

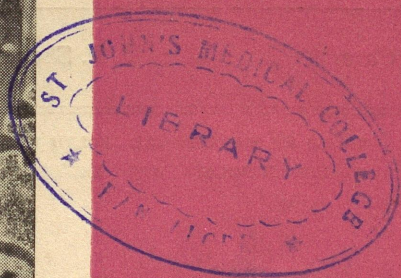
# swasth hind

Vol. 28 no. 8

August 1984



- \* Health and family welfare  
— A year of progress
- \* Blood pressure
- \* Indian Childhood cirrhosis
- \* Thirty-seventh World Health  
Assembly
- \* Meeting the threat of rabies



# swasth hind

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## Readers Write

I am very much impressed for the articles, brief reports, case studies published in the **Swasth Hind** with up-to-date information on various Health matters and about National Health Programmes.

—Dr K. Subbe Rao, MBBS,  
Medical Officer,  
Govt. Dispensary,  
JEELUGUMILLI,  
West Godavary Distt.

Every health personnel should study **Swasth Hind** as it contains many valuable items regarding different health programmes of India. It is really uncommon.

Santosh Mandal,  
Health Technical Personnel,  
Dist 24 Pargs.,  
West Bengal.

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

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(Postage Free)

# HEALTH AND FAMILY WELFARE

## —A Year of Progress

C. R. VAIDYANATHAN

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It has been possible to record substantial achievements as a result of various policy and strategic interventions. Inclusion of the Family Planning Programme in the 20-Point Programme and the keen interest and initiative of the Prime Minister has given it the necessary political commitment. This has helped in creating a very favourable climate for its effective implementation.

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THE two major events of 1983-84 which brought the activities of the Ministry of Health and Family Welfare to the focus of public attention were the approval, by Parliament, of the National Health Policy and the presentation of the United Nations Population Award to the Prime Minister, Smt. Indira Gandhi. The National Health Policy was approved of by the Rajya Sabha in the Monsoon Session and by the Lok Sabha in the Winter Session of Parliament. While addressing the World Health Assembly in May 1981, Prime Minister said that "in India we should like health to go to homes instead of larger numbers gravitating towards centralised hospitals. Services must begin where people are and where problems arise." This and the other statement of the Prime Minister that the "needs of the many must prevail over those of the few" form the bed rock of the National Health Policy. The National Health Policy is based on a firm recognition of the fact that the health status of the people must be raised, if their quality of life is to

improve. Health services would, thus, become a part of human resources development in which horizontal and vertical linkages are sought to be established among all the inter-related programmes like protected water supply, environmental sanitation and hygiene, nutrition, education, etc.

Our efforts at population control received international recognition when Prime Minister, Smt. Indira Gandhi, became the first recipient of the United Nations Population Award after its inception. The Award was presented to the Prime Minister at a special function organised on 30, September, 1983, at New York. Speaking on that occasion, the Prime Minister observed that "it is said that prosperity is a good contraceptive. But the effects of development are submerged unless we bring about a low birth rate. Family planning is an input for development, an indispensable exercise in human capital formation. Education, better capacity for producing and earning a higher rise in per capita income are possible only when population growth is curbed. Individuals are not moved by statistics but by emotions. We have been able to convince an increasing number of people that in our circumstances family planning means better health for the mother and child and more opportunities for the family as a whole".

Health and Family Planning are rightly considered as indispensable inputs in the process of socio-economic development and as such they have been accorded due importance in the new 20-Point Programme of the Prime Minister which, *inter alia*, is committed to:—

- (i) promote family planning on a voluntary basis as a people's movement;

- (ii) substantially augment universal primary health care facilities and control of leprosy, T.B. and blindness; and
- (iii) accelerate programmes of welfare for women, nursing mothers and children, specially in tribal, hilly and backward areas.

All our efforts are now directed towards achieving these objectives.

### Primary Health Care

Health is not only the starting point of all welfare but also a significant yardstick to measure the progress of a country. In the years after Independence, there has been a significant increase in the average life span of an Indian, from 27 years in 1947 to 52 years in 1981. This is partly due to our success to control or contain deadly diseases which used to ravage the country in epidemic form, and partly on account of ever expanding public health delivery system. But we have a very long and arduous journey ahead to reach our goal of 'Health for All by the Year 2000 A.D'. For this, it was considered essential to evolve an integrated and comprehensive approach towards the future development of medical education, research and health services. The National Health Policy provides the necessary direction for re-orienting and restructuring the health services with long-term perspective. The Policy envisages a conceptual change from the emphasis on curative services to the preventive and promotive aspects of health care, particularly of the weaker and deprived sections of the society. As a logical corollary to this change, there is going to be more and more stress on the preventive, promotive, public health and rehabilitative aspects of health care with provision of primary health care services to reach the population in the remotest areas. While envisaging health and human development as a vital component of overall integrated socio-economic development and a decentralised system of health care delivery with maximum community and individual participation, the Policy also emphasises the need for ensuring adequate nutrition, safe drinking water supply and improved sanitation. To translate these objectives into reality, the Health Policy lays down specified goals to be achieved by 1985, 1990, 1995 and the year 2000. Through the frame-works of the Sixth Five-Year Plan and the 20-Point Programme, steps are already under way to implement the Policy. Some of these are:

- (i) It has been decided to establish one sub-centre for every 5,000 rural population (3000 in tribal

and hilly areas) with one male and one female worker. 18,471 new sub-centres have been opened in the last three years and as on 1-4-83, their total number stood at 64,643.

- (ii) In place of one Primary Health Centre for every Community Development Block covering a population of nearly one lakh, it is now proposed to have one Primary Health Centre for every 30,000 rural population (20,000 in hilly and tribal areas). Nearly 6,000 PHCs are functioning in different States and Union Territories. Out of these 3,182 are Subsidiary Health Centres/new Primary Health Centres started during the last three years.
- (iii) Four hundred and seventy one Community Health Centres (each serving a population of one lakh) with specialised services, viz., surgery, medicine, gynaecology and obstetrics, paediatrics, including X-Ray and laboratory facilities have also been established since 1-4-1980.
- (iv) In order to effectively follow the Primary Health Care approach for involvement of local communities, a programme has been evolved to train Health Guides selected by the community for every village or every 1,000 rural population. Nearly three lakh Health Guides had been trained upto November, 1983.
- (v) An extensive programme has been undertaken to train traditional birth attendants or Dais with a view to improving their knowledge and skills. Over 4.5 lakh Dais have already been trained. The target is to provide one trained Dai to each village by the end of the Sixth Plan.
- (vi) Under the Multi-purpose Workers Scheme, training of the various categories of staff, viz., Medical Officer (PHC), Block Extension Educator, Health Assistant (Male) and Health Assistant (Female) has been completed in 333 districts and it is going on in another 40 districts.

These schemes are expected to ensure the availability of adequate infrastructure and medical and paramedical manpower to take us nearer to the goal of universal provision of primary health care as envisaged in the National Health Policy.

Tangible progress has been achieved in the reduction of morbidity and mortality due to preventable communicable diseases. Smallpox has been eradicated in the country and no case of plague has been reported since 1967. Malaria, Leprosy, T.B. and Blindness

are the major health problems for which national programmes are being implemented all over the country. Public health measures are also being continued against diarrhoeal diseases, filaria, goitre, Japanese encephalitis and guinea worm.

### **Malaria eradication**

Malaria has been a major public health problem in the country. To combat this disease, National Malaria Eradication Programme is being implemented vigorously all over the country. Surveillance, spray of insecticides along with health education on sanitation, personal protection measures, etc., are being undertaken under this Programme. Research activities are being continued regarding effect of insecticides on vector control and resistance of malaria parasite to common anti-malarial medicines. As a result of efforts put in, the incidence of malaria has been declining in the country. Particular attention is being given to the cases of *P. falciparum* in the country. During 1983 (upto November) 11,57,385 malaria cases were reported in the country which is 28 per cent less compared to the same period of last year. Recently the Government of India have decided to provide 100 per cent Central assistance to the States for the cost of malathion required for spray in the areas where the vector mosquitoes for malaria have been found to have developed resistance to BHC and DDT. The Programme is being reviewed regularly at various levels.

### **Leprosy eradication**

Leprosy is a major health and social problem in the country. Following the recommendations of the Working Group headed by Dr Swaminathan, the then Member, Planning Commission, the Government have taken up the National Leprosy Eradication Programme for implementation all over the country. A National Leprosy Eradication Commission with the Union Minister for Health and Family Welfare as Chairman has been set up as the policy guidance body with the National Leprosy Eradication Board as the executive instrument for implementation of its policies. Similar policy guidance and implementation bodies are being set-up in the hyper endemic States. Intensive case detection and treatment, application of multi-drug regimen, extensive health education and rehabilitation of cured patients are the main features of the new strategy. Of the estimated 3.2 million population in the country suffering from Leprosy, about 2.9 million have already been detected and 2.74 million, brought under treatment. During the year, the case detection and treatment activities were continued vigorously. The pace of es-

tablishment of various leprosy control units/centres, survey education and treatment centres, temporary hospitalisation wards, reconstructive surgery units, etc., was also geared up. Our ultimate object is to eradicate this scourge by the year 2000 A.D.

### **Tuberculosis control**

Tuberculosis is another major health problem in the country. The BCG vaccination continued to be administered to children upto 4 years with a view to preventing T.B. Under the National T.B. Control Programme, the detection of T.B. cases and treatment of the detected cases continued to be done through the network of T.B. Centres in the country. At present 354 fully equipped T.B. Centres are functioning in the country. The targets for case detection fixed in 1982-83 were achieved. During 1983-84, the target for detection of T.B. cases was raised to 12.5 lakhs and the progress of case detection is satisfactory. For the first time, during this year, targets have also been laid down to ensure at least 50 sputum examinations per month at each Primary Health Centre in order to provide easy case detection facility in the rural areas. Under this programme, the provision of Central assistance for supply of anti-T.B. drugs has been raised.

### **Blindness control**

National Programme for Control of Blindness has been launched to reduce the incidence of blindness from the present level of 1.3 per cent to 0.3 per cent in the country by the year 2000 A.D. Cataract has been identified as the major cause for blindness. Sample survey of the population has indicated that 55 per cent of the 9 million blind in the country are due to cataract. Under the Programme, intensive efforts are being made to perform as many cataract operations as possible by pooling all the available resources in various health institutions under Government and non-Government Sectors and also involvement of voluntary agencies. Camp programmes are also organised for the performance of cataract operations in the rural areas. According to the reports available, so far 3.04 lakh cataract operations have already been performed during the year. This programme has received a considerable boost-up following the Government decisions on the recommendations of the Working Group headed by Dr Swaminathan. It is proposed to strengthen the infrastructure for eye care services at various levels, viz., PHCs, District Hospitals, Medical College Hospitals, Regional Institutions and Dr R.P. Centre of the All India Institute of Medical Sciences, New Delhi. The facilities for performance of cataract operations

*(Continued on page 174)*



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## OTHER HIGHLIGHTS

### Indian Systems of Medicine and Homoeopathy

"Indian Systems of Medicine" include all the non-allopathic systems of medicine and regimens excluding Homoeopathy, viz. Ayurveda, Siddha, Unani, Nature Cure, Yoga, and Amchi (Tibetan). In the Sixth Plan, Rs. 29 crores have been provided in the Central Sector for the development of Indian Systems of Medicine and Homoeopathy. The various schemes included in the Sixth Plan aim, mainly, at improving the quality of education, promotion of research programmes based primarily on their respective philosophies, planned production of herbal and other medicines on a large scale and their standardisation.

A large number of practitioners of Indian Systems of Medicine and Homoeopathy are practising in the rural and urban areas of the country. Generally speaking, the cost of medical treatment in these systems is less compared to that under the modern system (Allopathy). The National Health Policy recognises the important role of the Indian Systems of Medicine and Homoeopathy, in the delivery of primary health care in the context of the national target of achieving "The Health For All by 2000 AD". It envisages the private practitioners of Indian Systems of Medicine and Homoeopathy to be involved in the preventive and promotive aspects of health care of people.

#### Four Apex Bodies for Research

The four Research Councils, viz. (i) Central Council for Research in Ayurveda and Siddha (CCRAS); (ii) Central Council for Research in Unani Medicine (CCRUM); (iii) Central Council for Research in Homoeopathy (CCRH); and (iv) Central Council for Research in Yoga and Naturopathy (CCRYN); continued to initiate, aid, guide develop and coordinate scientific research in different aspects—fundamental and applied of the respective systems. Registered

under the Societies Registration Act, 1860, these Central Councils are administered by the respective governing bodies, consisting of official and non-official members as provided in the respective memorandum of association, rules, regulations and bye-laws of the Council concerned. These Councils are the apex bodies for research in the concerned systems of medicine and are fully financed by the Government of India.

### Prevention of Adulteration of Food and Drugs

The Prevention of Food Adulteration Act, 1954, has been in force since 1 June, 1955, to prevent adulteration of foods and thus to protect the consumers against deceitful practices and hazards of adulteration. The Act defines the powers and duties of various functionaries besides defining the terms adulteration and misbranded and the penalties for such offences.

The Act is enforced by the State Governments and Local Bodies in their respective jurisdictions. However, the States of Andhra Pradesh, Gujarat, Madhya Pradesh, Maharashtra, Tamil Nadu, Kerala & Uttar Pradesh, and Union Territories of Delhi, Goa, Daman & Diu & Pondicherry have taken up the responsibility of implementation of the Act at their level by establishing a separate Directorate or a Wing.

#### Amendment to Food Standards and Regulations

The Prevention of Food Adulteration Rules covering the standards of various items of foods, use of additive, presence of contaminants, etc., are amended from time to time on the recommendations of Central Committee for Food Standards which is a statutory committee, constituted by the Central Government under the provisions of the Act to advise the Central and the State Governments on matters relating to the implementation of the Act. The committee had met 29 times. △

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*National Programme for Control of Blindness has been launched to reduce the incidence of blindness from the present level of 1.3 per cent to 0.3 per cent in the country by the year 2000. Health education and facilities for early detection of various eye diseases like glaucoma and correction of vision are continued to be provided under this programme.*

(continued from page 171)

are also being augmented under this Programme. Health Education activities and facilities for early detection of various eye diseases like glaucoma and correction of vision are continued to be provided under this Programme.

### Medical education

The National Health Policy suggests that a separate National Medical and Health Education Policy should be evolved. The Government had some time back appointed a Medical Education Review Committee to bring about overall improvement in the under-graduate and post-graduate medical education, etc. In the light of the recommendations of the Committee, the work of evolving a National Medical and Health Education Policy is expected to be taken up soon.

### Indian systems of Medicine

Indian Systems of Medicine and Homoeopathy have important role in the delivery of primary health care. The Indian Systems of Medicine include Ayurveda Siddha, Unani, Nature Cure and Yoga. During the Sixth Plan period, generally speaking, while State Plan schemes deal with the graduate level education and delivery of health care, the Central Sector schemes deal with standards of graduate and post-graduate education, development of post-graduate education, research, quality control and production of herbal and other medicines. During the current year, Central assistance was continued to the States for the maintenance of upgraded post-graduate departments in Government Ayurvedic Colleges and for the development of State Pharmacies in the field of Indian Systems of Medicine. The Indian Medicine Pharmaceutical Corporation Ltd., established by the Government of India at Mohan in Almora District of Uttar Pradesh, as a public sector undertaking of the Government of India with joint collaboration with the Government of Uttar Pradesh for the manufacture of quality medicines of Ayurveda, Siddha and Unani went into commercial production during the year. The Research Councils on Ayurveda and Siddha, Unani and Yoga and Naturopathy and Homoeopathy continued their research activities during the year. A new anti-malaria drug (Ayush 64) has been found by the Central Council of Research in Ayurveda and Siddha for which some firms have been licensed for production and marketing. An Ayurvedic anti-epileptic drug found by this Council is also in its initial process of commercialisation. The elections of members for the Central Council of Indian Medicine

from the States and Universities were held for the first time under the provisions of the Indian Medicine Central Council Act, 1970, during the year and the new Central Council of Indian Medicine is expected to be re-constituted soon.

### Family Welfare

Population is a human problem intimately concerned with the quality of life of the people. This is the basic postulate of the Family Welfare Programme which is sought to be promoted as people's own programme. In this one of the most difficult areas of social engineering, our main thrust continues to be towards securing maximum participation of the people by activating opinion leaders, social and voluntary organisations and democratic institutions at all levels. Alongwith motivation and education of the people, intensified efforts are being made to make available adequate supplies and services at convenient points and to improve their quality.

These efforts have steadily been gaining momentum as is reflected by the rising couple protection levels during the last few years. The couple protection level which had fallen from 23.7 per cent in 1976-77 to 22.3 per cent in 1979-80, again showed an upward trend when it touched 22.7 per cent in 1980-81 and 23.7 per cent in 1981-82. These efforts have since gathered further momentum. In 1982-83, couple protection rate (C.P.R.) was 25.9 per cent. By the end of March 1984, it is expected to improve further—around 29 per cent. The graph of family planning acceptors shows a similar pattern. There were 5.5 million acceptors in 1979-80. This increased to 6.5 million in 1980-81, 8.1 million in 1981-82, and 11 million in 1982-83; a two-fold increase in three years. The performance figures upto the end of January, 1984, show a step-up in the number of sterilisations and I.U.D. insertions by 12.8 per cent and 62.6 per cent respectively over the corresponding period of the last year. Similarly increase in the case of conventional contraceptive users and oral pill users was 13.1 per cent and 84.7 per cent respectively during the period April to December, 1983.

### M.C.H. programme

There is a direct relationship between decline in infant mortality and decline in birth rate. Small family size is also essential for the good health of people, especially of women and children. Maternal and Child Health (MCH) Care, as such, forms a very important component of the Family Planning Programme and

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Tangible progress has been achieved in the reduction of morbidity and mortality due to preventable communicable diseases. Smallpox has been eradicated in the country and no case of plague has been reported since 1967. Malaria, Leprosy, T. B., Blindness are the major health problems for which national programmes are being implemented all over the country. Public health measures are also being continued against diarrhoeal diseases, filaria, goitre, Japanese encephalitis and guinea worm.

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is being administered through the overall primary health care delivery system. Important elements of MCH programme include care of pregnant women and new-born children, control of tetanus of the new-born, immunisation of children against various diseases, especially polio, promotion of breastfeeding, ensuring proper growth by nutritional supplements, prevention of anaemia and blindness due to Vitamin A deficiency, and training of personnel of all categories. As a result of this Programme, the infant mortality rate has come down to 114 (in 1980) for 1000 live births after remaining static for many years at around 127.

#### **Linkages with other programmes**

There is increasing realisation of the fact that Family Planning cannot be promoted in isolation from other socio-economic development programmes. In view of this, vigorous efforts were made for forging closer linkages with agricultural and other rural development programmes such as provision of safe drinking water, proper sanitation, etc. Social factors like improved status of women through education, more and better employment opportunities for them, delayed marriages, equal treatment to sons and daughters, etc., also play an important role in fertility control. Involvement of youth through formal and non-formal educational programmes and community leaders through orientation training camps are important planks of the programme to create an all-pervading social milieu in which small family norm becomes a way of life.

It has been possible to record substantial achievements as a result of various policy and strategic interventions. Inclusion of the Family Planning Programme in the 20-Point Programme and the keen interest and initiative of the Prime Minister has given it the necessary political commitment. This has helped in creating a very favourable climate for its effective implementation.

In order to step up the tempo of the Family Welfare Programme, a number of administrative measures and initiatives have been taken during 1983-84. These include increase in the compensation money payable to individual acceptors of terminal methods from Rs. 70 to Rs. 100, and I.U.Ds. from Rs. 6 to Rs. 9; awards to the best performing States and Union Territories; monetary awards in the form of community assets to organised identifiable groups; issue of green cards to individual acceptors of terminable methods after two children as a mark of recognition and priority attention in certain matters; revamping of the organisational and service delivery out-reach system in urban slums and congested areas in conjunction with the overall augmentation of the health and family welfare delivery systems. All these steps are expected to show their full impact in the succeeding years.

A close liaison and communication was maintained with the States and Union Territories to facilitate the implementation of various health and family welfare programmes. The Ninth Joint Conference of the Central Council of Health and the Central Family Welfare Council was held from 7 to 9 July, 1983, in New Delhi, under the Chairmanship of the Union Minister for Health and Family Welfare. A number of issues were discussed in the national perspective and important recommendations made for acceptance by the Government. Earlier, the progress of performance of various States and Union Territories in the preceding year and targets for the current year were reviewed in the six regional meetings held by the Union Health Minister. A conference of Health Secretaries of low performing States was also held to boost up their performance. These meetings proved very useful in understanding the problems faced by the States and finding solutions to them.

*—Excerpts from the Introduction to the Annual Report 1983-84 of the Union Ministry of Health and Family Welfare.*



## Family Welfare—A People's Programme

FROM promotion of simple contraceptive devices to integration with the national strategy of growth which treats the family as the primary basic unit of development and regards family welfare as an essential input in it—the family planning programme in India has come a long way and holds forth the promise that in the not very distant future it may be accepted as a way of life by most people. It is no longer being treated as a programme in isolation with birth-control as its be-all and end-all. Birth control no doubt continues to occupy the same important position in the programme as it used to in the earlier days; but the programme now aims at achieving a higher end—and that is, to improve, in conjunction with other development programmes, the quality of life of the people.

This, the programme seeks to do directly; on the one hand, by strengthening the health base of the community, particularly through expansion of maternal and child health care services, and on the other by providing to married couples free advice and services

in relation to contraception. Indirectly, the programme is a source of strength to all other schemes of socio-economic development, whatever may be their immediate goal.

### New Strategy

Smt. Mohsina Kidwai, Minister of State for Health and Family Welfare, in a statement informed the Rajya Sabha on 25 April, 1984, that the following steps were being taken to achieve the objectives of the Family Welfare Programme :

- (a) Adoption of "small family norm" was being continued to be promoted entirely on a voluntary basis.
- (b) Intensified efforts were being made to spread awareness and information about small family concept by effective and imaginative use of multi-media and interpersonal communication strategies.
- (c) Each couple was allowed to choose the method most suitable to it.

(d) Services and supplies were being provided as close to the door steps of the acceptors as possible.

(e) The programme was designed to continue to be an integral part of health care and socio-economic development efforts.

(f) Facilities and efforts for rapid increase in female literacy were being intensified and expanded.

(g) Population education was being extended to youth in schools and colleges as well as those out of school. It would also be introduced in all workers' education and training programme conducted by Government departments/agencies and by the organised sector.

(h) Elected Representatives of the people at all levels—grass-root level, village organisations, voluntary organisation, etc., were being closely assisted and provided encouragement and support.

(i) Linkages with other concerned Ministries and Departments had been strengthened.

(j) Effective observance of the law relating to minimum age for marriage for girls and boys was being pursued.

(k) Maintenance of records of all marriages at the village or community level was being pursued.

(l) In respect of States lagging behind in performance area specific approach was being followed.

(m) Under the "Village Health Guide Scheme" which had now been made a fully Centrally funded scheme, the Health Guides (who will prominently be women) were responsible for spreading knowledge and information to each individual household and to provide at peoples door-steps supplies for non-clinical methods.

The Government had also set up a Population Advisory Council consisting of Members of Parliament and prominent persons from fields relevant to population control as members to analyse the implementation of the family welfare programme and also initiate and suggest new ideas and strategies with a view to improving the performance of the Programme and achieving the demographic goals.

In order to further accelerate the pace of the Programme, Government had taken a number of important decisions:

(i) Monetary rewards in the form of community assets would be given to recognised and identifiable groups actively engaged in the implementation of the Family Welfare Programme.

(ii) Cash awards were being given to the best performing States. The prize money was to be utilised for the promotion of the Family Welfare Programme.

(iii) Innovative publicity in selected areas on campaign basis was being organised. This would be suitably dovetailed with services and supplies.

(iv) With a view to revamping the organisation and service delivery out reach system for Family Planning and MCH, health posts consisting of nurse, midwives and health workers were being established in urban slums and congested areas.

(v) States had been requested to introduce, a scheme of issue of 'Green Cards' to individual acceptors of terminal methods after two children as a mark of recognition and priority attention. This card would enable the acceptors to be accorded preferential treatment in schemes where such preferential treatment was feasible.

(vi) States had been requested to give to acceptors of sterilisation, 5 State lottery tickets for the next draw.

(vii) Compensation money payable to individual acceptors of sterilisation had been increased by Rs. 30 raising it from the present level of Rs. 70 to Rs. 100.

(viii) The amount payable to the acceptors of IUDs had been increased from Rs. 6 to Rs. 9.

## GREAT STRIDES IN COUPLE PROTECTION

THE target of providing 60 per cent "couple protection" to couples in the reproductive age group under the Family Welfare Programme may well be exceeded by the target date of 2000 AD.

A rise of 2.2 per cent in the couple protection level which reached 25.9 per cent in 1983 from 23.7 per cent in 1982 gives substance to this hope.

Performance rates in sterilisations, IUD insertions, conventional contraceptives and oral pill use popularisation, all registered considerable growth in 1983. Oral pill use rose by 78.5 per cent and IUD insertions rose by 56.3 per cent as compared to 1982.

The total number of family welfare acceptors is also increasing substantially. From 45 lakhs in 1978, it rose to 110 lakhs in April 1983. Workers are maintaining this tempo.

Another hopeful fact is a fall in the population growth rate. It fell from 2.2 per cent in 1970 to 1.9 per cent in 1983. This is all the more encouraging because a lower growth rate in population was achieved in spite of a substantial fall in death rate.

These statistics are based on reports made available from about 330 districts in the country. Fifteen States with 47 per cent of the total population registered declining trend in population growth rate.

During the first nine months of 1983, sterilisations totalled 2,539,938, IUD insertions 1,015,498, contraceptive use to 5,577,090 and oral pill, use to 2,60,032.

Even though performance levels differ from State to State, the target set for the year 2000 for family Welfare may in all probability be achieved by 1991.

# Maternal And Child Health Care

The overall perspective of health problems in India is dominated by over-population which causes a considerable strain on the health care system. The brunt of this strain is borne by the vulnerable group, mothers and children. Therefore, control of population and provision of appropriate care to mothers and children play a pivotal role in a family welfare programme. An integration of these two components of family welfare, MCH and Family Planning, can lead to a better effectiveness of the programme on account of being directed towards the recipient and improving its credibility with increased acceptance of family planning.

In a broad perspective a newly married couple desires to have only the wanted children and take a good care of them. Thus, a family welfare programme is directed towards.

- (i) to bring about wanted conceptions, which should develop into healthy newborns and reared into healthy children;
- (ii) to avert unwanted conceptions and to regulate the interval between pregnancies; and
- (iii) to accept a small family norm.

Essential activities of the MCH Programme are directed towards achieving the above objectives, the salient features being an effective antenatal care, ensuring a safe and aseptic delivery, an appropriate postnatal care, early initiation and maintenance of

breast feeding, timely immunisation against common infectious diseases, control of diarrhoea, attention to growth and provision of basic medical care, when necessary.

## FACTS ABOUT WOMEN

- \* according to 1981 census, the total population of females in India is more than those of the USA and the USSR.
- \* In India, female male ratio is 935:1000. The only Indian State where females outnumber males is Kerala, with a ratio of 1034:1000.
- \* mortality rates are higher among females during infancy and child birth.
- \* life expectancy ratio was 51.6:49.7 for males and females respectively.
- \* upto the age of four male death rate in rural India is 58 per 1000 as against 70 per 1000 death rate of females.
- \* the rate of female literacy increased from 0.60 in 1901 to 24.88 in 1981.
- \* working women who constituted only 12.13 per cent of the total population in 1971, increased their percentage to 14.44 per cent in 1981, while for men the percentage fell from 52.61 to 51.23 over the same period.

—PIB

## FAMILY WELFARE

### Targets for the Year 2000

#### Births, Deaths and Average Life Span Targets for 2000 AD

Long term goals for birth, death, infant mortality, couple protection rates and life expectancy as set out in the National Health Policy document and the present position are:

	Birth rate	Death rate	Infant mortality rate (per 1000 live births)	Couple protection % age	Exception of life at birth (years)
	per 1000 population				
Targets for 2000 A. D.	21	9	Below 60	60%	Male 64 Female 64
Current available level	33.6 (1982)	11.8 (1982)	114 (1980)	25.9 March (1983)	Male 55.6 Female 56.2 (1983) based on projected figures for 1981--86.

(Registrar General of India)

Steps being taken to achieve these goals include intensified promotional efforts, augmentation of Health, Family Planning and MCH Services, increase in female literacy and spread of Health and population education.

This information was given by Shri B. Shankaranand, Minister of Health and Family Welfare, in Rajya Sabha on 2 May, 1984.



## Targets and Achievements under MCH

The performance in respect of all the maternal and child health activities (except prophylaxis against blindness due to Vitamin--A deficiency) have shown improvement during the period 1983-84 as compared to the corresponding period of last year. The performance under MCH programme during 1983-84 (Upto November) is given in the table below:

TARGETS UNDER MCH PROGRAMME DURING 1983-84 AND ACHIEVEMENT  
DURING 1982-83 AND 1983-84

(Figures in 000's)

Activity	Target for 1983-84	Achievements*		%increase† (+) or de- crease (—)	.%Achvt. of annual target††
		1983— 84	1982— 83		
		April to Nov., 83 Corres- ponding period)		of per- formance in 1983--84 as compared to 1982-83	
1	2	3	4	5	6
<b>A. <u>Immunisation</u></b>					
(i) Tetanus Immunisation for expectant mothers	11,500	4,420	3,987	(+) 10.9	38.4
(ii) DPT Immunisation for children	14,500	5,595	4,844	(+) 15.5	38.6
(iii) DT Immunisation for children	13,000	5,523	5,222	(+) 5.8	42.5
<b>B. <u>Prophylaxis against Nutri- tional anaemia among</u></b>					
(i) Total Women	12,000	9,400	8,219	(+) 14.0	79.1
(ii) Children	12,000	8,430	7,394	(+) 14.0	70.9
<b>C. <u>Prophylaxis against Blind- ness due to vit. 'A' deficiency.</u></b>					
1st Dose	25,000	10,437	11,609	(—) 10.1	46.0
<b>D. <u>Polio</u></b>					
	7,500	3,202	1,791	(+) 78.7	42.7
<b>E. <u>Typhoid</u></b>					
	10,000	2,627	2,088	(+) 26.1	26.4

\*Figures provisional

†Excluding the States for which the corresponding figures are not available.

††Worked out after excluding targets in respect of States/Union Territories for which performance figures have not been received.

# Rural Health Services

THE National Health Policy lays stress on the preventive, promotive, public health and rehabilitative aspects of health care as a package. Under this policy it is sought to establish comprehensive primary health care services to reach the population even in the remotest areas, with the maximum community and individual self-reliance and participation.

## Minimum Needs Programme

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

### (A) Sub-Centres

These sub-centres will be established on the basis of one sub-centre for every 5000 population in general and for every 3000 population in hilly, tribal and backward areas. The additional sub-centres to be established during the 6th Plan period will raise the number to about 90,000 against the estimated total requirements of 1,22,000. Their progress is as follows:—

a) Functioning on 1. 4. 1980	47172
b) Target for the 6th Plan Period	37940
c) Established during 1980-83	18471
d) Target for 1983-84	9010

### (B) Primary Health Centres

The additional Primary Health Centres will be established in places where the existing Primary Health Centres cater to a larger population, so as to reduce the work-load on existing Primary Health Centres for providing better services.

a) Functioning on 1. 4. 1980	5484
b) Target for the 6th Plan period	756
c) Established during 1980-83	475
d) Target for 1983-84	405

### (C) Subsidiary Health Centres

It is proposed to convert the Rural Dispensaries into Subsidiary Health Centres. The ultimate objective is to involve all the rural dispensaries at present providing only curative service, in providing the package of promotive, preventive and curative services:—

a) Functioning on 1. 4. 1980	2056
b) Target for the 6th Plan Period	2270
c) Established during 1980--83	1126
d) Target for 1983--84	804

### (D) Upgraded PHCs

It is proposed to establish rural hospitals by upgrading the existing PHCs. Each of the upgraded PHC will have 30 beds to meet the need of the rural population.

a) Functioning on 1. 4. 1980	218
b) Target for the 6th Plan period	315
c) Established during 1980-83	253
d) Target for 1983-84	70

### Health Guide Scheme

With the objective of preparing a cadre of voluntary health workers, selected by the community, the Health Guides' Scheme (formerly known as Community Health Volunteers) was introduced in the country on 2 October, 1977. A Health Guide undergoes training in promotive, preventive and elementary health care components so as to provide an integrated primary health care at the grass-roots level. The training is arranged in the nearest Primary Health Centre, Sub-Centre or any other suitable place for a duration of 200 hours, spread over a period of 3 months. During the training period, the Health Guide is paid Rs. 600 as stipend and on completion of the training a manual, a kit and simple medicines are provided. The Health Guide receives an honorarium of Rs. 50 per month to meet out-of-pocket expenditure and drugs worth Rs. 50 per month.

States and Union Territories of Gujarat, Haryana, Himachal Pradesh, Madhya Pradesh, Maharashtra, Manipur, Nagaland, Orissa, Sikkim, Tripura, West Bengal, Mizoram, Pondicherry, A & N Islands, Chandigarh, D & N Haveli, Delhi (Rural Health Training Centre, Najafgarh) and Lakshadweep have been fully covered by the Scheme. Punjab, Bihar, Assam and Rajasthan which discontinued the scheme earlier have reintroduced the same.

States and Union Territories of Jammu & Kashmir, Kerala, Tamil Nadu and Arunachal Pradesh are covered by the alternative scheme. Jammu & Kashmir is implementing 'Rehbar-i-Sehat' scheme through the primary school teachers and has covered 38 primary Health Centres. 1130 primary school teachers have also been trained. Kerala is implementing an alternative scheme in the two districts of Calicut and Travandrum covering 34 Primary Health Centres. The State has provided Child Specialist in each of the Primary Health Centres and additional grant for purchase of drugs. Tamil Nadu has started 264 'Mini Health Centres' in the State. Arunachal Pradesh is implementing 'Medic' scheme and is expected to achieve the target of training 600 Medics during the current year.

From 1977-78 to 1978-79, the scheme operated as 100% Centrally sponsored scheme while during 1979-80, the scheme was converted into category-II Central scheme on 50:50 basis. However, 100% financial assistance is again being provided under the Family Welfare Programme since 1 December, 1981.

Four thousand two hundred and forty seven Primary Health Centres have been covered and 2,51,030 Health Guides trained upto 30-9-1983. During 1983-84, it is expected that all the remaining States and Union Territories except Bihar will be fully covered by the Scheme. A budgetary provision of Rs. 50.56 lakhs has been made for this scheme for the current year.

#### Multi-purpose Workers' Scheme

The Multi-purpose Workers' Scheme aim at establishing a Health Delivery System in the rural areas through a team of Multi-purpose Workers—one male and one female for every 5000 rural population. Implementation involves (a) intensive training programme to train uni-purpose workers in the technical concepts and skills of the Multi-purpose Workers at all levels and (b) employment of additional of workers.

△

## ENHANCED GRANT TO VOLUNTARY ORGANISATIONS IN RURAL AND BACKWARD AREAS

Shri B. Shankaranand, Minister of Health and Family Welfare, in a statement in Lok Sabha on 19 April, 1984 on enhanced grant to voluntary organisations said, "the pattern of financing has been revised in favour of voluntary organisations under one of the grants-in-aid schemes for setting up hospitals/dispensaries in rural areas only. The salient features of the new scheme, known as Special Health Scheme for Rural Areas are:

- (1) Financial assistance would be available to voluntary organisations for setting up new hospitals/dispensaries in rural areas only.
- (2) The maximum number of beds should not exceed 30.
- (3) One third of the beds will have to be kept as free beds.
- (4) The contributions of the various parties will be in the following proportion:

(i) *Construction (other than residential accommodation) and equipment:*

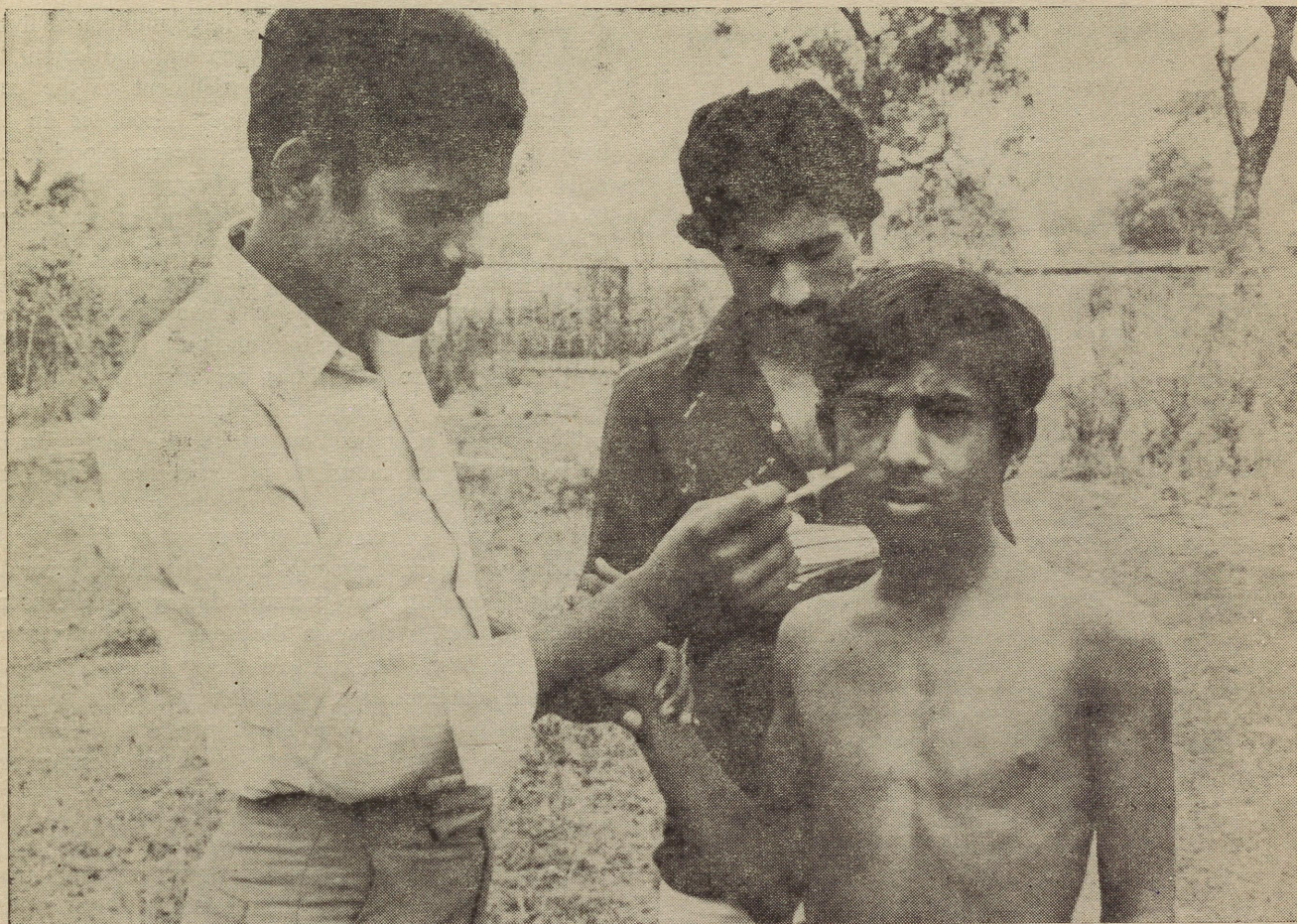
Central Government	40%
State Government	40%
Institutions	20%

(ii) *Construction of residential accommodation*

Central Government	50%
State Government	35%
Institutions	15%

- (5) For determining the shares of the Central Government and the State Governments, the standard cost of construction of a 30 bedded Community Health Centre or the cost as estimated in the project report, whichever is less will be taken into account.
- (6) In exceptional cases assistance can be given by the Government of India beyond the limits indicated in (4) above with the approval of the Ministry of Finance.
- (7) The grantee Institutions shall prominently display information about the amount of grants received and the number of beds available as free beds.
- (8) The applications from voluntary organisations for financial assistance will be routed through the State Governments.

Since the scheme has been revised only recently, the response of the voluntary organisations for financial assistance will be known on receipt of applications under the modified scheme."



## Detection Treatment and Rehabilitation of Leprosy Cases

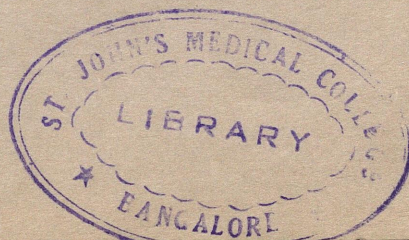
Kum. Kumud Joshi, Deputy Minister for Health and Family Welfare, informed the Lok Sabha on 1 March, 1984, that with the inclusion of leprosy programme in the 20-Point Programme of the Government a Working Group had been appointed by the Government of India and based upon their recommendations the Programme was launched as a National Leprosy Eradication Programme with main thrust on early detection and regular treatment through trained medical, non-medical and technical personnel of the Leprosy Control Units, S.E.T. (Survey, Education & Treatment Centres), Urban Leprosy Centres and Voluntary Centres. The total number of each of them is given below:

Leprosy Control Units	392
S. E. T. Centres	6980

Urban Leprosy Centres	657
Voluntary S. E. T. Centres	60

Free treatment through Leprosy Clinics, Leprosy Centres, SET Centres, Voluntary Centres and indoor beds have been provided to leprosy patients. Drugs like Dapsone, clofazimine and Refampicin, Prothionamide and combined tablets were being supplied free of cost to the patients through these centres.

A scheme for the promotion of rehabilitation of cured leprosy patients had been introduced under the 6th Plan period. This scheme envisaged establishment of 15 leprosy Rehabilitation Promotion Units in different States to provide necessary surgical treatment for the correction of physical deformities and for jobs and tools adaptation. Out of these 15 units, 7 had been sanctioned by various States to be established in the respective States.



# BLOOD PRESSURE

DR. R. TANDON

The blood pressure has to be kept normal. If we control our diet and weight, if we do not smoke or indulge in excess of alcohol, if we do regular exercise, and actively practice relaxation, we are helping ourselves in lowering of blood pressure. By taking these measures we will be reducing the total amount of drugs required to control the blood pressure.

OUR body is made up of a large number of living cells. The cells require oxygen and nourishment for survival. The oxygen and nourishment to the cells is provided through blood. Blood circulates in the body in arteries and veins. Arteries carry blood to the cells to provide nourishment whereas veins carry blood away from the cells to get rid of waste products. The pressure under which the blood is circulating through the body is the blood pressure. The heart working as a pump generates the blood pressure and maintains the circulation. Normally the heart beats 60 to 100 times per minute. Each beat is made up of a phase of contraction called systole and a phase of relaxation called diastole. During systole the heart contracts to expel the blood into arteries for distribution into the body. During diastole the heart relaxes and fills up with blood to be expelled in the next systole. Since the heart generates the blood pressure, the pressure during systole, as recorded in the arteries, is the same as the pressure within the heart. In diastole the pressure reaches a minimum and increases again at next systole to reach a maximum value. The blood pressure, therefore, has a high reading during the systolic pressure and a low reading during the diastolic pressure.

## Normal Value

The normal value of blood pressure increases from birth to adolescence and then remains more or less stationary for the rest of the life. The blood pressure does not increase with advancing age. The blood pressure fluctuates markedly in a 24 hour period. The level of blood pressure depends on the state of mind as well as the state of body. A change in the mental attitudes of a person may result in a drop or increase in blood pressure, depending on whether he is tense or relaxing. Similarly the blood pressure increases during exercise and falls if we are relaxing.

When the blood pressure of an individual is recorded as high, it is called high blood pressure, or hypertension. There are a large number of known reasons which may result in high blood pressure. If the cause is known it is called as secondary hypertension. If the cause cannot be determined it is called essential hypertension. Since the blood pressure can fluctuate significantly from time to time, the physician's first responsibility is to establish that high blood pressure is really present. Then he has to determine if it due to a known cause. If the cause can be determined then it is possible to treat the cause of high blood pressure to control it.

Unfortunately most of us who develop high blood pressure beyond the age of 30 years, have the type

Swasth Hind

called as essential hypertension. It has been observed that essential hypertension tends to run in families and is most likely inherited. Recent observations indicate that the tendency for essential hypertension is established in early childhood.

### **Bad effects**

The next important fact one should know is that high blood pressure causes its bad-effects by producing hardening or thickening of arteries over a period of time. This in medical term is called atherosclerosis. The hardening of arteries can affect any part of the body, however, when the hardening of arteries affect the heart, brain or kidney, it results in heart attacks, strokes or kidney failures. It may affect the arteries of the eyes causing diminution or loss of vision. The hardening of arteries of any part of the body results in a compromise of the function of that part. It is unfortunate that hypertension by itself does not result in any symptoms. If symptoms are present, it indicates that the function of that part of the body has been compromised. It is for this reason that high blood pressure has been called as the 'Silent Killer'.

Another important fact to remember is that once a person becomes hypertensive he or she is permanently hypertensive. The means that the persons suffering from high blood pressure will have to take measures to control the blood pressure for the rest of the life. Initially the blood pressure may fluctuate between normal and high levels but sooner or later it will be come fixed permanent hypertension.

### **Precautions**

What should we do if we have high blood pressure. Firstly, it is essential that the blood pressure be kept under control at normal levels all the time. Since all the adverse effects of high blood pressure are related to arterial thickening they can be prevented if the blood pressure is kept normal. Today we do not accept that  $100 + \text{age}$  is the normal systolic blood pressure. Both the systolic pressure as well as the diastolic pressure have to be controlled. The heart generates the blood pressure. As such if the systolic pressure is 170, the pressure within the heart would also be 170. Obviously if the pressure within the heart is 170 it has to work more compared to the situation when the pressure was only 130. The risk to heart or damage to the heart is more closely related to systolic pressure than the diastolic pressure.

### **Controlling Blood Pressure**

Once we know that the blood pressure has to be controlled and we have to live with controlled blood pressure we should also know as to what we can do

## **TREATMENT OF HYPERTENSION**

### **Advice for Doctors**

It has been proved beyond doubt by several epidemiological studies in different parts of the world including India, that the compliance of the orders of the doctors by patients with heart disease is particularly low among hypertensives.

One of the reasons for this state of affairs is the fact that hypertensives often feel well and energetic and do not experience their hypertension either as an impairment or as a threat to health.

Like the obese patient the absence of a recognisable disharmony in life by the absence of discomfort and lack of overt symptoms, the hypertensive patient is more likely to ignore medical advice.

Additional reason for the poor response of hypertensives to medical advice is the lack of information which experience has found to be below the awareness of diabetics about the nature, hazard, and necessity for treatment.

In spite of the efforts that have been made to raise public awareness, more information can also have negative effects. Recent augmentation of information about drugs and their possible side effects have made many people reluctant to take pills. Listing of potential side effects on labels seems to have aroused fears. Advice by the doctor to a patient must stress on the need for treatment without break for success of therapy.

—HEART NEWS, May 1984.

to help ourselves in maintaining and controlling our blood pressure:

*Periodic check-up:* The first step is to have a periodic check-up of our blood pressure beyond the age of 30 to 40 years. Once or twice a year check-up is sufficient if it is normal. We should not forget that we are getting older everyday. A person with a normal blood pressure today may develop high blood pressure next year. Hence periodic check-up will pick up the tendency for high blood pressure early and prevent permanent irreversible damage to our body.

*Control of diet and weight:* The second step in this direction is the control of diet and weight. Both are closely related to each other and to blood pressure. The hardening of arteries is related to deposit of cholesterol in the blood vessels. As such the diet should contain as little cholesterol and fat from animal sources as possible. The total cholesterol in diet should be less than 300 mg. per day. The weight should be maintained near ideal levels. Reduction of weight to ideal levels will reduce the blood pressure. The diet should not have too much salt and very salty foods should be avoided. However, stopping of salt

is not necessary unless the treating physician has so advised.

*Regular physical exercise:* The next step in this direction would be to do regular physical exercise. The exercise should be done empty stomach. We are empty stomach four hours after a meal. The most useful exercise is walking. Jogging, specially for an overweight person is not justified. Jogging is also not advisable after the age of 50 years. Walking during working hours is also not exercise. It is exercise only if done during leisure hours. If a person is not used to it he can start with 1 to 2 km. a day, at a stretch. The distance should gradually be increased till one is walking 5 km. a day. Once the distance of 5 km. is achieved, the speed should be gradually increased till the 5 km. distance is covered in one hour or less. Control of diet and regular exercise will reduce the weight to ideal levels. Although during exercise the blood pressure increases, it falls rapidly to below pre-exercise levels when the exercise is over. Exercise increases the functional capacity of the heart and reduces blood pressure over a period of time.

*Stop smoking:* The next step is to completely stop smoking. Smoking increases blood pressure. Secondly smoking accentuates arterial thickening. The evidence for use of alcohol is somewhat controversial. Alcohol is a poison for the cells of the body. There is some evidence to suggest that up to 80 ml. of alcohol is useful, however, if one exceeds 80 ml. of alcohol per day then higher the intake of alcohol the more the chances of developing high blood pressure.

*Relaxation:* Relaxation and control of tension reduces blood pressure. As such one should learn to relax. It is a habit one has to learn and develop. Relaxation may be provided by reading, gardening, playing games or taking part in other hobbies. Yogic exercises specially the *Shavasana* is very useful in relaxing the mind as well as the body. The second part of specific measures is regarding blood pressure lowering medicines. It is necessary to emphasise

that medicines can control the blood pressure of any individual, whatever its cause. One of the most unfortunate aspects of the blood pressure lowering medicines is that all of them have side-effects which can be troublesome. An individual who had no symptoms because of high blood pressure may develop symptoms due to the side-effects of the medicines. However, the side-effects of the medicines are a nuisance but do not threaten life. On the other hand high blood pressure threatens life. In order to control the life threatening problem of hypertension we have to bear with or accept some side-effects. They generally tend to disappear in four to six weeks. If the blood pressure becomes normal with medicines it does not mean that the blood pressure has been cured. It appears that with medicines it is normal. The anti-hypertensive medicines should not be discontinued suddenly. Sudden stoppage of some of the medicines can have serious side-effects which can be life threatening. If the blood pressure can be kept normal for 6 to 12 months or longer, it is possible to gradually reduce the total dosage.

#### **Misconceptions**

There are many misconceptions about high blood pressure. It is not correct that the blood pressure increases with age and that 100+ age indicates the correct systolic blood pressure. It is wrong to believe that ladies tolerate high blood pressure better than men. They also suffer from the same bad effects. It is also wrong to believe that high blood pressure is normal for some people and that the body has so adjusted itself that lowering of blood pressure will harm the body.

Lastly, I would like to re-emphasise that the blood pressure has to be kept normal. If we control our diet and weight, if we do not smoke or indulge in excess of alcohol, if we do regular exercise, and actively practise relaxation we are helping ourselves in lowering of blood pressure. By taking these measures we will be reducing the total amount of drugs required to control the blood pressure.

*Courtesy: All India Radio*

## **National Health Policy**

The Ministry of Health and Family Welfare has evolved a 'National Health Policy' keeping in view the national commitment to attain the goal of Health for All, by the Year 2000. The policy lays stress on the preventive, promotive, public health and rehabilitative aspects of health care and points to the need of establishing comprehensive, primary health care services to reach the population in the remotest areas of the country, the need to view health

and human development as a vital component of overall, integrated socio-economic development, decentralised system of health care delivery with maximum community and individual self-reliance and participation. The Policy also lays stress on ensuring adequate nutrition, safe drinking water supply and improved sanitation for all segments of the population. Emphasis is also placed on health education.

## Comprehending the Nature of Hypertension

THE USSR State Committee for Inventions and Discoveries has registered a scientific discovery in the field of medicine. The "Phenomenon of the extensive malfunction of positively charged ion transport in the plasmatic membrane of cells at the initial stage of arterial hypertension" was disclosed by Prof. Y. Postnov and S. Orlov, Doctor of Biology. Prof. Y. Postnov outlines the significance of this discovery which brings scientists nearer to a comprehension of the nature of hypertension.

Many aspects of the development of hypertension have been recently clarified. Progress has been made in the search for and use of medicine for decreasing the blood pressure. However, this serious illness is still far from being fully defeated.

On many occasions, it is possible to retard the development of the disease, decreasing its occurrence and complications. Some years ago, a new trend appeared, regarding the nature and origin of the disease. Experts from the Central Scientific Research Laboratory of the USSR Ministry of Public Health, headed by Academician E. Chazov have found that the disease originates from specific malfunctions of cellular membranes.

They have determined that the blood cell membranes of the patients suffering from hypertension have some defects which disturb regulation of the free (ionised) calcium concentration and impair the membrane permeability to physiologically vital sodium ions.

The calcium ion, alongwith molecules of cyclic nucleotides, serves in each cell of the organism to transmit hormone and nerve signals to complex intracellular systems which control the vital activity and characteristic functions of the cells, such as the contraction and excretion functions. The cellular membranes maintain inside the cells a low ionised calcium concentration indispensable for the proper functioning of the cell—the free calcium concentration outside the cell is a thousand times higher than inside. The calcium ions arriving at the cell are pumped out by membrane pumps which are large protein molecules built in the membrane. Their activity is initiated by a special activator of protein origin called calmoduline.

The investigations of the scientists have revealed that the pathologic changes in the cellular membranes

of hypertensives decrease the efficiency of the action of calmoduline upon the membrane calcium pump as compared to people with normal blood pressure.

The inadequate regulation of the calcium ion concentration in the cells dictating the response of the latter to hormone and nerve signals is the first link in the complex chain of such changes. Apart from causing the shrinking of the walls of small arteria, these changes bring about an intensification in the secretion of vasoconstricting noradrenaline by the nerve endings. Thus, hypertension appears in a new light—as a sort of membrane pathology. The experiments give evidence that the disease originates from the congenital genetically predetermined structure and functions of the cellular membranes.

However, this does not mean that these features inevitably lead to hypertension. It depends largely on additional "developing" factors; above all on chronic stress, excessive consumption of salt, inactivity, smoking and drinking.

At the same time, the discovery opens wide possibilities for deciphering the molecular fundamentals of membrane malfunction and its relation to the genetic mechanism of the cells. Today, it allows the differentiation of hypertension from the states in which increased blood pressure is only a symptom of other illnesses. The discovery makes it possible to use such a test for detecting predisposition to hypertension, especially among young people.

—Soviet Features

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### ORGANISED SECTOR AND VOLUNTARY ORGANISATIONS

Organised Sector which employs hundreds of thousands of people who are available in relatively compact communities presents a vast potential for the promotion of Family Planning Programme. This Ministry provides funds to meet the establishment expenses for the staff employed at the Headquarters as well as in the field (medical, non-medical and para-medical) under the Ministry of Defence, Ministry of Railways, P & T Board, Ministry of Labour and Department of Coal for the coordination of Family Welfare activities as also for the payment of compensation money to the acceptors of the sterilisation and IUD.

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# INDIAN CHILDHOOD CIRRHOSIS

## A Liver Disease of Indian Children

DR. B. SHARDA

THE most common liver disease of Indian children, *i.e.*, Indian Childhood Cirrhosis (ICC) is frightening especially to those whose children were victims of this fatal malady. Indian children from middle class families between 9 months to 3 years of age; boys to whom either breast feed was not available or was available only for short duration; past history of similar illness in family; and in families; where brass peetal and/or copper utensils are used for milk boiling and its storage and water storage, are the unfortunate ones to be involved by ICC. Once the disease is established, it is not only difficult but impossible to treat it. Hence it is fatal.

### Symptoms of Cirrhosis

Boys between 9 months to 3 years of age from middle class families become irritable, there is slight distension of abdomen with loss of appetite. They may have white stools. (Jaundice may or may not be present). When such children are shown to specialists there is detectable enlargement of liver which is not normal in texture with mild derranged liver functions.

As the disease progresses irritability, loss of appetite, distension of abdomen, swelling over legs, jaundice, white coloured stool and yellow coloured urine become prominent; liver is very hard in texture with significant palpable spleen. Ultimately jaundice, swelling over body, distension of abdomen increases and most of the children die. There is no effective remedy for this mysterious, fatal malady of Indian children.

Recent studies by the author and others, published in U.K. and Indian journals show that when milk is boiled and stored in brass (peetal) utensils copper content increases 6 to 40 fold and the same holds true for water but to a smaller extent. There is

possible increase in copper intake in milk by these children which may lead to high liver, blood and urine copper since this is the constant finding reported by all workers. If milk is boiled and stored in steel, aluminium and tin coated brass utensils (peetal with palai) there is no change in copper level of milk. Once the disease is established, it is not easy to treat by removing liver copper since by that time permanent liver damage has already occurred.

### Prevention of the disease

The treatment for this disease is very difficult. But it is possible to prevent the disease. Following preventive measures are to be followed:

1. Breast feed your child—Breast milk is sufficient exclusively upto 5 months of age. Breast feeding should be continued throughout the first year with supplementary foods.
2. Avoid the use of brass (peetal) utensils whose 'kalai' (tin coating) is abraded or which are not tin coated, for milk boiling and storage.
3. Get your brass utensils tin coated (*kalai*) regularly since this prevents the increase in copper level in milk.
4. Steel and aluminium utensils may be safely used for milk boiling and storage.
5. Similarly, water should be stored in earthenware pots, steel, aluminium and tin coated brass utensils.
6. Avoid cooking in brass utensils which are not tin coated.
7. Immediately consult your doctor for further opinion, if the symptoms of the disease are observed in a child and if a child in the family has suffered or died from liver disease in the past. △

## Evaluation of Progress Towards Health for All

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*The 37th World Health Assembly was held in Geneva from 7 May, 1984, for a period of two weeks. The assembly evaluated the progress so far accomplished towards Health for All by the Year 2000. Over 1000 delegates, including 114 Ministers of Health and 26 Directors General of Health, participated in the Assembly. We publish below a brief report of the highlights of the Assembly.*

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THE 37th world Health Assembly urged Member States of the World Health Organisation (WHO) to accelerate efforts in support of the goal of Health for All by the year 2000. It also urged all Member States to speed the reorientation and the modifications of health systems towards primary health care and to give the highest priority and assure full responsibility for the continuous monitoring and evaluation of their strategies.

With the detailed recommendations to speed efforts and mobilize resources a five-day debate concluded on 15 May, 1984, which enabled the Assembly to evaluate the progress so far accomplished for the first time since the new policy was adopted in 1981.

In a report submitted to the Assembly earlier, the Director-General of WHO reviewed the progress made in implementing national strategies to attain Health for All by the turn of the century. The report itself was based on answers to questionnaires sent to all Member States so that results could be presented in a uniform fashion. Since it was the first report of its kind, the main emphasis was placed on the extent to which health strategies have already been formulated and put into action.

Almost two-thirds of WHO's Member States have endorsed, at the highest official level, the policy of Health for All. Of the 160 nations who received the questionnaire, 38 did not respond for various reasons, many of them because they do not yet have adequate information systems.

Most delegates recognised the imperative need for monitoring and evaluating their progress towards Health for All.

If all delegates unanimously agreed on the need for monitoring and evaluating progress, some expressed reservations on the format and complexity of the questionnaires they had received.

### **Importance of community involvement**

Most delegates insisted on the need for community involvement, one of the main factors to achieve Health for All. Of the 97 countries that provided information on community involvement, 78 replied affirmatively, two indicated a partial involvement, and 17 stated that there was no participation.

In general, countries experience difficulties in measuring the percentage of their Gross National Product (GNP) spent on health. Just over half the countries, 63 out of 122, provided an estimate of the percentage of GNP spent on health. A majority of the 63 reporting countries spent less than five per cent of their GNP on health. Only 50 countries were able to provide the percentage of their health budget devoted to local health care.

Among the major obstacles which slow the implementation of Health for All, delegates mentioned: insufficient management capacity, lack of trained manpower, difficulty in obtaining inter-sectoral cooperation and in changing the distribution of existing

health budgets. Many delegates from Latin American and African countries indicated that the economic recession had hampered their efforts to devote more funds for health. Several countries also called for a stop in the armaments' race and urged that expenditure on arms be used in a more productive way. The Assembly also unanimously called on all Member States to give every possible support to technical cooperation among developing countries, an important vehicle for health development and for the implementation of national health strategies.

#### **WHO Director-General calls for imaginative management**

Earlier on 8 May, 1984 introducing his biennial report of the Work of WHO in 1982-83, the Director-General, Dr Halfdan Mahler, called for imaginative management :

"In reality, what is required is imaginative management to orchestrate the never-ending arduous tasks that have to be performed—by ministries of health and related social and economic sectors; by social security organizations; universities and research and development institutes; by people in all walks of life as individuals, families and associations; by community health facilities, health centres, hospitals and laboratories; by storehouses, factories and the

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#### **New President of the Assembly**

The World Health Assembly elected on 7 May 1984 Professor Guillermo Soberón Acevedo, Secretary of Health and Welfare, Mexico, President of its 37th annual session.

Before holding his present post, Professor Soberón Acevedo was Director Biomedical Research Institute, Mexico (1965-1971); then Rector, University of Mexico (1973-1981). He is also President of the International Association of Universities, with a mandate until 1985.

like. In this gigantic human beehive each and every individual and institution has a specific role to play—planning and identifying priorities in such a way as to bring epidemiological needs and social preferences into line with each other; in allocating resources; in deciding on the most appropriate technology; in taking preventive action; in providing care. Yes, even keeping health centres and hospitals clean and shining; without that nobody will have any faith in them.

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#### **The Leon Bernard Foundation Medal and Prize**

Professor Guillermo Soberón Acevedo, President of the 37th World Health Assembly, on 14 May 1984 awarded the Léon Bernard Foundation Medal and Prize to Dr Mao Shou-Pai, Director of the Institute of Parasitic Diseases of the National Centre for Preventive Medicine of the People's Republic of China, in recognition of his outstanding contribution to the fight against schistosomiasis in his own country.

Dr Mao Shou-Pai offered his prize to the UNDP/WHO/World Bank Special Programme for Research and Training in Tropical Diseases, as a contribution to continued research on schistosomiasis.

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"Permeating all that is the information and education of people and the everlasting training, training and training again of health workers for the specific jobs they have to perform; and ensuring that they are provided with conditions that will be sufficiently attractive to recruit them to the service and keep them there and yet be commensurate with the social and economic realities of the country and community in which they live and hopefully serve. I realize fully well that all of this is easier to preach from this platform than to practise in real life. But that practice is the real challenge; mere repetitions of the sermon in countries and in WHO will get us absolutely nowhere."

#### **President stresses importance of political will**

Speaking of the goal of Health for All by the Year 2000, Professor Guillermo Soberón Acevedo, President of the 37th World Health Assembly, declared that "There has never been in the history of humanity a concerted effort on such a scale to achieve higher levels of well-being. It may be added, nevertheless, that the importance of this initiative by the World Health Organization has been paralleled by the effort made in the field to achieve this goal" ... "In this year of 1984 we are coming ever closer to the year 2000 which the countries of the world, joined together in the World Health Organization, have chosen to mark a substantial step forward for the benefit of all peoples of the world: namely, to ensure that they enjoy a state of health compatible with an agreeable life and adequate social and economical development. This goal, although possible, is not one that will be easy to achieve. Nevertheless, the difficulties which are being encountered can only spur on the determination of those who are participating in this task."

"Political will on the part of governments is indispensable", Professor Soberón Acevedo added. "They must realize", he said, "that in order to meet popular demand in regard to health, health must be conceived as a social objective of deep significance and political importance. Despite the serious constraints laid upon us by the international financial situation, by virtue of which the basic activities contribute to the process of integration and political and democratic development of the society, it is essential that primary health care programmes be accorded the necessary budgetary support. Otherwise we shall not go beyond rhetoric and pious wishes."

#### THE ROLE OF UNIVERSITIES

The need to strengthen the involvement of universities in achieving Health for All was stressed by Dr David Hamburg, as he opened two days of Technical Discussions of the 37th World Health Assembly, on "The Role of Universities in the Strategies of Health for All" on 11 May 1984. Dr Hamburg is President of the Carnegie Corporation and General Chairman of this year's Discussions, which bring together 350 participants from around the world. Among the participants were several Ministers of Health who used to be University Rectors, Ministers of other sectors, such as Education, and over 80 academics—30 Deans, Rectors, Vice-Chancellors, Vice Presidents, and Professors of Medicine and other disciplines.

#### A. T. Shousha Foundation Medal and Prize

Dr Mohammad Ilyas Burney, Executive Director of the National Institute of Health, Islamabad (Pakistan) on 15 May 1984 received the Shousha Foundation Medal and Prize from the President of the 37th World Health Assembly. The award is for "significant health service" in the Eastern Mediterranean Region of the World Health Organization (WHO), where Dr. A. T. Shousha was the first Director of the WHO Regional Office.

Dr Hamburg stressed that "the major task before us is to think creatively about how to forge linkages between universities and communities that are effective for health and at the same time are protective of academic freedom." These various linkages could give a powerful impulse to the Health for All movement, which was in essence "an act of solidarity of the more developed countries with their less developed neighbours".

Underscoring the traditional missions of universities as a combination of transmission of knowledge

#### Eleven New Members for WHO Executive Board

The Thirty-Seventh World Health Assembly elected the following 11 Member States entitled to designate a person to serve on the Executive Board of the World Health Organization (WHO):

**Egypt, Equatorial Guinea, Guinea, Hungary, Indonesia, Ivory Coast, Kenya, Republic of Korea, Thailand, United Kingdom of Great Britain and Northern Ireland and United States of America.**

through teaching and training, and creation of new knowledge through research and service, Dr Hamburg noted: "Our challenge is to find and propose incentives for universities to perform their traditional functions in the service of health and to derive traditional benefits from so doing."

There was a particular need to enhance cooperation between universities and government ministries, especially ministries of health. Decision makers needed access to the information and ideas generated by universities while "universities need access to the health system so that their students will be prepared to function realistically within it".

Given the breadth of the Health for All concept, Dr Hamburg suggested that the participation of universities might first be focused on the vital question of education for health. Dr Hamburg added: "A particularly interesting question is whether ways can be found to make more extensive use of the lessons of agricultural education in dealing with the problems of health, family planning and nutrition in developing countries."

This is also becoming true in developing countries. But accumulated evidence has shown that carefully conceived and developed media campaigns aimed at excessive smoking, alcohol abuse and healthy diets have had a positive effect in altering health-damaging behaviour. Dr Hamburg stressed the role that universities can play in strengthening research on behaviour and the health of populations, particularly in the developing world.

Dr Hamburg voiced several thoughts for participants to consider regarding the role universities can play in Health for All: considerable initiative should come from the community; the education and training of health workers should take place in their local areas; and universities should assess for themselves how they can best work, and which populations they would like to work with.

In a resolution, the Assembly urged Member States "to encourage universities and other higher learning institutions to include the social and technical concepts of Health for All in the education and training of all categories of students and post-graduates and to acquaint the general public with these concepts."

The resolution also invited universities throughout the world to disseminate the goal of Health for All through integrated teaching, collaboration with governments, and education of the general public. It also requested the Director-General of WHO to play a leading role in furthering the involvement of universities in the strategies for Health for All, through advocacy, information dissemination and support to governments in this area.

#### **Action Programme on Essential Drugs**

The Assembly urged Member States to intensify action of implement national drug policies and strategies with WHO support. Many delegations reported activities which reflect the commitment of Member States to the lines of action recommended at previous Assemblies and indicate that the WHO Action Programme on Essential Drugs and Vaccines is rapidly accelerating and unstoppable.

The Assembly also called for the dissemination of unbiased and complete information on drugs and an exchange of information between Member States on drug use and marketing practices.

It requested the Director-General to arrange a meeting in 1985 of experts representing the parties concerned—including governments, the pharmaceutical industry, and patients' and consumers' organizations—"to discuss the means and methods to ensure rational use of drugs ... and the role of marketing practices in this respect, especially in developing countries". The Director-General was asked to submit a report on the results of this meeting to the Thirty-Ninth World Health Assembly in 1986.

#### **Prevention of blindness due to vitamin A deficiency**

Some 10 million children are affected by vitamin A deficiency and xerophthalmia in Asia alone and more than a million become blind every year. The disease is also prevalent in Africa, the Western Pacific and limited areas of the Americas. Safe, effective and cheap techniques exist to control vitamin A deficiency. The Assembly, therefore, urged all Member States to give high priority to the prevention and control of vitamin A deficiency and xerophthalmia wherever these problems exist, through appropriate nutritional programmes, as part of primary health care.

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### **Parisot Medal Award**

Dr Yayehyirad Kitaw, Head of the Department of Community Health at the Faculty of Medicine, Addis Ababa University, Ethiopia, was presented with the Jacques Parisot Foundation Medal Award for research in social medicine, on 16 May, 1984, by Professor Guillermo Soberón Acevedo, of Mexico, President of the Assembly.

The medal honours the memory of Dr Jacques Parisot, of France, a pioneer figure in social medicine. A year earlier, the fellowship that bears his name was awarded to Dr Kitaw, thus enabling him to conduct a study entitled "Self (lay) care in Ethiopia—an exploratory epidemiological survey".

The objectives of the study were to describe the nature and importance of self (lay) care in selected urban and rural communities of Ethiopia; to examine the relationship between traditional medicine and self-care and between modern medicine and self-care; and to draw recommendations for the introduction of self-care in the strategies for Health for All by the Year 2000.

In accepting the medal, Dr Kitaw said that his study had shown how much self-care was used in Ethiopia and that the issue was now to support this movement and bring it into the mainstream of primary health care and avoid "unduly medicalizing it".

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#### **Importance of technical cooperation**

The Assembly reaffirmed the importance of technical cooperation among developing countries and called upon developed countries to continue to provide technical cooperation and financial resources, particularly to the least developed countries.

#### **Abuse of narcotics and psychotropic substances**

The Assembly, recognizing the dramatic increase in drug addiction, all the more alarming in that the young are the chief victims of narcotics dependence, noted with satisfaction the development of the WHO programme on drug dependence, and requested the Director-General to strengthen epidemiological surveillance systems.

#### **Infant and young child nutrition**

Recognizing that the implementation of the International Code of Marketing of Breast-milk Substitutes is an important action to protect healthy infant and young child feeding, the Assembly requested WHO to intensify collaboration with Member States in their efforts to implement and monitor the Code.  $\Delta$

## Meeting the Threat of Rabies

Rabies, a killing disease, has long menaced the lives of people and animals around the world. Today, in spite of greatly improved technology, this menace continues to spread and may be worsening. The Seventh Expert Committee on Rabies of the World Health Organization (WHO), which met in Geneva from 20-27 September, 1983, calls on governments to use the best modern methods available to counter this trend.

### The situation today

Rabies is endemic today in about 100 countries and territories in the world. It is most disquieting that in about 90 of these the disease still persists in its most dangerous reservoir, the dog.

### Recent Progress

Due to the development of new techniques, much knowledge has been accrued on the rabies virus and its variants. This now permits better understanding of the epidemiological patterns in nature and improved control of rabies. Recent scientific advances have permitted the first trials in nature of oral immunization of fox populations to prevent the further spread of the disease in this wildlife reservoir in Europe. Considerable improvements have been made in new vaccines for prevention of rabies in man and animals. WHO is presently concentrating its efforts on technical and managerial aspects of human and canine rabies in developing countries. A special programme is being tailored for this purpose to counteract dog rabies which still accounts for over 98 per cent of all human deaths from the disease.

### Protecting human life

Because clinical rabies is fatal, prevention of rabies following exposure is of utmost importance. The first step remains prompt treating of the wound with soap and water. This must be followed by specific immunization to save the patient's life.

### Danger from dogs

For the control of dog rabies a range of methods has been recommended. The most important method consists of prophylactic vaccination.

In a large number of developing countries, particularly in urban areas, there is a large and growing population of stray dogs and in many cases efforts to control them have slowed down or stopped entirely.

As a result, some countries have diverted their efforts and resources into the expensive process of vaccinating humans who have been bitten by rabid dogs. This is not the best or most economic way to tackle the problem.

WHO recommends a number of control measures which begin with the formation of a national committee to draft a programme backed up by proper legislation which will permit authoritative and flexible action. In cities, such a programme could aim at immunizing 80 per cent of the entire dog population. Coloured plastic collars or tags would easily identify vaccinated dogs and contribute to the success of the campaign. If unvaccinated dogs, cats or any other pets, are bitten by rabid animals, they should be destroyed immediately. Only if they have been vaccinated can such bitten animals be detained under veterinary control.

Depending on local conditions, stray dog populations should be reduced to stop the transmission of the disease. Control measures should be applied to canine rabies irrespective of the presence or absence of rabies reservoirs in wildlife.

Other recommendations of the WHO Expert Committee concern the importation of dogs and cats. Their entry should only be permitted under proof of proper vaccination supplemented by periods of quarantine and observation depending upon the disease status in both the exporting and importing countries.

To be effectively applied, control programmes must be based on the ecology of the dog in different cultures and societies. Therefore, WHO's research programme will emphasize learning more about how dogs live and survive in urban conditions.

The Expert Committee stressed that authorities in countries where rabies constitutes a public health problem should urgently consider three major objectives:

- \* To establish and strengthen surveillance.
- \* To control the spread of rabies by animals and eventually to eliminate the infection in its animal reservoir.
- \* To prevent, detect and treat human exposure to rabies. △

# NEWS

## WHO SOUTH-EAST ASIA ADVISORY COMMITTEE ON MEDICAL RESEARCH

The tenth session of the WHO South-East Asia Advisory Committee on Medical Research (SEA/ACMR), was opened in Dhaka, Bangladesh, on 9 April, 1984 by Maj. Gen. M. Shamsul Haq, Minister of Health and Population Control.

The session, chaired by Professor Prawase Wasi, Vice Rector, Mahidol University, Bangkok, was attended by eminent scientists and researchers from various health-related disciplines in the Region. Prof. V. Ramalingasami, Director General, Indian Council of Medical Research, also attended the session as a special invitee in his capacity as Chairman, WHO Global Advisory Committee on Medical Research.

The SEA/ACMR which was established in 1976, advises the WHO Regional Director on all aspects of medical research, especially with regard to policies for the promotion of research in the Region. It also defines priorities for research and coordinates efforts between the Region and WHO Headquarters on the one hand and between the Region and Member countries on the other.

Addressing the opening session, the WHO Regional Director for South-East Asia, Dr U Ko Ko, said that research had placed in the hands of the medical profession a powerful instrument to relieve suffering and prolong life, but the results of research must be applied through health programmes within reasonable cost in order to significantly advance the health of the people in developing countries. To achieve this the research must be relevant to peoples needs.

The research policies of the Organization stressed the optimal use of the existing resources and the need for mission oriented research. The policies also dictate the need to rely and further develop a national research potential in all its aspects and to apply research findings, past and present, in solving health problems.

As a result of these policies a judicious mixture of basic and applied research had been instituted. Research was being conducted on priority health problems in the Region, such as malaria, filariasis, leprosy, diarrhoeal diseases, nutrition, maternal and child health, environmental health and health care systems.

Though the primary concern of health services research was the organization and management of health services, it was also concerned with the application of health technology to treat diseases, promote health and prolong life. Recognizing its relevance, the Member countries and WHO had embarked on health services research which would contribute very significantly to the attainment of the goal of health for all by the year 2000.

Over the years, medical research in the Region had evolved with the emphasis on more broad-based research. The programme included research focussed on the development of epidemiological surveillance and disease prevention, health services research, community participation and social and behavioural sciences research in addition to basic research of particular relevance to the priority problems of the Region.

The necessity for institutional strengthening, including manpower and physical facilities and the promotion of existing mechanisms for coordination in research with identification of priorities, their implementation and utilization of research results were also highlighted in the programme.

During its six-day session, the SEA/ACMR, among other agenda items, including progress of medical research in the Region, reviewed the development of evaluation methodology for primary health care, research related to acute respiratory infections and the spiritual dimensions of health. △

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## SURVEY AND PREVENTIVE MEASURES FOR CANCER

"No all-India survey on the incidence of cancer has been carried out by the Central Government. However, the Indian Council of Medical Research has augmented/established three population-based and three hospital-based Cancer Registries in different regions of the country since 1981. The population-based Registries located at Bombay, Bangalore and Madras registered 4019; 2455 and 2258 cancer cases, respectively, during the year 1982. The hospital-based Cancer Registries at Chandigarh, Dibrugarh and Trivandrum registered 2688; 1205 and 3483 cancer cases respectively, during the same year.

It is not possible to state from the limited available data that mostly poor people in the far flung rural areas are victims of cancer.

Under the Cancer Research and Treatment Programme, the Central Government have set up 9 Regional Cancer Centres and 17 Early Cancer Detection Centres. Under the All India Hospital Postpartum Programme, 25 Postpartum Detection Centres have also been set up. These Regional Centres and Cancer Detection Centres carry out periodical programmes on mass education and mass screening the adjoining areas. In addition, the Indian Council of Medical Research is engaged in working out feasibility modules for primary and secondary prevention of cancer of the oral cavity and cancer of the uterine cervix in females which together constitute over 50 percent of cancer cases in the country."

This information was given by Kumari Kumud Joshi, Deputy Minister for Health and Family Welfare, in Lok Sabha on 1 March, 1984.

## STUDY ON PESTICIDE RESIDUES

Kumari Kumud Joshi, Deputy Minister for Health and Family Welfare, informed the Lok Sabha on 19 April, 1984, that a survey work was done on the pesticides residue in human food in Calcutta by the Department of Preventive and Social Medicine, All India Institute of Hygiene and Public Health and the Central Food Laboratory, Calcutta. In the survey report published in the Indian Journal of Medical Research, October 1980, it has been stated that out of the 400 foodstuffs tested; 95 (23.7%) were positive for pesticides. Out of the 95 samples, Malathion was detected in 44 samples, followed by BHC in

27 samples and DDT in 24 samples. Of the 95 samples, 35 samples exceeded the prescribed limit at the time of survey, the details of 35 samples that exceeded the prescribed tolerance limits were as follows:—

Vegetables	—	24
Foodgrains	—	10
Animal products	—	1

Another study of pesticides residues in various foods was also carried out in collaboration with Punjab Agricultural University, Ludhiana; Industrial Toxicological Research Centre, Lucknow; and Central Food Technological Research Centre, Mysore; Central Food Laboratory, Calcutta and Indian Grains Storage Research Institute, Hapur. The findings were as under:

Out of 976 samples of foodstuff, analysed, 778 samples were positive for pesticides. Of the 778 samples, 137 samples exceeded the prescribed limit.

The break-up of 137 samples was as follows:—

Cereals	—	42
Dairy products	—	91
Pulses	—	4

The measures taken by the Government to eliminate the Pesticide residues from food items were:

1. The limits of pesticides residues have been laid down in Rule 65 of P.F.A. Rules 1955.

2. State Governments had been advised from time to time to make an effective control on pesticides residues by drawing frequent samples of food articles.

3. The Central Government had organised some of the training programmes for the benefit of the analysts so as to make available the techniques for analysis of various pesticides. Four such international programmes had been organised in India under the auspices of FAO/WHO.

4. Ministry of Agriculture which was responsible for registration of insecticides and their use of agricultural crop had been advised to ensure their safe use by the farmers and growers through their agricultural services.

5. Efforts were also being made to augment the State Laboratories by providing equipments through WHO funds.

## INTERNATIONAL CENTRE FOR GENETIC ENGINEERING AND BIOTECHNOLOGY

At the meeting of the Preparatory Committee held in Vienna from 24 to 27 January, 1984, with regard to the proposed International Centre for Genetic Engineering and Biotechnology, the following resolution was voted and approved:

"Based on the mandates from Belgrade high level meeting, ministerial level meeting in Madrid and the deliberations of the two preparatory Committee Meetings in Vienna, it is decided that the Centre, should consist of two components. These may be located in Trieste, Italy, and New Delhi, India.

These component centres of scientific excellence should serve the interests of developing countries and international cooperation in accordance with the objectives of the ICGEB as contained in Article 2 of the statutes.

The Preparatory Committee considers that in establishing the criteria that will be followed in granting the status of affiliated centre according to article 9 para 2 of the statutes, particular consideration should be given to all those countries who made generous offers for hosting components of the centre in the spirit of international cooperation. The affiliated centres could participate actively in the ICGEB training, research and development activities, and they may establish an integrated network of clustered centres to take up work in specialised areas, as well as to interact closely in their work between each other and the component centres of the ICGEB. Both the affiliated centres and the integrated networks would be eligible to receive project funds from international sources allocated by the board of governors.

After a period of three years, the board of governors shall examine the activities of the ICGEB and may decide on expanding the constitution of the ICGEB by converting some of the affiliated centres into component centres having regard to the scientific requirements and financial resources available."

It may be recalled that based on an initiative taken by UNIDO for the establishment of an International Centre for Genetic Engineering and Biotechnology, India offered to provide host facilities for such a

Centre at a meeting of interested countries held in Belgrade in December, 1982. Since many offers were received, the subject was discussed at a Plenipotentiary Meeting held in Madrid in September, 1983 and it was resolved that the ICGEB should be established preferably in a developing country and the offers from India and Thailand were found attractive. The meeting also took note of the offers made by certain developed countries such as Italy and Spain, and felt that these generous offers could also be taken note of.

The statutes for the Centre were agreed to by 27 countries. The preparatory committee consisting of representatives of these 27 countries met in Vienna in November, 1983. Since several countries offered to host component centres, the Committee invited interested countries to provide detailed offers. A further meeting of the PREPCOM has taken place from 24 to 27 January, 1984, at Vienna. The offers made by Italy and India were considered to be the most attractive.

India has in particular offered to carry out scientific research in areas related to human and animal health, fertility and in the area of agricultural production. Italy has offered to concentrate in areas of industrial microbiology and energy. After detailed discussions, the resolution was formulated and favoured by 14 countries. Other countries which have offered smaller component centres did not participate in the voting. The meeting has resolved that there could be room for other component centres to be integrated with the two main location centres depending on the initial functioning of such Centres.

—P. I. B.

## MASS EDUCATION AND MEDIA ACTIVITIES

The Family Welfare Programme in India is voluntary and its success depends on educating and motivating the people to adopt one or the other method of family planning. A broad-based mass education programme utilising all available mass media, supplemented by group and inter-personnel communication, has been launched to promote the acceptance of various temporary and permanent contraception methods by couples in the reproductive age group.

Swasth Hind

# BOOKS

**The role of community groups in furthering the impact of Primary Health Care, Kondowe, G. and Others. Journal of Tropical Pediatrics 1983 Dec; 29(6) : 332-36**

The activities of two community organizations, viz., the Farmers' Clubs and the Women's Organization (Mahila Mandal) were studied in an innovative project of primary health care in India. The role of such organizations in the rapid spread and acceptance of new ideas and technology has been demonstrated. Such forms of community organization are supportive of the services provided by the village health worker, and help to develop self-reliance in health and other matters.

**ROLE OF INDIGENOUS FOLK REMEDIES FOR CERTAIN ACUTE ILLNESS IN PRIMARY HEALTH CARE. Audichya, K. C. and Others. Nagarjun 1983 May; 26(9) : 199-201**

The fifteen medicinal lores/folk remedies, related to 14 medicinal plants, being practised by the local tribal people of the area narrated in the present paper are quite authentic as practised by the tribals of the area. The drugs are easily available and abundant in nature, it is safe with virtually no side effects and are very simple as far as their administration is concerned. It is earnestly hoped that these claims after successful trials can add to the knowledge of medical science and can play a vital role in the management of some of the acute illness in Primary Health Care Programmes of our country particularly in the rural areas.

**TRADITIONAL BIRTH ATTENDANTS AS AN EFFECTIVE CHANGE AGENT FOR HEALTH PROGRAMMES. Deoki Nandan, Dwivedi, S. and Agnihotri, S.P. Nagarjun 1983 May; 26(9) : 3-14**

'Dai Maa' or Traditional Birth Attendants (TBA) by dint of their services command the highest-degree of confidence in the family. If TBAs are properly utilized they may function as the best link for promoting primary health care amongst rural masses. Various areas in which these powerful change agents can function efficiently and effectively have been identified. Their availability and accessibility, their harmony and similar identity as the community members, enhance their acceptability with the masses. To enable them to function, more constructively in promoting 'health' of the masses, their training programmes need to be properly monitored. These should be tailored according to local needs and should be realistic.

—Highlights from Current Health Literature;  
Vol. III, No. 8, May 1984

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## WORKSHOP ON DRUG ABUSE CONTROL

Measures that have proved successful in promoting greater community participation in the prevention and reduction of drug abuse in Asia and the Pacific was the focus of a workshop convened from 11-15 June in Bangkok by the Division of Narcotic Drugs.

The importance of prevention and demand reduction is stressed in the International Drug Abuse Control Strategy approved by the General Assembly in December 1981.

Three regional workshops were held in 1982. The present workshop was the second in a series of three regional workshops to be held this year. They are examining progress achieved since 1982 in national pilot projects for the utilization of community resources in the prevention and reduction of drug abuse. The first 1984 workshop was held in January in Europe, the third will be held in South America.

The Bangkok workshop addressed a wide range of issues including, in particular, ways to encourage the adoption of successful measures to promote further community involvement in the prevention and reduction of drug abuse in other States within and outside the Asia and Pacific region. Particular attention was given to ways of encouraging greater involvement by non-governmental organizations in drug abuse control activities.

—UN Weekly Newsletter 22 June, 1984

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