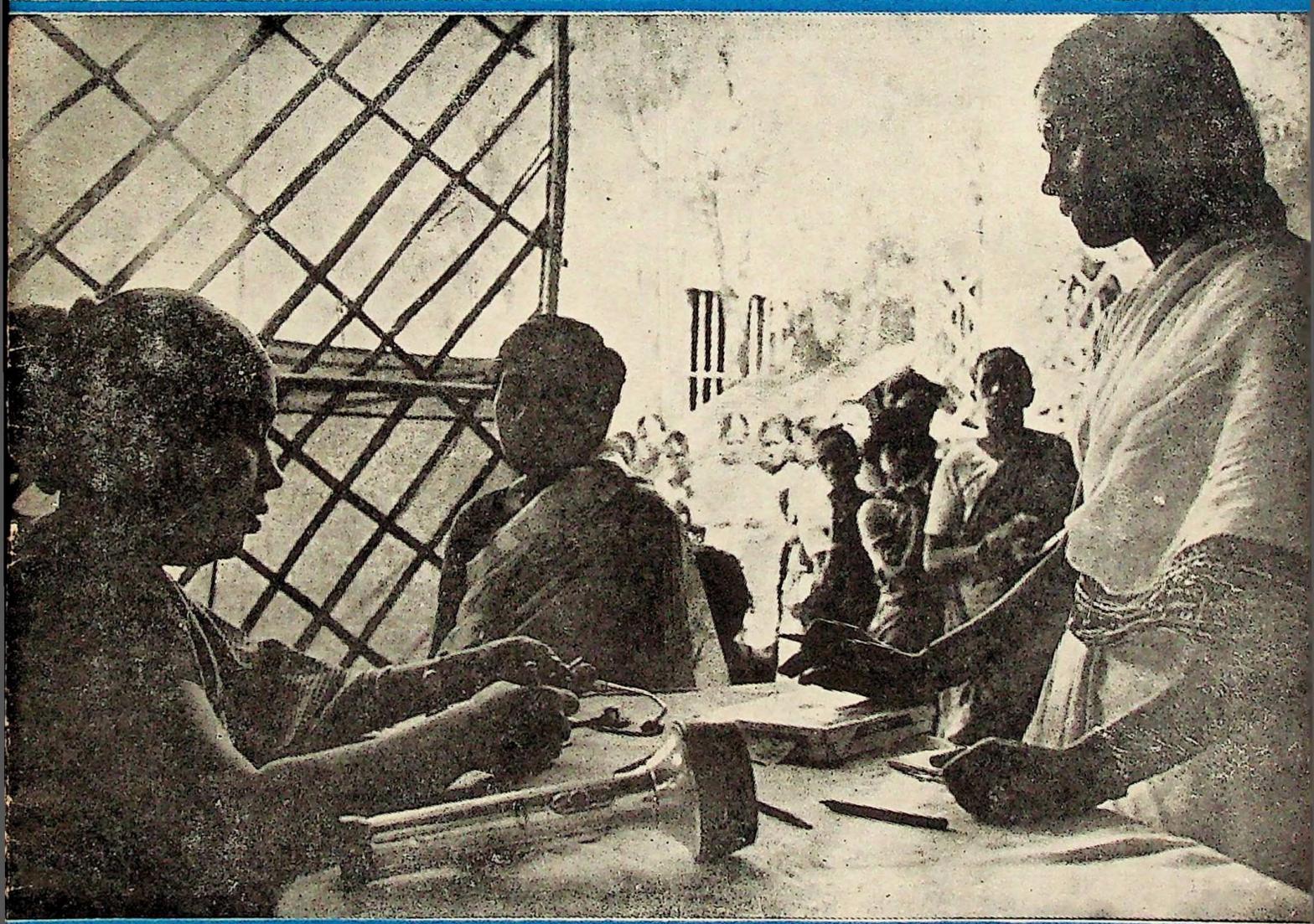


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HEALTH PROGRESS IN INDIA

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OBJECTIVES

Swasth Hind (Healthy India) is a monthly journal Published by the Central Health Education Bureau, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, New Delhi, Some of its important objectives and aims are to :

REPORT and interpret the policies, plans, programmes and achievements of the Union Ministry of Health and Family Welfare.

ACT as a medium of exchange of information on health activities of the Central and State Health Organizations.

FOCUS attention on the major public health problems in India and to report on the latest trends in public health.

KEEP in touch with health and welfare workers and agencies in India and abroad.

REPORT on important seminars, conferences, discussions, etc., on health topics.

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IN THIS ISSUE

Page No.

Health in 1982-83	
Year of achievement	181
<i>Dr. S. S. Sidhu</i>	
Maternal and child health care	187
Rural health services	188
Towards population control in India	190
<i>J. S. Baijal</i>	
Water supply and sanitation programme in India	194
<i>V. Venugopalan</i>	
Training of para-medical personnel in control of blindness	199
—scope and possibilities	
<i>Prof. Madan Mohan</i>	
A roof over every head	203
<i>M. K. Mukharji</i>	
Books	III cover

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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YEAR OF ACHIEVEMENT

DR S. S. SIDHU

To improve the quality of people's lives is a very important function of a Government. The strength of a Nation depends upon the strength of its people. All national plans and programmes are aimed at improving the economic, social and moral status of the people so that the Nation can become strong and self-reliant. The Family Welfare Programme is a crucial one to the success in the national efforts towards progress and prosperity. It is equally important that the people should be healthy so that they can fully enjoy the fruits of progress. Health and family welfare have, therefore, been rightly given a prominent place in the new 20-Point Programme announced by the Prime Minister. The Ministry of Health and Family Welfare is committed to:

- (1) promote family planning on a voluntary basis as a people's movement;
- (2) substantially augment universal primary health care facilities, and control of leprosy, T.B. and blindness; and
- (3) accelerate programmes of welfare for women and children and nutrition programmes for pregnant women, nursing mothers and children, specially in tribal, hilly and backward areas.

FAMILY WELFARE —A People's Programme

Family planning on voluntary basis continues to be the sheet anchor of our developmental strategy. Integrated with primary health care and welfare of mothers and children, the programme aims at promoting an informed change in individual and social perceptions and behaviour for enabling adoption by the people of planned parenthood as a life style. After the setback suffered during 1977-79, sustained and vigorous efforts have restored and enhanced the credibility of the programme. The year 1981-82 witnessed a significant upsurge in public enthusiasm for the programme. Encouraged by the significantly improved performance in 1981-82, the Ministry set before it-

self, for the year 1982-83, ambitious though attainable tasks and targets.

Small family norm

It is a matter of some satisfaction that the efforts made so far have yielded encouraging results. About 28 lakh sterilizations were carried out during the period April 1982 to January 1983, as against 19.6 lakhs during the corresponding period of the previous year. This was a step-up of 43 per cent. In the field of IUD insertions, the improvement in performance is to the extent of 35 per cent. Considerable improvement has also been achieved in respect of the use of Nirodh and Oral Pills as well as in the various activities under the MCH Programme. The Couple Protection Level which was 22.7 per cent on 1-4-1981 and 23.7 per cent on 1-4-1982.

A well-defined long-term strategy has been evolved to ensure that adoption of the 'small family norm' is done entirely on a voluntary basis. The salient features of this strategy are: intensified efforts to spread awareness and information through imaginative use of multi-media and inter-personal communication strategies; provision of services and supplies as close to the door steps of the acceptors as possible; development of facilities for rapid increase in female literacy; population education to the youth in schools and colleges as well as those out of schools; assistance and support of the elected representatives of the people; proper linkages with other Ministries and Departments concerned; and close monitoring and follow-up of the programme at all levels.

Population Advisory Council

The Ministry has set up a 20-Member Population Advisory Council under the chairmanship of the Union Health Minister to analyse the implementation of the Family Welfare Programme and to advise the Government suitably. The Population Ad-

visory Council has set up five Working Groups to discuss and suggest innovations to the various aspects of the Programme including Organisation and Management, Incentives and Disincentives, Communication Strategy, Research and Technology and Community Participation. A series of meetings were held with opinion leaders, editors of vernacular newspapers, industrialists, public sector undertakings, film producers as well as local bodies to enlist their support to the programme. In the voluntary sector, a major initiative was taken by the Indian Association of Parliamentarians on Problems of Population and Development. This Association held its first national level meeting in May 1981, which was addressed by the Prime Minister.

The Programme will continue to be integrated with a package of health services and area specific attention will be given to States and within States to districts or areas requiring special attention with a view to cover every nook and corner of the country, specially the weaker and deprived sections of the

The Government envisages a conceptual change from the emphasis on curative aspects to preventive and promotive health services at all levels of the health care delivery system, both in rural and urban areas.

population. Supported by the emerging national consensus at all levels, strong commitment of the Government, increasing public enthusiasm, the programme is set for further forward movement. The Government feels that the long term-goal of reducing the per thousand birth and death rates to not more than 21 and 9 respectively is attainable.

MATERNAL & CHILD HEALTH

Maternal and Child Health care contributes to better health and improves the chances of survival of children and thereby provides motivation for couples to accept the norm of small family. A comprehensive programme of immunization to protect pregnant mothers and children from diseases and nutritional anaemia is, therefore, being implemented vigorously at all levels of the health delivery system. The infrastructure of delivery of maternal and child health services is being continuously expanded both

in rural and urban areas by setting up PHCs, rural and urban centres and sub-centres, and post-partum centres. There has been significant improvement in the performance under the programme during April-December 1982-83 over the performance during the corresponding period of 1981-82 in respect of various components of the MCH Programme, ranging upto over 95 per cent in the case of typhoid immunisation. Significant step-up in performance (+49.2) in the polio immunisation programme is also evident. It is planned to cover 140 lakh children under DPT, 125 lakh under DT, 9 lakh under Tetanus and 10 lakh under Typhoid immunization.

NATIONAL HEALTH POLICY

Keeping in view the national commitment to attain the goal of 'Health for All by the year 2000 A.D.', the Government has evolved a National Health Policy, which has been placed before the Parliament. The Policy lays stress on the preventive, promotive, public health and rehabilitative aspects of health care, and points to the need of establishing comprehensive primary health care services to reach the population in the remotest areas, the need to view health and human development as a vital component of overall integrated national socio-economic development, decentralised system of health care delivery with the maximum community and individual self reliance and participation. The policy also lays stress on ensuring adequate nutrition, safe drinking water supply and improved sanitation for all. Great emphasis has also been placed on Health Education. The Policy sets out specific goals to be achieved by 1985, 1990, 1995 and 2000 A.D., in pursuance of the national commitment for the attainment of the goal of Health for All by 2000 A.D.

PRIMARY HEALTH CARE

In order to achieve the goal of 'Health for All by the year 2000 A.D.' and with the motto "the needs of the many should prevail over those of the few" the Health Sector envisages a conceptual change from the emphasis on curative aspects to preventive and promotive health services as well at all levels of the health care delivery system, and strives to provide comprehensive primary health care and medical services to the deprived and weaker sections of the society. A strategy has been evolved to provide comprehensive health care services to the rural, tribal, scheduled caste areas and the poor people at the periphery. The Primary Health Care infrastructure would consist of primary health centres each

The new Health Policy sets out specific goals to be achieved by 1985, 1990, 1995, and 2000 A.D., in pursuance of the national commitment for the attainment of the goal of Health for All by 2000 A.D.

...serving a population of 30,000 (20,000 in the case of tribal and hilly areas and sub-centres each serving a population of 5000 (3,000 in the case of hilly and tribal areas). The village or a population of 1000 would form the base unit where there will be a trained Village Health Guide. The dispensaries will be converted into subsidiary health centres to include the preventive, promotive and participative services. The Sixth Plan envisages the implementation of a 'Minimum Programme of Rural Health Care.' In this Minimum Rural Health Care Programme the schemes which are included are, Multipurpose Workers' Scheme, Health Guides' Scheme, Components of the Revised Minimum Needs Programme, Training and Promotional Training Programmes for Birth Attendants (Dais), Auxiliary Nurse/Midwives/Health Workers (Female), Community Health Officers and the setting up of Regional Teachers Training Institutes. These schemes are expected to ensure availability of adequate infrastructure and medical and paramedical manpower to make the universal provision of Primary Health Care a reality.

DISEASE CONTROL/ERADICATION

Malaria, Leprosy, T.B. and Blindness are the major diseases which need to be tackled. Other diseases which need attention are the diarrhoeal diseases, Filaria, Goitre and Japanese Encephalitis. The deprived and weaker sections of the population are more prone to these diseases. The intensified efforts put in by the Ministry, specially in the wake of the new 20-Point Programme, are expected to reduce the gravity of the epidemiological situation in the country.

Malaria

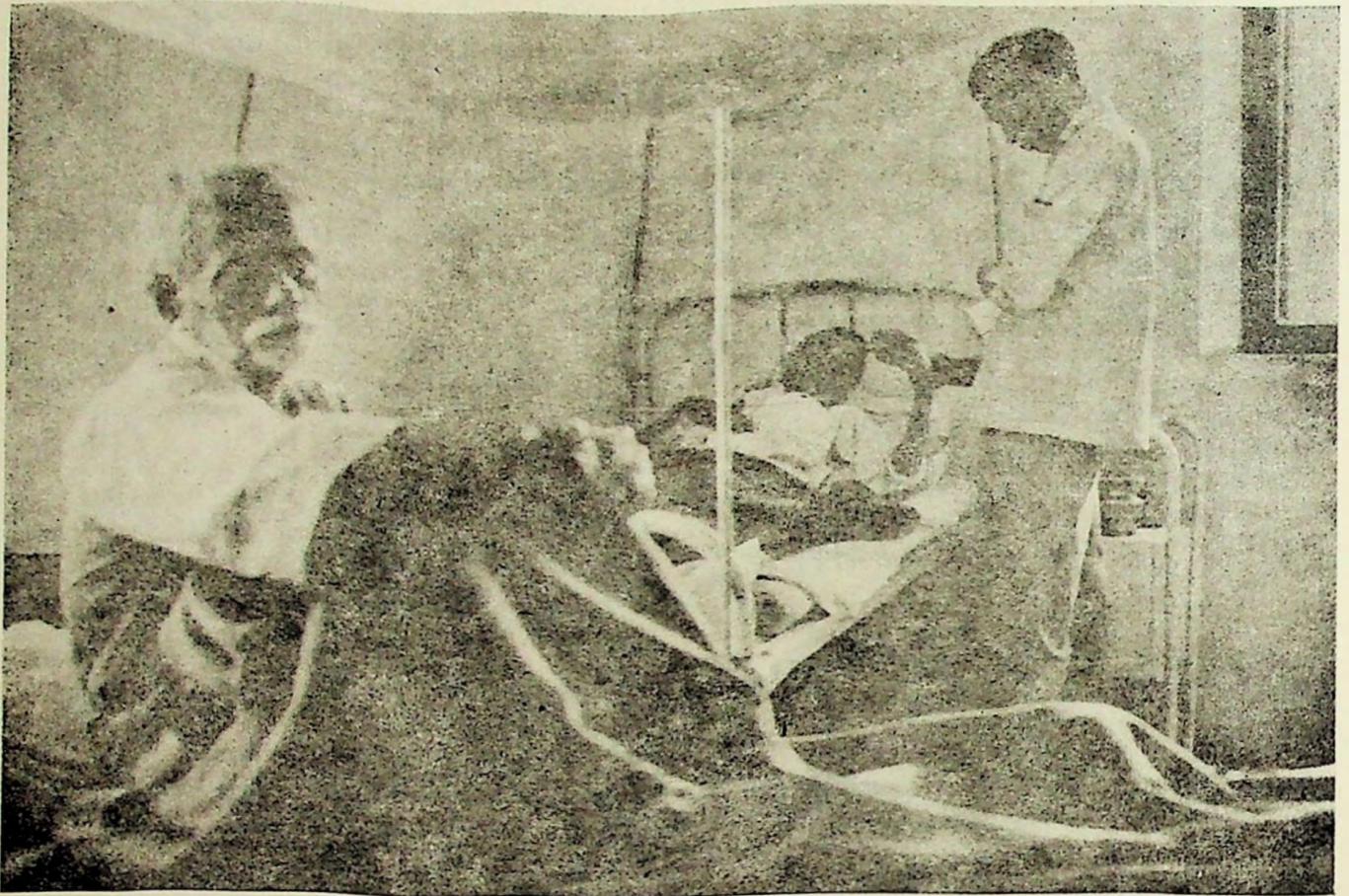
Malaria has been a major public health problem in the country. To combat this disease, National Malaria Eradication Programme was implemented with much greater vigour during 1982-83. As a result of Government efforts, people's participation and continuing research, the incidence of malaria has been declining over the years. By very vigorous follow-up and continuous liaison with the State authorities, it has been possible to bring down the morbidity on account of malaria in general and of *p. falciparum* type of malaria in particular. During

1982, the total incidence of malaria was lower by 27 per cent and that of *p. falciparum* was lower by 15 per cent over the previous year.

Leprosy

It is estimated that about 0.59 per cent of the population suffers from Leprosy. A serious social stigma has also come to be attached with this disease. The Prime Minister has given a call for eradication of Leprosy on a time-bound basis. As a first step in that direction, the Leprosy Control Programme had been converted into a 100 per cent Centrally financed programme. Financial provisions for this programme has been stepped up from Rs. 3.4 crores in 1980-81 to Rs. 11 crores in 1982-83. A target of 4.74 lakhs of new case detection was fixed for the year 1982-83. According to the reports received, upto January 1983, the progress of new case detection (3.39 lakhs) and bringing these cases under treatment, was 7 per cent higher than that of the last year.

A working Group was set up under Dr M. S. Swaminathan, to devise the strategy for the eradication of Leprosy. The Group made important and far reaching recommendations which have been examined by an Empowered Committee. As a result, the National Leprosy Control Programme would now be called as the National Leprosy Eradication Programme. A National Leprosy Eradication Commission, under the chairmanship of Union Health Minister with other Central Ministers concerned as a policy guidance body and a National Leprosy Eradication Board under the Union Health Secretary will be set up for the effective implementation of the policies evolved by the Commission. In the States where there is a high incidence of Leprosy, there will be similar policy guidance and implementation bodies. A sizeable step up in the Sixth Plan allocation for the National Leprosy Eradication Programme has also been envisaged. A new multi-drug regimen strategy for interruption of transmission of Leprosy in hyper-endemic districts has been launched and it covers at present the two districts of Wardha (Maharashtra) and Purulia (West Bengal). This scheme has been extended to further hyper-endemic districts.



Tuberculosis attacks both young and old. Bed rest in a sanatorium used to be considered vital to tuberculosis treatment. A major study in Madras showed that chemotherapy was just as successful at home.

Photo: W.H.O./P. Alamy

Tuberculosis

Tuberculosis is a major health problem in the country. Under this programme, District T.B. Centres are provided by the Health Ministry with modern X-ray equipment, mini-X-ray films and anti-T.B. drugs. The main strategy of the programme is to detect as many cases of Tuberculosis as is possible and to bring such cases under treatment. A target of 10 lakh new case detection was fixed for the year 1982-83. Till January 1983 about 80 per cent of the target had been achieved. In order to ensure proper involvement of the Primary Health Centres in the fresh T.B. case detection, States and Union Territories have been asked to fix a monthly target of microscopic examination of sputum of 50 symptomatics in every Primary Health Centre and to utilise the existing microscopic/laboratory technicians and the microscopes provided under the NMEP for

this purpose. A Task Force had been constituted to review the present programme and recommend measures to make the programme effective and time-bound. Their report has been finalised and is being examined by the Government. One of the important recommendations is the conversion of the programme from 50 per cent Centrally Sponsored to 100 per cent.

Blindness

The National Programme for Control of Blindness envisages the development of various services at the peripheral, intermediate and Central levels. Mobile units will provide comprehensive eye care including survey of villages and screening of school going children, out-patient treatment and surgical treatment. Loss of vision due to cataract is the most common. It

is totally curable and vigorous efforts are being mobilised through Government and voluntary sectors to maximise the number of cataract operations. A target of 12.95 lakh cataract operations was fixed for the year 1982-83 and according to the available information, over 5.15 lakh operations had been done till January 1983. It has been impressed upon the State and Union Territory Governments that they should pay urgent attention to complete their targets through a large scale organisation of eye camps in view of the fact that the winter months are generally congenial for such operations. 100 per cent assistance is offered to the State Governments/Union Territory Administrations in the form of material and equipment as well as a cash subsidy for the development and operation of these services. Under this programme, a major step forward has been the launching of a nation-wide scheme for training of Ophthalmic Assistants. This category of personnel forms the key to the delivery of ophthalmic services at the PHC level. It is expected that by the end of the VI Plan, as many as 3,500 PHCs will be provided with Ophthalmic Assistants.

A Working Group was set up by the Government of India under the Chairmanship of Dr Swaminathan, ex-Member, Planning Commission, to study in depth the problem of blindness and to suggest measures to tackle the problem. The working Group has submitted its report to the Government. The recommendations of the Working Group are under active consideration of the Government.

Other programmes

Facilities for Cancer diagnosis and treatment are being developed in almost all major hospitals attached to medical colleges. Nine selected institutions are being developed as Regional Cancer Research Centres; Central Assistance is given for installation of Cobalt Therapy Units and for setting up Early Cancer Detection Centers. An agreement has been signed with the Government of Japan for a project for manufacturing Japanese Encephalitis Vaccine and the project is in progress. For combating Diarrhoeal diseases, oral rehydration therapy is being adopted and the health workers and the masses are being educated for the purpose. National Programmes for nutrition and Control of Goitre are also continuing with increased effectiveness. Major steps have been taken to promote voluntary blood donation.

MEDICAL EDUCATION

A Medical Education Review Committee headed by Dr S. J. Mehta was constituted to review the

present Medical Education System in the context of the national commitment to attain the goal of 'Health for All by the year 2000 A.D.' through the universal provision of primary health care. The terms of reference of the Committee included a thorough review of the current admission procedures, course duration, measures to bring about overall improvement in the undergraduate and post-graduate medical education, etc. It was also to evolve realistic projections of medical manpower requirements during the Sixth Five Year Plan and beyond. The Committee has submitted its Report to the Government which is being examined. In the light of the report of the Medical Education Review Committee the work of evolving a "national medical and health education policy" will be taken up.

MEDICAL RESEARCH

Research in the medical fields and demographic research are being promoted. The research priorities coincide with the national health priorities and cover the control of communicable diseases, promotion of maternal and child health control and prevention of nutritional and major metabolic disorders and non-communicable diseases such as cancer, cardiovascular diseases, blindness, diabetes, drug research (including the Traditional Systems of Medicine), and developing alternative strategies for Health care delivery systems through the primary health care approach.

INDIAN SYSTEMS OF MEDICINE

Indian Systems of Medicine include all the non-allopathic systems of medicine and regimens excluding Homoeopathy, viz., Ayurveda, Siddha, Unani, Nature Cure and Yoga. The Central Sector Sixth Plan provides for the development of Indian Systems of Medicine and Homoeopathy. The various schemes included in the Sixth Plan aim, mainly, at improving the quality of education, promotion of research programmes based primarily on their respective philosophies, planned production of herbal and other medicines on a large scale and their standardisation. Primarily rural based programme, these systems of medicine are helping to narrow the gap existing in medical care between the rural and urban sectors. The Government is conscious of the fact that these systems have an important role in achieving the target of 'Health for All by 2000 A.D.'

The Governmental effort in the field of health and family planning will have to be supplemented by

that of the numerous voluntary agencies engaged in this field. Recognising this need, the Ministry has taken effective measures to encourage participation in the programmes by Voluntary Organisations.

Health being a State subject, the effective implementation of various Health & Family Welfare Programmes can be ensured only through proper liaison and communication with the States/Union Territories. The Eighth Joint Conference of the Central Council of Health and the Central Family Welfare Council was held from 18th to 20th August, 1982 at New Delhi under the Chairmanship of the Union Minister for Health and Family Welfare. The conference reviewed a number of issues and made wide ranging recommendations for adoption. Six Regional meetings with the Health Ministers of States/Union Territories were held by the Union Health Minister in June 1982 to review the progress of performance of various Health & Family Welfare Programmes

and to chalk out strategies for 1982-83. Two conferences of the Health Secretaries of all the States/Union Territories were convened; one in February 1982 and the other in January 1983. The conferences facilitated a first hand appraisal of the implementation of the various programmes, besides enabling identification of gaps in the implementation, their filling up and evolution of future strategies.

During the year, much higher targets were set in relation to Health and Family Welfare. The realisation of these objectives required an acceleration of the tempo of work generated during the previous year. As is evident from the trends the performance during the year is very encouraging.

—Excerpts from the Introduction to the Annual Report—1982-83 of the Union Ministry of Health and Family Welfare.

More medical facilities for Scheduled Castes and Scheduled Tribes

The Ministry of Health and Family Welfare gives utmost priority to provide medical facilities to the Scheduled Castes and Scheduled Tribes. With a view to accelerating the tempo of activities the Ministry of Health and Family Welfare has set up a Tribal Development Planning cell which coordinates the framing of Tribal Sub-Plan (TSP) and special component plan for Scheduled Castes (SCP).

According to the report of the Ministry of Health and Family Welfare the outlay for these two plans is Rs. 25 crore (Rs. 11 crore for TSP and Rs. 14 crore for SCP) for the year 1982-83. In 1981-82 it was Rs. 19 crore.

Of the 38 million tribal population (1971 census) 28.5 million is covered under the Tribal Sub-Plan

areas. These areas have 782 PHCs and 4,571 Sub-Centres. The average population covered by a PHC and a Sub-Centre in these areas are 36,500 and 6,235 respectively, which in case of other areas are 84,400 and 8,830 respectively.

100 out of the 600 new PHCs proposed to be established during the Sixth Plan are to be located in the tribal areas. Full provision has been made for the construction of the buildings and the staff quarters for the proposed PHCs in tribal areas, though no such provision could be made for the PHC in non-tribal areas. 100 per cent of the Sub-Centres required to be opened in tribal areas will be established by the end of the Sixth Plan. △



Photo: UNICEF

Maternal and Child Health Care

During 1982-83, special emphasis was given to improve the health status of mothers and children in view of the Prime Minister's new 20-point programme. It includes acceleration of programmes of welfare for women and children and nutrition programme for pregnant women, nursing mothers and children.

THE maternal and child health services refer to the broad and currently accepted meaning of promotive, preventive, curative and rehabilitative health care for mothers and children. Since mothers and children have additional requirement for reproductive growth and development and are biologically more vulnerable to environmental influences, special programmes are required in pregnancy, child birth and childhood in addition to the general health measures. During 1982-83, special emphasis was given to improve the health status of mothers and children in view of the Prime Minister's New 20-Point Programme which includes acceleration of programmes of welfare for women and children and nutrition programme for pregnant women and nursing mothers and children. 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, immunization of expectant mothers against tetanus, immunization 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.—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 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 tablet. Pregnant and nursing mothers and women acceptors of family planning and children are the beneficiaries.

Prophylaxis against blindness.—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 containing 2 lakhs international units of Vitamin 'A' is given to children in the age group of 1-5 years every six months.

Supply of Drugs and Vaccines.—The Department of Family Welfare procures all vaccines, iron and folic tablets and Vitamin 'A' solution and supplies to the State Governments and UTs. as per their requirement.

Oral Rehydration therapy for control of Diarrhoeal Diseases.—Ministry of Health and Family Welfare is supplementing the efforts of State Governments by supplying the oral rehydration salts to combat dehydration from diarrhoeal diseases which is a major cause of deaths in children. The budget provision during 1982-83 is Rs. 50 lakhs. 50 lakh packets of oral rehydration salt have been supplied to various States and UTs. during the year. Δ

Rural Health Services

INDIA being a signatory to the Alma-Ata Declaration 1978, is committed to attaining the goal of 'Health for All by the Year 2000 AD' by providing comprehensive universal Primary Health Care. In view of this, the Ministry of Health and Family Welfare has launched a number of intensive programmes for providing not only curative but also promotive and preventive health care facilities to the extensive rural population of the country. The Sixth Plan, therefore, envisages the implementation of a 'Minimum Programme of Rural Health Care.' In this Minimum Rural Health Care Programme the main schemes/programmes are as indicated below:

Multipurpose Workers' Scheme

The Multipurpose Workers' Scheme aims at establishing a Health Delivery System in the rural areas through a team of Multipurpose Workers; one male and one female for every 5,000 rural population. Implementation involves (a) intensive training programme to train unipurpose workers in the technical concepts and skills of the Multi-purpose Workers at all levels and (b) employment of additional workers.

Training

- (a) The seven Central Training Institutes conduct training programmes for the Key Trainers and for the District Level Medical Officers.
- (b) The forty-seven Health and Family Welfare Training Centres impart training to the Medical Officers and the Block Extension Educators (BEEs) of the Primary Health Centres (PHCs).
- (c) Trained MOs and BEEs organize training at their own PHCs/at the selected PHCs for their para-medicals.

Health Guides Scheme

The Health Guides Scheme has been introduced with the objectives of preparing a cadre of voluntary

health workers selected by the community, who will undergo training in promotive, preventive and elementary health care aspects so as to provide an integrated primary health care at the grass-roots level. The training is arranged in the nearest Primary Health Centre or Sub-centre over a period of three months and Rs. 600 is given to each candidate as stipend. On completion of training, each Health Guide is supplied with a manual, a kit and harmless simple medicines. The Health Guide receives an honorarium of Rs. 50 per month to meet out pocket expenditure and drugs worth Rs. 50 per month.

Minimum Needs Programme

Under this, the following Health Institutes are meant for the most vital function of the Health Schemes in the rural areas of the country:

1. Primary Health Centres.
2. Upgraded Primary Health Centres.
3. Subsidiary Health Centres.
4. Sub-Centres.

The different functions which these institutes are supposed to perform are based on need of the community in general with emphasis on promotive and preventive aspects. The PHCs are also training various groups of health personnel who are involved in delivery of primary health care at the door-steps of the people.

As on 1 April, 1982, there were 5902 PHCs, 56173 Sub-centres, 373 upgraded Primary Health Centres and 2622 Subsidiary Health Centres in position in various States and Union Territories.

The targets for establishment of these institutes during the 6th Plan period, and 1982-83 as well as institutes established during 1980-81 and 1981-82 are indicated as below:

(A) *PHC*.—These additional PHCs will be established in places only where the existing PHCs cater to a larger population.

(a) Target for the 6th Plan period	721
(b) Target for 1982-83	190
(c) Likely performance during 1982-83	143

(d) Established in 1980-81	280
(e) Established in 1981-82	137

(B) *Sub-Centres*.—These sub-centres will be established on the basis of one sub-centre for every 5000 population. The additional sub-centres to be established during 6th Plan period will raise the number to about 90000 against the total requirement of 122000.

(a) Target for the 6th Plan period	37964
(b) Target for 1982-83	7909
(c) Likely performance during 1982-83	8080
(d) Established in 1980-81	2223
(e) Established in 1981-82	6280

(C) *Upgraded PHCs*.—It is proposed to establish the rural hospitals by upgrading the existing PHCs. Each of the upgraded PHC will bear 30 beds to meet the need of the rural population.

(a) Target for the 6th Plan period	316
(b) Target for 1982-83	85
(c) Likely performance during 1982-83	95
(d) Established in 1980-81	100
(e) Established in 1981-82	64

(D) *Subsidiary Health Centres*.—It is proposed to convert the rural dispensaries into Subsidiary Health Centres. The ultimate object is to invite all the rural dispensaries in the implementation of Health and Family Welfare and M.C.H. Programme.

(a) Target for the 6th Plan period	2364
(b) Target for 1982-83	1842
(c) Likely performance during 1982-83	1636
(d) Established in 1980-81	202
(e) Established in 1981-82	304.

△
Annual Report 1982-83 of Ministry of H & FW

TOWARDS POPULATION CONTROL IN INDIA

J. S. BAIJAL

The National Planning Committee under the Chairmanship of Jawaharlal Nehru, set up by the Indian National Congress in 1935, observed, "In the interest of social economy, family happiness and national planning, family planning and limited numbers of children are essential and the State should establish a policy to encourage this." At about the same time, on the invitation of All India Women's Conference, Margaret Sanger visited India and stimulated a great deal of interest in the country in Family Planning. By this time, Prof. Karve had already put in fifteen years of dedicated service to this cause at his centre in Bombay. However, it was to take a decade and a half before independent India officially adopted, under Nehru's leadership, a programme for family limitation and population control under the First Five Year Plan. With promotion of health and welfare of the family as the main plank of appeal for the programme, it was perceived by the policy makers as the means of securing a reduction in the birth rate to extent necessary to stabilise the population at level consistent with the requirements of the national economy. This was the first time that a national Government had taken cognizance of the threat posed by unlimited and unregulated increase of population and launched a country-wide programme to overcome it.

WHEN the country attained freedom in 1947, the population stood at 344 million, with an annual growth rate of 1.3 per cent. With the adoption of the Constitution and its objective of welfare State and rapid improvement in the production of foodgrains and consequent disappearance of famines, expansion of health facilities and the successful implementation of preventive health programmes, eradication of large scale epidemics, introduction of new drugs and modern methods of treatment, there was a visible decline in mortality. By 1981, the crude death rate came down from about 27.4 to 12.5 per thousand and the life expectancy at birth rose from 32 to over 52 years. With such a steep fall in mortality it was no wonder that the population increased to 439 million in 1961, to 548 million in 1971 and 685 million in 1981, becoming larger than the combined population of the Americas.

Changing dimensions

Clinic-oriented approach—With the galloping growth of the population, Government's awareness of the various dimensions of the problem also grew. New strategies were evolved and suitable modifications were made in the family planning programme, with the objective of guiding demographic change rather than merely observing it, at times belatedly. During the First Five Year Plan, the programme was clinic-oriented. The newly established clinics, all over the country, were to provide advice and services to those who came to seek them. Voluntary organizations were also encouraged to set up clinics in the urban areas. This approach continued during the period of the Second Five Year Plan (1956-61).

Extension approach—During the Third Plan (1961-66), specific targets to reduce the birth rates to specified levels were adopted. The clinic-oriented approach was replaced by the "extension" approach. The objective of the new approach was to establish the small family norm in every community, through education and dissemination of information to every eligible couple regarding the various contraceptive methods, provision of such service facilities as were socially and psychologically acceptable, and involvement of the community leaders. It was during this period that use of IUDs and conventional contraceptive was successfully included in the governmental programme. By

about the same time, the social marketing of contraceptives was taken up for the first time in collaboration with the private sector. This approach has been continued successfully, ever since.

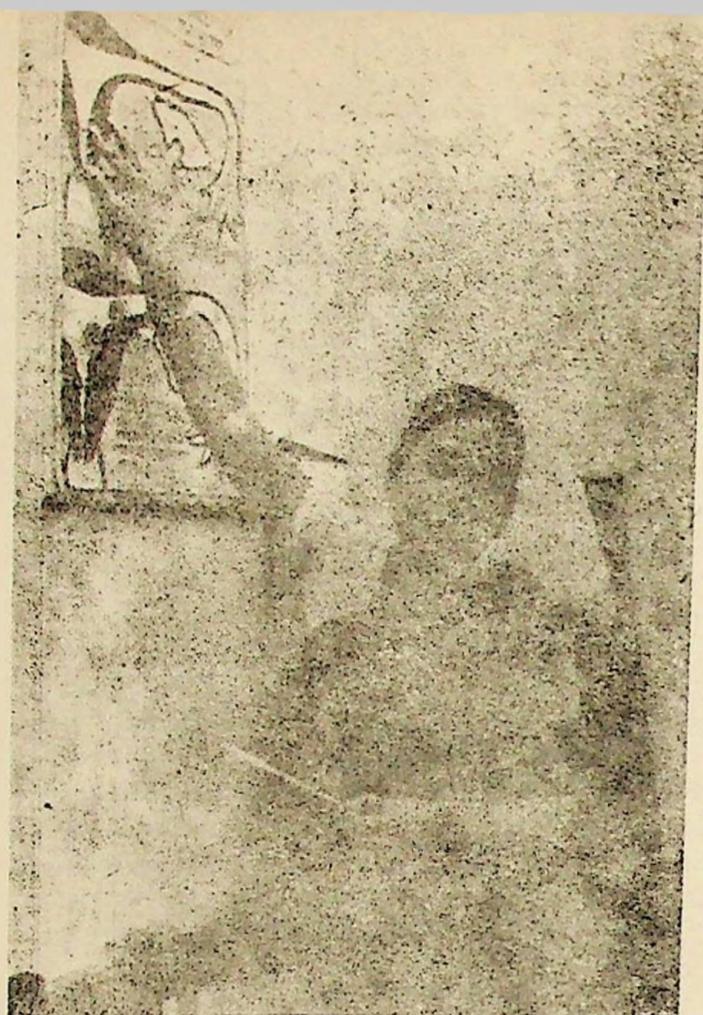
The programme steadily gained momentum and by 1977 protection against conception had been provided to 23.7 per cent eligible couples. During the next three years (1977-80), the political commitment to the programme received a jolt resulting in a severe setback which brought down the eligible couple protection rate to 22.3 per cent in 1979-80. After the present Government assumed office, in 1980, political support to the programme was restored and several new organisational and technological inputs were added. Financial allocations were increased. As a result, there has been steady improvement in performance. Despite a very large increase in the number of eligible couples, the couple protection level has risen to about 25 percent by December 1982.

Fifty million births averted

The 1981 Census placed the country's population at a level higher than expected. However, it also revealed certain redeeming features. For the first time, in over four decades, the population growth rate established at a more or less constant level. Compared to the preceding decade (1961-71), as against eight States and Union Territories (with 13 per cent of the population) which had shown a declining growth rate, 19 States and Union Territories (comprising 49 per cent of the population) showed such decreasing trends during 1971-81. Birth rate, which was around 42 in 1951 came down to about 33 in 1981. It has been estimated that since inception, the Family Planning Programme has averted 50 million births upto March 1982. The significance of the achievement has to be viewed against the background of the vital fact that

Planned parenthood: *The programme aims at promoting an informed change in individual and social perceptions and behaviour for enabling adoption by the people of planned parenthood as a life style.*

Photo: PIB



A well-defined long-term strategy has been evolved to ensure that adoption of the small family norm is done entirely on a voluntary basis, through education and dissemination of information to every eligible couple regarding the various contraceptive methods.

Photo: PIB

it has been secured entirely within the democratic framework through a completely voluntary programme of family limitation.

Integration with other programmes

In the initial stages, the Family Planning Programme was implemented as a vertical programme within the over-all health organizations of different States, largely because the application of majority of the birth control methods require the advice and support of medical and para-medical personnel. Over the years, there has been a gradual integration of the programme with the health care delivery system. It was but natural that the widespread network of health infrastructure should be involved in the challenge. Further more, having realized the strong nexus between infant mortality and fertility, Government has, during the past several years, fully integrated family planning with the Maternal and Child Health Programmes which include nutritional and immunization activities.

Multi-media approach

The fertility patterns in various parts of the country vary considerably on account of the sharp differences in the socio-economic-ethnic factors. Consequently,

Having realized the strong nexus between infant mortality and fertility Government has, during the past several years, fully integrated family planning with the Maternal and Child Health Programmes which include nutritional and immunization activities.

the receptivity of communities to suggestions for family limitation also varies widely. To effectively combat this situation, area specific educational and communication programmes have been developed. Organized efforts are also in progress to provide services and supplies as close to the homes of the people as practical. Multi-media approaches, supported by inter-personal communication, are being tried out for increasing contraceptive prevalence. Since small families are a pre-requisite for raising the health status of the people, expansion and augmentation of the primary health delivery system has been taken up as an instrument of promoting both family planning and health facilities.

Programmes are underway to provide a Health Guide in every village and a Sub-Centre, consisting of an ANM and a male Multi-purpose Worker for a population of 5,000. For a unit of 30,000 population, there will be one primary health centre (PHC) and for each 100 thousand population, there will be an upgraded PHC providing beds and specialized services. At the next higher level are the District Hospitals, serving as referral centres. Today, about 220 thousand trained and equipped Village Health Guides are already in position; 56,000 sub-centres have been established and 6,700 Primary Health Centres have been fully established. In addition, about 400 thousand Traditional Birth Attendants, residing in their villages, have been trained to perform aseptic deliveries and advise couples regarding the care of children and adoption of family planning methods. Influential village leaders are continuously being educated and involved in the efforts to convey the message of "small family norm" among their people.

Planned parenthood concept

Planning steps have also been taken to secure the cooperation of various governmental agencies and increasing participation of non-governmental organizations in the overall effort to promote a voluntary change in individual and social perception and behaviour so that planned parenthood (including care of the mother and the child) as a concept is accepted, adopted and woven into the life styles of the people. In the words of our Prime Minister, Smt. Indira Gandhi, the goal is to "make the programme a people's movement."

Considerable progress has been achieved in the field of population control, but much still remains to be done. The potential for future population growth in India is indeed awesome. Over 40 per cent of India's population is under the age of 15. This vast and growing young population will inevitably lead to larger additions to the reproductive age groups. Even if each couple produces a lesser number of children, the total increase will continue to grow for a long time.

Targets for the year 2000

With the implementation of the strategy to achieve the goal of Health for all by the Year 2000, a further drop in death rate is envisaged. In view of the inevitable prospects of a significant increase in the number of couples in reproductive age group and a further drop in mortality, it would be necessary to ensure a larger decline in the birth rate. In this context, the country has set before itself the goal of bringing about a reduction in the birth rate to 21 per thousand, death rate to 9 per thousand and infant mortality to no more than 60 per thousand live births by the turn of the century. To achieve these various objectives, it would be necessary inter-alia, to increase the protection of couples to around 60 per cent along with effective measures to raise the age of marriage for girls.

Community participation

The tasks before us are indeed formidable. However, taking into account the raising wave of acceptance, success appears to be very much within reach. Of the 400 districts in the country, 92 have achieved couple protection levels exceeding 30 per cent while 60 districts have crossed 36 per cent—the target set for 1985. These achievements support the view that visible fertility decline is well on the way of being established, all over the country. Further expansion and improvement of the delivery systems, appropriate efforts towards spreading information and education and community participation are envisaged to quicken the fertility decline and thus enable the achievement of the targeted goals.

Besides the efforts aimed directly at intervention in fertility, constant endeavours are afoot to raise the educational levels of women, greater opportunities for gainful employment and thus raising their status in

society. Success in this direction would also help raise the age at marriage for girls, and their acceptance of the small family norm.

The demographic transition in Europe encompassed nearly half a century, to pass from a birth rate of about 35 per thousand to about 20 per thousand. We have set for ourselves a target of bringing about a similar transformation in less than half the time. Our task is more difficult because of our large population base and low economic and educational levels. However, our need and sense of urgency is greater. The fruits of modern scientific research are available to us. We have the advantage of a committed Government to this cause, and a national consensus to ensure that excessive population growth is not allowed to come in the way of raising the standards of living of our people. We have also a large working force of medical, para-medical, social and voluntary workers who have taken up the challenge in right earnest. Besides the national will, the requisite manpower and organization, we have developed a technological framework of a high order by any standards. India is thus in a position to face the future with confidence.

International effort

Resolution of the population problem is most vital for accelerating economic development. No attempt towards self-reliance can succeed unless the increase in population is curbed. Rapid population growth not only widens the gap between the rich and the poor within a country but also between nations globally. The overall economic rate of growth of the low income

developing countries nearly matched that of the industrialised nations during the past over two decades. Their per capita income growth, however, remained much less, because of the surge in population. For bridging this gap—the gap between the North and the South, and establishing the new international economic order, it is essential that all the developed and the developing countries as well as concerned international agencies should join hands, without any delay, to pool resources and experiences and work for an effective implementation of relevant population policies.

Today, the single most important objective before all the developing countries, without any exception, is to improve the quality of their populations. This calls for a quantum jump in the investment in people. Such investment has to be sizeable if significant results are to be achieved. This will be possible only if population growth is controlled.

The population problem is common to most of the developing countries. Some of them have implemented very successful population programmes. They have been able to develop considerable expertise and are in a position to assist others. India is fortunate in having gained a long and varied experience in this field. It has a large stock of trained personnel and excellent institutions dealing with medical, demographic and other aspects of the problem. It is thus in a unique position to collaborate with other developing countries in the march towards population control, health and human development and improvement in physical, mental and social well being of their peoples. Δ

1987

INTERNATIONAL YEAR OF SHELTER FOR HOMELESS

The General Assembly has proclaimed 1987 as the "International Year of Shelter for the Homeless". The Commission on Human Settlements will act as the United Nations' Centre for Human Settlements (HABITAT), which will serve as the Secretariat for the Year and as the lead agency for co-ordinating the relevant programmes and activities of other organisations and agencies concerned.

On 8 April, 1983, the Executive Director of the United Nations' Centre for Human Settlements (HABITAT), Arcot Ramachandran, has requested all countries to establish national focal points for the International Year of Shelter for the Homeless.

The National Focal Point for the Year could be a specific person, existing agency or a new unit or committee specifically established to stimulate and co-ordinate national and local action for the Year, according to Mr. Ramachandran. Although the functions of a national focal point would vary from country to country, they could include:

- developing, reviewing and selecting proposed shelter demonstration projects, and submitting them to the appropriate national and international agencies for support.
- contacting and discussing with non-governmental organisations their projects, plans and possibilities relevant to the Year,
- stimulating and coordinating all local and national activities and projects.
- receiving and distributing information on the programme and plans for the 1987 observance, on relevant activities in other countries and on other programme support information.
- organizing relevant meetings, seminars and training courses, and
- reporting periodically on the progress and achievements of the Year's activities and projects in the country concerned. Δ

August 1983

193

WATER SUPPLY AND SANITATION PROGRAMME IN INDIA

V. VENUGOPALAN

Sincere attempts are being made both by the States, Union Territories and the Centre to cover all the 2.31 lakh identified problem villages with safe drinking water supply facilities by the end of current Five Year Plan. An amount of Rs. 2007.11 crore has been provided in the Sixth Plan for this purpose. Out of Rs. 2007.11 crore an amount of Rs. 1407.11 crore is provided under the state Sector Minimum Needs Programme and Rs. 600 crore under the Centrally Sponsored Accelerated Rural Water Supply Programme. During the years 1980-81 and 1981-82, 25,978 and 29,837 problem villages respectively have been covered by the various States and Union Territories and the target set for the year 1982-83 was to cover about 42,000 problem villages.

THE provision of safe and adequate water supply and hygienic disposal of wastes is a basic necessity for the healthy living of the community. Its importance is self-evident and requires no emphasis. India has recognized this fact long back and accordingly in the First Five-Year Plan (1951-56) an outlay of Rs. 49 crore was allocated and gradually it has stepped up to a figure of Rs. 3922 crore in the Sixth Five-Year Plan (1980-85).

The science of environmental hygiene gained importance with the shifting of the emphasis from the curative to the preventive aspects of public health. Accordingly Public Health Engineering has been realized as specialized subject, which includes in its purview all essential activities bearing on the environment of man, viz. town and village planning; housing—rural, urban and industrial; safe water supply; collection and disposal of community wastes; prevention of river, marine and air pollution; control of industrial and trade wastes; food sanitation; etc.

The preventive approach to secure environmental hygiene gained momentum in the country with the formation of Environmental Hygiene Committee in 1949, which pin-pointed attention to this important subject and urged greater activity in this direction. The Committee recommended a comprehensive plan to provide safe water supply and sanitation facilities for 90 per cent of the population within a period of 40 years and also suggested a scheme of priorities for certain areas. The provision for Water supply and sanitation projects were later included by the State Governments as part of their planned development. Some headway was then made by the different States in this direction depending on their financial capacity to promote such a programme. Later, the Central Ministry of Health announced their National Water Supply and Sanitation programme in 1954. The object of the programme was to assist the States in the implementation of their urban and rural schemes and to channelize their activities in a planned direction. Under the programme, the State Governments were given a loan assistance for their urban schemes and a 50 per cent grant-in-aid towards their rural schemes. The Programme was to continue as an integral part of the first, second, and successive Five-Year Plans. The provision made against this programme formed a sizeable proportion of the total provision made towards health schemes under the plan. Thus, the Water Supply and sanitation Programme in the country gained momentum year by year. The outlays and expenditures



Supply of safe drinking water to all problem villages forms a significant point of the new 20 point programme. The Government proposes to provide at least one source of safe and assured drinking water supply to all the identified problem villages by the end of Sixth Five Year Plan.

in the various Five-Year plans for the Water Supply and Sanitation Sector shown in the Table I indicate

clearly the degree of importance given to this vital sector in the country.

TABLE I
Water supply and sanitation sector outlay/expenditure during various plans (Rs. in crore.)

	First Plan (1951-56)	Second Plan (1956-61)	Third Plan (1961-66)	Fourth Plan (1969-74)	Fifth Plan (1974-79)	Sixth Plan (1980-85)
1. Total Plan Outlay	3360	6750	8575	15902	39303.49	97500
2. Outlay for Water Supply and Sanitation	49	72	105.70	497*	930.68@	3922
3. Percentage of total Plan outlay	1.46	1.07	1.23	2.56	2.37	4.02
4. Actual Expend. on Water supply & Sanitation	11	74	110.17	548†	1107.46	—

* Excluding Rs. 34.10 crore provided for Centrally sponsored Rural W. S. Programme (ARP) subsequent to Plan finalization.

† Including L I C loan assistance, which was not reflected in the State Plans.

@ Excluding Rs. @ 100 crore provided for ARP subsequent to Plan finalization.

Situation in India

According to World Health Organization, the estimated service coverage for drinking water supply in developing countries by the year 1980 was 75 per cent in the urban areas and 29 per cent in the rural areas. With regard to sanitation facilities, the coverage figure was 53 per cent in urban and 13 per cent in the rural areas of the developing countries. In comparison to the aforesaid global coverage figures, in India as on 31 March, 1981, about 77 per cent of the urban population and 31 per cent of the rural population had been provided with protected drinking water supply facilities. With regard to urban sanitation, the coverage through sewerage and other excreta disposal methods was 27 per cent. The rural population, however, do not enjoy safe sanitation facilities to any significant degree.

Water Supply and Sanitation Decade

The U.N. Conference of Human Settlements (HABITAT) held in 1976 recommended that safe water

supply and hygienic waste disposal should receive priority from governments and International Agencies with a view to achieve target of serving all the population by 1990. The laudable objectives were approved in the U.N. Water Conference held at Mar-del-Plata, Argentina, in March 1977, and it was also decided that 1981-90 will be observed as "International Drinking Water Supply and Sanitation Decade". The thirtyfirst U.N. General Assembly which met in late 1977 endorsed the recommendations of the Water Conference. India was signatory to the resolution seeking to achieve the target for 1990 in the Water Supply and Sanitation Sector, namely, provision of minimum levels of service of access to safe water supply and sanitation to the people of this country. Accordingly, Decade Programme in India was launched on 1 April, 1981.

Targets for the decade

Considering the existing levels of coverage and anticipated constraints with regard to the resources

available, such as human, material and financial, the following targets have been set for the Decade:

1. Urban Water Supply — 100 per cent of the population to be covered by March 1991.
2. Rural Water Supply — — as above —
3. Urban Sewerage and Sanitation — 100 per cent of the population to be covered in respect of Class I Cities and 50 per cent in respect of Class II and other towns. Overall coverage in each State should be 80 per cent of the Urban population by means of sewerage or simple sanitary methods of disposal.
4. Rural Sanitation — 25 per cent of the population to be covered with sanitary toilets.

From the data collected from the States/Union Territories, it has been assessed that the total target population to be benefited with safe drinking water supply facilities by 31 March, 1991, would be about 7.44 crore in urban areas and 44.57 crore in rural areas, respectively. Similarly, the total target population to be benefited with sanitation facilities by the end of the Decade would be about 11.32 crore in urban areas and 14.94 crore in rural areas, respectively.

Coordinated action

Recognising the need for coordinated action and approach to achieve the aforesaid targets, the Government of India constituted an Apex Committee under the Chairmanship of the Secretary, Ministry of Works and Housing. This Committee is responsible for formulation of a National policy, guidance and over-view of the programmes to be undertaken during the Decade.

The Apex Committee in turn established three working groups: (1) Programmes and Manpower, (2) Financial Resources, and (3) Materials and Equipment, to evolve specific and comprehensive recommendations on these activities. The Working Groups had submitted their reports to the Apex Committee and the Apex Committee also accepted these reports. Necessary follow-up action on various recommendations of the Working Groups has already started at the Centre.

It has been assessed tentatively that about Rs.14,167 crore will be needed to achieve the Decade goal. Sub-Sector-wise break up of the fund is as follows:

(i) Urban Water Supply	—	Rs. 3,150 crore
(ii) Rural Water Supply	—	Rs. 6,525 crore
(iii) Urban Sanitation	—	Rs. 3,745 crore
(iv) Rural Sanitation	—	Rs. 747 crore
Total	—	Rs. 14,167 crore

Note: Above figures are based on 1980 price level.

Sixth Five Year Plan

The Government of India accorded a high priority to the Rural Water Supply programme in the Fifth Five-Year Plan and the allocation in the Sixth Five-Year Plan has been further stepped up. During the Sixth Plan, an outlay of Rs. 1542.58 crore has been earmarked under Minimum Needs Programme as well as other than Minimum Needs Programme of the State Sector. It is further supplemented by an outlay of Rs. 600 crore under the Centrally Sponsored Accelerated Rural Water Supply Programme. Under these two Programmes, the Government proposed to provide at least one source of safe and assured drinking water supply to all the identified problem villages numbering 2.31 lakhs in the country by the end of the Sixth Five Year Plan, i.e., by March 1985, (under Point No. 8 of the New 20-Point Programme of the Prime Minister). As per the Government of India norms, the problem villages are those:

- (i) Villages which do not have water within a distance of 1.6 kilometres or within a depth of 15 metres. (In hilly areas, the elevation difference between the habitation and the source is not to exceed 100 metres.)
- (ii) Villages where the existing water contained excess of fluorides, salinity, iron and/or other toxic elements hazardous to health; and
- (iii) Villages where the existing water sources were prone to transmit diseases like cholera, guinea-worm, etc.

In regard to urban sanitation, class I cities will be provided with sewerage and sewage treatment facilities during the Decade. However, in fringe areas of the Class I cities as well as other urban areas from Class II to Class IV cities, it is proposed to provide low cost sanitation facilities, such as converting bucket latrines into sanitary water-seal toilets with septic tanks and soakage pits arrangements. This is because of the fact that sewerage systems are not economically feasible for majority of the communities in these areas.

In regard to rural sanitation, simple sanitary water seal flush out latrines are proposed for each individual house. Small per capita cash provision in the form of subsidy at the rate of Rs. 50 per head may also be made available for construction of such latrines. Since such subsidy will alone be not sufficient for construction of toilets in each house, it is very much essential to mobilise local manpower and also procure locally available materials for such toilet construction programme.

During the Sixth Five-Year Plan an outlay of Rs. 1775.08 crore has been allocated for urban water supply and sanitation including urban sewerage and low cost sanitation. However, for the rural sanitation sector, a total sum of Rs. 15.08 crore has been provided in the current Plan.

Priorities for the Decade

For successful implementation of above programme, sound policies, such as priority to under-served population and careful strategies such as appropriate technology, service level, community participation, inter-sectoral coordination, efficient operation and maintenance of the constructed systems will be very much necessary. The Conference of State Ministers, Secretaries, Chief Public Health Engineers and Heads of Implementing Agencies held in Delhi during 3-5 February, 1982, recommended the following priorities for implementing the Water Supply and Sanitation Decade Programme in the country:

- (a) Safe drinking water to problem villages;
- (b) Safe drinking water to uncovered towns or uncovered urban areas;
- (c) Rehabilitation of urban water supply;
- (d) Low cost sanitation to towns other than Class I;
- (e) Safe water supply to non-problem villages;
- (f) Augmentation of urban water supply system;
- (g) Sewerage facilities to Class I cities lacking them at present; and
- (h) Sanitation in rural areas.

Link up with related sectors

There are many activities in the various Ministries and departments of the States and Central Government which have a direct or indirect bearing on the Water Supply and Sanitation Sector. The dovetailing of these activities will maximize the inputs and streamline the Water Supply and Sanitation Sector. Therefore, the Government of India is very much concerned and seriously thinking to link up the programmes for the Decade with the related sectors like rural development, health, irrigation, technical education, social welfare, etc. For instance, water supplies can be implemented as part of irrigation schemes particularly in the villages situated near major or minor irrigation projects and also those located on the banks of irrigation canals free of cost, as *gram panchayats* are generally

without sufficient financial resources to support such investments. Therefore, State Governments may advise their Irrigation Departments to integrate drinking water supply schemes as part of irrigation projects wherever possible and feasible. Similarly, agencies like Railways, Public Sector Enterprises and various Industrial Development Corporations have drinking water supply and sanitation schemes for their colonies/ areas. This activity as well as sector activities of public townships should be integrated and coordinated with the programmes of their respective State Governments. Construction of drinking water wells is one of the activities which can be undertaken by the States under the National Rural Employment Programme (NREP).

Health Education

While implementing the Decade Programme, it is felt that support programmes such as "Health Education" and "Community participation" are also very much needed. It is a known fact that without proper "education" there will be no impact on community health despite huge investment on water supply and sanitation facilities. It appears that over 1,70,000 health guides have been trained by the Health Ministry to impart health education among the rural people and there is a proposal to train up at least one guide for every village by the end of Six Five-Year Plan. These guides are expected to educate rural masses on proper maintenance of sources of drinking water, proper storage, chlorination and use. They are also instrumental in initiating community action for converting open wells into sanitary ones, use of water seal toilets, construction of septic tanks, 'soakage' pits for disposal of human and animal wastes. While appreciating the efforts of the Health Ministry in this task, there is still a great need to step up this activity during the Water Decade period. Another important aspect that should be kept in view is "community participation and involvement". The beneficiaries should be taken into confidence and be involved with various stages of project planning, execution, operation and maintenance of water supply and sanitation schemes in order to achieve the best results during the decade.

Role of Voluntary Organizations

Several non-governmental organizations (voluntary organizations) are presently working in the execution, operation and maintenance of water supply and sanitation projects in the country. These Organisations can definitely play a vital role for the the success of

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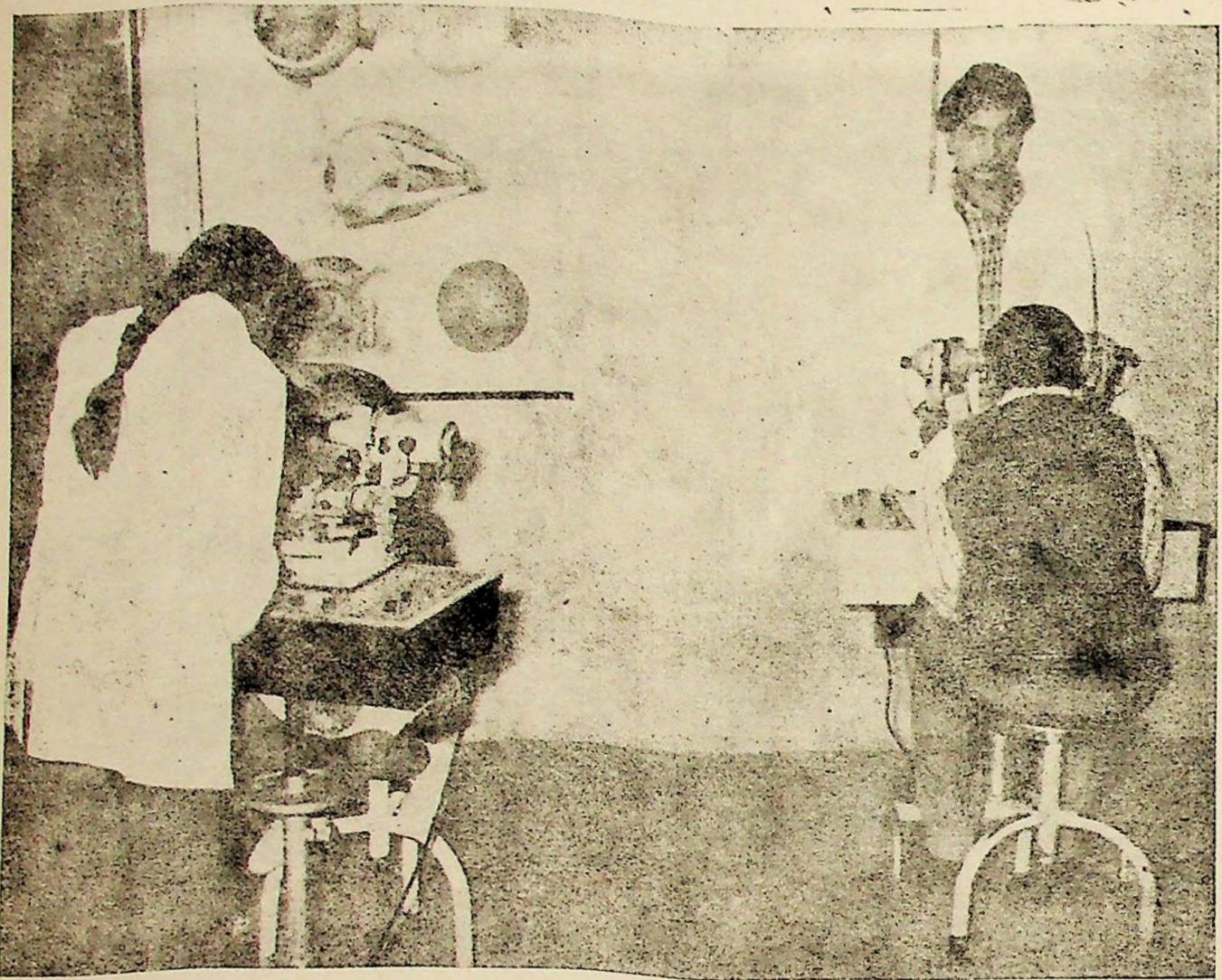


Photo: R. P. Centre, AIIMS, New Delhi

Training of para-medical personnel in control of blindness —Scope and possibilities

PROF. MADAN MOHAN

It is impossible to provide specialist's eye care services to all in the foreseeable future. In such a situation, the only alternative is to maximally utilize the existing manpower and simultaneously create an army of personnel trained precisely according to the needs and job requirements.

SUCCESSFUL execution of any public health programme depends on the quality and number of field workers. The implementation of National Programme for Control of Blindness, therefore, demands training of paramedical personnel with sufficient knowledge and skills to carry out their day-to-day activities.

Like other branches of medical science, ophthalmology has made great strides in the diagnostic and therapeutic techniques, but the incidence of blindness

and morbidity pattern has made little change in our country. One of the major reasons for higher prevalence of blindness in India is lack of awareness with regard to prevention of blindness. Lack of facilities for early diagnosis and primary eye care further add to the magnitude of the problem.

To be able to meet the challenge, it is essential to provide eye health education for prevention of blindness and facilities for early diagnosis and proper management of common eye diseases.

Shortage of ophthalmologists

The human eye is a very delicate and complex organ of sight. To be able to fully understand, diagnose and treat adequately all kinds of eye diseases, one needs institutional training of three years after M.B.B.S. and many years of experience to become a specialist.

There is an acute shortage of Ophthalmologists in the country. It is estimated that there is one ophthalmologist for 1,20,000 population. Most of them are practising or working in hospitals in the cities. Thus major chunk of the population can hardly avail of their specialized expertise.

The medical graduates (M.B.B.S.) posted at primary health centres are now within the reasonable reach of an average villager. Such doctors can provide necessary primary eye care if their training and evaluation is made more job specific. It has, however, been noted that these doctors are often over-burdened with patients suffering from general systemic disorders and family planning work that they tend to refer all eye patients to ophthalmic surgeons.

The para-medical field staff, *e.g.*, multipurpose workers and the village health guides are not adequately trained and equipped to render proper advice and provide primary eye care to the needy. Consequently many school going children and other persons suffering from preventable eye diseases and easily correctable visual defects remain handicapped due to lack of these services.

Orientation of field staff

In a vast and populous India, it is utterly impossible to provide specialist's services to all in the foreseeable future. In such a situation, the only alternative is to maximally utilize the existing manpower and simultaneously create an army of personnel trained precisely according to the needs and job requirements.

The immediate need is to create awareness by health education with regard to prevention of common diseases of eyes. It is possible if all para-medical field

staff is given orientation and is involved to educate the community with regard to:

- (1) The importance of the care of the eyes.
- (2) The simple measures of prevention of eye diseases, by better nutrition, improvement of personal hygiene and environmental sanitation.
- (3) The need for taking necessary precautions against eye accidents.
- (4) The importance of early detection and treatment of eye diseases in children.
- (5) The need to have regular eye check-ups after the age of 40 years for reading glasses detection of cataract, glaucoma and other blinding diseases.

To meet the long-term needs and to achieve health for all, primary eye care needs to be provided to all who need them. This can be achieved by launching a two pronged attack for preparing the required manpower.

1. The personnel providing general health services should be given short-orientation (one week) in the prevention of blindness. The existing medical colleges can function as training centres for this purpose. The District Medical and Health Officers, Medical Officers working at Primary Health Centres and interested private practitioners could be trained in a phased manner.

2. Permission of basic services through para-medical personnel is also possible, provided they are properly trained and function under the supervision of a qualified doctor. Such persons being from the local community, are more easily approachable and acceptable by the community. They are usually knowledgeable about the local customs, beliefs, practices, health problems and are responsive to local needs.

Training methods and course contents

Training should be conducted in regional languages as far as possible and it should be field-oriented. Major period of training may be covered by practical demonstrations and field visits, supplemented with lectures on important topics.

The course content of the training programme for the workers at the periphery level should include:

1. Organizing health education campaigns on eye care.
2. Arranging mass meetings to create awareness, group talks and health education by doctors and health educators on causes of blindness.

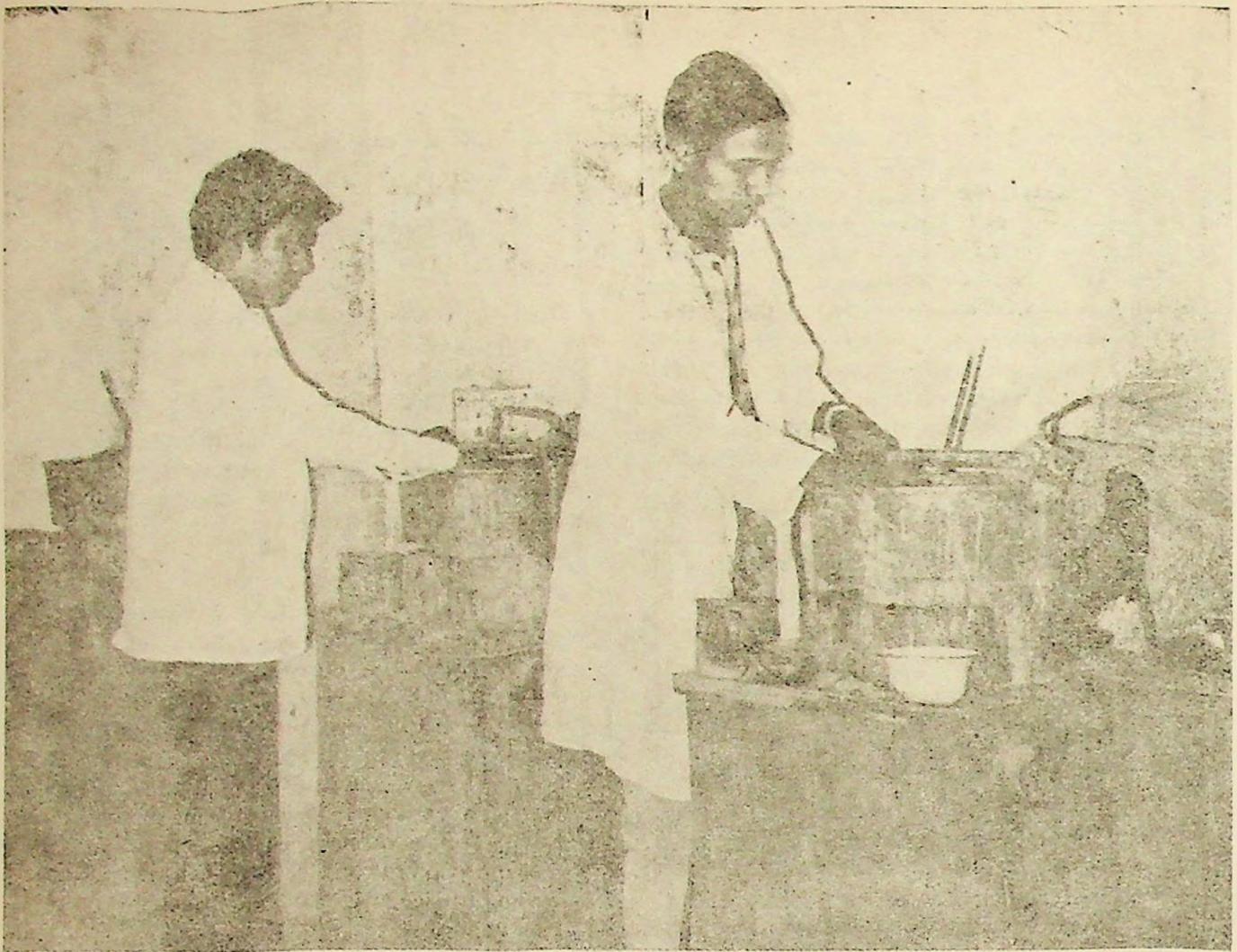


Photo: R. P. Centre, AIIMS, New Delhi

Optical assistants undergoing training in manufacturing and fitting of ophthalmic lenses.

- (3) Arranging contacts of the rural people with the voluntary organizations for providing eye care services at their door-step.
4. Securing the help of the concerned health authorities for the people for prevention of blindness.
5. Distribution of Vitamin A to the children to prevent nutritional blindness.
6. Distribution of antibiotic tubes and teaching of method of application for control of trachoma and other common infections of the eye.

The test of effectiveness of the training programme depends on the job efficiency of the participants in their work situation. Training must emphasise the fact that the health worker maintains a self-critical attitude towards himself, his methods and achievements. Objective evaluation must be a part of all training programmes for para-medical personnel.

Para- medical personnel for ophthalmic services

Some of the existing medical auxiliaries, specially trained to look-after the various aspects of eye problems are as under:

(a) *Optometrists*: Optometrist is a health personnel who is trained to detect refractive errors, prescribe and dispense eye glasses. In India there are a few institutions which award diploma in optometry after two years of training.

(b) *Orthoptists*: Orthoptist is a health personnel who is trained for investigating cases of squint and disorders of ocular mobility, for giving exercises and medical treatment of squint and allied conditions. In India, there are a few schools for training orthoptists (two years diploma).

(c) *Optical Assistants*: Optical assistant is a person who is trained in manufacture and fitting of ophthalmic lenses. There are very few training centres which turn out such technicians. Recently a vocational course

(10+2 examination) for optical assistants has been developed at Dr Rajendra Prasad Centre for Ophthalmic Sciences, AIIMS, New Delhi. The scope and possibilities for starting such courses need to be further examined. There are many optical shops, at least in all big cities. These need to be manned by technicians trained in making spectacles prescribed by the ophthalmologists and optometrists. At present the job is largely being done by untrained labour since there is hardly any facility for training of these workers. Training institutions, therefore, need to be established in different parts of the country to meet the country's requirements.

(d) *Ophthalmic Assistants*: A Two-year diploma course for ophthalmic assistants has been recently started under the National Programme for Control of Blindness. The Ophthalmic Assistant so trained will be required to:

- (i) Promote health education on eye care.
- (ii) Organize school health clinics for early detection of eye diseases.
- (iii) Perform refraction check-up and prescribe eye glasses.
- (iv) Assist the primary health centre doctors in handling all eye cases.
- (v) Help in choosing proper referral to District Ophthalmic Surgeons.

- (vi) Assist in organizing eye camps, and
- (vii) Assist in the training of the volunteers, social workers, para-medical staff such as, the VHGs, MPWs and MCH staff in the prevention of blindness.

Training is being imparted in the medical colleges for six months and in the field areas for one and a half (six months each in mobile eye unit, district hospital and PHC) leading to a diploma of para-medical ophthalmic assistant. This training has already been started in 20 different institutions and other 17 institutions are to start it very shortly. About 1,000 ophthalmic assistants will, thus, be trained every year.

Till mid-seventies the pattern of training of para-medical technicians for ophthalmic services was largely borrowed from the West. In India, only a few universities conducted two diploma type courses, i.e., for the optometrists and orthoptists. Now realizing the growing needs of the rural areas, for providing primary eye care, the training activities/courses are being widely expanded. With an inbuilt referral system at the primary/district level hospitals, it will thus be easier to control blindness and visual impairment as envisaged under the 'National Programme for Control of Blindness'. △

(continued from page 198)

Decade Programme. It is, therefore, essential to identify such Organizations working in different parts of the country and ascertain their field of specialization and potential. In this regard already United Nations Development Programme (UNDP) took up a project in India and recently a Conference on "National Voluntary Non-governmental Organization Consultation" was also conducted in Delhi. Follow-up action on various recommendations of the Conference will soon be initiated.

Guineaworm problem and eradication programme

Dracontiasis, popularly known as guineaworm disease is prevalent in certain rural areas of the country. As on 31 December, 1981, there are seven endemic States (Andhra Pradesh, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, Rajasthan and Tamil Nadu) with 80 districts, 468 blocks and 10,582 villages having been affected by guineaworm disease. Areas with very low water table where ponds, tanks or stepwells form the main drinking water sources are favourable for transmission of this disease. When an infected person

with ulcer (blister) gets into a water source such as stepwell, pond or a tank, large number of embryos are liberated from the worm inside the wound. These embryos are swallowed by cyclops (immediate host). Consumption of such contaminated water containing infected cyclops, by the people causes the infection. Thus, infected man is a big reservoir of the disease. Due to this infection, presently about 12.2 million people are suffering in the country. A Task Force constituted by the Government of India formulated the strategy for the eradication of this disease. The National Institute of Communicable Diseases is entrusted with the responsibility of planning, guiding, monitoring and evaluating the programme.

One of the best ways of eradication of guineaworm disease is by providing alternative safe drinking water supply sources in the affected areas. As mentioned earlier under the new 20-Point Programme of the Prime Minister, it is proposed to cover all the 2.31 lakh identified problem villages in the country with at least one source of safe drinking water by the end of Sixth Five-Year Plan, i.e. March, 1985. △

A ROOF OVER EVERY HEAD

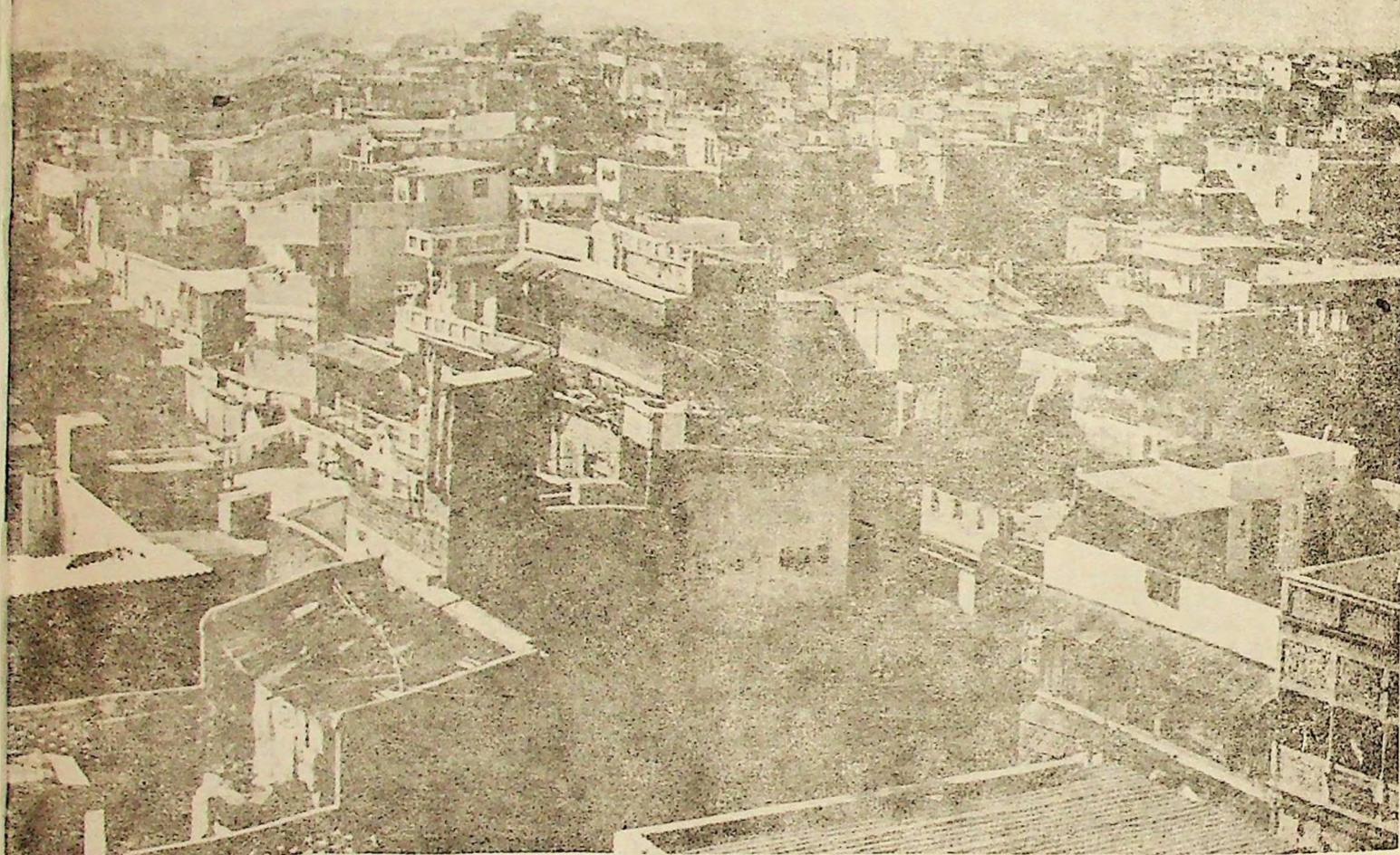


Photo: M.Y. Khan/CHIEF

M. K. MUKHARJI

In the formulation and implementation of housing development schemes in the public sector, the target groups are mainly the economically weaker sections and low income groups and to some extent the middle income groups which are the weakest sections of the society. The major thrust is to concentrate on general improvement of the environment, public health and hygiene.

HOUSING is undoubtedly a basic need. The magnitude of the problem is great and the housing conditions of the people, particularly of the poor and the less privileged, continue to cause grave concern. In the developing countries more and more people are coming to the cities in search of jobs. The rising cost of construction and the accelerated pace of urban growth coupled with the acute scarcity of developed land for the construction of residential houses have made the problem more difficult. The task of providing a roof over every head is, therefore, formidable and would require sustained effort over a long period.

In the rural areas the problem is not so much of land or the absence of a roof above the head but of access to even the most rudimentary level of services. In the urban areas, in a situation of shortage of land and appropriate types of shelter, squatter settlements and slums proliferate to provide some kind of accommodation to the rural-urban migrants. Most of them cannot afford any other form of shelter. Our major concern is for this category because they constitute the majority.

It is estimated that about 25 per cent of our urban population live in slums and squatter colonies. Assuming that most of them belong to the Economically Weaker Sections, *i.e.*, with a family income of less than Rs. 350 per month and the group can afford to spend not more than 15 per cent of their income on housing, an average family in India living in a slum will be able to afford Rs. 17.50 per month for housing. But shelter cannot be considered in isolation and has to be linked with municipal infrastructure and delivery of services. In our efforts to tackle the problem, therefore, we have to very carefully weigh the available options and select the most affordable and the most cost effective solution even if it means reduction in the standards of services.

The shortage

Housing shortage in India has been estimated to be about 20.7 million—16.1 million in rural and 4.6 million in the urban areas. This is only a rough estimate and does not take into account certain types of semi-permanent and temporary structures which may be serving the needs of a large section of our population. However, the figures do give us a broad idea of the extent of housing shortage in our country.

The shortage is most marked amongst the economically weaker sections of the society and the low income groups, but the gap is quite substantial in the case of the middle income groups also. The Economically Weaker Sections are those who have a total family income of upto Rs. 350 per month; Low Income Group are those with a family income of upto Rs. 600 per month. The corresponding amount for the Middle Income Group (MIG) is upto Rs. 1,500 per month and for the High Income Group above Rs. 1,500 per month.

In the formulation and implementation of housing development schemes in the public sector, the target groups are mainly the Economically Weaker Sections and Low Income Group and to some extent the Middle Income Group which are the weakest sections of the society. This will be evident from the fact that the Housing and Urban Development Corporation allocates 55 per cent of its funds for the Economically

Weaker Section and the Low Income Group and about 25 per cent for the Middle Income Group.

Sixth Plan

The Sixth Plan has identified that the public sector has a 'marginal though promotional' role to play in respect of housing and has mentioned that the emphasis of the public sector will be on the 'absolutely shelterless'. In rural housing the primary target group is the landless families and the plan objective is to provide developed house sites to cover each one of the rural landless families. The total number of eligible families has been estimated to be 14.5 million by 1985.

The scheme of provision of house sites to the rural landless which was in operation since 1970 had provided house sites to 7.7 million families before the commencement of the Sixth Plan. The Plan target is to provide house sites to the remaining 6.8 million. The programme component is such that it adopts a low cost solution using locally available building materials as far as possible, and the beneficiaries are expected to play a positive role by providing their own labour as a major input. The total provision in the State Plans for provision of house sites and construction assistance is about Rs. 354 crores. Under social housing schemes which again are in the State Sector of the Plan the total Sixth Plan outlay is Rs. 837.37 crores.

Slums

In the case of slums the stress is on providing a package of essential services like potable water supply, paved pathways for access, street lighting facilities and sanitary latrines in place of manually cleaned privies. The components of the programme will show that the major thrust of the scheme is to concentrate on general improvement of the environment and public health and hygiene. This approach is in preference to the less cost effective programme of slum relocation and re-housing of slum dwellers.

There is no doubt that the quality of housing in slums is very poor but they do serve the basic need of shelter and in the context of overall shortage the more practicable and pragmatic approach is to make the existing houses in the slum areas more liveable by eliminating squalor and filth and improving the environment and providing the basic sanitary facilities and water supply, rather than go in for a large scale rehabilitation programme.

Sites and services programme

The programme of improvement of slums *in situ*, however, cannot take care of the needs of the new

migrants and, therefore, the conventional housing programmes are supplemented with what is known as the sites and services programme. Briefly the programme consists of provision of developed house sites with a sanitary core and access to potable water supply in well planned and well laid out colonies. The beneficiary individuals are then free to construct the type of house according to their preference with the built in flexibility of 'incremental housing'. Under the Central Sector Plan Scheme for the development of Small and Medium Towns, the Government of India provides financial assistance to the State Governments and Union Territories for taking up housing schemes including Sites and Services schemes provided suitable land is identified and made available by the State Government.

Position elsewhere

Let us now have a look at the international scene. By and large the attention given to the subject of providing appropriate shelter has been inadequate.

Two significant events marked the growing interest of the international community to the deficiencies of shelter and infrastructure services. One was the Vancouver Habitat Conference of 1976 and the other was the Mar-Del Plata Water Conference of 1977. The Vancouver Resolution for the first time identified Human Settlements as a separate subject area as distinct from other activities and for the first time recognized the need for considering human settlement development programmes not merely in welfare terms but as positive instruments of national development. The Mar-Del Plata resolution decided to launch an international water supply decade from 1981 to 1990 where the global programme of safe drinking water to cover the entire world population was drawn up. Both these are momentous decisions and call for comprehensive action programmes.

The International Year of Shelter

So far as human settlement is concerned the historic Vancouver declaration was followed by the important 'Manila Communique' of 1981 which, while expressing grave concern about the deteriorating conditions of shelter for the poor, urged the countries to draw up positive action programmes for meeting the challenge. A very important development in respect of human settlement improvement programme is the Resolution

passed in the 36th Session of the U.N. General Assembly proclaiming 1987 as 'the International Year of Shelter for the Homeless'. The Fifth Session of the U.N. Commission on Human Settlement at Nairobi, where the author had the privilege of leading the Indian Delegation, had the subject as one of the principal items on the Agenda. The decision to proclaim 1987 as the International Year of Shelter for the Homeless was reiterated at the Nairobi Session.

Indeed the Proclamation is more than a mere slogan. It starts from the common concern about inadequate shelter provision and culminates in formulating a programme of action involving national and international agencies. The goal is quite ambitious. It is to improve shelter and neighbourhood to all the poor by the year 2000.

Our strategy

Happily India is one of the very few countries which, in its internal planning, has been acting on these principles for some years. India's National Plan Strategy is based on the principle of direct attack on poverty. It has a well articulated action programme to improve the physical quality of life of the people. The multi-point Minimum Needs Programme, most of which is incorporated in the new 20-Point Programme, includes rural house sites, rural health, rural education, rural electrification, rural roads, rural water supply and slum improvement in urban areas and shows thus the awareness and commitment of our country to the programmes involving the improvement of living conditions. Our objective is to provide, by the end of the Sixth Plan period, house sites to all the rural landless and at least one source of potable water supply to each of the 2.31 lakh problem villages and cover 10 million slum dwellers through the slum improvement programmes.

Considering the magnitude and complexities of the problems in a country of the size of India it will be idle to presume that the task is a simple one. While one can say confidently that the progress of the different schemes is quite encouraging there can be no room for complacency and long and sustained efforts will be necessary to reach our goal. The International Declaration will only help us to rededicate ourselves to our task. ^

NATIONAL LEPROSY ERADICATION COMMISSION CONSTITUTED!

A National Leprosy Eradication Commission has been constituted for the guidance and surveillance of the leprosy eradication programme under the chairmanship of the Minister for Health and Family Welfare, Sri. B. Shankaranand. The National Leprosy Control Programme has also been renamed as the National Leprosy Eradication Programme.

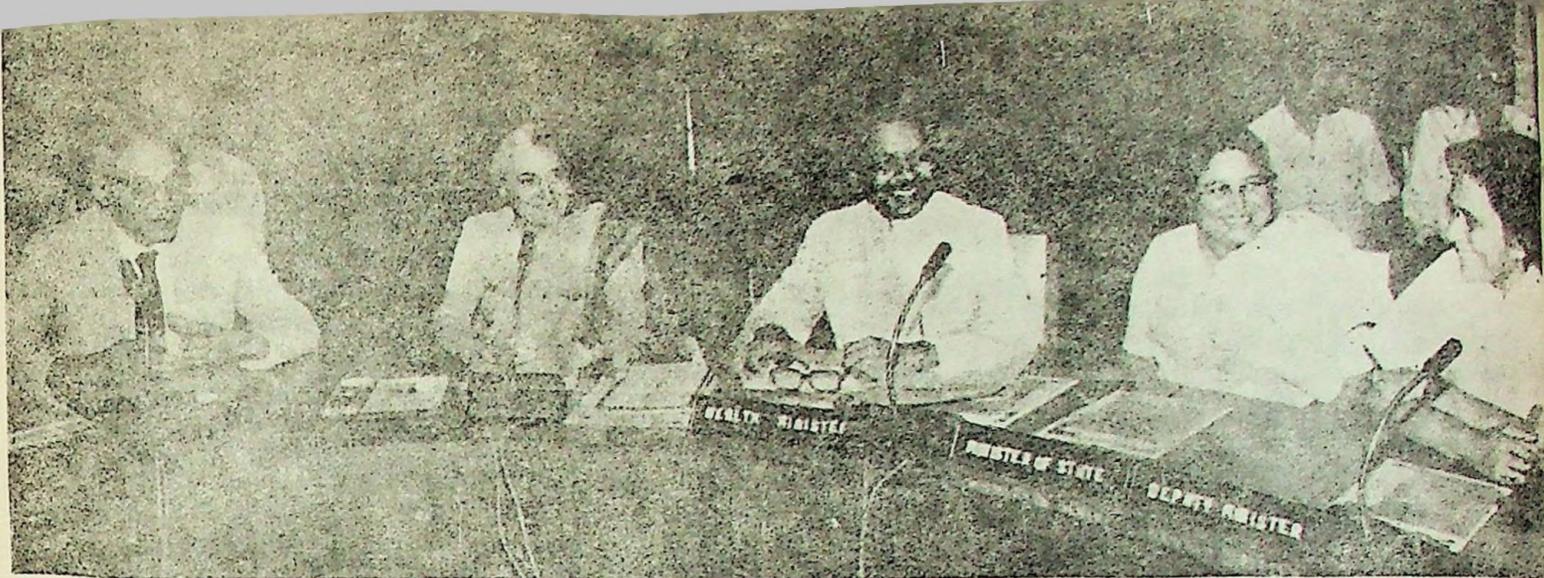


Photo : PIB

Prime Minister calls for raising the health status of people

PRIME MINISTER SMT. INDIRA GANDHI called upon medical researchers to produce medicines at prices which people can afford. She said that as far as possible medicines should be indigenously produced—preferably from herbal sources. She also wanted the medical men to encourage the use of traditional remedies and if possible establish their properties on modern scientific basis.

Prime Minister was addressing the meeting of the directors of the Indian Council of Medical Research and other medical institutes and centres from all over the country on 22 April, 1983, in New Delhi.

Smt. Gandhi said that many of those things which were earlier described as old grandmothers' tales and dismissed as superstitions were now known to be effective. We should try to use this knowledge for the benefit of our people. Prime Minister also stressed the need for early detection of tuberculosis, cancer, leprosy and some other dreaded diseases. She asked the experts to suggest how this could be achieved.

Smt. Gandhi said that as our resources were limited, a beginning could be made by introducing compulsory medical check-up in institutes, schools, colleges and other places where a large number of people worked under the same roof.

While commending the success achieved in several fields, she said that there were many more areas which required new tools, which were effective, safer, simpler and less costly. She congratulated medical researchers for the breakthrough which had taken place in many of these areas like malaria, vaccine and contraception.

Smt. Gandhi said that pollution due to economic factors as well as by industries was leading to an increase in chest diseases. She hoped that some ways would be found to check this trend.

Speaking about the family planning programme, the Prime Minister said that we still needed a breakthrough to make the family planning methods cheap and

convenient enough to be really effective. For this close co-operation and interaction between the various scientific and technological institutes was required. The Prime Minister said that the most important need was not only to spread sophisticated knowledge, but the basic facts about sanitation and prevention of illness among our children through education. Smt. Gandhi said often science was used for political ends and medicines for profit. She warned that developing countries like India should be doubly vigilant and careful regarding such practices.

Earlier in his welcome address, Shri B. Shankaranand, Union Minister for Health and Family Welfare, said that the Indian Scientists had made brilliant achievements because of the keen interest taken by the Prime Minister in the development of science and technology and research activities. The Minister further said that the danger of population explosion had shown signs of abatement because of the Prime Minister's support to the family welfare programme.

The research priorities of the Indian Council of Medical Research (ICMR) coincided with the national health priorities, viz. control of communicable diseases, fertility control, promotion of maternal and child health, control of nutritional and major metabolic disorders, developing alternative strategies for health care delivery systems through the primary health care approach for the fulfilment of the goal of Health for All by the Year 2000 A.D. and containment within safety limits of occupational and environmental health problems. The Minister explained that selected studies in other important areas like mental health, cancer, cardiovascular diseases, blindness, tuberculosis, leprosy, diabetes and drug research were also being undertaken.

Smt. Mohsina Kidwai, Minister of State and Kum. Kumud Joshi, Deputy Minister for Health and Family Welfare, were also present. △

National Health Programmes Reviewed

THE Conference of State Health Secretaries, which concluded on 24 April, 1983, reviewed the performance of the national health programmes for control of leprosy, blindness, tuberculosis. The conference stressed the need for improving the operational efficiency of the programmes by removing bottlenecks and providing the adequate inputs like manpower, equipment and funds.

The Centre had already conveyed the physical and infrastructural targets as also financial allocations to the States and they were asked to act with speed to realize these targets spreading them evenly all over the year.

Leprosy eradication

In so far as the National Leprosy Eradication Programme is concerned, a new dimension was given to it through structural changes which envisaged a National Leprosy Eradication Commission, under the Chairmanship of the Union Health Minister, as a policy guidance body and a National Leprosy Eradication Board under the Union Health Secretary for the effective implementation of the policies evolved

by the Commission. Similar policy guidance and implementation bodies were proposed to be set up in the States where there was a high incidence of leprosy.

The Conference suggested the desirability of repealing Lepers Act of 1898. Proposals were also mooted either to give special incentives to the medical and para-medical staff posted in the leprosy-endemic districts or to create a special cadre for anti-leprosy work.

Tuberculosis control

The Conference noted that the National Tuberculosis Control Programme had registered a reasonable success in 311 district tuberculosis clinics out of a total of 353. The main strategy of the programme was to detect as many tuberculosis cases as possible and to bring such cases under treatment. With the district tuberculosis centres playing a pivotal role, attention was now sought to be focussed on the Primary Health Centres which have been given monthly targets for sputum tests.

Shri B. Shankaranand, Minister for Health and Family Welfare, inaugurating Health Secretaries meeting in New Delhi on 23 April, 1983. On the extreme left is Kum. Kumud Joshi, Deputy Minister for Health and Family Welfare and on extreme right is Dr. S. S. Sidhu, Secretary, Ministry of Health and Family Welfare.

Photo. PIB



Blindness control

Under the National Programme for Control of Blindness, it was proposed to develop various services at the peripheral, intermediate and central levels. Mobile units were also sought to be pressed into service. Cataract was identified as the main cause of loss of vision. As it was curable through surgery vigorous efforts were needed to mobilize Government and voluntary sectors. In this context the States were asked to hold meetings with the voluntary organizations early in the year with a view to planning the programme for implementation throughout the year. The grant-in-aid for holding such camps in rural areas and towns having a population of 50,000 was extended for eye camps to be held in towns having a population of one lakh and also in metropolitan slums. This relaxation, it was felt, would go a long way in extending the reach of blindness control measures.

Monitoring the disease incidence

The States were requested to ensure a proper monitoring of the incidence of various communicable diseases so that effective programmes could be chalked out for their control. It was pointed out that in the absence of correct information about the incidence, prevalence and surveillance of the various diseases realistic targets could not be set. The targets for the various programmes under family welfare had been intimated to the States and they were asked to communicate them further down the line to the districts and primary health centres.

States were asked to ensure availability of services through a proper review of the facilities already avail-

able and identify the gaps. They were asked to ensure that training programmes for medical and para-medical staff were intensified.

A vigorous marketing approach in relation to mass education and media activities was advocated.

Family Planning

Follow up action was proposed on the recent decisions of the Central Cabinet about giving green cards to the acceptors of terminal method of family planning, so that they could claim priority in various socio-economic development schemes. The scheme of group incentives and awards should also be implemented as fast as possible. It was recommended that schemes should be evolved, wherever possible, for individual awards to the best workers in the field of family welfare. These could include study visits and in some cases foreign tours.

The States were requested to implement the central scheme for the reorganization of urban family welfare centres, with a view to increasing family planning acceptance in the urban areas particularly slums.

It was impressed upon the State Health Secretaries that the promotion of IUD acceptance may be taken up more vigorously. These could be achieved by the States only with imaginative campaigns and concerted efforts. The example of Punjab which achieved 1.61 lakhs of IUD insertions during 1982-83 was commended to be followed by other States. Emphasis on IUD insertions was necessary because the promotion of spacing methods must go hand in hand with conventional terminal methods. △

MEDICAL RELIEF CAMP

A Medical Relief Camp was organised by the District health authorities at the Primary Health Centre, Rajound, Distt. Jind on 26 February, 1983 with a view to provide specialized surgical and medical care services nearest to the door steps of the people. A health and family welfare exhibition was also set-up. Picture shows Smt. Parsani Devi, Health Minister of Haryana, on a round of the exhibition along with the Director of Health services, Haryana.



NOISE

Noise and Accidents. —*A Review Wilkins, P.A. and Action, W.I. Annals of Occupational Hygiene.* 1982 25(3) 249-60.

This review examines the evidence for a possible relationship between accidents and noise in industry. It has often been asserted that noise can be the cause of accidents; however, only five studies have attempted to assess the extent of this problem. These studies have indicated that high noise levels may be associated with higher accident rates and, therefore, provide suggestive but not conclusive evidence that noise is a contributory factor in the causation of accidents. The possible mechanisms of such an effect include the role of noise in causing a lack of attention and the masking of important auditory signals such as warning shouts, sirens and machinery sounds which indicate impending danger. In addition, the effects of a noise-induced hearing loss and the need to wear personal hearing protection to counter the noise which could contribute indirectly to accidents by interfering with auditory communications. It is concluded that the possible link between noise and industrial accidents further emphasizes the need for reducing noise in industry and that this should be achieved wherever possible by means of noise control. (AA)

CANCER

Cancer—India, Asia and the World: *A Brief Epidemiological Review. Shanta, V. and others. Asian Medical Journal, 1982 Aug; 25(8): 554-63.*

The time honoured concept of the etiology of cancer that it is a disease of modernization has taken a reverse turn with various global epidemiological studies. The magnitude of the cancer problem the world over is the same irrespective of modernization, affluence, poverty and illiteracy.

South-East Asian countries show the similar predominance of the tobacco cancers, viz., oral, throat, oesophageal and nasopharyngeal cancers. The co-existence of the cancer of the uterine cervix with high parity is seen in form of higher incidence of cancer cervix

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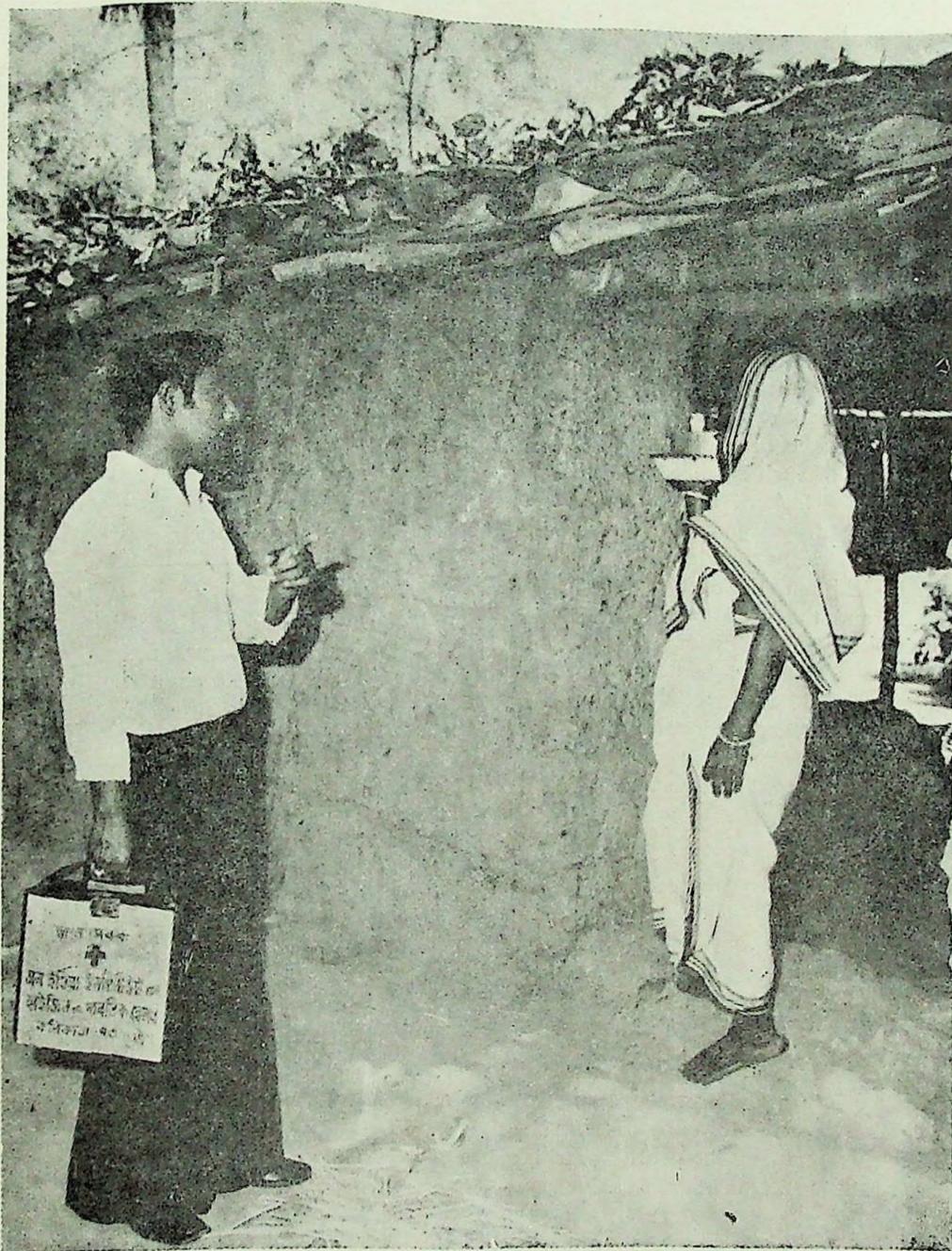
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in these population dense areas. Active population control has proved this point with decline in the incidence of cancer cervix in some places in India.

The common cancers of the west, e.g., lung and breast cancers are not so common in our areas, however, the knowledge of its etiology has resulted in the cancer control in the west. Cancer caused by the tobacco in its different forms is the major killer in the Indian sub-continent. The billion dollar grant for the cancer research in the developed countries has resulted in the fall of mortality rates of the cancers prevalent there. Attempts at reduction of tar content in the cigarettes and banning of tobacco farming are the land marks in the cancer prevention. India is yet to take a decision on this 'pendora Box' tobacco, which has immense potentials to improve Indian economy.

The problems of cancer control in South-East Asia is still an accessible one. The policy decision on tobacco taxation and population control will provide billion dollars as return for health care in these under-developed countries. (AA).

—National Medical Library



RURAL HEALTH SERVICES: The Government is striving to provide comprehensive primary health care and medical services to the deprived and weaker sections of the society. The Multi-purpose Workers' Scheme aims at establishing a health delivery system through a team of Multipurpose Workers – one male and one female for every 5,000 rural population.

Photo: W. H. O.