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HEALTHY CHILDREN - A HAPPIER WORLD

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OBJECTIVES

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

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

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

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

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

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

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In this issue

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

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

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SAFE CHILDBIRTH—A MOTHER'S RIGHT

ENSURING SAFE CHILDBIRTH

DR RAKESH KUMAR

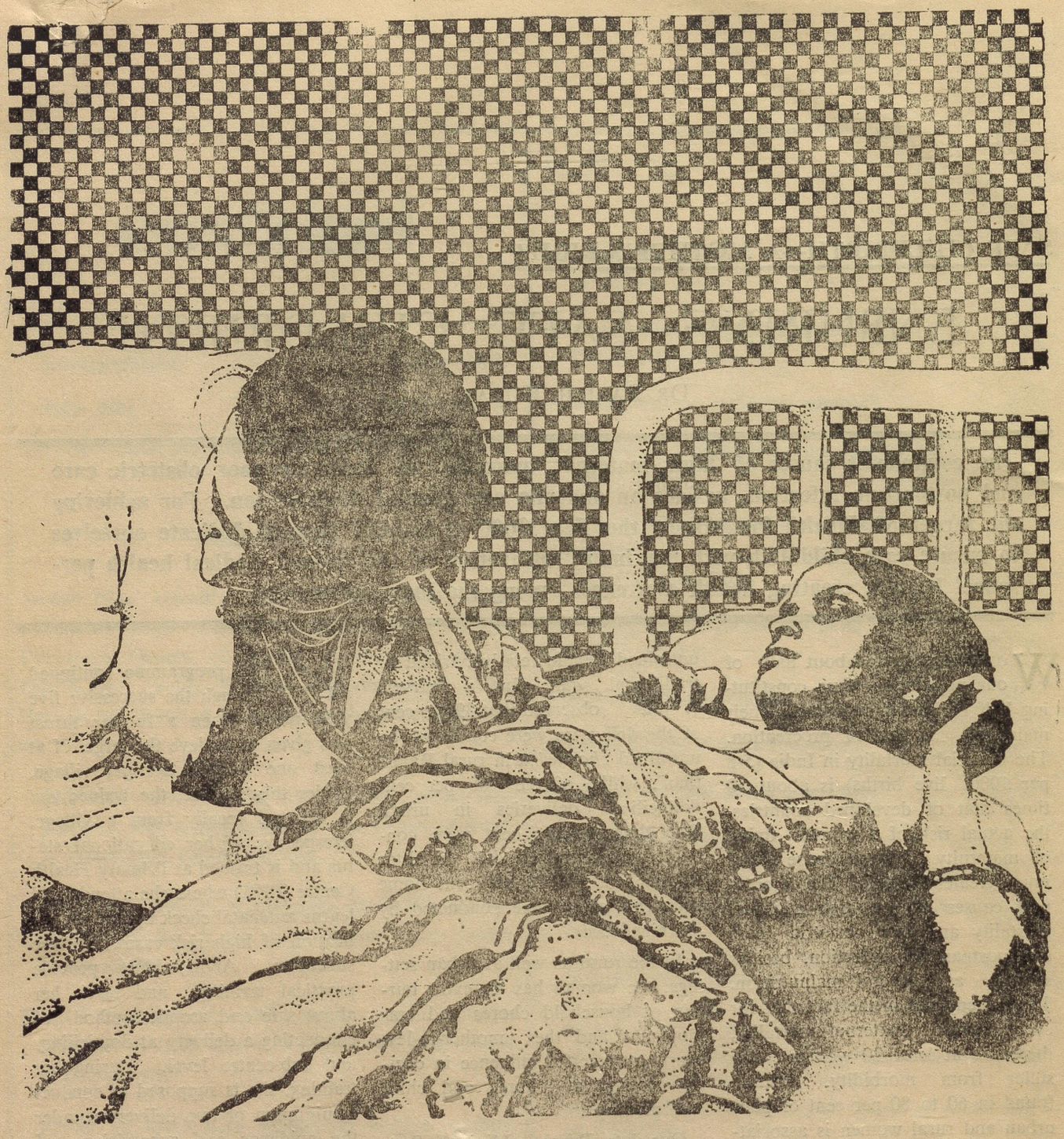
The commonest causes of high maternal mortality in India are poor obstetric care and postpartum infection, besides an anaemia and general malnutrition. For achieving the target of 'Health for All by the Year 2000' it is high time to dedicate ourselves to ensure safe childbirth with maximum utilization of the trained medical health personnel besides creating health awareness among the local community.

WOMEN constitute about half of our population, thus constituting half of human resources. Their main role is that of procreation. The material mortality in India (5-8 per 1000 live births) is about 50 times that of developed countries, the actual risk of a woman dying of maternity related cause being much greater in India.[1] The commonest causes of this high maternal mortality are poor obstetric care and postpartum infection, besides anemia and general malnutrition. The tragedy lies in the fact that for every single maternal mortality, there are at least 20 women who suffer from morbidity. Anemia found in 60 to 80 per cent of poor urban and rural women is associated with 20 per cent of maternal deaths. There is lower life expectancy of women at birth in India than men. This lower female life expectancy is due to higher female mortality up to 35 years of age.

India, being a signatory to Alma Ata Declaration on Primary Health Care (1978), has committed herself to decrease the maternal mortality. About three-fourth of the deliveries in the rural areas are still conducted within the home with the help of untrained female relative, friend or traditional *dai*.[2] In a survey, it was observed that 39 per cent of the deliveries were conducted by untrained *chamarins* in rural Rajasthan[3], while, of the 68 per cent domiciliary deliveries in urban Rajasthan, 65 per cent were conducted by untrained *dais*. In Uttar Pradesh, of the 90 per cent home deliveries, most were conducted by untrained *dais*.

In the rural as well as urban settings, the woman has an extra burden of household chores and employment and the mother-in-law exerts a powerful influence in decision-making at home and child care practices.

Our late Prime Minister Smt. Indira Gandhi, in her message to a symposium (1983) mentioned that "Women's health is the basis of healthier families and a healthier nation." In order to narrow down the maternal mortality differential between India and developed country, *dai* training programme was introduced in the second five year plan, as a centrally-sponsored Maternal and Child Health Programme, to ensure safe childbirth which is the basic right of every expectant mother. This programme continued till 1977 through the successive five year plans, when a further thrust was given to achieve the target of at least one trained *dai* per village. Under this scheme, the trained *dai* is selected locally from a village, irrespective of her educational status and is trained at Primary Health Centre (PHC) where she attends and learns antenatal check up and identification of high risk cases. At the subcentre, ANM/LHV provide practical training and teach her about safe and aseptic method of conducting a delivery at domiciliary and sub-centre level. During her training, she is supposed to conduct a minimum of two deliveries under the guidance and supervision of ANM/LHV. The main emphasis is given to asepis, developing skills for practising midwifery and recognition of high-risk cases and promoting family welfare programme. At the successful completion of her training, the *dai* is provided with sterile delivery kit, the items of which are replaceable whenever she reports the delivery to the ANM, and a remuneration of Rs. 300. She gets two rupees for registration of every delivery case.



There is lower life expectancy of women at birth in India than men. This is due to higher female mortality upto 35 years of age.

In order to contribute effectively towards building a healthier nation and achieving the target of Health for All by the year 2000, it is high time to dedicate ourselves to ensure safe childbirth with the maximum utilisation of the trained paramedical health personnel, besides creating health awareness among the local community.

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NATIONAL POLICY FOR CHILDREN AND CHILD WELFARE

KUMARI RATNA SAHU

Adequate financial input, proper coordination of organisation and administration and immense community participation and active extension education are required to improve the status of children.

SIGNIFICANTLY child population in India poses wide and varied problems because of its immense size and its diverse demands on limited resources. The majority of our children are under privileged. They become a prey to various problems like overcrowding, poverty, lack of resources including suitable food and safe drinking water, recurring illness, ignorance, sociocultural practices, leading to high morbidity and mortality among them. Thus, the need of child welfare is of paramount importance in view of ensuring proper environment and facilities for all the children in the country.

The Constitution of India provides for the care and protection of children in Article 24 under Fundamental Rights and Articles 39 and 45 under the directive principles—Article 24 prohibits employment of children below 14 years age in Factories, mines or any other hazardous employment. Article 39 requires the State to ensure that children aren't forced by economic necessity to enter vocations unsuited to their age and strength. It also prescribes that children are given opportunities and facilities to develop in a healthy manner in free environment. Further, it requires that childern any youth are protected against exploitation and against moral and material abandonment. Article 45 requires the State to provide free and compulsory education for all the children until they complete the age of 14 years. Besides constitutional provisions there exists a number of legislative provisions to safeguard the interests of children. Unfortunately the implementation of these Acts at the Central and State level leaves much to be desired. While one cannot find serious flaws in the provisions of children's Acts their application is limited to urban areas only. Furthermore, an efficient administrative machinery for the enforcement of these laws in order to serve the educational and protective functions of children is badly lacking.

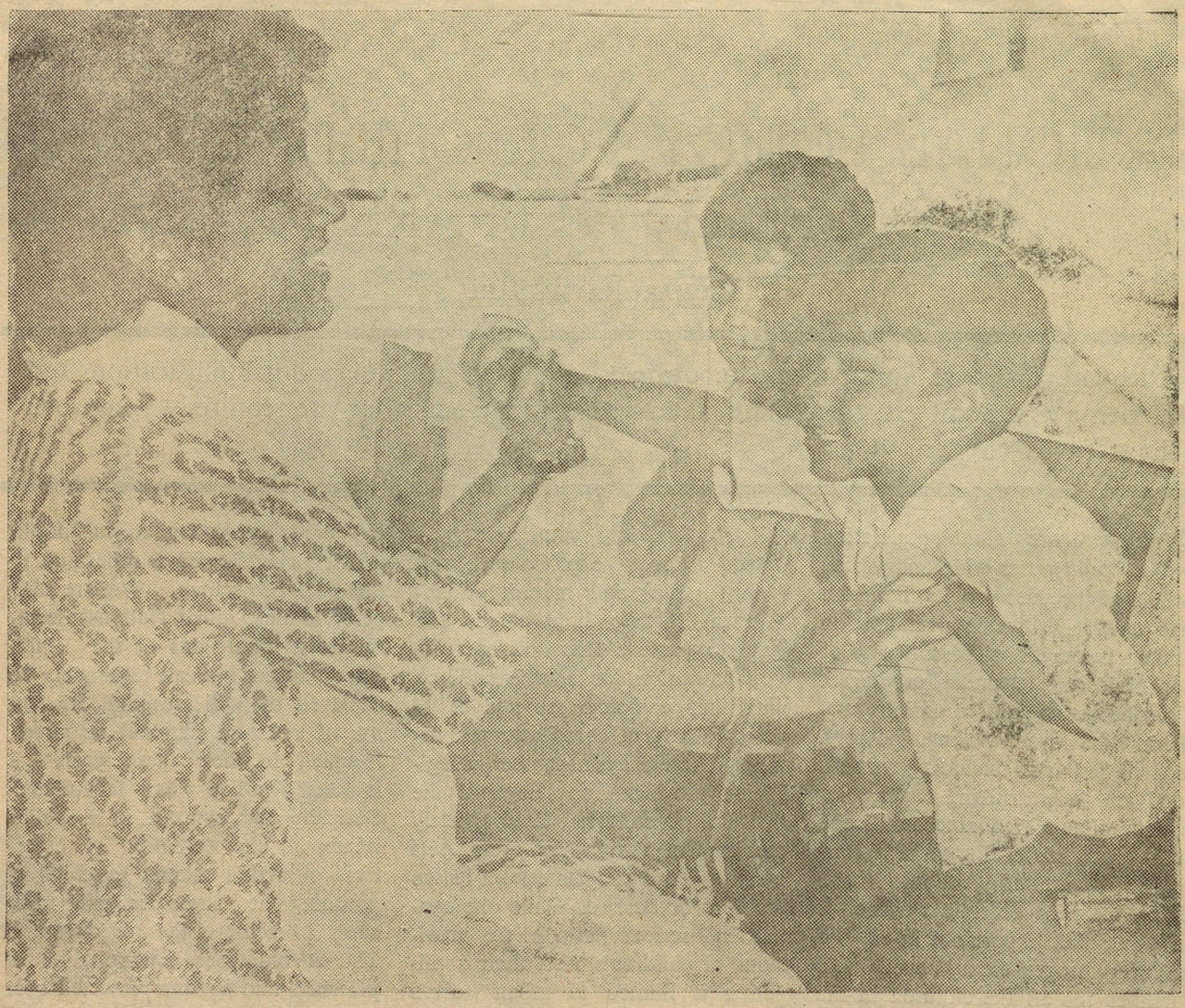
A clear and consistent national policy for children was absent in India till the adoption of the National Policy for Children in 1974. The Government of India expressed a keen concern for the adoption of a national policy since children are supremely important asset of a nation, their nurture and solicitude is of great significance for the development of human resources. Indian Parliament adopted in August, 1974, the National Policy for Children which is considered a milestone in the field of welfare. We are also party to the United Nations' declaration of the Rights of the child. The goals set out can reasonably be achieved by judicious and efficient use of available national resources. Keeping in view these goals a national policy was formulated. Basically the concept of a policy relates to the definition of objectives of action related to children, outlining the strategies and measures to achieve the objectives. It also encompasses determination of priorities and actions projected over a time period and delineation of roles assigned to government, voluntary agencies, the family and community in achieving these objectives.

Adequate services

The policy requires the State to provide adequate services to children, both before and after birth and through the period of growth, to ensure their full physical, mental and social development. It envisages that:

(i) all children shall be covered by a comprehensive health programme;

(ii) programmes shall be implemented to provide nutrition



The national policy for children is not just a policy direction for observance of [State laws. It is also an expression of the commitment of the people to do what ought not to be done for the children of the country.

services with the object of removing deficiencies in the diet of children;

(iii) programme to be undertaken for general improvement of health and for the care, nutrition and nutrition education of expectant and nursing mothers;

(iv) the State shall take steps to provide free and compulsory education to all children up to the age of 14 years. Informal education for pre-school children is also included in it;

(v) children who are not able to take full advantage of formal school education should be provided with other forms of education suited for their requirements;

(vi) physical education, games, sports and other types of recreational as well as cultural and scientific activities shall be provided in schools, community centres and other institutions;

(vii) to ensure equality of opportunity, special assistance shall be provided to all children belonging to the weaker section of society like Schedule Castes and Schedule Tribe and economically weaker sections in urban and rural areas;

Immunization is one of the most powerful public health weapons available today if the 1990 goal of universal child immunization is to be attained national programmes must not only be accelerated but also sustained

(viii) children who are socially handicapped and have become delinquent or have been forced to be begging or are otherwise in distress shall be provided facilities of education, training and rehabilitation and will be helped to become useful citizens;

(ix) children shall be protected against neglect, cruetly and exploitation;

(x) no child under 14 years age shall be permitted to engage in any hazardous occupation or be made to undertake heavy work;

(xi) facilities shall be provided for special treatment, education, rehabilitation and care of children who are physically handicapped, emotionally disturbed or mentally retarded;

(xii) children shall be given priority for protection in times of distress and natural calamity;

(xiii) special programmes shall be formulated to identify, encourage and assist gifted children, particularly those belonging to weaker sections of the society;

(xiv) laws to be amended so that in all legal disputes between parents and institutions, the interests of children are given paramount consideration;

(xv) in organising services for children, efforts would be directed to strengthen family ties so that full potentialities of growth of children are realised within the normal family, neighbourhood and community environment.

Expression of commitment of the people

Thus, the national policy for children is not just an instrument or a policy direction in the hands of the State for observance of State laws. It is also an expression of the commitment of the people to do what ought to be done for the children of the country.

During the past few decades significant progress has been made in the provision of services for children. There has been considerable expansion in the health, nutrition, education and welfare services. Rise in the standard of living, wherever it occurred has indirectly met children's basic needs to some extent. All these jobs need a focus and a forum for planning and review and proper coordination of multiplicity of services striving to meet the needs of children. As a sequel to the National Policy, a National Children's Board was constituted on the 3rd December, 1974 in pursuance of provisions in the policy dated 22nd May, 1974. Similar Boards were also constituted at the State level. The National Children's Board in 1978 proposed to set up National Children's Fund at the Centre and similar funds at the State level. It is a standing fund to be utilised by voluntary organisations for extending various child welfare services. A scheme of Integrated Child Development Services (ICDS) was launched with the aim of developing a package of basic services for children consisting of supplementary nutrition, immunization, health checkup, maternal services, nutrition and health education and nonformal education to children in the age group of 0-6 years, pregnant women and nursing mothers in rural, tribal and urban areas.

Besides the Central Bureau of Correctional Services was reorganised and set up in the new name of National Institute of Social Defence concerned with preventive, correctional and rehabilitative measure to various areas of social defence of children involved in juvenile delinquency, crime, probation, beggary and drug addiction. Similarly in the context of launching of the programmes of ICDS the Central Institute of Research and Training in Public Cooperation was reconstituted as National Institute of Public Cooperation and Child Development in July 1975, with the addition of a division to look after the work relating to research and training in child development. Another programme of child development which has been given a particular thrust is universalisation of elementary education.

In the Year of the Child in 1979, two new Schemes emerged--one was the Institution of the National Award for Child Welfare and the other was the Institution of the National Children's Fund to assist. During the Five Year Plans the need to give greater consideration to children has been realised and malnutrition as a major cause for ill-health and retardation has been recognised. The First Five Year Plan accorded high priority to maternal and child health services and tried to improve the quality by supporting the training of health personnel.

The Second Plan coordinated welfare extension projects initiated by community development blocks thus emphasizing the role of local bodies and communities in promoting services to children by implementing ICDS schemes. The Fifth Plan gave a new orientation to social welfare by the adoption of prevention and developmental approach. The Sixth Plan aimed at enabling the deprived sections of the population to overcome social, economic and physical handicaps and improve their quality of life. During the Seventh Plan a greater thrust has been given to child welfare and the ICDS scheme has been given supreme priority.

While it is gratifying that the movement is going in the right direction and a national consciousness has been generated to improve the quality of life of that the children of India live, the efforts have touched only a fringe of the problem as yet. Child welfare schemes are now administered by different ministries and departments. In order to coordinate the child welfare services the various agencies involved should be brought under a separate and new ministry of Child Welfare and Development at the Centre and corresponding ministries at the State level.

Child development has to be given a high priority in the national plan. Its present status as a part of another residuary sector like social welfare has to be established. To sum up, adequate financial input, proper coordination of organisation and administration and immense community participation and active extention education are required to improve the status of children to achieve our proclaimed national goals.

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Need of Children to be Happy and Healthy

A child's happiness is often decided before the child is even conceived; among the important components is the health of the mother, the habits and attitudes of the father, and the genes the child inherits. Unfortunately, if he or she comes too quick after the last, or if the mother is too young or too old, the new life often has already begun with a handicap.

A child enters life as a helpless babe, unable to care for himself or herself, much less to know what is good for survival. Gradually, during the early months and years of a child's life, mental and physical powers develop. Soon, the child is able to think clearly, to express himself or herself, and to have opinions.

With good guidance children become better able to take responsibility for their own activities. Educators and sociologists generally recognize that of the many factors that influence children's happiness during their period of development, the influence of the home stands out even above the school. It is in the first two to three years of life that children's personalities are being actively moulded by the attitude of their parents or of the others who take care of them. For example, a neglected child may develop behaviour disorders or unsocial habits. Every child needs continuity of relationship, security and the greatest gift—love.

In the overpopulated regions of the world, with their attendant economic constraints, many a child suffers physical, nutritional and mental deprivation. Under these circumstances it is not uncommon to find a child joining the vast army of exploited child labour.

It is today well established that health is determined by the interaction between the child, his environment and the society in which he lives, and is not a measurable quantity independent of this relationship.

There is no better way to ensure health and happiness to a child than to accept and implement the Declaration of the Rights of the Child, adopted by the United Nations on 20 November 1959. Its spirit?

MANKIND OWES THE CHILD THE BEST IT HAS TO GIVE.

A HEALTHY CHILD—A POSITIVE APPROACH

The goal of approach to good health should be to promote the optimal functioning of each individual, not only in childhood but also during adult life, by implementing measures that will maintain health and prevent disease.

To adopt a positive approach for the health and happiness of a child, a strong move away from the common practice of measuring health against a norm of ill-health must be taken. For example, it has been opined that no child whose growth is faltering should be considered well, and, coversely, if a child is growing, he or she could not be very sick. Rather, a standard for a normal healthy child in each country, taking factors of environment, society and health data, if available, would be of prime importance to judge each child against a yardstick of normality.

The first few years of life are very important in laying the foundations of good health and improving the quality of life. In South-East Asia, a large number of children, because of adverse environmental conditions, will not enjoy good health or develop to their full potential which, in turn, will affect their economic or social potential. Therefore, the goal of the approach to good health should be to promote the optimal functioning of each individual, not only in childhood but also during adult life, by implementing measures that will maintain health and prevent disease.

Basic health services for mothers and children are now part of Maternal and Child Health services throughout the Region. Special care should be taken to ensure that health services for children are integrated into the total health system of the country and properly coordinated, particularly as the health of the child is affected by the environment and many kinds of care are needed by the child and the family.

Health services for children, which include physical, emotional and social needs, should be conveniently available to all. Even today, specialist services are only available to a small section of the population, namely, the urban children; rural children sometimes do not even have the benefit of basic care. Every effort must be made to provide basic health services through primary health care to all children, and most important, provide these close to their homes. This is possible only if a positive approach is made to establish an efficient coordination between the health services and local community participation, particularly the participation of volunteer women and youth groups. Often forgotten is the fact that for optimum benefit many preventive activities must be carried out by the child, the parents and the community rather than administered merely by health professionals. A positive action is called for to establish a definite programme to involve children, in addition to their parents, to manage their own health.

Health services for children can be expected to prevent illness in four general areas: genetic, environmental, life style and direct personal

medical and health care. Prevention of genetic illness is achieved by prenatal counselling and screening for asymptomatic diseases. Environmental controls are generally within the scope of the national service but there is still much that the community can do. Changes in the life style of the child through health education must become an important activity, for example. Immunization as a major means of personal health services has been very successful. Prompt treatment facilities must also be made available to all chldren.

A positive approach to health services for children, therefore, must cover the promotion and maintenance of health; specific protection against diseases; early detection of health problems; and prompt treatment so as to limit disability and rehabilitation.

Parents play a major role in keeping the children physically sound, mentally alert and socially adjusted, provided they play a responsible role. To ensure that they do so, parents must be provided adequate knowledge of hygiene and the nutritional and health needs of the growing child. They must appreciate the needs for proper cleanliness, nutrition, breast feeding, weaning diets, hygiene, immunization, accident prevention in the home, family planning and normal growth and development.

Since social and economic factors play a determinant role in the health of children, health workers need to become actively involved in improving programmes in such areas as housing, adoption, delinquency, social behaviour as in the prevention of AIDS and sexually transmitted diseases. A school health programme must be efficiently managed. It should include regular health check-ups so that preventive and concrete measures can be taken. Dental hygiene and health must be ensured and the physical and emotional environment made satisfactory. Parents, teachers and students must be updated on health matters affecting them. Finally, the seeds of community involvement are sown.

Each country may adopt different types of health delivery systems, but an adequate approach to meet basic health needs must provide:

— Prenatal, intranatal and postnatal care and, in particular, recognition of high-risk mothers.

— Family planning services.

— Careful supervision of children particularly those under 6 years of age, with emphasis on identification of children at risk.

— Nutritional education, assessment and supplementation.

In order for health education to be effective, the advice given should be relevant and given at the appropriate breast feeding is best done time, e.g. motivation for during pregnancy.

— Immunizations; health education for the public; diagnosis and treatment of minor illnesses and recognition of serious diseases; first aid; facilities for referral and emergency treatment; maintenance of standardized health records, including growth charts for children; simple laboratory tests; continuous protection of water supply; sanitation and vector control.

— Care of handicapped children.

— Social services like a creche, adoption, etc.

SOME POSITIVE APPROACHES TO HEALTH

1. Infant and toddler feeding, particularly breast feeding and weaning; personal hygiene, sanitation, prevention of home accidents, family planning.

2. Parents need to realize that for children to grow and develop normally they also need love, security, proper discipline, activity, rest, etc.

3. Growth monitoring is absolutely essential. Its objective is to detect early growth faltering and not as utilized presently to detect severely malnourished children for various government and non-government supplementary nutrition programmes.

4. Protection against common diseases, such as through immunization, and provision of a safe environment, including safe water supply, excreta disposal, etc.

5. Early detection of health problems and prompt treatment, specially of abnormalities such as congenital malformations and nutritional deficiencies. Tests for hearing and vision, mental retardation, speech disorders and physical handicaps

GROWTH MONITORING

Growth monitoring can be defined as an operational strategy for promotion of health to enable mothers to visualize growth or lack of it, and to obtain specific, relevant and practical guidance to ensure continued regular growth and health of child.

It implies a regular measurement of growth, recognizing it to be the result of overall health, nutrition, environment and psychosocial factors.

It is aimed at achieving behavioural changes and the adoption of action within community to promote optimal health.

In short, growth monitoring is a communication strategy for making health and nutrition education more individualized, convincing and effective.

should be readily available and an efficient screening system should be adopted. It is recommended that it is worthwhile to screen newborn infants for glucose-6-phosphate dehydrogenase (G6PD) deficiency as this deficiency is fairly common in South-East Asian countries. The test is relatively cheap and easy to perform. The prevention of kernicterus from this cause would reduce the incidence of mental retardation.

6. Adolescent health care has assumed importance as most of the countries of South-East Asia demographically have a young population. Because of customs and tradition, many marry young and become parents before they are biologically ready for it and can accept responsibility. Although major illnesses are not a feature of this age group (10-19 years), eating disorders, accidents, smoking, drug and alcohol abuse, teenage pregnancies, emotional problems, mental difficulties and sexual problems, are fairly common. Health facilities for the adolescent have been sadly neglected and positive action is needed to correct this lapse. ○

Problems Seen in High Risk Children

(a) Genetic or chromosomal abnormalities

(b) Serious abnormalities developing during intrauterine life (for example cardiac insufficiency, diabetes, etc.)

(c) Abnormalities occurring during pregnancy, e.g. caused by iodine deficiency: placental insufficiency.

(d) Illnesses in new-born babies such as sepsis, etc.

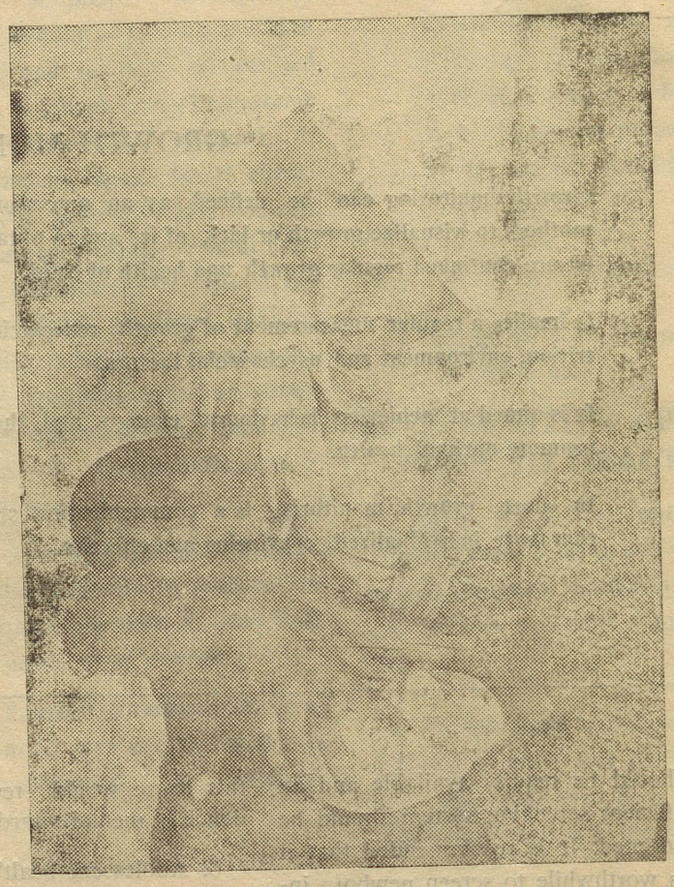
(e) Babies born less than 1500 gms.

(f) Morphological immaturity in babies.

(*Source*: Professor Eloisa G.A. de Lorenzo).

Young Mother Should Learn Something Special

KAMLA ARYA



MOTHER'S ignorance is responsible for losing a fair proportion of the children before their first birthday. Unhealthy motherhood accounts for many of these deaths. Hence the first duty of every expectant mother is to care for her own health.

Hygiene of pregnancy is important for an expectant mother. The term "hygiene of pregnancy" includes proper diet and exercise for the mother during the months before the baby is born, and the provision of fresh air, rest and healthy sleep. The expectant mother ought not to overfeed herself. Indiscretion in diet cause the dyspepsia with heartburn which makes so many mothers miserable at this time. Light, nourishing food must be the rule. Plenty of raw fruits and vegetables should be eaten.

Mother's ignorance is responsible for losing a fair proportion of children before their first birthday. Unhealthy motherhood accounts for many of these deaths. Hence, the first duty of every expectant mother is to care for her own health.

The breast require a little special attention to prevent cracked nipples, which interfere with natural feeding. The nipples should be washed daily with warm water, carefully dried, and hardened by gentle friction. If the nipples are small, they should be rolled between an oiled finger and thumb to develop them. Clothing should be light and loose, and supported from the shoulders.

Expectant Mother Must Take Exercise

Regular exercise and a certain amount of work are far better for her health. The expectant mother can carry on her business or profession for several months as least, provided her work is not physically or mentally exhausting. A brief rest of 20 minutes after lunch and also before the evening meal is excellent. Every effort should be made to obtain restful sleep by regular bedtime, a well-aired room, a comfortable bed and a tranquil mind.

Indigestion and constipation are perhaps the commonest ailments at this time.

The only medicine for indigestion which should be taken without a doctor's prescription is a tumbler of hot water with a pinch of bicarbonate of soda added, half to three-fourth of an hour before meals.

For constipation take plenty of water and raw fruit between meals,

Half or more than half of infant mortality occurs during the first month of life or the neonatal period. The preterm, low birthweight infant is at greatest risk during the neonatal period.

Of the neonatal infections, community-based surveys reveal that neonatal tetanus mortality rates range from less than 5 to more than 60 per 1000 live births. In some settings, these deaths represent between 23 per cent and 72 per cent of all neonatal deaths.

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besides taking regular exercise. If these simple measures are not successful consult a doctor without delay. Morning sickness is not so much a digestive disorder as a symptom caused by chemical changes in the body at this time; it usually passes off at the end of the third month, but if it persists consult the doctor.

Vericose veins are often quite painful in pregnancy, so rest is most important. When resting, keep the feet up on a couch or stool, and do not stand more than is strictly necessary. The teeth should be watched, stoppings attended to and decayed teeth removed before baby is born. Bad teeth will infect the milk.

Feeding the New-Born Baby

The average normal child weighs from 7 to 7½ lb. at birth. Mother's own milk is baby's right and natural food. In almost every case it is possible for a mother to feed her child herself. Nevertheless quite a common mistake is lack of patience because the breast milk does not seem satisfy the baby, and artificial feeding is resorted to help the breasts. Test-weighing will show whether or not there is need to complement the breast milk. Sometimes all that is needed is a little sweetened water after the breast-feed, keep baby a little hungry, otherwise he has not an incentive to suck strenuously, and the milk is apt to go.

During the first two days he should be fed every six hours; on the third day at four-hourly intervals, and after that every four hours, or every three hours in the case of a weakly or premature baby. No night feeds are given to the modern baby from birth, unless to a premature or very weakly child.

When the milk is insufficient, the baby should not be weaned, but the natural food is supplemented by giving a feed immediately after the breast of diluted and modified fresh cow's or dried milk. Give both breasts at each feed, so that each is regularly stimulated.

When baby cannot be breast fed through abscesses of the breast or other serious cause, then the child must be brought upon the bottle. His chances of health and even of suvival are diminished by bottle-feeding. It is the duty of every woman to nurse her own child unless advised not to do so by the physician for serious health reasons. Breast milk is free from germs; it is most easily digested, and it is of the right temperature.

To improve the quantity of the mother's milk, she should take extra water to drink between meals. To improve the quality she should see to her health. See that she has more rest—two hours bed rest every afternoon may make all the difference—and teach her to douche and massage the breasts. This is done as follows:

Get half a bucket of hot water and half a bucket of cold water and put a piece of soft towel in each. Bathe the breasts alternately with hot and cold water for 10 minutes once or, better sill, twice daily. Dry and massage for 10 minutes. With proper care, 90 per cent of women can nurse their babies. When bottle feeding has to be resorted to, use the best quality cow's milk which can be modified so that the sugar fat and protein content approximates to that of human milk. Dried milk can be modified in the same way. The vitamin destroyed by boiling the former or with preparation of the latter can be replaced by orange juice. Give half a teaspoonful of orange juice after the first two months in the same amount of boiled water and work up to three teaspoonfuls at six months and six teaspoonfuls at one year.

The following table shows the percentage in human milk and cow's milk:

	Sugar	Fat	Protein
Human milk	7%	3.5%	1.3%
Cow's milk	5%	3.5%	3.3%

To reduce the protein content, dilute with boiled water. As this reduces also the sugar and fat contents these must be made up.

The proportion for an average baby of 3 to 10 months are as follows: To make 150 gm of food take 75 gm of cow's milk, 1 teaspoonful of sugar, 60 gm of water, and 6 gm of lime water. 1 teaspoonful of emulsion of cod lived oil is given to make up the fat content. A younger baby would need more dilution, and older less.

To Prepare : Stir milk before measuring off desired quantity. Boil in clean open Pan, add lime water and cold boiled water and strain.

Make the food once in 24 hours, and always stir the mixture before measuring off into the feeding bottle. Before giving to baby keep bottle, containing milk in hot water to warm to 100° Fahernheit. Cover bottle with flannel bag to maintain temperature during feed.

The most careful attention should be given to the bottles. The best type of bottle is the boat-shaped one, since it is easy to clean and comfortable to hold. After a feed the bottle, teat, and valve must be rinsed out thoroughly, then placed in a basin of cold boiled water.

The bottles should be boiled before using again, a special saucepan being kept for this purpose. Place the bottles in cold water, boil for five minutes and cool before the bottles are removed.

Turn teats inside out, Rub well with dry salt inside and then out. Scald teats once a day, never boil. ○

Reducing Incidence of Low Birth Weight Babies in India

The birth-weight of an infant, simple as it is to measure, is highly significant in two important respects. In the first place it is strongly conditioned by the health and nutritional status of the mother. In the second place, low birth weight is, universally and in all population groups, the single most important determinant of the chances of the new-born to survive and experience healthy growth and development.

Any baby weighing less than or equal to 2,500 grams at birth is called a 'low-birth-weight' baby. This baby is at risk to various health and nutritional hazards and frequently succumbs to common childhood diseases. Half of all perinatal and one-third of all infant deaths are due to low birth weight. Further, prematurity contributes to mental and physical handicaps, especially in those children who have not received adequate expert neonatal care.

For these reasons, increasing attention is now given to birth weight distributions, and especially to the frequency of low birth weight as a general indicator of the health status of population groups. While not directly measuring the health of the whole population, the frequency of low birth weight draws attention to those groups (i.e. mothers and young children) which are the most vulnerable and require the highest priority in health.

One of the most serious challenges in maternal and child health, in both the developing and the developed countries, is improvement of birth weight. The proportion of infants with low birth weight ranges from 2-3 per cent in some developed countries. It has been estimated that more than 21 million low-birth-weight babies are born throughout the world each year, of which 20 million are in the developing countries.

In 30 to 50 per cent of the cases, the cause of low birth weight is unknown. The most important causes, as far as India is concerned are maternal malnutrition and anaemia, while the other causes include maternal, foetal and placental causes.

Attention has been given in recent years to ways and means of preventing low birth weight through maternity care and intervention programmes during pregnancy, rather than treatment of low-birth-weight babies born later. Low birth weight affects 30 per cent or more of the infants in India, in contrast to only 7 per cent in U.S. and Europe. Unless birth weight can be substantially increased, it is unlikely that infant mortality can be lowered.

Keeping in view the objectives of 'Health for all by 2000 A.D.' with special focus on children, the working group on health (1981) has recommended a reduction in the incidence of low birth weight to 10 per cent by the year 2000 A.D.

(From: Report of National Seminar on Reducing Incidence of Low Birth in New Delhi)

Role of Voluntary Organizations in Child Development

SMT VIDYABEN SHAH

Voluntary organizations do have a major role to play in child development. The ongoing programmes managed by such agencies are extremely successful. More such agencies need to come forward for child development.

THE focus of a nation's development must be in the development of its people and not merely its material resources. The later are only a means to an end and not an end in itself. The best way to develop the national human resources is to take care of the children, as they are "Supremely important assets" for the nation, as stated by the National Policy for Children. Our beloved Pandit Jawaharlal Nehru, the first Prime Minister of India always underlined the importance of development of children for the growth of the nation.

Development may be defined as the total complex of processes arising from external and internal forces, resulting in changes in the form, structure and functioning of the individual, reaching towards the goal of his self-realization. Child Development therefore refers not only to the physical growth and wellbeing of the child but to the social, emotional, creative and cognitive growth as well.

Childhood is a period of rapid growth and the child must get proper stimulation at this stage so that he can attain optimum development physically, emotionally, socially and intellectually. A child not only needs food, clothing and shelter but also love, understanding, recognition and appreciation to develop feelings of trust, friendliness, security and belonging.

The primary responsibility of meeting the child's needs lies with the family. There is research evidence to show that home environment of a child influences his social adjustment, *i.e.*, self-confidence, friendliness etc. If parents focus on positive points in a child by encouraging the child for his achievements through spontaneous appreciation, it will help the child in his all round development.

Similarly, the school can also provide rich experiences to the child and help him develop a good physique, good habits, proper attitudes and a questioning mind.

Present status of children

If we look at the situation of children in India today, it is a pathetic scenario. The infant Mortality Rate in India today is 95 which is very high as compared to the developed nations. Out of the total population of 772.7 millions it is estimated that children in the age group of 0.4 years are above 120 million and the estimated death rate for this age group is 37.6 per thousand live births. This is an alarming proportion as these children account for over 40 per cent of total deaths in the country.

We find thousands of children dying everyday from malnutrition, starvation, diseases and neglect. Most of these deaths are avoidable by providing proper nutrition, immunization etc.

Unheatlhy environment

The children who do survive grow in a hostile environment of deprivation and scarcity. About 75 per cent of children in rural areas do not have access to potable water supply. A synergistic cycle of infections and malnutrition is set into operation due to inadequate food and insanitary conditions. Eye ailments, blindness due to Vitamin A deficiency respiratory diseases, fevers and digestive disorders take a heavy toll. Immunizable diseases like polio, tuberculosis etc. also affect a large proportion of child population but only a small proportion has the benefit of total immunization. Hence

Development may be defined as the total complex of processes arising from external and internal forces, resulting in changes in the form, structure and functioning of the individual, reaching towards the goal of his self-realization.

implementation of immunization services calls for an elaborate organisational management as this is a major intervention strategy in saving children from epidemics and fatal diseases.

Malnutrition

Malnutrition is responsible for more child deaths than all other causes combined together. It is the underlying cause, either exclusively or jointly in 53 per cent of deaths in the age group 0-5 years.

Much of the malnutrition in young children is prevalent due to improper feeding and weaning practices. Therefore, education of the mother is extremely important.

Poverty

About 40 per cent of the Indian population is estimated to be below subsistence level. It is the child who suffers the most in poverty conditions. On the one hand, he is deprived of all opportunity of education, recreation and play and on the other he has to join the labour force for supplementing the income of his family. Poverty becomes a major cause of illiteracy and ignorance. These in turn lead to more incidence of disease and malnutrition.

Currently running child welfare programmes

Some of the major programmes for children are Welfare Extension Projects, Maternal and Child Health Services, Intergrated Pre-school Projects, School Health Programmes, Minimum Needs Programme, National Expanded Programme of Immunizations, Balwadi Nutrition Programme, Applied Nutrition Programme, Special Nutrition Programme, Creches for Children of Working and Ailing Mothers, Early Childhood Education Centres and Integrated Child Development Services.

These programmes provide services like immunization, education, nutrition, recreation, health services etc. to women and children. ICDS programme—the largest and most widely acclaimed of these delivers its package of services through an *Anganwadi* Worker who is a female voluntary worker from the local community.

Role of voluntary organisations

Voluntary action in the area of Child Development is not so recent in origin. The pre- and post-independence era has seen several voluntary movements and efforts in order to improve the situation of our children. Much of this effort was greatly inspired by Mahatma Gandhi. Gradually, the area of child development attained a professional status. Training Institutes were set up for *Gram Sevikas* and *Balsevikas*. *Balwadis* set up in the 1950s are run by voluntary organisations with financial support from the Government.

Child development refers not only to the physical growth and well-being of the child but also to the social, emotional, creative and cognitive growth as well.

There is an absolute necessity of voluntary action to supplement the efforts of the Government in this area. For any programme to be a success, some voluntary efforts must go into it. In a country fragmented by diversity of religious, cultural, social and ethnic backgrounds, it is imperative that the programmes must cater to the "felt needs" of the people. The programmes must have their support and confidence. This calls for flexibility in approach along with consistency and continuity so that gradually the programme becomes integrated into the social fabric of the community. In the case of children's programmes, the services must cater to the demands of parents as well. Voluntary organisations have the advantages of remaining in close contact with communities, primarily because of emphasis on rapport, flexibility of approach and dedication of workers.

The Government has a vast bureaucratic organisation with a hierarchy in terms of authority and power and therefore the Govern-

ment usually remains outside the social fabric of people. Although voluntary organisations suffer from lack of resources due to which the momentum of their work is affected we must strengthen them if we are to reach out to the unreached children.

We must implement our objectives at the field level through active participation of the community. We should look at the socio-economic situation of a region, determine the priorities of its child population and then try to amalgamate the services being provided into the prevailing local conditions so that there is an effective demand of these services. This can only be done through active involvement and reliance of voluntary agencies.

Scope of Voluntary Organisations in Child Development

The voluntary organisations can and are contributing effectively towards child development in several different ways.

There is an absolute necessity of voluntary action to supplement the efforts of the Government in this area. For any programme to be a success, some voluntary efforts must go into it.

Fund raising

As the voluntary workers are the closest to the people in the community, they are in the best position to generate funds which can then be utilised for child development/welfare programmes. For instance, Indian Council for Child Welfare (ICCW) generates funds through its Greeting Cards Scheme, Sponsorship Scheme and other donations and utilizes them for child welfare activities.

Running child development programmes

Voluntary organisations can manage various child welfare programmes effectively for example— running of creches for children of working mothers as well as running of *anganwadis*/*balwadis*/child care centres. Although these programmes can and are being run by the Government also, the voluntary organisations definitely have the advantage of getting the confidence of the community and therefore the programme can be a greater success. ICCW has been running approximately 2000 *Balwadis* and creches all over the country.

Voluntary agencies can play an important part in trying out pioneering ideas and to bridge some of the gaps that exist in the government health system.

As these organisations are in contant touch with the mothers of the beneficiary children, they know when and how to mould the contents of the programme as per the erstwhile needs of the community.

Training of child development workers

It is important to have qualified, skilled and trained workers for the successful implementation of Child Development Programmes. Therefore, there exist various training programmes as under :—

1. Balsevika Training
2. Anganwadi Workers Training

A child not only needs food, clothing and shelter but also love, understanding, recognition and appreciation to develop feelings of trust, friendliness, security and belonging.

3. Creches Workers Training
4. Training of Dais
5. Pre-Primary Teacher Training.

Voluntary organisations, if suitably equipped, can also run these training programmes. ICCW started the formal training of child care workers through a handful of *Balsevika* Training Units which have now expanded to approximately 150 child care workers training centres all over the country. These training centres provided a variety of training not only to the *Balsevikas* and *Anganwadi* workers but to creche workers helpers as well.

It is, therefore, an undisputed truth that voluntary organisations do have a major role to play in the area of child development. It is evident from the fact that the presently running programmes managed by voluntary organisations are extremely successful. Thus, more and more of these agencies should come forward for the good cause of child development. ○

HEALTH STATUS IN 1987-88

PROVIDING BASIC HEALTH SERVICES TO ALL

S. S. DHANOA

During the year 1987–88 efforts were continued to provide basic health services to all and promoting health status of the people. However, the problem of improvement of quality of services and their accessibility and availability to community would continue to demand serious attention on our part.

THE year 1987-88 witnessed the Ministry of Health and Family Welfare moving steadily towards its goal of providing basic health care services to all and promoting health status of our people. We have set unto ourselves the goal of Health For All by 2000 A.D. attainment of which is possible only if population stabilization is achieved alongside.

During this third year of the Seventh Five Year Plan, the Ministry continued its efforts to provide effective and efficient health and family welfare services to the people in the rural areas by expanding its network of Sub-Centres, Primary Health Centres (PHCs), and Community Health Centres. We are all set to achieve a substantial portion of our targets for establishing primary health care network by the end of the current Plan period. However, the problem of improvement of quality of services and their accessibility and availability to the community would continue to demand serious attention on our part.

It is envisaged to establish one Sub-Centre for every 5,000 population in plains and in case of hilly, tribal and backward areas for every 3,000. It is also planned to have one Primary Health Centre for every 30,000 population in the plains and for every 20,000 in hilly, tribal and backward areas. We also propose to convert all the existing rural dispensaries into Primary Health Centres (PHCs). Gradually, hospital facilities are being provided to all people in the villages by upgrading PHCs and equipping them with additional facilities and services. Each of the upgraded PHCs known as 'Community Health Centre' has thirty beds, services of four medical specialists, laboratory and X-ray facilities. It is proposed to have one Community Health Centre for every 1.20 lakh population. In case of hilly, tribal and backward areas, it may be set up for a population of sixty to eighty thousands.

Rural infrastructure

At present, the primary health infrastructure includes 1,02,160 Sub-Centres, 14,409 PHCs and 1,293 Community Health Centres. At the grassroots level, we have 5,58,919 trained dais, 3,92,344 Village Health Guides and 84,993 Multi-Purpose Workers (Male) and 1,07,593 Multi-Purpose Workers (Female) to take the basic health care services to the doorsteps of the people.

Communicable diseases

The National Programmes for control and eradication of communicable diseases maintained a steady progress. Leprosy, a major socio-health problem, continued to receive 100% assistance. Multi-Drug Therapy (MDT) is presently available in 48 endemic districts. All 76 highly endemic districts will be covered by MDT by the end of the current Plan. An in-depth evaluation in seven districts after 4 years of Multi-Drug Treatment has revealed a reduction of 60 to 80 per cent in the prevalence rate of leprosy. There has also been a fall in the new-case-detection rate which further confirms the fall in the prevalence rate. However, the evaluation noted an increase in childhood-leprosy cases which needs further investigation. Two new vaccines against leprosy have been developed by our research institutions and clinical field trials have been taken up this year. Increased attention is being paid to detection of T.B. cases by involving PHCs in a big way. Nearly 46,000 beds have been provided for T.B. patients in need of hospitalisation. We also have programmes for controlling Malaria, Filaria and Kala Azar. We have initiated action to evolve a common and effective strategy for Vector Control to successfully check further spread of these diseases. A sustained effort to provide eye care services to the people through PHCs has been going on and ophthalmic cells are being added to PHCs in a phased manner.

Nearly 145 million people are living in Goitre endemic regions and 40 million of them are estimated to be suffering from this disease. Iodised salt has already been introduced in the endemic areas and a total coverage is expected by 1992. With this end in view production of Iodised salt is being stepped up and by the end of the Seventh Plan period 30 lakh metric tons of iodised salt will be produced annually. Facilities for early diagnosis and control of Cancer are being provided throughout the country. Widespread awareness has been created and preventive steps taken against the spread of AIDS—a deadly disease that has emerged to be a major threat to the mankind. Two new programmes, one for Diabetes Control and another for Dental Health Care have been introduced during this year with a view to strengthening the national health care management system.

Population growth

The success of the Health programmes is evident from the fact that life expectancy at birth today is 56 years as against 32 in 1947. The country's population is increasing at the rate of 15 million per year and was estimated to be around 776 million as on 1st March, 1987. About 85.4 million births are estimated to have been averted since the inception of the Family Welfare Programme. A number of facilities and serivces are being offered free to eligible couples to plan their families. As a result, the Couple Protection Rate (CPR) has been going up in the last four years and 37.5 per cent couples have been protected by March, 1987.

In terms of numbers, an all time high record of 20.57 million acceptors of family planning methods was achieved in the year 1986-87. There was an increase of 2.6% in sterilisation cases as compared to 1985-86. Only partial figures upto December, 1987 are available for the current financial year which indicates that 13.73 million persons have adopted family planning methods. This shows an increase of about half a million over the corresponding period in the previous year.

The alarming rate of population growth, if not arrested in time, is likely to nullify all our efforts for socio-economic development of the community. Population control should, therefore, no longer be viewed as the responsibility of one Ministry or Department alone. We have to aim at population control through planning process. Unless it becomes an integral part of the total plan-development-efforts, we may not be able to accord it the over-riding priority that it demands.

Targets

Our target is to reach Couple Protection Rate of 60% by 2000 A.D. so that we can achieve Net Reproduction Rate of Unity by that time, as envisaged in our Health Policy. We are also striving to achieve the goal of reducing the present birth rate of 32.4 to 21 per thousand. During the same period the death rate is to be brought down from 11.1 per thousand at present to 9 per thousand and infant mortality rate from the present 96 to 60 per thousand.

A global awareness is being created about the need for ensuring safe motherhood for all women, specially those from the under-privileged sections of society. A majority of them have been suffering for years because of unplanned, unsafe and repeated pregnancies and Childbirths. It is an established fact that morbidity and mortality in young women can be substantially reduced if information and services for contraception and safe child-bearing are brought within their easy access. The Government has always given priority to Mother and Child Health Programme which is being further consolidated. There are prophylaxis schemes providing nutritional supplements to expectant and lactating mothers and mal-nourished children against anaemia and blindness. Oral Rehydration Therapy has been taken up to reduce the death rate among children below 5 years by about 40 to 50 per cent. The expectant mothers are also being protected against Tetanus, and the infants and children against six vaccine preventible diseases through Universal Immunization Programme. By 1990, the Universal Immunization Programme aims to cover 85 per cent of infants and 100 per cent of pregnant women. Immunization services are available free throughout the country at the doorsteps of the beneficiaries and 18 million women and 24 million infants are being immunized every year.

Technology Mission

Recognising the prime importance of the Universal Immunization Programme in the overall health plans, a Technology Mission on Vaccination and Immunization of Vulnerable Population, Especially Children, was taken up by the Ministry this year with the objective of reducing morbidity and mortality of infants and children and achieving self-sufficiency in vaccine production. Besides extending the coverage under the present Immunization Programme and building up the logistic support, the Mission aims to develop a surveillance system, promote community participation and encourage research and development of new vaccines. The Universal Immunization Programme has proved itself to be the most cost-effective of the health programmes and is vital to our attaining the objective of Health for All by 2000 A.D.

It is proposed to bring about a greater communication between the community and the health functionaries. It is planned to induct more and more women as Health Guides so that they can serve as effective links between the village women and the Health personnel. Greater stress is being laid on IEC (Information, Education and Communication) Schemes in the high fertility districts.

The Government is also promoting voluntary effort to augment the programme at the grassroot level and evoke community participation through all agencies. Facilities are being made available to the voluntary agencies to take up projects related to the reproductive care, child care and family planning services. A number of schemes have been designed to encourage and support their involvement. A scheme to involve the private practitioners of Indian Systems of Medicine and Homoeopathy in family welfare work is being introduced in Uttar Pradesh and Rajasthan on

(Contd. on Page 234)

NATIONAL HEALTH PROGRAMMES

COMMUNICABLE diseases used to take a heavy toll of life in the past. Though provision of medical services has reduced mortality and morbidity from these diseases today to a considerable extent, yet constant work is required on this front at national level. Therefore, the programme implementation for their control is being consolidated at all levels. Continued research work and the Primary Health Care system are being fully utilised for better control of the diseases and the delivery of services in the country.

National Malaria Eradication Programme

National Malaria Eradication Programme of India is the world's biggest health programme and continues to be the country's most comprehensive and multi-faceted public health activity.

There has been a gradual downward trend in Malaria Positive Incidance in the country. As against 6.47 million cases in 1976, there were 1.79 million cases in 1986 showing a reduction of 72.3% over a period of 10 years. The incidence of *P. Falciparum* was 7,53,715 in 1976 which came down to 6,38,276 during 1986 showing a reducation of 15.3% However, the rate of decline varies from State to State.

During 1987, according to reports received upto 31-10-87, there is a decline both in total cases and *P.F.* infection by 27.8% and 2.5% respectively as compared to the corresponding period of 1986.

However, the situation is not uniform everywhere. In some States total malaria cases and *P.F.* cases have shown increase during 1987 as per reports received upto 31-10-1987.

Surveillance Operations: An analysis of the malaria situation in the country over the last six years from 1981 to 1986 shows that number of blood smear examination fluctuated between 64.29 million to 67.69 million.

ABER which is an index of operational efficiency, was above the expected level in 1981. Afterwards, the ABER was fluctuating within 9.18 to 9.60 per cent.

However, in the States of Bihar, Kerala and West Bengal, ABER continues to be less than 3% which is very low against the national target of minimum of 10%.

Spray Operations: During 1986, the projected population with 2 API and above in the country was 357.008 million and the same was required to be sprayed.

Urban Malaria Scheme: The scheme is functioning since November, 1971. At present, 127 towns distributed in 17 States and 2 Union Territories are being covered under the Scheme. The malaria cases registered upto October, 1987 in Urban Malaria Units are 79,466, while the same in the corresponding period of 1986 were 1,21,778.

Kala-azar

The Kala-azar unit of National Malaria Eradication Programme (NMEP) is monitoring the Kala-azar situation in India. This Unit is regularly collecting the Kala-azar incidence reports and is keeping a close vigil over the situation. Kala-azar incidence for the last three years is given below:—

Year	Cases	Deaths
1985	17277	44
1986	17801	72
1987 (Prov)	11891	35 (upto Nov. 6, 1987)

Kala-azar is endemic in Bihar and West Bengal and 24 and 7 districts of respective States are regularly reporting Kala-azar incidence. The States have been requested to spray DDT in the affected areas alongwith ensuring early case detection and treatment. The Dte. of NMEP is providing technical guidance and meterial assistance in terms of insecticides out of its regular budget. No specific funds for Kala-azar control are available. The Govt. of India constituted a Group of Experts on Kala-azar which has proposed to take up anti-Kala-azar activities as an extension of NMEP.

National Filariasis Control Programme

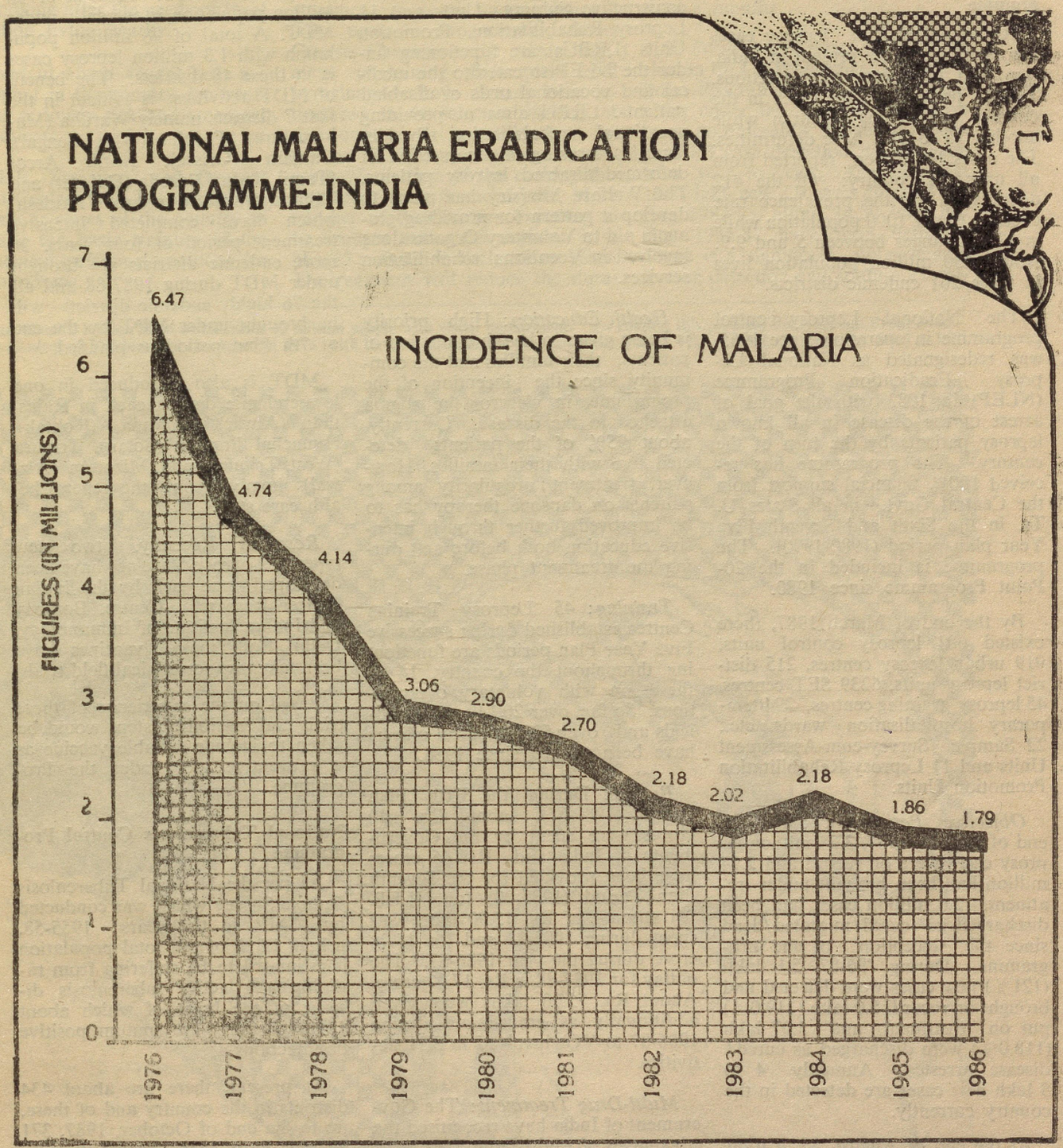
All the States/Union Territories except Jammu & Kashmir, Himachal Pradesh, Delhi, Chandigarh, Punjab, Haryana Meghalaya, Arunachal Pradesh, Sikkim, Rajasthan, Tripura, Mizoram and Manipur are endemic for filariasis. Present estimates indicated that bout 342 million people are living in known endemic area of which about 91 million are in urban areas and the rest in rural areas.

For the control of filariasis, the National Filaria Control Programme was launched in 1955. Under the Programme activities in regard to de-limitation of the problem in hitherto unsurveyed areas, control of urban areas through recurrent anti-larval measures and anti-parasitic measures are being undertaken.

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

Control Units — 190

NATIONAL MALARIA ERADICATION PROGRAMME-INDIA



Survey Units	—	28
Clinics	—	166

At present, about 40 million Urban people are being protected through anti-larval measures by 199 Control Units.

300 districts are situated in endemic areas, of which 238 districts have been surveyed for de-limitation of filaria problem and 173 have been detected to be endemic for filariasis. 28 Survey Units are carring out de-limitation survey in equal number of districts. It is observed that 94 per cent of the towns where control measures are in operation for more than five years, have shown marked reduction in microfilaria rate.

National Leprosy Eradication Programme

About 4.0 million leprosy cases are estimated to be present in India, one fifth of whom are infectious. Twenty per cent of the cases in the country are among children while another 15 to 20% have deformities. The cases have been reported from all over the country: Of the 412 districts, in 76, the prevalence rate exceeds 10 per 1000 population while in 125, it ranges between 5 and 9.9. About 430 million population lives in these 201 endemic districts.

The National Leprosy control programme in operation since 1955, was redesignated as National Leprosy Eradication Programme (NLEP) in 1983 with the goal of arrest of the disease in all known leprosy patients by the turn of the century. The programme has received 100% financial support from the Central Govt. in all States/U. Ts. in the Sixth and Seventh Five Year plan period (1980-1990). The programme is included in the 20-Point Programme since 1980.

By the end of March 1987, there existed 601 leprosy control units, 919 urban leprosy centres, 215 district leprosy units, 6239 SET centres, 45 leprosy training centres, 294 temporary hospitalisation wards, etc., 22 Sample Survey-cum-Assessment Units and 11 Leprosy Rehabilitation Promotion Units.

Objective Performance: At the end of August, 1987, 3.28 million leprosy cases were on record and 2.97 million had been brought under treatment. 2.6 million cases had been discharged as cured/migrated/dead since the inception of the programme. During '86-87 5.1 lakh (121%) new cases were detected and brought on record, 5.0 lakh (119.0%) put on treatment and 5.07 lakh (118.0%) were discharged as cured/disease arrested. Annually 4 to 5 lakh new cases are detected in the country currently.

At the end of August '87, a total of 8,40,849 cases were on record of which 6,36,441 cases were under treatment with voluntary organisations. VOs operate under the direction of the National Leprosy Eradication Programme and are subjected to the same type of monitoring and evaluation system.

Rehabilitation: Seventy-five Reconstructive Surgery Units and 11 Leprosy Rehabilitation Promotion Units (LRPUs) are functioning under the NLEP to cater to the medical and vocational neds of disabled patients. LRPU aims at providing vocational rehabilitation besides facilities for surgical correction of deformed/disabled leprosy patients. The Welfare Ministry has plans to develop a pattern for providing grants in aid to Voluntary Organisttions involved in Vocational rehabilitation services.

Health Education: High priority is being given to health education of patients, their families and the community since the inception of the programme, in view of the stigma attached to the disease. Currently, about 95% of the patients detected live with their families. However, treatment regularity among patients on dapsone therapy has to be improved further through intensive education both before and during the treatment phase.

Training: 45 Leprosy Training Centres established during successive Five Year Plan periods are functioning throughout the country, 14 of these are with voluntary organisations. So far, over 20,140 para-medicals and over 5000 medical officers have been trained since 1956.

Budget: During the Sixth Plan period (1980-85), about Rs. 40 crores were spent by the Government of India and Rs. 65 crores have been provided for the Seventh Plan Period (1985-90) for NLEP. An amount of Rs. 13.90 crore was spent during 1985-86 and Rs. 15.28 crore during the year 1986-87. The outlay for 1987-88 is Rs. 17.00 crore. About Rs. 75.00 lakhs were given additionally as grant-in-aid during 1986-87 to VOs involved in SET activities.

Multi-Drug Treatment: The Government of India have recognised the advantages of Multi-Drug Treatment (MDT) of leprosy cases over traditional dapsone mono-therapy. In view of the pre-requisites and the large quantity of anti-leprosy drugs required for MDT coverage of all the cases in the country, MDT is introduced in a phased manner. 48 leprosy endemic districts are currently under MDT. A total of 98 million population is currently under MDT. A total of 98 million population with 1.3 million leprosy cases is in these 48 districts. The benefit of MDT activities is evident in the first 7 districts namely Wardha (Maharashtra), Purulia (West Bengal), Ganjam (Orissa), North Arcot (Tamil Nadu), Baroda (Gujarat) and Vijianagaram (Andhra Pradesh) which have completed intensive treatment period of four years. 26 more endemic districts are brought under MDT during 1987-88 and all the 76 highly endemic districts will be brought under MDT by the end of 7th Plan period as planned.

MDT is also introduced in one low endemic district each in Rajasthan (Alwar), Haryana (Rohtak), Himachal Pradesh (Solan), Tripura (West Tripura) and Mizoram (Aizwal) involving only the general health care staff.

Research: Recently, two new types of Leprosy Vaccines have been developed one each by the Indian Cancer Research Centre, Bombay and Indian Institute of Immunology, Delhi. Both these vaccines have been taken up for clinical field trials.

Based on the experience of these trials and feasibility, steps would be taken to include suitable vaccine as a preventive tool under the Programme.

National Tuberculosis Control Programme

As per the National Tuberculosis Sample Survey which was conducted by ICMR in the years 1955-58, nearly 1.5% of the total population is estimated to be suffering from radiologically active tuberculosis disease of the lungs of which about 1/4th or 0.4% are sputum positive or infectious.

At present, there are about 434 districts in the country and of these, up to the end of October, 1987, 371 districts have been provided with District TB Centres equipped with essential equipments and manned by trained Staff undertaking district-wise T.B. Programme in association with general health and medical institutions. In addition, there are about ordinarily 300 TB clinics functioning in the country which are

mostly located in big towns and cities looking after the needs of local population living nearby.

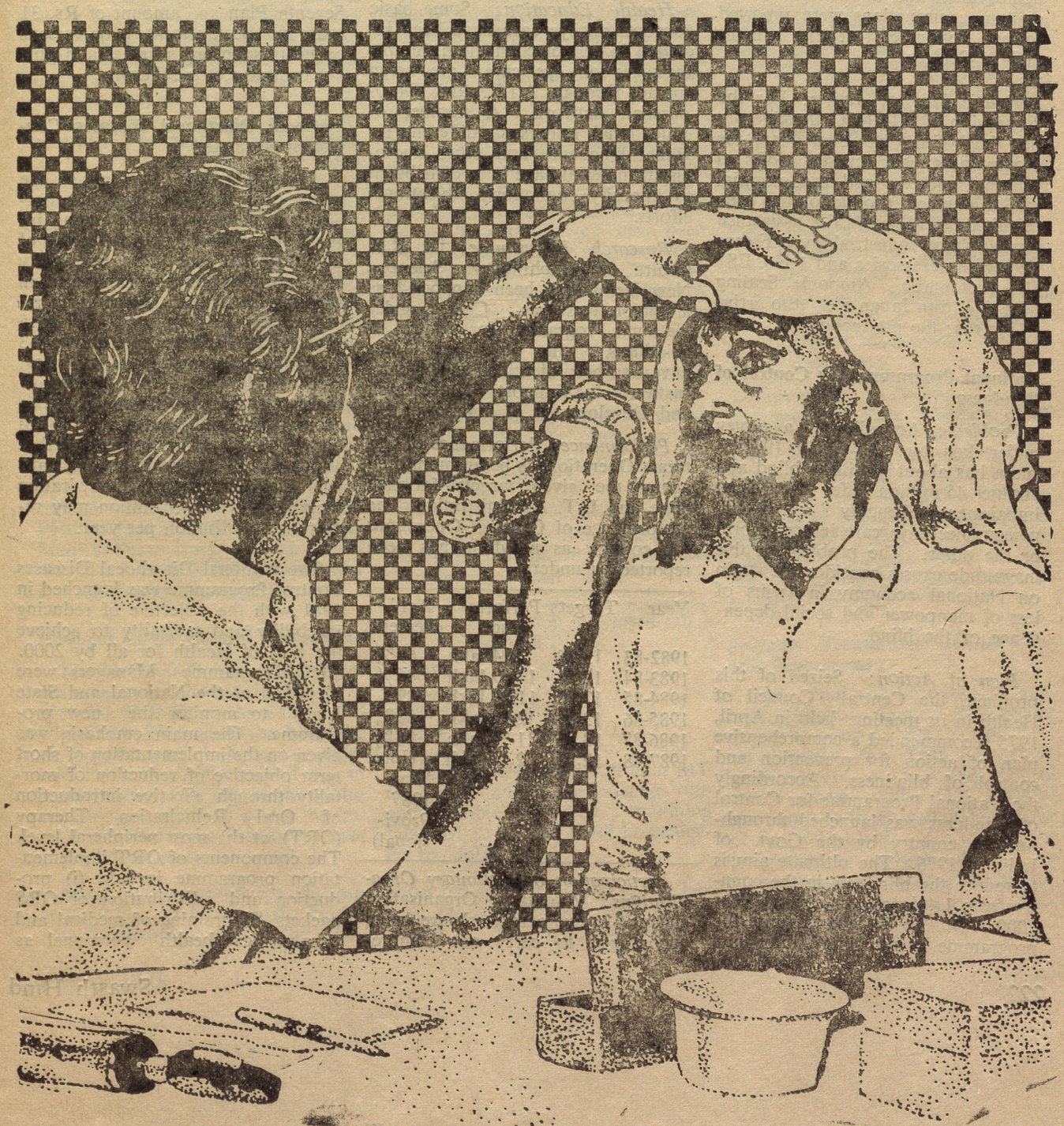
A total of about 46,000 beds are functioning in the country for treatment of seriously sick and emergent T.B. patients.

17 T.B. Training and Demonstration Centres have been established in major states of the country to undertake the basic training of the para-medical personnel required for the programme.

As a part of new strategy in the treatment regimen under National TB control Programme, Short Course Chemotherapy drug regimens containing Bifampicin and pyrazinamide have already been introduced in 44 selected districts of the country. It is proposed to introduce SCC drug regimens in another 75 districts of the country during the current financial year. More number of districts are expected to be brought under this regimen in a phased manner in the ensuing years. The regimens will reduce the duration of treatment from 18 months to 6 to 8 months.

20-*Point Programme*: With the inclusion of TB Programme in the 20-Point Programme, the essential activities under the programme have been considerably expanded. The new TB case detection is increasing from year to year. Against about 10.81 lakh new TB cases detected during 1982-83, about 14.39 lakh during 1986-87 have been detected. There is a significant improvement in case detection and sputum exami-

India has about 9 million blind and another 45 million people with visual impairment. To combat this problem the National Programme for the Control of Blindness was launched in 1976 with the aim of reducing the blindness from 1.4% to 0.3% by the year 2000 A.D.



nation. During 1986-87 about 22.67 lakh sputum examinations were conducted.

Targets for 1987-88: Considering the high prevalence rate of tuberculosis in the country, it was considered necessary to step up the tempo of new TB case detection during 1987-88. Accordingly, the target for detection of new TB cases has been raised to 15 lakh and Primary Health Centres continue to be involved in case finding activity. Upto the end of the 2nd quarter of 1987-88, nearly, 7.48 lakh new TB cases have been reported to be detected by the States/U.Ts. with 99.71% achievement and about 10.79 lakh sputum examinations were reported to be conducted at the Primary Health Centres.

Future Plan of Action: For the Expansion of F.D BCG Vaccine under the VIIth Five Year Plan, the Government has created posts in different cadres and the essential staff to augment production has been recruited. The UNICEF assistance for supply of Industrial Type Freeze Dier with accessories and 1 No. ES/100 Automatic Ampoule Sealing Machine from Japan are yet to arrive to increase the production.

National Programme for Control of Blindness

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

Plan of Action: Seized of this problem, the Central Council of Health in its meeting held in April, 1975 recommended a comprehensive plan of action for prevention and control of blindness. Accordingly the National Programme for Control of Blindness was launched throughout the country by the Govt. of India in 1976. The ultimate aim is to reduce the blindness in the country from 1.4% to 0.3% by the year 2000 A.D. To achieve this aim the programme is providing immediate relief to the needy by camp approach and by establishing permanent eye care facilities with graded expertise at different levels coupled with 'Health Education' measures.

Training Programme: Each Primary Health Centre and district Hospital is to be provided with one Ophthalmic Assistant each. To train the Ophthalmic Assistants, 37 Training Schools have been established throughout the country. They are conducting two years' training course for Ophthalmic Assistants. About 900 Ophthalmic Assistants were expected to be trained during 1985-86.

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

Research Programme: Dr. R.P. Centre for Ophthalmic Sciences, New Delhi, has been supported as a major Research Centre under National Programme for Control of Blindness. Nine other institutions have also been identified as Regional Institutes for Support on Research and Development of manpower.

Performance: Performance of Cataract Operations is being monitored against the given targets for each State and U.T. Administration. The performance of Cataract Operations for country as a whole has been reported as under:

Year	Targets	Performance	Achievements
1982-83	13.36	9.04 lakh	68%
1983-84	12.58	10.69 lakh	85%
1984-85	12.78	11.34 lakh	89%
1985-86	13.84	12.18 lakh	88%
1986-87	13.83	11.71 lakh	85%
1987-88	12.25	2.11 lakh	(Upto Sept, 1987 Provisional)

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

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

Financial Allocations: During Seventh Plan an amount of Rs. 31 crore has been allocated for various centrally sponsord schemes and purely central sector schemes.

National Diarrhoeal Diseases Control programme

Acute diarrhoea is one of the major causes of morbidity and morality in India, especially among infants and children below 5 years of age. Results of 20 morbidity and mortality surveys conducted in different parts of the country revealed that the children below 5 years may suffer from about 2-3 episodes of diarrhoea per year. Accordingly, the total episodes of diarrhoea may be estimated to be around 500 million per year in all age groups. It is estimated that about 50-100 million diarrhoea patients may be requiring rehydration therapy of which 5 million may require hospitalisation per year.

The National Diarrhoeal Diseases Control Programme was launched in 1981 with the objective of reducing morbidity and mortality to achieve the goal of Health for all by 2000. CDD Programme Managers were identified at the National and State levels to monitor the new programme. The main emphasis was given on the implementation of short term objective of reduction of mortality through effective introduction of Oral Rehydration Therapy (ORT), at the most peripheral level. The components of ORT implementation programme include (i) production and distribution of ORS packets, (ii) training of medical and para-medical health personnel as

well as education of mothers and other members of the community and (iii) operational/health services research for identification of suitable strategy for implementation.

Operational studies on the implementation of oral rehydration therapy at the community level shows that over 90% of cases of diarrhoea at the community level have no dehydration and there is no need to rehydrate these patients with the expensive ORS solution. On the other hand dehydration can be prevented from occurring in these patients by simple use of 'home available fluids' like salt sugar solution (Sharbat), butter milk (lassi), rice water (Maand), green cocoanut water etc. In a pilot study it was observed that prompt use of 'home fluid' can drastically reduce the requirements of ORS packets. A 3-tier approach was developed on this basis where mothers can be educated to use any 'home fluid' available at the house, and packets of ORS are to be kept with the village-based health workers and more serious cases can be taken to the hospitals/dispensaries.

Training: State Programme Officers and most of the District level Health Officers have been trained in ORT. The programme has also been extended to the PHC level staff. In addition, private practitioners are also being trained through ORT seminars. Principals and faculty members of HFWTC in the country are being trained on ORT. So far, 94 of them have already been trained. In turn, they will train the PHC Medical Officers and Non-Medical Supervisors. Health education at all levels is being augmented for community participation.

National Goitre Control Programme

The National Goitre Control Programme was launched by the Government of India at the end of 2nd Five Year Plan with the objective of identification of the goitre endemic areas, to supply iodised salt in place of common salt in the goitre endemic areas and to assess the impact of goitre control measures over a period of time.

Nearly 145 million people are estimated to be living in the known goitre endemic regions of the country which exists in the entire sub-Himalayan region and in almost all the states viz. entire states of Jammu & Kashmir, Himachal Pradesh, Arunachal Pradesh, Haryana, Punjab, Uttar Pradesh, Goa, Tripura, Manipur, Meghalaya, Mizoram, Assam, Nagaland, Sikkim, U.Ts. of Chandigarh, Delhi, Dadra & Nagar Haveli, 30 districts of Bihar, 12 districts of Madhya Pradesh, 6 districts of Maharashtra, 5 districts of West Bengal, 3 districts each of Gujarat and Andhra Pradesh, 1 district each of Karnataka, Kerala and Rajasthan. Nearly 40 million persons are estimated to be suffering from goitre in these regions.

In view of the widespread prevalence of goitre and other Iodine Deficiency Disorders, the Govt. of India have introduced the scheme envisaging 'Universal Iodisation' of edible salt in a phased manner by 1992 from 1986-87.

To augment the existing production of iodised salt, the Govt. of India have since liberalised production of iodised salt under the Private Sector. Licences have also been issued to nearly 700 salt manufacturers out of which nearly 220 have commenced production. The installed capacity of these units is nearly 33.00 lakh MT. A record production of 7.50 lakh MT was achieved in 1986-87. During 1987-88, it is envisaged that the production of iodized salt will be raised to 12.00 lakh MT; from April to Sept., 1987, 5.30 lakh MT has actually been produced.

The scheme to iodise the entire edible salt has the following phasewise targets of production and distribution of iodised salt:—

Year	Production of iodised salt in lakh M.T.
1986-87	7.53
1987-88	16.00
1988-89	22.00
1989-90	30.00

Against the target of 50 lakh MT required annually for iodising the entire edible salt, the remaining target of 20 lakh MT will be achieved by 1992.

An outlay of Rs. 20.00 crores has been approved for iodisation of salt during the 7th Five Year Plan.

During 1987-88 the National Goitre Control Programme has been expanded to the entire State of Uttar Pradesh, 3 districts of Bihar. Further expansion is contemplated in 11 districts of Haryana, 2 districts of Gujarat and the entire States of Assam, Tripura, Meghalaya and Goa and the UT of Delhi. The concerned State Governments have been advised to issue notification banning the sale of salt other than iodised salt under Prevention of Food Adulteration Act in the above mentioned districts/states.

So far 10 States have set up goitre control cells in their Health Directorates, the remaining States/UTs. are also required to set up the same. Central Assistance @ Rs. 1.00 lakh will be provided to each state. Provision has also been made for similar assistance for carrying out Health Education Activities and surveys in the remaining districts of respective State/U.T.

Monitoring: The programme is being monitored as a key item of the 20-Point Programme (TPP, 86) with the following parameters:—

1. Production of iodised salt vis-a-vis targets.
2. Quantities of iodised salt despatched/lifted by the goitre endemic states against the allocated quota.

Performance of States: In spite of requests the state Governments of Haryana, Punjab, Jammu & Kashmir, West Bengal, Tripura, Manipur, Himachal Pradesh, Kerala, Karnataka, Goa and the UTs. of Delhi, Chandigarh have not yet set up goitre control cell in their State Health Directorates. These States/Uts are required to take immediate action to establish the same.

Sexually Transmitted Disease Control Programme

The National Sexually Transmitted Diseases Control Programme during the current plan period, i.e., the Seventh Five Year Plan functions/operates as a purely central sector scheme with 100% Central assistance with an approved outlay of Rs. 100.00 lakh. The main components of the scheme are:

Teaching & Training, Research, Community Education and Epidemiology.

The scheme during the current financial year, i.e., 1987-88 operates with an approved outlay of Rs. 30.00 lakh. During the current year the above components are being operated on a Zonal basis by the Regional STD Teaching-cum-Training Centres, Regional STD Reference Laboratories and Regional Survey-cum-Mobile STD units located at Calcutta, Delhi, Hyderabad, Madras and Nagpur. All the above centres are actively engaged in the training and orientation programmes of the inservice medical and para-medical personnel, conducting short orientation courses for the laboratory technicians, conducting inter-laboratory evaluation of VDRL tests for setting up a uniform standard of doing the VDRL tests throughout the country, research work leading to the laboratory diagnosis of STD, and conducting epidemiology work in the rural and backward and tribal areas of the country to know and understand the magnitude of the problem.

The achievements made by the centres during the current year (i.e. upto October, 1987) are as under:—Medical Officers trained 47 and—Para Medical Personnel trained 49.

During the current year the south zone Regional Survey Unit has successfully conducted a survey-cum-treatment camp at Puzhamathu, Muduranthagam Taluka (Tamil Nadu) and at Dr. Santosh Nagar, Egmore, Madras. The survey unit is also launching a survey-cum-treatment camp in the various backward areas during the current year also, namely, Kattupakam, Sipoy Nagar, Lakshmipuram, Melama Nagar, Mappur (Malayampakkam), Melmanampedu, Kodapakkam, Chittukadu, Kavalchri, Kolapancherri, Sorancheri, Annampedu, Karunagaracheri, Puddor, Thirumazhisai (Pryampattu).

National AIDS Control Programme

AIDS has emerged as a devastating fatal disease causing widespread concern amongst not only the medical profession but also the public in general. Though officially recognised in 1981 for the first time, during the subsequent years it has assumed a pandemic proportion. As on 1st January, 1988, as many as 73747 cases of AIDS have been reported to WHO.

Situation in India: Upto the end of 31st January, 1988 as many as 79729 high risk persons viz. patients attending STD clinics, prostitutes, intravenous drug abusers, recipients of blood transfusion or blood products, symptomatic contacts of AIDS infected cases eunuchs, foreign students, inmates of vigilance homes, Nari Niketan, prisons etc. were screened. The State-wise break-up is as under:—

West Bengal	—	2405
Tamil Nadu	—	27593
Maharashtra	—	12962
Delhi	—	11497
Pondicherry	—	2509
Other States	—	22763

Of these, 222 have been confirmed to have AIDS infection. Amongst 222, as many as 15 are full blown cases of AIDS and the remaining 207 were asymptomatic carriers. Of these 15 full blown cases for AIDS, 8 are Indians, 1 is a non-resident Indian and 6 are foreigners (2 from USA, 2 from Switzerland, 1 from Canada and 1 from Spain). Of the 8 Indian cases, all have succumbed to the disease and the evidence suggest that they contracted the infection from abroad. Of the remaining 207 asyptomatic carriers, foreign students are 23, foreigners 12 and the remaining are Indians.

Government's Action: With the spread of AIDS from one country to another, Government of India become concerned about importance of the disease and its subsequent spread in the country. It constituted a task force in the year 1985 with D.G., I.C.M.R. as Chairman and 2 surveillance centres viz. National Institute of Virology, Pune and Christian Medical College, Vellore were established to screen high risk people for AIDS.

The first evidence of AIDS infection in the country came from Tamil Nadu in the month of April/May, 1986 when six women prostitutes were found positive for AIDS infection confirmed by Western Blot test and soon the AIDS control activities were strengthened and expanded to cover the entire country.

An AIDS cell was established in the Directorate General of Health Services to co-ordinate all activities pertaining to AIDS control in the country.

In consultation with Indian Council of Medical Research and all State Health Authorities, a **national action plan** was worked out by the Directorate General of Health Services and the same was implemented.

Implementation of the Programme and Achievements: As on date, 37 surveillance centres and 4 referral centres are fuctioning in the country. In the referral centres confirmatory diagnostic facilities viz. western blot tests are available. Efforts are also being made to isolate the AIDS virus from the indigenous cases of AIDS infection in these referral centres. A.I.I.M.S. surveillance centre has been able to isolate the virus from 3 women prostitutes in Madras. Detailed characterisations are being made.

All these surveillance centres have been provided with diagnosis equipment and reagents.

All the State Health Authorities were requested to establish State AIDS Cell and most of the States responded to it favourably.

High risk areas identified were places of tourists interest like Goa, Bombay, Delhi, Varanasi, Trivandrum, Madras, Jammu & Kashmir in addition to vigilance homes, remand homes, red light areas, jails etc. and the high risk groups identified were patients attending STD clinics and their contracts, I/V or I/M drug abusers, Professional blood donors, Homosexual inmates of jail, inmates of vigilance homes, remand homes etc., prostitutes, call girls, eunuchs, Haemophiliacs or other patients requiring repeated blood transfusion, patients attending medical college hospitals with typical syndrome.

Three physicians were trained in clinical aspects of AIDS and 4 scientists have been deputed to U.K. for training in the AIDS virus isolation work.

Instructions have been issued to all the State Health Authorities to strictly adhere to proper sterilisation

practices and to use disposable syringes and needles as far as possible.

Instructions have been issued not to import any blood or blood products without AIDS clearance certificate.

AIDS diagnostic kits have been made duty free.

Instructions have been issued for screening of foreigners including foreign students.

The Planning Commission has earmarked Rs. 7 crores for the National AIDS control scheme for the remaining period of 7th Five Year Plan. For the year 87-88, a sum of Rs. 50 lakh has been given for AIDS control work.

National Mental Health Programme

The Government of India has decided to launch the National Mental Health Programme during 7th Five Year Plan period.

The Planning Commission has tentatively allocated a sum of Rs. 1.00 crore for implementing the programme during the 7th Five Year Plan period.

National Diabetes Control Programme

Diabetes is associated with complications like vascular, renal, neurological, ocular and other complications. Incidence of diabetes is increasing in India because of rising standard of living, food habits, increase in life span (the appearance of Diabetes late in life). Also, better methods of detection are revealing more number of cases. Survey indicates that in urban societies 20-60 people per 1000 have Diabetes in India. It also shows large reservoir of undiagnosed diabetes in our country.

An Expert Committee: An Expert Committee was constituted by the Government of India in 1986 to formulate a national plan of action for the implementation of the National Diabetes Control Programme during the Seventh Five Year Plan for which an outlay of Rs. 25 lakh has been provided in the Seventh Plan Allocation.

The objectives of the National Diabetes Control Programme in the Seventh Plan are as under: (i) Identification of high risk subjects at an early stage, and imparting appropriate health education with focus on primary prevention; (ii) Early diagnosis of disease and institution of appropriate management so as to reduce morbidity and mortality; (iii) Prevention, arrest or slowing of acute metabolic as well as chronic cardio-vascular-renal complications of the disease; (iv) Provision of equal attainments to ensure scholastic as well as physical attainments and job satisfaction, thus ensuring social and emotional adaptation leading to an improved quality of life; and (v) Identification of subjects with partial or total physical handicaps due to the disease, and to ensure their rehabilitation with emphasis on optimal organ or body function.

Plan of Action: The central focus of the National Diabetes Control Programme (NDCP) would be on a District Diabetes Control Programme (DDCP). The programme will function at three levels:

Level One

Action & Surveillance	Distt. Hospital (Third Contact Doctors)	— Specialists
	Taluka Hospital/ CHS (Second contact Doctors)	— Specialists/ Generalists
	Primary Health Centres—(First contact Doctors)	— /Mostly Generalists Some Specialists
	Sub-Centre	— MPW(H&F)
	PHC Workers	— VHG
	Community	

Level Two

Training & Implementation at State level	Teaching Hospital DHS	— Super Specialists

Level Three

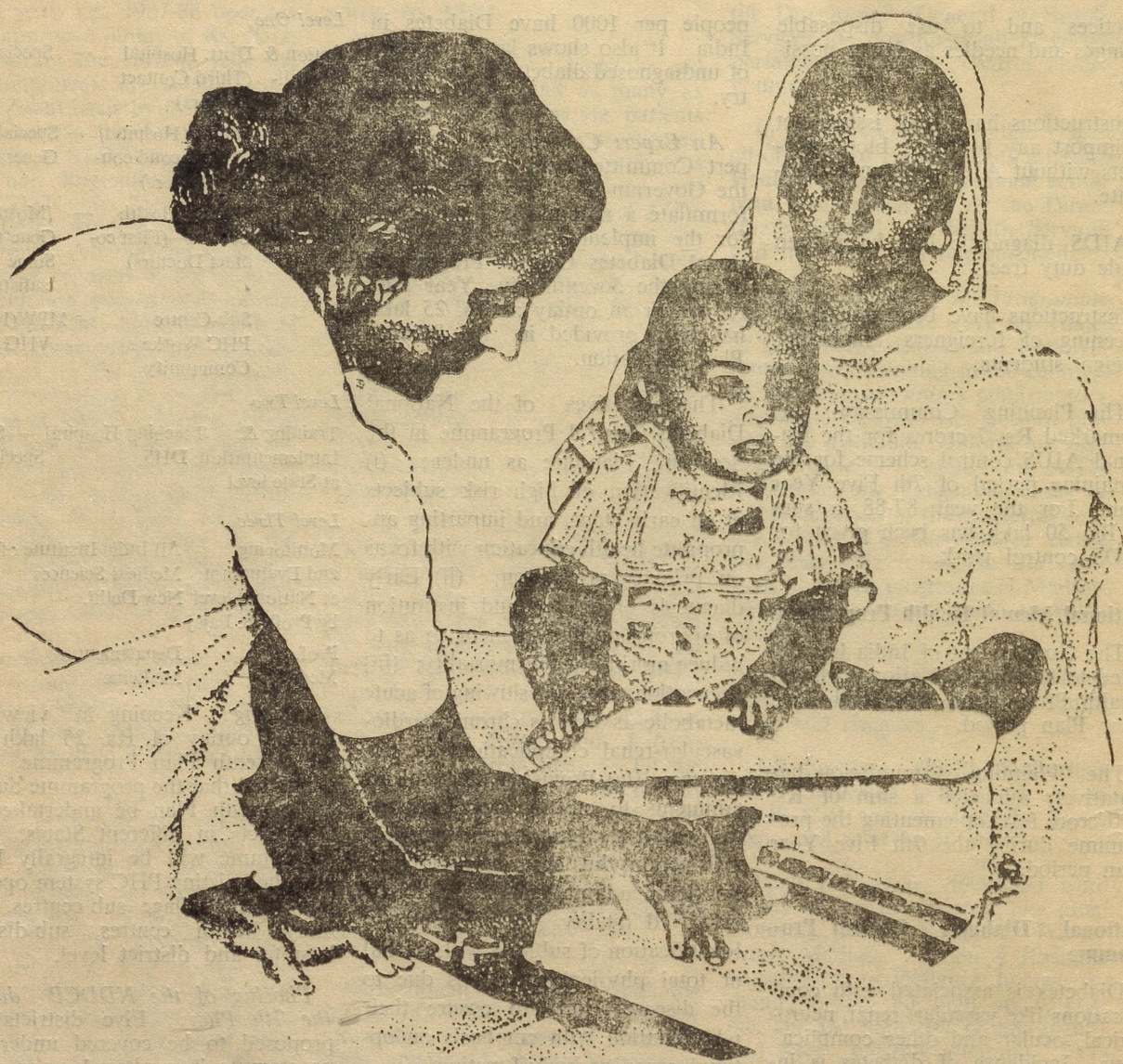
Monitoring and Evaluation at National level by Prof.J.S. Bajaj	All India Institute of Medical Sciences, New Delhi.
Prof. of Medicine	Department of Medicine

Phasing: Keeping in view the limited outlay of Rs. 25 lakh for the Seventh Plan Programme, it is stipulated that the programme during the Seventh Plan be undertaken in 5 districts in different States. The programme will be integrally built into the existing PHC system operating at the village sub-centres, primary health centres, sub-district hospital and district level.

Phasing of the NDDCP during the 7th Plan: Five districts are proposed to be covered under the programme in a phased manner i.e. 2 each during 1987-88 and 1988-89 and one during 1989-90.

The Government of Tamil Nadu has already agreed to initiate the programme in two districts of Salem and South Arcot. ○

WHO estimates that every year at least half a million women (90% in the Third World) die needlessly from causes related to pregnancy or child birth. These are women in the prime of life whose death is not only untimely but leaves their children orphaned and far more vulnerable to sicknsss and death.



NATIONAL FAMILY WELFARE PROGRAMME

The rapid population growth has serious implications for the socio-economic development of the country. This problem can no longer be left with one Ministry or Department. All ministries, departments and agencies must accept population stabilization as their main objective and reflect it in all their programmes.

GENESIS of the Problem: One of the most crucial problems facing the nation today is the burgeoning population which has been growing at an alarming rate. Census of 1981 counted India's population at 685 million which is double the 1947 figures of 342 million. India presently has 15% of the world's total population and 2.4% of the land area. Population of the country as on 1st March, 1987, is estimated at around 776 million and it is increasing by about 15 million

every year. This rapid increase in population has serious implications for the overall socio-economic development of the country.

Infant Mortality Rate: (IMR) The infant mortality rate per thousand live births on all India basis which reached a high level of 140 in 1975, has now come down to 97 (1985 SRS estimates). But this is quite high as compared to developed nations of the world. The IMR continues to have sharp variations from State to State and in different areas of the same State also.

Policy Frame-work

National Health Policy : India is committed to attaining the twin goals of 'Health For All' and a 'Net Reproduction Rate of Unity' by the year 2000 A.D. through the universal provision of comprehensive primary health care services to all and an easy access to family planning and maternal and child health care facilities. The National Health Policy approved by the Parliament in 1983 enunciated the broad policy frame-work for attaining these goals and also defined the specific goals to be achieved under particular indicators of Health as well as Family Planning. Attaining of these goals would require securing of complete integration of all plans for Health and Human Development with the overall national socio-economic development process.

Goals to be Achieved : The major long-term goal to be achieved for the country is to reach a replacement level of fertility (NRR=1) by the year 2000 A.D. The lowest feasible levels of mortality have been enunciated in the National Health Policy as follows:

(a) Crude Birth Rate —21 per thousand;

(b) Crude Death Rate —9 per thousand;

(c) Infant Mortality Rate —Below 60 per thousand live births;

(d) Effective Couple Protection Rate — 60%

(e) Life Expectancy at Birth — 64 years.

The corresponding goals to be reached by 1990 are: crude birth rate of 27, crude death rate of 10.4, infant mortality rate of 87 per thousand, live births and couple protection rate of 42 per cent.

Programme Implementation

In keeping with the democratic traditions of the country, the Family Welfare Programme seeks to promote on a voluntary basis, responsible and planned parenthood with 'twochild norm', male, female or both, through independent choice of family planning method best suited to the acceptors.

Performance under the Programme

The programme is estimated to have averted over 85.4 million births in the country so far. The average annual population growth rate which rose from 1.25% in the 40s to 1.96% in the 50s and 2.20% in the 60s, reached a plateau during the 70's when the growth rate was 2.25%. Since the inception of the programme, in every Plan period, there have been varying levels of shortfalls in the family planning performance. In particular, the programme suffered a serious setback during 1977-82 and picked up during the later period of the VI Plan. During the VI Plan period, achievements in sterilisation, IUD, Conventional Contraceptives (CC) and Oral Pill users were 79%, 82%, 85% and 129% respectively. It is estimated that an overall couple protection rate of 37.4% has been achieved as on March 31, 1987.

About 49.70 million couples (37.5% of the total eligible couples in the reproductive age group whose wives were in the age group of 15-44 years) were effectively protected against conception by one or the other approved family planning method as on March 1987. Of these, 27.9% were protected by sterilisation alone.

Family Planning Targets for 1987-88 and During the 7th Five Year Plan

The Family Planning targets for 1987-88 and during the 7th Five Year Plan are given below:—

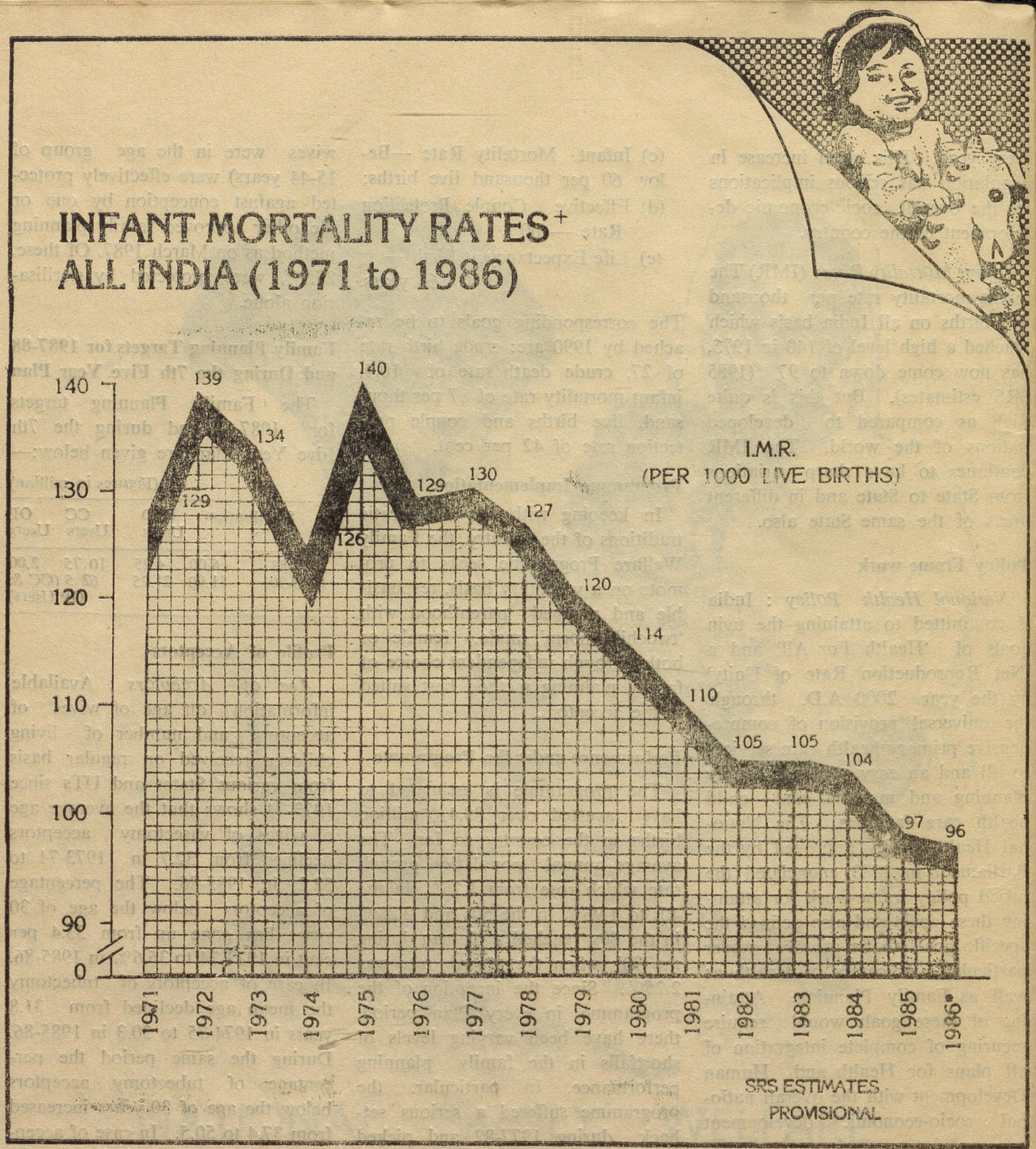
(Figures in million)

	Sterilisation	IUD Users	CC Users	OP Users
1987-88	6.00	4.25	10.75	2.00
1985-90	31.00	21.25	62.5 (CC & OP Users)	

Profile of Acceptors

Age of Acceptors : Available information on age of wives of acceptors and number of living children received on regular basis from various States and UTs since 1973-74 shows that the average age of wives of vasectomy acceptors declined from 32.7 in 1973-74 to 32.2. in 1985-86. The percentage of acceptors below the age of 30 years has gone up from 33.4 per cent in 1973-74 to 36.6% in 1985-86. In case of acceptors of tubectomy the mean age declined from 31.8 years in 1974-75 to 30.3 in 1985-86. During the same period the percentage of tubectomy acceptors below the age of 30 years increased from 37.4 to 50.5. In case of acceptors of IUD also, a decline in the mean age has been observed; the mean age declined from 29.8 years in 1974-75 to 27.5 years in 1985-86 in the country as a whole.

Parity of Acceptors : The data available for the period 1978-79 to 1985-86 show only marginal decline in the average number of living children. It was 3.4 during both the years in the case of acceptors of vasectomy. It declined from 3.7 to 3.5 in case of tubectomy acceptors



and from 2.8 to 2.3 in case of IUD acceptors during the same period implying that couples with relatively lesser number of children are now coming for family planning acceptance. The percentage of acceptors with three or less number of children has gone up somewhat both in case of tubectomy and vasectomy acceptors during the same period. It increased from 61.2 per cent to 62.7 in case of vasectomy, from 53.6 to 60.1 in case of tubectomy acceptors during this period. In case of IUD, the percentage of acceptors with two or less children increased from 47.5 per cent in 1978-79 to 61.3 in 1985-86.

Educational Status : Available data on the educational status of wives of the acceptors show that percentage of illiterate acceptors was 46.2 in case of vasectomy, 49.5 in case of women who underwent tubectomy and 39.9 in case of IUD acceptors. Percentage of wives with matric or higher qualifications was 7.6 in case of vasectomy, 6.9 in case of women who underwent tubectomy and 11.9 in case of IUD acceptors.

Demographic Impact and Trends

It is estimated that out of the 132.6 million eligible couples, 49.7 million couples constituting 37.5

per cent, were effectively protected under various methods of family planning as on March 31, 1987. Since 1979-80, there has been an increase by about 15% in the level of couple protection. The rate of step-up in Couple Protection has accelerated during the last four years i.e., since March, 1983. Since inception of the programme, over 85.4 million births are estimated to have been averted by the end of 1986-87. Because of increase in the performance levels during the last four years, the annual number of births averted has gone up from 5.5 million in 1982-83 to 9.0 million in 1986-87. The evidence of decline in the birth rate is also avilable from the SRS estimates of the Registrar General of India. Based on reverse survival methods, a birth rate of 41.2 was estimated for the decade, 1961-71 (centred in 1966). The estimate of birth rate as per SRS for the year 1985 was 32.9. Thus, the birth rate declined from 41.2 in 1966 to 32.9 in 1985.

Services and Supplies

Services and supplies are provided entirely free of cost at various levels of the health delivery system according to the facilities available, though as an adjunct to these, supply of Nirodh and Oral Pills is additionally being made through commercial channels at a highly subsidised rate. Supplies at all government-run centres remain free of charge. While all services are available at district and sub-divisional hospitals and above, the Primary Health-cum-Rural Family Welfare Centres provide all services except female sterilisation (many PHCs are now providing this service also) and the sub-centres manned by Auxiliary Nurse Mid-wife (ANM) usually provide only non-terminal methods other than IUD (IUD insertion is also being carried out in many sub-centres by ANMs/LHVs after training of these functionaries).

Incentives

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

Future Policy Approach

Population control can no longer be the responsibility of one Ministry or Department. It has to be total governmental approach and effort reflecting the total and complete political and administrative commitment of the government across the board embracing all governmental agencies, developmental and non-developmental. The entire planning process must be geared towards controlling population. Every action of government must be evaluated in terms of its impact on population. All Ministries, Departments and agencies must accept population stabilisation as one of their main objectives and reflect it in their programmes, in their messages, in their extension work and in their normal day to-day activities. The Planning Commission must review the performance of States in terms of their efforts to stabilise the population and evaluate the activities of various departments in terms of their contribution towards holding population growth. The planning and development process of this country must indicate the adoption of Small Family Norm as the objective of all programmes. The governmental agencies must also communicate to non-governmental agencies in the country the need to spread the message of Small Family Norm. National apex institutions such as National Development Council, Reserve Bank of India, Planning Commission, JCM and apex bodies set up in the various Ministries to advise and direct activities should reflect the national concern in the area of population control.

In addition to 60 districts covered during 1985-86 and 90 districts and catchment area of all the medical colleges covered during 1986-87, another 120 districts are proposed to be covered during the current year under the Universal Immunization Programme. The efforts at universal immunization are expected to go a long way in reducing infant and child mortality and enhancement of acceptance of family planning.

The Scheme of National Awards to the best performing States continued. States of Punjab, Kerala, Tamil Nadu, M.P., U.P., Rajasthan, Goa, Daman & Diu and Dadra & Nagar Haveli were awarded for their performance during 1986-87.

Looking Ahead

All the above initiatives are expected to have a salutary effect on the overall acceptance of the small family norm by the eligible couples who are being approached through all available media of communication. ○

It is estimated that one-fourth of diarrhoeal deaths could be eliminated by a 90 per cent coverage with measles immunization.

MATERNAL AND CHILD HEALTH PROGRAMME

THE maternal and child health services are provided as a part of total health care to the community through the existing health infrastructure in rural and urban areas. Ministry of Health & Family Welfare, Govt. of India, have sponsored immunization schemes for infants and children against common vaccine-preventable diseases and for expectant mothers against Tetanus. Prophylaxis schemes against nutritional anaemia among mothers and children and prophylaxis against blindness due to Vitamin 'A' deficiency are also operating. Programme for oral rehydration therapy is another important child survival scheme.

Prophylaxis against nutritional anaemia among mothers and children

Anaemia is one of the important causes of morbidity and mortality among mothers and children. Under the scheme of prophylaxis against nutritional anaemia, pregnant and nursing mothers, acceptors of family planning and children of 1-5 years are given daily dose of iron and folic acid for a period of 100 days as a prophylactic measure.

Prophylaxis against blindness due to Vitamin 'A' deficiency among children

Severe form of Vitamin 'A' deficiency associated with malnutrition and infection may cause blindness among children. It has been found that children between 1-5 years show signs of Vitamin 'A' deficiency in many parts of the country. 2 lakh international units of Vitamin 'A' is given to children of this age group every 6 months as a preventive measure.

Targets and achievement upto 30th November, 1987 and financial outlays are given below:

Seheme	Target 1987-88 Financial (Rs. in Lakhs)	Target 1987-88 Physical	Achievement upto Nov. 1987 (Physical)	%age achievement of annual target during 1987-88
Prophylaxis against nutritional anaemia among:				
Mothers	500.00	220	90.54	41.4
Children		220	89.97	41.2
Prophylaxis against blindness among children due to Vitamin 'A' Deficiency		300	253.04	48.4

Countess of Dufferin's Fund Scholarship

The Countess of Dufferin's Fund constituted originally to encourage medical and nursing education among women is now operated by the Government. Under these, scholarships are awarded to 83 undergraduate medical students, 8 M.Sc. nursing, 30 B.Sc. nursing, 4 Public Health Nursing and 2 DMCW students.

Supply of Drugs and Vaccines

The Department of Family Welfare procures all vaccines, iron and Folic Tablets and Vitamin 'A' solution and supplies to the State govts. and U.Ts. as per their requirement. The expenditure incurred on these items is debited to the accounts of the respective States at the close of the financial year.

Programme for Oral Rehydration Therapy

Diarrhoeal Diseases are a major health problem in the country especially amongst children below 5 years of age. The incidence of the disease is more in the lower-socio-economic segments. Longitudinal surveys carried out in different parts of the country indicate that child may suffer from as many as 3 episodes of diarrhoea per year.

One hundred million children below 5 years of age suffer about 300 million episodes of diarrhoea of which 10% i.e. 30 million may develop dehydration and 1% i.e. 3 million may face death. To reduce the death rates among children below 5 years by about 40-50% the scheme of Oral Rehydration Therapy has been taken up. The Programme primarily aims at educating mothers on the problem of dehydration in diarrhoeal diseases which can be prevented by the use of home made/available solutions, or the use of Oral Rehydration Salt to overcome dehydration which is often the cause of death in children. The medical and para-medical workers at all levels will be trained in the education of the community as a whole and mothers, in particular, under this programme.

180 Districts with 3341 Primary Health Centres are to be covered during the current financial year 1987-88 (i.e. upto the end of March, 1988). The remaining Districts and Primary Health Centres are expected to be covered upto the end of Seventh Five Year Plan.

Distribution of O.R.S: The provision for distribution of O.R.S. Packets has also been made in the O.R.T. Programme.

Immunization Programme

Universal immunization is an important step towards achieving the goal of Health for all by 2000 A.D.

Dimensions of the problem

Inspection of the impressive all-round gains, the demographic and health picture of the country still causes serious concern. The mortality rates for mothers and children are distressingly high. Extensive sample surveys were conducted with regard to two diseases. Tetanus and Poliomyelitis under the programme to collect baseline epidemiological data. Information in regard to other vaccine preventable diseases still remains sketchy and incomplete.

Neo-natal Tetanus

Based on the results of the sample surveys held in 1981, it was estimated that 2.3 lakh to 2.5 lakh infants die within the first month of their birth due to Neo-natal Tetanus. The mortality rate in the country is estimated to be 13.3 and 3.2 per thousand live births in the rural and urban areas respectively. It is aimed to reduce the neo-natal tetanus mortality to less than one per thousand live births.

The monthly returns from the Institutions indicated that about 50,000 tetanus cases occur every year.

Diphtheria

As per the annual reported incidence of Diphtheria obtained from the various Institutions ranged from 25,000 in 1975 to over 15,000 in 1982.

Pertussis

Nearly 3 lakh cases of pertussis are reported annually. According to WHO estimates, at least 80% of the children in an unimmunized population will contract the disease and, some 1.5% of the children in developing countries who acquire pertussis die due to it or complications from it.

Poliomyelitis

Poliomyelitis is an important cause of lameness in the children. About 15,000 cases of Poliomyelitis are reported annually through the routine reporting system. Based on sample survey, it was estimated that the annual incidence rate of Poliomyelitis varied from 1.5-1.7 per thousand children (0-4 Years) in urban and 1.6-1.8 in the rural areas. It is aimed to bring down the incidence of Poliomyelitis to a negligible level by the end of 1990.

Measles

Measles is a highly infectious disease and virtually all children get the disease if not protected by vaccination. Data on Measles are poor. Approximately, 1 lakh cases are reported annually. Rash and Fever Surveillance Report conducted in 1976 and 1977 recorded 0.53 million and 0.96 million cases (incomplete). Based on the available information, it is assumed that the case fatality rate of measles ranges from 1 to 3 percent.

Tuberculosis

It is estimated that nearly 1.8% of the population above the age of 5 years is suffering from Radiologically Active Tuberculosis of the lungs of which nearly 1/4th, i.e. 0.4%, are infectious. It is further estimated that nearly 2.8% of the children below the age group of 5 years and nearly 13.4% of the population in the age group of 5-9 years are infected with Tubercale Bacilli. The annual incidence (attack rate) of infection in the age group of 0-4 years is 0.8% and 5-9 years age group 1.1% and 10-14 years age group nearly 2%.

Typhoid Fever

Over 3 lakh cases of Typhoid Fever are reported annually. The majority of the victims are school children. Whatever data available from various sources become a matter of concern. Recognising the potential immunization as a low cost effective tool for child survival, Government of India have decided to extend the programme rapidly with the aim to provide Universal Immunization by 1990.

Strategy and Delivery System

The EPI Programme was started in 1978 with the objectives of providing vaccination services to the eligible children and pregnant women. Although some vaccines were available prior to EPI, the coverage was low and the vaccines were being given to a very broad age groups, thereby decreasing the effectiveness of the programme. Therefore, efforts are now concentrated on the coverage of the infants

with doses of DPT, Polio and one dose of ECG and Measles before 12 months of age. To achieve maximum effectiveness of the programme, targets have been laid down under the National Health Policy as indicated below:

EXPECTED IMMUNIZATION STATUS BY 1990

Infants	Implementation Status (Percentage Population)
DPT —	85
Polio —	85
BCG —	85
TT Pregnant women	100
TT For school children	
(for 10 years)	85
(for 16 years)	85
DT New School Entrants	
(5-6 years)	85
Typhoid—do—	85

It is planned to immunize 85% infants against vaccine preventable diseases namely: Diphtheria, Tetanus, Pertussis, Measles, Poliomyelitis and Tuberculosis and 100% of the expectant mothers with tetanus vaccine to prevent maternal and neonatal tetanus by 1990. The coverage will be extended over a 5 year period in a phased manner immunising about 18 million infants and 24 million mothers every year.

In 1985-86, Universal Immunization Programme (UIP) was launched for accelerating Immunization activities. In the first year, 30 districts and catchment areas of fifty medical colleges were covered. During 1986-87, 62 districts and the catchment areas of the remaining medical colleges were taken up. In 1987-88, 90 more districts were added and, in subsequent two years (1988-90) it is proposed to cover the remaining districts in the country. Under the Universal Immunization Programme, it is proposed to cover all eligible infants and pregnant mothers by the end of 1990.

Strategy thus developed requires development of service infrastructure so that the facilities are provided to the beneficiaries at their doorsteps. Incidentally this infrastructure is already available with the State and UTs through the network of Community Health Centres (1293), PHCs (14,409), Sub-centres (1,02,160), Rural Family Welfare Centres (5461), Urban Family Welfare Centres (1592), Post Partum Centres (1383), Health Posts (960),

YEAR-WISE NUMBER OF BENEFICIARIES
1985-86 to 1989-90

(Figures in million)

Beneficiaries	Vaccines	Actual		Proposed		
		1985-86	1986-87	1987-88	1988-89	1989-90
Preg. Women	T.T.	12.9	15.2	16.9	21.9	23.9
		(50)	(60)	(65)	(75)	(100)
Infants	DPT	14.0	15.3	17.2	17.7	18.3
		(60)	(67)	(75)	(80)	(85)
	Polio	14.0	15.3	17.2	17.0	18.3
		(60)	(67)	(75)	(80)	(85)
	BCG	14.0	15.3	17.2	17.0	18.3
		(60)	(67)	(75)	(80)	(85)
	Measles	2.3	5.7	11.2	14.2	18.3
		(10)	(25)	(45)	(65)	(85)

(Figures in bracket are % coverage)

City Family Welfare Bureaux (14), besides dispensaries (26842); and hospitals (7474) throughout the country.

The Voluntary and Charitable Organisations also played an important role in the Immunization Programmes. Large number of children are also vaccinated by Private Medical Practitioners in the country. Indian Medical Association, Rotary International, Impact India are some of the large type voluntary organizations supporting the Immunization programme.

Budget

During the 7th Five Year Plan there is an allocation of Rs. 240 crores for the programme under Central Sector. This includes Rs. 26.27 crores set apart for vaccine production. Large part of this goes for the supply of vaccines and supply of cold chain equipments under the programme. Funds for the creation of additional posts, supply of syringes, needles and meeting expenditure and training modules etc. are also included in this.

Vaccines

India is self-sufficient in vaccines except for the Oral Polio and Measles vaccines. Oral Polio vaccine is imported in bulk by M/S HBPCL, Bombay and after dilution, it is distributed to the different States and UTs for the Programme. HBPCL is the sole supplier of Polio vaccine in the country whenever required. OPV was imported through the DGS & D also. Measles vaccine is imported through UNICEF as commodity assistance.

Cold Chain

Cold Chain logistics have provided equipments for storage and/or transportation of vaccines from the manufacturers to the outreach areas. The success of the immunization programme lies in the administration of potent vaccine at the right age and right dose. Therefore, the maintenance of cold chain for the vaccine efficacy from the manufac-

turer to the field, is absolutely necessary. Several States have taken up task to strengthen the cold chain for storage and transportation of vaccine, training manpower in logistic of vaccines and handling of refrigerators. Various equipments supplied to the institutions under the programme are: Refrigerated trucks for the manufacturing institutions, walk-in-coolers to the State Headquarters, refrigerated vans, ice-lined refrigerators, cold boxes, vaccine carriers, day carriers, thermocol boxes and delivery vans.

Performance and Achievements in EPI

Yearwise targets and achievements from 1978-79 to 1986-87 with regard to the EPI are given in Appendix XIV/1 below and 1987-88 upto October '87 is given in Appendix XIV/2 on next page.

Universal Immunization Programme

National Health Policy accords high priority to MCH Programme, and it aims at bringing down the Infant Mortality Rate below 60 per thousand live births by 2000 AD from the current level of 97 (SRS 1985). It also aims at reducing perinatal mortality from 67 to 30-35 and pre-school child (1 to 5 years) deaths from 24 to 10 by the turn of the century.

In order to improve the Vaccine Coverage of eligible population and ensure high quality of services a major shift in the strategy was adopted in 1985 with the launching of the Universal Immunization Programme.

The Programme was started in 30 districts and field practice areas of 50 Medical Colleges in 1985-86. 62 districts and rest of 56 medical colleges have been taken in 1986-87 and 90 districts in 1987-88 for implementation of Universal Immunization Programme. 120 districts to be covered during 1988-89 have been indentified. It is proposed to take up remaining 135 and odd districts in 1989-90 i.e. the last year of the 7th Plan. Additional inputs have been provided in the districts which have been selected for implementation of the universal Immunization Programmes (UIP) to make it operationally feasible. The main thrust of the programme in selected districts is the improvement in the logistics and managerial aspects for the optimal utilization of the available resources and cost effective implementation of the programme.

Universal immunization programme is part of a package of services. This is the single largest Immunization Programme, undertaken anywhere in the world and probably one of the most cost effective public health measures which forms an integral programme of PHCs services. In 1989-90, we will be having approximately 25 million pregnant women and 22.7 million infants to be covered under this programme. During the entire Seventh Five Year Plan Period we expect to cover over 90 million pregnant women and more than 80 million infants.

EXPANDED PROGRAMME ON IMMUNIZATION

Vaccination Performance (April '87 to October '87)

Vaccine	Annual targets (1987-88)	Prop. targets	ACHIEVEMENT Apr.'87 to Oct.'87 (1987-88)	Corresponding period (1986-87)	% increase(+) or decrease (—)	% achievement of Prop. target
T.T.(FW)	169.31	70.58	60.26	53.35	(+) 12.9	85.6
D.P.T.	172.09	70.92	65.10	53.98	(+) 20.6	91.9
Polio	172.09	70.92	54.72	48.21	(+) 13.5	77.3
B.C.G.	172.09	72.13	70.20	51.28	(+) 28.1	97.5
Measles	112.09	47.13	39.98	—	——	85.0
D.T.*	130.00	41.92	38.73	36.31	(+) 6.7	92.5
Typhoid*	130.00	41.22	24.87	26.36	(—) 5.6	60.4
T.T. 10 yrs*	78.00	25.24	22.80	18.61	(+) 22.5	90.6
T.T. 16 yrs*	48.00	15.87	13.11	11.44	(+) 14.6	82.8

*Figures upto September '87

£ Worked out after excluding the target for which the performance figures not received.

——Figures not available.

Performance under UIP, 1987-88:

Under the Universal Immunization Programme, it is aimed to achieve 100% coverage of pregnant women and at least 85% of infants in 182 districts under the Programme. Annual vaccination targets are coverage of 119.76 lakh women with 2 doses of TT & 93.17 lakh infants with 3 doses each of DPT and Polio vaccine and one dose each of BCG and Measles vaccines. According to proposed plan, 65% of Annual targets were expected to be achieved by the end of December '87. Vaccinewise achievements are given in the following Table.

PERFORMANCE UNDER UNIVERSAL IMMUNIZATION PROGRAMME

(Fig in lacks.)

Vaccine	Annual Target	Achievement* upto Dec.'87	%Achvt. Annual target	%Achvt. prop. target
TT(PW)	119.76	42.05	35.10	54.01
DPT	93.19	44.43	47.67	73.33
POLIO	93.19	37.11	39.82	61.26
BCG	93.19	48.14	51.65	79.47
MEASLES	93.19	35.79	38.40	59.00

*Figures provisional

(Contd. from page 217)

an experimental basis. They will be imparted training for this work.

The Pill-Social Marketing

After a successful experiment in Niroth Marketing, the social marketing of oral contraceptive pill has been launched this year. Four pharmaceutical companies have been involved in the marketing of the pill under the brand name Mala-D. The oral contraceptive pill will, however, continue to be available free of cost at the government hospitals and dispensaries under the brand name Mala-N. Both the products are to be prescribed by a doctor.

The communication strategy has been totally revamped for converting a near universal awareness into acceptance and bringing in a change in social behavioural patterns and making family planning widely acceptable. The health and family welfare messages have been integrated and made more broad-based to cover socio-cultural areas that determine the community acceptance of the two-child-family norm. With this end in view, the communication was made more informative, 'people sensitive' and area-specific and included issues that impinge on family planning such as literacy, employment and status of women, age at marriage, male-child-preference syndrome, etc.

Reports of increased number of abortions of female foetus from certain regions of the country, after finding out the sex of the foetus by amniocentesis and similar tests, have been causing all-round concern. These tests, which are meant to find out genetic defects, if any, in the foetus are being misused by certain unscrupulous elements to ascertain the sex of the foetus and resultant abortions of female foetus. In view of the complexity of the problem which is more of a social than legal and health problem, the Government convened a high level meeting of medical experts, administrators, voluntary organisations and legal experts to consider the matter and suggest ways of preventing the misuse of amniocentesis and other techniques. Following this, the Government set up a committee to suggest effective legislative steps for the purpose. At the same time, there is need for generating educated public opinion against these sex determination tests. Perhaps a voluntary movement is needed for awakening the social conscience to stop further female foeticide.

—Excerpts from the Introduction to the Annual Report of the Ministry of Health and Family Welfare for 1987-88.

RURAL HEALTH SERVICES

Minimum Needs Programme

The main programmes and 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 as follows:

Sub-Centres : The Sub-Centres are being established on the basis of one Sub-Centre for every 5000 population in general and for every 3000 population in hilly, tribal and backward areas. The total number of Sub-Centres established upto the end of the 6th Plan Period that is by 1st April, 1985 was 84968, as against the estimated total requirement of 1.30 lakh. The progress is as under:—

Functioning on 1-4-85	84968
7th Plan Target	54883
Functioning on 1-4-87	101922
Target 1987-88	9233
Achievements during 1987-88 (April—September, 1987)	238
No. Functioning on 30-9-87	102160

Primary Health Centres : It is envisaged to establish Primary Health Centres on the basis of one PHC for every 30,000 population in plain areas and for every 20,000 population in hilly, tribal and backward areas. It is proposed to convert all the existing rural dispensaries into PHCs. The ultimate objective is that by providing additional inputs in terms of man-power, equipment and addition in the existing building, the rural dispensaries which are providing curative service only will function as Primary Health Centres and shall provide package of promotive, preventive and curative services. The existing position in respect of PHCs is given below:

Functiong on 1-4-85	11140
7th Plan Target	12390
Functioning on 1-4-87	14309
Target 1987-88	2274
Achievements during 1987-88 (April—September, 1987)	100
Functioning on 30-9-87	14409

Upgraded PHCs/CHCs : It is proposed to establish rural hospitals with specialist facilities by upgrading the existing PHCs. Each of the upgraded PHC will have 30 beds. It is envisaged to cover a population of about 1 lakh. The position in respect of upgraded PHCs/CHCs is given below:

Functioning on 1-4-85	791
7th Plan Target	1553
Functioning on 1-4-87	1280
Target 1987-88	257
Achievements during 1987-88 (April—September, 1987)	13
No. Functioning on 30-9-87	1293

Scheme of Training of MPW (Male)

This scheme was initiated in the year 1982 to meet the future requirements of Multi-Purpose Workers (male) after conversion of the uni-purpose to multi-purpose workers. It is a 100% Centrally-sponsored scheme and was introduced in the 6th Five Year Plan. The duration of training was one and a half year which has now been reduced to one year and the basic qualification for the new entrants was 10th pass. 47 training centres (44 HFWTCs+3 others) were strengthened with additional inputs to take up this training programme. As this training capacity was not enough to train the required 50,000 Multi-Purpose Workers (male) during the 7th Five year Plan at the norm of one MPW (male) per Sub-Centre, and EFC Memo for opening of 85 new schools was approved by the Expenditure Finance Committee. Sanctions for 50 of these new schools have already been issued during the current financial year and the remaining 35 new schools are proposed to be sanctioned during 1988-89.

Orientation Training of Medical and Paramedical Staff

4.1.1. This scheme was earlier named as the scheme of Continuing Education for Primary Health Centre Staff. This is a Centrally sponsored scheme under family welfare programme envisaging continuing education for each category of health functionaries working at Primary Health Centres (PHCs) and Sub-Centre level and their trainers. The duration of training is two weeks to be given once in every 5 years in institutions where they were imparted basic training. Accordingly, selected ANM Schools (40) Promotional Schools for Health Assistants (Female) (14), Selected Rural Health and Training Centres (20) and one College of Nursing were proposed to be strengthened for undertaking continuing education for respective categories. The Health and Family Welfare Training Centres which are supposed to impart reorientation training for Health Assistants (male) and Health workers (male) are being strengthened under the scheme of "Training and Employment of Multi-purpose Workers (Male)." Govt. of India would be bearing 100% non-recurring and 50% recurring expenses.

The main health programmes are being implemented to provide primary health care relevant to the actual needs of the community in the rural areas through a network of sub-centres, primary health centres, and community health centres.

Schemes of Providing Laboratory Facilities at Primary Health Centres.

6.1.1. This is a 100% Centrally-sponsored scheme. Under this scheme, financial assistance is made available to the States for setting up of laboratories at the Primary Health Centres (PHCs) catering to 30,000 population. The States should work out the assistance needed for setting up laboratory facilities and also indicate in their proposal the number of PHCs which are functioning without a laboratory facility. Financial assistance would be made available as per their requirement. The State would be, however, called upon to give an undertaking that the post of Laboratory Technician will be filled where the Laboratory facility is set up.

Training and Employment of MPWs (MPW Scheme)

To make primary health care services available to the rural population it has been the persistent endeavour on the part of Government of India to make most rational and cost efficient utilisation of available resources. With this aim in view, the MPW Scheme was launched in 1974. The objectives of the scheme are:

1. **To convert all existing uni-purpose workers at different levels into Multi-purpose Workers after reorientation training.**

2. **Integration of organisation and structure on various health and family welfare programmes at PHC, District and State levels.**

3. **Provide funds for manuals, kits and educational aids. This scheme is under 50:50 Central assistance.**

Achievement : The Scheme was to be fully implemented in the country before the end of Sixth Five Year Plan. According to the information received upto June 1987, training under the Scheme has been completed in 349 districts out of 414 districts in the country. The training is in progress in 49 districts. The States and UTs which have not completed the training so far are J & K, Andhra Pradesh, Tamil Nadu, Bihar, Assam, Nagaland, Manipur, Arunachal Pradesh, Delhi and Andaman & Nicobar Islands.

Village Health Guide Scheme

Village Health Guide Scheme was launched in 1977 as a 100% Centrally sponsored scheme with the objective of training a person selected by the community for primary health care. On an average one person per 1000 population/a village, is trained for 3 months and is equipped with a manual of instructions and a medicine kit. A stipend of Rs. 200 per month is paid during the training. Thereafter, a monthly honorarium of Rs. 50/- and medicines worth Rs. 50 are provided to the trained Village Health Guide. The scheme suffered set back in 1979 when it was included in the category entitled for 50% Central assistance. The Scheme was taken under Family Welfare Programme and 100% funding was resumed and a revised scheme was communicated to the States in 1981. The salient feature of the scheme was that females should be selected as Health Guides and preferably be 30 years of age and should be residing in the village permanently. Male Health Guides were to be selected only if females were not available and preference was to be given to ex-servicemen, freedom fighters or a person known for his social service in the village. The Guide is meant to be a vital link between the community and Health functionaries thereby ensuring community participation and preparing a cadre of Volunteers selected by the community itself for providing primary health care services, with greater emphasis on child survival and maternal health programmes. In 1986, the states were requested to discontinue the service of Male Health Guides and replace them by female VHG. The VHGs in different parts of the country got a stay order on the communications of the Govt. of India. Hence, the States were requested not to give effect to the earlier communications and continue with the Male Health Guides who are in record. Excepting for the States of Gujarat, Assam, Rajasthan and Goa where Male Health Guides have been discountinued, the other States continue to have Male Health Guides on their roles. ○

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"Every birth should be viewed as a medical emergency. We should be prepared to meet the challenge of 23 million medical emergencies in our country every year."

—**Dr Meharban Singh**
A.I.I.M.S.
New Delhi

IT's TIME

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Larger number of younger couples to be covered under family welfare programme

THE NEED TO COVER UNDER FAMILY WELFARE PROGRAMME a larger number of couples in the younger age-groups was emphasised at the Conference of Health Ministers of States and Union Territories held in New Delhi in June last. The Conference also underlined the need to reach the targets in terms of CPR (Couple Protection Rate) which had been set for the Seventh Plan. While noting a gradual increase in the percentage of couples protected by temporary methods of contraception the Ministers stressed the need to step up the efforts in this regard.

The Conference discussed in detail the recommendations of the Committee of Ministers on Targets and awards, and observed that keeping in view the fertility trends in the older age-groups, the importance attached to the terminal methods should be continued, particularly with a view to having an impact on high maternal mortality and infant mortality rates associated with higher parity and higher age.

Targets of various methods under the Family Welfare Programme were finalised following detailed discussions at the Conference. A target of 5.37 million sterilisations for the year 1988-89 has been finalised as against 4.88 million sterilisations performed in 1987-88, representing a 10 per cent increase. The targets for individual States and Union Territories have been communicated to them.

The Conference decided that the State Governments would be initiating immediate action for achievement of the targets set for the current year, thus providing necessary impetus to the family welfare programme. The target set for IUDs is 4.97 million, an increase of 15 per cent over the 4.30 million IUDs performed in 1987–88. For conventional contraceptives and oral pill users, a target of 15.17 million has been fixed as against a performance of 13.32 million acceptors in 1987-88.

The Conference recommended that the States should gear up their rural health infrastructure to ensure that targets for the 7th Plan were fulfilled.

The Conference appreciated the initiative taken by the Maharashtra Government in inacting a legislation against the sex determination test. States were requested to examine this legislation and take appropriate action. The Conference also asked the Central Government to pursue action and consider the feasibility of a Central legislation in this regard. ○

Courtesy : YOJANA, July 16—31, 1988