month. Other areas will be covered in a phased manner. △

National Goitre Control Programme

ENLARGEMENT of thyroid gland is known as Goitre. Goitre is said to be endemic when this condition affects a significant number of people living in any circumscribed areas. From the public health point of view, it has been suggested that endemic goitre can be defined as prevalence of 10 per cent or more among the population.

Goitre is primarily caused due to environmental iodine deficiency. Apart from disfiguring swelling in the neck endemic goitre may cause respiratory difficulties. The most serious health consequences of endemic goitre are the high incidence of endemic cretinism, deaf-mutism and mental retardation.

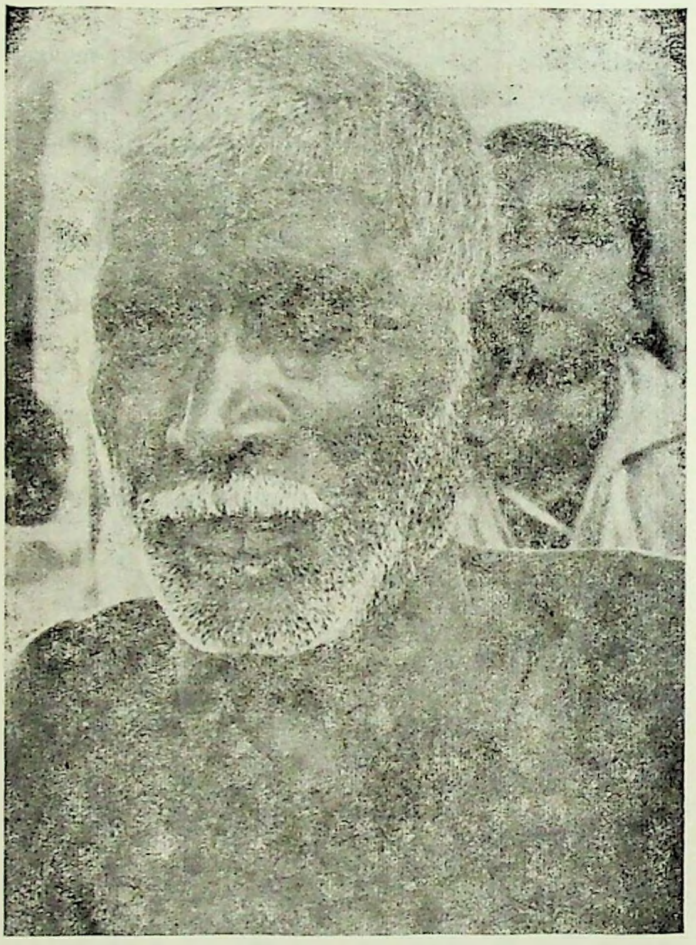
Activities/performance: For the identification of goitre endemic regions two survey teams have been established in the Directorate General of Health Services. These teams have completed surveys in various parts of the country.

The findings of the surveys have revealed that nearly 40 million people are suffering from varying degrees of goitre and an estimated number of 140 million people are living in the known hyper goitre endemic areas. Further, goitre problem has been found to be equally alarming in areas which were not known to be goitre prone earlier. Rather these results suggest that no region in the country can be considered completely free from goitre.

In order to control the problem of goitre, the Ministry of Health is supplying iodized salt to the population living in the goitre endemic areas under the National Goitre Control Programme. The Ministry of Health also provides subsidy for extra cost of iodization of salt in order to avoid any financial burden on the consumers.

Twelve iodization plants are working under the Management of the Hindustan Salts Limited and Salt Commissioner, Government of India for the production of iodized salt with the following units:

Sambhar Salts Ltd., Sambhar Lake	5 Plants
Hindustan Salts Ltd., Kharaghoda	3 Plants
Govt. Salt Golhas, Howrah	4 Plants



The two iodization plants installed at Gauhati have not yet been commissioned. These plans have now been handed over by the Salt Commissioner to the Government of Assam.

The existing 12 iodization plants in the public Sector produce on an average less than 2.00 lakh M.T. of iodized salt per annum against the total annual requirement of 8—10 lakh M.T. Even though the annual production capacity is 3.76 lakh M.T. Actual production of iodized salt during the last 5 years is given below :—

1978	1979	1980	1981	1982	1983	1984
1.06	1.20	1.22	1.29	1.23	1.30	1.40 (Anticipated)

Keeping in view the very fact that the public sector is not in a position to meet the requirement of iodised salt for the goitre endemic areas, the Ministry of Health and Family Welfare have decided to liberalise, the production of iodised salt in the Private Sector in addition to the Public Sector.

Surveys on goitre were conducted in Ernakulam district of Kerala, Buldhana district of Maharashtra and Pauri Garhwal of Uttar Pradesh.

1.18 lakh M.T. of iodised salt was produced at the various iodization units and 1.6 lakh MT of iodized salt was supplied to the goitre endemic areas of Himachal Pradesh, Jammu and Kashmir, Punjab, Haryana, Madhya Pradesh, Uttar Pradesh, Gujarat, Maharashtra, Bihar, West Bengal, Manipur, Nagaland, Sikkim and Union Territories of Delhi, Chandigarh, Arunachal Pradesh.

During the period under report, supplies of iodized salt have been introduced in 4 Districts of Madhya Pradesh, viz., Shahdol, Sarguja, Raigarh & Sidhi. Partial supplies have been introduced in Sikkim and Union Territory of Mizoram.

The working group constituted for the purpose of advising the Govt. of India on Iodization of entire edible salt in the country by 1990 has submitted the draft report.

Goitre Control Committee

In order to periodically review the progress made under the National Goitre Control Programme, three quarterly review meetings of the Goitre Control Committee were held under the Chairmanship of Additional Secretary, Ministry of Health & Family Welfare. The meetings were attended by the representatives of the Ministries of Health, Industry, Railways Food & Civil Supplies, Social Welfare, Salt Commissioner's Office, UNICEF, State Governments of Jammu & Kashmir, Himachal Pradesh, etc.

The major recommendations of the Committee are:

1. Since the problem of goitre is wide-spread in the country, the entire edible salt should be iodised by 1990 to tackle the problem urgently.
2. The State Governments should set up Goitre Control Cells in their State Health Directorates for effective implementation of National Goitre Control Programme.
3. In order to ensure regular supplies of iodised salt, the concerned State Governments should set up a single agency for procurement and distribution of iodised salt in their endemic areas.
4. The Directorate General of Health Services should bring out a quarterly news bulletin on goitre for information of all concerned.
5. Constitution of a working group to go into various aspects of iodization of entire edible salt in the country, viz., production centres, technology of iodization, participation of private sector, subsidy and quality, etc. ○

Mental Health Programme

Important work is being done in the field of Mental Health by the Central Institute of Psychiatry at Ranchi and the National Institute of Mental Health and Neuro Sciences, Bangalore. The Government of India have also been keen that the Indian Lunacy Act, 1912 should be replaced by a more comprehensive enactment covering the latest concepts on the scientific treatment of the mentally ill in the country. For having this replacement, the Government introduced a comprehensive legislation on the subject in the Rajya Sabha in December, 1981, viz., the Mental Health Bill, 1981. The Bill was referred to the Joint Select Committee of Parliament and is receiving their attention. This Bill aims at consolidating and amending the present law relating to treatment and care of mentally ill and to make better provision with respect to their properties and affairs and other matters connected therewith and incidental thereto. This Bill would replace the existing Indian Lunacy Act, 1912 which is out-moded as the concepts of mental illness and the mentally ill have since been changed. The broad features of the Bill are:—

(i) To provide regulations for admission to mental hospitals of such mentally ill persons who do not have sufficient understanding to seek treatment on a voluntary basis, and to protect the rights of such persons while being detained.

(ii) To protect society from presence of mentally ill persons who have become or might become a danger or nuisance to others.

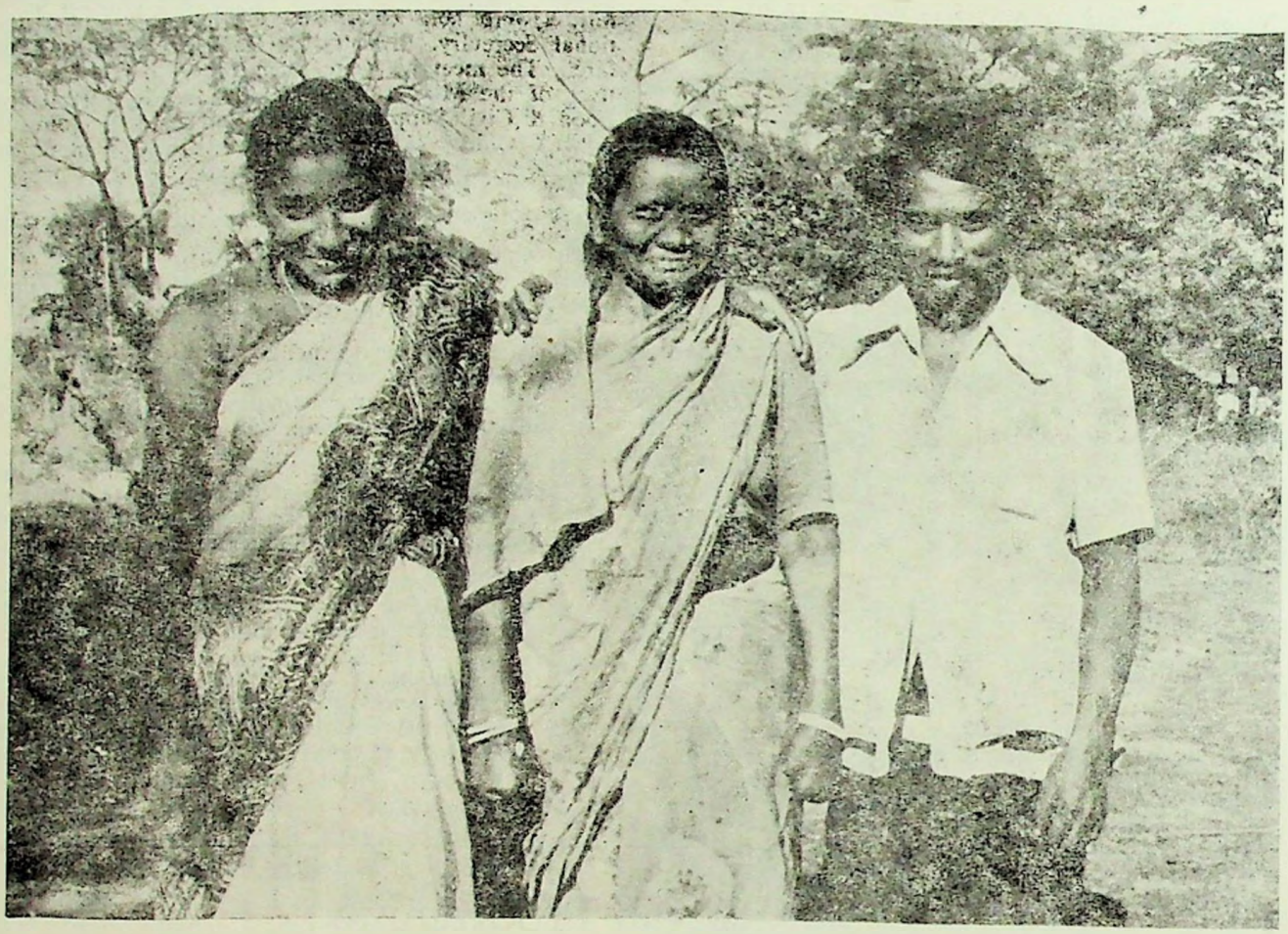
(iii) To protect citizens from being detained in mental hospitals without sufficient cause.

(iv) To regulate responsibility for maintenance charges of mentally ill persons who are admitted to mental hospitals.

(v) To provide facilities for establishing guardianship or custody of mentally ill persons who are incapable of managing their own affairs.

(vi) To regulate the powers of the State Governments for establishing licensing and controlling mental hospitals and similar institutions for mentally ill persons; and

(vii) To provide for legal aid to mentally ill persons at State expense in certain cases. △



National Leprosy Eradication Programme

LEPROSY is one of the major health and socio-economic problems in the country. It is a chronic infectious disease and spreads mainly by close contacts with infected patients. However, droplet infection is also considered responsible as a mode of spread of the disease. The disease is associated with crippling deformities and destitution, if not treated in time.

According to the 1981 census, about 400 million population in 31 State and Union Territories is living in the hyper endemic zones of Leprosy. Projected on the basis of 1981 census population, about 4 million people are estimated to be suffering from leprosy in the country at an average prevalence rate of 5.77 per 1000 population. Out of this estimated total number, about 3.19 million cases have been detected and 2.96 million cases have been brought under treatment till October 1984. This number is not constant each year as about 3-4 lakhs new cases are detected and about 2 lakhs cases are discharged annually as cured, disease arrested, died, left, etc. As per assessment of I.C.M.R. and some voluntary organisations, there has been reduction of the disease in some control areas while there has not been noticeable reduction in many other areas.

In addition to the augmentation of the 5th Plan Scheme of upgradation of old centres, several new schemes have also been proposed during the 6th Plan Scheme. The new schemes are (i) establishment of more Regional Leprosy Training-Cum-Referral Institutes to impart training to medical and non-medical personnel engaged in leprosy control,

(ii) establishment of leprosy rehabilitation promotion units in the country for referral treatment, and (iii) establishment of epidemiological surveillance teams and sample survey cum-assessment units for studying the epidemiological situation and defining the magnitude of the problem to assessing the impact of the Control programme and the introduction of intensified field trials with the multi-drug regimen in hyper-endemic districts to convert infectious patients into non-infectious within a short period so that the chances of the infection in the community are successfully interrupted and controlled. Out of the total 6th Five Year Plan outlay of Rs. 4000 lakhs, Rs. 1500 lakhs have been allocated for the year 1984-85.

(A) Physical achievement

Since the inception of the programme the following components have been achieved.

Sl. No.	Components	1984-85 T	1984-85 A	Achievement till October
1	Leprosy Control Units	11	3	398
2	Survey, Education & Treatment Centres	20	..	6985
3	Urban Leprosy Centres	6	2	661
4	Temporary Hospitalisation Wards	15	2	250
5	Reconstructive Surgery Units	..	..	75
6	Upgradation of Leprosy Control Units	..	..	165
7	,, Urban Leprosy Centres	..	..	52
8	,, District Leprosy Unit	..	..	76
9	,, Leprosy Training Centres	..	..	21
10	Non-Medical Supervisors	20	10	1157
11	Leprosy Training Centres	..	..	42
12	District Leprosy Units	45	7	178
13	Leprosy Rehabilitation Promotion Units	..	..	8 (Sanctioned)
14	Maintenance of Voluntary Leprosy Beds.	18275	1159	4850
15	Sample Survey-cum-Assessment Unit	..	..	5
16	Total number of Leprosy Beds	..	..	32480
17	Voluntary Organisations	..	..	42

(B) Field Achievement

With the help of the above mentioned physical infrastructure the objective achievement position till the end of October 1984 is as under:

	Million
1. Total population covered till Octover, 84	351.00
2. New case detected during 84-85 till October	0.217
3. Progressive total of cases detected till Oct. 84	3.19
4. New cases registered for treatment druring the year till October, 1984	0.204
5. Progressive total of cases registered for treatment till October, 1984	2.99
6. Cases discharged during 1984-85 till October	0.13
7. Total cases discharged till October, 84	1.69

(C) Research

Research on the various aspects of leprosy is being conducted by several institutions in the Government Sector on the recommendation of the I.C.M.R. The Central JALMA Institute for Leprosy at Agra, U.P., CLTRI, Chingleput Cancer Research Centre Bombay, A.I.I.M.S., New Delhi. School of Tropical Medicines, Calcutta, are carrying out various researches on leprosy including development of a suitable vaccine against leprosy. A number of voluntary organisations are also carrying out specified items of research. The WHO is providing apporpriate financial assistance from the Tropical Disease Research $. Fund to certain Institutes engaged in the research in the country.

Intensified leprosy control project with multidrug regimen (M.D.R.P.) has completed its 3 years on 2nd October, 1984 in the districts of Wardha and in the district of Purulia will be completing its 3 years in Feb., 1985. In the first phase, six districts were covered under the M.D.R.P. and six more have been taken under the programme during the year, 1984-85. All the 98 hyper-endemic districts having a prevalence rate of 10 per 1000 and above are planned to be undertaken under the MDRP as the Programme has shown very good results in the areas where it has been started. The project is being assisted by the Swedish International Development Agency towards supply of anti-leprotic drugs, i.e., Rifampicin and Clofazimine capsules and meeting the operational cost. The object of this scheme is to detect all infectious cases in the districts and treat them with the combination of anti-leprotic drugs namely Dapsone, Rifampicin and Clofazimine capsules with a view to rendering them non-infectious within a short time so that risk of development of drug resistance is minimised and the chances of transmission of the disease in the community are effectively reduced.

The bill introduced in the Parliament to repeal the Leper Act, 1898, to create a favourable climate for removal of the age-old social stigma of leprosy and to obtain cooperation of patients and public, has been passed by the two houses of Parliament. The same has been sent to all the States/U.Ts. for the similar action and two States, viz., Tamil Nadu and Maharashtra have already repealed the Act.

The National Leprosy Eradication Board constituted on the recommendation of the Working Group

(continued on page 201)

Health Education Progress

THE Central Health Education Bureau has completed 28 years of its existence. The Bureau implements the policies and programmes of health education in the country. The Bureau has six Technical Divisions, i.e, Training; Research & Evaluation; Media; Field Study and Demonstration Centre; Health Education Service; School Health Education and an Administrative Division.

Training activities

The Bureau conducted long and short term training courses in health education.

(i) *CHE Course*: Two Courses in Certificate in Health Education i.e., 17th and 18th were conducted during the year in which 37 and 43 candidates were trained respectively.

(ii) *Media Personnel Training Courses*: This course of one month's duration was conducted for artists, photographers and audiovisual technicians. Eight trainees from various States attended the course.

(iii) *District Extension Media Officer's Courses*: This course of 60 days duration was conducted in which seven officers participated.

Diploma Course in Health Education (DHE): The XIII Diploma Course in Health Education with 13 students concluded in March 1984, and the XIV course began from Ist April, 1984, with 15 students.

Orientation in Health Education: Orientation training in health education was provided to 19 WHO fellows. Orientation training was also provided to 526 visitors from 14 institutions in the country.

Research studies

The Bureau continued to promote behavioural research activities in the country. The following research studies were in progress:

(i) Social-cultural Aspects of Venereal Diseases and Health Education opportunities.

(ii) Study on community participation in Expanded Programme on Immunization in Maharashtra and Orissa.

(iii) Study on Impact of Different Educational and Health Education Methods on Practices of Health Behaviour of Mothers in Management and Prevention of acute Diarrhoea.

(iv) Health Education acivities as perceived by the Physicians and Non-physicians Health Educators.

Besides the research studies, the Bureau was engaged in preparing the report of the Working Group in Health Education and Community Participation in Water Supply and Sanitation Decade Programme. The Bureau is also monitoring the activities relating to the celebration of the International Youth Year.

The Bureau plans to undertake studies on tropical diseases and water and sanitation programmes in future.

Media

The Media Division of the Bureau which comprises Editorial and Exhibition Sections, continued to provide media support to all the on-going health and other programmes. Health education material was produced to disseminate health information to the public for creating awareness and also produced educational aids for health workers. The Media Division maintained liaison with AIR and Doordarshan, DAVP, Films Division and other wings of the Information and Broadcasting Ministry for strengthening educational programmes in respect of various health programmes including those mentioned in the 20-Point Programme The Media support included publication of posters, folders, reports, etc.

The monthly journals; Swasth Hind (English): Arogya Sandesh (Hindi) were brought out regularly covering various issues relating to health education, public health, health programmes, behavioural research, book reviews, information for States, etc Special issues of 'Swasth Hind' and 'Arogya Sandesh' were brought out on World Health Day and Children's Day. The quarterly journals "D.G.H.S. Chronilcle" and "Swasthya Shiksha Samachar" were published to disseminate technical information on health and to report about the achievements of the Directorate-General of Health Services.

Health Education material: The Division produced various prototype material in English and Hindi; posters, pamphlets, folders, hand-bills on health programmes which were provided to the States and Union Territories.

Educational material in the form of folders on Thread Worm, Round Worm, Dengue Fever, Guinea Worm. When the unexpected happens, show card on Immunization and posters on regular treatment cures T.B. and Persistent Cough—Have Sputum Test were brought out both in English and Hindi during the year.

In addition to the above, four folders each on safe water, jaundice, dysentry and goitre; two booklets, each on food adulteration and diarrhoea; posters one each on accidents, guinea worm and goitre; one hand-bill on goitre and one flipbook on guinea worm have been prepared.

The Bureau prepared a proposal to develop and produce a health telecast series which would make the community aware of the body-structure, its functions and various health problems and how to take preventive and promotive measures for healthy living.

Campaigns: Suggestions for observance of the World Health Day and the background material of the World Health Day 1984 were issued. An advertisement on the theme "Children's Health' Tommorrow's Wealth" was also issued to newspapers through D.A.V.P.

Health Education drive was launched in four hospitals, i.e., All-India Institute of Medical Sciences, Ram Manohar Lohia Hospital, Lady Hardinge Hospital and Safdarjang Hospital.

Thirteen exhibitions on varied areas of health were arranged including the World Health Day and the Children's Day—script of which was sent to the States for developing similar exhibitions in their areas.

As a part of hospital health education campaign, four exhibitions were put up in major hospitals of Delhi. Exhibition material and teaching assistance was given to other agencies requisting such assistance.

T.V. & Films: As many as 191 film shows were organised on demand from different quarters. Film

prints numbering 1,599 were loaned to various organisations. Scripts have been completed for production of 8 video films to be used on Doordarshan.

Photo: During the period under review, 2,839 prints including 751 big sized photographs (enlargements) were prepared as an integral part of the material for use in different communication activities. In addition, 142 slides were produced for these programmes.

Field Study & Demonstration Centre

As a part of health education activities in the F.S.D.C. (U), five projects were undertaken in DDA flats, Mata Sundari Road in LNJP Hospital, Vikram Nagar, Government of India Press, residences, and C.G.H.S. Dispensary, Minto Road.

The students undergoing Certificate Course in Health Education and Diploma in Health Education were provided field training. Moreover four trainees of Diploma in Health Education from the Gandhi Gram Institute of Rural Health and Family Welfare were provided 2-months supervised field training.

A proposal has been made to strengthen the FSDC of the Bureau and set-up an Urban FSDC demonstration room in the Bureau.

Health Education Services

The Bureau worked for growth and development of health education services in the country. It maintained liaison with international agencies like WHO, UNICEF, UNDP to facilitate their support and assistance for overall development of health education programmes in the country. It maintained close liaison with State Health Education Bureau, through which it helped to develop Health Education Programmes in the whole country. It also helped in developing Health Education in various health agencies, organizations, and institutions. The National Health programme wing attended to development and promotion of health education component in all the national health programmes. The implementation of Centrally sponsored scheme for strengthening health education in the 9 Union Territories was continued. The Union Territories of Pondicherry, Mizoram, Andaman & Nicobar Islands, and Arunachal Pradesh have taken action to strengthen their Bureau.

School Health Education

The Bureau continued to strengthen educational programmes for younger generation and to work as a technical resource with the Ministry of Education, NCERT and Directorate of Adult Education and helped in population education and produced type instructional material. The Division has developed syllabi for classes IX and X for Central Board of Secondary Education as separate subject under Physical Education and Health education for classes XI and XII of Central Board of Secondary Education. It also developed syllabi of health education to integrate health education in training of Adult Education, B.T. & B.Ed. Population Education Guide for Secondary School Teachers was developed for School Health Education Departments.

Under the Intensive Pilot Project the Bureau is also monitoring Centrally sponsored "National School Health Scheme" for the primary class students in eight U.Ts except Delhi.

Workshops

1. One-day Workshop on Teachers' participation in the Prevention of Blindness among Primary School Children was organised at the Bureau with Dr A. V. Baliga Memorial Trust for training of teachers to take up their responsibilities and develop educational material.

2. Training was provided to different batches of NSS volunteers from Delhi College at CHEB Scripts of 16 brochures on different health areas for National Services Scheme Volunteers in the country were finalised with representatives of the Ministry of Sports.

The Bureau is collaborating with Indian Council of Medical Research for development of educational motivational material in relation to injective contraceptives.

Out of 22 states, 21 have established Health Education Bureau/Units/Cells. Most of the States and UTs produced health education material and also have liaison with publicity units like AIR/TV, etc., in their respective States. Some of the State Bureau also produced monthly health magazines. △

National Programme for Control of Blindness

THE National Programme for Control of Blindness has been included in the 'New 20-Point Programme'. The object of the programme is to make a significant reduction in the incidence of blindness from the present level of 1.4 per cent to 0.3 per cent by 1999. The Programme envisages the development of various services at peripheral, intermediate and central levels. The peripheral sector includes development of mobile units to provide immediate relief to the community in remote villages and strengthening of eye care services at primary levels. The Central Sector includes upgradation of medical colleges, Regional Institutes and National Institutes mainly responsible for training of personnel and research on eye problems besides providing specialised eye-care service.

Hundred per cent Central Assistance is offered to State Govt./U.Ts. for procurement of material and equipment and also for meeting recurring expenditure on maintenance and operation of these services.

Cataract cases constitute 55 per cent of the total blindness in the country. Emphasis is being laid on performance of as many cataract operations as possible both through Governmental and non-Governmental Institutions including Voluntary Organisations.

The present position of development of various services is given below:—

Services	Targets upto VIth Plan	Achievement upto 1983-84	Target 1984-85
1 Mobile Units	80	80	..
2 Primary Health Centres	2000	1660	340
3 District Hospitals	400	360	40
4 Medical Colleges	60	51	9
5 Regional Institutes	10	5	5
6 Training Schools for Opthalmic Assistants	37	35	2
7 District Mobile Units	30	..	30
8 Eye Banks	30	..	30
9 Ophthalmic Cells	18	..	18

Under the Programme, financial assistance is offered to Social/Voluntary Organisations for holding eye camps in rural and urban areas upto the population

of 1 lakh. Financial assistance is being given @ Rs. 60/- per intra-ocular operation performed within a ceiling of Rs. 12,000/- per eye camp. In order to enhance the participation of voluntary organisations in eye relief work, the procedure of disbursement of financial assistance has been decentralised with effect from 1 September 1982. The metropolitan slums and Panchayat bodies have also been covered under this scheme.

Community eye health education is an important part of the programme as a built-in component at all levels of implementation. The programme provides for different activities involving mass media and interpersonnel channels of communication. Sufficient funds are provided every year to produce literature on eye care and develop other eye health education activities.

One of the most important factors responsible for blindness is the loss of vision by cataract. Cataract is curable through surgery. Efforts are being mobilised through Government and voluntary sectors to maximise the number of cataract operations. The performance has shown significant increase ever since the programme formed a part of the 20-Point Programme. The performance on this front from various States during the last three years, is as indicated below :

Years	Performance (In lakhs)
1981-82	5.5
1982-83	8.05
1983-84	10.67
1984-85	2.04 (April to October 84)

Family Welfare — A Big Leap Forward

IN order to realise the long-term demographic goals of the country as spelled out in the National Health Policy, to attain a Net Reproduction Rate of one by the year 2000, efforts to give further fillip to the acceptance of small family norm were intensified. The programme gathered so much momentum as to yield a record level of 14.4 million acceptors during the year 1983-84. This represents a big leap forward over the level of 5.5 million acceptors during 1979-80. In the current year which is the closing year of the Sixth Plan, the performance is expected to be still better. This will give us a good base to build on during the 7th Plan period. At the end of the 7th Plan, the couple protection rate is expected to reach around 42 per cent.

Consistently improved performance during the last 5 years has been possible due, among other things, to a close monitoring of the Programme at the highest level. The system of annual regional meetings with Health Ministers of States and UTS taken by the Union Health Minister, in which detailed State-wise reviews are made, followed by the Joint Conference of the Central Council of Health and Family Welfare in which all aspect of the Programme are discussed in the national perspective, has yielded rich dividends by way of removing the bottlenecks and fostering a sense of urgency. This year the 10th Joint Conference of the Central Councils of Health and Family Welfare was held at New Delhi from 9th to 11th July, 1984 after a series of regional meetings held earlier. The two meetings of the Population Advisory Council were held in quick succession on 8th June and 29th June, 1984 after an earlier meeting on 8th March, 1984. In these meetings the Reports of the five Working Groups, viz., incentives and disincentives, organisation and management community participation, research and Technology and communication strategy, were discussed in detail. At the official level the Health Secretary, the Additional Secretary and Commissioner for Family Welfare, and other senior officers of the Ministry maintained a close liaison and follow-up with the State Governments.

A highlight of the 10th Joint Conference was the presentation of cash awards to the best performing States and UTs for 1982-83 in the field of family welfare. In group A States Maharashtra got the first prize (Rs. 2.5 crore) and Haryana the second prize (Rs. one crore). In group B Punjab bagged the first prize (Rs. 2.5 crore) while Karnataka won the second price (Rs. one crore). In group C, Madhya Pradesh got the first award of Rs. 2.5 crore. In group D, Himachal Pradesh won the award (Rs. 50 lakhs) while in group E, the UT of Dadra & Nagar Haveli got the award of Rs. 25 lakhs.

The awards for the year 1983-84 have also been announced which are as follows:—

Group A	.	Maharashtra (1st prize): Haryana (2nd prize)
Group B	.	Punjab (1st prize) West Bengal (2nd prize)
Group C	.	Assam (1st prize): Madhya Pradesh (2nd prize)
Group D	.	Himachal Pradesh
Group E	.	Pondicherry

A recommendation of the Conference to give suitable cash awards to the States/UTs who achieve 100 per cent of their annual targets in terms of equivalent sterilization, is also under the consideration of the Central Government.

Under the leadership of the Union Health Minister a broad-based delegation of India participated in the International Conference on Population held in Mexico City from 6 to 14 August, 1984. One hundred and forty seven governments participated in the consensus on the 88 recommendations for the further implementation of the World Population Plan of Action. At the conclusion of the Conference and under the leadership of Mexico and 28 States, including India, the Mexico City Declaration on Population and Development was approved.

Approach and Strategy

As part of the new 20-Point Programme, the family welfare is sought to be pursued on a purely voluntary basis as a people's own programme. Our approach is to promote responsible and planned parenthood through a well designed strategy.

Continuous efforts are being made to expand and streamline the network of health and family welfare services, to the doorsteps of the people. These include:

(i) With a view to provide liaison between the community and health services network, a Village Health Guide functions in each village or within a population of one thousand in larger villages. About 350,000 Health Guides are already working. Health Guides are selected by communities from amongst themselves and preference is given to females. These voluntary workers are trained for a period of three months and arrangements for continuous training are in-built in the

Efforts to give further fillip to the acceptance to small family norm were intensified. →

scheme. The Village Health Guides also promote small family norm and the use of contraception.

(ii) Deliveries by trained health personnel in hygienic and aspetic conditions are critical in reducing the maternal mortality and infant mortality. Most villages in the country have traditional birth attendants who are customarily handling deliveries in their areas. A scheme to train these traditional brith attendants to upgrade their skills has been in operation and till now over 4,00,000 birth attendants have been given training. It is proposed to trained all untrained 'dais' during the 7th Plan.

(iii) Health Sub-Centres are being established for every three to five thousand population. These are manned by a team of one qualifield male and one female (paramedic). They promote small family norm and meet the health needs of the community. They also provide maternal care and immunisation services in addition to family planning education, motivation, and supplies and services in spacing methods. There are over 70,000 sub-centres in the country and their number will increase to about 120,000 by 1990. The current year's target is 9,071 new sub-centres. One male and one female Health Supervisor provide support and assistance for every four Sub-Centres.

(iv) There are nearly 7,000 Primary Health Centres (PHCs) one for every 100,000 population. Each PHCs is to have three medical officers (including one Lady Medical Officer) to provide curative and clinical services, including MTP and they supervise and guide family planning programme performance. The team of medical and paramedical personnel at the PHC level have been trained well in all the family welfare/planning methods, in-

cluding sterilisation, follow-up care and treatment of complications when they arise. This network of medical services are to be strengthened by opening new one-doctor Primary Health Centre for every 30/20 thousand of the population. Existing Primary Health Centres will be upgraded as referral, consultative and supervisory centres with the addition of more beds and specialist services.

(v) At the apex of the pyramid of health services are the district level (412) and State level referral service Centres. There are 106 medical colleges which impart medical education and also provide specialist services and help supervise, guide and train the personnel at lower levels.

Services and Supplies

Services and supplies are provided entirely free of cost at various levels of the health delivery system according to the facilities available. While all services are available at district and sub-divisional hospitals and above, the Primary Health-cum-Rural Family Welfare Centres provide all services except female sterilisation (many PHCs are now providing this service also) and the sub-centres manned by Auxiliary Nurse Mid-wife (ANM) usually provide only non-terminal methods others than IUD (IUD) insertion is also being carried out in many sub centres after training of ANMs/LHVs).

Post Partum Programme

Post-partum scheme is one of the more successful components of the family welfare programme. It is hospital-based and maternity oriented. At the time of delivery, a woman is generally more receptive to adopt one or the other family planning method so as to stop further addition to the family. The programme offers necessary facilities to such women. The number of medical institutions approved under the programme at district level or above is 554 and 400 at the sub-district level.

Medical Termination of Pregnancy

India does not permit abortion as a means for fertility regulation. However, from 1972 onwards Medical Termination of Pregnancy has been allowed as a part of health care facility for pregnant mothers on health and related socio-cultural considerations. Primarily, this facility is provided to save health hazards to the millions of women who take recourse to clandestine abortions by ill-qualified doctors or quacks in un-hygienic conditions. We believe that child bearing should be a joy, not a burden; and since it is the mother who bears and rears the child, we are concerned not only with her health but with her will and well-being. More than 10,000 doctors have been trained in MTP technique and over 32 lakh pregnancies terminated since the inception of this programmes. It is proposed to make available at least one trained doctor in M.T.P. in each PHC.

Mother and Child Health Care

Maternal and Child Health (MCH) services play an important role and constitute a vital component of the family welfare programme. These services contribute to better health and better chances of survival of mothers and children. We are pledged to provide basic health care facilities like safe and aseptic delivery and immunisation of children against childhood diseases. In view of the vastness of the country, it may take some time to provide full package of services to every child and expectant mother. We aim at providing universal immunisation by 1990. This presents an enormous problem in logistics, supplies and trained manpower which are proposed to be tackled in the 7th Plan.

Some New Initiatives

With a view to giving further fillip to the Programme, the Government have taken some policy decisions and initiatives. More important of these are outlines below:

(i) Major States have been asked to conduct detailed exercises taking into account their present couple protection level, conditions in the field and their management capacity so as to fix appropriate targets for themselves in order to realise the overall national goals. This is intended to decentralise the process of target-setting and ensure the participation of the programme managers in the planning process.

(ii) The staffing pattern at various levels under the Family Welfare Programme was laid down in 1966. Since then there has been manifold increase in the size and sweep of the programme. A high level Task Force was set up in November, 1983 to review the existing situation *vis-a-vis* staff pattern at various levels and suggest appropriate need-based staffing pattern for various levels at the Centre, States and Union Territories.

(iii) In consultation with the Planning Commission and the Ministry of Finance, a special fund has been created at the Centre to provide expenditure on items which may not be covered by the approved pattern of assistance under the Family Welfare Programme. This step is expected to remove quite a few bottlenecks experienced in the implementation of the programme. This scheme is being continue during the current year with an allocation of Rs. 1.5 crore and is known as the Additional Secretary 'Commissioner Family Welfare' Discretionary Fund.

(iv) Keeping in view the importance of birth interval for child survival and mother's health as well as the contraception needs of younger couples who have not yet achieved the desired family size, the government has initiated a vigorous policy to promote spacing methods —IUD devices like Copper T, oral pills and condoms— on a large scale. This will be done on campaign basis. A Contraceptive Marketing Organisation has since

been registered under the Societies Registration Act to promote spacing methods and arrange for needed supplies and materials. It is estimated that by 1990 spacing methods will account for 20 per cent of protected couples against the present level of 5.5 per cent.

(v) Injectable contraceptives as yet do not form a part of the programme. A pilot project, on injectable contraceptives— NET — OEN — at PHCs attached to 15 medical colleges is underway. Based on the results this pilot project, it is hoped to introduce this spacing method next year.

(vi) Indian Council of Medical Research is also continuing its studies with Norplant —a female contraceptive device. It is expected that an appropriate version of this device will be available by the end of 1985 to enable to start the programme introduction studies at the PHCs.

(vii) The scheme for involvement of private medical practitioners of modern and integrated medicine in performing sterilisation operations and IUD insertions has been extended till 31-3-1987. An evaluation of this scheme is also being undertaken to make it more effective.

(viii) Last year a new scheme was initiated for involving local village communities with a view to ensure that all the eligible couples in a particular village community start practising one or the other family planning method. Mahila Mandals and Village Health Committees were motivated to implement the campaign. The scheme has made a very good impact in a few selected districts of Rajasthan and it is proposed to recommend this innovative scheme of "Parivar Kalyan Villages" with cent per cent acceptance of family planning methods to other States after perfecting the strategy.

(ix) A popular family programme—Hum Log—on the pattern of the Mexico Soap Opera has been introduced on the Doordarshan. Some such popular programmes on the radio and T.V. are in the pipeline and are expected to carry forward the process of mass education and motivation vis-a-vis adoption of small family norm.

People's Participation

Family Planning being a voluntary programme, needs the participation of millions of men and women. The aim is to conduct this programme as a people's movement with the active involvement of voluntary and non-governmental organisations. A favourable climate in support of small family norm is sought to be created with the help of mass media, folk media and inter-personnel communication by trained personnel. Opinion leaders, especially elected representatives of the people from the gram panchayat to the national Parliament, are getting increasingly involved in this programme. Motivation and training camps where such leaders get together for discussion is an important extension strategy being pursued with vigour. Thus, acceptance and practice of family planning is being promoted by motivation and education regarding the benefits of the small family norm, community involvement and provision of supplies and services of good quality. △

[*Continued from page 193*]

headed by the then member Planning Commission Dr M. S. Swaminathan has held its three meetings so far.

Medical and Technical personnels are being given enhanced stipends, from Rs. 450/- p.m. to Rs. 800/- p.m. to doctors and from Rs. 250/- p.m. to Rs. 620/- p.m. respectively for training in leprosy.

Govt. of India have revised the rates of (i) grants to voluntary Training Centres, (ii) POL for vehicles supplied under the NLEP, (iii) construction of leprosy training centres, Leprosy Rehabilitation promotion units.

The following quantum of anti-leprotic drugs was supplied to the various States/U.Ts. during the year 1984-85 till November.

1. D.D.S. Tablets-13.07 ton (includes 5 ton from German Leprosy Relief Association).
2. (a) Clofazimine (100 mg) capsules-2.50 lac capsules
   (b) Clofazimine (50 mg) capsules-200.00 lac capsules
   (c) 3 lac Clofazimine capsules from the Leprosy Mission.

   In addition to above 10 lac Rifampicin (300 mg) capsules and 32 lac Clofazimine (100 mg) capsules are expected to be received from WHO soon.

   (d) SIDA has been requested to supply 40 lac Rifampicm 300 mg capsules and 80.00 lac Clofazimine (100 mg) capsules for MDRP districts.

   (e) 17.50 lac Clofazimine (100 mg) capsules and 7.50 lac Rifampicin (300 mg) capsules are expected to be received soon for MDRP use.

   (f) One ton DDS received from Italian Leprosy Association and six ton DDS received from Danion Foundation are under release. △

Prevention of Food Adulteration

THE prevention of Food Adulteration Rules covering the standards of various items of food regulating use of addictive, presence of contaminants etc., are amended from time to time on the recommendations of Central Committee for Food Standards, which is a statutory committee, constituted by the Central Government, under the provisions of the Act to advise the Central and the State Governments, on matters arising out of the implementation of the Act. The Committee had met 31 times. The last meeting of the CCFS was held on 24-25th August, 1984 at Ahmedabad.

In order to keep the knowledge of all functionaries at all time up-to-date in service training courses for Food Inspectors, Analysts and Senior Officers of the States are organised with the objective of achieving uniform implementation in food laws. The PFA Cell in the Directorate General of Health Services regularly conducts such training programme in collaboration with various institutions.

Food Contamination Monitoring Programme: The Food Contamination Monitoring Programme which was in operation in co-operation with FAO and Nine National Laboratories since 1979, terminated on completion in December 1984. The survey has been in operation for estimating the presence of pesticides, toxic metals and all toxins occurring in commonly used food articles.

W.H.O. Fellowship: The 4th meeting of Coordinating Committee for Asia was held at Patchburi, Thailand from 28th February to 5th March 1984, to discuss the interests of the countries in the region in area of international food standards and acceptance of Codex Standards. The country was represented by a two member team from Directorate General of Health Services/Ministry of Health. The Indian deligation also included representative from the Department of Food.

Visits of Consultants and Fellows: The Directorate General of Health Services in the Ministry of Health and Family Welfare organised a visit of the FAO consultant which visited India in October 1984, to study the current situation and capabilities of various countries of the Asian region for manufacture and distribution of infant formulae and weaning foods with special reference to preparations based on locally available raw materials.

Education & Publicity: As only legislation may not be able to curb menace of food adulteration until and unless the consumers and traders are made aware of their responsibilities in the implementation of PFA Laws, the Central Government advises the State Governments from time to time to undertake educational programme through seminars, exhibitions and talks and through use of other mass media to create an awareness among the consumers and traders and also to make them familiar with the provisions of the Act and Rules. Some pamphlets on Food Adulteration have been published by the Central Government for the purpose of educating the consumers. The Central Health Education Bureau is bringing out pamphlets on food hygiene and documentary films on programme of food adulteration. In addition, cinema slides on programme of food adulteration are also proposed to be brought out for mass education.

Central Food Laboratories: A Central Food Laboratory is an appellate laboratory under the PFA Act whose report is considered to be final. At present, there are four Central Food Laboratories functioning under the provisions of the PFA Act. Two Laboratories, namely Central Food Laboratory, Calcutta and Food Research and Standardisation Laboratory, Ghaziabad are under the administrative control of D.G.H.S. while the Central Food Laboratory, Mysore and Central Food Laboratory, Pune are under the administrative control of C.S.I.R. and State of Maharashtra, respectively, in addition to legal samples, these laboratories also undertake research and investigational work relating to problem of analysis and standardisation of Food articles. The Central Food Laboratory, Pune and Mysore are provided an annual grant of Rs. 3.00 lakhs for undertaking the responsibilities of appellate work.

The number of samples of food articles analysed and found adulterated during the last five years are as follows:—

Year	No. of samples analysed	No. of samples found adulterated	Percentage of adulteration
1978	1,32,975	24,682	18.4
1979	1,32,003	19,520	14.8
1980	1,29,698	17,847	13.8
1981	1,33,242	19,050	14.2
1982	1,29,595	16,765	12.9

△

Maternal and Child Health Programme

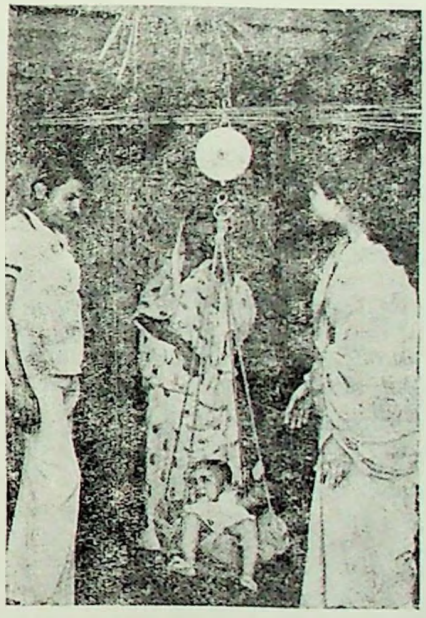
DURING 1984-85 special emphasis was laid on the health status of mothers and children in the context of the 20-point Programme which stipulates acceleration of programmes of welfare for women and children and nutrition programme for pregnant women and nursing mothers and children. The National Health Policy has also attached great importance to the MCH Programme. The infrastructure of delivery of maternal and child health services has been and is being expanded both in rural and urban areas by the setting up of primary health centres, rural family welfare centres and sub-centres, urban family, welfare centres and post-partum centres. In addition, the Department of Family Welfare has sponsored several schemes namely, immunisation of expectant mothers against tetanus; immunisation of children against Diphtheria, Whooping cough, tetanus, poliomyelitis typhoid and tuberculosis, prophylaxis against nutritional anaemia among mothers and children as well as prophylaxis against blindness due to Vitamin 'A' deficiency in children. The performance of most of these programmes during the current year has shown improvement compared to that of the corresponding period of last year.

Prophylaxis against nutritional anaemia among mothers and children: Anaemia is one of the major health problems affecting women of child bearing age and children contributing to maternal mortality and morbidity leading further to a still-birth, premature birth and low-birth weight babies. In order to prevent nutrition anaemia among mothers and children, daily dietary requirements for iron and folic acid, the deficiency of which causes anaemia, is given in the form of tablets. Pregnant and nursing mothers and women acceptors of family planning, and children are the beneficiaries.

Prophylaxis against blindness due to Vitamin 'A' deficiency among children: Vitamin 'A' deficiency is found to be prevalent among children of pre-school age in many parts of the country. Severe forms of Vitamin 'A' deficiency Keratomalacia coupled with malnutrition and infection is believed to be an important cause of blindness among children. As a preventive measure, concentrated Vitamin 'A' solution in oil form is given to children in the age-group of 1—5 years every six months. Targets and achievements upto 30th September, 1984 are given below:

(figures in lakhs)

Scheme	Target 1984-85 Physical	Achievement upto Sept. 84 Physical	%age achievement of annual target during 1983-84
1	2	3	4
Prophylaxis against nutritional anaemia			
(Mothers)	130	84.54	65.1
(Children)	130	78.75	60.6
Prophylaxis against blindness among children due to Vitamin 'A' deficiency	270	131.55	53.7



A child is being weighed as a part of nutritional monitoring programme which helps in preventing blindness by detecting vitamin 'A' deficiency.

The Expanded Programme on Immunisation: The expanded programme on immunization was started in India in 1978 with the objective of reducing the morbidity and mortality due to diphtheria, pertussis, tetanus, poliomyelities, tuberculosis and typhoid. Vaccination services are proposed to be made available to all eligible children and pregnant women by 1990. It is also proposed to include measles in the EPI during the 7th Plan. It was also aimed to achieve self sufficiency in the production of vaccines required for the programme.

Rural Health Services

THE main programmes/schemes being implemented under the Minimum Needs Programme, to provide primary health care relevant to the actual needs of the community in the rural areas are indicated below:

Sub-Centres: The additional sub-centres to be established during the 6th Plan period will raise their number to about 80,000 against the estimated total requirements of 1,30,800. Their progress is as follows:—

(a) Functioning on 1-4-1980	47172
(b) Target for the 6th Plan period	40000 (approx.)
(c) Established during 1980-84	27135
(d) Target for 1984-85	9071

Primary Health Centres

(a) Functioning on 1-4-1980	5484
(b) Target for the 6th Plan period	756
(c) Established during 1980-84	1726
(d) Target for 1984-85	192

Subsidiary Health Centres/New Primary Health Centres: It is proposed to convert the Rural Dispensaries into Subsidiary Health Centres/New Primary Health Centres.

(a) Functioning on 1-4-1980	2056
(b) Target for the 6th Plan period	2270
(c) Established during 1980-84	1558
(d) Target for 1984-85	396

Upgraded Primary Health Centres: It is proposed to establish rural hospitals by upgrading the existing Primary Health Centres. Each of the upgraded Primary Health Centre will have 30 beds to meet the need for the rural population.

(a) Functioning on 1-4-1980	217
(b) Target for the 6th Plan period	315
(c) Established during 1980-84	258
(d) Target for 1984-85	118

Health Guide Scheme: Upto 30-9-84, 4234 Primary Health Centres have been covered under the Scheme. From the inception of the Scheme, till 30-9-1984, 3,45,548 Health Guides have been trained. In 1984-85 upto September 84, a total of amount 2300 Health Guides had received training.

The states of J&K, Kerala, Tamil Nadu and U.T. of Arunachal Pradesh have not accepted the Health Guide Scheme. They are implementing alternative schemes. J&K is implementing 'Rehbar-e-Sehat' Scheme. Under this as per the information available 29 bocks have been taken up and 2450 volunteers have been trained. Kerala is implementing 'Strengthening of Primary Health Centres' in three districts of Trivandrum, Kozhikode and Wynad. Tamil Nadu is implementing 'Mini Health Centre' Scheme. 251 Mini Health Centres are functioning there. In Arunachal Pradesh 'Medics' scheme is in operation. 542 persons are functioning under this scheme.

Multipurpose Workers Scheme: Implementation of the scheme involves: (i) conversion of all the existing unipurpose workers at different levels into multipurpose workers after suitable training, (ii) integration of all National Health and Family Welfare Programmes and (iii) employment of additional workers.

Training

(a) The seven Central Training Institutes conduct training programmes for the key trainers and the District Level Medical Officers;

(b) The 47 Health and Family Welfart Training Centres impart training to the Medical Officers and the Block Extension Educators (BEEs) of the Primary Health Centres (PHCs).

(c) Trained Medical Officers and BEEs organise training at their own PHCs. at tht selected PHCs. for their para-medicals.

Achievements: According to the information received and compiled as on 30th September, 1984, retraining is complete in 348 districts and it is in progress in 30 districts. The States of Gujarat, Karnataka, Maharashtra, Madya Pradesh, Haryana, Punjab, Kerala, Himachal, Orissa, U.P., Rajasthan, Meghalaya and Sikkim have completed the training. The position with regard to the total number trained is:

S. No.	Category	Total No Trained upto 31-3-84	No. of Persons trained during 1984-85 upto 30-9-84
1.	Distt. Level Medical Officers	1650	16
2.	Key Trainers	706	20
3.	D.E.M.Os./Dy. D.E.M.Os.	304	8
4.	Medical Officers	17256	218
5.	B.E.E.	5998	261
6.	Health Assistant (Male)	27128	479
7.	Health Assistant (Female)	12849	719
8.	Health workers (Male)	84037	823
9.	Health Workers (Female)	58286	2786

38th World Health Assembly

Health for All and All for Health

The Thirtyeight World Health Assembly was held from 6—20 May, 1985, in Geneva. Over 1000 delegates, including over 100 minister of health, representing most of the 166 Member States of the World Health Organisation participated. We publish here the highlights of the Assembly.

A growing partnership between governments and non-governmental organizations (NGOs) is essential for the attainment of Health for all by the year 2000. The World Health Organization (WHO) has a crucial role to play in promoting, fostering and strengthening this partnership. These are the overriding conclusions of the eminently successful Technical Discussions held in connection with the 38th World Health Assembly.

Nearly 600 people, including numerous representatives of national nongovernmental organizations, participated in these discussions on the theme of Collaboration with Nongovernmental Organizations in Implementing the Global Strategy for Health for All. Under the chairmanship of Dr Maureen Law (Canada), these discussions consisted of two plenary meetings and three sessions held by eight working groups.

Participants defined and debated in detail both the scope for collaboration between NGOs and governments, and the obstacles to be overcome in such collaboration. The discussions underscored the fact that it is often the unmet needs of a country or region which stimulate nongovernmental organizations to creative action.

Action at community level

Many NGOs work primarily or entirely at the community level. As a result, they are often particularly sensitive to the needs of the community, especially those whose health needs are greatest. Relatively unbound by the legislative framework of governments, NGOs in general have the flexibility to experiment with innovative approaches to solving health problems. They often achieve cost-effective breakthroughs which can provide new models for national planning.

It is vital that the momentum generated by the Technical Discussions be neither lost nor allowed to weaken. The final report devoted to these particularly successful Technical Discussions underlines the importance of taking immediate follow-up measures to harness this enthusiasm, notably by encouraging Member States to take stock of the existing NGO community, and to determine what must be done to reinforce collaboration with them at all levels. WHO will undertake new steps to facilitate and support Member States and the NGOs with which it works, so that the new partnership sketched out during the World Health Assembly in Geneva in May 1985 quickly becomes a reality.

Dr Halfdan Mahler, Director-General of WHO, who welcomed participants to the Technical Discussions, said that this meeting was convened at a time when millions of people had empty stomachs and were living in despair. He had been impressed with the build-up emotional energy which must now be harnessed in the direction of primary health care. In the closing session of the Technical Discussions, Dr Mahler expressed satisfaction that this emotional energy was so clearly present in participants' discussions, and that they were looking to WHO to promote this new alliance between governments and NGOs in a partnership which is the chief recommendation of the report. The Director-General wholeheartedly echoed the formulation which naturally emerged from these discussions: "Health for all and all for health".

Earlier on 6 May, 1985, Dr Suwardjono Surjaningrat, Minister of Heath of the Republic of Indonesia was elected by acclamation President of the 38th World Health Assembly when it opened in Geneva.

Dr Surjaningrat, a specialist in obstetrics and gynaecology, was chairman of the national family planning coordinating body and later secretary general to the Ministry of Health, before becoming Minister of Health.

Addressing the opening session of the Assembly, Professor Guillermo Soberon Acevedo, President of the 37th World Health Assembly, told delegates that improving the health of the people and safeguarding social rights was now part and parcel of many National Constitutions. Governments, he said, have a responsibility to organize the resources of society to ensure better health for all, including the true development of human potential.

IOC and WHO join hands

Strong support for the possibility of future collaboration between the International Olympic Committee (IOC) and the World Health Organization (WHO) was voiced by Mr Juan Antonio Samaranch, the IOC President, in an address to the World Health Assembly on 10 May 1985.

"It is not surprising to see that the World Health Organization and the International Olympic Committee have adopted many similar ideas, including the recognition of the importance of physical activity for better health", said Mr Samaranch. "You call it 'Health for All', we call it 'Sports for All' ".

Mr Samaranch said that in addition to physical exercise the IOC would like to stress the importance of proper nutrition and diet as a means both of preventing disease and improving health. His Organization was fully in agreement with WHO in emphasizing the importance of personal responsibility in health.

FIRST SASAKAWA HEALTH PRIZE
INDIA AMONG THE RECIPIENTS

Dr Suwardjono Surjaningrat, President of the 38th World Health Assembly, on 9 May, 1985, presented the first Sasakawa Health Prize and Statuette to three recipients: Dr Jesus Azurin (Philippines), Dr David Bersh Escobar (Colombia), and the Rural Society for Education, Welfare and Action (SEWA) of Gujarat Province, India, in recognition for their innovative work in health development. The prize was established and funded by Mr Ryoichi Sasakawa, Chairman of the Japan Shipbuilding Industry Foundation and President of the Sasakawa Memorial Health Foundation.

These contributions have been shared by a number of WHO programmes including leprosy control, the smallpox eradication campaign, the Special Programme for Research and Training in Tropical Diseases (TDR), the Expanded Programme on Immunization (EPI), the Programme for the Prevention of Blindness (PBL), various activities in the Western Pacific Region, and primary health care programmes in a number of countries.

Dr Lata Desai, representing the Rural Society for Education, Welfare and Action (SEWA) in the Gujarat Province of India, is Associate Director of SEWA's Rural Community Health Project. SEWA is a recently created voluntary organisation working with the Government to develop primary health care for disadvantaged rural populations. SEWA's dedicated efforts have already led to the adoption of several innovative yet simple approaches to strengthen community-based health services.

Mr Samaranch said that a joint working group has now been set up by the two organizations: its members include Prince Alexandre de Merode, Chairman of the IOC Medical Commission, and Dr Jacques Hamon, Assistant Director-General of WHO. This group, which has begun a series of contacts, is studying various areas and possibilities of collaboration.

Mr Samaranch said the aim would be to develop programmes designed to encourage sport and health in a strongly positive sense, and to encourage personal responsibility in maintaining health.

JACQUES PARISOT FOUNDATION MEDAL

Dr Anant Menaruchi (Thailand) was presented on 16 May 1985 with the Jacques Parisot Foundation Medal by Dr Suwardjono Surjaningrat, President of the 38th World Health Assembly, for his study of a methodology for community-based sanitation programmes.

Dr Menaruchi was awarded the Jacques Parisot Foundation fellowship in 1984, which enabled him to carry out a project located in rural villages of the Ban Phai district of the Khon Kaen province in the northeast region of Thailand.

In the course of the past five years, Dr Menaruchi has been deeply involved with numerous primary health care (PHC) activities in his country, including the organisation of PHC field demonstration projects leading to the creation of village drug cooperatives, sanitation cooperatives, and nutrition cooperatives. He set up PHC training programmes for religious leaders, school teachers and primary school children, emphasizing health promotion and health education. He also paid particular attention to the role of communications for health through primary health care at village level.

The IOC President said the two organizations should set themselves a target—to make the year 2000 a year of victory for health and well-being everywhere. "We must win this race against time. It is the only race in which everyone can win. Let us all be winners for health", he concluded.

Maturity of debate

Closing the general debate at the 38th World Health Assembly on 10 May, 1985 Dr Halfdan Mahler, Director-General of the World Health Organization (WHO) welcomed the frankness of delegates' comments on their countries' health problems.

"This frankness is a sure sign that we *are* becoming more mature as an Organization", commented Dr Mahler.

The Director-General reiterated his plea for "faith in human development", noting that technical, material and financial resources are only well used if they give rise to an improvement in the quality of life of the people who inhabit this planet.

Dr Mahler expressed satisfaction with the importance given by delegates to the role of nongovernmental organizations in the Health for All movement. He added that this recognition of people's desire to assume ever-increasing responsibility for the health and welfare of all was an additional sign of maturity.

Keep Political Matters Out.

Dr. Suwardjono Surjaningrat, President of the Assembly, made an earnest plea to the Assembly in its Plenary Session on the "imperative needs for all of us to constantly remaind ourselves that we *must* make sincere efforts to keep extraneous political matters away from our deliberations."

New Members for Executive Board

The Assembly elected the following 12 States as Members entitled to designate a person to serve on the Executive Board of the World Health Organization (WHO).,

They are: Lesotho, Canada, Cuba, Ecuador, Indonesia., Germany, Federal Republic of, Malta, Poland, Cyprus, Democratic Yemen, Australia, and Tonga.

Their term of office begins immediately after the closure of the 38th World Health Assembly.

THE LEON BERNARD PRIZE

For outstanding services in the field of social medicine Professor Raoul Senault (France) was awarded the Léon Bernard Foundation Prize and Medal, presented to him by Dr Suwardjono Surjaningrat, President of the Assembly on 14 May 1985.

Professor Senault, who heads the French delegation to the Assembly, is Professor of Public Health at the Faculty of Medicine of Nancy. During his 30-year career in social medicine and public health, he contributed to many aspects of public health, including education for health, the control of tuberculosis, cancer and alcoholism, maternal and child health, studies in atmospheric pollution, and regional epidemiological and laboratory studies. He always managed to combine hospital work with social medicine activities. Since 1961, he has been a member of France's Higher Council for Public Health, of which he was a Vice-Chairman from 1975 to 1984.

RESOLUTIONS

The Assembly concluded its work on 20 May 1985 on a background of earnest pleas made by its President, Dr Suwardjono Surjaningrat, and by the Director General of the World Heath Organization (WHO), Dr Halfdan Mahler, to concentrate efforts on the attainment of health for all by the year 2000 and keep extraneous political matters out of WHO.

The Assembly displayed renewed faith in the potenial for people's development and the dynamic role of strategies for health for all in ensuring it.

A.T. SHOUSHA FOUNDATION MEDAL AND PRIZE

Dr Mohamed Hamad Satti (Sudan) was awarded the Dr Aly Tewfik Shousha Foundation Medal and Prize by Dr Suwardjono Surjaningrat, President of the Assembly, on 15 May 1985 for his most significant contribution to the solution of health problems in the Eastern Mediterranean region in which Dr Shousha served the World Health Organisation (WHO).

Dr Satti is at present Director of the Institute of Tropical Medicine Research at the Medical Research Council of Sudan. Since his early years, his interests covered many different aspects of public health, including communicable diseases such as leishmaniasis, malaria, smallpox, yellow fever, filariasis and onchocerciasis, to which he devoted vigorous and brilliant attention.

The Assembly also decided to strengthen WHO support to countries cooperating amoung themselves for health development on their own initiative and to involve nongovernmental organizations more than ever before, to attain the goal of healh for all as a social contract between governments, people and WHO.

Technical and economic cooperation

Action to build up a critical mass of health-for-all leaders was supported by the Assembly as suggested by the Director-General. A comperhensive strategy for leadership development is required and all concerned, including Member States, international organizations and bilateral, multilateral, nongovernmental and voluntary agencies, were urged to concentrate on activities strengthening technical and economic cooperation among developing countries (TCDC/ECDC).

Women, health and development

There was general concern about the slow progress in realizing the objectives of the UN Decade for women, particularly regarding high maternal mortality rates, the frequency and severity of the repercussions on women's health of certain practices, inadequate conditions of domestic work or paid employment, the frequency of nutritional anaemia, and the prevalence of adolescent marriages and pregnancies. The Assembly felt there should be greater concern for the protection of women's health and suggested "inter alia" information and education campaigns to intensify the participation of women—who play a key role in health and development—in the implementation of the global strategy for health for all by the year 2000.

Prevention of disability and rehabilitation of the disabled

Emphasis was placed on the prevention of disability paticularly through the Expanded Programme on Immunization (EPI), and by strengthening environmental, occupational and other health programmes. Member States were also requested to increase opportunities for the participation of disabled persons in community life and in decision-making; to expand education, training and job opportunities for disabled persons; to facilitate their acceptance by the general population; to increase public information and education so as to prevent disabling accidents; and to remove all barriers which prevent disabled persons from leading socially and economically productive lives.

Prevention of deafness and hearing impairment

Deafness is estimated to afflict 70 million people in the world, and hearing impairment effects at least eight per cent of the population in every country. Most of the hearing impairment results from causes that can be prevented at the primary health level. Great advances in technology in otolaryngology and audiology have also been achcived. Aware of these facts, the Assembly requested the Director-General of WHO to "assess the extent, causes and consequences of hearing impairment and deafness in all countries". Proposals for strengthening measures of prevention and treatment of hearing impairment and deafness are to be made to the 39th World Health Assembly.

Childbearing and maturity

Premature pregnancies in immature adolescent women, have disastrous world-wide consequences especially when they occur in a context of poverty, illiteracy, undernutrition, and an unhealthy environment. WHO is requested to increase its collaboration with Member States in providing programmes for adolescents based on primary health care, with an emphasis on information, education and guidance. The same resolution urges all Member States to advocate the delay of childbearing until both parents, but especially the mother, have reached maturity.

Malaria control

The spread of malaria jeopardizes health and development in many developing countries. To prevent a further deterioration of this situation, the control of malaria is essential, with full and active community participation. It should be integrated into national primary health care programmes. The Assembly therefore urged Member States concerned; (1) to undertake an immediate appraisal of the malaria situation and of existing control strategies, (2) to plan antimalaria activities, utilizing appropriate technologies, to be integrated into PHC programmes. WHO continues to support research for malaria vaccines.

Chronic noncommunicable diseases

Member States are called upon to promote studies on population behaviour with the aim of preventing and controlling cardiovascular diseases, lung cancer, diabetes mellitus and chronic respiratory and other noncommunicable diseases. The Assembly also requested the Director-General to foster and support community studies aimed at the joint control of a number of risk-related noncommunicable diseases, related to styles of life.

This resolution was passed bearing in mind that information is accumulating which points to a number of features common to several noncommunicable diseases, such as their origins in, and aggravation by, tobacco smoking and other lifestyle factors. The adverse effect of smoking on health was stressed on a number of occasions. △

CHILD HEALTH FOUNDATION MEDAL AND PRIZE

Professor Perla Santos Ocampo (Philippines) was presented with the Child Health Foundation Medal and Prize by Dr Suwardjono Surjaningrat, on 17 May 1985 for her outstanding service in the field of child health.

Professor Santos Ocampo received many awards and scholarships in her career. She is the author of some 100 publications in the field of child health. Since 1981, she has held the position of Chairperson of the Department of Paediatrics at the University of the Philippines. The quality of life of children in the Philippines and elsewhere has been immensely improved following her community involvement in numerous innovative projects. In 1962, she organised a medical centre for indigents. As Secretary of the Manila Medical Society, she persuaded the Ministry for Education and Culture to establish the first school for chronically-ill children in the Phillippines General Hospital.

As President of the Philippines Paediatric Association, she inaugurated child advocacy centres in Manila and mobilized paediatricians to facilitate access to health care for children at all school levels. With UNICEF's support, she organized courses for medical and auxiliary personnel in deprived and disadvantaged areas. △

BOOKS

ALCOHOL RELATED PROBLEMS

Public health implications of Alcohol production and trade, by B. Walsh & M. Grant. Geneva, 1985, 55 and pages (WHO Offset Publication No. 88). ISBN 92 4 170088 2 Price: Sw. fr. 8.—.

Concern has now been expressed by many Member States about the seriousness of the growth in alcohol-related problems that they are currently experiencing, and much of this concern relates specifically to the situation in developing countries.

The Technical Discussions at the Thirty-fifth World Health Assembly provided an opportunity for identifying areas for priority action. One pressing demand was for more reliable information about trends in global production and trade in alcoholic beverages. A new WHO publication analyses these trends and relates them to public health issues.

The publication is based on data from a wide range of international statistical reports and trade publications. It reveals that world commercial *beer* production more than doubled between 1960 and 1980. The long established beer producing countries in Europe and North America still have the highest rates of consumption per person. A number of developing countries have, however, experienced sharp increases in recent years, as shown in the graph, which compares beer production per person in the United Kingdom and Cameroon over the period 1960-81.

By contrast, the production of *wine* has kept approximate pace with world population growth. Production remains concentrated in the traditional wine growing areas of Europe and European settlement, although there has been a sharp fall in consumption per person in France, Italy, and Portugal.

Commercial production of *spirits* rose by two-thirds between 1965 and 1980, while consumption per capita rose by about one-third. Non-commercial production is, however, likely to be particularly important and the recording of commercial production is far from satisfactory, so that these increases may be underestimates. Very rapid increases took place in several countries, such as the Republic of Korea, Mexico, and the Philippines, where production was initially very modest.

The publication also looks at total production of alcohol and finds that it rose by almost 50% between 1965 and 1980, while production per capita rose by about 15%. Although most alcoholic beverages are still consumed in their country of origin, it is not only those with the highest levels that are of concern from a public health perspective. In some other countries, although consumption per person is comparatively low, the rate of increase is very steep. If sustained, it will result in high consumption levels by the end of this century.

The fact that the production of beer, wine, and spirits has been increasing more rapidly than population in most parts of the world suggests that the available public health resources will be increasingly burdened with additional alcohol-related problems in the future. This prospect is of particular concern in those developing regions of the world where very steep rates of increase in drinking are being recorded. In view of this, the WHO publication suggests ways in which countries can use data on production and consumption to help in the process of developing alcohol policies and programmes, within the context of national health planning.

RABIES

WHO Expert Committee on Rabies. Seventh report. Geneva, 1984, 104 pages (WHO Technical Report Series, No. 709). ISBN 92 4 120709 4 Price: Sw. fr. 9.—.

In spite of recent advances in research and field control methods, rabies continues to exact a heavy toll in many countries and is even spreading. The WHO Expert Committee notes in its seventh report that over 98% of all human cases of rabies of the world are due to rabies reservoirs in dog populations, and that such reservoirs are almost exclusively in the developing countries. A full chapter is devoted to national programmes for the control of rabies in dogs and other domestic animals.

New approaches to the control of rabies presented in the report are based upon: (a) a managerial guide for the initiation and step-by-step development of national programmes of rabies control, taking into consideration the needs for intersectoral cooperation and community participation; (b) the endorsement of a WHO Programme for the Control of Human and Canine Rabies; (c) schedules for the use of (and potency requirements for) new rabies vaccines used in human pre- and post-exposure treatment; (d) potency requirements for animal rabies vaccines, which should confer immunity for at least two years after a single inoculation and would thus be particularly suitable for use in mass campaigns of dog immunization; (e) a proposal to simplify the multiplicity of national requirements for the international transfer of animals depending on the epidemiology of rabies in the countries of origin and destination; (f) an evaluation of research on the ecology and natural barriers of wildlife rabies and on the use of attenuated oral rabies vaccine to stop the spread of the disease or to eliminate the infection in its national reservoirs; and (g) consideration of a great number of other new laboratory, management, and field techniques as well as advances in basic virology and epidemiology with a view to improving diagnosis, vaccines, dog population management, and disease control in domestic animals and wildlife.

As in previous reports, the Expert Committee includes in its report a brief guide to the local treatment of wounds and to specific systemic treatment after human exposure to rabies.

The main recommendations formulated by the Expert Committee concern the above-mentioned approaches to programme development and improvement of regulations and methods, especially the step-by-step development of national programmes and the WHO Programme for the Control of Human and Canine Rabies. Emphasis is also placed on the improvement of rabies surveillance techniques in countries and the use of new diagnostic methods to classify rabies field isolates, the replacement of present human rabies vaccines by safe and highly potent tissue culture vaccines of low cost, the development of virus strains and application procedures for oral vaccines for wildlife and stray dogs, ecological studies of host species including vampire bats, and research on dog population control.

—WHO Chronicle

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INFORMATION FOR CONTRIBUTORS

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Articles on every aspect of public health are invited. They should be such as have not been published or accepted for publication elsewhere.

The articles should be written in simple and non-technical language so as to be understood by the laymen.

Articles should not exceed 1,500 words in length.

The name, designation and all relevant details about the author should be clearly indicated in the beginning of the article itself.

Manuscripts should be typed on the one side of the paper, double space and sent *in duplicate*.

Good illustrations enhance the value of the articles and contributors are requested to submit photographs, drawings, charts, etc.

Photographs should be in black and white on glossy paper, easily reproducible and of 6×8 inches in size.

All photographs, charts, etc., should bear captions clearly on the back.

Lettering on charts, tables, etc., should be in black ink (Indian ink) and should be large enough to be read when reduced. Good quality of white paper should be used.

While sending photographs, drawings, etc., contributors should take care to see that they are not damaged in transit. They should be placed between hard card boards and never pinned to anything.

Each contributor whose article is published receives two complimentary copies of the issue.