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HEALTH PROGRESS IN INDIA

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READERS WRITE

It is really an achievement to have such an informative and useful magazine with such a little amount. All the educational institutions must subscribe to the 'Swasth Hind'.

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Articles on health topics are invited for publication in this Journal.

State Health Directorates are requested to send reports of their activities for publication.

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Broad objectives of the health programmes have been to control and eradicate communicable diseases, to provide preventive, curative and promotive health services to the people with improved primary health care services in rural and tribal areas.

HEALTH ACHIEVEMENTS 1985 - 86

S. S. DHANOA

Secretary

Ministry of Health and Family Welfare

IN the year 1985-86, the Ministry of Health and Family Welfare continued their efforts to place the health and family welfare programmes on a sound footing, to bring about more effective integration between them, to extend outreach, particularly in rural areas, and to achieve greater participation of the community in schemes intended to improve its own health standards. There was a renewed emphasis on the child survival programmes. "Universal Immunization Programme" was launched on 19 November, 1985, as a living memorial to Smt. Indira Gandhi, for whom the health of the mother and the child had been of paramount consideration in all developmental programmes. This programme aims at providing protection to children against six vaccine preventable diseases—diphtheria, tetanus, whooping cough, tuberculosis, polio and measles. For this, a beginning has been made in 30 districts and catchment areas of 50 medical colleges in 628 blocks to cover 66 million population by the end of this financial year. The programme will be expanded in a phased manner to cover the entire country by 1990.

This is the first year of the 7th Five Year Plan and during the plan period, it has been decided that the emphasis will be laid on preventive and promotive aspects and organising effective and efficient health services which are comprehensive in nature, easily and widely available and accessible to and affordable by the people. Accordingly, broad objectives of the health programmes have been to control and eradicate communicable diseases, to provide preventive, curative and promotive health services to the people with improved primary health care services in rural and tribal areas.

Emphasis on indigenous skills

All the peripheral level facilities for health delivery system were enlarged to meet the health needs of the people closer to their doorsteps. Long term measures have been formulated to expand the network of primary health centres, sub-centres under the Minimum Needs Programme. As on 31 December, 1985, there were 11,530 Subsidiary/Primary Health Centres, 84,013 sub-centres, 1.80 lakh Multipurpose Health Workers of which 0.94 lakh are females. In fact, the Ministry's efforts have been directed towards

improving indigenous skill and human development. We have now 3.85 lakh trained Health Guides, and about 5.16 lakh trained Dais. A programme for training of traditional birth attendants is being continued, and it is envisaged that 25,000 Dais will be trained during 1985-86.

Malaria eradication

Great emphasis has been given to the National Malaria Eradication Programme by the Government. During the year 1985, as per reports received upto 31 December, 1985, total malaria incidence and *P. falciparum* cases recorded a decline of 16.87% and 24.49% respectively as compared to the corresponding period of 1984. However, during 1985, the States of Bihar, Himachal Pradesh, Jammu & Kashmir, Punjab, Sikkim, Tamil Nadu, West Bengal and UTs of Chandigarh, Dadra & Nagar Haveli, and Mizoram have reported some increase in the total incidence in comparison to last year. Increase in *P. falciparum* cases was observed in Bihar, Jammu & Kashmir, Karnataka, West Bengal, Andaman & Nicobar Islands and Mizoram.

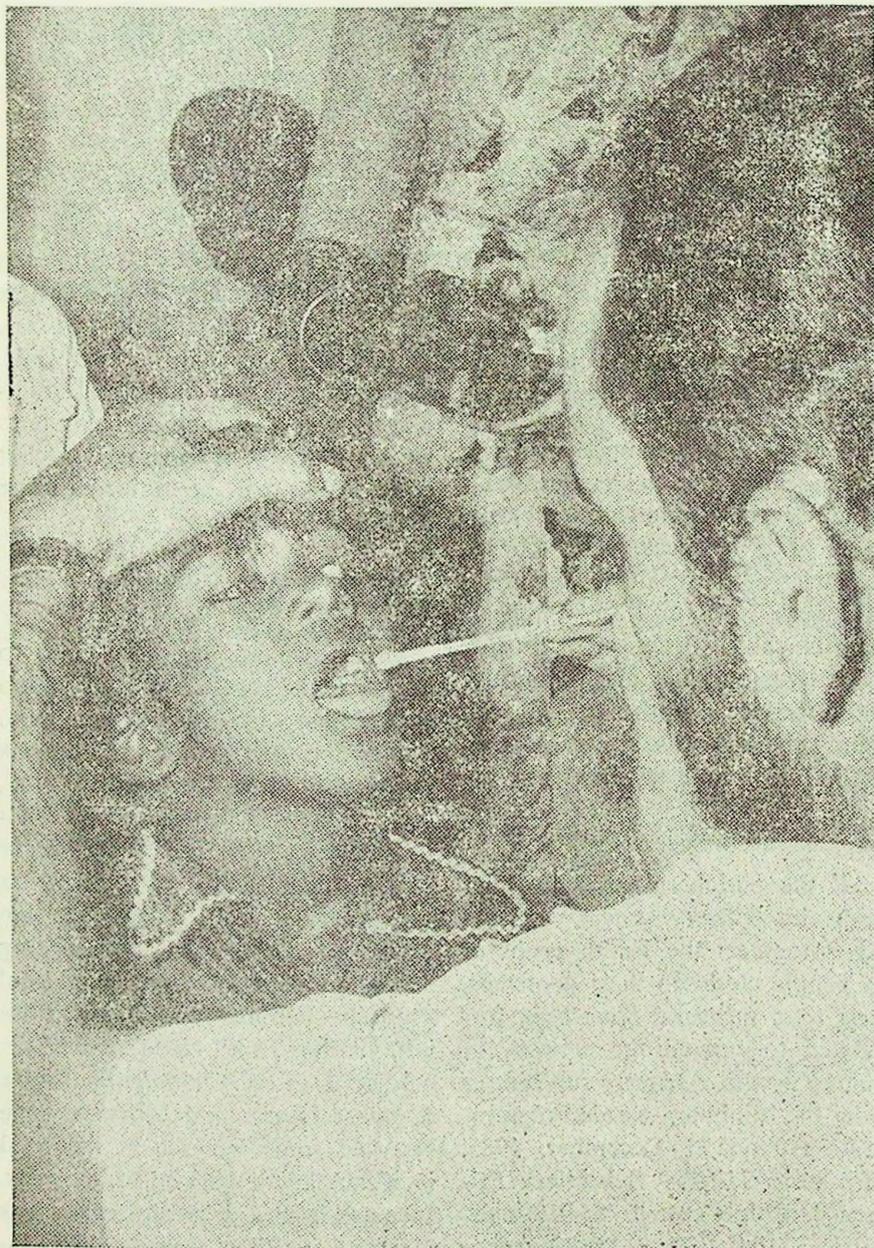
Newer drugs for leprosy

Concerted efforts are being made to educate the people for early detection of leprosy, its treatment and rehabilitation of the patient. At the end of the 6th Plan period, 3.24 million leprosy cases were on records and 3.02 million have been brought under treatment. 1.93 million cases have been discharged as

cured since the inception of the programme.

Newer drugs, rifampicin and clofazimine, have been introduced in the programme. These drugs and dapsone, when given in proper combination, have been found to produce complete cure and make the cases non-infectious and interrupt

the spread. Over a comparatively short period of 2 to 3 years. The preliminary indications are that cases have become non-infectious and the disease activity has been arrested in over 85% of cases in a 3-year period. During 1985-86, nine more highly endemic districts are being taken up for Multi-Drug Treatment.



All the peripheral level facilities for health delivery system were enlarged to meet the health needs of the people closer to their doorsteps.

T.B. Control Programme

Under the National Tuberculosis Control Programme, 364 Districts in the country have been provided with District T.B. Centres with essential equipments. These are manned by medical and para-medical personnel duly trained at National Tuberculosis Institute, Bangalore. From April to November 1985 these centres have detected 11.35 lakh new T.B. cases. Besides, 11.70 lakh sputum examinations were conducted out of the chronic chest symptomatic cases during this period. Ten X-ray units and 25 Odelca cameras are being supplied to States/U.Ts.

Control of blindness

To control blindness, the PHC infrastructure is being strengthened and central mobile units are provided. Upgradation of Departments of Ophthalmology in the Medical Colleges have also been taken up along with the strengthening of District Hospital infrastructure. As against the target of 10, so far 9 Regional Institutes under the National Programme for Control of Blindness have also been providing training, health education and research which forms an integral component of the programme. Voluntary organisations engaged in the eye-care work are being encouraged

(Contd. on page 176)

India on way to Achieving the goal of Health for All

SMT. MOHSINA KIDWAI

Smt. Mohsina Kidwai has said that the global economic crisis had hit the efforts of the developing countries resulting in substantial cuts in health budgets. If one fifteenth of the expenditure going in for the production of deadly weapons was diverted to health programmes, the goal of health for all could be achieved easily, she added.

The then Union Health Minister was speaking at the plenary session of 39th World Health Assembly in Geneva on 6 May, 1986.

On the subject of increasing population and high birth rate, Smt. Kidwai said that though the birth rate had declined from 36.8 per 1000 population in 1971 to about 33 in 1982, the rate of growth of population was increasing. In this context the Health Minister said that around 70 million births had been averted by family planning methods in India.

About the high rate of infant mortality prevailing in India, Smt. Kidwai said that India had launched a massive programme of Universal Immunization in 1985. Under this programme all expectant mothers and infants were proposed to be immunised by 1990. This programme of universal immunization was expected to bring in the reduction in morbidity and mortality with vaccine preventable diseases, she added.

On communicable diseases which were taking a heavy toll of life in developing countries, Smt. Kidwai said that India had launched a massive programme to eradicate leprosy, malaria and such other dreaded diseases. The incidence of malaria had declined from 2.18 million in 1984 to 1.74 million in 1985.

On the emerging disease of goitre, the Health Minister said that the arrangements were being made to

iodise the entire edible salt in India by 1992 with a view to eradicating the iodine deficiency diseases.

Smt. Kidwai said that India had formulated a drug policy as early as 1978 and was in a position to supply a whole range of drugs and medicines to other developing countries. India had also established an elaborate drug control machinery for ensuring the quality of drugs, she added.

On medical education and research, the Health Minister said, "Medical education and practice cannot respond to the present day needs if they also do not train people to identify the community's special problems and assist the individual to tackle them. Primary health care approach would succeed only when the personnel involved in delivering the services have faith in the system and are imbued with the same degree of commitment and responsibility for the health of community members as for hospital patients. Besides, there is need for a close inter-action between medical colleges and health departments of State Governments".

"We are reviewing our strategy with a view to re-orienting the medical education system to make it more responsive to the needs of the society. We hope to evolve a new medical and health education policy very soon", the Health Minister added.

She called upon the world community to find out ways to find 'necessary resources to translate into concrete action the goals we set before ourselves in Alma Ata'. Unless the necessary resources were mobilised to finance the health programmes throughout the world the cherished goal of Health for All by 2000 AD might remain nothing more than a pious intention, Smt. Kidwai added. △

International agencies and some foreign Governments have shown interest in our Health and Family Welfare Programmes. They have come forward with a helping hand to augment our efforts which have been taken up with our own resources. Though much has been done to ensure "Health for all by 2000 A.D." and bringing down the NRR to one by the turn of the century, more concerted efforts are needed to reach these cherished goals.

(Contd. from page 174)

to carry out comprehensive eye health care activities particularly in remote rural areas. During the 6th plan, an expenditure of Rs. 23.73 crores was incurred. For the 7th Plan, an amount of Rs. 31 crores has been allocated.

Family Welfare

Country's population presently is estimated at around 75 crores and it is needless to emphasise the need to control the population growth rate. As such, the Family Welfare Programme seeks to promote on voluntary basis the two-child norm, irrespective of the sex of the child. We are aiming at reducing the crude birth rate to 21, crude death rate to 9 and infant mortality rate below 60 per thousand live births by 2001 AD. We can take credit of averting about 68.25 million births upto March, 1985 since the inception of the Family Welfare Programme.

In order to speed up our Family Welfare activities, we are refining the strategy to achieve hastened decline in the birth rate. The task of motivating the people to accept the programme is stupendous and the challenge is great. It is only through effective information, education and communication strategy that we can convince the masses to adopt contraception as a way of life and thereby limit the family size. Commu-

nity participation through voluntary organisations and non-governmental agencies is being encouraged so that Family Planning becomes a people's movement. 300 voluntary organisations are working in the field of family welfare. Voluntary organisations operating in social welfare and income generation sectors are also being encouraged to lend their helping hands for the National Programme.

The Ministry have instituted innovative schemes and additional incentives during the year to encourage people to come forward and help the acceptance of this programme. All available methods and media will be used to educate the people about the need to have a small family and a planned parenthood. In this endeavour, Govt. has also involved private medical practitioners in the programme by providing necessary help to them. 'Opinion Leaders Training Camps' have greatly helped in dispelling apprehensions and mis-conceptions about methods and the programme. The number of acceptors of all methods of family planning during the first nine months of 1985-86 was 25.6 per cent higher than the level reached last year.

The Family Welfare Programme is being implemented as a package deal of Health, Family Welfare and

Maternal and Child Health Care services. Our efforts are being augmented through Post-Partum Programme and upgraded PHCs. It needs mention here though we do not provide services for the medical termination of pregnancy as a family planning method, an appreciable work has been done by providing services for MTP to avoid health hazards to more than 41 lakh pregnant women who came forward to benefit themselves from these services. The services have been a great help to check clandestine abortions.

International agencies and some foreign Governments have shown interest in our Health and Family Welfare Programmes. They have come forward with a helping hand to augment our efforts which have been taken up with our own resources. Though much has been done to ensure "Health for All by 2000 A.D." and bringing down the NRR to one by the turn of the century, more concerted efforts are needed to reach these cherished goals. This Ministry has the commitment to fulfil the 7th Plan objectives, political will to support its activities and people's participation to help realising the goals.

(Excerpted from the Introduction to the Annual Report of the Ministry of Health and Family Welfare 1985-86)

Communicable diseases account for more than two-thirds of the total morbidity and mortality in the country. For the control and eradication of communicable diseases, the programme implementation at all levels is being strengthened. The Primary Health Care system is being utilised for delivering comprehensive frontline care and for better diseases surveillance and control.

NATIONAL MALARIA ERADICATION PROGRAMME

RESURGENCE of malaria in late sixties and seventies necessitated renewed vigorous antimalaria activities and the programme was modified in the context of escalating malaria situation and available resources in the country to tackle the deteriorating situation of malaria, to prevent deaths from malaria and to maintain the agricultural and industrial growth. The Modified Plan of Operation was implemented from 1st April, 1977, and it paid rich dividend and during the next 6 years the incidence was reduced from 6.46 million in 1976 to 2.18 million in 1982. By and large, the incidence has been maintained at that level during the subsequent years till 1984. The present anxiety is that further desired reduction has not been forthcoming and spread of outbreaks have been reported in some areas in the country. In addition, the problem has been further aggravated by the fact that though the malaria incidence has been stationary around 2 million, the *P. Falciparum* cases have been recording a gradual increase during the same period.

Incidence of malaria

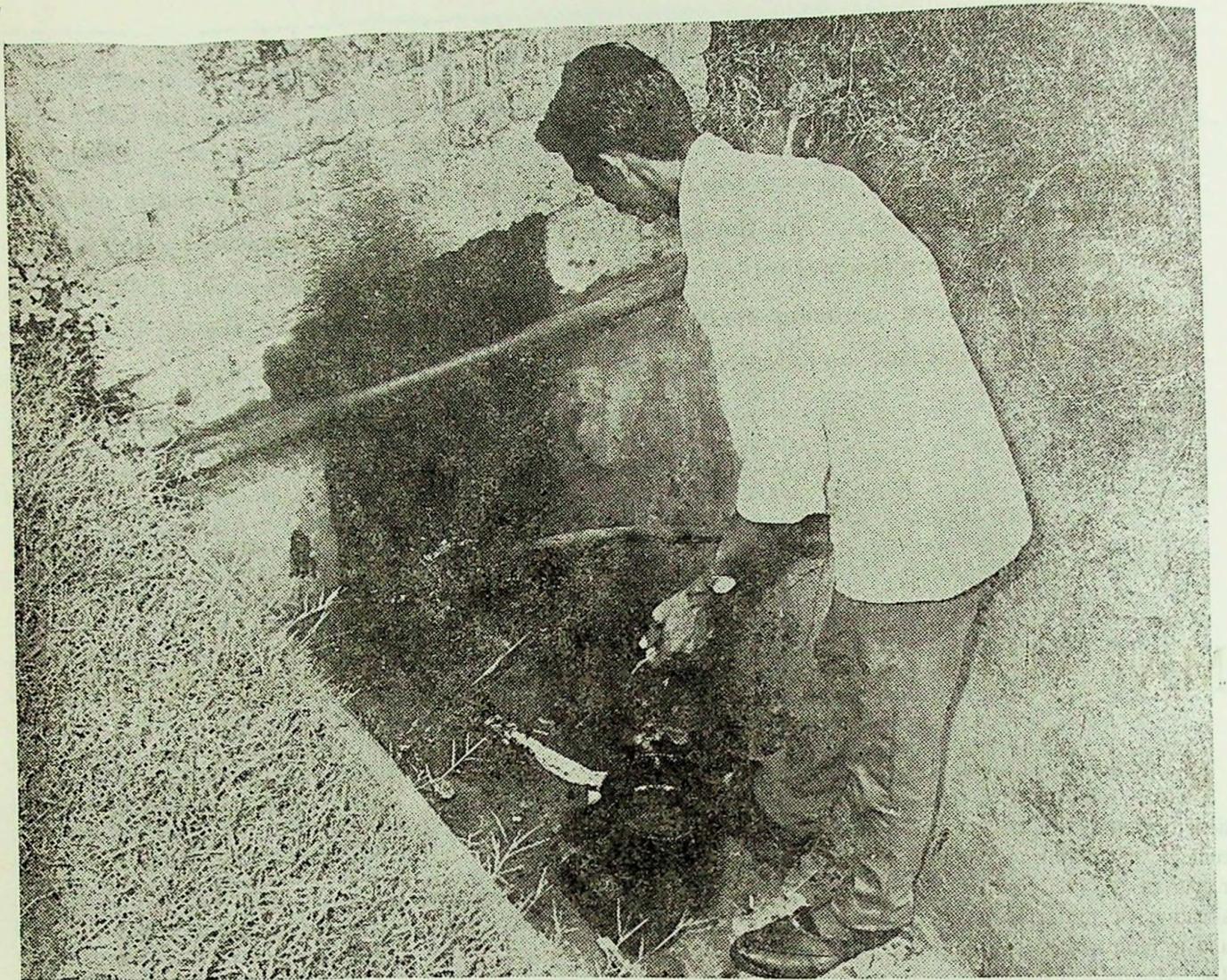
Malaria situation as recorded in the country following implementation of modified plan of operation is given below:

Year	Blood slides examined (in Mill)	Total incidence	<i>P. Falciparum</i> cases	Total deaths
1	2	3	4	5
1976 . . .	55.98	6467215	753713	59
1977 . . .	57.01	4740900	461484	55
1978 . . .	50.46	4144385	548567	74
1979 . . .	61.42	3064697	558433	198
1980 . . .	67.17	2898140	588011	207
1981 . . .	67.84	2701141	589591	170
1982 . . .	65.03	2182303	551057	187
1983 . . .	64.29	2018605	600964	239
1984 . . .	66.36	2184446	655453	32

During the year 1985 (as per reports received upto 31-12-1985) total malaria incidence and *P. falciparum* cases recorded a decline of 16.87% and 24.49% respectively as compared to the corresponding period of 1984. However, the situation is not uniform everywhere. In some States total malaria cases and *P. falciparum* cases have shown increase during 1985 as per reports received upto 31-12-1985.

Training

Malariology training courses are being conducted by National Institute of Communicable Diseases,



Vigorous measures are being undertaken to tackle the menace of malaria

Delhi. These courses were conducted out of WHO regular Budget for 1985. The total allocation of funds for training was 51400. Directorate of National Malaria Eradication Programme extended help with Faculty Members to National Institute of Communicable Diseases for conducting such courses.

Research

Monitoring of *P. falciparum* resistance to Chloroquine was carried out during 1985. 555 *P. falciparum* cases were tested, 10 resistant foci have been detected, but none was found to be of R-3 level. 88 per cent cases with *Pf* infection were cleared with Quinine.

Analysis of spray coverage and epidemiological data clearly indicated that the timely spraying with

qualitative and quantitative improvement would bring down malaria incidence markedly in spite of the vector(s) exhibiting resistance to a particular insecticide. This has been amply demonstrated by the State Entomological zones of Gujarat and Maharashtra. In the absence of spraying steep increase in malaria incidence was evident.

Urban Malaria Scheme : The Scheme is under implementation in 122 towns. 71 towns (60%) out of 117 towns, from where comparable data was available showed a decline in malaria cases during 1984 as compared to that of 1983. But towns like Madras, Calcutta, Chandigarh, Ahmedabad, Gandhi Nagar (Gujarat) etc., recorded a very large number of cases leading to an overall increase in incidence.

P. Falciparum Containment Programme: This is a component of the Modified Plan of Operation designed to deal with some of the hardcore areas of the country where the intensity of malaria is high, transmission period is prolonged, terrain and accessibility are difficult and majority of the population belongs to tribals of different ethnic groups. Besides, there is the problem of drug resistance in some parts specially in the north-east zone. The total population involved is 98 millions, i.e. about 14% of the people of the entire country. There are 84 districts (entire or in part) within the sphere of influence of PFCP.

Epidemiological Situation in 1985 (January—September) indicated that when compared to 1984, in 80 per cent of the PFCP areas *P. falciparum* remained contained (15%) or declined significantly (in 64% areas). In the rest 20% of the areas, there has been some increase in falciparum malaria. This is particularly noticeable in the State of Bihar and parts of West Bengal where the programme is faced with a number of constraints.

National Filariasis Control Programme

Filariasis is one of the major public health problems in the Country. All the States/Union Territories except Jammu & Kashmir, Himachal Pradesh, Delhi, Chandigarh, Punjab, Haryana, Meghalaya, Arunachal Pradesh, Sikkim, Rajasthan, Tripura, Mizoram and Manipur are endemic for filariasis. Present estimates indicated that about 304 million population is living in known endemic areas of which about 82 million are in urban areas and the rest in rural areas.

For the control of filariasis, the National Filariasis Control Programme was launched in 1955. Under the programme the following activities are being undertaken:—

1. Delimitation of the problem in hitherto unsurveyed areas.
2. Control in urban areas through.
 - (a) recurrent antilarval measures.
 - (b) anti-parasitic measures.

Present set-up: The following is the present set-up in endemic States and Union Territories.

Control Units	189
Survey Units	27
Clinics	122
Rural Filariasis Control Project	2

During the year 1985-86, it was proposed to set-up 10 new control units, one survey unit and fifty clinics.

Progress: At present about 27 million Urban population is being protected through antilarval measures by 189 control units. Another 5 million rural population is being protected by 2 Rural Filariasis Control projects through detection and treatment of Filariasis cases. Use of common salt medicated with Diethylcarbamazine citrate powder for the control of filariasis was implemented with success in Lakshadweep during 1976—1978. This method is being carried out in Karaikal district of Union Territory of Pondicherry from April, 1982. During the year 1985-86, one control unit, one survey unit and seven Clinics have been established so far.

Achievement: 300 districts are situated in endemic areas. Of which 238 districts have been surveyed for delimitation of filariasis problem and 173 have been detected to be endemic for filariasis. 27 survey units are carrying out delimitation survey in equal number of districts. It is observed that 94 per cent of the towns where control measures are in operation for more than five years have shown marked reduction in microfilaria rate.

Future Plans: In addition to the continuing set-up, it is proposed to set up 10 new Control Units, One Survey Unit and Fifty Clinics during 1986-87.

KALA-AZAR

The Kala-azar unit of NMEP is monitoring the Kala-azar situation in India. This unit is regularly collecting the Kala-azar reports and is keeping a close vigil over the situation. The Kala-azar incidence in India since 1982 is given below:

Year	Cases	Deaths
1982	12360	38
1983	14406	135
1984 (Prov.)	16459	65
1985 (As per report received upto 8-11-85)	10708	24



NATIONAL LEPROSY ERADICATION PROGRAMME

LEPROSY remains a major public health and social problem in India, in spite of three decades of National Leprosy Control Programme activities since 1955. Over 400 million population is covered with an infrastructure created under National Leprosy Eradication Programme (NLEP). The important existing physical set up is as follows:

In India 403 Leprosy Control Units, 661 Urban Leprosy Centres, 6985 Survey Education Treatment Centres, 253 Temporary Hospitalisation Wards, 190 District Leprosy Offices, and 43 Leprosy Training Centres are functioning at present. A total of 19.5 lakh leprosy cases have been discharged after treatment.

During the year 1985-86 till the end of September 1985, the objective performance under the programme continues to be good. A total of 2.08 lakh new cases were detected till September 1985 against the annual target of 3.81 lakh. 1.94 lakh new cases detected were put on treatment, and 1.65 lakh cases were discharged against the annual target of 3.74 lakh. Effective and short term multidrug treatment of leprosy cases has been introduced under the programme in selected districts replacing the less effective, prolonged dapsone monotherapy. The districts of Visakhapatnam (AP), Puri (Orissa) and Chengleput (Tamil Nadu) have been brought under Multi-drug Treatment of all leprosy cases during the current year with the financial assistance of UNICEF and the districts of Belgaum, Dharwar in Karnataka and Varanasi in U.P. with the assistance of Swedish International Development Agency through WHO. Thus, a total of 15 districts with a population of about 37 million and 3.2 lakh leprosy cases are under multi-drug Treatment currently.

It is proposed to create infrastructure on priority in hyper-endemic districts to enable introduction of multi-drug treatment.

The Central Leprosy Training and research Institute, Chengleput (Tamil Nadu) and Regional Training and Referral Institutes at Aska (Orissa), Raipur (Madhya Pradesh) and Gauriput (West Bengal) continue to support the programme in technical, operational and training personnel. △

Sexually Transmitted Diseases Control Programme

THE S.T.D. Control Programme has been a continuing scheme since the second Five Year Plan. The disease could not be checked during the past plan periods and 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. The scheme was then restructured to induct the scheme as a purely central sector scheme with 100% central assistance during the 6th Five Year Plan. For teaching, training and research in the field of S.T.D. (a) Regional Teaching-cum-Training centres for imparting orientation courses to the in-service Medical and Para-Medical personnel in the discipline of Venereology have been/are being established at Calcutta, Nagpur, Hyderabad, in addition to the existing teaching and training centres at Institute for S.T.D. Madras Medical College, Madras and S.T.D. Training and Demonstration Centre, Safdarjang Hospital, New Delhi; (b) Regional S.T.D. reference Laboratory to provide orientation courses to the Laboratory Technicians working in the district hospitals/PHCs/Civil Hospitals/STD Clinics in the Lab. diagnosis of STD and to conduct inter-Laboratory evaluation of V.D.R.L. test to set up a uniform standard of doing V.D.R.L. test throughout the country 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. Regional Survey-cum-mobile STD units provide immediate therapy to the patients suffering from S.T.D.

Achievements

The details of the achievements under S.T.D. Control Programme are given below:

Item	1983-84	1984-85	1985-86
1	2	3	4
1. Training of M.O's	25	47	25
2. Training of Para-Medical Personnel	50	82	52
3. Inter-Lab. evaluation of VDRL test	36	55	..
4. Estt. of VDRL testing at District Hospital/P.H.Cs.	..	61	100

△



364 Districts in the country have District T.B. Centres with essential equipments which are being manned by trained Staff. These centres are undertaking T.B. Programme in the Districts in collaboration with general health and medical institutions. In addition, there are about 300 TB Clinics functioning in the country which are mostly located in big towns and cities looking after the needs of local population living nearby.

A total of about 45,500 beds are available in the country for treatment of seriously sick TB patients. 17 TB Training and Demonstration Centres have been established in major States of the country to undertake the basic training of the para-medical personnel required for the programme.

Anti-TB Drugs for free treatment of T.B. patients are being supplied to the TB Clinics run by State Governments as a Centrally Sponsored Scheme on 50 : 50 sharing basis between the Centre and the States. The Scheme of supply of anti-TB Drugs to the TB Clinics run by voluntary bodies and scheme of supply of material and equipments/ Anti-TB Drugs to U.Ts., however, continues as 100% Centrally Sponsored Scheme.

A patient waiting to give sputum sample at the health centre.

(W. H. O. Photo by P. Almasy)

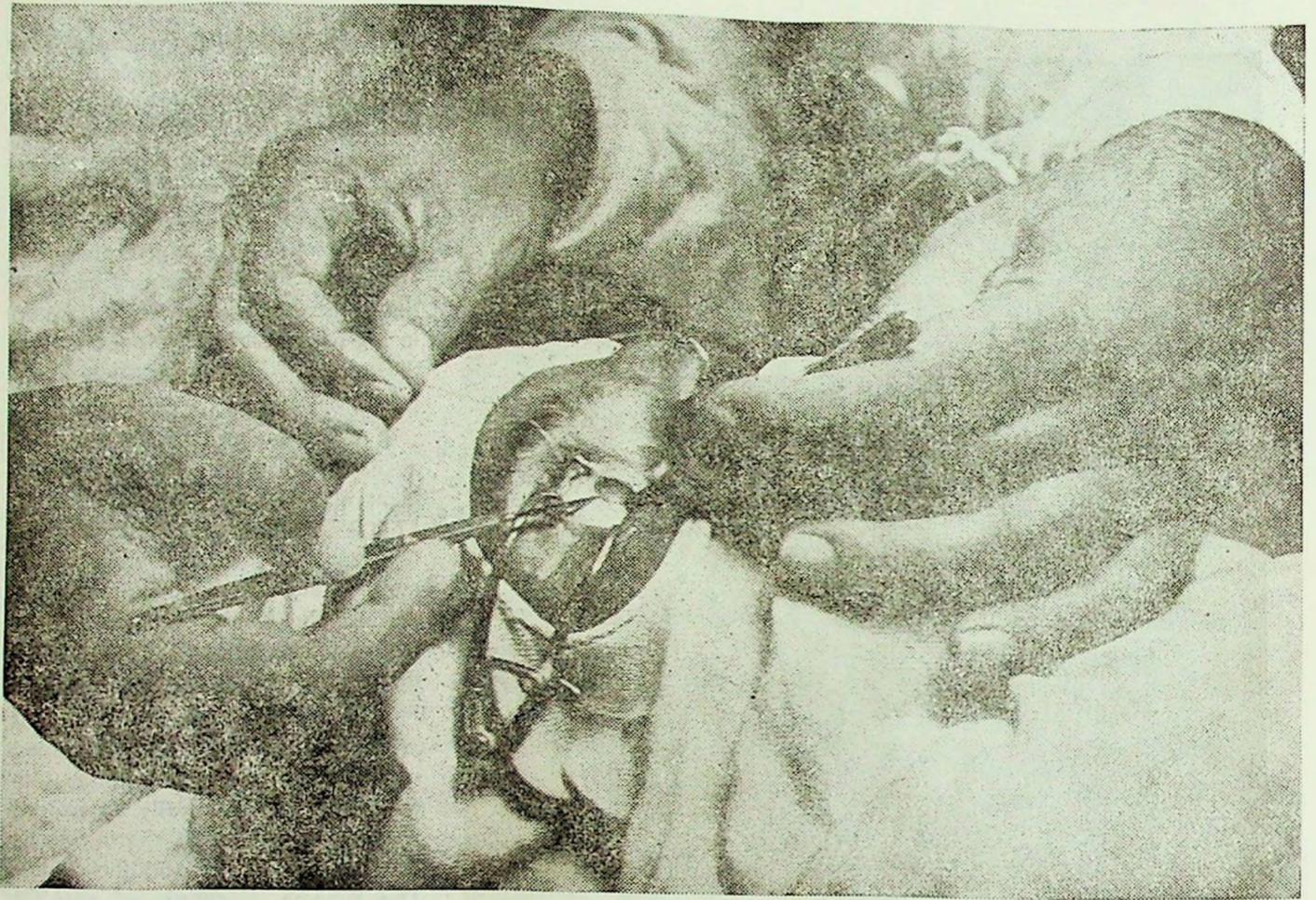
NATIONAL TUBERCULOSIS CONTROL PROGRAMME

TUBERCULOSIS is a major public health problem in the country. As per the National T.B. Sample Survey which was conducted by I.C.M.R. in years 1955-58, nearly

1.5% of the total population is estimated to be suffering from radiologically active T. B. Disease of the lungs of which about 1/4th or 0.4% are sputum positive or infectious.

20-Point Programme: with the inclusion of TB Programme in the 20 Programme, the essential activities have been considerably expanded. The new TB case detection is increasing from year to year. Against 10.80 lakh new TB cases detected during 1982-83, nearly 12.08 lakh cases were detected during 1983-84 and 12.55 lakh during 1984-85. Further, to expand the TB case detection among the rural population and

(Contd. on page 184)



(W. H. O. Photo by T. S. Satyan)

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

ACCORDING to a Survey undertaken by I.C.M.R. in 1971-73 India has about 9 million blind and another 45 million suffer from visual impairment. Roughly 8 out of 100 persons need eye care in some form or the other. The problem of this magnitude causes considerable strain on National economy in terms of loss of manpower and social dependence of the blind.

Plan of Action: The National Programme for Control of Blindness was launched throughout the country by the Govt. of India in 1976. The ultimate aim is to reduce the blindness in the country from 1.4% to 0.3% by the year 2000 A.D. To achieve this aim, the programme is providing immediate relief to the needy by camp approach and by establishing permanent eye care facilities with graded expertise at different levels coupled with 'Health Education' measures.

The Programme has received explicit recognition in the new 20-Point Programme of the Govt. of India.

Financial Allocation: The programme is 100% Centrally Sponsored Scheme.

The total allocation during the sixth plan period was Rs. 22.50 crores.

In the VII Plan a Budget allocation of Rs. 31 crore has been proposed.

Development of Infrastructure : The following infrastructure has been developed up till now:

	Target	Achievement
	1	2
Strengthening of PHCs	2000	2000
Central Mobile units	80	80
Strengthening of Distt. Hospitals	400	404

carried out by Dr. R.P. Centre in collaboration with National Programme for Control of Blindness.

Performance: Cataract operations are being monitored against the given targets for each State and UT Administration. The Performance of Cataract Operations for the country as a whole has been reported as under:

	Target (in lakhs)	Achievement (in lakhs)
1982-83	13.03	9.04
1983-84	12.54	10.49
1984-85	12.78	10.82
1985-86	13.84	2.05
		(upto September 1985)

Participation of Voluntary Organisations: Voluntary organisations engaged in eye care work are being encouraged to carry out comprehensive eye health care activities, particularly in remote rural areas. Voluntary Organisations are being assisted for eye camps @ Rs. 60/- per intra-ocular operation to the maximum of Rs. 12,000/- per eye camp.

Monitoring and Evaluation: Central Ophthalmic Cell at the Central Govt. level has been proposed. 18 State Ophthalmic Cells at the State Level of 18 major States are continuously monitoring the various aspects of the programme including quantitative and qualitative evaluation of the programme.

	1	2
Upgradation of Department of Ophthalmology in Medical Colleges	60	59
Establishment of Regional Institutes	10	9
Ophthalmic Asstt. Training Centres	37	37
Setting up of Distt. Mobile Units	30	30
Setting up of State Ophth. cells	18	18

Training Programme: Each Primary Health Centre and District Hospital are to be provided with one Ophthalmic Assistant each. To train the Ophthalmic Assistants 37 training schools have been established throughout the country. They are conducting two years training course for Ophthalmic Assistants. About 900 Ophthalmic Assistants are expected to be trained annually.

Health Education: Some basic concepts on eye care have been included in school curriculum. Simple messages on eye care are being spread through A.I.R. and Doordarshan net work. A number of educational folders in different regional languages and other audio visual material have been distributed to intensify community educational efforts.

Research Programme: Dr. R. P. Centre of Ophthalmic Sciences, New Delhi, has been developed as a major Research Centre under National Programme for Control of Blindness.

In the Sixth Plan total allocation to develop this Centre was 1.69 crores. Presently a survey to measure the quantum of blindness in the country is being

Photo shows a group of cataract patients

(W. H. O Photo by T. S. Satyan)



DIARRHOEAL DISEASES CONTROL PROGRAMME

DIARRHOEAL diseases still remain a major cause of morbidity and mortality in India especially in children below 5 years of age. Though cholera which was very prominent in the early years, has almost disappeared, other diarrhoeal diseases caused by Bacillary Dysentery, ELTOR, E.Celi, Rota-Virus still take a heavy toll of human life. Unlike 1984, when a major outbreak of Shigella Dysentery has been reported from all the districts of West Bengal, during the current year, no major outbreak was reported from any State. However, small outbreaks of diarrhoeal diseases caused by ELTOR and Shigella were reported from the states of Orissa, Manipur, Maharashtra, West Bengal, etc. These outbreaks were reported during the summer and were precipitated due to scarcity of drink water supply in the affected regions.

A national plan of action to control the diarrhoeal diseases problem as part of the primary health care programme has been drawn up.

Training: Training programme for the doctors at the district level has been geared up. In comparison to 2 courses of supervisory skill training for the district

level officers conducted during 1984, 8 courses have been conducted during the year under review.

Supply of O.R.S.: Under the Village Health Guides Scheme, the supply of oral rehydration salt to the village health guides during the year has been increased from 60 to 100 packets per year. In addition 200 packets of ORS supplied to the 80,000 sub-centres functioning under the Family Welfare Programme.

Survey: A multi-centric survey on the morbidity and mortality from diarrhoeal diseases in children below 5 years of age has been conducted during the year from the following areas:

- (a) *Urban Areas:* Delhi, Bombay, Calcutta, Madras, Hyderabad and Coimbatore.
- (b) *Semi-urban areas:* Burdwan and Nizamabad.
- (c) *Rural areas:* Bishnupur and Thubal districts of Manipur and Kangra District of Himachal Pradesh, Primary Health Centres attached to the 7 medical Colleges of Uttar Pradesh. Δ

(Contd. from page 181)

to involve the Primary Health Centres in TB case finding activities, targets were also laid for conduction of 50 Sputum Examinations per month at each of the Primary Health Centres for the first time during 1983-84 and nearly 12.11 lakh examinations were conducted. There was a significant improvement during 1984-85, and about 17.30 lakh sputum examinations were conducted by the Primary Health Centres.

Targets for 1985-86 : Considering the high prevalence of Tuberculosis in the country, it was considered necessary to step up the tempo of new TB case detection during 1985-86. Accordingly, the target for detection of new TB cases has been raised to 14 lakhs, and Primary Health Centres continued to be involved in case finding activity. Up to the end of 2nd Quarter of 1985-86, nearly 6.03 lakh new TB cases (provisional figures) have been reported

to be detected, and nearly 8.18 lakh sputum examinations (provisional figures) conducted at the Primary Health Centres.

BCG Vaccine Laboratory, Madras

B.C.G. Vaccine Laboratory, Madras, was established in 1948 at Guindy. Madras, with the assistance of UNICEF and W.H.O. to produce and supply BCG Vaccine and Tuberculin PPD Dilutions to all the States and Union Territories of

India. The supply to States and Union Territories is done under the Expanded Programme on Immunisation and supplies are also made to Medical Institutions and Private Practitioners. This is the only BCG Vaccine producing Laboratory in India.

The Production and Supply of biologicals made by this Laboratory during the period April to October 1985 is as under:

	Production (Lakhs)		Supply (Lakhs)	
	Ampoules/ Vials	Doses	Ampoules/ Vials	Doses
1	2	3	4	5
Freeze Dried BCG Vaccine 20 doses per ampoule	5.066	101.32	4.60	92.00
Tuberculin 100 doses per vial	0.11	11.00	0.12	12.00

Future Plan of Action: With a view to meeting the increased requirement of Freeze Dried B.C.G. Vaccine under the E.P.I., the go-

vernment has tentatively allocated one crore of Rupees under the VII Five-Year Plan for the Expansion of the BCG vaccine Laboratory. Δ

NATIONAL GOITRE CONTROL PROGRAMME

IODINE Deficiency is the primary cause of goitre and it occurs in areas where food is produced on lands deficient in iodine. 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.

In order to control the problem of goitre in the country, the National Goitre Control Programme was launched by the Government of India towards the end of 2nd Five Year Plan with the following objectives:

- (1) Identification of the goitre endemic regions.
- (2) To supply iodized salt in place of ordinary common salt to the goitre endemic areas.
- (3) To assess the impact of goitre control measures over a period of time.

Activities/Performances: 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 and their findings 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 such as Madhya Pradesh, Gujarat, Maharashtra, Kerala, Delhi, etc.

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 coordinating the supply of iodised salt to the population living in the goitre endemic areas under the National Goitre Control Programme. The Ministry of Health continues to provide subsidy for cost of iodization of salt.

Achievement :

- (a) *Survey:* During the year, the central teams have completed surveys in Satara District of Maharashtra and Bilaspur district of Madhya Pradesh. Surveys are also contemplated in Gujarat & Karnataka this year.
- (b) *Production Distribution of iodised salt:* 170 lakh MT of iodised salt was supplied to the various goitre endemic areas from April to September 1985.
- (c) *Expansion of the Programme:* It has been proposed to expand the National Goitre Control Programme to 11 more districts each of Uttar Pradesh and Bihar, 8 districts of Madhya Pradesh, 3 districts of Maharashtra, 1 Districts each of Gujarat, Andhra Pradesh and Kerala, entire State of Assam, Tripura, Sikkim and Mizoram.

Future Plans: The Govt. have recently approved a proposal to take up the iodization of edible salts in the country in two phases. During the first phase (1985-90) it is proposed to take up the iodisation of 30 lakh tonnes of common salt and supply the same to the goitre-endemic areas. △

RE-ORIENTATION OF MEDICAL EDUCATION

The scheme of Re-orientation of Medical Education was launched by the Government of India in 1977. It is a 50 : 50 centrally sponsored scheme requiring the State Govts., U. T. administrations to give, a matching proportionate grant of an equivalent amount for both recurring and non-recurring. The responsibility for the implementation of the scheme rest entirely with the concerned State Governments and U. T. Administrations.

The main objectives of the scheme are : (i) involvement of Medical Colleges in the community health problems and direct

delivery of health care services to the rural and semi-rural population; (ii) exposing the students and faculty members of the medical colleges to the rural environment; (iii) upgrading the quality of health services in rural and peripheral areas with provision of expertise and assistance in specialised services such as Laboratory services, Radiology services, Clinical services, etc.; (iv) phased transfer of total and comprehensive health care namely preventive, promotive and curative to community development blocks and later on in the whole district in which the medical college is situated. △

FAMILY WELFARE — MAKES HEADWAY

THE importance of Family Welfare Programme in our socio-economic developmental plans is well established and needs no emphasis. The most crucial problem facing the nation today is the galloping population, which has been growing at an alarming rate. The country's population stood at 68.5 crores in 1981 and is estimated to touch 74.2 crores in 1985. It has been estimated that the population of the country would increase to 83.7 crores in 1991 and to 98.6 crores in 2001. According to the estimates based on the 1981 Sample Registration System, the annual growth rate was 2.2%, whereas the growth rate in the seventies was 2.25%. The decaded growth rate of population has now started showing a declining trend. However, in view of the serious implications of the current population growth, it is imperative to devise suitable policies and strategies in order to achieve a very rapid decline in birth rate. This is possible only if substantially more and more couples can be made to restrict their family size by using one or the other method of family planning. Experience shows that acceptance of family planning method is closely associated with the level of infant mortality and socio-economic status of women. Maternal and Child Health Care (MCH) services are, therefore, provided as part of the Family Welfare Programme.

The family welfare programme seeks to promote on a voluntary basis, responsible parenthood, with a two-child norm—male, female or both—through independent choice of the family planning method best suited to the acceptor. Family Planning services are offered through the total health care delivery system. People's participation is sought through all institutions, voluntary agencies, opinion leaders, people's representatives and Government functionaries. Imaginative use of the mass media and inter-personal communication is restored to for explaining the various methods of contraception and removing socio-

cultural barriers, wherever they exist. As a result of this strategy the number of acceptors of various methods of family planning has started to register an increase from year to year.

National Demographic Goals

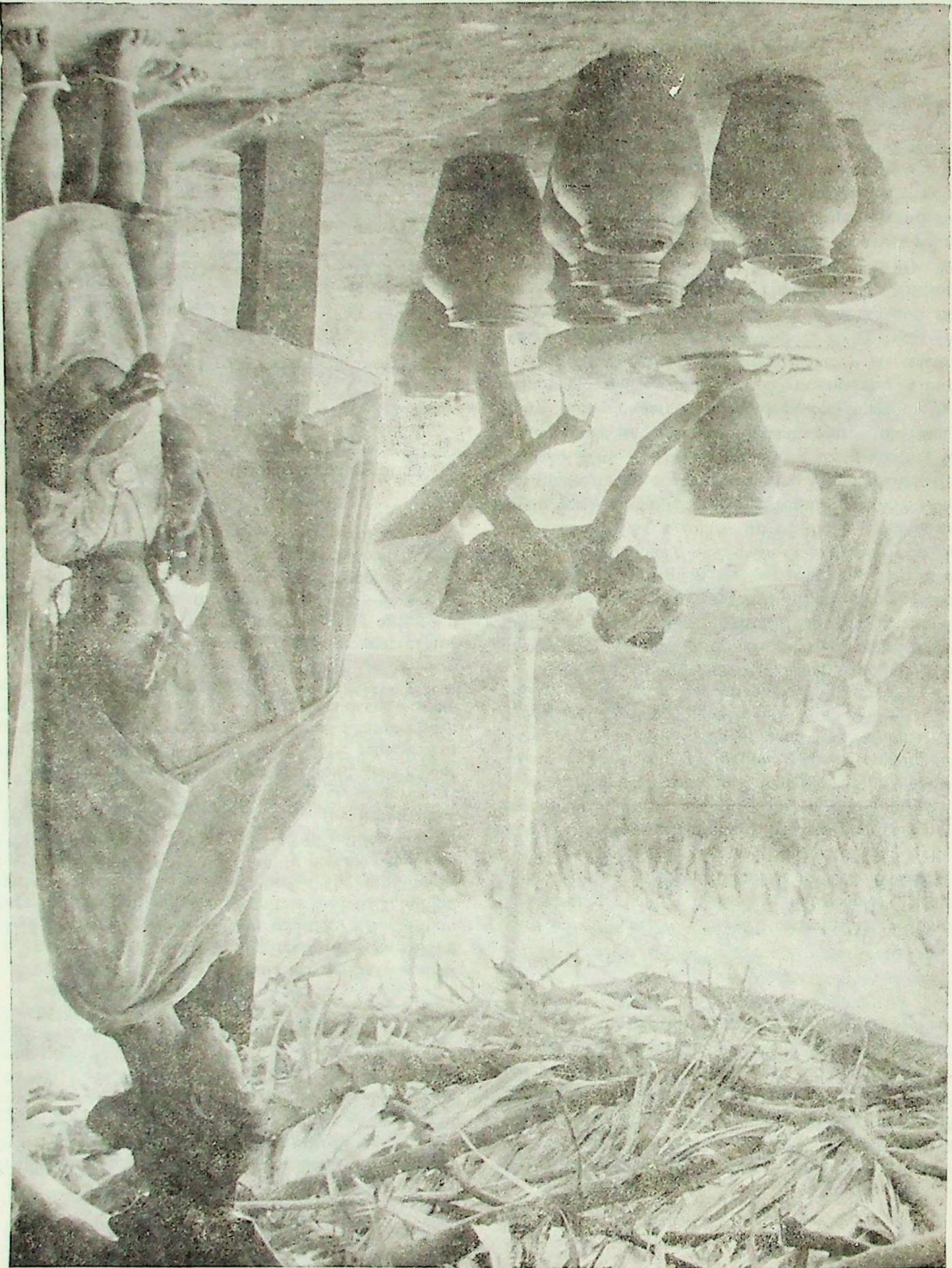
The long-term demographic goals set out in the National Health Policy document to be achieved by the year 2000 A.D. are : crude birth rate of 21, crude death rate of 9 and infant mortality rate below 60 per 1000 live births. Achievement of these goals is expected to yield a net reproduction rate (N.R.R.) of one. Demographers are of the view that the goals of $NRR=1$ can be achieved if 60% of the eligible couples are effectively protected. The corresponding goals for the VII Five Year Plan period (by the year 1990) are —crude birth rate of 27, crude death rate of 10, infant mortality rate of 87 per 1000 live births and couple protection rate of 42 per cent.

Performance under the Programme

The family welfare programme in India has gone through several phases in its evolution. It started in a small way in 1952 but continued to receive greater emphasis in successive five year Plans. It is estimated that the crude birth rate declined by about 8 points in 16 years—from 41 per 1000 population in 1966 to 33 in 1983 which account for an average decline of 0.5% per year. Approximately 7.0 crore births have been averted since the inception of the programme so far. The programme performance touched a fairly high level in the mid-seventies. During the year 1976-77 about 12.5 million acceptors of

The family welfare programme seeks to promote responsible parenthood, small family norm on a voluntary basis. —>

(W. H. O. Photo by E. Schwab)



family planning methods were enrolled. Subsequently, in the three years that followed, the programme received a severe set-back and the number of acceptors steeply declined to 4.5 million during 1977-78. During the 6th Plan the programme started gaining momentum once again with reviewed political commitment and performance under the Programme has been improving since 1980-81.

During 1984-85, nearly 4.08 million sterilisation operations were performed and a total of 2.56 million IUD insertions were done. In addition, 8.38 million users of conventional contraceptives and 0.93 million users of Oral Pills were enrolled. The total number of acceptors of different family planning methods in 1984-85 was of the order of 15.95 million—an all time record since the inception of the programme. In relation to targets at all India level, achievement in sterilisation was 70.01 per cent, and that under IUD insertions was 80.04 per cent. The achievement of targets with respect to Conventional Contraceptive (C.C.) users and Oral Pill (O.P.) users were respectively about 84% and 93%.

About 40.22 million couples (31.0 per cent of the total eligible couples in the reproductive age-group whose wives were in the age group 15—44 years) were effectively protected against conception by one or the other approved family planning methods, as on March 1985. Of these, 25.0 per cent were protected by sterilisation alone.

The performance under the programme during the VI Five Year Plan is as given below :

Family Planning	1980-85 (in million)	% of target achieved
Sterilisation	17.44	79.1
IUD	7.17	81.7
C.C. & O.P. Users (Couple year Protection)	31.84	83.6
Total acceptors	56.45	
Increase in couple protection rate 9.7%		

Family Planning Targets for 1985-86 and the VII Five Year Plan

The Family Planning targets for 1985-86 and during the VII Plan are given below:

	Sterilisation	IUD	C.C. Users	O.P. Users
(Figures in million)				
1985-86	5.56	3.24	9.51	0.96
1985-90	31.0	21.3		62.5

The achievements from April to September, 1985 were 1.52 million sterilisations and 1.19 million IUD insertions. During the period April to August 1985, 5.02 million CC Users and 0.56 million Oral Pill Users have been recorded. The total number of acceptors of different Family Planning methods recorded during the period (April—September 1985) was 8.29 million.

Action Plan and New Initiatives

In order to achieve a fast decline in the birth rate by bringing about a change in the peoples' perceptions in favour of small families, an Action Plan has been prepared. The major elements of the Action Plan are increased community participation, improved communication strategy, provision of suitable incentives, improving programme management and appropriate research and evaluation. The various initiatives taken in these different areas are summarised below :

Community Participation: Two national level conferences of well known Non-governmental Organisations were held in March 1985 and September 1985 to explore the ways and means of expanding their area of operation and securing involvement of NGOs in the family welfare work particularly in the rural areas. As a follow up of these conferences high level committees at the Ministerial and other levels are being constituted at the Centre and in the States. With a view to simplifying the procedure for grants-in-aid to voluntary organisations, the States have been delegated increased powers upto the extent of Rs. 5 lakhs to sanction such grants. Grants have been given to the Family Planning Association of India to set up a small fund of Rs. 5 lakhs to encourage smaller organisations for taking up family planning projects. The National Institute of Health and Family Welfare (NIHFW) has been provided a sum of Rs. 30 lakhs to assist voluntary organisations for project formulation and to monitor and evaluate their working. A subsidy of Rs. 5,000/- is now available to private medical practitioners for purchase of laparoscopes. The scheme is being implemented through the Federation of Obstetric and Gynaecological Society of India, Bombay.

Communication Strategy: An Annual Plan of action has been drawn up both in physical and financial terms for the mass media organisation of the

Government. With a view to induct greater professionalism in the task of demand generation for Family Planning, the Ministry has launched upon an exercise to seek participation of leading advertising concerns. Meetings have already been held with five leading advertising agencies. Further, this Ministry is also taking steps to seek participation of leading film personalities in preparation of films for Family Planning. Studies are being conducted to assess the knowledge, attitude and practices of the people towards family planning which would provide clues and material for framing appropriate communication strategies, plans, programmes and messages.

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 these services also) and the sub-centres manned by Auxiliary Nurse Mid-wife (ANM) usually provide only non-terminal methods other than IUD (IUD insertion is also being carried out in many sub-centres after training of ANMs/LHVs).

Post-Partum Programme: Post-Partum Programme is a hospital-based and maternity-oriented component of the programme. 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 additions to the family. The programme offers necessary facilities to such women, and promotes all methods of contraception. A ten-bedded ward and an operation theatre have been provided to each participating institution, alongwith other inputs in the form of staff and equipment.

The programme at present covers 554 medical institutions throughout the country including 106 Medical Colleges and leading hospitals run by the voluntary organisations. Almost all the institutions functioning at Medical Colleges, State and District level organisations have since been covered under the programme.

With a view to providing maternal and child health and family welfare services in rural and semi-urban

areas, as well as to bring an overall improvement in the health status of mothers and children, the Post-Partum Programme has been extended to 400 Sub-Divisional hospitals.

Medical Termination of Pregnancy (MTP) : Abortion is not permitted 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 millions of women who take recourse to clandestine abortions by ill-qualified doctors or quacks in un-hygienic conditions from health hazards. More than 10,000 doctors have been trained in MTP technique and over 41 lakh pregnancies terminated upto June 1985. It is proposed to make available at least one trained doctor in MTP in each PHC.

Maternal and Child Health Care Services : In fact, Maternal and Child Health (MCH) is an important part of any sound health care system. Because of the close relationship between population control and improved health of mothers and children an integrated approach for both these programmes is being followed. Δ

INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY

"Indian Systems of Medicine" include all the non-allopathic systems of medicine and regimens excluding Homoeopathy, viz. Ayurveda, Siddha, Unani Medicine, Nature Cure, Yoga and Amchi (Tibetan system of medicine). In the Seventh Plan Rs. 40 crores have been provided in the Central Sector for the development of Indian Systems of Medicine and Homoeopathy. The various Schemes included in the Seventh Plan aim, mainly, at improving quality of education, promotion of research programmes based primarily on their respective philosophies, enhancing the availability of raw drugs, planned production of herbal and other medicines on a large scale and their standardisation.



(W. H. O. Photo by P. Merchez)

MATERNAL AND CHILD HEALTH PROGRAMME

MATERNAL and child health services are provided as part of total health care to the community through the existing health infrastructure in rural and urban areas. The health infrastructure is gradually being expanded to reach the population as near to their door-steps as possible. Further, the Ministry

of Health and Family Welfare have taken up immunisation scheme for infants, children and mothers against common vaccine preventable diseases, prophylaxis schemes against nutritional anaemia among mothers and children and prophylaxis against blindness due to Vitamin A deficiency etc.

Goals under M.C.H. Programme

Prophylaxis against nutritional anaemia among mothers and children: Anaemia is one of the important causes of morbidity and mortality among mothers and children. Under the scheme of prophylaxis against nutritional anaemia, pregnant and nursing mothers, acceptors of Family Planning and Children (1-12 years) are given daily dose of iron and folic acid for a period of 100 days as a prophylactic measure.

The Expanded Programme on Immunization (EPI) was started by the Government of India in 1978 with the objective of reducing the morbidity and mortality due to diphtheria, pertussis, tetanus, poliomyelitis, tuberculosis and typhoid fever by making vaccination services available to all eligible children and pregnant women by 1990. Measles was included in the programme in 1985-86. It was also aimed at achieving self-sufficiency in the production of vaccines required for the programme.

The immunization programme is one of the most cost effective public health measures and an important component of the primary health care services. The vaccines available for the control of the diseases are effective, safe and relatively cheap. Besides the reduction of the vaccine preventable diseases, the positive impact of the immunization programme is also likely to be reflected in related programmes of maternal and child health and family planning. The immunization programme is, however, a long-term one.

The immunization services are provided through the existing health care delivery systems and there is no separate cadre of field workers. The services are available in the hospitals, dispensaries and MCH clinics in the urban areas and the primary health centres (PHCs) in the rural areas.



Maternal and child health is an important part of any sound health care system.

(UNICEF Photo by T. S. Nagarajan)

The health workers also organize outreach sessions in the sub-centres and villages which are not within easy reach of the health centres.

Coverage under the immunization programme : The immunization programme has been expanding steadily during the sixth plan, 37.2 million pregnant women received 2 boost-

er dose of TT vaccine, 49.8 million and 26.5 million infants received three doses each of DPT and Polio vaccines, respectively during the same period. 66.7 million children were given 1 dose of BCG. The services would, however, have to be intensified more rapidly to meet the objective of universal coverage by 1990.

was introduced in the programme in 1985-86 is planned to be given to over 50 million infants by 1990. More than 93 million expectant mothers are likely to receive protection against tetanus by TT vaccination services as part of the antenatal care.

Universal Immunization Programme: While the aim of universal immunization for the country as a whole has been set for 1989-90, areas are being identified which have the capability of achieving this goal earlier. Besides achieving high levels of coverage, such areas will be required to sustain them over the years. Minimal additional inputs are being provided to make the programme operationally feasible. The main thrust of the programme in these areas would, however, be the improvement in the logistics and managerial aspects for the optimal utilization of the available resources and cost effective implementation of the programme.

(Contd. on page 194)

GOALS FOR MOTHER AND CHILD HEALTH CARE

Indicator	GOALS			
	Current	1985	1990	2000
Infant Mortality (thousand live birth)	125 (1978)	106	87	Below 60
Peri-natal Mortality (thousand live birth)	67 (1976)			Below 30-35
Pre-School Child (1-5 yrs) Mortality	24 (1976)	20-24	15-20	10
Maternal Mortality Rate	4-5 (1976)	3-4	2-3	Below 2
Pregnant mothers receiving ante-natal care (%)	40-50	50-60	60-75	100

The programme ahead : Additional inputs are being provided and infrastructure expanded during the seventh plan period to rapidly extend the services to larger number of

beneficiaries. During the next five years it is planned to cover over 82 million infants with three doses each of DPT and polio vaccines and 1 dose of BCG. Measles vaccine which



RURAL HEALTH SERVICES

ONE of the significant things that happened during the Sixth Plan was the adoption of the National Health Policy by both Houses of the Parliament. Health Care Programmes were restructured and re-oriented for achieving the objectives of the Policy. Priority was given to extension and expansion of the rural health infrastructure through a network of Community Health Centres, Primary Health Centres and sub-centres on a liberalised population norm. Efforts were made to develop promotive and preventive services alongwith the curative services.

High priority was given to the development of primary health care located as close to the people as possible. The approach and strategy for developing health care delivery system in rural areas initiated in the sixth plan is being pursued vigorously during the seventh plan to consolidate the health infrastructure and making up the deficiencies in respect of training personnel, equipment and other physical facilities. Co-

ordinated efforts are being made under various programmes to provide effective and efficient rural health services to the people.

Minimum Needs Programme

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 :

Sub-Centres : The sub-centres are being established on the basis of one sub-centre for every 5000 population in general and for every 3000 population in hilly, tribal and backward areas. The additional sub-centres established during the sixth plan period raised the number to 82,946 against the estimated total requirement of 1,30,000. The progress is as under:—

(a) Functioning on 1-4-1980	47,172
(b) Target for the Sixth Plan period	40,000 (approx.)

(c) Established during 1980-85	35,774
(d) Target for 1985-86	6,132

health centre providing package of promotive, preventive and curative services. The progress achieved in this regard is stated below :

Primary Health Centres : The additional Primary Health Centres are being established in places where the existing Primary Health Centres cater to a larger population, so as to reduce the work-load in existing primary health centres. Details are given below :

(a) Functioning on 1-4-1980	2,056
(b) Target for the Sixth Plan period	2,270
(c) Established during 1980-85	1,689

(a) Functioning on 1-4-1980	5,484
(b) Target for the Sixth Plan period	756
(c) Established during 1980-85	1,800
(d) Target for 1985-86	1,446

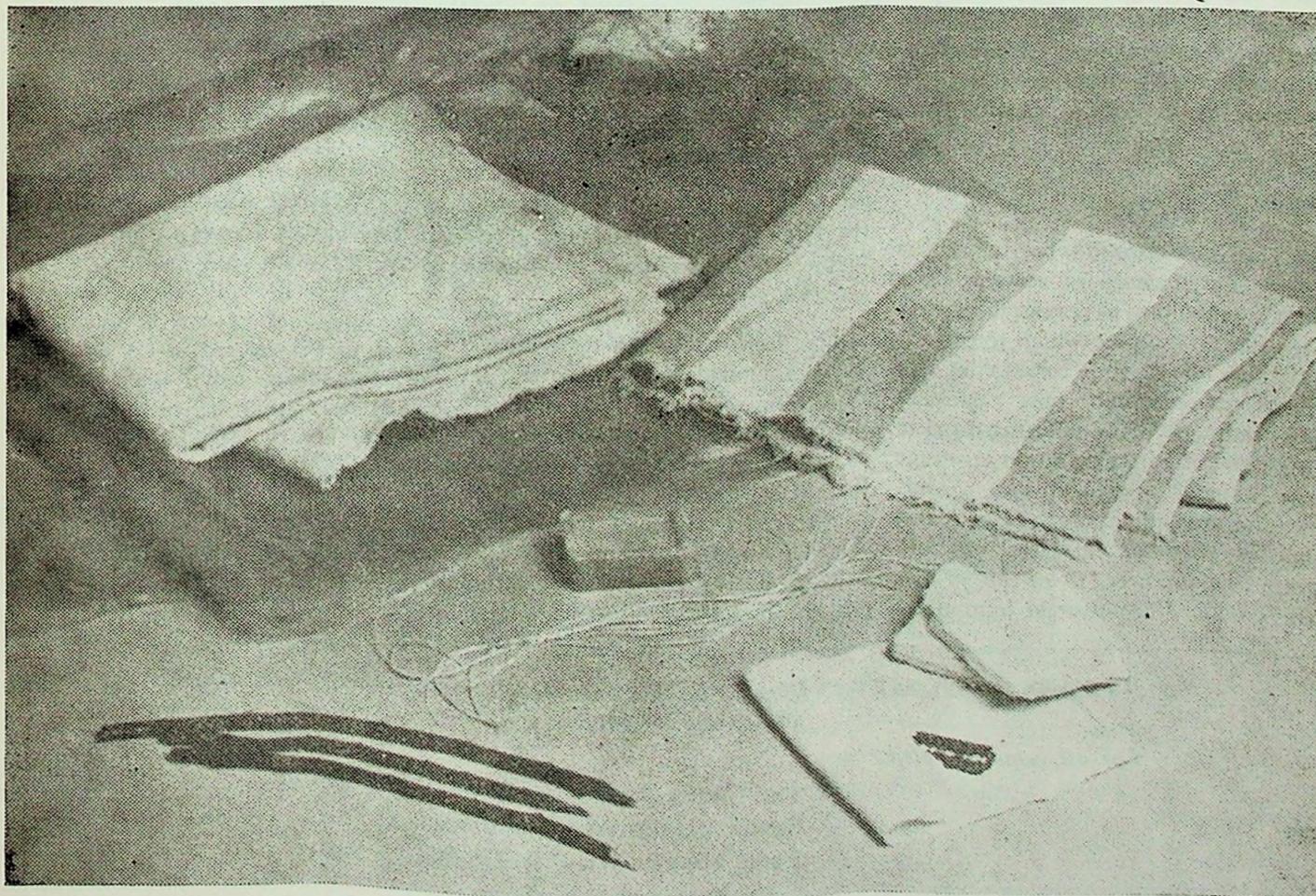
Upgraded Primary Health Centres : It is proposed to establish rural hospitals with specialists facilities by upgrading the existing primary health centres. Each of the upgraded Primary Health Centres will have 30 beds.

New Primary Health Centres : It is proposed to convert the Rural Dispensaries into Primary Health Centres. The ultimate objective is that by providing additional input, the rural dispensaries which are providing curative services only, will function as primary

(a) Functioning on 1-4-1980	217
(b) Target for the Sixth Plan period	315
(c) Established during 1980-85	438
(d) Target for 1985-86	298

In rural areas most of the deliveries are conducted by Traditional Birth Attendants (Dais). Photo shows the simple basic midwifery kit.

(W. H. O. Photo)



Training & Employment of Multi Purpose Workers (MPW) Scheme

To make Primary Health Care Services available to our rural population, it has been a persistent endeavour on the part of the Government of India to make most rational and cost efficient utilisation of the available resources. With this aim in view the MPW Scheme was launched in the year 1974.

Health Guide Scheme

With a view to provide Primary Health care in the rural areas, Health Guide Scheme (formerly known as Community Health Volunteer Scheme) was started in the country on 2-10-1977. These persons are purely Voluntary Workers, selected by the Village Health Committees as per the Guidelines issued by Government of India. The important deviation from the previous instructions is that only women should be selected as Health Guides and trained. The selected candidates are given training for 200 hours spread over 3 months. During the training, the candidates are paid Rs. 200/- per month as stipend. At the end of the training, these health guides are given a kit with medicines and manual. Thereafter, each health guide is provided with drugs periodically at an overall annual cost of Rs. 600/-. Health Guides are also given

monthly Honorarium of Rs. 50/- to cover their out of pocket expenses.

4,172 Primary Health Centres have been covered under the scheme upto 31-12-1984 since the inception of the scheme. 3,58,043 Health Guides have been trained till 31-12-1984.

'Dais' Training Programme : In rural areas most of the deliveries are conducted by traditional Birth Attendants (Dais). It has been endeavour of Government of India to utilise this available manpower in the field by imparting training in basic aspects so that the deliveries are conducted under hygienic conditions thereby reducing the maternal and infant mortality. The trained Dai is also expected to play a vital role in propagating small family norm since she is more acceptable to the community. Each Dai is also provided with a mid-wifery kit to conduct safe and hygienic delivery.

During the year 1984-85, 23,206 Dais have been trained against the target of 50,000 Dais. The target fixed for the year 1985-86 is 25,000. Total number of Dais trained from 1974 to date is 5.15 lakhs. Our objective in the seventh plan is to train 1 lakh Dais. Efforts are being made to start re-orientation training for Dais similar to that of village health guides.

(Contd. from page 191)

The immunization programme is part of a package of services. It is not the intention to develop a vertical type of programme which might adversely affect the functioning of other, equally important national programmes. While selecting districts for universal immunization coverage the main criteria taken into consideration was, therefore, the availability of adequate infrastructure and trained manpower. 19 of the 30 districts under the universal immuniza-

tion programme are supported by the Area Projects. As many as 100 of the 628 blocks are covered under the ICDS.

The 30 districts under the universal immunization programme include one or two districts from all the large States. The total population of these districts is over 66 million. Except for 4 districts the population of the districts ranges from 1.1 to 5.1 million. The birth rate varies from 28 to 39.6 per 1000 population and the IMR from 40.2 to 159.0 per

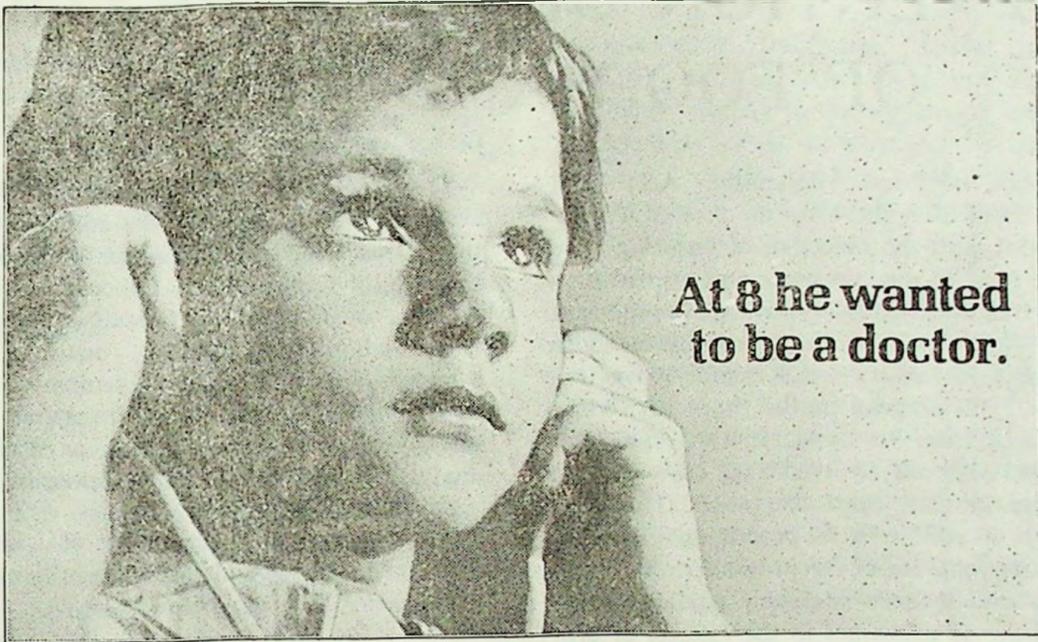
1000 live births. There are 628 PHCs and 100 ICDS blocks in the 30 districts. 19 districts are also covered by the Area Projects. The number of expectant mothers and infants proposed to be covered is 1.6 and 1.4 million respectively. This would constitute about 75% of the estimated number of eligibles in these areas.

The Universal immunization Programme is also proposed in the catchment areas of 50 medical colleges in 17 states and 3 union territories.

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PREVENTION OF ADULTERATION OF FOOD AND DRUGS

THE Prevention of Food Adulteration Act, 1954, had been enacted in 1954 by an Act of Parliament (37 of 1954) with the objective of ensuring pure and wholesome food to the consumer and also to protect them from fraudulent and deceptive trade practices. Enforced since June 1955 the Act stands extended to the entire country. In Jammu and Kashmir it was extended in year 1972 whereas in the State of Sikkim it came into force from 1st January, 1980. The Act is, by and large, enforced by the State Governments and local bodies in their respective areas. However, the Centre plays a vital role in proper coordination, monitoring and surveillance of the programme throughout the country and extends necessary guidance and coordination whenever expedient in the interest of proper functioning.

The Act was amended in 1964 in order to provide powers to the Central Government to appoint its own functionaries, namely, Food Inspectors, Public Analysts, etc., to supplement the efforts of the State Government. In 1976, the Act was again amended, plugging the loopholes and making the provisions for punishments more stringent. The new concept of introducing the definition of "Primary Foods"; streamlining the procedures for sampling and analysis were also included in this amendment.

Implementation: Though the implementation is carried out by both State Govts. as well as local bodies in general, yet, in the States of Andhra Pradesh, Gujarat, Madhya Pradesh, Maharashtra, Sikkim, Tamil Nadu and the Union Territory of Delhi, the State Governments have taken up the responsibility of implementation of the Act at their level by establishing separate Food and Drug Administration/Directorates or Food Wings. A Committee known as the Central Committee for Food Standards (CCFS) has been constituted under the provisions of the Act of guide the Central and the State Govts. in implementation of the Act. The CCFS is vitally involved in the various amendments to the Prevention of Food Adulteration Rules, 1955 formulated under the provisions of the Act and prescribed various food standards.

The Central Food Laboratories provide essential assistance to the courts in the adjudication of prosecution cases launched under the PFA Act. Presently, there are 4 Central Food Laboratories in the country, namely, at Ghaziabad, Calcutta, Mysore and Pune. These laboratories, besides analysing the appellate samples, also analyse food samples forwarded to it by various Departments of the Govt. of India for investigation and research. Review of methodology for analysis is also their vital responsibility.

Performance: The number of samples of food articles analysed and found adulterated during the last 3 years is given below:

Year	No. of samples analysed	No. of samples found percentage of	
		adulterated	adulteration
1981	1,33,242	19,050	14.2
1982	1,29,595	16,765	12.9
1983	1,29,062	17,965	13.9

Training: The Directorate General of Health Services in the Ministry of Health and Family Welfare have been arranging Orientation Training Courses for various functionaries, namely, Food Inspectors, Public Analysts and Local (Health) Authorities.

The main thrust in these in-service orientation training courses has been to enhance the knowledge and skills of the existing personnel by exposing them to the latest advancement in technology, market fluctuations and price spirals, in order that they are able to tackle the problem of adulteration against a background of changing perspectives.

Education and Publicity: Considering the importance of education and publicity in creating awareness among the general public against the evils of adulteration, in order to familiarise the consumer with unscrupulous trade practices and the various remedial provisions of the Act and Rules, the Dte. General of

Health Services have brought out the following pamphlets: (i) Help Fight Food Adulteration, and (ii) Quick Tests for detection of common adulterants in food.

Future Programmes: With a view to streamline and increase the effectiveness of the implementation of the Prevention of Food Adulteration Act in the country, under the 7th Five Year Plan it is envisaged to augment the infrastructure presently available in the Dte. General of Health Services for continued monitoring, surveillance and evaluation.

Drugs standard control

The quality control over drugs is exercised in the country under the provisions of the Drugs and Cosmetics Act, 1940 as amended from time to time. The Central Drugs Standard Control Organisation is responsible, alongwith the State Organisations, for enforcing the provisions of this Act and functions in the Directorate General of Health Services under the Drugs Controller (India).

The main functions of this Organisation are :

1. To control the quality drugs.
2. To co-ordinate the activities of the States and advise them on matters relating to uniform administration of the Act in the country.
3. To lay down the regulatory measures and standards of drugs.
4. To grant approval to "New Drugs" proposed to be imported into or manufactured in the country.

Quality Control over Imported Drugs: Control over quality of imported drugs continued to be exercised by the Offices of the Organisation located at Bombay, Calcutta, Madras, Cochin and Delhi.

During the period April to October, 1985 bulk drugs, drug intermediates and Chemicals and solvents, etc., valued at Rs. 131.34 crores were imported into the country. 534 samples of drugs were sent for test, out of which 63 samples were found to be not of standard quality. In respect of consignments of drugs which were found to be not of standard quality and where the defect noticed is not remediable the Custom Authorities have been advised to take

action to either re-export the drug to the country of origin or cause them to be destroyed. In case where the defects are remediable reconditioning of the drug is allowed.

Approval of New Drugs : Under the provisions of the Drugs and Cosmetics Act and Rules, the Drug Controller (India) is the approving authority in respect of New Drugs proposed to be imported or manufactured in the country and only such drugs as are considered safe and efficacious are permitted to be marked.

Central Drug Laboratory, Calcutta: The Central Drugs Laboratory, Calcutta is the Statutory Laboratory under the Drugs and Cosmetics Act for the testing of drugs. The main functions of this Laboratory are : (i) To test samples of drugs imported in the country; (ii) To act as an appellate authority in cases where the report of the Govt. Analyst is challenged in the Court of Law, and (iii) To act as Govt. Analyst on behalf of those States/Union Territories which do not have their own facilities for testing of drugs.

At present this Laboratory is acting as Govt. Analyst for 21 States/Union Territories.

Central Indian Pharmacopoeia Laboratory, Ghaziabad : The CIPL is the Statutory appellate Laboratory for testing of condoms under the Drugs and Cosmetics Rules. In addition, this Laboratory functions as Govt. Analyst for the States of Andhra Pradesh, Bihar, Delhi, Goa, Punjab, Tripura, Orissa and Rajasthan and also tests samples on behalf of some Central Govt. Departments. Besides, the Laboratory is also responsible for carrying out Laboratory investigations in connection with standards for drugs included in the Indian Pharmaceuticals.

Drugs Technical Advisory Board : The Drugs Technical Advisory Board is a statutory Board constituted under the Drugs and Cosmetics Act to advise the Central and the State Governments on technical matter arising out of the administration of this Act.

Training Programmes : The Central Drugs Standards Control Organisation has been conducting training programmes for training of Drugs Inspectors and Drug Analysts concerned with Drug Standard Control. During the period April to October, 1985 one training programme for Drug Inspectors was arranged at Bombay, which was attended by 18 Drug Inspectors from the State Drug Control Administrations. Δ

39th World Health Assembly

PROPER BALANCE BETWEEN SUCCESSSES AND DIFFICULTIES

THE 39th World Health Assembly concluded its work in Geneva on 16 May, 1986, in a spirit of full support of the Health for All Strategy. The Assembly, which had as its President Dr Zeid Hamzeh, Minister of Health of Jordan, noted with appreciation that almost 90% of the countries making up the World Health Organisation (WHO) submitted reports on the evaluation of their national strategies.

The Director-General of WHO, Dr Halfdan T. Mahler, told delegates "You have been very open in your statements about the health situation in your countries, and I think you have struck a very proper balance between reporting on both your successes and your difficulties". The Director-General added that this readiness to exchange health information across geographic and ideological borders ".....is a must, if WHO is to fulfil its constitutional role as the directing and coordinating authority on international work".

Earlier in his address to the Assembly, the Director-General emphasized the importance of good organization and management in order to build up health systems based on primary health care. Dr Mahler suggested that countries be divided into manageable units for the delivery of primary health care. The optimal size of these areas will vary from one country to the next, but such a unit will need to have "primary health care facilities in communities and possibly for groups of communities,...a referral hospital, laboratory facilities inside or outside the hospital, and a district health office with a full time health officer".

Emphasizing this point, the Director-General added, "I believe the time has come to concentrate on building up district health infrastructures". The way to achieve this would be to draw up action programmes with defined targets, such as the number of districts to be set up in a given time, for example.

The World Health Organization (WHO) will intensify its action in coordinating the collection, analysis

and speedy dissemination of information on the health effects of accidents resulting from the peaceful use of atomic energy, the Director-General Dr Halfdan Mahler, told the 39th World Health Assembly.

Presidential Address

Dr Zeid Hamzeh, Minister of Health of Jordan, and President of the Thirty-Ninth World Health Assembly, warned the delegates in his inaugural address against "irrational expenditure" on sophisticated medical care and expensive hospitals. This, he said, "constitutes a burden to many countries with limited resources and consequently undermines the attainment of health objectives".

Dr Hamzeh went on: "What is the use of advanced medical technology to someone suffering from emaciation and malnutrition, or who has not been immunized against diseases and epidemics?"

International cooperation in the field of health, he said, was indispensable for the well-being of all nations. This included the rich ones "who by contributing to the promotion of the health standard of the not-so-rich nations would in actual fact be also protecting their own health...Diseases and epidemics know no frontiers, whether political or geographical, and need no passports or visas to cross any such barriers".

Intersectoral Action

Member States of the World Health Organization (WHO) pledged themselves to combat inequities in health, whether in the developed or developing worlds. The 39th World Health Assembly accepted without a dissenting voice the recommendations which emerged from Technical Discussions held concurrently with the Assembly. The discussions were on "the role of intersectoral cooperation in national strategies for Health for All".

One of the recommendations was that combating inequities in health must be "an overriding, concern"

in national strategies for attaining Health for All by the Year 2000, since vulnerable groups among the population are often by-passed in the general process of social and economic development.

Immunization—major gains over the decade

Some 60 per cent of children are now receiving either a first dose of diphtheria, pertussis and tetanus (DPT) or polio vaccines, and 40 per cent a third dose—up from negligible levels in 1974—a report by the World Health Organization (WHO) says.

WHO launched its Expanded Programme on Immunization that year to protect against the four diseases, plus measles and tuberculosis.

The report, presented to the Thirty-Ninth World Health Assembly gives an account of the achievements thus far in the world-wide immunization drive. But its main thrust is on what needs to be done to reach all children by 1990.

Water Supply and Sanitation

Progress made during the first half of the International Drinking Water Supply and Sanitation Decade (1981—1990), and the situation at its mid-point and the prospects for the remaining years up to the end of 1990, were reviewed.

It was concluded that although the establishment of the Decade had resulted in an increase in the number of people in the developing countries with access to an adequate and safe water supply and appropriate sanitation facilities, and in an improvement of the standards of existing services during the first half of the 1980s, progress had fallen short of aspirations. In fact, if programmes are not decisively expanded, slightly more people will still be without water in 1990 than at the start of the Decade and approximately 200 million more will have no access to an appropriate means of disposal of faecal wastes.

Although it seems clear that greater attention and priority is being given to the rural populations and urban poor in the developing countries, the services to these groups still fall far short of the level and quality of service found in better equipped urban areas. In general, much will have to be done if the levels of sanitation service coverage are to be brought up to match those for water supply.

WHO drug Strategy Approved

The World Health Assembly unanimously approved a strategy designed to make the use of drugs more

rational throughout the world. It contains no mention of any international code of drug marketing, a subject that has given rise to considerable polemic in recent years.

The strategy is based on recommendations made to the WHO Director-General, Dr Halfdan Mahler, at the WHO Conference of Experts on the Rational Use of Drugs, held in Nairobi, Kenya, in November 1985. Assembly delegates maintained the "spirit of Nairobi"—that is, a spirit of cooperation rather than confrontation—in Geneva this week, as Dr Mahler had urged them to do.

The strategy requires WHO to secure the cooperation of a number of "concerned parties" in fulfilling the responsibilities which were laid down for each at the Nairobi conference.

HEALTH INNOVATORS AWARDED SASAKAWA HEALTH PRIZE

The President of the 39th World Health Assembly, Dr Zeid Hamzeh, 8 May, 1986 presented the second Sasakawa Health Prize for outstanding innovative work in health development to three recipients: The Ayadaw Township People's Health Plan Committee from Burma, Drs Lucille Teasdale Corti and Pietro Corti from Uganda, and Dr Amorn Nondasuta from Thailand.

The Sasakawa Health Prize of US Dollars 100,000 was established and first awarded in 1985 by Mr Ryoichi Sasakawa, Chairman of the Japan Shipbuilding Industry Foundation and President of the Sasakawa Memorial Health Foundation. This year, the Ayadaw Township Health Plan Committee has been awarded US Dollars 40,000 and Dr Lucille Teasdale Corti, Dr Pietro Corti and Dr Amorn Nondasuta US Dollars 30,000 each. The prize is not intended as a reward for the laureates, but to encourage further development of their outstanding innovative work.

These parties are: governments; the pharmaceutical industry; health personnel involved in prescription, dispensing, supply and distribution; universities and other teaching institutions; professional non-governmental organizations; the public; patients' and consumer groups; and the mass media.

RESOLUTIONS

AIDS Prevention and Control

Over 20 delegates took the floor to describe the programmes undertaken in their respective countries and to express their satisfaction with the measures WHO had rapidly taken to invest funds to control the serious health problem posed by Acquired Immunodeficiency Syndrome (AIDS), despite current financial constraints. The Assembly adopted a resolution which urges Member States to continue their collaboration among themselves and with WHO to control the AIDS epidemic. WHO is requested to cooperate with countries to study the problem and set up national and collective programmes for the prevention and control of AIDS.

Tobacco or Health

The Assembly affirmed that tobacco smoking and its use in all forms is incompatible with the attainment of health for all by the year 2000. In a resolution, the Assembly called for a global public health approach and action now to combat the tobacco pandemic. It appealed to other Organizations of the United Nations system to support WHO in all ways possible within their fields of competence and to show solidarity with WHO in stemming the spread of tobacco-induced diseases by protecting the health of non-smokers on their premises. The difficulties of small farmers who derive their living from the growing of tobacco in developing countries was another subject of concern. The Director-General of WHO was requested to ensure that WHO plays an effective global advocacy role in tobacco and health issues and that, in common with other health institutions, it plays an exemplary role in non-smoking practices.

The Executive Board

The Assembly considered a proposed amendment to the WHO Constitution which would increase membership of the Executive Board from 31 to 32 Members so that the Western Pacific Region would be entitled to designate four persons to serve on the Board and adopted amendments to Articles 24 and 25 of the Constitution accordingly. Notification of acceptance of these amendments will be effected by the deposit by each Member State of a formal instrument with the Secretary-General of the United Nations.

Abuse of Narcotic and Psychotropic Substances

In response to the dramatic increase of serious health and social problems related to the abuse of nar-

cotic and psychotropic substances, the Assembly urged Member States to further develop national prevention and treatment programmes. It also requested WHO to formulate a plan of action aimed at controlling health problems related to drug abuse, and suggested the United Nations should increase its financial support to this area.

Strategies for the Advancement of Women in the Health Sector

The Assembly endorsed and Nairobi forward-looking strategies for the advancement of women as providing a comprehensive policy framework for advancing the status of women to the year 2000 and decided that WHO will take all appropriate measures with other Organizations of the United Nations system in the implementation of these strategies.

Infant and Young Child Nutrition

Nearly fifty delegates commended WHO on its overall approach to maternal and child health and nutrition. Many of them stressed the importance of women's status and their education in relation to infant and young child nutrition. There was overwhelming recognition of the importance of breast-feeding.

The Assembly passed a resolution noting that though many Member States had made substantial efforts to implement the international code on marketing of breast-milk substitutes, concerted efforts would continue to be necessary to achieve its full implementation. The resolution urged Member States to implement the code if they had not yet done so.

The International Year of Peace

The Assembly recalled the provisions of the WHO Constitution concerning the close relationship of health with the promotion of peace and international security as well as the provisions of the United Nations General Assembly Resolution 34/58 stating that peace and security are important for the preservation and improvement of the health of all people and that cooperation among nations on vital health issues can contribute significantly to peace.

Use of Alcohol in Medicines

The Assembly accepted a proposal requesting the Director-General of WHO to set up an Expert Working Group to examine the scientific and health effects of alcohol in medicine and the implications of its possible reduction or elimination. △

BOOKS

Low-cost water supply and sanitation technology : pollution and health problems. New Delhi, WHO Regional Office for South - East Asia, 1984, 40 pages (SEARO Regional Health Papers, No. 4) ISBN 92 9022 1739 Price: Sw. fr. 5.—.

Under the aegis of the International Drinking Water Supply and Sanitation Decade (1981-90), designated by the United Nations, there has been progress in the provision of water supply and sanitation facilities in the developing countries. However, if the Decade targets are to be met, nearly half a million people would have to be given access to new water supply and sanitation facilities *every day*. It would be impossible to achieve this using conventional technologies alone owing to their high costs and the level of skills required. Hence alternative approaches have to be tried—approaches that are simple and cheap. Many such methods have been tried and tested for water supply, particularly in the rural communities, and several applications have also been designed for excreta disposal. Some of these technologies have proved socially acceptable and economically viable, and hence have come to be called “appropriate technologies”.

While some of these technologies can undoubtedly increase the coverage, their improper use can give rise to health problems. This aspect assumes special significance in developing countries where the incidence of waterborne and water-related diseases and diseases resulting from soil pollution and food contamination is very high. It has thus become imperative that the provision of simple low-cost technologies be preceded by an assessment of their design, quality, and the existence of adequate maintenance facilities.

This publication, based on a report submitted to the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), starts by summarizing the health problems that can result from the improper use of low-cost technologies.

The apparent paradox of how a high coverage by water and sanitation facilities can actually lead to low health status is discussed, using the example of a typical family that lives in a mud hut with a thatched roof. A chapter is devoted to a few principal applications on low-cost technology in water supply based on rainwater, groundwater, surface water, and piped water. Water-quality surveillance is also discussed.

The chapter on low-cost technology applications in sanitation covers on-site excreta disposal systems, pit latrines, groundwater pollution, septic tanks, aquaprivies, waste-stabilization ponds, fish ponds, biogas digesters, nightsoil disposal systems, land irrigation systems, and refuse disposal.

A 10-page summary table also lists suggested precautions and remedial measures to be applied with different types of low-cost technology.

Written in simple and lucid language, this publication should be useful to public health administrators, health planners, health educators, designers, sanitary engineering personnel, and all those actively engaged in planning and maintaining low-cost water supply and sanitation technology.

COLD FACTS ABOUT POPULATION GROWTH

The outstripping of the world's resources by a population projected to reach 6,000 million people in 15 years is the focus of the *State of the World 1986* report by the World Watch Institute.

Per capita grain production has dropped since 1950 in 40 developing countries, home to more than 700 million people, states the report.

The decline in per capita grain production in most countries is not exclusively due to ecological deterioration. Failed or non-existent population policies can expand demand for food and undermine agricultural support systems. In essence, population growth hastens the process of ecological decline.

A quarter of the world's families live in makeshift shelters. Fully half of the third world's urban dwellers live in shantytowns which double in population every 5 to 10 years.

A thousand million people lack safe drinking water and 2,000 million have no basic sanitary facilities.

According to *State of the World 1986*, two per cent of the world's tropical forests are destroyed each year. Far faster in South-east Asia and West Africa, where moist tropical forest will have virtually disappeared by the end of the century. 7 per cent of the earth's topsoil is lost each decade. The fish catch per person, including from fish farming, is down 15 per cent since 1970. Biggest consumption cuts are in third world countries such as the Philippines. Water demand is outpacing sustainable supplies in many parts of the world.

One in ten children born in developing countries dies before its first birthday. Every year, 5 million infants and children die from malnutrition and diarrhea and 12 million more die from infections and preventable diseases. Almost half a million women die in childbirth each year. Half of these lives could be saved through access to family planning.

(Source: *State of the World 1986*).

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SPECIAL NUMBERS 1985

January	The International Youth Year (Theme: Participation, Development and Peace)
February	Nutrition
March-April	World Health Day, (Theme: Healthy Youth; Our Best Resource)
June	Environment and Health
July	Heart Disease
August	Health Progress
October	Behavioural Research and Health
November	Universal Children's Day (Theme: Community Participation)
December	Women, Health and Development

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