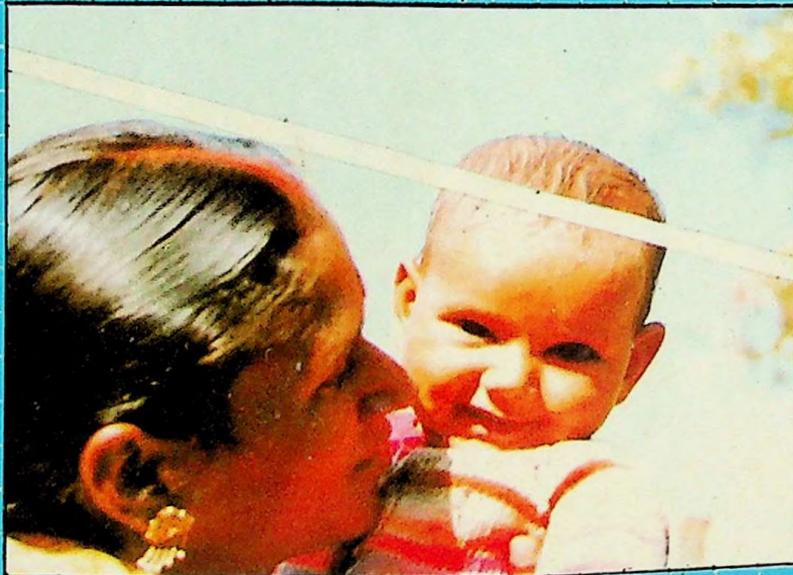


SWASTH HIND

AUGUST 1993

INFANT MORTALITY RATE

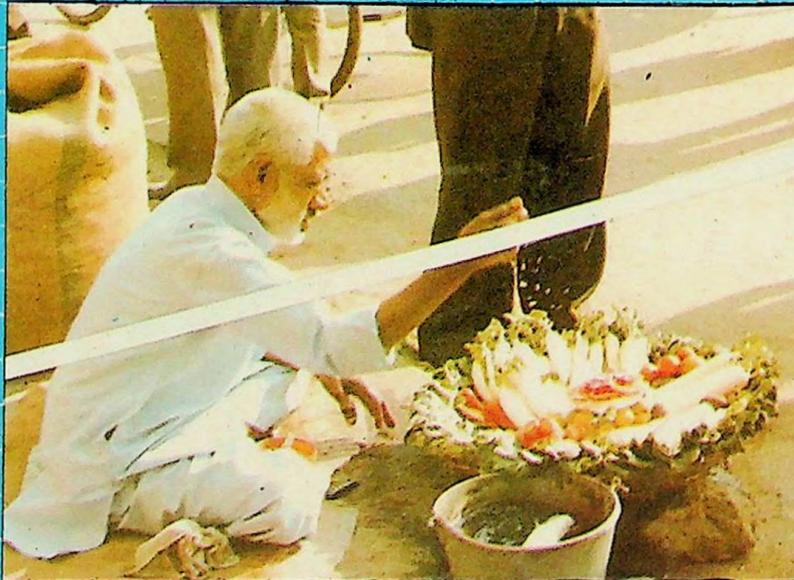
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LIFE EXPECTANCY AT BIRTH

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HEALTH PROGRESS IN INDIA

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August 1993
Vol. XXXVII, No. 8

HEALTH SCENARIO

The health problems are indeed complex and daunting. Thanks to the concerted efforts of the Government of India, the health hazards due to communicable diseases like leprosy, tuberculosis and malaria have been brought under control. But, we have to face the challenge of post-transitional diseases like cardiovascular disease and cancer. To top it all, we have to combat the horrendous implications of AIDS in India.

The country has, however, many achievements to its credit in the field of health. The expectation of life at birth has gone up to 58.6 years from 32.45 years in 1951. The death rate has been reduced from 22.8 per 1000 population during 1951-55 to 9.8. Infant mortality rate has come down from 146 per 1000 live births in 1951 to 80. Smallpox and plague have been eliminated.

With a view to providing health care to the people, a network of comprehensive health services has been provided both in the urban and rural areas.

Keeping this in view SWASTH HIND devotes this issue to:

"HEALTH PROGRESS IN INDIA"

READERS WRITE

I am a regular reader of your journal—*Swasth Hind*. It has been very much informative and useful for me.

—Dr. Arun Kumar Singh
S/o Dr. S.D.S. 'PRABHAKAR',
Reshamkothi-7
Birganj; Nepal

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Editorial and Business Offices

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

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

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Bid To Eliminate Leprosy And Control TB & Malaria

R. L. MISRA
Secretary (Health)
Ministry of Health & Family Welfare

The importance of the state of health on our people can scarcely be over-emphasised. The ultimate objective of all socio-economic development is to bring about a meaningful and sustained improvement in the well-being and welfare of our people; and there is no better index of the well-being of a people than the state of their health.

THE health problems being faced by us are highly complex and challenging. While we are still struggling to meet the health hazards of communicable diseases like leprosy, TB and malaria, we also have to now cope with the challenge of post transitional diseases like cardiovascular and cancer. On top of all these, we have to reckon with the horrendous implications of AIDS and in the timely preventive steps to avoid the Catastrophe that has overtaken some of the African Countries. Hence, the need for urgent, concerted, planned and sustained action to avert the potential danger of AIDS. As if all these were not enough, the complexity of the health problems is aggravated by wide-spread poverty leading to malnutrition, unhygienic sanitation, illiteracy and ignorance: these negative forces are reinforced by the rate at which our large population is growing.

While the health problems are indeed complex and daunting, the importance of the state of health of our people can scarcely be over-emphasised. As a matter of fact, the ultimate objective of all socio-economic development is to bring about a meaningful and sustained improvement in the well-being and welfare of our people: and, there is no better index of the well-being of a people than the state of their health.

Financial step-up

While investment—both public and private—in power generation, industry, agriculture and education etc. would finally impact on health, the importance of direct investment in the health sector to improve the health status of the people and the contribution of a healthy population to socio-economic development is too obvious to need any elaboration. However, somehow, the share of health sector in the total

public outlay has not been commensurate with the challenges facing the country. We need to ensure a quantum jump in the allocation of Plan resources for the health sector in order to have the wherewithal of meaningfully meeting the formidable tasks before us. Fortunately, this need has been satisfied to a very large extent during the year 1992-93. As against the Plan outlay of Rs. 302 crore for the central health sector in 1991-92, the amount for 1992-93 is Rs. 447 crore—a step up of almost 50%. As the process of planning essentially implies incremental investment from year to year, it can be reasonably hoped that the plan outlay for 1993-94 and the years following it would use the previous year's outlay as the base for determining the amount of annual step up.

External assistance

The contribution of external assistance in this process is

noteworthy. The World Bank has agreed, in principle, to provide assistance from its soft loan affiliate,—the International Development Association—of the order of about S 100 million per year through the 8th Plan period. The National AIDS Control Project, involving an investment of Rs. 225 crore, has already been launched with IDA Credit of S 84 million. IDA Credits of about S 100 million and 150 million is expected to be available during 1993-94 for the leprosy control and blindness control programme respectively, as these projects have been appraised/pre-appraised in January 1993. The World Bank has also positively responded to our concept papers on tuberculosis and tribal malaria control programmes and substantial IDA Credits for these are expected to be tied up during 1994-95. With the completion of these externally aided projects by the year 2000 A.D., it could be reasonably hoped that we would eliminate communicable diseases like leprosy or bring diseases like TB and malaria under control: the quality of life and productivity of our elderly citizens would also vastly improve as the focus of the blindness control project is on taking full care to prevent cataract induced blindness. The reduction of morbidity and mortality thus brought about would enable us to have a healthier population, which, in turn, would contribute in accelerating the process of development and would not be a drag on it. It would also free the resources for squarely meeting the challenges posed by non-communicable diseases and reinforce measures to prevent the danger of AIDS.

National Health Policy

Health, in our scheme of things, is a State subject. While the

States have been fully consulted in the new initiatives taken by us in the health sector, as the implementation of the revamped and expanded communicable disease programmes, etc., would have to be done by them, it is hoped that the States too would step up their plan allocations for meeting the health needs of their people and also gear up their health machinery for effectively delivering the programmes. The States have also been fully involved in the comprehensive review, that has been initiated, of the National Health Policy 1983 in order to redefine and re-design it to meet the quantitative and qualitative challenges, like the change in the epidemiological pattern following the change in the demographic profile, that have taken place during the decade since it was adopted.

Medical education/quality drugs and food

As medical education and quality assurance of drugs and food are Concurrent subjects under our Constitution, the Centre has taken appropriate measures in these areas in view of its role as a coordinator and catalyst. Ordinances were promulgated during the year under report to prevent the mushroom growth of medical and dental colleges in order to ensure that the standards of medical and dental education are not allowed to be compromised: henceforth, prior approval of the Medical and Dental Councils of India would be required before a new medical/dental college can be set up. These ordinances would be replaced by appropriate Acts in due course. Similarly, in order to ensure the quality of blood and blood products, vaccines, sera and I.V. fluids, the Drugs & Cosmetics Rules have been amended to

provide concurrent jurisdiction of the Drug Controller of India over licensing the establishment of concerned manufacturing facilities. Further, measures have been taken to both strengthening the Central Drugs Standard Control Organisation by augmenting its staff and testing facilities. Centrally sponsored schemes for strengthening the State testing laboratories have been operated to improve the capability of the States to assure better quality of drugs and food. Another centrally sponsored scheme for augmenting the state enforcement machinery is also being finalised. The States, who have a primary role in this behalf, have been urged to take suitable action to strengthen their enforcement machinery and establish/augment testing facilities, as that would go a long way in assuring the supply of quality drug and food to our people.

High priority to ISM

The promotion of the Indian System of Medicine—Ayurveda, Unani & Siddha—and Homoeopathy continued to get high priority: the Plan allocation for ISM and Homoeopathy has been stepped up and attention is being paid to standardise and improve the standard of education and research in these areas through their respective Councils.

Mental health

Mental health of the people is no less important than their physical health. Accordingly, the Indian Lunacy Act 1912 has since been replaced by the Mental Health Act of 1987, which recognises the crucial role of treatment and care of mentally ill persons: the new Act would come into force on 1-4-1993. □

—Excerpts from the Introduction to the Annual Report of the Ministry of Health & Family Welfare for 1992-93.

SWASTH HIND

NATIONAL HEALTH PROGRAMMES

The Centre takes concerted measures to combat communicable, non-communicable and other major diseases. For this purpose, several national health programmes are directly run by the Ministry which can have a bearing in the reduction of mortality and morbidity and also have a salutary effect on efforts to improve the quality of life of the common man. These programmes also reinforce the delivery of primary, secondary and tertiary health care throughout the country.

National Malaria Eradication Programme

THERE has been decline in malaria incidence by 67.4% (in 1991) as compared to malaria incidence in 1976. However, when compared with malaria incidence of 1990, there is slight increase of 4.6% in total malaria cases and 8.3% in p.f. cases in

1991. Moreover, as compared to malaria incidence of 1991 with 1992 (upto August) there is decrease of about 20% in total malaria cases and about 29% in p.f. cases.

Mortality due to Malaria: During 1991 (Prov.), 421 deaths were reported from various States as compared to 353 deaths during

1990. During 1992 (upto August), 81 deaths have been reported from the States so far.

Spray Operations: The insecticidal spray is done in areas registering 2 API and above in the past 3 years. During 1991-92, 172.32 million population was targeted for spray with different insecticides.

Insecticide	Target	State Target	Average Population covered (Pop. in mill.)	% Coverage
DDT	115.75	116.23	81.03	
BHC	41.44	45.17	32.69	70.10
MALATHION	15.13	8.54	7.08	
TOTAL*	172.32	169.94	120.80	70.10

*Figures are provisional.

Population (in million) projected for spray for 1992 is as follows:

DDT	118.06
BHC	42.29
MALATHION	15.42
TOTAL	175.77 million

Budget: The NMEP is a category II centrally sponsored scheme on 50:50 fund sharing basis between the States and Centre. The budget provision and estimated expenditure under 50% Central share is as follows:

Year	Budget Provisions	Actual/Estimated Expenditure
1985-86	8868.00	8856.91
1986-87	8500.00	7815.14
1987-88	8200.00	8456.98
1988-89	8300.00	8750.00
1989-90	8900.00	8862.17
1990-91	8200.00	7660.45
1991-92	8960.00 (Final)	8793.04
1992-93	9700.00	—

Current Strategy: It is proposed to intensify the efforts for the full containment of the disease to acceptable levels. Accordingly, major focus is being given to insecticidal spraying for vector control in areas having more than 2/1000 cases reported and early case detection and treatment. In the remaining areas, focal spraying and effective case surveillance is being taken up. These efforts are being appropriately dovetailed with training of workers and enthusing community participation, alongside decentralisation of drug distribution and fever treatment, etc.

Proposed Strategy for the Future: With a view to bring down the incidence of malaria in the country, it is now under consideration to revise the approaches adopted earlier. The new strategy consists of an attempt to (i) categorise the malarious areas into high, moderate and low for a more focussed, need-based, cost-effective and rational implementation of anti-malarial measures (this approach of malariogenic stratification is being attempted in the States of Maharashtra, Karnataka, Gujarat, Rajasthan, Andhra Pradesh and Madhya Pradesh); (ii) focussed attention to the tribal areas of all 14 States (while tribals constitute 8% of total malaria cases and over 60% of the *P. falciparum* cases in the country); and (iii) urban malaria

which is indicating a very high trend in the levels of incidence.

Proposed Project for World Bank Assistance: It is proposed to formulate a project proposal for malaria control in the tribal areas of the 7 States of Andhra Pradesh, Madhya Pradesh, Bihar, Gujarat, Maharashtra, Orissa and Rajasthan. These areas are high endemic zones accounting for the maximum incidence of *P. falciparum* cases in the country. The focus of attention would be not only the application of different approaches—preventive as well as curative but also to strengthen the health delivery system in a manner that would help achieve the objectives.

Urban Malaria Scheme: The Urban Malaria Scheme (UMS) came into effect in 1971. The main objective of the Scheme is to control malaria by reducing the vector population in the Urban Areas through recurrent anti-larval measures. The Ministry has sanctioned the Scheme in 181 towns distributed in 18 States and 2 Union Territories, but the State Governments have implemented the Scheme in 128 towns till now. The States of Karnataka, Orissa, West Bengal and Rajasthan have not implemented the Scheme in 6 towns. The malaria cases recor-

ded in 1991 in 121 towns were 211,870.

(i) It is observed that 121 out of 128 towns from where comparable data was available, showed an increase in malaria cases during 1991 as against 1990. Ahmedabad, Madras and Delhi, etc., recorded an upward trend, but Hyderabad and Bombay showed a downward trend in comparison with corresponding period of 1990.

(ii) Madras, Delhi and Bombay recorded 66,937, 8,491 and 5,335 cases of malaria respectively during 1991.

Kala-azar

Kala-azar has become a serious Public Health Problem in Bihar and West Bengal. After its resurgence in Bihar in early 70s, the disease spread from 4 districts to adjoining areas and now 30 districts in Bihar and 9 districts in West Bengal are affected by Kala-azar. As is evident, the problem has assumed serious dimensions in Bihar, where there has been a steep rise in reported incidence which itself is not an actual magnitude of the problem because some cases go to private practitioners and remain unreported. The disease is on increasing trend and the incidence for the last 5 years is given below:

KALA-AZAR INCIDENCE:

YEAR	BIHAR		WEST BENGAL		TOTAL COUNTRY	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
1986	14079	47	3718	25	17806	72
1987	19179	77	4447	10*	23685	94
1988	19639	123	3068	2*	22739	131
1989	30903	477	3573	20	34489	497
1990	54650	589	3037	16	57742	606
1991	59614	834	2030	+3	61670	838
1992	66959	1266	1212	1	68175	1267

(Prov. upto October)

In view of the rising problem, organised control measures were initiated. Until 1990-91, the assistance for Kala-azar control was being provided by Government of India out of NMEP budget provision. However, specific funds were made available during 1990-91 wherein Rs. 4.06 crore was provided in the final estimates for Kala-azar control in the States of Bihar and West Bengal.

Strategy

The strategy for Kala-azar control broadly includes 3 major activities:

- (i) Interruption of transmission for reducing vector population by undertaking indoor residual insecticidal spray twice annually,
- (ii) Early diagnosis and complete treatment of Kala-azar cases, and
- (iii) Health education for community awareness in involvement.

District action plan development

In view of the financial constraints in implementation of an effective control strategy, the Government of India decided to provide total cost of medicines and insecticides for Kala-azar control in Bihar. An Expert Committee was constituted under the Chairmanship of Director General of Health Services, to finalise the estimated requirements.

To ensure optimum utilisation of available limited resources, a concept of district action plan development has been suggested to the State. The State Government have agreed to deploy exclusive infrastructure for Kala-azar activities and adequate material and equipment with strict supervision, monitoring and concurrent and

consecutive evaluation. The concept of making different functionaries at various levels responsible and accountable for Kala-azar control activities is to provide a good impact with consequent reduction in incidence.

Government of India is providing insecticides and imported anti Kala-azar drug *i.e.*, pentamidine isothionate to West Bengal.

Actions taken by the Government of India during last two years: Assistance provided to Government of Bihar: Assistance in terms of cash as well as kind has been provided during the last two years as below:

Year	(Rs. in lakh)		
	Cash	Kind	Total
1990-91	—	389.49	389.49
1991-92	102.27	1423.72	1535.99

A budget provision of Rs. 1500.00 lakh has been made to provide material assistance for Kala-azar control. However, in view of the seriousness of the problem, commitment of the Government of India and to ensure availability of material for effective control, a Revised Estimate for Rs. 2376.55 lakh has been proposed to meet the cost of insecticides and anti Kala-azar drugs.

In addition, UNICEF assistance of Rs. 15.55 lakh has been provided (1990-91) at the disposal of State Government for public information, education, communication activities and orientation training of medical profession. UNICEF is providing assistance on continuing basis directly to the State Government of Bihar.

Material assistance included the insecticide DDT and the imported drug pentamidine

isothionate year-wise quantitative supplies are given below:

Year	DDT	Pentamidine	S.S.G.
1991-92	4000 MT	35000 Vials	224581 Vials
1992-93	2083 MT	45000 Vials	264304 Vials
Upto December, 1992			

National Filaria Control Programme

Filariasis is a major Public Health Problem in India. Whenever the disease becomes chronic, it is irreversible. The disease has been prevalent throughout India except Jammu & Kashmir, Punjab, Himachal Pradesh, Mizoram, Meghalaya, Tripura, Manipur, Rajasthan, Arunachal Pradesh, Delhi, Chandigarh, Haryana, Sikkim and Nagaland. Present estimate indicates that about 389 million people are living in 175 known endemic districts of which about 103 million are living in Urban Areas and the rest in Rural Areas.

Under the Programme, the following activities are being undertaken :

- (i) Delimitation of the problem in hitherto unsurveyed areas;
- (ii) Control in Urban Areas through:
 - (a) Recurrent anti-larval measures.
 - (b) Antiparasitic measures.

Present Set up: The following is the present set up of endemic States/Union Territories :

Control Units	—	206
Survey Units	—	27
Clinics	—	195

Progress : At present, about 43.43 million people in Urban Areas are being protected through anti-larval measures by 206 control units and 195 clinics are giving treatment with Diethylcarbamazine to clini-

cal cases and microfilaria carriers.

Achievements : It is observed that 73 per cent of the towns in microfilaria rate and 69 per cent of towns in disease rates, where con-

trol measures are in operation for more than five years, have shown marked reduction.

Budget and Expenditure during 1985-86 to 1991-92 are given in the Table below :

BUDGET AND EXPENDITURE IN NATIONAL FILARIA CONTROL PROGRAMME

(Rs. in Lakh)

Year	Budget			Expenditure		
	Cash	Kind	Total	Cash	Kind	Total
1	2	3	4	5	6	7
1985-86	40.00	92.00	132.00	40.00	100.55	140.55
1986-87	50.00	100.00	150.00	36.89	113.11	150.00
1987-88	49.57	100.43	150.00	73.93	76.07	150.00
1988-89	54.72	145.28	200.00	64.26	135.74	200.00
1989-90	64.00	154.00	218.00	69.87	116.11	195.98
1990-91	83.00	146.00	229.00	83.00	146.00	229.00
1991-92	48.00	96.00	144.06	21.00	4.30	25.30

National Leprosy Eradication Programme

Out of the 10 million cases of leprosy in the world, 2.5 million are estimated to be found in India. The disease is widely spread all over the country. The prevalence rate of leprosy exists above 5 per 1000 population in 201 districts out of 468 districts of the country. About 15% of the leprosy sufferers are children below 14 years of age. The proportion of infectious cases varies from 15 to 20% and equal number of patients suffer from deformities. At the time of launching of the National Leprosy Eradication Programme in 1983, the disease was highly prevalent in the States/UTs of Tamil Nadu, Andhra Pradesh, Lakshadweep, Pondicherry, West Bengal, Maharashtra, Karnataka, Bihar, Nagaland, Sikkim and Andaman & Nicobar Islands. By now the incidence of leprosy has registered a decline in many of these States.

Programme Objectives : The Government of India launched the

National Leprosy Eradication Programme in 1983 with the objective of arresting the transmission of the disease by 2000 A.D. It is a 100% Centrally-sponsored programme.

Strategies : The strategy adopted under the programme involves : (a) provision of domiciliary multi-drug treatment coverage in 135 districts having problems of 5 or more cases per 1000 population, by specially trained staff in leprosy; (b) Introduction of modified MDT scheme in the remaining 66 endemic districts through existing health care staff; (c) Introduction of MDT services through existing general health care services in the low endemic districts; (d) Multi-drug therapy to Dapsone refractory cases in other districts. Treatment with combination of drugs include treatment with 3 drugs viz., Rifampicin, Clofazimine and Dapsone. Education of the patients and the community about the curability of the disease and their socio-economic rehabilitation are other two key components of the control strategy.

Infrastructure : Over the years, a vast infrastructure of leprosy workers has been developed in the country, specially trained for providing leprosy services. In the endemic rural areas, these services fan out from Leprosy Control Units (one for 0.4 to 0.5 million population) while its urban counterpart called Urban Leprosy Centre caters to a population of about 30 to 40 thousand. Temporary hospitalization ward having 20 bed capacity has been established at least one in each endemic district to render hospitalization services. Under the programme, 49 Leprosy Training Centres are engaged in providing training to various categories of health workers in leprosy. Following infrastructure exists at the end of March, 1992. Leprosy Control Units-758; Urban Leprosy Centres-900; Survey Education and Treatment Centres-6097; Temporary Hospitalization Wards-291; District Leprosy Units-285; Leprosy Training Centres-49; Reconstructive Surgery Units-75; Leprosy

Rehabilitation & Promotion Units-13; and Sample Survey cum Assessment Units-39.

Infrastructure thus created has been predominantly established by the States in the endemic districts. In districts with endemicity of less than 5/1000 population, the general health care staff provide the services. However, there are still gaps in the 66 endemic districts due to financial constraints. To extend the benefit of MDT to over 7 million patients living in these 66 districts, Government of India sanctioned a modified MDT approach from January, 1991. This modified approach includes the involvement of PHC in the delivery of services to leprosy patients.

Achievements: Currently, about 70% of leprosy patients are getting the benefit of multi-drug therapy in the country. Available information indicates that MDT is well accepted by the patients, the tolerance is good and side-effects

are minimum. There is marked reduction of over 90% in the prevalence rate in the 40 districts which have completed MDT of 5 years or more. 6.39 million cases have been discharged as cured by March, 1992.

Targets and Achievements in 1991-92: During the year 1991-92 against the target of 335200 for new case detection and treatment, a total of 508390 new cases have been detected out of which 500242 cases have been put under treatment.

(i) The target for case discharge was 612500 during 1991-92 against which 816538 cases have been discharged.

(ii) The physical target allocated for 1992-93 consists of 289600 cases for detection and treatment and 573900 for case discharge. The budget estimate for 1991-92 was Rs. 2280 lakh and for 1992-93 also same amount has been allocated.

8th Plan: During 8th Plan, it is proposed to provide MDT coverage to all the districts with endemicity of 2 or more per 1000 population

and MDT service will also be extended through primary health care in other districts.

World Bank Assistance: To spread the MDT coverage to uncovered areas and to further intensify the efforts, the Government have sent a comprehensive proposal to World Bank for financial assistance of Rs. 300.00 crore. In the proposed World Bank Project, it is envisaged to provide the leprosy services with separate workers in the 66 endemic districts currently under the Modified MDT Programme, and additional 77 districts would be taken up for introducing the Modified MDT Programme. The monitoring information would be strengthened and a foundation laid to embark on a rehabilitation programme.

Leprosy Scenario: It must, however, be realized that even after the achievement of the goal of disease eradication, the daunting task of promoting the social acceptance of the treated cases and their economic rehabilitation would remain to be accomplished.

PLAN WISE EXPENDITURE INCURRED UNDER THE PROGRAMME

Budget	(Rs. in lakh)	
Period	Expenditure	Pattern of Assistance
1st Plan (1955-56)	35.00	Centrally Aided
2nd Plan (1956-61)	529.00	-do-
3rd Plan (1961-66)	425.00	-do-
Annual Plan (1966-69)	63.00	-do-
4th Plan (1969-74)	286.00	100%
5th Plan (1974-79)	2023.00	50 : 50
Annual Plan (1979-80)	232.00	50 : 50
6th Plan (1980-85)	4004.43	100%
7th Plan (1985-90)	8582.00	100%
8th Plan (1990-91)	2225.54	100%
(1991-92)	2208.14	100%
(1992-93)	2280.00	100%
	B.E.	

National Tuberculosis Control Programme

Tuberculosis is a major public health problem in India. Nearly 1.5% of the total population is estimated to be suffering from radiologically active tuberculosis disease of the lungs of which about 1/4th or 0.4% are sputum positive or infectious.

Out of about 440 districts in the country, upto the end of September, 1992, 388 districts have been provided with District T.B. Centres equipped with essential equipments and manned by trained staff for undertaking District-wise T.B. Programme in association with general health and medical institutions. In addition, there are about 330 T.B. Clinics functioning in the country which are mostly located in big towns and cities to look after the needs of the local population.

About 47,000 beds are available in the country for treatment of seriously sick T.B. patients. T.B. Training and Demonstration Centres have been established in the major States of the country to undertake the basic training of the medical and para-medical personnel required for the programme.

Anti-TB drugs for free treatment of T.B. patients are being supplied to the T.B. clinics run by the State Government as a Centrally-Sponsored Scheme on 50:50 sharing basis between the Centre and the States. The scheme of supply of anti T.B. drugs to the T.B. clinics run by voluntary bodies and schemes of supply of material and equipments and anti-T.B. drugs to Union Territories, however, continue as 100% Centrally Sponsored Scheme, Swedish International Development Agency (SIDA) continues to assist the National T.B. Control Programme as per the

agreement entered into by the Government of India with SIDA authorities. The SIDA authorities agreed to supply X-ray Units with Odelca Cameras, miniature X-ray film rolls, vehicles and limited quantities of anti-TB drugs for short course Chemotherapy pilot study and microscopes to the needy rural PHCs to augment the case finding activities in the rural areas.

New Strategy

As part of new strategy in the treatment regimens under National Tuberculosis Control Programme, short course Chemotherapy drug regimens containing Rifampicin and Pyrazinamide have been introduced in 253 districts of the country so far. More districts are expected to be brought under these regimens in a phased manner in the ensuing years. These regimens will reduce the duration of treatment of the tuberculosis patients from 18 to 24 months to 6 to 8 months.

As a result of high priority given by the Government to the National Tuberculosis Control Programme, the essential activities under the programme have been considerably expanded increasing from year to year. As against detection of about 10.81 lakh new T.B. cases during 1982-83, about 12 lakh new T.B. cases were detected during 1991-92. Further, to expand the T.B. case detection among the rural populace and to involve the Primary Health Centres in T.B. case finding activities, targets were also laid for conducting 50 sputum examinations per month at each of the Primary Health Centres for the first time during 1983-84 and nearly 12.12 lakh sputum examinations were conducted. There is a significant improvement of this activity and during 1991-92 about 20.00 lakh

sputum examinations were conducted in the Primary Health Centres.

Targets

The targets for 1992-93 in respect of new T.B. case detection is 17.50 lakh and about 39.96 lakh in respect of sputum examination of new chest symptomatics at the Primary Health Centres. During the period from April, 92 to July, 1992 about 3.96 lakh new T. B. cases (provisional) have been detected by the States and Union Territories and nearly 5.83 lakh (provisional) sputum examinations were conducted at the Primary Health Centres.

BCG Vaccine Laboratory, Guindy

The Ministry of Health and Family Welfare set the target for supply of BCG Vaccine for 1992-93 at 470.00 lakh doses to meet the requirements of Universal Immunisation Programme in India. Out of this, the production target for BCG Vaccine laboratory is 250 lakh doses. Upto the end of September, 1992, a total of 156.48 lakh doses have been produced by this laboratory. Till date 344.30 lakh doses were supplied which includes imported vaccine as well.

The biologicals produced and supplied during the period April, 1992 to September, 1992 are as under:

	Production	Supply
F.D. BCG Vaccine (20 doses per amp.)	156.48 lakh doses	344.30 lakh doses
Tuberculin PPD RT-23-ITV (100 doses per vial)	7741 Vials	7457 Vials
2 TV	191 Vials	190 Vials

Future Plan of Action : The expansion of the BCG Vaccine Laboratory was included in the Seventh Five Year Plan with an outlay of Rs. 1 crore which excludes the imported machinery costing about Rs. 2 crore procured through the UNICEF. The machines have been received and except the Industrial Type Freeze, Industrial Drier and Type Dessicator, all the others were installed, which has increased the installed capacity from 240 lakh doses to 400 lakh doses. After complete installation of all the machines, the installed capacity will be 500 lakh doses.

Construction for setting up of the 3rd Unit to achieve self-sufficiency in production of BCG Vaccine has also been undertaken.

National Programme for Control of Blindness

National Programme for Control of Blindness (NPCB) was launched in 1975-76 which incorporates the earlier Trachoma Control Programme started in 1963. This is a 100% centrally sponsored scheme. The approach under the NPCB, consists of intensive health educa-

tion for eye care through the mass media and extension education methods; extension of ophthalmic services in the rural areas through mobile units and eye camps and establishment of permanent infrastructure for eye-health care as an integral part of general health services. Since 1981-82, cataract operations have been accorded high priority in the programme and targets for different States/UTs have been set. The targets and achievements in respect of performance of cataract operations under the programme are as under:

TARGETS & ACHIEVEMENTS FOR CATARACT OPERATIONS

Year	Target	Achievement	%age of Achievement
1990-91	12.86 lakh	11.90 lakh	92.53
1991-92	19.90 lakh	14.62 lakh	73.47
1992-93	20.00 lakh	2.74 lakh (provisional)	13.74

The preliminary findings of the All India Survey (1986-89) on evaluation of blindness activities in India have indicated that the total magnitude of blindness has not decreased significantly and the cataract is now responsible for 81% of the blindness. In view of these findings, it is envisaged to gradually increase the number of Intraocular cataract operations. Besides the strategy of augmenting various eye care services at peripheral, intermediate and Central levels alongwith the camp approach for cataract surgery to continue in 1992-93 under the NPCB. The targets for various activities for 1992-93 are as follows:

1. Cataract Operations	20 lakh
2. Strengthening of PHCs	600
3. Establishment of Distt. M. Units	90
4. Strengthening of Eye Banks (in Voluntary Sector)	5
5. Development of Distt. Hospitals	10
6. Upgradation of Medical Colleges	4

7. Replacement/Repair/Maintenance of Equipment in CMUs 20
8. Additional Inputs to Districts 100
9. Replacement of Vehicles at CMUs 40

Financial Allocations :

1990-91	5.88 crore
1991-92	12.80 crore
1992-93	20.00 crore

Allocation VIII Plan 120.00 crore

As regarding Foreign Aid assistance an agreement between the Govt. of India and the Govt. of Denmark was signed in October, 1989 and accordingly, DANIDA is providing an assistance of Rs. 22.25 crore over a period of 5 years (1989-94) under Phase-II for the Control of Blindness. These funds are to be released in a phased manner depending upon the actual expenditure incurred by the various State Governments under this Project.

Voluntary organisations play a very significant role in NPCB. They are active in the field of educative, preventive, rehabilitative and surgical services for control of blindness.

One of the recent concept in the field of prevention of blindness is the formation of District Blindness Control Societies. All States/UTs have been asked to establish these Societies which would be registered under Societies Registration Act XXI of 1860. These Societies will function under the Deputy Commissioner/District Magistrate of the District for implementation of NPCB by involving the voluntary organisation of the area and raising funds from local sources. The District Ophthalmic Surgeon is the Member-Secretary of the Society. So far 159 such societies are formed and have started functioning.

National Iodine Deficiency Disorders Control Programme

Iodine is one of the essential elements for normal human growth and development. Its daily per capita requirement is 150 micrograms. Deficiency of Iodine in the daily diet may result in the development of goitre and other iodine deficiency disorders (IDD) including mental and physical retardation and endemic cretinism. Iodine deficiency disorders constitute a major public health problem in India. There is an increasing evidence of widespread distribution of environmental Iodine deficiency not only in the

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Himalayan regions but also in the Sub-Himalayan Tarai areas (especially those subjected to recurrent flooding), riverine areas and even the coastal regions.

Surveys conducted have revealed high prevalence of endemic goitre in different States. Results of sample surveys conducted in 216 districts of 25 States and 4 UTs have identified 186 districts as endemic for IDD. Survey results also indicate that manifestations are not only limited to endemic goitre and cretinism, but include a wide spectrum of disability including deaf-mutism, mental retardation and various degrees of neuro-motor dysfunction.

In India, as of now, it is estimated that nearly 167 million persons are exposed to the risk of IDD of which 54 million are having goitre, 2.2 million are cretins and 6.6 million have mild neurological disorders. It is estimated that with every passing hour, 10 children are being born in this country who will not attain their optimum mental and physical potential due to neonatal hypothyroidism caused by iodine deficiency. With continuous depletion of iodine from natural resources, the situation is expected to worsen in the coming years unless measures are taken to control the situation.

Realising the magnitude of the problem, Govt. of India launched a 100% Centrally Sponsored National Goitre Control Programme (NGCP) in 1962 with focus on provision of iodised salt to identified endemic areas. For effective control of IDD, on the recommendations of the Central Council of Health (1984), the Govt. of India, in 1985, took a decision of Universal Iodisation of edible salt by 1992. The scheme started from April, 1986 in a phased manner. To meet the requirement of iodised salt, the annual production of iodised salt was targeted from the existing 5 lakh M.T. in 1985 to 50.00 lakh M.T. per year by 1992.

Achievements: The achievements made under the programme from its inception to date are as under:

- (i) To promote the production of iodated salt, 592 private

manufacturers have been licensed by the Salt Commissioner, out of which nearly 441 units have commenced production so far;

- (ii) Annual production of iodised salt has been raised from 5.0 lakh M.T. in 1985-86 to 26.0 lakh M.T. in 1991-92. This is expected to be further raised to 30.00 lakh M.T. in 1992-93;
- (iii) To emphasise the importance of all the IDDs including Goitre, the nomenclature of National Goitre Control Programme has been redesignated to National Iodine Deficiency Disorders Control Programme (NIDDCP);
- (iv) To ensure availability of the required quantity of iodine to the consumers, iodine content of iodated salt has been fixed under the PFA Rules at not less than 30 and 15 PPM at the manufacturing and consumer levels respectively;
- (v) In order to ensure use of only iodated salt, all the States/UTs have been advised to issue notification banning the sale of salt other than iodated salt for edible purposes under PFA Act. So far, 22 States/UTs have completely banned the same while another 5 States have banned in the endemic areas;
- (vi) For ensuring quality control at consumption levels, testing kits for on the spot quantitative testing have been developed in collaboration with UNICEF and they are being distributed to the District Health Officers in Endemic States for regular monitoring;
- (vii) For effective implementation of NIDDCP, all the States/UTs have been advised to set up IDD Control Cells in their respective State Health Directorates

for which cash assistance is being provided by the Ministry of Health. Till date, 22 States/UTs have set up IDD Control Cells;

- (viii) To speed up the survey work, an additional grant of Rs. 10,000/- per district is being given to States and UTs whenever a request is received from them.
- (ix) Training programmes have been carried out by the Central Goitre Survey Team for the States of Karnataka and Uttar Pradesh (one district each); and
- (x) During the current financial year, initial goitre surveys have been carried out in the State of Karnataka, and survey work will be completed by March, 1993 in Uttar Pradesh, Gujarat and Kerala as intimated by respective State Governments.

Intensive monitoring

Although the programme is in operation since 1962 with considerable achievements, yet optimal results have not been achieved. As a result, India today continues to have a high incidence of goitre cases, *i.e.*, 54 million as compared to 200 million globally. To intensify Iodine Deficiency Disorders Control Programme, a project has been finalised with UNICEF assistance amounting to Rs. 1.20 crore for intensive IDD monitoring in 4 States (5 districts each) namely Uttar Pradesh, Himachal Pradesh, Madhya Pradesh and Assam during 1992. **The project objectives are to reduce goitre prevalence in the age group 10-14 years to less than 5% and a fall to zero in number of cretins born by 2000 in the selected districts of the States.**

Proposal of IDDCP-Project, 1993-95 for UNICEF assistance to the tune of Rs. 8.835 crore is being finalised. Under this Project, apart from 4 States already covered under the on-going 1992 Project, additional States of Sikkim, Arunachal Pradesh, Mizoram and

Northern districts of West Bengal are proposed to be covered. The strategy to be adopted to achieve the declared goals and objectives would be :

- (i) Launching of intensive IDD programme integrated within the existing salt production and distribution system to ensure that the selected districts will be supplied only iodated salt;
- (ii) Establishment of a monitoring system with the involvement of the salt producers, wholesalers, retailers, frontline workers, as well as consumers, to ensure that the iodine content of iodated salt is assessed at the levels of production, distribution as well as consumption level. Use of low cost iodated salt testing kits will be promoted at every level from manufacturing to consumption level. In addition, a network of Iodine Monitoring Laboratories will be established at salt production centres and at the nodal consumer points within each State. For the effective implementation and monitoring of the programme, the Central and State IDD Cells will be strengthened and suitable training centres will be established; and
- (iii) A multi-sectoral social communication strategy will be developed at the field level with the involvement of ICDS, DWCRA and education sectors. The district communication plan will be implemented to create positive consumer demand and change consumer behaviour with the objective of ensuring consumption of iodated salt by the total population.

National Sexually Transmitted Disease Control Programme (STD)

STD was introduced as a National Control Programme during

the Second Five Year Plan by the Government of India. The Programme was then primarily a centrally aided scheme concerned mainly with : (i) establishing STD Clinics throughout the country; (ii) supply of drugs to the earlier existing and newly established clinics; and (iii) conducting training courses for the inservice medical and para-medical personnel.

The scheme was, however, converted into a Centrally sponsored scheme during the Fourth Five Year Plan and the Central Government assistance was limited to (i) giving grant-in-aid to States for establishing new STD clinics and (ii) supplying drugs (Benzathine, Penicillin) to the STD clinics for the inservice medical and para-medical personnel.

Recognising STD as one of the major factors for transmission of HIV infection, the Programme has been merged with the AIDS Control Programme. The existing components of the programme viz. Teaching, Training, Research and Epidemiology, however, has been retained outside the World Bank assisted activities of the National AIDS Control Programme.

Under the National STD Control Programme following achievements have been made :

- (i) As on December, 1992 the Regional STD Centres have trained as many as 86 medical officers and 92 para-medical personnel like Laboratory Technicians, Nurses, Health Educators, Social Workers, etc.
- (ii) About 56 medical colleges-hospital laboratories/-public health laboratories are participating in the inter-laboratory evaluation programme of VDRL tests being conducted by the Central STD Reference Laboratory, Madras and Hyderabad;

It is proposed to launch a crash programme for the training of Medical Officers working in Primary Health Centres in Tamil

Nadu, Andhra Pradesh, Maharashtra, West Bengal and Delhi at the 5 Regional STD Training Centres; and

STD Planning Workshops for the State Programme Officers of STD, AIDS and Epidemiologists of various States shall be held at Delhi and Madras during the current financial year.

Blood Safety Programme

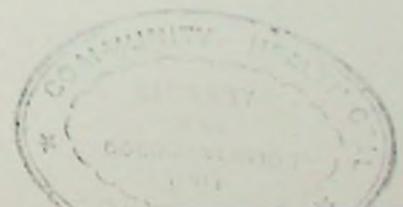
A scheme on prevention of infection and strengthening of blood banking system in the country is being implemented since 1989 under which State Governments are provided assistance for establishment of testing facilities including HIV in the blood banks, strengthening and modernisation of Government managed blood banks, development of manpower and rational use of blood.

During 1992, a programme for the prevention and control of AIDS has been launched with World Bank assistance. One of the major components of this programme is "Blood Safety."

Modernisation of Blood Banks: Under this programme, it is proposed to upgrade all the 608 Government managed blood banks in the country with provision of equipments and recurring assistance for consumables in a phased manner. Upto March 1992, 138 blood banks were upgraded. During 1992-93, 90 more blood banks will be modernised under the World Bank assisted National AIDS Control Programme. The remaining 380 blood banks will be taken up for upgradation in a phased manner under the National Budget. During 1992-93, 88 blood banks will be taken up for upgradation.

Development of Man-power: The ten training institutes operationalised for training doctors and technicians are continuing their training programme. Institutional facilities have already been upgraded for training. 110 doctors/technicians have been imparted training in blood banking technology in this short term orientation course. Training material

(Contd. on Page 220)



PREVENTION OF ADULTERATION OF FOOD AND DRUGS

Adulteration of food and drugs can cause serious damage to human life. This anti-social menace is sought to be countered by making the legal provisions more stringent and deterrent, even entailing life imprisonment for adulterations causing grievous hurt and danger to human life. This malpractice is also being tackled through effective health education measures. The drug de-addiction centres are being strengthened to provide treatment facilities for the drug abuse problem and drug dependence disorders.

FOOD is the basic need for survival. It is, therefore, imperative to ensure that whatever we consume is pure and wholesome. With this objective, the Parliament had enacted the prevention of Food Adulteration Act, in the year 1954. The aims envisaged under this Act are:—

- (1) To ensure quality food to the consumers;
- (2) To protect the consumers from fraud or deception;
- (3) To encourage fair trade practices.

Amendments and Penalty Provisions: The Act, which came into effect from 1st June, 1955 was amended thrice—firstly, in 1964 secondly, in 1976 and lastly in 1986 for plugging the loopholes and for making the punishments more stringent. It was by the amendment of 1976 that punishment for adulteration which could cause such harm so as to amount to grievous hurt within the meaning of Section 320 of I.P.C. or death, punishment of imprisonment for a term which shall not be less than 3 years but which may extend to a life term with fine which shall not be less than Rs. 5,000/- was included. With the amendment in 1986, the consumers and voluntary organisations have been empowered under the Act to take samples of food and initiate legal action, whenever necessary.

Central Food Laboratories

At present, we have two laboratories under the administrative control of the Directorate General of Health Services, viz., Central Food Laboratory, Calcutta and Food Research and Standardisation Laboratory, Ghaziabad which are moderately equipped. Two more Laboratories—one at Pune and another at Mysore have also been declared as Central Food Laboratories under the Act. The Pune Laboratory is under the Government of Maharashtra and the Mysore Laboratory is under the Council of Scientific and Industrial Research, Government of India. Both these laboratories are receiving grant-in-aid from this Ministry @ Rs. 5.00 lakh per year for doing work under the Prevention of Food Adulteration Act.

State Food Laboratories

There are 78 food laboratories under the administrative control of the State/Local Bodies. Out of these, 65 are managed by State Governments and the remaining 13 by the Local bodies. The State laboratories are moderately equipped whereas regional/local bodies laboratories need to be equipped.

Steps initiated to improve the programme

During the current year, there is a proposal to strengthen the P.F.A. Division at the Headquarters.

Other steps are :

(i) During the year, a Centrally sponsored scheme has been in operation whereby six state Food Laboratories are proposed to be assisted with lumpsum grants for purchase of equipments.

(ii) Assistance has also been provided to the State Food Laboratories in the form of equipments out of W.H.O. funds.

(iii) 35 training programmes have been arranged by P.F.A. Division under which more than 450 officials comprising of Food (Health) Authorities/Local (Health) Authorities/Public Analysts and Food Inspectors have been trained.

(iv) 11 Examinations have been conducted so far in which 209 chemists have been declared qualified to hold the post of public analyst.

(v) Consumer Education Programmes have been organised whereby a number of voluntary organisations have been exposed to various facets of the programme of Food Safety and Quality.

(vi) The Central Team has visited the States and assisted the State P.F.A. implementation authorities in sampling activities.

(vii) Steps have been initiated to improve the Food Safety and Sanitation measures in Government run Departmental eating establishments.

Future Proposals

Under the Eighth Five Year Plan, following proposals have been submitted for improving the programme on Food Safety and Quality:

(a) *Central Scheme*: Total allocation Rs. 3 crores for (i) strengthening of P.F.A. Division in the Headquarters and creation of units at the ports to regulate the quality of imported food.

(ii) Setting up of one Central Food Laboratory in West Zone and Zonal offices in Bombay, Calcutta, Madras and Ghaziabad.

(iii) Augmentation of laboratory facilities at Central Food Laboratory, Ghaziabad.

(iv) Augmentation of laboratory facilities at Central Food Laboratory, Calcutta.

(b) *Centrally Sponsored Scheme*: Total allocation Rs. 7 crores for augmentation of State Food Laboratories.

Additional Information: A statement on the working of P.F.A. Act in the country indicating the number of samples examined, found adulterated, percentage of adulteration, prosecution launched etc. is given here:

WORKING OF THE PREVENTION OF FOOD ADULTERATION ACT, 1954 IN INDIA 1981-1990

Year	No. of samples examined	No. of Samples found adulterated	Percentage of adulteration	No. of prosecutions launched	No. of convictions	No. of cases acquitted/discharged	No. of cases pending in the Courts of Law
1	2	3	4	5	6	7	8
1981	1,33,242	19,050	14.2	15,801	4,588	4,326	28,364
1982	1,29,595	16,765	12.9	15,006	3,617	5,483	36,781
1983	1,29,062	17,965	13.9	15,581	5,294	4,818	40,715
1984	1,22,296	14,990	12.2	13,334	4,530	4,577	43,761
1985	1,28,511	14,677	11.4	11,783	4,702	3,947	44,610
1986	1,21,969	13,730	11.2	10,445	3,864	3,391	44,389
1987	1,31,391	14,091	10.7	9,597	3,347	5,016	47,637
1988	1,30,390	15,365	11.78	9,599	2,576	3,251	50,931
1989	1,22,599	11,549	9.42	8,197	1,990	2,743	53,595
1990	1,18,580	11,124	9.38	7,970	2,464	2,316	54,700

Note: Information is based on the available reports from the States/Union Territories.

Central Drug Standard Control Organisation

Quality Control Over Imported Drugs: The statutory control on imported drugs is exercised by various ports and airports offices of Central Drug Standard Organisations located at Bombay, Nhavashava, Calcutta, Madras, New Delhi and Cochin. During the period from April to September, 1992, the value of imported drugs, drug intermediates, finalised formulations, chemical solvents etc. was Rs. 581.34 crores approximately and export during this period was upto Rs. 618.03 crores.

Co-ordination and liaison with the States: Four zonal offices located at Bombay, Calcutta, Madras,

Ghaziabad and sub-zonal offices at Lucknow and Patna co-ordinate with the State Drug Control authorities under their jurisdiction for uniform standard of inspection and enforcement of the Drugs rules: (i) The zonal officers inspected either jointly with the State Drug Control Authorities or independently as many as 146 manufacturing units, 58 blood banks and 10 approved laboratories, (ii) The State Drug Control Authorities were informed of the deficiencies observed during these inspections.

Approval of New Drugs: Permissions to import 14 new drugs under Rule 122-A and 15 new drug formulations under Rule 122-B and 122-C were granted during the

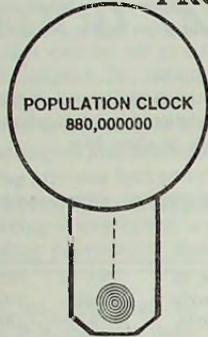
period April to September, 1992 for manufacture in the country. During this period, 49 new applications were received for grant of approval under the above mentioned rules.

Central Drugs Laboratory, Calcutta: The main function of this laboratory is to test samples of imported drugs and to act as appellate laboratory under the Drugs and Cosmetics Act and as Government Analyst for 21 States/UTs. and as well as for samples drawn by the Central Drugs Inspectors. It also supplies reference standard of various drugs to drug manufacturers. During the period, April-September, 1992, 1227 samples were tested and 179

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FOCUS ON HEALTH

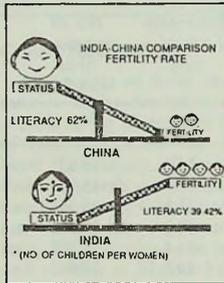
DAUNTING DEMOGRAPHIC PROFILE



- The population clock ticked past the 88 crore mark recently.
- 46 more persons are now living in the area which was supporting 221 persons in 1981.
- More than an Australia is added to India's population

every year. - an addition of 1.7 crore per year and 71,000 each day.

- India accounts for 16 per cent of world population and 2.4 per cent of global area.
- An Indian woman produces, on an average 4 children during her lifetime as compared to 2 in China.

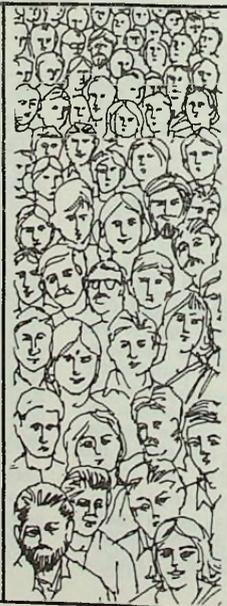


GRIM SCENARIO

- The decline in birth rate has not kept pace with the dramatic decline in death rate.
- The slow decline in Birth Rate, dramatic decline in Death Rate and increase in life expectancy all reinforce the high potential for exponential population growth.

During the decade 1981-91, 16.3 crores have been added to India's population - more than the number added in three decades (1931-61).

- It took 1800 years to add 50 Crores of people to the world population, starting 1st century A.D.
- In the next 130 years, 100 Crores of people were added, to bring the population size to 200 Crores.
- Another 50 years and the population size increased to almost twice its previous size.
- At this rate, global population will increase by 3 times the present size in the next 100 years.



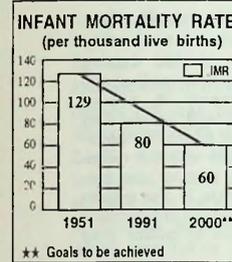
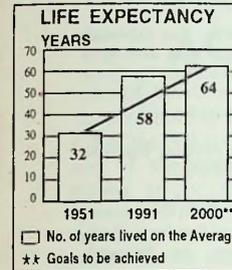
The Economic Imperative

- At the present rate of population growth, there would be a shortage of 4.1 crore units of housing.
- Per capita availability of cereals has gone up from 374 grams in 1976 to 471 gm in 1991.
- However, given the present production of 15.5 crore tonnes and a requirement of 17.4 crore tonnes of cereals for a population of 87 crores, the nutritional requirement of 168 kg per capita per annum is unlikely to be met.
- The population growth rate of 2.14% is eating into a growth rate of 3.3% per capita national income.
- Thirty percent of the people still live below the poverty line.

Old Chinese Saying

*Go to the people
Live with them
Learn from them
Love them
Start with what they know
Build on what they have
And when the job is done
The people will say
We did it ourselves.*

ACHIEVEMENTS



Outlays on family welfare have increased from Rs. 10 lakhs in the First plan to Rs. 6,500 crore. The outlay for 1993-94 alone is Rs. 1270 crore.

14.4 crore births have been averted since the inception of the family welfare programme.

If these births had taken place, population would have grown at 2.7 per cent instead of 2.14 per cent.

Effective Couple Protection rate has gone up from 24 per cent in 1976-77 to 44 per cent in 1990.

The share of spacing methods (IUD, oral pill, conventional contraceptives) has increased from 69.1% in 1974-75 to over 80% in 1992-93.

HEALTH & FAMILY WELFARE IN PARLIAMENT



Indian Medical Council Amendment Bill 1993, and the Dentists (Amendment) Bill 1993 were passed by the Lok Sabha. Under the amended provisions, any person desirous of establishing a new medical/dental college has to seek prior permission of the Central Government. The aim is to control the quality of medical education.

A Bill to regulate transplantation of human organs has been passed by the Rajya Sabha. It will be taken up by the Lok Sabha soon.

At least eight lakh people in India died due to tobacco related diseases in 1991. It was estimated that six lakh new cancer cases occur every year.

A Bill banning female foeticide will soon be introduced in the Parliament. The Joint Select Committee of Parliament has submitted its report on the proposed enactment.

ACTION PLAN

- The Eighth Plan focus: increase people's involvement in the nation building process.
- 90 districts, identified with birth rate of 39 and above for special attention.
- The Child Survival & Safe Motherhood Programme launched in 1992 with an outlay of Rs. 1125.8 crores. It aims at strengthening the Universal Immunisation Programme, and making a significant reduction in maternal mortality.

DID YOU KNOW ?

- that vaccine preventable diseases account for 16% of deaths of children under five.
- that immunisation has brought down deaths from vaccine preventable diseases in infants by thirty lakhs per year.
- that immunisation coverage in the developing world has gone up by 80 per cent during the last 10 years.
- that 17 lakhs deaths due to vaccine preventable diseases are still occurring in the developing countries.
- that there has been 99 per cent fall in reported cases of polio in Latin America and the Caribbean. Only nine cases of polio were reported in 1991 from this region.
- that there are five lakhs maternal deaths every year, 99 per cent of these are in the developing world. India has a Maternal Mortality Rate of 450 per lakh live births as against 2 in Ireland and 8 in the U.S.A.
- that diarrhoea, which is preventable by low cost method accounts for 2.7 lakh deaths of children under five.

GUIDE CHART FOR IMMUNISATION

For the pregnant woman :

Early in pregnancy	T. T.-1 (injection)
One month after T.T.-1	T.T.-2 or T.T. booster (injection)

For the infant :

At one & half month	B. C. G. (injection)
	D. P. T.-1 (injection) and O. P. V. 1 (dose)
At two & half month	D. P. T.-2 (injection) & O. P. V.-2 (dose)
At three & half months	D. P. T.-3 (injection) & O. P. V.-3 (dose)
At 9 months	Measles
At 16 to 24 months	D. P. T. Booster (injection) and O. P. V. Booster (dose)



(Continued from Page 205)

samples were found as not of standard quality. Out of these, 372 tested samples related to National Survey on Quality of Essential Drugs Programmes. 5 samples found to be as not of standard quality related to NSQED. During this period, two training programmes on (1) Advanced Chromatographic and Spectrophotometric methods of analysis of drugs and (2) Pharmacological and toxicological method of testing of drugs were conducted in which a total of 8 participants were trained.

Central Indian Pharmacopoeia Laboratory, Ghaziabad: During the period April to September, 1992, a total of 513 number of samples were tested out of which 82 were found as not of standard quality.

Biological Laboratory and Animal House, Madras: A total number of 205 samples were tested out of which 27 samples were found as not of standard quality during the period of April to September, 1992.

Drug Consultative Committee: The 28th meeting of Drugs Consultative Committee was held in New Delhi during the month of July, 1992, in which representatives of Central and State Governments discussed various matters relating to uniform administration of Drugs and Cosmetics Act in the country.

Weeding out of Irrational Combination: Following two notifications were issued during the period April to September, 1992 under Drugs and Cosmetics Act, 1940:

(i) Prohibited the manufacture and sale of all products licensed as tooth paste/tooth powder containing tobacco.

(ii) Prohibition of the manufacture and sale of all ayurvedic drugs licensed as tooth paste/tooth powder containing tobacco.

Indian Pharmacopoeia Committee: During the period from April to September, 1992, the clinical medicine and pharmacology sub-committee finalised the list of items to be included in the Fourth Edition. More than 100 monographs were finalised and 23 monographs in respect of veterinary were received from veterinary subcommittee. One meeting of the Working

Group was held in September, 1992. Amendments in respect of 15 drugs were finalised during the meeting and a circular to this effect was issued to all concerned.

Drugs Inspectorate Training Programme: During the year 1991-92, three regular batches were conducted. Two programmes on inspection of blood banks were also held.

By the end of March 1992, Drug Inspectors Training imparted training to a total of 572 Drugs Inspectors of various States/Union Territories, 40 other officers of Drugs Control Organisation of State and Central Governments.

Drug De-addiction Programme

The Ministry of Health & Family Welfare is basically responsible for providing treatment facilities for the drug abuse problem so as to ensure that the patients are not deprived of required medical facilities.

The expert committee on drug de-addiction was appointed by the Government of India to draw up a plan for implementation of health services in the area of drug dependence keeping in view the provisions of the 'Narcotic Drugs and Psychotropic Substances Act'.

The following steps have been taken to set up Drug De-addiction Treatment Units in the country:

Model De-addiction Unit at Delhi: A 30 bedded model De-addiction Unit was set up in July, 1988, in Deen Dayal Upadhyay Centre at the A.I.I.M.S. with the objective of providing the highest standards of medical care to the individuals having drug dependence disorders. The model de-addiction centre also envisaged an operationalised development of an appropriate course and curricula for Medical and Para-medical professionals:

(i) The institute has also developed a Data Monitoring System which can be utilised by all other centres.

(ii) A 10 bedded de-addiction centre is functioning at Sucheta Kriplani Hospital, New Delhi and Dr. R.M.L. Hospital providing De-addiction Services. In addition, a 10 bedded drug de-addiction centre is also functioning at P.G.I., Chandigarh, J.I.P.M.E.R., Pondicherry is also providing de-addiction services.

Other Centres: Under the Central Sector, in Delhi, the de-addiction

services are being provided at Smt. Sucheta Kriplani Hospital and Dr. R.M.L. Hospital. Outside Delhi, such services are also being provided at J.I.P.M.E.R., Pondicherry and P.G.I., Chandigarh.

Centres of Excellence: The following three institutions are being developed as Centres of Excellence with the financial assistance from United Nations Drug Control Programme:—

(i) Deen Dayal Upadhyay Hospital, New Delhi (AIIMS).

(ii) KEM Hospital, Bombay.

(iii) Institute of Post Graduate Medical Education & Research, Calcutta.

These three Institutions, besides providing the health care services to the drug addicts, also provide training facilities for the training of medical and para-medical personnel in various aspects of drug-addiction; besides they also prepare health education literature; develop linkages with the voluntary organisations; monitor the prevalence of drug abuse in the regions and help in assessing the effectiveness of health promotion to reduce drug abuse etc.

The Ministry are taking steps to provide financial support to North Eastern States to set up de-addiction centres.

Special Steps initiated during 1992-93: In continuation of the earlier strategy; it was decided to assist the State Governments to set up their own Centres and to train their medical personnel. This will increase the outreach in the drug infested areas in the States and the Central Hospitals will serve as back stocking arrangements to provide them technical guidance for setting up the de-addiction Centres.

During 1992, 13 training courses of General Duty Medical Officers have been conducted by the Central Institutes and State Governments. It has also been decided to strengthen 12 De-addiction Centres by way providing equipment at Medical Colleges/District Hospitals in various States. Besides, special arrangements are being made to provide additional facilities in North Eastern States, namely Manipur, Nagaland and Mizoram. □

FAMILY WELFARE

EXTRA EFFORTS REQUIRED TO ACHIEVE EIGHTH PLAN GOALS

ACCORDING to the final figures of the 1991 census, the population of the country was 846.3 million on 1st March, 1991 as against 683.3 million in 1981. Thus, the absolute addition to the population in the decade of 1981-91 was 163 million which is almost equal to the population added during the three decades 1931-41, 1941-51 and 1951-61. The annual average exponential growth rate of population has marginally come down from 2.22% during 1971-81 to 2.14% during 1981-91. Another important feature of the 1991 census was that the sex ratio (number of females for every 1000 males) which was 934 in 1981 declined to 927 in 1991. The literacy rate among females had gone up from 29.75% in 1981 to 39.29% in 1991. The high growth of population is overshadowing the achievements that the nation has made on the economic front. Every year around 17 million people are added to the population which needs additional resources for clothing, housing, food, education, health, schooling, etc. With 2.4% of the world land area, India is presently supporting 16% of the world population.

Dynamics of population growth

The salient features of the growth of population and the demographic situation obtaining in India over the different census periods (1901-1991) are given below. It would be seen that the rate of population growth had been fluctuating and slow until 1921. Both the birth rates and the death rates were at a high level around 48. The period from

1921-1951 was one of slow but steady growth primarily because of gradual reduction in mortality. During the next four decades, mortality declined by nearly 57% from 22.8 per 1000 population in 1951-61 to 9.8 in 1991 (SRS). The birth rate also declined during these years but at a much slower pace (29.7%) reaching a level of 29.3 per thousand population in 1991 (SRS) from 41.7 in 1951-61.

During 1981-91, among the major States (except Assam and J&K where census could not be held during 1981 and 1991 respectively), three States Haryana, Madhya Pradesh and Rajasthan recorded growth rates higher than 2.3%; whereas seven States which recorded growth rate lower than 2% are Gujarat, Himachal Pradesh, Karnataka, Kerala, Orissa, Punjab and Tamil Nadu. The highest growth rate of 2.50% was recorded by Rajasthan and lowest of 1.34% was recorded by Kerala.

(i) The growth rate declined in 11 States but increased in 4 States—Andhra Pradesh, Madhya Pradesh, Maharashtra and West Bengal.

(ii) Even among the 11 major States registering decline in annual growth rate in 1981-91 as compared to 1971-81, there are wide variations ranging from 0.54 per cent in Gujarat, 0.47 in Karnataka, 0.43 in Kerala, 0.06 in Bihar, 0.02 in Orissa and 0.02 in Uttar Pradesh. In the remaining five States, there was 0.37 percent decline in Rajasthan, 0.27 in Punjab, 0.26 in Himachal Pradesh, 0.20 in Tamil Nadu and

0.13 in Haryana. This analysis shows that the most populous States viz., U.P. and Bihar, whose population taken together constitutes about 27% of the country's total population, have shown an insignificant decline in the growth rate.

Long term goals

According to the National Health Policy (1983), the long-term goals set are to reach NRR: 1 by 2000 A.D. which corresponds to achieving the birth rate of 21, death rate of 9 and natural growth rate of 1.2%. It also stipulated that the IMR would be brought below 60 per 1000 live births and the couple protection rate increased to 60% by the turn of the century. As against 10.4% of the eligible couples protected by contraception under family planning programme in 1970-71; the CPR has gone up to 43.5% in 1991-92 (as on 31-3-1992). The total number of eligible couples (wives aged 15-44 years) has been estimated to be 148.4 million (as on 31-3-1992) in the country. Since the inception of the family planning programme, about 143 million births have been averted upto 31-3-1992. The birth rate has also declined from a level of 37.2 in 1971-81 to 29.3 (provisional) in 1991 as per SRS. The death rate also declined during the same period from 15.0 to 9.8. Infant Mortality Rate has declined from 140 per thousand live births in 1975 to 80 in 1991.

(i) For the first time, the 1991 census has shown a decline in the growth rate which is now estimated at 2.14%. Against this, a natural growth rate obtained as a difference between birth rate and death rate from SRS, shows a decline from 2.05% in 1990 to 1.95% in 1991.

Consequent to the implementation of the Family Welfare Programme, during the decade 1981-91, if the averted births had taken place, the growth rate of population could have been 2.7% per annum as against 2.14% as enumerated in the census. However the 8th Plan document of the Planning Commission has assessed that the growth rate of population should be 1.78% by the end of 8th Plan, i.e. 1997 and should come down to 1.65% during 1996 to 2001. It has been reckoned that the NRR:1 level may be attained only in the period 2011 to 2016 A.D. India's fertility and mortality levels and the age distribution of the population are such that even after attaining NRR:1 in the above period, the zero growth rate of population (stabilisation of population) may be achieved only after several decades.

Extra efforts required

Assessment of population projections by the end of VIIIth Plan and during 1996-2001 are based on assumptions as adopted by the Standing Committee of Experts of Population Projection (1989). As per final population count of 1991 census, the figure now stands at 846.30 million as against a provisional figure of 844.32 million i.e. net addition of about 2 million at the national level. With this upward revision of population count, the population projection as assessed by the VIIIth Plan is likely to go up slightly. However, if we take into account the same extent of undercount as of 1981 census, as the 1991 census figure of undercount is not yet available; the country's population may go up further to 861.53 million for 1991. This requires extra efforts in the field of Family Planning to achieve the goals indicated in the VIIIth Plan i.e. to achieve a birth rate of 26 and IMR of 70 by the end of 1997.

Child Survival and Safe Motherhood Programme (CSSM): With

effect from 20th August, 1992 an integrated MCH and Immunisation Programme has been taken up for implementation. This Programme, named Child Survival and Safe Motherhood Project, is being implemented with financial assistance of World Bank and UNICEF and has two components: UIP Plus package consisting of UIP, ORT, Prophylaxis Schemes and ARI Control Programme for all States/UTs; and Safe Motherhood initiatives for six high IMR/MMR States of Assam, Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh.

(i) The Project will be operationalised in a phased manner over 5 years. The proposed phasing of the districts covers 51 districts under UIP Plus and 21 districts under Safe Motherhood Programme during the year 1992-93, leading to a total phased coverage of 446 districts under UIP Plus and 219 districts under Safe Motherhood Programme by the year 1996-97.

Social Safety Net (SSN): An agreement has been signed with the World Bank under the SSN for upgradation of facilities at PHC (30,000 population) to reduce maternal mortality and provide institutional deliveries. Selected PHCs (30000 pop) in 90 weak districts will be strengthened with the provision of an operation theatre for simple surgical intervention, a labour room, an observation room, staff quarters for Lady Health Visitor (LHV)/Lady Doctor and Auxillary Nurse Midwife (ANM) provision for running water and electricity. Necessary training components, where required, will also be built in. PHCs (30,000 population) to be selected by the State Government will be those which are farthest from urban agglomerations, first referral units

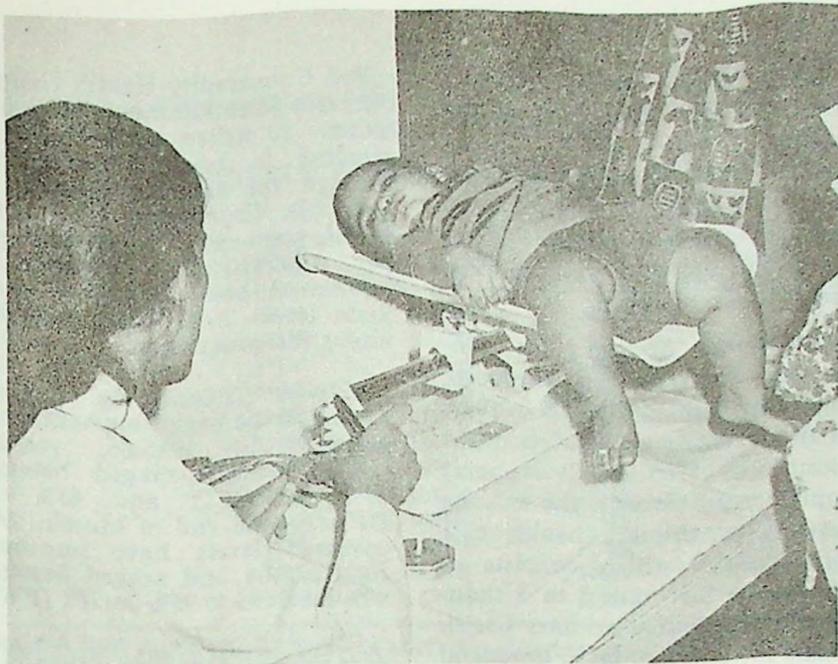
and district hospitals. The objective of the Scheme is to reduce maternal mortality and morbidity and to provide specific institutional services to high risk pregnancies. The State Governments will be required to provide services of a lady doctor and staff nurse. The scheme will be a one-time non recurring grant.

U.P. Project: A USAID-assisted project for Uttar Pradesh, the most populous State of the country will be taken up. The 10-year Project envisages gearing up of implementation of the family welfare programme in order to bring down the crude birth rate and bring up Couple Protection rate. An improvement in performance in U.P. can have a positive impact on the overall national index and population parameters.

NGOs: Schemes for the involvement of NGOs are being revamped, to provide for greater community participation. The new schemes will have a clear thrust towards promoting spacing methods for ensuring population stabilisation. Closer involvement of organised sectors in adoption of areas and in taking family planning programmes outside their own employees are being promoted.

IEC: Various innovative schemes are proposed to be implemented. Due to the vast differences in performance in different States and districts, a differential strategy will be implemented for information, education and communication whereby area specific approaches will be promoted. Use of local dialects, folklore and folk media will be enhanced and appropriate media mix will be used. Emphasis will be given to inter-personal communication and attempts will be made to bring electronic media closer to the people through video vans.

(Contd. on Page 219)



MATERNAL AND CHILD HEALTH

Care of mothers and children—the most vulnerable sections of our society—occupies a paramount place in our health services delivery system. These services have been further reinforced during 1992-93 by introduction of a National Child Survival and Safe Motherhood Programme. The impact of the Universal Immunisation Programme introduced in 1985-86 is becoming perceptible in the declining trends of disease incidence and Infant Mortality Rate.

as well as children upto 5 years of age and against blindness due to Vitamin A deficiency among children of under 5 years of age (since 4th Plan period).

The progress made under the above programmes during the year is given here:

Universal Immunisation Programme

The Universal Immunisation Programme (UIP) was launched in 1985 as part of the overall national strategy to bring down infant and maternal mortality in the country by providing immunisation to all infants against six vaccine preventable diseases and pregnant women against tetanus. Prior to 1985, immunisation activity was implemented under the Family Welfare Programme but the Scheme was limited primarily to major hospitals and the coverage levels were also very low.

When this programme was launched in 1985, infant mortality for the country as a whole was 97 for every 1000 live births. It was estimated that vaccine preventable diseases were responsible for about one-fourth of the total infant-deaths. Neo-natal tetanus itself was responsible for 13 out of every 1000 infant deaths, *i.e.*, a total of 300,000 deaths every year. 150,000 children, in the absence of immunisation, were likely to develop paralytic poliomyelitis every year.

In 1986, the Universal Immunisation Programme was named as one of the Technology Missions and the following objectives were spelt out:

As part of the overall strategy for reduction of infant mortality to below 60 per 1000 live births; child mortality to 10 per 1000/child population and maternal mortality to below 200 per 100,000 live births by 2000 AD, following specific programmes have been under implementation in the country as 100% Centrally Sponsored Schemes:

- (a) Universal Immunisation Programme, (since 1985-86).
- (b) Oral Rehydration Therapy Programme for control of deaths due to dehydration due to diarrhoea (since 1986-87), and
- (c) Prophylaxis Schemes against nutritional anaemia among pregnant and lactating mothers

- (a) To cover all pregnant women against tetanus and at least 85% of all infants against six vaccine preventable diseases by March, 1990.

- (b) To increase production, upgrade testing facilities and develop the means, support and distribution of vaccines at the required low temperatures, to maintain their potency.
- (c) To achieve self-sufficiency in vaccine production and manufacture of cold chain equipment.

With effect from 1990-91 the target for UIP has been increased to 100% i.e. to cover all infants.

The Target Group: Under the UIP, every year about 23 million infants are to be vaccinated before they are one year old with three doses of DPT vaccine (Diphtheria, Pertussis and Tetanus), three doses

of polio vaccine (orally administered) and one dose each of the measles and BCG vaccines. About 25 million pregnant women are also to be administered two doses of tetanus toxide (TT) as prevention against tetanus to them and to their newborn.

Operational Strategy: The programme was taken up in phases, beginning with 31 districts in 1985-86 and covering all districts in the country by 1989-90. It is being implemented through the existing network of primary health care infrastructure which consists of Sub-centre for every 3 to 5 thousand population, a primary health centre for every 20 to 30 thousand population and a referral Centre,

called Community Health Centre, for every 80 to 120 thousand population. In urban areas, the programme is being implemented through the existing network of hospitals, dispensaries and urban health posts, etc. To ensure proper supervision, a number of additional posts at district and State levels have been provided under the programme.

Progress: (i) Increasing Coverage Levels: At the beginning of the programme in 1985-86, vaccine coverage levels ranged between 29% for BCG and 41% for DPT. By the end of March, 1992 coverage levels have improved significantly and ranged between 89% for BCG to 75% for TT (PW).

(ii) The year-wise and antigen-wise achievement during 1985-86 to 1991-92 is as under:

ACHIEVEMENT AS PERCENTAGE OF ESTIMATED INFANTS AND PREGNANT WOMEN

(Compiled on the Basis of Reports of States/U.Ts.)

Year	DPT	OPV	BCG	MSL	TT(PW)
1985-86	41.12	35.66	28.84	1.34	39.85
1986-87	56.55	48.41	52.19	16.17	45.27
1987-88	72.23	60.46	70.70	44.06	56.48
1988-89	79.61	74.83	79.29	55.17	65.15
1989-90	82.00	89.00	89.00	69.00	69.00
1990-91	98.00	99.00	97.00	89.00	78.00
1991-92	87.89	88.18	88.98	82.50	75.44

*Measles vaccine was introduced in the programme from 1985-86.

Impact: The universality of the programme was achieved only in 1989-90 when it was expanded to cover the entire population. But the impact of the Programme is already seen in declining trends of disease incidence. Poliomyelitis, for example, which was reportedly around 38,090 cases in 1981, and had declined only marginally by

1987 to 28,264 cases has shown a significant decline after that year when the coverage levels of children immunised with 3 doses of OPV had reached 50-60%. In 1990, the number of polio cases reported were of the order of only 6,028. In the ten better performing States/U.Ts. of Haryana, Himachal Pradesh, Karnataka, Kerala,

Maharashtra, Punjab, Tamil Nadu, Chandigarh, Goa, and Pondicherry which account for more than 252 million population, the reduction in the poliomyelitis cases has been far more pronounced. These States/UTs. can in the foreseeable future become polio free zones.

The disease incidence since 1980 is given below:—

REPORTED INCIDENCE OF VACCINE PREVENTABLE DISEASES, INDIA

Year	Dip	Per	Tet	NNT	Pol	Mea	Total
1980	39231	320109	43837		19051	124036	546264
1981	26315	359288	39175		38090	197129	659997
1982	17191	279635	39955		26302	146196	509279
1983	13776	211282	32870		24727	129639	412294
1984	17058	189148	29965		23250	190881	450302
1985	15686	184368	37647		22584	160216	420501
1986	9426	167225	30994		20169	155076	382890
1987	12952	163786	31844		28264	247519	484365
1988	17146	145469	24343	11849	24257	157800	380864
1989	9790	137374	17763	11114	13866	162560	352467
1990	8425	113016	14043	9313	10408	87446	242651
1991	12550	73520	15036	11241	6028	79655	198030

*Tet—includes cases in adults. Cases of NNT also included upto 1987.

Impact on Infant Mortality Rate: Intensification of immunisation programme has contributed to a significant decline in the Infant Mortality Rate in the last few years. The decline has been particularly pronounced in 1990 as compared to earlier years. During that year the IMR declined by 11 points to 80 per thousand live births from 91 in 1989.

Self-sufficiency in Vaccine Production: The annual requirement of different vaccines for the country for 1993-94:

Vaccine	Annual requirement in lakh doses
DPT	1250
OPV	1600
BCG	470
Measles	470
Tetanus Toxoid	1700
DT	537

The country is self-sufficient in all vaccines except Oral Polio vaccine. When the Programme was initiated in 1985, the entire quantity of measles vaccines required was imported but today this vaccine is being indigenously produced at the Serum Institute of India and spare capacity of measles vaccine is now

available to the tune of 25 million doses. At present about 80% of the OPV vaccine is being blended in the country by the indigenous firms.

The indigenous capacity of BCG is being enhanced from 300 lakh doses to 500 lakh doses and it is expected that the production, with the enhanced capacity, will start within the current year itself.

The capacity built up for the production of all vaccines in India is sufficient to meet future demands. Upgradation and modernisation of vaccine production institutes is going on simultaneously in the existing production units.

Testing of Vaccine: Statutory testing of vaccine is done by the National Quality Control Laboratory at Kasauli. The protocols of all vaccines are scrutinised before use and are released only after these are declared standard by this laboratory. In addition, samples of OPV are picked up from various levels of storage and sent to designated laboratories for potency testing to monitor effectiveness of the cold chain system. Earlier there were only three testing laboratories i.e., CRI, Kasauli,

NICD, Delhi and Enterovirus Research Centre, Bombay. Seven new additional laboratories have been set up for OPV testing.

The test results for the last six years indicate steady improvement in the efficacy of the cold chain system in keeping vaccines safe. In 1987 about 40% of the field samples failed, at present the failure rate is only about 10 per cent as per table given below:

POTENCY TEST REPORTS OF FIELD SAMPLES OF OPV

Year	Samples tested	Samples satisfactory	%age Samples satisfactory
1987	1290	790	61%
1988	2196	1454	66%
1989	5423	4580	84%
1990	8148	7550	93%
1991	9208	8354	91%
1992	8012	6993	87%

(Upto Sept., 92)
(Provisional)

Training for Refrigeration Technicians: Cold Chain System is one of the most crucial components of the programme as its effective functioning will ensure the potency of the vaccines stored. In order to remedy the faults in the ILRs,

Freezers, WIC etc., the Refrigeration Technicians are imparted training at:

- State Health Transport Organisation, Pune;
- HER Division, SHTEMO, Gauhati;
- HER Unit, Hyderabad;
- T.B. Hospital, Bhopal; and
- HER Training Centre, Madras.

So far (upto Aug., '92), 378 trainees have been trained in Refrigerator Repair Training Course, 243 trainees have been trained in WIC Repair Training Course and 85 trainees have been trained in Stabilisers Repair Training Course.

Cold Chain Equipment Supplies: Overall supplies made to the States/UTs during the period of 1985-86 to 1992-93 (upto September, 1992) in respect of major items are given below:-

Item	Unit Supplied till Sept., 1992
Walk-in-Cooler	105
Walk-in-Freezer	3
ILR-240 Ltr.	3041
ILR-140 Ltr.	549
Chest Freezer 300 Ltr.	10710
Chest Freezer 140 Ltr.	10762
Cold Box 22 Ltr.	16662
Cold Box 5 Ltr.	22464
Vaccine Carriers	173037
Vaccine Day Carriers	166438
Autoclaves	13729
Sterilising Drums	145471
Steam Steriliser Pressure Cookers (DR.)	112432
Stove Kerosene	179046
Jeeps and Vans	1387
Tempo Travellers	16

The details of allocation of needles and syringes being supplied during 1992-93 are as follows:-

2 ml. Syringes	55.70 lakh
2 ml. Syringes	18.57 lakh
5 ml. Syringes	9.28 lakh
23 g. Needles Box	18.57 lakh
26 g. Needles Box	6.19 lakh
20 g. Needles Box	1.55 lakh

Maintenance of Cold Chain equipment: Till 31-3-1991, the maintenance of cold chain equipment was under contract between UNICEF and commercial agencies. With effect from 1-4-1991, all the States/UTs. have taken over the responsibility of maintenance of cold chain equipment. In January, 1992 the States were requested to review the existing arrangement for maintenance of cold chain equipment with a view to identify the strengths and weaknesses of the existing system and take remedial action in this regard.

To assist the States to formulate Action Plans for maintenance of cold chain, workshops are being held in States jointly by Ministry of Health & F.W. and UNICEF. So far (Oct., '92), workshops have been held in the States of U.P., Bihar, West Bengal, Assam, Gujarat, Rajasthan and Kerala.

International Review: An independent review of the immunisation programme was conducted by teams of National and International experts in August, 1992 to objectively document coverage levels and assess quality of the immunisation services, cold chain and surveillance systems. Two randomly selected districts in five States representing each geographical region were covered: Haryana (North), Madhya Pradesh (Central), Maharashtra (West), Orissa (East) and Tamil Nadu (South).

The review confirmed high levels of immunisation coverage of above 90% in 5 of the 10 districts with a range of 54 to 99% with third dose of DPT and OPV. Drop-out rates were less than 8% in all but three districts. Coverage of pregnant women with TT ranged from 53 to 97%. Four districts had achieved coverage levels in excess of 90%. Community awareness and acceptance of immunisation ser-

vices was high except in two districts.

The cold chain and logistics network was found to be operating satisfactorily in all districts. The prospective vaccine efficacy of three doses of OPV was in the range of 83 to 98% and comparable to the rates in other countries. The surveillance system was well established in Haryana, Maharashtra and Tamil Nadu while it needed strengthening in Orissa and Madhya Pradesh.

In Haryana, Maharashtra and Tamil Nadu as well as districts in other States with a similar status of the immunisation programme elimination of neonatal tetanus and eradication of poliomyelitis was a realistic goal in the near future.

Management and Control of Diarrhoeal Diseases

Diarrhoeal diseases are a major health problem in the country especially among children below five years of age. On an average, a child suffers three episodes of diarrhoea per year. Diarrhoea contributes to a significant mortality in this age group. It is estimated that about 1 million deaths occur every year because of diarrhoea or diarrhoea related causes.

Studies reveal that 90% of the children suffering from diarrhoea can be managed successfully at home by administering home made/home available fluids at the onset of diarrhoea. Only 10% of the cases would need Oral Rehydration Salts (ORS) for correction of dehydration.

Thrust areas: The National Diarrhoeal Diseases Control Programme, initiated in the 6th Plan, was, therefore, intensified in the 7th Plan with a conscious decision to promote Oral Rehydration Therapy with the following thrust areas.

(i) Educating mothers and communities to enable them to take care of 90% of the children suffering from diarrhoea at home by home made or home available fluids, continuing feeding during diarrhoea and recognising early signs of dehydration.

(ii) Improving the case management of diarrhoeal cases at all health facilities by training health personnel involved in primary health care services/district hospitals and medical colleges.

Providing Free ORS Packets at all Health Facilities: This 100% centrally sponsored Family Welfare Programme, was taken up in a phased manner, became operational in all districts of the country during 1989-90. Funds have been provided to the States and Union Territories for following activities:—

- (i) Training of medical and para-medical personnel on management of diarrhoea;
- (ii) Procurement of Oral Rehydration Salt (ORS); and
- (iii) Organising mothers meeting for educating them in the use of the home available fluids and ORS.

Progress: (i) More than 4 lakh medical and para-medical personnel have been trained in the Oral Rehydration Therapy Programme in the last three years upto March, 1992. Indian Medical Association was also involved in organising training for more than 30,000 private medical practitioners.

(ii) One of the objectives of the programme has been to set up Diarrhoea Treatment-cum-Training Units (DTUs) in Medical Colleges, in a phased manner. These DTUs, which have been set up in the paediatrics units of 55 medical colleges and would be expanded to all medical colleges

in a phased manner, are acting as resource centres in propagating correct case management of diarrhoea. Besides this, the DTUs also provide training ground for medical students, interns and health workers.

(iii) A national standard for ORS packets has been developed. The standard includes a logo, a packet design and instructions (written & graphic) for use on ORS packets.

(iv) Availability of ORS packets is being increased so that all cases of diarrhoea reporting to the health facilities can be given ORS. Even in cases with no dehydration, one packet of ORS is to be given to prevent dehydration and early treatment of dehydration.

(v) Inter-personal communication for promotion of ORT, through mothers' meeting was started in 1990-91. Twenty two States, from where the information is available in this regard, have held 1,02,787 such meetings in which 22.67 lakh mothers were oriented during 1991-92.

The programme emphasises on rational use of drugs in diarrhoea. Anti-diarrhoeal drugs have no place in the treatment of diarrhoea in children and their use is discouraged. Antibiotics are recommended only in cases of cholera and bacillary dysentery.

New Initiatives: The training for medical and para-medical personnel for Oral Rehydration Therapy has become a part of the Child Survival and Safe Motherhood (CSSM) programme which is being operationalised in 51 districts in the current year (1992-93). It has, however, been seen that States like Madhya Pradesh, Orissa, Uttar Pradesh, Rajasthan, Assam and Himachal Pradesh have been reporting a higher number of diarrhoea cases in the recent

years. The Child Mortality Rate (1989) in these States is also higher than the national average of 29.9 per thousand child population. It has, therefore, been decided to continue with the separate vertical training programmes in these States. Andhra Pradesh, Madhya Pradesh, Orissa and Himachal Pradesh will be covered in 1992-93. This will be followed by similar training programmes in UP, Rajasthan and Assam in the next year.

District level DTUs

(i) As a part of CSSM programme, DTUs will also be set up in the district hospitals of 100 districts in 1992-93. Besides providing case management services, these DTUs will train the medical and para-medical personnel of the concerned districts.

(ii) *Procurement of ORS:* Upto last year (1991-92), funds were being provided to the States for procurement of ORS. While some of the States were able to use these funds effectively, others were found to have some problems in ensuring regular and timely procurement. From this year, therefore, procurement of ORS has been centralised and the States will now receive ORS packets in place of cash grants. More than 1.80 crore packets are being procured through DGS&D and would be directly supplied by identified suppliers to the States/U.Ts.

(iii) As a part of improved logistics planned under CSSM Programme, 51 districts have started receiving drug kits for the sub-centres. ORS will be part of this kit. By the end of the 8th Plan all districts of the country will start receiving these drug kits. ORS supplied under the national programme is standardised and carries a national logo for easy identification.

(iv) *Communication*: Four new spots for telecast on the National Network of Doordarshan have been prepared and sent to Doordarshan for telecast.

Prophylaxis Schemes

Nutritional anaemia is one of the major public health problems specially affecting pregnant and lactating women and pre-school children. Anaemia affecting the mother also affects intrauterine growth of the foetus. Similarly, nutritional anaemia among pre-school children makes them susceptible to more diseases and deaths. Various studies conducted in the country indicate that 50% of pregnant women and 50% of pre-school children suffer from anaemia. In order to tackle this problem, a scheme which was launched during the 4th Five Year Plan and being continued through successive plans, seeks to supply iron and folic acid tablets to pregnant and lactating women and children between 1 to 5 years of age. The doses for the adult are two tablets of 60 mg. or one tablet of iron with 0.5 mg. folic acid to be given daily for a period of 100 days. In case of children, 20 mg. elemental iron and 0.1 mg. folic acid is given daily for a period of 100 days.

Vitamin 'A' deficiency is widely prevalent in the country specially among the pre-school children. Studies have also revealed that Vitamin 'A' is given to children by mouth in large doses, can be stored in the liver for more than 6 months and the same is released in small quantities required for the body. Thus if a child is administered 2 lakh I.U. doses of vitamin 'A' every six months between 1 to 5 years of age, Vitamin 'A' deficiency can be prevented.

Administration of Vitamin A for prevention of blindness due to

Vitamin A deficiency among pre-school children was started in 4th Plan period. At that time Vitamin A deficiency as a cause of blindness accounted for 0.3% of blindness prevalence, according to the survey conducted by ICMR. The programme has continued since the 4th Plan period and, according to another survey carried out by Ministry of Health in 1986-89, blindness due to Vitamin A deficiency has declined to 0.04% of blindness prevalence. However, the prevalence of Vitamin A deficiency in children 0-6 years is still high at 6.0% (survey 1986-89).

Lack of resources have hindered universalisation of the prophylaxis schemes to cover all the beneficiaries. So far, it has been possible to provide Iron and Folic Acid tablets and Vit. 'A' solution to about 50% of the pregnant and lactating women and 30 to 35% of the children.

It has, therefore, been decided to prioritise all pregnant women for IFA administration and children under 3 years of age for Vitamin 'A' administration from the current year. In addition, the States/UTs have been advised that prophylaxis doses of IFA to pregnant women be provided alongwith TT immunisation. Similarly the first two doses of Vitamin 'A' are to be given alongwith measles and DPT/OPV booster immunisation doses.

Pilot Schemes Taken Up in the 7th Plan

In addition to the above programmes, two more programmes, to reduce maternal and child mortality, were taken up after 1988 as pilot projects with financial assistance of UNICEF:

- (i) Intensification of dais, training for improving pre-natal and natal care for domiciliary deliveries, and

- (ii) Initiating a programme for the control of acute respiratory infections (ARI) among children.

The main components of Dai's Training programme include training of dais in aseptic delivery practices, provision of disposable delivery kits to them as well as to pregnant women and payment of a reporting fee of Rs. 10.00 when they interact with the ANM to promote ante-natal care and TT immunisation.

The main components of the ARI programme are:

- (i) Home care for coughs and cold;
- (ii) Administration of anti-microbials by para medicals in children at sub-centres and out patient department of hospitals;
- (iii) Referral of severe cases to hospitals;
- (iv) Promotion of immunisation against measles to cover all eligible children; and
- (v) Health education training of staff including doctors and para-medical workers.

Out of the 24 districts, field operations, that is the standard management by the para-medical workers at sub-centres has begun in 16 districts. According to the data available about 30,000 children with pneumonia have been treated with cotrimoxazole in these districts upto July, 1992.

Child Survival and Safe Motherhood Programme

Implementation of the Universal Immunisation Programme in the last five years has provided an opportunity of reaching infants and pregnant women, for provision of other health interventions necessary for achieving the goals set in the National Health Policy.

With effect from 1992-93, therefore, a UIP PLUS programme, which is an integrated MCH programme has been taken up for implementation. This programme, named as Child Survival and Safe Motherhood Project, is being implemented with financial assistance of World Bank and UNICEF and has following objectives:

- (i) Sustaining the Universal Immunisation Programme for infants and pregnant women, intensified during the 7th Plan;
- (ii) Continuing Oral Rehydration Therapy Programme for children below 5 years of age, intensified during the 7th Plan period;
- (iii) Universalising the existing prophylaxis scheme for control of anaemia for pregnant women through administration of Iron and Folic Acid tablets;
- (iv) Universalising the existing prophylaxis scheme for control of blindness due to deficiency of Vitamin 'A' for children upto the age of three years through administration of Vitamin 'A';
- (v) Introducing and expanding the programme for control of Acute Respiratory Infections (ARI) for children below 5 years of age; and
- (vi) Initiating and implementing a safe motherhood programme for the high IMR States of Assam, Bihar, M.P., Orissa, Rajasthan and U.P. For demonstration purposes, however, one district each from Andhra Pradesh, Karnataka, Maharashtra and West Bengal have been included in the first year of the project. Similarly, two districts of Tamil Nadu, which were taken up earlier

under UNICEF assisted pilot project, have also been included in the first year.

The project has the following two components:

- (a) UIP plus package consisting of UIP, ORT, Prophylaxis schemes and ARI control programme for all States/U.Ts.; and
- (b) Safe Motherhood initiatives for the six high IMR/MMR States of Assam, Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh.

The project will be operationalised in a phased manner. The proposed year-wise phasing of the districts is as under:

Year	UIP PLUS		SAFE MOTHERHOOD	
	New	Cumulative total	New	Cumulative total
1992-93	51	51	21	21
1993-94	100	151	32	53
1994-95	101	252	50	103
1995-96	98	350	48	151
1996-97	116	466	68	219

Progress in Operationalisation: In addition to continuing supply of vaccines, cold chain equipment, needles and syringes, IFA tablets, Vitamin A solution and ORS packets and release of cash assistance to the States, following specific progress has been made in operationalising the CSSM programme in 51 districts in the current year.

Training: Training under CSSM envisages to strengthen management skills and ensure effective implementation of services through understanding of (i) programme component; (ii) management information, including status of utilisation of services by the community; (iii) materials management including cold chain maintenance; (iv) district planning,

implementation and supervision; and (v) disease surveillance.

Upto October, 1992, eleven regional training/orientation workshops for State core members have been organised in which 327 DIO/DHOs and principals of HFWTCs have been trained. Training of para-medical workers in the 51 districts taken up in 1992-93 is in progress.

Supply of Medicine Kits: The programme envisages supply of IFA tablets, Vitamin A solution, ORS packets and Cotrimoxazole tablets in the form of a kit to all the project districts every six months. Safe motherhood districts are to be provided with an additional kit containing essential drugs for use at the sub-centres. First six monthly instalment of the supplies have started reaching the district headquarters (October, 1992).

Health Facility Survey: For safe motherhood districts, a health facility survey was required to be carried out for identifying first level referral units (FRUs). This survey has been completed by the Institute for Research in Medical Statistics (IRMS), an associate body of ICMR.

Equipment Kits: The programme also has a provision for supply of essential equipment to the sub-centres which are located in proper buildings, primary health centres having a labour room and identified FRUs. While the exact locations of the facilities to be supplied with various equipment kits will be known only when the health facility survey referred above have been discussed with the district/State authorities procurement of these equipment kits through UNICEF is already in progress. First of these kits, midwifery kits for the ANMs (these will be provided to all ANMs in a phased manner), are now being despatched by UNICEF to the State headquarters (October, 1992). □

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like Technical Manual on Transfusion Medicine has been published and widely circulated to all concerned.

National AIDS Control Programme

HIV infection in the country has been reported from as many as 23 States/UTs and of these Maharashtra, Tamil Nadu, Delhi and Manipur States have the highest incidence. In Maharashtra and Tamil Nadu, the pattern of HIV infection is that on sub-saharan type, i.e., through sexual transmission. In the North Eastern States, the pattern of HIV infection follows a course similar to that of Southern Europe and Thailand, i.e., through Drug Abuse.

As per epidemiological report available, as many as 15,75,950 persons practising high risk behaviour have been screened, of which 11,330 have been confirmed seropositive for HIV infection as on 31-12-92. The sero positivity rate per thousand is 7.18 and the total number of full blown AIDS cases in the country, as reported, is 290.

Government of India during the plan period has established 62 surveillance centres for screening persons practising high risk behaviour; 29 zonal Blood Testing Centres in 4 metropolitan cities of the country, viz. Bombay, Calcutta, Delhi and Madras and additional 89 blood Testing Centres in 83 large cities for screening all pooled plasma for HIV infection. 62 surveillance centres functioning in 33 cities have also been indentified as

Zonal Blood Testing Centres for screening blood samples received from the blood banks. With this testing facilities have now become available at 110 cities of the country.

For strengthening and supplementing the National AIDS Control Programme for containing the Infection, the Government of India has launched a scheme at an estimated cost of Rs. 222.6 crore during the 8th Plan with assistance from World Bank to the extent of US \$ 84 million and another \$ 1.5 million from WHO. The World Bank loan becomes effective from 21-9-92.

Ministry of Health and Family Welfare has set up a National AIDS Control Organisation as a separate wing within the Ministry to implement and closely monitor the various components of the programme as documented in the Staff Appraisal Report of I.D.A. (World Bank). The ultimate objective of the Project would be to arrest the pace of HIV infection in the country with a view to reducing the future morbidity, mortality and impact of AIDS.

The Project would consist of following components :

(i) *Strengthening Programme Management Capabilities* : National AIDS Control Organisation would primarily be involved in planning, consulting, implementing and monitoring the various activities under the project through the AIDS Control Cell at the State/UT level;

(ii) *Strengthening of IEC* : The project would seek to carry out an intensive public awareness and community support campaign through mass media and sustained dissemination of information and health education about HIV and AIDS to all level and categories of personnel;

(iii) *Prevention of Transmission through Blood and Blood Products* : The project seeks to upgrade the blood banking capabilities in the public sector and expansion of HIV screening of all blood used for transfusion and blood-products in the country;

(iv) *Strengthening Clinical Management capabilities* : The project seeks to strengthen the institutional capabilities at the State/UT level for monitoring the development of HIV and AIDS epidemic and planning and programming interventions to control such epidemic; and

(v) *Controlling STD* : One of the predominant mode of transmission of HIV infection is through sexual contact. The project seeks to take up activities to strengthen the clinical services and case management activities in STD centres in 130 medical colleges and 242 District level STD clinics.

National Mental Health Programme

The Government of India decided to launch the National

Mental Health Programme during the 7th Five Year Plan period to ensure availability and accessibility of minimum-mental health care for all in the foreseeable future, particularly to the most vulnerable and under privileged sections of the population, to encourage application of mental health knowledge in general health care and social development, and to promote community participation in the mental health service development and stimulate efforts towards self help in the community.

A National Advisory Group on Mental Health was constituted under the Chairmanship of the Secretary, Ministry of Health & Family Welfare for the effective implementation of the National Mental Health Programme.

A provision of Rs. 18 lakh has been made for implementation of this scheme during this year. Eleven institutions have been identified for imparting training to health personnel under the programme.

These 11 colleges will be providing training in basic knowledge and skills in the field of Mental Health to the Primary Health Care Physicians and para-medical personnel. These centres will also coordinate the various Mental Health activities in the region and supply the health education materials to the other training centres in their respective regions and coordinate with the Ministry of Health & Family Welfare. The Central assistance for component

of the Programme shall be as under :

	No. of Posts	Annual Financial implication
(A) Staff		
(i) Clinical Psychologist	1	Rs. 50,000
(ii) Psychiatric Social Worker	1	Rs. 50,000
(iii) Occupational Therapist	2	Rs. 50,000
(B) TA/DA for Staff and Trainees		Rs. 20,000
(C) Contingency		Rs. 10,000
(D) Expenditure For 11 institutions @Rs. 1.80 lakh per institution recurring		Rs. 19,80,000

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DYNAMICS OF POPULATION GROWTH : 1901-1991

Period	Population at the end of the period (as on 1st March)		Growth rate %		Vital Rates per 1000 Population		
	Total (millions)	Urban (%)	Decadal	Average Annual (Exponential)	Birth Rate	Death Rate	Natural Growth Rate
1901-11	252.09	10.29	5.75	0.56	49.2	42.6	6.6
1911-21	251.32	11.18	-0.31	-0.03	48.1	49.6	-0.5
1921-31	278.98	11.99	11.00	1.04	46.4	36.3	10.1
1931-41	318.66	13.86	14.22	1.33	45.2	31.2	14.0
1941-51	361.09	17.29	13.31	1.25	39.9	27.4	12.5
1951-61	439.23	17.97	21.51	1.96	41.7	22.8	18.9
1961-71	548.16	19.91	24.80	2.20	41.2	19.0	22.2
1971-81	683.33	23.34	24.66	2.22	37.2	15.0	22.2
1981-91	846.30	25.73	23.85	2.14	29.3*	9.8*	19.5*

Note:— (1) The 1981 Census Population total has been revised in the light of the 1991 Census results.

(2) The 1991 Census figure includes projected population of Jammu & Kashmir.

(3) The Vital Rates except for 1981-91 have been calculated from the Census of India data by Reverse Survival Method.

*As per SRS provisional estimates for 1991.

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RURAL HEALTH SERVICES

Health Infrastructure in rural areas is of prime importance for realisation of the objectives set forth in the National Health Policy and for attaining the goal of "Health for All by the Year 2000 A.D."

Coordinated efforts are being made under various Rural Health Programmes to provide effective and efficient services to the people in the rural areas.

NUMEROUS programmes and schemes are being implemented under the Minimum Needs Programme to provide Primary Health Care relevant to the actual needs of the community in the rural areas. The status of establishment of the Sub-Centres, PHCs and Community Health Centres under the Minimum Needs Programme, is detailed in ensuing paragraphs.

Sub-Centres: A Sub-Centre is established on the basis of one Centre for every 5,000 population in plain areas and for 3,000 population in hilly and tribal areas. Upto the end of the 7th Plan, 1,29,291 Sub-Centres, were functioning while their number rose to 1,30,782 by the end of Sept., 1992 against the estimated requirement of 1.38 lakh Sub-Centres for the Seventh Plan. Due to non-availability of funds for opening new Sub-Centres, the targets were not allotted to the States/U.Ts. during the years 1990-91, 1991-92 and 1992-93.

Primary Health Centres: A Primary Health Centre is established on the basis of one PHC for every 30,000 population in the plain areas and for every 20,000 population in hilly, tribal and backward areas. Number of PHCs functioning in the country was 18,888 by the end of 7th Plan (1-4-90) which rose to 20,847 PHCs by the end of Sept., 1992.

Community Health Centres (CHCs): Rural hospitals with specialist facilities established by upgrading PHCs have 30 beds, to cover a population of 80,000-1.20 lakh. By the end of 7th Plan (1-4-90) the number of CHCs functioning was 1,820 which rose to 2,060 CHCs by the end of Sept., 1992. The CHCs act as referral Centres for four PHCs in a Block.

Auxiliary Nurse Midwives (Female Health Worker) Training Programme

Each Sub-Centre is manned by one Male Health Worker and one Female Health Worker (Auxiliary Nurse Midwife). In order to train the required number of ANMs in the rural areas, there are 468 ANM Training Schools functioning in the country with an annual admission capacity of 19,775. Duration of the training is 18 months. It is expected that 10,000 to 12,000 ANMs are likely to qualify in the current year. It is proposed to utilise these training institutions for providing continuing education programme for ANM besides providing basic training programme of 18 months duration.

Female Health Assistant Training Programme (LHV)

One Female Health Assistant has to supervise the work of six Sub-Centres in the rural areas. She provides technical guidance

and supervision to the ANMs who are working in rural areas. The senior ANMs are trained for six months to take up the post of LHV, which is a promotional post. There are 45 training schools with an admission capacity of 2,838 that are functioning in the country. These training schools are utilised for giving continuing education programme for the Female Health Assistant (LHV) besides providing basic training programme of six months duration.

Training of Dais: Majority of deliveries in the rural areas are conducted by dais. The objective of training the untrained dais is to enable them to conduct safe and hygienic delivery in the rural areas. They are also involved in propagation of small family norm. It is estimated that about 1.18 lakh untrained dais are working in the rural areas. These dais will be trained in a phased manner. Efforts are being made to provide continuing education programme for dais and also to improve the link between ANM and Dai so that quality of MCH services provided in the rural areas can be improved. So far, about 6.023 lakh dais have been trained.

Village Health Guide Scheme

The Village Health Guide Scheme was initially started as a Village Health Worker Scheme on 2nd October, 1977 in all States except Tamil Nadu, Jammu & Kashmir, Kerala and Arunachal Pradesh who had their own alternative schemes. The present Village Health Guide (VHG) Scheme was started in 1981. According to the scheme, the village community selects a volunteer as VHG who educates the community in sanitation and personal hygiene. He/She is also to render assistance in maternal care and

educate the mothers about immunisation and family welfare scheme. He/She has to keep track of communicable diseases and treat minor ailments and provide first aid to the patients.

Till now, 4.15 lakh VHGs have been trained. Each trainee is imparted 3 months training at the PHC level during which period he/she is paid a stipend of Rs. 200/- per month. During training a VHG is also provided kit containing common articles of use and medicines and a manual. At present 3,31,948 VHGs are on roll of the State Governments/Union Territories. Each VHG is paid an honorarium of Rs. 50/- per month.

To evaluate the working of the scheme in various States and UTs and also to suggest steps required for improvement of the scheme, a Task Force was set up in the Ministry of Health and Family Welfare in 1989. The Task Force made some valuable suggestions for improvement of the scheme. These recommendations are under active consideration of the Government.

Multi-Purpose Worker (Male)

As per the norms, each Sub-Centre is required to be manned by a trained Female Health Worker (ANM) and a trained Male Health Worker known as Multi-purpose Worker (Male). The Govt. of India had initiated a scheme of training and thereby converting the Unipurpose Workers under various programmes to Multi-purpose Worker in 1978. This training was continued till 1990. However, because of the shortage of MPW (Male) at Sub-Centre level, a scheme of basic training for MPW (Male) was initiated during Seventh Plan period. Under this scheme, the 10th pass candidates are selected and trained for one year before they are inducted into the service.

The basic training of MPW (Male) has been initiated by opening 44 such schools in various States as against the sanctioned

strength of 50 schools. As these 44 schools were found to be inadequate to meet the requirement of training of MPW (Male), this training was also initiated in 36 HFWTCs. Additional staff was sanctioned for training of MPW (Male) in HFWTCs.

Orientation Training of Medical and Para-Medical Personnel

This is a Centrally Sponsored Scheme under Family Welfare. It was started with the objective to train Medical and Para-Medical Personnel working at PHCs and Sub-Centres. Each category is placed to be imparted training in the same institution, where they had their basic training. The duration of training is two weeks.

Pattern of Assistance: The financial assistance admissible under the scheme is in the form of 100% non-recurring grant towards hostel for 20 trainers alongwith lecture and demonstration room, kitchen articles, training equipment and aides. The recurring grant is admissible on 50 : 50 sharing basis between the Government of India and the State Governments and the components covered under this are : rent for hostel (till the building is completed), contingency; consumable training material; additional teaching staff for hostel and class rooms of the HFWTCs and stipend for the trainees. For HFWTCs, which have been augmented under the scheme of orientation training of medical and para-medical personnel; only stipend is admissible to trainees. Regarding UTs, as they do not have enough training facilities available with them, they will seek the assistance of adjoining States to train their personnel.

Progress: The scheme is in operation in the States of Andhra Pradesh, Assam, Bihar, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Orissa, Punjab, Tamil Nadu, Uttar Pradesh and West Bengal.

Progress of Expenditure: The 7th Plan allocation for the scheme was Rs. 1,000 lakh. The details of allocation, releases made and anticipated expenditure is as stated in the following table :

DETAILS OF ALLOCATION FOR ORIENTATION TRAINING OF MEDICAL AND PARA-MEDICAL PERSONNEL

Year	Allocation	Anticipated expenditure (Rs. in Lakh)
1985-86	Nil	0.00
1986-87	50.00	Nil
1987-88	150.00	67.37
1988-89	100.00	43.74
1989-90	50.00	50.00
1990-91	50.00	49.90
1991-92	83.00	78.00
1992-93	80.00	39.96

During 1992-93, Rs. 80 lakh in two instalments have been sanctioned for this scheme. Funds, would be required for meeting the continuing liability of existing institutions.

Health and Family Welfare Training Centres (HFWTCs)

Health and Family Welfare Training Centres are established in the country with the objective of giving in-service training to health personnel in the rural health sector. These training centres are set up with 100% financial assistance from the Central Government.

The category of health personnel given in-service training at HFWTC and the period of training is as below :

Medical Officer	2 Weeks
Health Assistant (Male & Female)	2 Weeks
Block Extension Educator	4 Weeks
Key Trainers of ANM School	2 Weeks

In addition to the above training, the HFWTCs take up in-service training under various vertical National Programmes also. From 1982, HFWTCs are giving basic training to MPW(M) also. □

