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NEW NATIONAL FAMILY WELFARE STRATEGY

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OUR COVER

Children are the most vulnerable group in the community who suffer more from various communicable and other diseases and malnutrition. Breastfeeding and traditional weaning diet offer safeguards against these diseases. *Our cover* shows supplementary feeding of a child. We devote this issue of *Swasth Hind* to Children's Day, observed every year on 14th November in the country.

In this Issue

Editorial and Business Offices

Central Health Education Bureau
(Directorate General of Health Services)
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Articles on health topics are invited for publication in this Journal.

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

EMPHASIS ON IMPROVING PRIMARY HEALTH CARE SERVICES

THE Union Health Minister, Shri P. V. Narasimha Rao, called for a revamping of the medical education system to meet rural health needs. While inaugurating the 12th Joint Conference of the Central Councils of Health and Family Welfare in New Delhi on 22 September, 1986, he said that the doctors must be motivated through knowledge and right training. "A doctor spends five years in the MBBS course learning curative medicine. How can he then provide preventive health care services in the village?", he asked.

The Minister expressed his resentment on the negligent approach to the blindings in the eye camps. He urged that a Committee be set up to go into the eye camp disaster and those responsible be held liable. Decrying the bickerings between the various Indian systems of medicine, he asked them to work in coordination with one another. He also called for round-the-year meetings to constantly monitor the health and family welfare programmes. The Annual meeting should be a wrap up, he said.

The revised family welfare strategy was approved by the 12th Joint Conference of Central Councils of Health and Family Welfare, which was held in New Delhi from 22-24 September, 1986. The Council also approved of the Honoured Citizen Card Scheme, recommended restructuring of medical education and proposed setting up of a Standing Committee chaired by Union Health Minister to ensure speedy follow-up on recommendations.

Medical Colleges

No new medical colleges can be established without approval of State Governments, the Medical Council of India and the Centre. The Council urged the Centre and States to ban capitation fees, and to establish Health Services Universities to ensure coordination between colleges of modern and alternative medicine systems. The M.B.B.S. course will now lay emphasis on preventive and promotive health care and include a family welfare component.

Primary Health Care

The Council emphasised the need to improve the quality of primary health care services and urged for increased outlays for PHCs. The Council expressed the view that reservation in MD courses should be given to candidates who have put in stipulated rural service and recommended that the legal and other aspects of this matter be gone into in detail. It called for incentives like rural and house rent allowance, etc. to doctors to work in villages. It also urged that technical and management skills at PHC levels be upgraded and modified to suit rural needs. Noting the urgent need to improve school health services, the Council called for coordination between Health, Education and I.C.D.S. programmes in the States.

Malaria Eradication

In the health field, the Council called for revamping of the Malaria Eradication Programme. The Centre may take responsibility for procurement and supply of insecticide drugs, spraying equipment. It recommended State Governments to fund operation and surveillance of the NMEP. Vector control measures like sanitation, social forestry, biological and environmental control must be integrated with the NMEP. It recommended that State Health Secretaries be authorised to sanction funds to avoid delays.

AIDS Control

The Council called for a fresh look at the AIDS control strategy to see if the course, content and profile of the programme need to be modified. The Council called for health education packages to prevent and detect cancer at early stage. Media campaigns against tobacco use including smoking and chewing and involvement of voluntary agencies in demystifying the disease were called for.

Goitre Control

The Council recommended that time bound actions to control and eradicate goitre be taken. Immediate action to increase production of iodised salt and its supply to goitre-endemic areas must be taken. The Council also called for an appropriate health strategy based on health education for prevention and cure of oral diseases, especially in children. The Council strongly called for linkages between the dental health programme and ICDS. Use of indigenous products like Jamun, neem, coconut must be incorporated in the overall health strategy.

Rehabilitation of Leprosy Patients

High priority is to be given to rehabilitation of cured leprosy patients in MDT districts. Facilities for reconstructive surgery should be made more easily available. The Council also called for specific reservation in jobs for leprosy cured physically handicapped persons. The general medical practitioners in urban areas be involved in the detection and treatment of leprosy cases, the Council recommended. It asked all States to repeal the Lepers Act 1898. Monitoring and evaluation at district level must be improved by creating sample survey-cum-assessment units at the rate of one for every three districts.

T.B. Control

The TB Control Programme must get priority on par with other programmes. The Council recommended that a multipurpose lab technician be posted in all PHCs.

Blindness Control

The conference emphasised that the monitoring of the National Blindness Control Programme must be strengthened. Voluntary efforts must be encouraged and agencies in this field must register themselves with the States. A high level Central Standing Committee to review eye relief camp activities may be set up. It also recommended posts of ophthalmic assistants at PHCs.

Family Welfare Programme

The conference praised the record achievement of 19 million fresh acceptors in the family welfare programme. The main planks of the new strategy are a multidisciplinary approach and people's involvement. The strategy adopts a beyond family planning approach. This means linkages with socio-economic factors having a bearing on fertility. Women's literacy, raising women's status and mean age of marriage, old age security, links with poverty alleviation programme, maternal and child health care, will for the first time be brought under the gamut of family welfare.

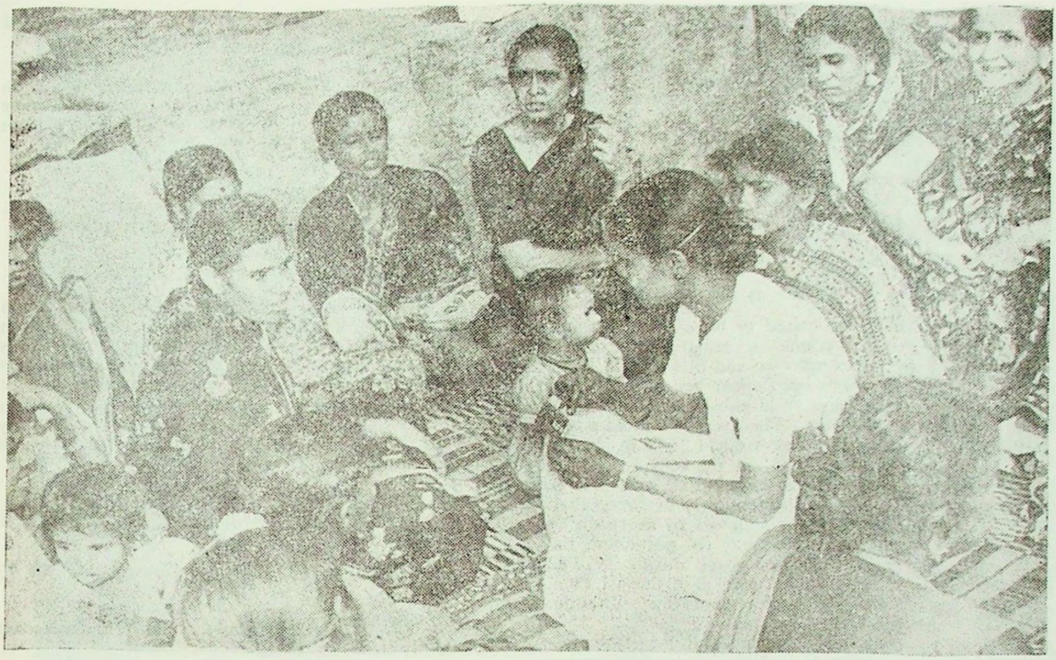
The Department has been holding talks with leaders of trade unions, cooperatives, ISM doctors, social scientists and voluntary agencies to involve them in this effort. The Council also recommended the setting up of a Family Welfare cell in all Ministries to ensure intersectoral coordination.

The strategy also seeks to launch a mass contact programme. A women's volunteer corps will be set up in villages to meet eligible couples and inform them of the need for planning a family. Differential area approach was emphasised and the need for proper maintenance of the Eligible Couple Register noted.

The Honoured Citizen Card Scheme is part and parcel of the incentives which will be rationalised and revamped. Couples with two children may get a package of benefits under Central and State schemes, including a preference in selection of beneficiaries. [Also see page 291].

The Council took note of the growing realization of the role played by practitioners of Indian Systems of Medicine and Homoeopathy (ISM&H). The Council called for monitoring of the time-bound action plan formulated by the ISM&H Division. It said funds should be placed at the disposal of State Governments for training and for compensation for retaining the interest of private practitioners in the family welfare programme. The conference called for increasing undergraduate and postgraduate facilities in ISM&H colleges. The conference also lauded the attempts to increase awareness of medicinal plants. It called for setting up of a Medicinal Plants Development Corporation, with 49 per cent Central aid. The Council said at least 50 per cent of the new PHCs and sub-centres under the Minimum Needs Programme should be of ISM&H.

The three-day conference was attended by State Health Ministers and Secretaries and other health and family planning experts. ○



NEW NATIONAL FAMILY WELFARE STRATEGY

The Ministry of Health and Family Welfare had commissioned three marketing research organisations in the private sector to carry out independent evaluation of the family welfare programme and make diagnostic studies about contraceptive attitudes and practices of the people. In addition, more than 120 studies and research papers on various aspects of the family welfare programme have been analyzed. The findings of these studies have formed a substantial basis for the new strategy.

The revised strategy gives family planning the broadest possible dimensions of social engineering including not only Health and Family Welfare but also child survival, women's status and employment, literacy and education and socio-economic development including anti-poverty programmes. It seeks to streamline the entire spectrum of programme management, formulate for family welfare a multi-disciplinary and integrated effort of all relevant developmental agencies and elevate the programme into a genuine voluntary people's movement. This will be the realisation of the call given by the late Prime Minister, Shrimati Indira Gandhi, who said "Family Planning must become a movement of the people, by the people, for the people".

THE National Family Planning Programme started in 1951 with a clinical approach. Extension education approach was adopted in mid-sixties and since late seventies Family Planning service delivery system has gradually expanded into a community oriented service network in which family planning services are offered as part and parcel of the overall health package of services particularly the maternal and child health and nutrition activities. Although, reduction in birth rates over the years has fallen short of the Plan targets, the Programme has made a significant impact on fertility. During 1970s, the birth rate declined from 40 to 34, but during 1979-84, it has been stagnating around 33.

The programme is estimated to have averted about 70 million births in the country so far at a total investment of Rs. 2400 crores upto the end of 1984-85. Thus, only about Rs. 340 have been spent per birth averted and this includes the cost of a substantive infrastructure which has been set up. The average annual population growth rate which rose from 1.25% in '40s to 1.96% in the '50s and 2.20% in the '60s reached a plateau during '70s when the growth rate was 2.25%. Since the inception of the programme, in every Plan period, there have been varying levels of shortfalls in the Family Planning performance. In particular, the programme suffered a serious setback during 1977-82 and picked up during the later period of the VI Plan. During the VI Plan period, achievements in sterilisation, IUD, CC and OP users have been 79%, 82%, 85% and 129% respectively. Nearly full target realisation of all family planning methods, an all-time annual record of over 19 million acceptors and an overall couple protection rate of over 35% has been achieved in 1985-86, the first year of the VII Plan.

A recent study (covering over 32,000 respondents) conducted through private marketing research companies has provided valuable information in addition to confirming and re-inforcing several findings of studies conducted earlier. The findings of the Study have highlighted the areas and issues that need to be focussed upon and have provided valuable clues to framing communication approaches and messages. The salient research findings are:

— Awareness of Family Planning is very widespread and over 60% people have attitudes favourable to restricting/spacing births.

— A majority of couples want 3 or more children with a preferable composition of 2 sons and one daughter.

— Customs and traditions play a major role in determining the age at marriage and there are favourable trends towards increase in age at marriage.

— Literacy increases the acceptance of one son as ideal and is positively correlated with the increase in marriage age.

— Medical institutions in urban areas are accessible and are being increasingly utilised; in rural areas easy access is lacking and so is the utilisation of the institutions.

— Apathy and concern regarding the effects on health, religious beliefs and illiteracy are some of the major inhibitors to adoption of various methods of contraception.

Future Goals and New Approaches

The long-term goal is to reach zero population growth rate by 2050 A.D. with an estimated population of around 1300 million. The medium-term goal is to reach Net Reproduction Rate of Unity (NRR : 1) by 2000 A.D. with a birth rate of 21, death rate of 9 and infant mortality rate below 60. According to the 7th Five Year Plan, the goals to be reached by 1990 are. birth rate of 29.1, death rate of 10.4 and Infant Mortality Rate of 87.

The specific objectives sought to be achieved during 1986-90 are to:

— Raise mean age at marriage for women over 20 years.

— Promote 'two-child family limit' as preferred family size.

— Substantially increase demand for contraception to achieve a couple protection rate of over 42%.

— Improve and strengthen the infrastructure and the quality of services.

— Enhance child survival through universal immunization and promotion of Oral Rehydration Therapy (ORT).

— Broad-base programme outreach by maximum involvement of non-governmental structures.

— Secure more effective Intra-sectoral and Inter-sectoral coordination.

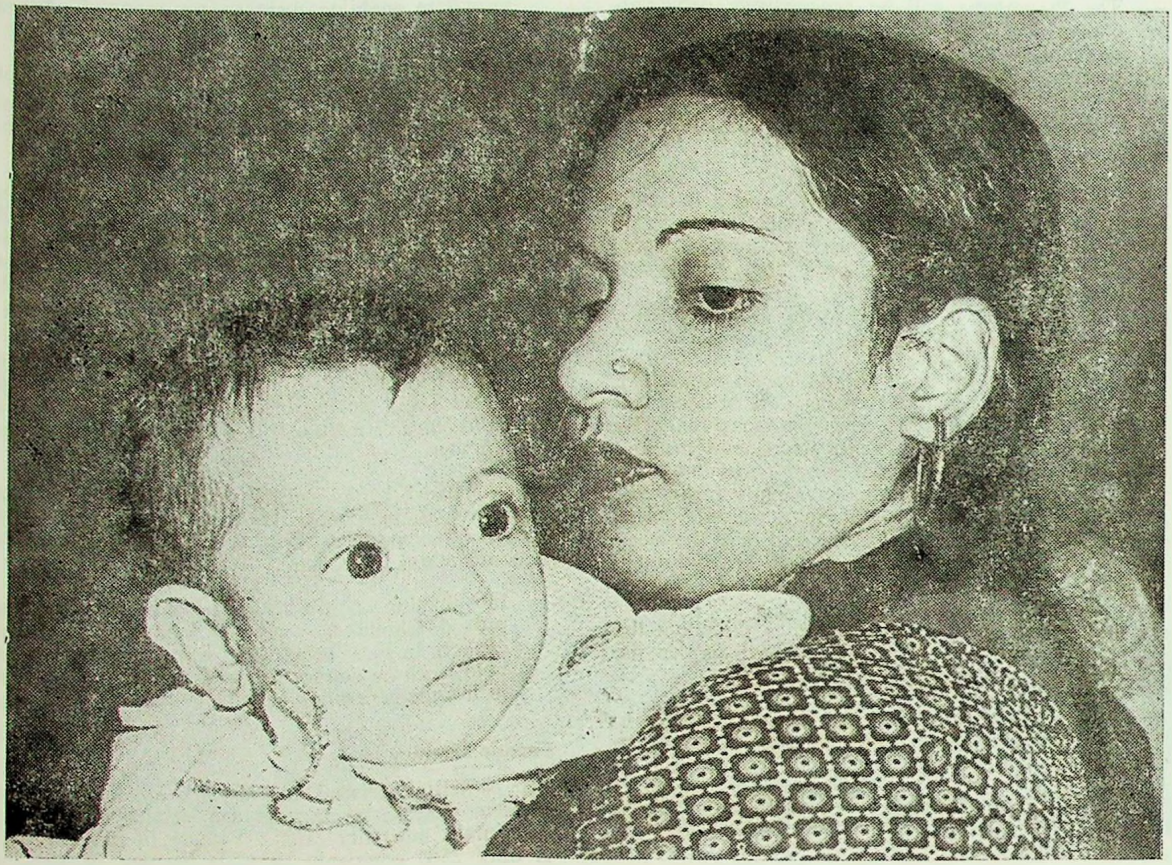
— Streamline and improve programme management at all levels.

— Generate environment for fertility decline through relevant socio-economic interventions.

Major tasks to be achieved during the 7th Plan are:

— 31 million sterilisations, 21.2 million IUD insertions to be achieved and 14.5 million CC and OP users to be enrolled by 1989-90.

— Attempt to reach higher targets by converting awareness and knowledge into acceptance through mass media and inter-personal communication and motivation.



Child survival through universal immunization and promotion of oral rehydration therapy—that is one of the aims of the revised National Family Welfare Strategy.

— Immunize 82 million infants and 90 million mothers.

Universalize (150 million households) the use of Oral Rehydration Therapy.

— Population Education to all children in the age-group of 11-15 years (estimated 109 million).

— Family life lessons for youths (15-19 years).

— Population Education to those out of schools and colleges as a part of Adult Education and Non-Formal Education System.

— One round of training for all personnel (about eight lakhs) to improve professional and other relevant skills.

— Success of the Population Control Programme depends upon effective linkages of Family Welfare Programme with other socio-economic development programmes of poverty alleviation, literacy, child survival, women's status and employment, MCH, Family Planning, nutrition, etc. Intra- and Inter-sectoral coordination amongst various developmental departments will be strengthened and enhanced. The present health and family planning infrastructure will be properly consolidated, suitably augmented and optimally utilised through organisational and management improvement.

— Various apprehensions about the existing methods of family planning will be removed through effective communication programmes and improved quality of services.

— Research focus will be on developing more acceptable techniques and improving the acceptability of the existing methods.

— The two-child family norm will be promoted through a structured system of material and non-material incentives.

— Female literacy and employment programmes will be substantially stepped up.

— The Programme will be progressively debureaucratised and non-governmental structures promoted on a much wider scale to effectively involve the community at large in the programme.

Approaches and Strategies Beyond Family Planning

Certain socio-economic correlates greatly influence fertility behaviour. These factors would require to be effectively tackled for creating an atmosphere to promote a more rapid fertility decline. Special focus will be given on the following:

Increasing Mean Age at Marriage

In India, every year about 4½ million marriages take place of which in about 3 million the brides are in 15-19 age-group. The salient reasons for early marriage are: pressure from elders, customs and anxiety of parents about the grown up unmarried girls. There are indications that slightly higher age at marriage is now being favourably perceived. This encouraging trend will be re-inforced to raise the mean age at marriage for women beyond 20 years through specific interventions indicated below:

— Intensified publicity campagin highlighting the specific benefits of delayed marriage for the health of the mother and the children.

— Appropriate amendments in the law relating to the minimum age at marriage and its better enforcement.

— Generating a social reform movement through voluntary action to combat the forces of custom and tradition.

— Intensive motivation through grass-root level workers.

— Preferential treatment to those beneficiaries under the development programmes who conform to the minimum legal age at marriage.

Raising Status of Women

Significant impact on fertility can be brought about when the status of women is raised and they become equal partners in decision making. The perception of women about themselves and the way society perceives them will have to be changed by a mass movement. A programme for women's mobilisation and upliftment will constitute a major thrust of the programme to bring to surface the latent demand for family planning services. This will essentially have to be the nodal responsibility of the Ministry of Human Resource Development which will coordinate various schemes and activities in this regard. The major interventions would be:

— A mass movement through voluntary organisations engaged in women's welfare for creating awareness about the equal constitutional rights and opportunities for women thereby promoting an atmosphere enabling them to act as equal partners with men.

— A massive IEC campaign through multi-media channels and grass-root level workers and volunteers for creating awareness and generating activities to raise women's status in society.

— Particular focus on schemes of educational and vocational training to help young girls to build up skills for their gainful employment. Vocational and nutritional elements of the 'Gopalan Plan' for young village women should be considered by the Ministry of Human Resource Development.

— Comprehensive district-wise surveys about employment opportunities for women to explore larger avenues and linking of supportive services such as child care, community cooking, etc. with these schemes.

Nationalised banks will be encouraged to provide loans through mahila mandals on collective security basis for income generating schemes to improve the economic status of women.

— Introduction of appropriate technologies like improved Chullah, bio-gas, inexpensive pressure cookers in rural areas, to reduce burden of household work on women to enable them to participate in income generating activities.

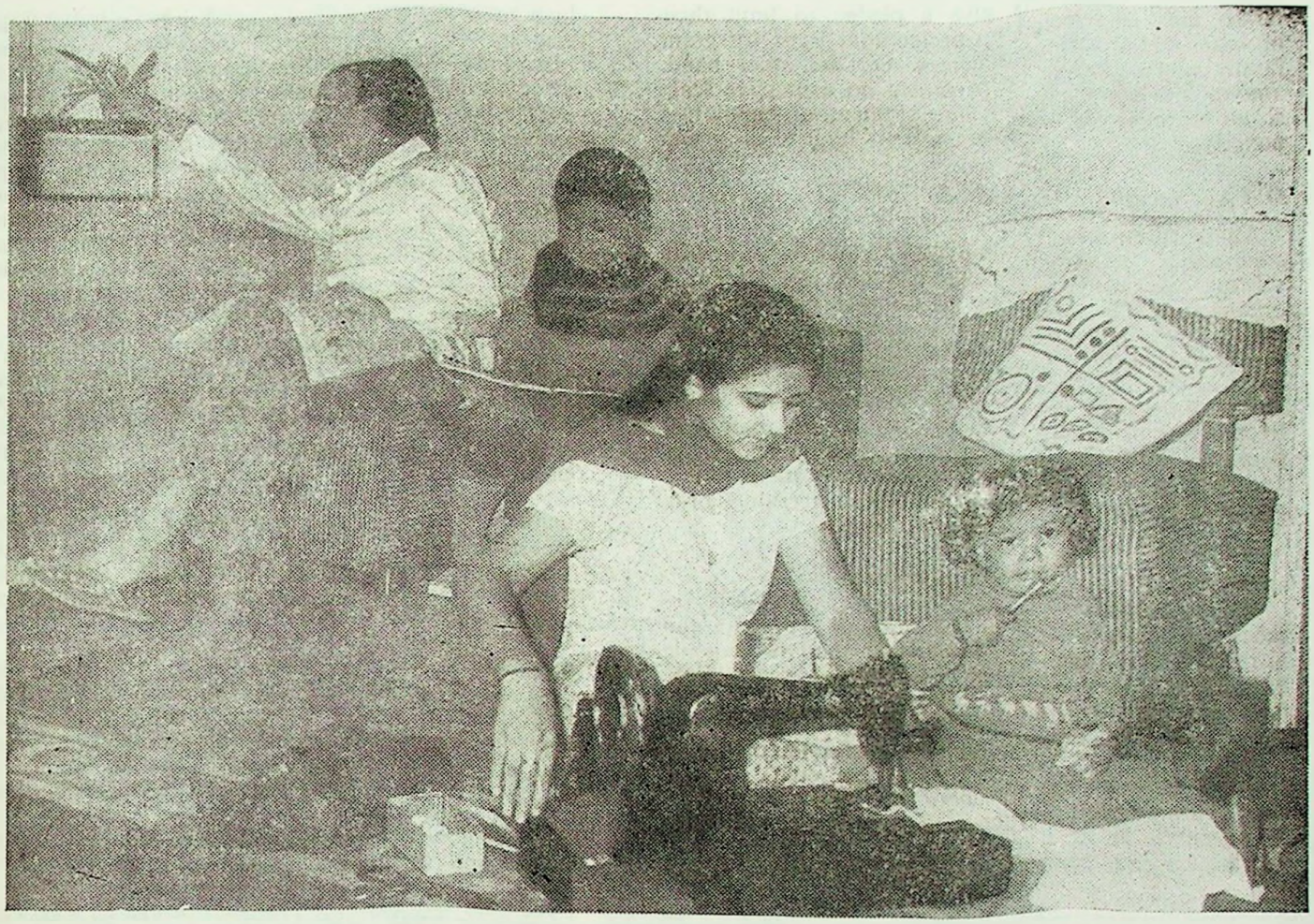
Female Literacy

It is well established that increase in female literacy leads to increase in marriage age, decline in birth rate and infant mortality rate. Female literacy in India is only 25% compared to male literacy of 47%. A massive push to the programme of female literacy is necessary. The health workers and women volunteers will also be utilised for propagating the message of female literacy. Special focus will need to be given to resistant pockets. Proper linkages will be forged between female literacy programmes and the family planning programmes.

Enhancing Child Survival and Development

A correlation between child/infant mortality and the desire to have large number of children is well accepted. A massive effort will be made in the 7th Plan to enhance infant and child survival and improve their physical and mental development. Programmes aimed at steep reduction in child and infant mortality will be given the highest priority. Special focus will be on the following activities:

— Programme of immunisation of expectant mothers and infants will be scaled up to reach the level of universal coverage by the year 1990. A Programme of this magnitude will be carried out with effective planning and management and will take care of production of adequate quantity of vaccines and streamlining of the service delivery sys-



The new National Family Welfare Strategy seeks to promote "two-child family limit" through a structural system of material and non-material incentives.

tem. Effective coordination with the Department of Education and Women's Welfare and Child Development and voluntary organisations will be secured for the successful implementation of this mission.

— Nutrition intervention programme will include distribution of iron and folic acid tablets, administration of Vit. A to children, popularisation of iodised salt as prophylaxis against anaemia, blindness and goitre respectively.

— Promotion of Oral Rehydration Therapy and appropriate feeding practices to prevent a large number of infant and child deaths and growth interruptions resulting from childhood diarrhoea. A massive educational programme will be undertaken in this regard along with production and easy provisioning of Oral Rehydration Salt (ORS) packets.

— The Integrated Child Development Scheme has helped in improving MCH Services and reduction of birth rates in ICDS blocks. Accelerated expansion of the Scheme will greatly help in reducing birth rate.

Linkage with Poverty Alleviation Programmes

There is a two-way relationship between fertility and poverty. During the 7th Plan anti-poverty efforts have been intensified. The major programmes in this regard are:

— The minimum needs programme which widens the access of the poor to the basic social services.

— Targeted assistance for social groups or areas like IRDP, NREP, RLEGP, TRYSEM.

It is proposed that while selecting beneficiaries under any of the poverty alleviation schemes, preference may be given to those who accept the small family norm. Couples with a two-child certificate and

youths who voluntarily give a pledge to limit their family may be selected on preferential basis for grant of loan under various schemes. On the other hand, family welfare has to be promoted on a massive scale among the below poverty line segment of population so as to break the vicious circle of high fertility and poverty.

Old Age Security

There is universal feeling that children especially sons are a security for old age. Old age security schemes are being run by States and few voluntary organisations, but these serve a very small fraction of the old age population. A tangible improvement in the social security coverage of old age people will have a definite impact on the desired small family norm. States will be persuaded to accord preference to parents of 'Small Family' in providing old age pensions. Similarly, old age couples with small family and with no male child may be given overriding priority in admission to 'old peoples' homes.

INFRASTRUCTURE

Various studies conducted through private and other organisations have highlighted that the existing infrastructure is not being optimally utilised mainly because of its inadequacies to provide proper services and relatively unfavourable attitudes of the people towards it. The major inadequacies relate to poor quality of services, non-availability of staff, lack of empathy of the staff and poor management. Energising existing infrastructure with a view to optimising its output is an area requiring priority attention. Towards this end, some major steps are being taken which include clear delineation of job responsibilities, filling up of vacant posts, improving employees' motivation and service conditions, improving skills and capabilities of the staff, improving PHC management system by devising appropriate monitoring and supervision systems. In addition, Block and Village level Committees would be set up to involve people in exercising vigilance over the work of various functionaries. These measures will lead to a favourable perception of the health facilities by the target groups and optimal utilisation of the existing infrastructure.

Augmentation of Infrastructure

In the rural areas services are provided through a network of integrated Health and Family Welfare delivery system. There are 83,000 Sub-Centres, 11,000 Primary Health Centres and Subsidiary Health Centres and 650 Community Health Centres in the country. This infrastructure will be expanded as envisaged in the strategy approved at the time of formulation of Sixth Plan : One Sub-Centre for 5,000 population (3,000 population for hilly-tribal areas); a Primary Health Centre for 30,000 population (20,000 for HTA's) and one Community Health Centre for four PHCs.

In addition there are Community Workers which include about 5 lakh trained Dais, 3.8 lakh Village Health Guides. Village Health Guides Scheme will be overhauled and Dais Training will be intensified. Rural infrastructure would need to be augmented to bring services within easy reach of the beneficiaries.

Following table provides an idea of the present situation and the future needs:

Category Institution	*Norm/Unit*	*Total No. required*	*In position as on 1-4-85*	*Target for 7th Plan (1985-90)*
1. Dias	All practising Dias in rural areas.	5.80 lakhs (approx.)	5.14 lakhs (approx.)	1 lakh
2. Health Guides	One for every village/1000 population.	4.50 lakhs	3.83 lakhs	1 lakh
3. Sub-Centres	One for 5000 population in general and one for 3000 population in tribal, hilly and difficult areas.	1.30 lakhs	82,946	50,000 (54,883)
4. PHCs/ Subsidairy Health Centres.	One for 30,000 population i.e. one for every six sub-centres.	21,666	11,029 (7,284 PHCs & 3,745 Subsidiary Health Centres)	12,390
5. Upgraded PHCs/ CHCs.	One for every 4 PHCs and for about 1 lakh population.	5,417	655	1,553

In the urban areas, there are 554 Post-Partum Centres at District level. 700 Post-Partum Centres have been sanctioned at the Sub-district level. During the Seventh Plan, 500 more Sub-district level Post-Partum Centres will be sanctioned. Studies have shown that the Post-Partum Programme has been providing Family Planning and M.C.H. services in a cost-effective manner.

There are 2583 Urban Family Welfare Centres and 2592 beds have been approved under the scheme of Reservation of Sterilisation Beds. During the Seventh Plan, 2000 more sterilisation beds will be reserved in Non-Government sector. Even with this expansion, the urban infrastructure would not be adequate to cope with the work. The urban infrastructure will be revamped and reorganised to include extension services, particularly in the slum areas. In addition, voluntary organisations will be encouraged to set up and operate facilities in the urban areas and tax rebates will be proposed for the corporate sector coming forward to establish such facilities in Urban and Rural areas.

Upgrading Technical Services

Poor quality of services has resulted in relative under-utilisation of facilities and lowering of the image and credibility of the health infrastructure. The apprehensions about possible adverse effects on health associated with sterilisation, IUDs and Pills are the major inhibitors to acceptance of those methods. Improving facilities and upgrading the technical quality of services will, therefore, be a major thrust for widening acceptance of Family Planning.

● All PHCs at Block level will be equipped to render the services like vasectomy, minilap, MTP and IUD insertions (Special emphasis will be given to improving the general environment in the PHCs).

● Medical Officers will be trained in a two-year time frame so that these basic family planning services are available on a continuing basis at Block Level PHC's. Various initiatives will be introduced to ensure enhanced services of doctors in rural areas.

● The medical curriculum will be amended to ensure that medical graduates undergo a minimum prescribed training in Family Planning Methods before they are awarded MBBS Degree—Post-Graduate courses will be established in Human Reproduction and Population Management in selected Institutes.

With a view to ensure observance of the existing guidelines, various types of FP services will be reviewed and updated to make them comprehensive and a strict system of providing appropriate follow-up services will be devised and enforced. One Centre of Excellence will be established in each major State for planning and coordinating training programmes of medical personnel. These Centres will also be equipped to provide recanalisation facilities. Operation research projects will be commissioned through autonomous/private agencies to assess and evaluate quality of services and to suggest measures for further improvement.

Improving and strengthening Maternal and Child Health and Family Welfare infrastructure and the quality of life—that is yet another aim of the new National Family Welfare Strategy.

Satisfied acceptor is the best ally of the programme. Only quality services can provide such satisfaction. Therefore, Monitoring and Evaluation of quality of services will be organised on systematic lines. High level technical committees at the Centre and State levels will be constituted to oversee and guide in all

(*Continued on page No. 308*)

About 25 lakh people are added each year to the 121.4 million eligible couples as of 1982-83 in India. Women over 30 account for no more than 30 per cent of all births in the country. Therefore, young women who produce 70 per cent of children in India need to be urgently covered by spacing methods. Of the 402.2 lakh couples in the reproductive age-group, 15-44 years, effectively protected (March 1985), 25 per cent are protected by sterilization.

SECRETS OF SPACING

DR (KUM) SNEHLATA MISRA

HEALTH of children and women is an important part of national health. For children to grow into healthy adults they need first of all a good start in life. It is possible only if the mother herself is healthy. Statistics show that women in child-bearing years and children under 15 make up about 70 per cent of the third world people. An estimated 150 lakh children below five years die each year in developing countries including India. Another five lakh women there die during pregnancy and child-birth every year. Of these, about 80,000 are in India alone. The Infant Mortality Rate (I.M.R.) in India is still very high, *i.e.*, 110 per 1000 live births (1981). The Government of India envisages to bring it down to below 60 by 2000 A.D. The maternal mortality which at present is 300 to 500 per 100,000 live births also must be brought down to less than 200.

How could all this be achieved? The answer is family welfare through spacing of children. The WHO Expert Committee on maternal and child health found that it could "favourably influence health, development and wellbeing of family and has a striking impact on health of mothers and children". It improves children's health by helping women to space child-births, have smaller families and avoid pregnancies at unfavourable ages. Best age for reproduction is 20 to 34. It can also prevent high-risk, teenage pregnancies. By providing women with safe contraceptives, unwanted pregnancies and illegal abortions are reduced. A study in Hyderabad showed that by increasing birth interval to three years the incidence of malnutrition could be reduced by 60 per cent effortlessly.

Spacing methods

Spacing of children can be achieved by various methods. Natural methods include coitus interruptus and rhythm methods. But since these methods require lot of self-control, they are not practical for the majority. Also rhythm method requires an adequate knowledge of menstrual periods and is practical only when the woman has regular periods. Failure rates of these methods are variable and high. Abstinence would be 100 per cent effective but it is not viable for the majority.

Artificial aids include conventional contraceptives such as condoms, diaphragms and spermicidal jelly creams, and Intra-Uterine Contraceptive Device (IUCDs) and oral contraceptives (OCs).

Condoms, IUCDs and OCs are very effective and convenient. Average failure rates of different artificial methods are—OCs 1-2 per 100 women per year, IUCDs 2-3 per 100 women per year, condoms 10 per 100 women per year, diaphragm 12 per 100 women per year and natural methods 20 per 100 women per year.

Average number of children, a woman has when she receives an IUCD is 2.6. It is 3.5 to 3.9 when she requests sterilization. So, spacing methods need to be promoted actively both for achieving demographic goal of achieving a net reproduction rate—one—and also because of their health promoting benefits both for the mother and children. Once the optimum family size, the usual being two children, is reached, sterilization should be advised. At present, by the time a woman opts for sterilization, the damage is already done as she is a mother of three or four children. Most Indian women at the peak of their fertility already have three to four children. Thus spacing methods are all the more important, both for delaying the first birth and for proper spacing of the next child. Three-to-four-year interval is best.

India's first

India is the first country to launch a National Family Welfare Programme (1952). At present, there is an extensive infrastructure both in the urban and rural areas. Family welfare services in urban areas are given by medical college hospitals, clinics, district hospitals and clinics and urban family welfare centres. In rural areas, these services are offered through primary health centres (PHCs) and sub-centres. There are 7284 PHCs and 82,946 sub-centres (1985). One PHC caters to 100,000 population and a sub-centre to 10,000—5,000 people.

Various spacing methods offered include IUCDs, OCs and nirodh. Acceptance of various spacing methods has varied from time to time. In early 1960s the focus was on IUCDs. In 1974, OCs were introduced and in 1975, Cu-T 200 was introduced. Use of Cu-T 200 has steadily increased and Lippes Loop is being phased out. Cu-T 200 use has increased from 45.5 per cent in 1980 to 85.7 in 1984-85. IUCDs are more popular among rural people. In 1970-71, it was 59 per cent and in 1982-83 it is 66 per cent. Performance of spacing methods has shown an improvement in 1984-85 as compared to 1983-84.

Smaller States like Punjab, Andhra Pradesh, Haryana, Karnataka and Maharashtra achieved more than 100 per cent of given targets. Big States like U.P., Bihar and M.P. are much below their annual goals.

About Pills

Oral contraceptive pill (the pill) consists of a combination of small doses of oestrogens and progestogens. It is the most effective of all reversible methods of fertility control available. Technical effectiveness of the pill is 100 per cent. Real effectiveness varies depending on the regularity with which it is used. The Pill prevents pregnancy by inhibiting ovulation. When it was introduced in 1956, fairly high doses of oestrogens and progestogens were used. Pills were used extensively in developed countries. Harmful effects of the pills on thromboembolic phenomenon were publicised widely resulting in baseless fears, both in developed and in developing countries. In developed countries because of the prevalence of smoking and high cholesterol diets, pills were not given to women over 35-40 years. Controlled prospective and case controlled studies from the U.K. and the U.S.A. now clearly show that O.Cs. containing oestrogens less than 50 mcg are safe. Low dose combined pills which contain only 30-35 mcg of oestrogens are even safer, and being used now. Government agencies are supplying two types of pills both containing Ethinyl-oestradiol and either Norethisterone acetite or D. Norgestrol (Progestogen). O.Cs. require prescription to purchase.

Advantages of O.Cs

The beneficial effects of O.Cs. are many. O.Cs are 100 per cent effective in contraception, if used properly. Real failure rate is 1-2 per 100 women in a year.

Menstrual disorders, *e.g.*, dysmenorrhoea, premenstrual tension and menorrhagia are relieved as ovulation is suppressed.

Protection against diseases like Pelvic Inflammatory Diseases (PID) by obstructing movement of bacteria and prevention of illegal abortion are additional advantages. Pills reduce iron deficiency anaemia by 50 per cent because it reduces menstrual flow. Benign breast diseases like fibrocystic disease and fibroadenoma are reduced by 50-75 per cent. Benign breast disease is a forerunner of breast cancer. Cancer endometrium (uterus cancer) and ovarian cancer are reduced by 75-90 per cent in pill users. They do not prepone or postpone menstruation.

Benign hepatoma (liver tumor) may develop in pill users in only 1 to 5 per 100,000 women per year. It can be readily discounted because of its rarity.

Studies confirm that subsequent fertility is also not affected; 25-30 per cent pill users become pregnant in the first post-pill cycle and fertility returns in 90-100 per cent cases within two days of discontinuation of pills.

O.Cs detrimental effects on cardiovascular system are minimal. The incidence is only one in 1000 women a year, much less in Indian women. In the U.K. and the U.S.A. and in a group 21 European countries there was no increase in death-rate of women despite great increase in O.C. use.

Since O.Cs. lower glucose tolerance, actual or potential diabetic women should not use the pill. Women having gall bladder disease or impaired liver function should not use pills.

Minor ailments like nausea, lack of appetite, headache, weight gain are temporary and pass off in couple of months. Breakthrough bleeding is easily controlled by adding a small dose of oestrogens for 6-7 days. The Indian women because of their genetic, constitutional, nutritional and environmental factors are less likely to develop C.V.S. diseases. Benefits of O.Cs outweigh the risks. Mother mortality from child-birth is 300-500 per 100,000 in our country whereas pill risk is only half per 100,000 women.

Pills are ideal for avoiding pregnancy in the adolescent and for delaying first pregnancy. For spacing of births, continuous use for 3 to 5 years is good.

The WHO Expert Committee on maternal and child health found that family welfare through spacing of children "favourably influence health, development and well-being of family and has a striking impact on health of mothers and children". It improves children's health by helping women to space child-birth, have smaller families and avoid pregnancies at unfavourable ages. Best age for reproduction is 20 to 34. It can also prevent high-risk, teenage pregnancies.

Where it should not be

There are certain conditions in which the pills should not be used. *e.g.*, heavy smokers, history of theomboembolic disorders, liver disease, jaundice, cancer (breast or genital tract), migraine, high blood pressure, fibroid uterus and diabetes.

O.Cs. users must be seen and examined by a medical officer within 3-6 months of starting O.Cs and later once a year.

O.Cs must be stopped if any of the following symptoms appear. Severe migraine, visual disturbance, sudden chest pain, severe cramps and pain in legs, excessive weight gain, severe depression and patient wanting pregnancy.

IUCDs

At present, two types of IUCDs are available—medicated and non-medicated. Cu-T 200 introduced in 1975 is becoming popular. A modification known as Multi load Cu-250 is also available. Non-medicated devices are generally for women who may not return for check-up. Initial side-effects like bleeding, pain and infection are minimal when insertion of IUCD is done. Any time there is excessive bleeding, pain or missed period, consultation with a doctor is needed. IUCDs prevent pregnancies by preventing implantation of fertilized ovum. IUCDs do not abort.

IUCDs should not be used for delaying first pregnancy. Perhaps it may cause infertility in about one per cent. These are not recommended for adolescents or older married women who want children. IUCDs also do not adversely affect fertility when used for spacing of children. 60 per cent conceived within three months and 90 per cent within a year after removal of IUCD. These are contra-indicated for women having irregular vaginal bleeding, tumors of cancer of genital organs, pregnancy and pelvic infection. IUCDs can be inserted any time, but post-mentrual insertion is best. Woman wearing an IUCD must have a check-up at least once after insertion. Cu-T 200 needs to be changed every 2-3 years. Any time when side-effects like excessive bleeding, pain or missed periods occur, a visit to the doctor is imperative. In the event of pregnancy occurring when using IUCDs, malformation of the foetus does not occur.

About 25 lakh people are added each year to the 121.4 million eligible couples as of 1982-83 in India. Women over 30 account for no more than 30 per cent of all births in India. Therefore, young women who produce 70 per cent of children in India need to be urgently covered by spacing methods. Of the 402.2 lakh couples in the reproductive age group, 15-44 years, effectively protected (March 1985), 25 per cent are protected by sterilization.

The usage of these methods needs to be promoted further and an all-out effort has to be made in this direction if we want to avert a population explosion.

MEDIA AND HEALTH— PARTNERS TO PROGRESS

JACK C. S. LING

Communication channels, traditional and modern, have a vital role to play in primary health care which is "essential health care, made universally accessible to the people through their full participation in the spirit of self-reliance and self-determination". Inter-personal educational methods "can only reach but a small percentage of the community. Media, when properly employed can reach a large number of people".

Jack Ling opines that media cooperation on a lang-term basis was needed; there should be a partnership between media and health sector and not competition. Also, "Fireworks syndrome", as Jack Ling refers to the episodic media support, should give place to permanent light. There is widespread interest in information and education for health. As part of efforts to strengthen education/communication of the health sector, two regional workshops in SEARO and AFRO have been held to develop training modules on community education.

THE health educators should be congratulated for their foresight in developing the "golden principle of involvement" long before others in the development field came to the same truth. The health educators championed this in the forties and fifties, stressing that there could be no learning and education without involvement and participation; the community development movement did not again ground until the fifties; the communications scientists did not focus on the two-way dialogue until the sixties; and social development specialists did not begin stressing marketing methods that identify the needs of people until the seventies and early eighties. Only recently the ecological view of health had made its appearance calling for involvement of all sectors in society for the promotion of health.

So, congratulations are in order for the pioneering work. Pioneers, as expected, often struggle against hostile environment, against conventional wisdom, against many odds. But no profession has been more misunderstood, more underappreciated, more wrongly blamed than health education. Most people equate health education with dissemination of information and teaching. Indeed, dissemination of information is part of health education, and a necessary starting point in most instances.

Learning Process

Not enough people realize that health education, above all, is a process, a learning process that should lead to action. To the woman and man in the street, education means schools, classrooms, blackboards. Since Ministries of Education which, among other tasks, build schools and train teachers, will continue to have extensive outreach, this popular definition of education will persist. Be that as it may, at least among the development workers, health educators have been vindicated, for there is now widespread recognition that community participation is the missing link, and in the development circle today the watchword is "involvement".

However, we should not rest on our laurels. The task is gigantic, the challenge is difficult and above all, health educators are still a relatively small number and the resources very limited. Time has come for us to do some advocacy for health education and to take postive steps to encourage a convergence of approaches, to form an alliance of all who share similar views—overlooking terminologies, narrow definitions and professional allegiances for the larger good of development.

Also, it is felt that community involvement alone is not enough—unless the term "community" embraces the whole of society—because community activities need support at various levels of the society. Without such support, community action will be frustrated from the start. There must be a supportive policy framework, which may require decisions at the political level; there must be legislative support; there must be supportive action by health-related sectors such as agriculture, education, public works; there must also be support from different professional societies, civic organizations, women's groups, cultural and religious institutions, and other bodies. Those, in health, need to reach out to the decision and policy makers, those in finance,

those in commerce, those in industry, etc. In short, there is need to mobilize everyone for social action for health, to promote health, to embark on a comprehensive approach in favour of physical and mental well-being, against disease, against abuse, against dependence.

Advocacy sans Betrayal of Democracy

Now, following the golden principle of involvement does not mean being passive. For it is well-known that, in a competitive world, advocacy is an indispensable part of any major effort. It is also known that there is a price to pay for being late when other interests fill the vacum. We can be forceful advocates, without betraying the democratic principle of "involvement" of listening and of learning from the people, of being empathetic.

The deliberations in different groups in the last four days of the conference have shown that there has been some progress in *health for all.* If, however, the term "health for all" is to be taken in its totality, it must be acknowledged that inter-personal educational methods can reach but a small percentage of the community. While the qualitative advantage of one-to-one dialogue is recognised, it should be realised that these are the very many who are beyond direct personal contact. At the very least, there is a need to awaken their interest, provide them with information, help them realize they can do much to improve their own health. This can and must be done through the various channels of communication—traditional as well as modern. Only then will we have paid heed to the "all" in Health for All. Otherwise, our critics may well criticize us for aiming at health for "some".

This means that all the means available must be utilised to reach people, to intensify our efforts—through the growing network of schools, through the existing social and cultural institutions, through religious organizations, through civic groups and through compatible special interest groups. Above all, we must not overlook the various mediated forms of communication to reach the total population.

Media cannot solve many problems but, when properly employed, media do reach large numbers of people. In fact, radio, when introduced early this century, worked like a blanket of democratization and was credited to have played a role in breaking down the rigid class barriers. When people had equal access to radio programmes, whether they were plays hitherto available only to the relatively wealthy theatre-going crowds or broadcasts of useful information about how people could take actions to improve their own lives, some movements towards equalization were strengthened and others were launched.

It is well recognised that any enlightened involvement of the people requires an informed public. The kind of decisions on the involvement of people rests on the quality of information they receive, which in turn rests on how well those in the health sector can get the messages across. There is today a clear, urgent need for better presentation and greater communication skills for health education.

Traditional forms of communication like puppet plays and popular theatres can be very effective, but unfortunately, are little utilized on a systematic basis. This is an area in which we need to do more, much more.

'Fireworks Syndrome'

Unfortunately, many attempts to harness the modern media have been done haphazardly, without thought to other elements of the package of activities that constitute a programme, without consideration of the many determinants of health behaviour.

The sporadic use of media is literally like fire-works that fizzle out in the dark night. We should turn the fireworks into a permanent light. Media activity that is not part of package of programmed activities, including inter-personal follow-up, with clearly defined objectives and a comprehensive strategy, would be wasteful.

It is true that many unplanned and poorly executed media efforts have failed in the past. This, however, should not deter us from working with the media. We should involve the media in our joint endeavour to reach the people to improve their health. This kind of involvement is just as valid and important as it is with the people at the community level.

The media sector is complex. Very often, health workers think of the media mainly in terms of news. Media professionals have a clear notion of what makes news; the item has to be timely, significant to a large number of people, fairly close to home and related to the interests of the audience or readers. If health workers want the support of news editors, they must take these criteria into account.

Reinforcing Social Norms

But media encompass more than news. There are service columns and educational pages, departments, for children and women, and of course, items and programmes of entertainment value. For lifestyle-related health issues, cultural and entertainment programmes are very important. Media can often confer status and certainly reinforce social norms and can be very effective, because health messages should be presented within real-life circumstances as entertainment programmes often reflect life situations and can provoke emotive response which is so necessary for behaviour modification.

Multi-sector Interest: When we seek cross-sectoral involvement for health, we tend to think of education, agriculture, community development, youth or whatever, but we often leave out media as a sector. This is probably because it is a sector that is cross-sectoral in itself. It is not organized like the other sectors and not confined to one aspect of our life. It has interests in all sectors and in fact can play a useful role to stimulate other sectors to support health. For example, news stories on smoking can point out contradicting policies of different Ministries. Health wants to curb smoking. Agriculture may encourage tobacco growing for

export; Industry wants to create jobs; and the Treasury cannot do without tax revenues. Media can help provide a forum for debate which is often a good platform for public education.

Social Responsibility: Going to the media for "help" in connection with a project might get us episodic support. What is needed is, rather their cooperation on a long-term basis. Media personnel today do recognize their social responsibility in the development process, and realize the power of mass media to help create a political will in favour of social issues including health.

Note Competitors: Sometimes the health sector appears to avoid the media, perhaps because some health professionals have viewed media as competitors, or critics, rather than partners. Perhaps we simply have not understood how to develop the partnership. In fact, of course, the two sectors have much to gain from effective collaboration. I would go further: I believe the media sector cannot fulfill its responsibility to society without the health sector, because the interest and concern of the public, the *raison d'etre* of public media certainly includes health. This means that media and health have to forge a partnership on the basis of mutual dependence, if each is to fulfill its purpose.

WHO Programmes

The latest WHO Expert Committee on Health Education concluded that the role of the mass media in the field of health was to:

- help strengthen political will by appealing to policy makers;
- raise general health consciousness and clarify options concerning action that have a strong bearing on health levels;
- inform decision-makers and the public about the latest developments and limitations in health sciences and publicize relevant experiences for replication;
- help deliver technical health messages for the public; and
- foster community involvement by reflecting public opinion, encouraging dialogue, and facilitating feedback from the community.

Soon after the Hobart Conference (IUHE Conference in 1983) we had an extremely successful Expert Committee on 'New Approaches to Health Education in Primary Health Care'. The Committee's report is being distributed widely and has received very positive response. The Technical discussions on New Policies for Health Education in Primary Health Care during the World Health Assembly in 1983 was very successful and some 300 participants took part in these discussions.

The Seventh General Programme of work of WHO (covering the period 1984-89) has brought together public information and health education. so that information and education for health now constitutes a continuum of activities ranging from advocacy at the policy level to mobilizing resources and various health-related professional support; from launching information projects to developing community education activities. We have a clear objective to foster activities which will encourage people to want to to be healthy, to know how to stay healthy, to do what they can individually and collectively to maintain health and to seek help as needed. And we are recognized as a major programme within the health infrastructure thrust, which the Director-General, Dr. H. Mahler, has singled out as the main emphasis of WHO, work.

Strengthening Communication

There has been an upsurge of interest in information and education for health. The next biennial budget of WHO, for instance, reflects a substantial increase of information/education expenses—both at country and regional levels. In fact, even with a real no-growth budget for 1986-87, information and education for health enjoys a substantial increase at the field level—for example, in the Africa Region the increase is 36% and for the Eastern Mediterranean it is 60%. During the discussion of this budget at the 1985 World Health Assembly last May, some 50 countries—an unprecedented number—spoke about information and education for health.

Regional Programmes

We are beginning to tackle the need to strengthen education/communication of the health sector—first with an international consultation on criteria and guidelines and now with two regional workshops in SEARO and AFRO to develop training modules on community education. And we hope to work with the Asia Pacific Academic Consortium of Schools of Public Health on testing and using the modules. We are increasing our cooperation with Member States on training of health education personnel, ranging from postgraduate level to community worker. We have had quite a number of interregional, regional and country round-tables or workshops, involving health and media sectors at both the policy and professional levels. We are also involving UNESCO and UNICEF in our forthcoming Consultation on Health Education for School-age Children, a very important area of work. The European Regional Office has launched a health promotion programme which is gaining momentum. We are also trying to develop some indicators for health educators.

Work at Policy Level: Though the overall pictures is somewhat encouraging, there lies also a danger. With the increase of attention and enthusiasm, we must move steadily to fulfill this rising expectation. We must strive to bring information and education for health to the policy level and include it in the managerial process for national health development. We must claim a larger share of staff and budgetary resources; we must improve our professional qualities, particularly in presentation and communication skills; we must do more to support the community health workers in reaching out to the people; and we must make a concerted effort in stimulating inter-sectoral support. Otherwise, education for health will suffer a loss of credibility and there will be retrogression.

—*Courtesy* : **SEARB Bulletin**
Jan. 1986 ○

WHO Regional Director's Annual Report for 1985-86

STEADY PROGRESS IN HEALTH DEVELOPMENT IN SOUTH-EAST ASIA

THE Thirty-ninth session of the WHO Regional Committee for South-East was held in Chiang Mai (Thailand) from 9 to 15 September, 1986.

The seven-day session of the Regional Committee was attended by senior health administrators and officials from Member Countries of the Region—Bangladesh, Bhutan, Burma, Democratic People's Republic of Korea, India, Indonesia, Maldives, Mongolia, Nepal, Sri Lanka and Thailand. Representatives from other United Nations agencies and several non-governmental and intergovernmental organizations in official relations with WHO also attended the meeting.

The Regional Committee, which is the highest-level constitutional governing body of WHO at the regional level, meets annually to review the health situation in the Region, examines the programme and budget estimates and sets policy guidelines. It also provides necessary direction to further strengthen health development efforts in the Member Countries of the Region.

The Regional Director's Annual Report for the year 1985-86 highlighting health developments in the Region was presented to the Committee. We publish here the highlights of the Report.

Organization of Health Systems

THE health infrastructure continued to expand leading to further increase in health care for the population in all countries of the Region. Greater attention was being paid to support primary health care and to improve the quality of services. Involving the community, encouraging intersectoral action for primary health care support, development of middle-level health managers and primary health care for the urban poor were some of the steps taken in this direction. Innovations in community involvement in planning and implementation had been tried in some countries. The experiment to train villagers to acquire management skills and ultimately take the responsibility for running health programmes as a self-managed village activity proved successful in Thailand. Similarly, the People's Health Programme was being extended in Burma, with the training of community health workers being focussed on quality and competence. As a mark of achievement, the Ayadaw Township's Primary Health Care Programme was awarded the Sasakawa Health Prize at the Thirty-ninth World Health Assembly in May 1986.

Health Manpower Development

The problem of shortage of appropriate and adequate manpower to support the national health systems persists. To bridge the gap, the Organization was collborating with the Member Countries to establish health services manpower development mechanisms for fostering an information-based dialogue between the users and producers of health manpower.

Steps were also being taken to streamline the utilization of available manpower to optimize their contribution to health development. Sharpening the job description for each category of health worker, introduction of sound supervisory practices, organisation of task-oriented training were some of the activities supported by the Organization. Continuing education had been identified as a priority to maintain the knowledge and skill of health workers of all categories and to help them to meet the changing needs of the health system.

Public Information and Education for Health

With the emphasis increasing towards ensuring community involvement and participation in health development activities, several initiatives had been taken by Member Countries to enlarge the degree of involvement of the media in health development. At the same time, steps were being taken to enhance the communication skills of both professional and non-professional health workers. The emphasis had been on bringing the health information and health education sectors closer in a mutually-supportive manner to develop a well-informed community that could take the right decisions towards maintaining positive health at both personal and community levels.

Research Promotion and Development

The Regional Research Promotion Programme continued to strengthen national research capabilities, coordinate research activities to solve priority health problems and to promote research to facilitate the use of existing and emerging scientific knowledge. The South-East Asia Advisory Committee on Medical Research had not only provided a sound framework for developing research in support of HFA/2000 but also emphasized the need for stimulating health services and health behavioural research. A conceptual base had been developed in this regard and was being elaborated into a plan of action.

The Organization had established a research management system in support of and in coordination with the national health research management institutions and a network of collaborating centres in the Region. Under the research programme, around 120 projects had so far been completed successfully.

Nutrition

The problem of malnutrition continued in most countries of the Region with a wide range of nutritional deficiency diseases. A multisectoral thrust including the health, education, agriculture and rural development sectors had been launched to tackle the problem. Steps had also been taken to promote the establishment of a mechanism for the coordination of nutritional activities at the national level. Most countries in the Region now have nutrition units or analogous bodies in their Ministries of Health for multisectoral nutritional activities.

Several encouraging developments had taken place at the Regional level, including the formulation of the Regional Iodine-Deficiency Disorders Control Programme, streamlining of the regional xeropthalmia/vitamin A deficiency blindness control activities and the initiation of a regional network for training in nutrition.

Maternal and Child Health

Mothers and children constitute a major target group for health development in all countries of the Region. Not only does this group constitute more than fifty percent of the total population, it is also the most vulnerable to malnutrition, infection and disease. Hence, maternal and child health and family planning activities as an integral part of health and socio-economic development efforts continued to be accorded high priority in all Member Countries of the Region.

The Organization's activities were concentrated on training manpower, evaluating ongoing programmes, strengthening and further expanding the programmes, instituting research on priority areas, and improving the relevant information base and information dissemination.

A number of research projects had been undertaken which covered, among other aspects, indicators for physical and psychosocial development in children, epidemiological studies on the growth of infants and children, assessment of the relative importance of factors leading to a high infant mortality rate and feeding patterns in infants.

Mental Health

The promotive and preventive aspects of mental health are being given due priority by Member Countries. Efforts have also been made to draw attention to the influence of psychosocial factors in the promotion of health and human development and have resulted in defining the indicators of mental health in its various facets.

Alcohol and drug abuse are threatening to become not only health problems but also a difficult socio-economic problem in several countries. This situation had led to increasing interest in India, Nepal and Sri Lanka in developing control programmes in this area similar to the ones in Burma and Thailand.

The prevention and early detection of mental and neurological disorders was also receiving increasing attention. Steps were being taken to train health workers in community-oriented mental health care and to provide appropriate health education using the existing primary health care infrastructure.

Environmental Health

A review in terms of the targets set under the International Drinking Water Supply and Sanitation Decade (1980-1990) revealed that water supply enjoys wide popular support, while sanitation continued to receive low priority. What was required was hard look at the procedures traditionally followed in planning and implementing rural water supply and sanitation projects. The gap between the planners and the people needed to be bridged by the adoption of the primary health care approach with greater community involvement, including the involvement of women and disadvantaged groups. Primary health care workers and others at the community level must be harnessed for bridging this gap. A proper mix between hardware and software components has to be found so that communities can operate and maintain their own facilities, protect their water sources and adopt hygienic practices.

Diagnostic, Therapeutic and Rehabilitative Technology

The major thrust of WHO collaboration in this area continued to be in the fields of development of technical and managerial manpower, introduction of appropriate technology in the diagnosis of priority diseases, and improvement in the quality of the laboratory work to provide effective support to primary health care programmes.

In the field of therapeutic technology, the Organization actively promoted the concept of essential drugs. Almost all countries in the Region have prepared lists of essential drugs and established mechanisms for their updating. Steps were also being taken to streamline storage and distribution systems so as to ensure timely supply of required quantities of essential drugs for the primary health care programmes.

Member Countries were being assisted in attaining self-reliance in

the production of vaccines. At least three countries in the Region had developed the technological competence and capability to produce veccines required for the Expanded Programme on Immunization (EPI). The Organization had collaborated with India in the transfer of technology for oral polio vaccine production. Burma, Indonesia and Thailand had plans for introducing appropriate technology for the production of viral vaccines against rabies, measles, polio and hepatitis B.

Expanded Programme on Immunization

Available data on the incidence of some of the target diseases showed a downward trend in some countries, indicating the impact of the programme. The Programme continued to follow the five-point strategy of integrated development with PHC, training of adequate and appropriate manpower, mobilization of adequate resources, continuous evaluation and use of feedback information to achieve the target of coverage and disease reduction, and, finally, health services research to solve problems related to the programme.

Malaria

Malaria continued to be a major communicable diseases in at least eight countries of the Region. While the malaria situation showed some improvement in terms of reduction of incidence in only two countries, namely, India and Thailand, it remained the same in the remaining six countries. The technical problems of vector resistance to insecticides and parasite resistance to drugs persisted. The menace of P. falciparum continued.

To deal with the situation the countries were developing realistic policies and programmes to rationalize the use of new antimalarial drugs like mefloquine, and to adopt an integrated vector control methodology including bioenvironmental methods. Steps were also being taken to stimulate community participation and intersectoral cooperation and to mobilize internal and external resources to maintain the smooth supply of appropriate insecticides.

Because of the changing nature of the problem and the emphasis on control rather than eradication, the process of integration of malaria control programme with the general health services was being actively pursued and control strategies adapted to local epidmiological situation and the availability of resources.

Diarrhoeal Diseases

Diarrhoeal diseases have been recognized as one of the major reasons for high infant mortality in several countries of the Region, leading to the development of contol programmes with the immediate objective of reducing mortality due to these diseases and the long-term objective of morbidity reduction.

The major strategy to achieve objectives has been prompt treatment by oral rehydration therapy (ORT). The countries had developed the capacity, to a great extent, to produce the appropriate packages of oral rehydration salts, either through large-scale manufacture or through small-scale cottage industry type of production, or a combination of both. These efforts needed further stimulation to enable the countries to become self-reliant. To achieve the proper and timely ORT and ensure appropriate nutrition of the patients, it was necessary to train the mothers and other members of the family and the community. In this regard, health education activities had been developed and relevant health workers trained in the epidemiological and therapeutic aspects of diarrhoeal diseases.

Tuberculosis

Tuberculosis continued to be a major public health problem. With the introduction of the multidrug regiment to treat infectious cases promptly with the aim of reducing transmission, the chances of controlling the disease have increased.

The strategies of national programmes in the Member Countries are mainly based on immunization with BCG, case-finding and treatment. The problems of identifying infectious cases as early as possible, providing adequate supplies of drugs and ensuring proper multidrug therapy required not only physical facilities, trained manpower and resources but also an effective organizational infrastructure and managerial skills, WHO support had been provided to meet some of these needs through technical advice, training of personnel and mobilization of resources. In addition, research related to therapy, immunology and prophylaxis had been stimulated in some countries.

Leprosy

Based on the success of the multidrug regimen for leprosy in cutting down the period of treatment and diminishing the possibility of resistance, most countries of the Region facing this problem had introduced this treatment regimen. The social stigma associated with leprosy, however, contributed to low rates of case detection, irregular treatment and inadequate case-holding which impeded the progress of the control programmes. Measuers were being taken to strengthen the infrastructure of the programme, training manpower, procuring drugs, organizing research and evaluating programme activities.

Research on the development of an immunizing agent against leprosy was continuing under the joint UNDP/World Bank/WHO Special Programme on Tropical Diseases Research, and a number of candidate vaccines were now ready for field trial.

Sexually Transmitted Diseases

The problem of sexually transmitted diseases was creating concern in some Member countries of the Region because of their increasing incidence and their human, economic and social implications. Control programmes were being implemented in several countries through strengthening of diagnostic facilities, organizing treatment centres, training health staff and promoting health education.

A new dimension had recently been added to the situation by the

"The health infrastructure continued to expand leading to further increase in health care for the population in all countries of the Region. Greater attention was being paid to support primary health care and to improve the quality of services. Involving the community, encouraging inter sectoral action for primary health care support, development of middle level health managers and primary health care for the urban poor were some of the steps taken in this direction. The emphasis had been on bringing the health information and health education sectors closer in a mutually—supportive manner to develop a well-informed community that could take the right decisions towards maintaining positive heath at both personal and community levels."

impending risk of Acquired Immuno-deficiency Syndrome (AIDS). Although no indigenous case of AIDS had been reported in the South-East Asia Region, the high fatality rate due to AIDS and the possibility of its introduction in the Region had become matters of concern. Nine countries had established task forces, reviewed the situation and developed guidelines to prevent introduction of the disease. The countries had been kept informed about the recent developments on the scientific and public health aspects of the disease and appropriate measures were being taken according to the needs of the situation in the Region.

Other Communicable Diseases

Dengue haemorrhagic fever was limited to Burma, Indonesia and Thailand as a public health problem. The WHO Collaborating Centre for DHF in Thailand had been engaged in developing a vaccine against DHF.

Regarding viral hepatitis, it had been established that non-A and non-B types of viruses were the major causes of viral hepatitis in the region. A number of studies on viral B hepatitis had been undertaken and had revealed that hepatitis B vaccine can successfully prevent placental transmission of HBsAg to infants born to HBsAg-carrying mothers.

Blindness

Although cataract, vitamin A deficiency, trachoma, glaucoma and trauma were the known common causes of blindness in this region, a recent assessment of the etiological factors of blindness in several countries of the Region had confirmed that cataract remained the leading cause of avoidable blindness.

The lack of access to surgical treatment had, in large sections of the population, led to an immense backlog of unoperated, yet curably blind persons. Efforts in most countries for the control of blindness have included the development of strategies for the restoration of vision in these persons through an outreach approach whereby facilities and opportunities for surgical treatment are provided closer to their homes.

Cancer Control

The thrust of control activities has been on preventive measures supplemented by early diagnosis and treatment. The most common cancers prevailing in the Region are oral and lung cancers in males and cervical and breast cancer in females.

So far as oral and lung cancers are concerned, it had been established that consumption to tobacco was the most important contributing factor. In view of this, WHO had mounted a programme on "Tobacco or Health". Eight countries in the Region had formulated plans of action to control tobacco-related diseases and more specifically to control tobacco consumption. Intensive health education, particularly among children of school-going age, had been emphasized.

Cardiovascular Diseases

Community approach in the prevention and control of cardiovascular diseases was continued to be pursued in the countries of the region. Health education played an important role to promote health life styles, physical exercise and proper diet among the target population. The Organization extended support in training manpower and provided research grants to the countries of the region. ○

technical aspects of the programme. These Committees would give appropriate feedback to subordinate formations on a continuous basis. ICMR and the Centres of Excellence will be involved in concurrent evaluation of the technical aspects of the programme. Special teams will be deputed from the Central Government to review and enforce the quality of services.

Integration of Family Planning with other Socio-Economic Development Programmes

The 'clinical' approach of the '50s developed into 'extension' approach during '60s and during '70s, was further consolidated when Family Planning services were integrated with the Mother and Child Health services. This integration has been perceived to be beneficial both by workers and beneficiaries and has resulted in increasing FP acceptance. The new strategy will further deepen the integration of the Health and Family Planning systems at the primary health care level through reorientation programmes for health workers, strengthening of existing facilities and increasing delivery outreach by using special mobile teams. In this new integrated system non-governmental structures will be involved. Recognising the interplay of social factors like family structure, property rights, inheritance, old age security etc., the approach of integrated action would be extended to link Family Planning with other programmes of socio-economic development, e.g., Poverty Alleviation, Social Welfare, Agricultural & Cooperative Development, Women's Welfare, Education, Employment Generation and Urban Development.

Information Education Communication—Demand Generation

The recent research study has shown that 60 per cent eligible couples hold favourable attitude to family planning. The percentage of those adopting family planning methods, however, is much less. The major communication task, therefore, is to convert the favourable attitude to practice of family planning. In working out the media campaign for the family welfare programme, professional talents available in Government and private sectors will be harnessed. A high level inter-media committee comprising communication professionals and eminent non-officials will be set up in the Ministry to advise on the use of appropriate media channels depending upon their capabilities for promoting specific messages and effectiveness of their reach.

Television is an effective medium but the availability of television sets in rural areas is limited. It is proposed to promote community TV viewing by providing sets with the co-operation of TV manufacturers and other development departments of the Government like Agriculture, Rural Development, Education, Women's Welfare, etc. Provisions of community TV sets could be linked to the interest shown by the village community in promoting acceptance of family planning. For villages which are outside the reach of TV transmission or have no electricity, it is proposed to undertake a programme for providing Video Cassette players and generators with TV sets. Appropriate software will be developed with the help of professional experts which will provide a package of messages relating to Health, Family Welfare, Agriculture, Women's status and welfare and other key areas of socio-economic development.

Cinema, which is watched by a large number of people both in urban and rural areas and is a powerful communication medium, will be fully exploited through more systematic distribution of films and persuading the State Governments to grant entertainment tax exemption liberally to films with family planning as the dominant theme. Emphasis will be given on films aimed at dispelling doubts and fears about methods of contraception and such films will be shown to rural masses in an interesting package organised with suitable entertainment. Newspapers, magazines and other print media will be utilised imaginatively. Journalists and Editors will be encouraged to write on population themes.

Multi-media communication campaigns will be mounted with primary focus on:

- Reinforcing the two-child family limit norm;
- Promotion of inter spouse communication;
- Child survival programme;
- Increasing the age of marriage;
- Neutralising male preference syndrome; and
- Improving the image of family planning and health workers.

Communication messages will be targeted not only at eligible couples but also other important influencers. The communication strategy will aim at maximising the total impact through judicious mix of mass media and inter-personal channels. It will not only promote contraception, but also address the different variables that influence decision making regarding family size. The strategy will also aim at stimulating discussion within the community on how rapidly increasing population is eroding the quality of life for each individual family as also that of the community through the degradation of the physical and ecological environment.

The preparation of software and messages will be professionalised by involving the private advertising agencies. The medical and para-medical workers will also be given proper education particularly about the safety and efficacy of spacing methods so that they could communicate convincingly with the people. In order to ensure that the messages put forth continue to be effective and meaningful, regular system of evaluation will be set up. Eminent communication experts from official and non-official areas will be associated

to assess the reach and effectiveness of the communication programme periodically in different areas. Campaign strategies will be revised in the light of this feedback.

Preparation of software based on regional, folk and traditional arts will be encouraged by setting up Regional Communication Resource Centres. These Centres will promote local skills of departmental workers and also take help from non-official bodies for designing, producing and evaluating the software including communication aids. They will also help in designing and implementing the training modules for basic health workers. The communication and extension personnel will be selected with care and on the basis of their professional capabilities for communication work. Wherever the reach of mass media like radio and television is insufficient, the interpersonal communication will be specially strengthened and made more efficient. Besides improving the knowledge and communication skills of the basic health workers, attention will be given to improving their image and credibility in the community.

Population Education

Population Education—Internalised to the whole spectrum of education system can greatly help in influencing the fertility behaviour of the coming generations in the desired direction. In 1981, out of 685 million population, there were 181 million children in the school age group of 6-17. Out of these, there were 106 millions in the schools. There are about 3.14 million students going to colleges and universities. The potential of population education in the formal and non-formal system will be fully harnessed. Training of resource/key persons, instructional material for different target groups and preparation of population education lessons will be the crucial activities for the success of population education programme. A high level committee will be set up to oversee and co-ordinate the programme.

Assistance from the United Nations Fund for population Activities (UNFPA) was made available to enable the Ministry of Education to initiate projects for imparting population education during the Seventh Plan with specific quantitative targets:

Target Group	No. to be covered
(i) Students in the age group 6 to 16 or classes I - X	56.44 million
(ii) Students in the age group 16-18 or classes XI - XII	2.75 million
(iii) Out of school children in the age group of 9-14	45.06 million
(iv) Teachers in Primary, Middle and Secondary Schools	2.49 million
(v) Teachers in Higher Secondary Schools	0.26 million
(vi) Instructions in Non-formal Education Centres	0.15 million
(vii) University/College students	3.14 million
(viii) University/College Teachers	0.21 million

It is recommended that for the students at 10 + 2 stage and college-going students, Population Education should include compulsory lessons on family life cycle to make them fully aware of the essentials of reproductive physiology and contraception. Population education through the non-formal school education system will be strengthened to cover the 45 million children out of schools. A population project has been developed for adults in the age-group of 15-35 under the Adult Education Programme. This project will greatly help in motivating this highly fertile age-group to limit their family size.

In the organised sector, there are 24 million workers who are involved in group activities. Trade union leadership and employers associations will be motivated to arrange population education amongst the members/employees. Population education will also be included in all the curriculum of vocational schools. This scheme will also be extended to unorganised sector on the pattern of pilot project for Bidi Workers by identifying suitable groups like handloom weavers and plantation workers. Nehru Yuvak Kendras, Mahila Mandals and Co-operatives will also be encouraged for imparting population education. Messages and materials will be developed by expert groups.

An integrated approach by the functionaries of various developmental departments at grass-root levels in promoting family planning will greatly enhance programme acceptance. A mechanism will be established whereby all these functionaries will inter-act with community not only in family planning, but in the entire range of programme of social engineering. The sub-centre can act as nucleus where liaison between the primary functionaries of different departments could be operationalised and linkages established with the public representatives. Their inter-action will have to be under the supervision of Panchayat Samities or Village Panchayats. The Block Extension Educators would be assigned the task of bringing into inter-play communication between the functionaries of different departments.

Incentives

Incentives which seek to directly influence fertility behaviour can play a crucial role in population control strategy. At present, some incentives are available to the employees of Central Government, Public Sector Undertakings and State Governments. Central Government does not give any incentives to the members of the general public except a small amount by way of compensation for the loss of wages. Some States have introduced incentives in the form of lottery ticket scheme and a scheme of issuing Green Cards which entitle the acceptors of sterilisation with two or less children, preferential treatment in certain areas. It is

NATIONAL FAMILY WELFARE AWARDS 1984-85

THE Union Minister for Health and Family Welfare and Human Resource Development, Shri P. V. Narasimha Rao, presented the Annual National Family Welfare Awards for the year 1984-85.

Punjab, Tamil Nadu and Assam were awarded Rs. 2.5 crore each for best family planning performance during 1984-85.

In all, awards to the tune of Rs. 10.25 crore were presented by the Minister. The other recipients were Haryana and Karnataka who got Rs. 1 crore each. Manipur was given Rs. 50 lakh, and the Andaman and Nicobar Islands got Rs. 25 lakh.

The awards scheme was started in 1983 to encourage the States and Union Territories to do better on the family planning front. The States were classified into five different categories on the basis of their population.

Punjab, which bagged the top prize in Group A, had during 1984-85 achieved 106 per cent of its targets, recording a 6.9 per cent rise in the State's couple protection rate.

Tamil Nadu in Group B, attained 98 per cent of its targets, while Assam, in Group C, achieved 97 per cent of the targets.

The couple protection rate of the three States had reached 49.8 per cent, 36 per cent and 24.7 per cent respectively by the end of March, 1985. The country has set for itself the target of reaching 60 per cent couple protection level by the turn of the century.

While Haryana and Karnataka bagged the second prize of Rs. 1 crore each in Groups A and B, no State qualified for this prize in Group C.

In Group D, which includes States and Union Territories with population ranging from 10 lakh to 1 crore, Manipur secured the top award of Rs. 50 lakh. It achieved 82 per cent of its target.

In Group E, comprising States and UTs with less than 10 lakh population, Andaman and Nicobar Islands bagged the top award of Rs. 25 lakh. The Union Territory achieved 109 per cent of the target. ○○

necessary to review the entire system of individual and community incentives. It is felt that any scheme of incentives should follow a differential approach encouraging limitation of family size within two children. Following are some of the incentive schemes which could be considered for introduction in the programme:

An economic incentive to the small family to be built into all the Socio-economic Development programmes of the Central and State Governments which are beneficiary oriented. A preference is to be given for the two or less child family norm in the selection of the beneficiaries and also additional subsidy/grant and an interest rebate is to be granted on loan/payment.

Schemes being considered for these economic linkages are the IRDP, NREP, RLEGP and other rural development programmes of assistance to individuals, loans under agriculture training and employment schemes, loans under small scale and village industries, welfare schemes of all beneficiary-oriented development corporations, insurance schemes, bank and co-operative loans, allotment of land and housing and such other activities are have a strong bearing on the citizens' life.

These benefits will be subject to a small family acceptor being eligible otherwise under a particular scheme. The non-governmental sector including corporate sector and voluntary sector is to be persuaded to implement the same economic linkages under their activities.

Acceptors of sterilisation with two or less children may be given 'Honoured Citizen Cards' which will entitle them to preferential treatment in all possible areas where facilities are available to the public.

Acceptors of sterilisation after two or less children will be entitled to an Insurance Policy of high value but low premium to serve them in old age.

A National Lottery Scheme for acceptors of sterilisation with two or less children offering attractive prizes.

Issuing of bonds of the face value of Rs. 25,000 maturing after 15 years to acceptors of sterilisation having two female children. Such a scheme will help in raising the age of marriage of women, their status and neutralise the male offspring preference.

Community Awards for Pariwar Kaiyan Villages which exceed contraceptive prevalence of 70 per cent.

State and National merit system and awards/recognition to workers, programme managers at various levels, individuals and corporate bodies in the private sector and voluntary organisations.

Voluntary Action

Non-Governmental Structures

Family Planning has to be made a people's movement. Non-Government structures will be promoted to supplement and strengthen the Family Planning activities. The following major initiatives will be taken in this regard:

All voluntary organisations, irrespective of their present field of operation will be encouraged to work in the sphere of family welfare and depending upon their capabilities they can take up motivational and educational work as also the task of providing services. A Committee for Supportive Voluntary Action (SCOVA) will be established which will provide consultancy services, identify suitable voluntary organisations, sanction financial assistance to them and monitor their performance. Procedures for giving grants will be simplified. An estimated number of 70,000 voluntary organisations exist in the country with the membership of nearly 1.75 million. The aim will be to involve the maximum number in the programme at all levels.

The organised sector has a total of over 25 million employees. Organised sector units will be persuaded to provide family welfare services to their employees and make available to them a minimum prescribed package of rewards and incentives. Larger units will also be persuaded to adopt areas and townships for intensive family planning motivation and service delivery. A Tripartite National Committee of Government, Employers Association and Trade Unions is being constituted to exploit the potential of the organised sector.

There are nearly 35,000 Co-operatives in the country covering 95% of villages and almost 50% of rural population. These are well-knit units with functional linkage systems that join the village to the district and State to the National level agencies. This sector will be used to act as a conduit for education, communication and motivational activities. Specific projects will be designed and entrusted to the Co-operative sector in areas where they have institutional facilities and capabilities.

The professional and financial capabilities of the Corporate sector will be harnessed by offering suitable tax incentives for setting up corporate structures for providing integrated family welfare services.

Community Participation

Community participation is vital for programme success. Following approaches will be pursued to secure full-scale community participation, particularly at the grass-root levels so that the concept of family planning is internalised in the social polity.

Popular Committees consisting of Government officials and eminent public leaders will be organised at State, District, Block and Panchayat levels for planning and overseeing the implementation of motivational and service delivery aspects of the programme. At least half of the members of these Committees will be women.

Special schemes will be developed for involvement of Organisations of Women and Youth such as Mahila Mandals and Youth Clubs in the Family Welfare Programme integrated with socio-cultural activities which such organisations are engaged in.

Medical students will be given proper orientation in community work through suitable restructuring of their syllabus. General student community will also be involved through a scheme of compulsory rural and urban slums work as part of the educational programme. The involvement of the student community will be for over all community development within which health and family welfare issues will have a primary focus.

The Parliamentarians, Members of State Legislatures, Zila Parishad Members, District Committee Members, Block Pramukhs, Gram Panchayat Members, Gram Pradhans, Youth Wings and Mahila Wings of the political parties, irrespective of their party affiliations, can bring about significant change in people's attitudes to family planning. They will be involved in motivational work.

It can also be considered whether the front organisations of the political parties, especially those of Women, Youth and Students can encourage their members to take a pledge to observe and promote small family norm. This pledge administered in large rallies will have good demonstration effect.

The large reservoir of practitioners of Indian Systems of Medicine will be harnessed to further the programme. They will be involved not only in motivational work but also in providing the services according to their capabilities. A scheme will be launched to improve their technical, managerial and motivational skills to get their best support for the programme.

The Opinion Leaders Training Camps will be more effectively organised in close co-ordination with Primary Health Centres and voluntary organisations in the local area. Apart from providing orientation, these Camps will also serve to extend family planning services.

Women Volunteer Corps

A village level Women Volunteer Corps will be organised. The volunteers would interact with the eligible couples in their areas and provide them with knowledge of health, immunisation, family planning, nutrition, etc. They would be given proper orientation training for this purpose. Women volunteers will be chosen at the rate of one for every 60 families both in rural and urban areas. These volunteers will be preferably those who are acceptors of family planning with three or less children and will be selected from amongst the concerned group of eligible couples. The role of women volunteers is not limited to family planning, but would include overall emancipation of women. A cadre of approximately 2 million such workers from within the community will be a major catalyst for social change.

Social Marketing of Contraceptives

The programme of social marketing of Nirodh has been in existence for the last 15 years and is being executed through 12 large and well established private and public sector undertakings. The sale of Nirodh through these channels was 16 million pieces in 1968-69 and is expected to cross 300 million next year. Even though there is sufficient awareness or the part

Improve Quality of Health Services

—Says Kum. Khaparde

We have achieved significant progress towards increasing the health status of our people. Smallpox and plague have been eradicated; malaria has been controlled to a large extent. We have also brought down the incidence of several communicable diseases which have been the scourge of developing countries, said Kum. Saroj Khaparde, Minister of State for Health and Family Welfare, while addressing the 12th Joint Conference of Central Councils of Health and Family Welfare in New Delhi on 22 September, 1986.

Since Independence, the mortality rates have been halved; the nutritional level of our people has improved; the life expectancy at birth of our country-men has increased from 32 years to 56 years. This has been possible because of the large investments made in setting up a net-work of health delivery system which reached out in the countryside. It is also a tribute to the medical professionals who managed these facilities, said the Minister.

She referred to some mishaps reported from eye camps conducted by voluntary agencies at Khurja and Moradabad in U.P. A large number of individuals who got their eyes operated in these camps were reported to have lost eye-sight. She said "Centre has been issuing guidelines and instructions regarding organisation of eye camps. It appears that these guidelines are not strictly adhered to. All the organisers of eye camps irrespective of the fact whether they solicit grant-in-aid from the Government or not, must invariably obtain prior approval and permission of the camps from the competent health authorities of the District. The authorities, while granting permission, should properly scrutinise the potential of these organisations, qualifications and experience of the surgeons conducting operations and other relevant details. One of the officers of the Health Department, preferably an Ophthalmologist, should oversee the activities in the camps".

She said that the Government hospitals were perhaps the major source available to the common people for curative services. Image of the health service was largely related to the functioning of these hospitals. The functioning of these hospitals required serious attention and improvement. Cleanliness, environmental improvement, courteous behaviour and proper management could go a long way in improving the quality of service. She urged to pay proper attention to this aspect of improving the services in a cost-effective manner. Hospital wards providing mother and child care would need special attention," she added.

of the consumers about Nirodh, adequate infrastructure and delivery system, the main job of creating a large demand leaves much to be desired. This demand creation depends upon aggressive marketing, advertising and product promotion. The present Cell in the Ministry is ill-equipped for mounting a large scale and successful programme. A marketing board will be set up in the Ministry to review periodically the policy on social marketing, draw up an action programme and oversee its implementation. This Board will have as Members, experts on marketing and communication. The Board will ensure a cohesive and integrated approach to marketing, provide policy guidance and Central Management Coordination, sales forecasting, review and related management support services.

Greater involvement of Marketing Companies will be enlisted and their responsibilities and areas of operation broadened. Better quality condoms will be introduced in the Social Marketing System. Apart from popular retail outlets, non-coventional outlets will also sell contraceptives. The main thrust will be that people should be able to purchase condoms in an impersonal atmosphere from easily accessible places.

The social marketing programme will also be extended to include oral pills and other spacing contraceptives. While extending the social marketing programme, free distribution of contraceptive will be scaled down. Community based distribution system worked by voluntary organisations will also be considered for participation wherever necessary. All these steps will lead to much higher level of knowledge and achievement than what has been targeted in the 7th Plan.

Improving Programme Management

Experience has shown that in States where programme has been handled more efficiently, performance has improved significantly. An analysis of the existing situation based on the research findings reveals that inadequate administrative structure, lack of management system at P.H.C. level, insufficient mobility, deficient supply systems, shortage and poor maintenance of equipments are some of the basic weaknesses in the programme. All these areas will be given priority and focussed attention.

At the National level, the administrative structure in the Department of Family Welfare will be reorganised and reoriented towards modern programme management. A number of initiatives will be taken to build professionally competent structures and substructures manned by most suitable resource persons so that policy, planning, implementation, review and evaluation aspects of the programme are handled with maximum efficiency. There will be apex

level bodies to review the policies, programme and their implementation. Separate satellite structures will be established within the Ministry for giving advice and direction on specific aspects of the programme. Full use will be made of the specialised autonomous organisations such as National Institute of Health & Family Welfare, Indian Council of Medical Research, International Institute for Population Sciences for the overall planning, decision making and implementation of the programme.

At the State level, there will be a high powered Committee for overall review and monitoring. Posts of Additional Chief Secretaries would be created in certain States for more effective coordination of family welfare with other social sector programmes. State Family Welfare Bureau would be strengthened and State level institutions like Population Research Centres will inter-act more effectively with the State machinery.

At the District level, the Collector will be invested with the overall supervisory responsibility of the programme to forge effective coordination. A Popular Committee will be set up under his leadership to serve as an instrument of bringing together various resources in the district for a common Action Plan. The Chief Medical Officer will serve as the principal resource to the Collector and his position will be strengthened. District Family Welfare Bureau will also be adequately strengthened in line with the district-wise thrust in the programme.

At the Block level, the Block Development Officer will be fully involved in the programme. A mechanism will be established by which he will get support and advice from various Government departments and popular institutions. He will coordinate and mobilise the functionaries of different development departments and work in close collaboration with the Medical Officers in charge of Primary Health Centres.

Improving Primary Health Centre Management

The Primary Health Centre at the Block level is a critical unit in the service delivery system. Planning and management of the programme in the Primary Health Centre requires talents of a Manager apart from the skills of an Epidemiologist. The Medical Officer in charge of the Primary Health Centre will have to be trained in the skills of programme planning and management so that he can organise both official ad non-official agencies for proper delivery of Family Planning and MCH services. A detailed exercise would be undertaken to assess management needs of the Medical Officer in charge of Primary Health Centre and of the functionaries working below him and modules developed for on-the-job and off-the-job training of these functionaries and a structure of incentives will be built up, allowing for upward mobility in their professional careers based on commitment and objective performance.

Improving mobility, streamlining Supplies and Equipments

Mobility is of prime importance for service delivery, supervision and emergency assistance. Regular availability of supplies and equipments is vital to the success of the programme. Following steps will be taken to improve the existing situation in these areas:

— Vehicles under the programme will be maintained at optimal efficiency. Old vehicles will be replaced and additional vehicles provided for districts of large size and difficult terrain.

— Para-medical workers will be given interest free loans to purchase Mopeds/Motor Cycles for their official use to increase their mobility and efficiency. Adequate allowance will be given to enable them to maintain the two wheelers and to meet the POL costs.

The necessary supplies and equipments like surgical instruments, refrigerators, vaccines, contraceptives, audio-visual equipment, will be regularly made. Their proper upkeep and maintenance will be ensured. Appropriate training will be given for scientific management of inventories.

Eligible couple registration system

Eligible Couple Register is the basic document for organising the work programme of Family Planning field workers. There are about 126 million eligible couples and this number is likely to increase to around 170 million before 2000 A.D. The system of preparing Eligible Couple Registers will be streamlined to make it an effective instrument of monitoring and management. Each functionary will have registers of couples falling within his jurisdiction. These will be regularly updated and definite responsibilities fixed for their preparation and authenticity of information. The Eligible Couple Roll will be printed and displayed at accessible points in each village for public scrutiny. These registers are vital in proper enforcement of a system of structured incentives apart from improving information on the vital statistics.

Differential Area, Region and group specific approaches

The socio-economic conditions and demographic situation in the country vary considerably from State to State and within a State, from region to region. This diversity dictates the need for differential approaches and region specific strategies. These are:

State level

Each State will devise its strategy to achieve the goal of unity NRR by the year assigned to it, besides preparing medium term Action Plans for the remaining period of the Seventh Plan. Each State will carry out a situational analysis to identify thrust areas and devise differential approaches for different districts, areas, communities and groups. To enable the State to efficiently implement their strategies, greater decentralisation and flexibility in implementing the programme will be provided.

PEOPLE AND RESOURCES

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

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

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

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

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

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

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

District level

Based on the State level strategy, each District will prepare an Action Plan for the next four years, which will include all aspects of planning, implementation, monitoring and evaluation. Specific targets to be achieved will be decided by the State Family Welfare Bureau in consultation with the District Family Welfare Bureau.

Block/PHC level Action

The Medical Officers in charge of the PHC will prepare Action Plan for the Block for extensive coverage of all eligible couples. This will include updating of Eligible Couple Registers, identification of low acceptance villages, schedules of holding family planning and immunisation camps and well planned supportive supervision.

Municipal/Urban areas special strategy

Population in poor pockets of urban areas is growing very fast. Most urban areas have Health & Family Welfare infrastructure, but that is 'clinic' oriented. The approach will have to be changed to a community-based motivation and extension services. Adequate coordination, lacking at present, will be provided among various health institutions and voluntary organisations will be mobilised in providing comprehensive and coordinated services.

Lagging Groups and Communities

Owing to various socio-economic reasons, acceptance of family planning amongst certain communities and identifiable groups is relatively much lower than the national level of acceptance. Each State and District will identify such groups and regions, assess their attitudes and perceptions and devise group specific programme of packages. A special feature will be to involve members of the lagging community groups, both for motivational work and for providing services. A package of group specific communication messages, special focus on education, provision of better facilities and involvement of members of specific groups will help in reducing the variations which now exist.

Programme Coordination

Intra-sectoral Coordination

A large number of agencies in Government, voluntary and corporate sectors are engaged in promoting family planning in one way or the other. There is no system of effectively coordinating their efforts in a purposive manner on regular basis. It is essential to harmonise the work of the various institutions and ensure that experience gained is commonly shared. For this purpose, specific tasks will be assigned to various agencies to avoid unnecessary duplication and a standing mechanism will be established for sharing of experiences and concerted joint action.

Inter-sectoral Coordination

Socio-economic development which is a major correlate of fertility is a process of overall national development effort. While it is the responsibility of the Ministry of Health and Family Welfare to promote contraception and provide necessary services, the responsibility to gear up efforts for economic and other developments which will help in fertility reduction falls within the purview of other Ministries. Apart from this, other Ministries will also have to inbuild some component of Family Planning in their programmes. All socio-economic development schemes

should have family welfare as an integral component. While dispensing benefits of various development schemes, other things being equal, preference should be given to those who observed two-child family norm. A standing mechanism will be set up at the Centre and in the States for securing effective inter-sectoral coordination from the National to the grassroot level of all the relevant Ministries, Departments and agencies.

Manpower Development, Training and Personnel Policies

Manpower Development is an essential element of programme improvement efforts. Doctors and paramedicals need to be trained for being developed into health administrators, programme managers and for rendering specialised family planning services. Paramedical personnel constitute the peripheral point of the delivery of family welfare services. Adequate facilities for training these categories exist except for male MPWs, which would have to be created. However, a general strengthening of these institutions in terms of faculty and equipment would also be necessary.

Awarness of family planning programme is nearly universal but acceptance rate is estimated to be only 35%. The role of extension personnel at village level becomes crucial for converting awarness into acceptance. This needs inter-personal communication skills. To impart necessary skills, communication training needs will be identified and training programmes introduced/reoriented.

There are nearly 6 lakh traditional birth attendants who conduct majority of the deliveries. Dai enjoys the position of an influential opinion leader in matters of maternal and child health. They, thus, constitute an excellent potential of developing into an effective agent for providing pre-natal care, asceptic delivery and post-natal care. To draft dai as an effective sales person for Family Planning/MCH services, her opposing interests to family planning would have to be neutralised through an incentive scheme. As the number of dais is declaining, new entrants would be encouraged through suitable schemes.

The Village Health Guide Scheme aims at involving community in health and family welfare programmes. Improper selection, inadequate training and incorrect implementation has resulted in unsatisfactory performance of the scheme. Male Health Guaides are sub-salient in family welfare services which mainly relate to women. It has been decided to replace all the male Health Gudies by female Health Guides.

The reluctance of doctors to move into rural and remote areas makes it imperative to think in terms of introducing a new category of health personnel with skills intermediate to those of doctors and paramedical workers. These Community Health Supervisors would be imparted training for a period of three years and equipped to deal with majority of the common ailments of the rural people nearest to their doorsteps. They would also become an effective link between the peripheral worker and the medical officer and thus be able to contribute substantially in the area of supplies and services of family planning programmes.

Under-utilisation and low quality of services highlight the need for an intensive training of the family planning workers. Areas critical for programme performance will be identified. An exercise of assessing training needs wil be carried out for each PHC. Regional training institutions will be strengthened to provide a continuing education programme to cover each health worker for a period of training upto three weeks once in five years. We have at present 7 Central Training Institutes and 47 Regional Health and Family Welfare Training Centres. About 8 lakhs para-medical and extension workers of different categories would need to be covered. To cover these workers, in addition to the existing infrastructure, PHCs and sub-centres are also to be developed as training resources.

Personnel Policies

A scheme of carrer development would be implemented to provide for adequate opportunities for upward mobility to various health functionaries combining merits and experience.

Research, Monitoring and Evaluation

Family Planning Research

Family planning research is a very critical element for improving the quality and effective out-reach of the programme. The main thrust would be to make research directly relevant to the programme needs. Following are the major areas which will receive priority.

The Research Study 1986 as well as other Studies done in the past have provided better understanding of people's response to family planning in terms of their socio-economic conditions, values and perceptions, availability and accessibility of services and suitability of the existing contraceptive methods, etc. This has helped in devising appropriate programme policies and strategies. Since human society is dynamic, similar psycho-social research will be taken up in future as a regular feature.

It is commonly believed by the Demographers that the couple protection rate of 60% will reduce the birth rate to 21. The validity of this hypothesis needs to be investigated empirically through field studies. Towards this end, a rigorous and properly designed research project will be commissioned.

High priority will be given to operational research aimed at bringing about more effective utilisation of the current delivery system and in identifying alternative and cost-effective strategies.

Research focus will be given on improving the acceptability of the existing methods by minimising the complications/inconveniences associated/perceived to be associated with them.

New technologies like injectables, sub-dermal implants are currently undergoing trials prior to their introduction in the programme. The procedures and protocols of induction of new technologies will be reviewed to enable faster introduction of such technologies in the programme.

Development of simple, reversible, safe and long-acting contraceptive such an Anti-Fertility Vaccine would seem to offer greater potential. Research efforts in developing such a vaccine will receive high priority. At the same time, contraceptive reseach by the Research Councils in the Indian Systems of Medicine will also be expedited.

Management information system

A Management Information System will be developed from the sub-centre level upwards to the national level. This system will have two functions. The first is to generate necessary information at the ground level and beam it upwards through PHCs to the district level and above. This will facilitate monitoring and evaluation of the performance. Secondly, the system will really information, guidance and feedback from higher levels to lower formations. Information collected at each level will be critically analysed in order to identify gaps and enable corrective responses.

Monitoring and Evaluation

A proper Monitoring and Evaluation system must provide for bench-mark data, periodic review, and evaluation of performance with a view to ensuring that the programme is moving on the lines laid down, in the time-frame prescribed and most importantly, produces the results which are sought to be achieved. States have the bench-mark data in terms of birth rates, deaths rates and infant mortality rates. Such data are not available at the district levels. For a proper monitoring and evaluation of the programme, a system will have to be devised to collect such baseline data for the districts. Thereafter, what has to be achieved during the next 4-5 years will have to be targeted.

Various targets for Family Planning and their method-mix will be decided to reach the targeted levels of birth rate, death rate, etc. The specific activities which need to be organised will be spelt out for each district yearwise. When this is done, it would be possible for the programme managers at higher levels to monitor the programme performance to see whether the activities are being performed on time and in the manner desired. This will facilitate mid-term corrections wherever necessary.

A system of concurrent evaluation will be introduced so that the quality of services being provided and the programme impact can be assessed from time to time in a more effective manner. The impact measurement in terms of reduction of fertility and mortalty rates wll be the most mportant index of the evaluation system and a semi-independent mechanism will be set up to continuously monitor the impact of the programme on birth rates and age specific fertility rates. The system should enable computation of the birth rate at any point of time obviating the time lag of waiting for the SRS estimates.

Computerisation

Monitoring and evaluation of the programme will be computerised firstly at the national level and subsequently at district levels. The programme of computerisation will be synchronised with the growth of the computer network NICNET of the National Informatics Centre. Currently, the facilities of the National Informatics Centre are being used to monitor and evaluate the achievements of the States in various programme components, setting of targets, etc. It is proposed to utilise the nation-wide network for linking the National Headquarters with the Regional, State and District Headquarters. Computer will be utilised to monitor the performance of each Block; vacancy positions; establishment of PHCs and Sub-Centres; evaluation of the impact on birth rates and age specific fertility rates. Appropriate software will be developed to measure cost-effectiveness of various schemes under the programme. △

SHIBIR ON FAMILY WELFARE FOR INDUSTRIAL WORKERS IN BARODA

A one-day Shibir on family welfare for industrial workers was organised at Baroda on 29 July, 1986, by the Federation of Gujarat Mills and Industries.

The Shibir aimed at making the family welfare campaign a people's programme, especially for involing labour leaders, industrial management and key personnel of the industries of the industrial complex of Baroda region.

The temporary and permanent methods of family planning, medical termination of pregnancy (MTP), and population explosion were discussed with the help of slides for the industrial workers to clarify their doubts, misconceptions, and apprehensions. The Assistant Professor, Dr Pankaj Desai, Medical Officer, Dr G. N. Patel and Health Education Officer, Shri A. B. Shah addressed the workers. A leading surgeon, Dr C. O. Sura spoke on the simple and safe method of vasectomy as well as recanalisation procedure besides treating of sterility under the family welfare programme.

The children who are born today can lead a longer and healthy life, thanks to the immunization services, said Deputy Health Officer, Dr Dalal and Shri S. C. Parikh from the Municipal Corporation of Baroda. A film show on I.U.D. insertion and M.T.P. was also a part of the campaign. The group of 44 participants included cross section of textile engineers, production officer and technical staff, representatives of labour union, etc. The Shibir would go a long way in spreading the message of small family among the labour population of about five lakhs around Baroda.

A. B. Shah

A. I. D. S.

How To Protect Yourself

A.I.D.S. is a serious disease and so far there is no known cure for it. You can protect yourself from the disease and prevent its spread if facts about it are understood.

What is Aids?

AIDS stands for Acquired Immuno-Deficiency Syndrome. It is caused by a virus that destroys the body's natural defence system.

Not everyone who carries the virus develop AIDS. In fact most will not. But anyone who has the virus can pass it on, even if they feel and look completely well.

How is AIDS spread?

The only likely way for someone to catch the AIDS virus is from the blood or semen from an infected person to get inside his or her body.

Most people get AIDS virus by having sex with an infected person. The rest have it by injecting themselves using needles shared with an infected person as happens commonly among the drug addicts. Only rarely transfusion of blood from an infected person have been responsible for its spread.

You do not get AIDS From

— Normal social contact such as shaking hands, touching and hugging.

— Coughs, sneezes and spitting.

— Swimming pools, restaurants and other public places.

— Clothing.

— Toilet seats, door knobs, food, glasses and cups.

You do not catch AIDS when you

— Donate blood

— Have injections or any other treatment from your doctor, dentist or any other health care worker.

What you should Avoid

— Casual sex with strangers. It is always risky. You may not know that the stranger is an infected person.

— Anal sex. It involves the highest risk and should be avoided.

— The more the sex partners the more is the risk to have sex with an infected person.

— Sharing injection needles.

Remember

AIDS is not a disease to take risk with. There is no cure. AIDS control depends on how people behave.

Fore more information

You may write to the Asstt. Director General (AIDS), Directorate General of Health Services, Nirman Bhavan, New Delhi- 110011

YOU CANNOT CURE AIDS
BUT YOU CAN CERTAINLY
AVOID IT

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