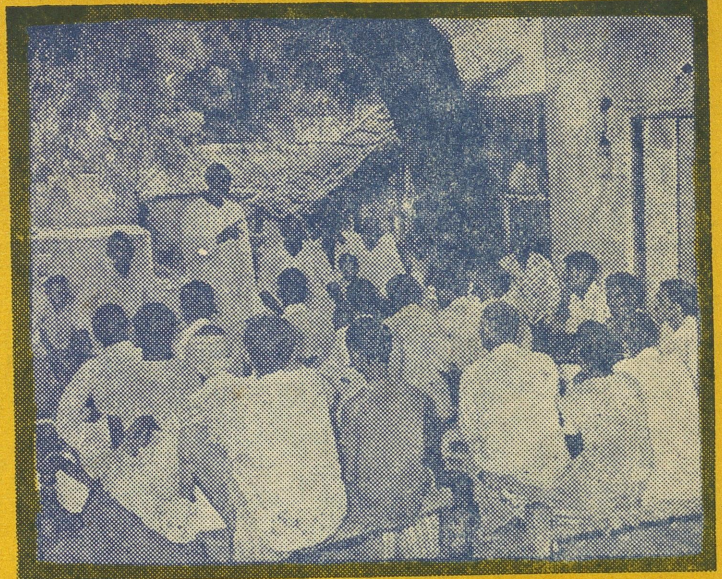
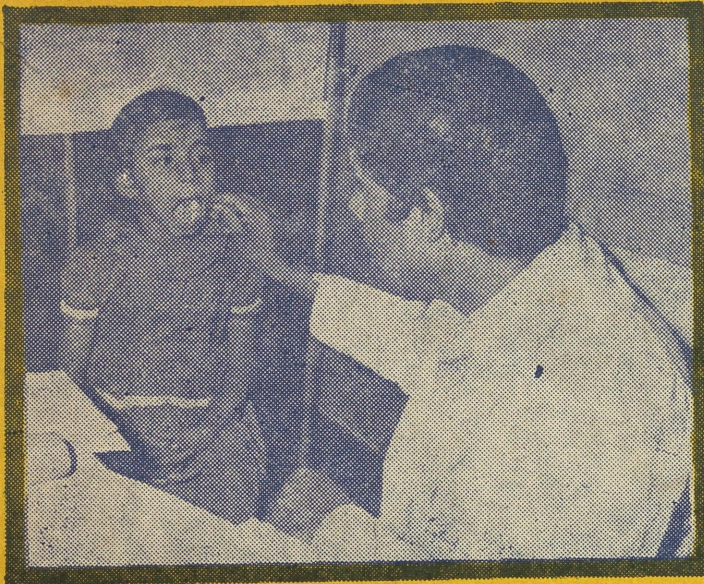


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40 YEARS OF INDEPENDENCE AND HEALTH

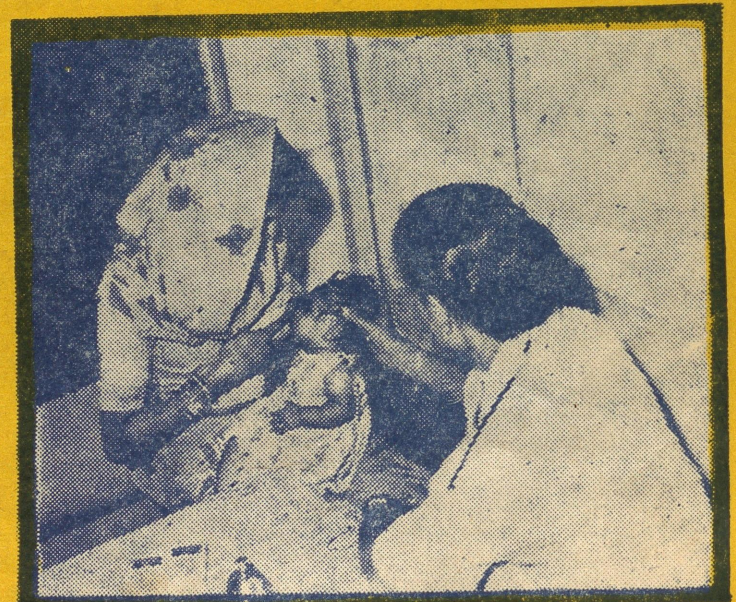
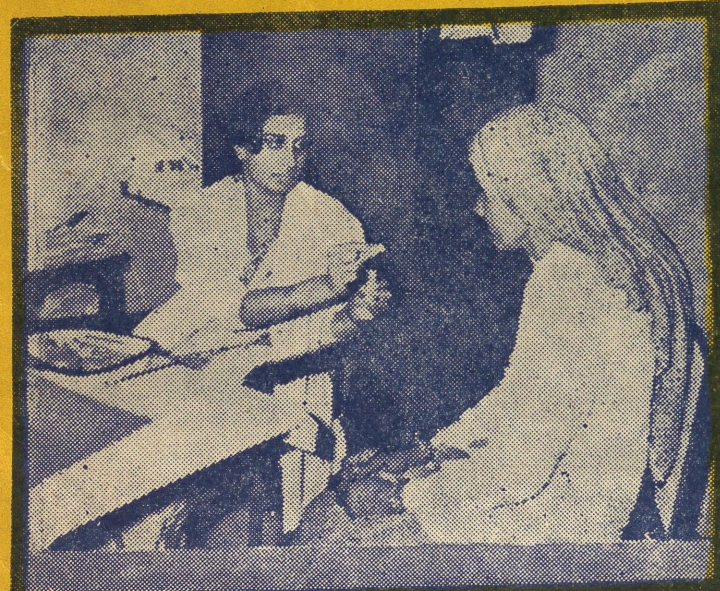


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It is a very reliable magazine equally useful for professionals and laymen. Every person who has heard the word 'Health' must subscribe to this magazine. Material, get-up printing are excellent. The department deserves congratulations for such a beautiful publication.

Prof. MALKIT S. GILL
Govt. College
Bhatinda (Punjab)

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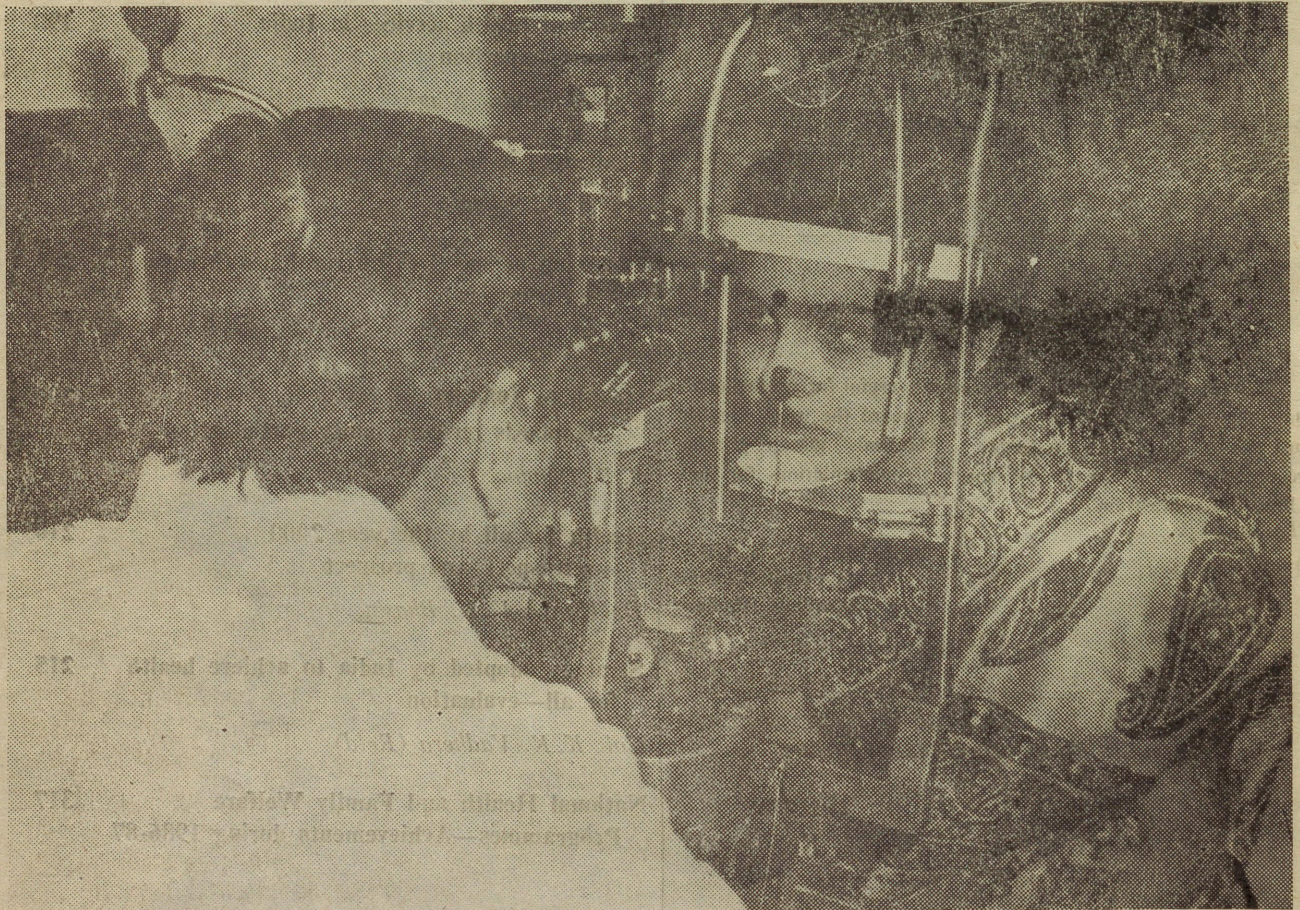
Articles on Health topics are invited for publication in this Journal.

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STATUS OF HEALTH SERVICES IN INDIA —A COMPARISON

DR. MAHENDRA SINGH

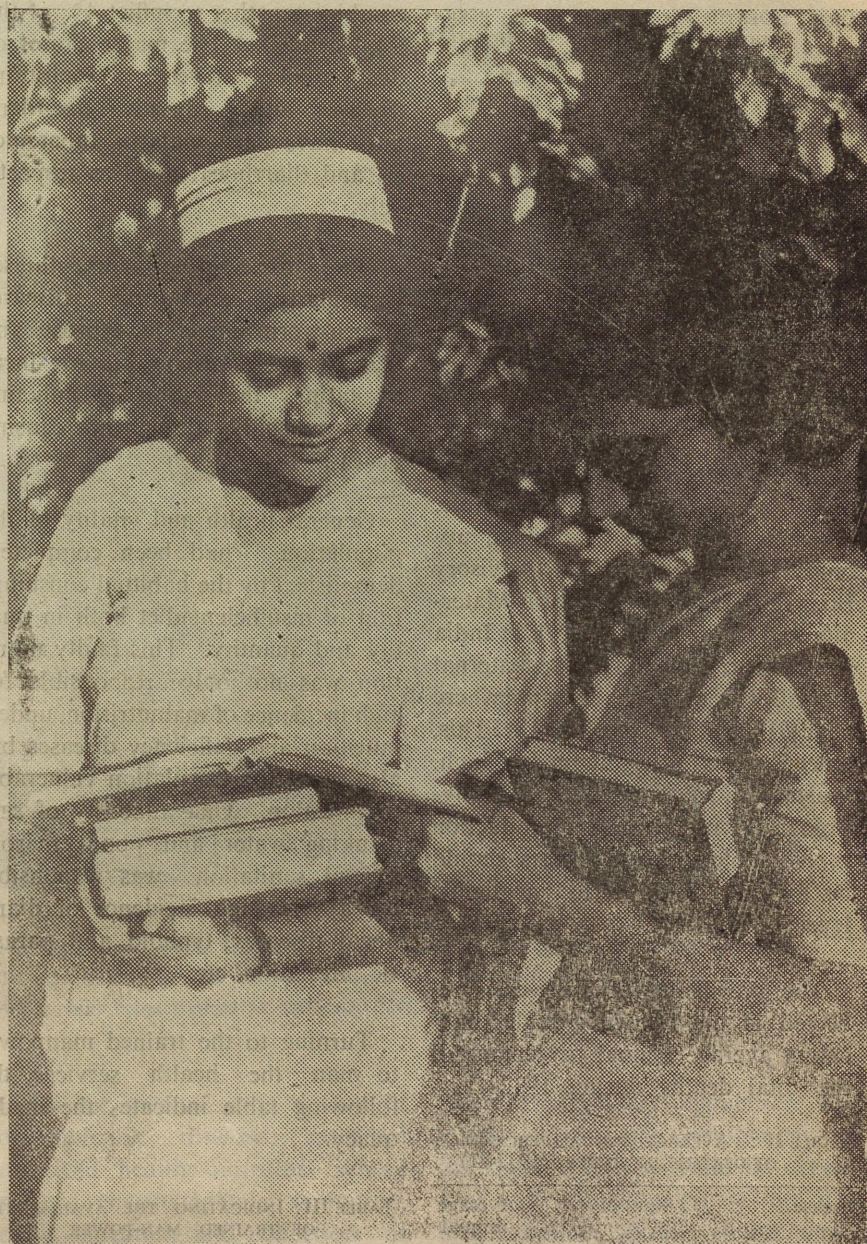
Considerable health progress has been achieved during the 40 years of India's Independence through the implementation of various programmes under the Health Services, strategies of which were reviewed and altered from time to time. These achievements could have been more spectacular, says the author, if we could have tackled our population problem more effectively.

HEALTH implies more than an absence of disease. It indicates a state of harmonious functioning of the body and mind in relation to physical and social environment to enjoy life to the fullest possible extent and to attain maximum level of productive capacity.

For an assessment of the status of health services, we have to rely on health information, which gives us certain indication of a given situation in a country. Since data on positive health are rather difficult to obtain than those relating to ill-health and death, we will compare the status of Health Services in the pre-independence with post-independence period in those variables which may help to measure the change. Limitations are obvious both then and now, because in order to have better indications, information has to be reliable, valid and also comparable.

Health Services in the Pre-Independence Period

Regarding the review of health services in India during pre-independence period, i.e., before 1947, it may be stated bluntly that the situation was grim. Death rate (1937) and infant mortality rate (1937) were 22.4 per 1000 population and 162 per 1000 live-births respectively. These rates were one of the highest in the world. The figures of expectation of life at birth 26.91 and 26.56 (1921-30) for males and females respectively were one of the lowest in the world. The corresponding figures about death rate, infant mortality rate and expectation of life at birth for England and Wales were 12.4; 58; and 58.74 (males) and 62.88 (females) respectively.



The trained manpower for curative and preventive health was far from adequate during the pre-Independence period. More emphasis was given on curative health as compared to preventive aspects. During the post-Independence period, stress has been laid on the re-orientation of medical education with emphasis on community care.

As for the specially vulnerable age group, the position was far from satisfactory. groups of the population, viz., children and women in the child-bearing

Deaths among infants, pre-school children and in the school children below 10 years are indicated in the following table:

TABLE I : DEATHS AT SPECIFIC AGE PERIOD SHOWN AS PERCENTAGE OF THE TOTAL DEATHS IN ALL AGES

| Age group (in years) | 0—1 | 1—5 | 5—10 | Total below 10 |
|----------------------|------|------|------|----------------|
| Deaths in Percentage | 24.3 | 18.6 | 5.5 | 48.4 |

From the above table, it will be observed that 48.4% of the total deaths were among children below 10 years and in this highly vulnerable age group, 50% of the deaths are among infants.

As for maternal mortality, reliable figures were not available. However, a special Committee appointed by the Central Advisory Board of Health to report on Maternity and Child Welfare work in India has indicated that in 1938, maternal mortality was "probably somewhere near 20 per 1000 live-births". This, indeed, was frighteningly high. Wastage of maternal lives in a physiological process of reproduction is avoidable and our efforts should be to pull it down to negligible level.

The prevalence of diseases is reflected in the following table, indicating average annual percentage of the total deaths during 1932-41.

TABLE II : AVERAGE ANNUAL PERCENTAGE OF DEATHS IN INDIA (1932-41)

| Disease | Average annual percentage of deaths |
|--|-------------------------------------|
| Fevers | 58.4% |
| Respiratory disorders | 7.6% |
| Digestive Disorders (Diarrhoea, Dysentery) | 4.2% |
| Cholera | 2.4% |
| Smallpox | 1.1% |
| Plague | 0.5% |
| Other causes | 25.8% |
| All causes | 100.0% |

From the above table, it is observed that information about causes of death is not specific except for cholera, smallpox and plague, which combine together to inflict 4% of the total deaths. The major causes of death under 'fevers': 'respiratory diseases' and 'digestive disorders' must have been malaria, tuberculosis and diarrhoeal diseases respectively.

Other diseases, e.g., helmenthiases particularly hookworm disease, guinea-worm infection, leprosy and filariasis were responsible for incapacitating the nation by inflicting heavy morbidity though not causing deaths.

General health and vitality of the population had been completely demolished by the habitual consumption of insufficient diet both in quality and quantity. This faulty nutrition was not only responsible for high incidence of malnutrition, under-nutrition and deficiency diseases but also made the population vulnerable to infection. Unavailability of safe drinking water and poor environmental sanitation was responsible for a very high incidence of diarrhoeal diseases, typhoid and parasitic infestation, etc.

Turning to the trained manpower to man the health services, the following table indicates the inadequacy.

TABLE III: INDICATING THE AVAILABILITY OF TRAINED MAN-POWER

| Category | No. of qualified personnel | Ratio to the population (300 million) |
|---------------------|----------------------------|---------------------------------------|
| Physicians | 47,400 | 1: 6300 |
| Nurses | 7,000 | 1: 43000 |
| Health Visitors | 750 | 1: 400,000 |
| Pharmacists | 75 | 1: 4,000,000 |
| Dentists | 1,000 | 1: 300,000 |
| Sanitary Inspectors | 3,000 | 1: 100,000 |
| Midwives | 5,000 | 1: 60,000 |

From the above table, it will be observed that the organisation for curative and preventive health was far from adequate. Of 47,400 physicians, only 13,000 (27.4%) were serving in medical facilities of the Government and other agencies. Rest of the physicians were self-employed in private practice. And the tendency for the private practitioners as usual was to cluster in the urban areas. Hence there was considerable neglect of the rural population.

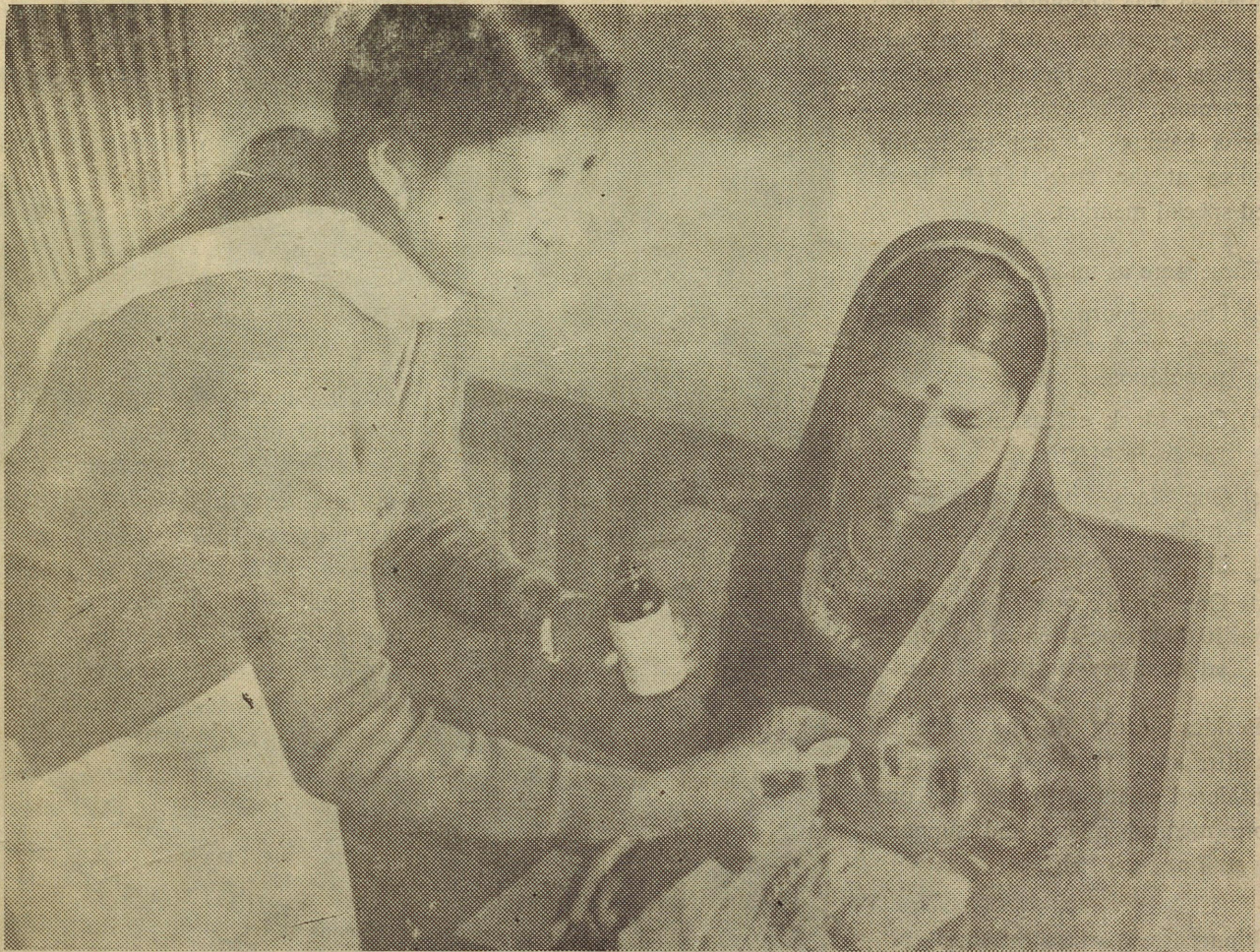
Apart from the insufficient number of hospitals and dispensaries for providing medical relief, the quality of services provided were, indeed, very poor. The dispensaries and the out-patient departments of the hospitals were over-crowded and medical services rendered to the people were not adequate. Only a total of 73,000 beds were available, i.e., about one bed for 4000 population.

From the above, it would be clear that the organisation both for curative and preventive health was altogether inadequate. More emphasis was on curative health and the preventive aspects were given little importance.

As for the social aspects, the problems of unemployment and poverty were indeed acute. The status of women was at the lowest and added to this the customs like 'purdah' and early marriages (even infant marriages) made it all the worst. This was further diluted since the literates were only of primary school level and ultimately lapsed into illiteracy.

Development of Health Services in the Post-Independence Period

We paid a heavy price for our Independence. There was partition of the country followed by mass



The primary health centres (PHCs) are a focal point where health services radiate to the people in rural areas. At present (as on 1-4-1987) there are 14,145 PHCs besides 98,987 sub-centres that serve rural areas. Before Independence, none existed. Photo shows a child being treated at one such PHC.

migration of the population, never known before in the history of the sub-continent. Apart from the law and order problem, rehabilitation of the displaced persons, provision of preventive and curative services in the refugee camps had to be dealt with on a war-footing.

Concept of Primary Health Centre

In 1952, under the Community Development Programme, one primary health centre with three sub-centres were planned to be established in one community development block. They were responsi-

ble for the medical care, control of communicable diseases, maternal and child health, nutrition, school health, environmental sanitation, health education and collection of vital statistics. In fact, we were asking for too much.

In 1961, Mudaliar Committee reviewed in detail all the aspects of medical care, public health, communicable diseases, medical education and population problem, etc. As for the primary health centre programme, it was recommended that a primary health centre (PHC) to be effective should not be given

more than 40,000 population and it should have full complement of the staff. There should be expansion and strengthening of the district hospitals. Mobile health teams of specialists from the district/taluka hospitals should provide necessary supervisory and consultancy services to the PHCs. The PHC should also provide residential accommodation and should have a bed strength of ten.

The Census in 1961 indicated disturbing trend of rising population in the country. Hence a special committee, viz. Mukherjee

Committee was appointed to review the staffing pattern and financial provision under Family Planning Programme. The main recommendations having impact on health services at the crucial PHC level need special mention.

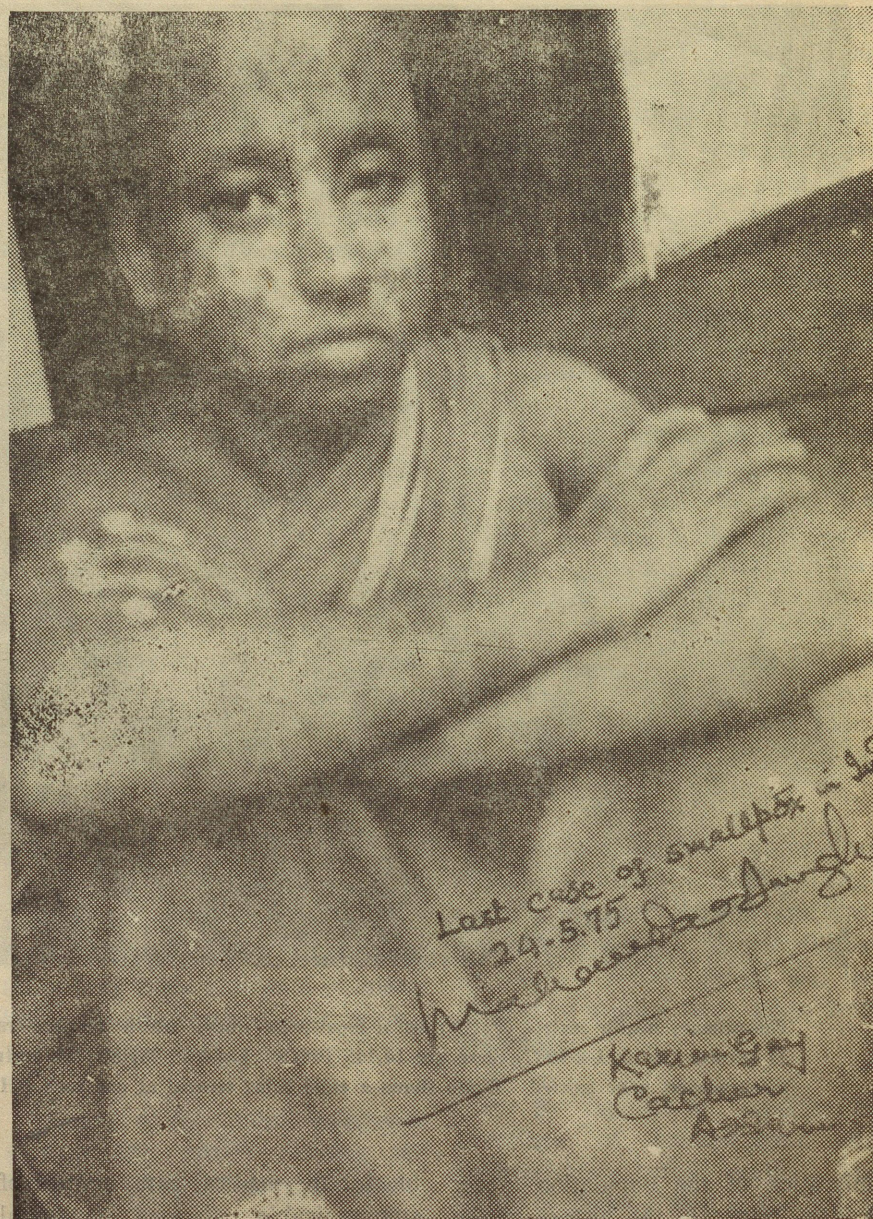
These were as under:

- (a) One unipurpose family planning worker for every 20,000 population.
- (b) One block extension educator for every PHC.
- (c) One lady health visitor to guide and supervise the work of four sub-centres.
- (d) One sub-centre for every 10,000 population with a trained auxiliary nurse midwife.

Besides adding to the physical facilities and equipment, it was also considered essential to provide one more medical officer and supporting staff at each PHC.

Multipurpose Workers Scheme

This pattern of development of health services continued up to IV Five Year Plan (1969-74). However, it was observed that though most of the PHCs and sub-centres were established according to the Plan, they were not able to effectively cover the entire population under their jurisdiction. In other words, the organisation did not fulfil its promise of providing primary health care to the population. Hence, in 1974, one of the main recommendations of the Kartar Singh Committee was to establish a sub-centre for every 5000 population and thus an integrated approach for the delivery of the health services,—the concept of multi-purpose workers scheme—came into being. Shrivastav Committee Report (1975)



Last case of smallpox in India, which occurred on 24 May, 1975. India emerged victorious and smallpox was eradicated.

recommended the speedy implementation of multi-purpose workers' scheme and also the introduction of three-tier plan for health care unit with a person from the community at the village level providing the base. It also proposed a plan for a re-orientation of medical education towards the need of the country with emphasis on community care.

Victory against Smallpox

In the meantime under the National Smallpox Eradication Programme a grim war was being fought against the dreaded scourge, smallpox, with the revised strategy of surveillance-cum-containment, utilising bifurcated needles with potent freeze-dried vaccine, India emerged victorious and smallpox

was eradicated; last case being Saiban Bibi, which occurred on 24th May, 1975. This was a public health miracle and a great success story to boost the morale of all the health workers throughout the country and the world. Author had personally investigated this outbreak for effective containment and follow-up action to wipe out this last case of smallpox from the country.

In 1978, an International Conference on Primary Health Care was held in Alma-Ata (6-12 September, 1978). The objective of the Conference was to focus world's attention on the facilities of the existing health services to serve the rural population and the urban poor and to seek firm commitment from the Government to remedy the prevailing situation. India, as a signatory to Alma-Ata declaration has committed itself to achieve the goal of 'Health for All by the year 2000 A.D.'

With a view to evolve a national strategy for securing the objective of 'health for all' and to identify specific programmes, a meeting of the health experts, research scientists, medical educationists, social scientists, health administrators and representatives of the Planning Commission, related ministries/departments of culture and State Governments and voluntary organisations was held in February, 1980. The Report of this meeting formed one of the important basis for the formulation of the National Health Policy.

Apart from the other important aspects, goals for health and family welfare programmes have been mentioned under 17 important indicators which will show the progress required to be expected by the year



Malaria has shown a significant decline in mortality with 1.66 lakh cases in 1985.

2000 A.D. Further, health and family welfare services have been given due importance in the New 20-Point Programme. For such important programmes like "Clean Drinking Water", "Health for All" and "Two-child norm", included in the new 20-Point Programme 1986, hawk-eyed supervision, continuous

monitoring, periodic programme appraisal and evaluation, it is absolutely essential to have research and feedback for prompt corrective measures.

PROGRESS ACHIEVED, ITS IMPACT AND A COMPARISON

By implementing the various programmes under the Health Services,

strategies of which were reviewed and altered from time to time as mentioned above, considerable progress has been achieved in the four decades of post-independence period as compared to the pre-independ-

dence period. These achievements could have been more spectacular, if we could have tackled our population problem more effectively.

The following table shows the achievements/impact during the last four decades since Independence.

TABLE IV : IMPACT OF HEALTH SERVICES IN COMPARISON TO THE POSITION BEFORE INDEPENDENCE AND EXPECTATIONS BY 2000 A.D.

| No. | Indicator | Before Independence | Data available after 4 decades of Independence | Expectations by 2000 A.D. |
|-----|--|--|---|---------------------------|
| 1. | Infant mortality rate (per 1000 live births) | 161 (1941-45) | 104 (1984) | below 60 |
| 2. | Crude death rate | 31.2 (1931-41) | 12.5 (1984) | 9 |
| 3. | Maternal mortality rate (per 1000 live-births) | about 20/1000 (1938) | 3.4 | below 2 |
| 4. | Crude birth rate | 45.2 (1931-41) | 33.8 | 21 |
| 5. | Expectation of life at birth (years) | Male 32.09 Female 31.37 Persons 31.72 (1941) | 54.1 54.7 54.4 | 64 64 64 |
| 6. | Literacy rate | Persons 12.5 | Male 46.10 Female 24.82 Persons 36.23 (1981 Census) | above 80% |

According to the latest available information as on 1st April, 1987, as many as 905 community health centres; 14,145 primary health centres and 98,987 sub-centres have been set up. Before Independence none existed. As for the buildings for these institutions, the expectations are that by the end of VII Five Year Plan (1985-90), 40%, 80% and 90% of the sub-centres, primary health centres and community health centres will have their own buildings.

As on 1st January, 1986 there were 5,35,735 beds as against 73,000 beds before independence.

As for the trained manpower is concerned, the increase is evident when Table III is compared with the following table:

TABLE V : TRAINED MANPOWER AFTER ABOUT FOUR DECADES OF INDEPENDENCE

| Category | No. of | Ratio to the qualified 1981 Census personnel population (685 million) |
|---|----------|---|
| Physicians (Registered) 1984 | 2,97,228 | 1: 2305 |
| Nurses (Registered) 1985 | 1,70,880 | 1: 4009 |
| Health Visitors (Registered) 1984 | 11,455 | 1: 59815 |
| Pharmacists (Registered) 1984 | 18,216 | 1: 37614 |
| Dentists (Reg) 1985 | 9,598 | 1: 71388 |
| Midwives (Registered) 1984 | 1,68,493 | 1: 4066 |
| Auxiliary Nurse Mid-wives (Registered) 1984 | 89,952 | 1:7617 |

Apart from the above, as on 31st March, 1986, there were 5568 block extension educators, 90211 multi-purpose workers (male) 67371 multi-purpose workers (female), 2711 health assistants (male) and 14083 health assistants (female) and 538523 trained dais. These categories of staff were not available before independence.

Per capita expenditure on health and family welfare are Rs. 32.85 and Rs. 4.30 respectively.

Communicable diseases

As for communicable diseases, smallpox has been eradicated, no case of plague has been reported after 1967. Cholera has shown marked decline both in morbidity and mortality. Malaria, too has shown a significant decline in mortality (about 150 deaths in 1985) with 1.66 lakh cases.

Diarrhoeal diseases, and tuberculosis are the major problems. Determined efforts are being made under National Programmes to eradicate leprosy and guineaworm infection and to reduce the incidence to nil of six vaccine preventable diseases covered under the Expanded Programme of Immunization viz., measles, diphtheria, pertussis (whooping cough), tetanus, polio and tuberculosis.

In conclusion, it must be mentioned that though considerable efforts have been put in and remarkable achievements like smallpox eradication, plague elimination have been made yet much will have to be done to attain all those objectives and goals which we have set for ourselves in the National Health Policy and the new 20-point Programme by the year 2000 A.D.—which is not even 13 years away from today.

REFERENCES

- Report of Health Survey and Development Committee — 1946.
- Compendium of Recommendations of various committees on Health Development 1943—1975, Central Bureau of Health Intelligence, Nirman Bhawan, New Delhi—1985.
- WHO/UNICEF—Alma-Ata 1978—Primary Health Care.
- National Health Policy, Govt. of India, Ministry of Health & Family Welfare, New Delhi 1983.
- Health Information of India—1986—Central Bureau of Health Intelligence, Nirman Bhawan, New Delhi.
- W.H.O./SEARO—Bulletin of Regional Health Information New Delhi-1986.
- The Twenty Point Programme—1986, Ministry of Information and Broadcasting, August, 1986.
- Singh, Mahendra—Review of current status of monitoring and evaluation mechanisms at Central, State and District level—W.H.O./SEARO—Consultative Meeting 27-28 November, 1986.

40 Years of Independence



CHALLENGES IN HEALTH EDUCATION

DR B. S. SEHGAL

All the successive five year plans have impressed that no single measure is as productive of greater returns in proportion to outlays than health education. Still the contributions of health education to the successful achievement of national health programme goals has left much to be desired, feels the author. This paper discusses some of the reasons responsible for this lacunae in health education development which stand as challenges to all administrators and planners interested in achieving national goals.

SINCE the advent of independence, greatest consideration at the policy-making level has been given to the willing assent and active participation of the people in the health development programmes. Realising how much illness is caused by the ignorance of simple hygienic laws or indifference to environmental hazards, all successive five year plans have impressed that no single measure is as productive of greater returns in proportion to outlays than health education. Still the contributions of health education to the successful achievement of national health programme goals has left much to be desired. This paper aims to explore some of the reasons responsible for this lacunae in health education development which stand as challenges to all administrators and planners interested in achieving national goals.

India has covered several milestones in the growth of Health Education. An extensive organization at the Central, State, District and Block levels has been established with the Central Health Education Bureau (CHEB) in the leadership role at the Centre. During the past three decades of its existence CHEB has developed as a unique institution and has amply demonstrated the multi-dimensional contribution of health education in the field of planning, training, media production and research. Its close coordinative activities with the Ministry of Education and with international agencies is creditworthy. Many State Health Education Bureaux have also passed through various phases of development. Some of them have a high level of competency in production and use of educational material.

The National Family Planning Programme was the first one to initiate the use of scientific health educational principles in its planning and implementation strategy. A large number of people were trained and an extensive use of mass media and publicity material was made. However, disproportionate emphasis on mass media and time-bound target achievement in sterilization made the staff leave out the people in planning, decision-making and implementation of the programmes. This lapse did not allow building up of a firm community base in programme implementation.

The strategy of the other national programmes like malaria, T.B., leprosy, etc., has been formulated on too much technological considerations and over-confidence in its scope. People's role in these programmes, though considered important, has been relegated to the background and very meagre provision for it was made in their budget outlays.

Since the Alma-Ata declaration in 1978, India has committed itself to attaining the 'Health for All' goal by the year 2000 A.D. through universal provision of comprehensive Primary Health Care services. These services integrally linked with the extension and health education approach will take into account the fact that a large majority of health functions can be effectively handled and resolved by the people themselves with the organised support of volunteers, auxiliaries and multi-purpose workers of various grades of skill and competency. Though community participation was already considered an essential component of most health activities, but it was usually equated with provision of voluntary labour for sanitary or

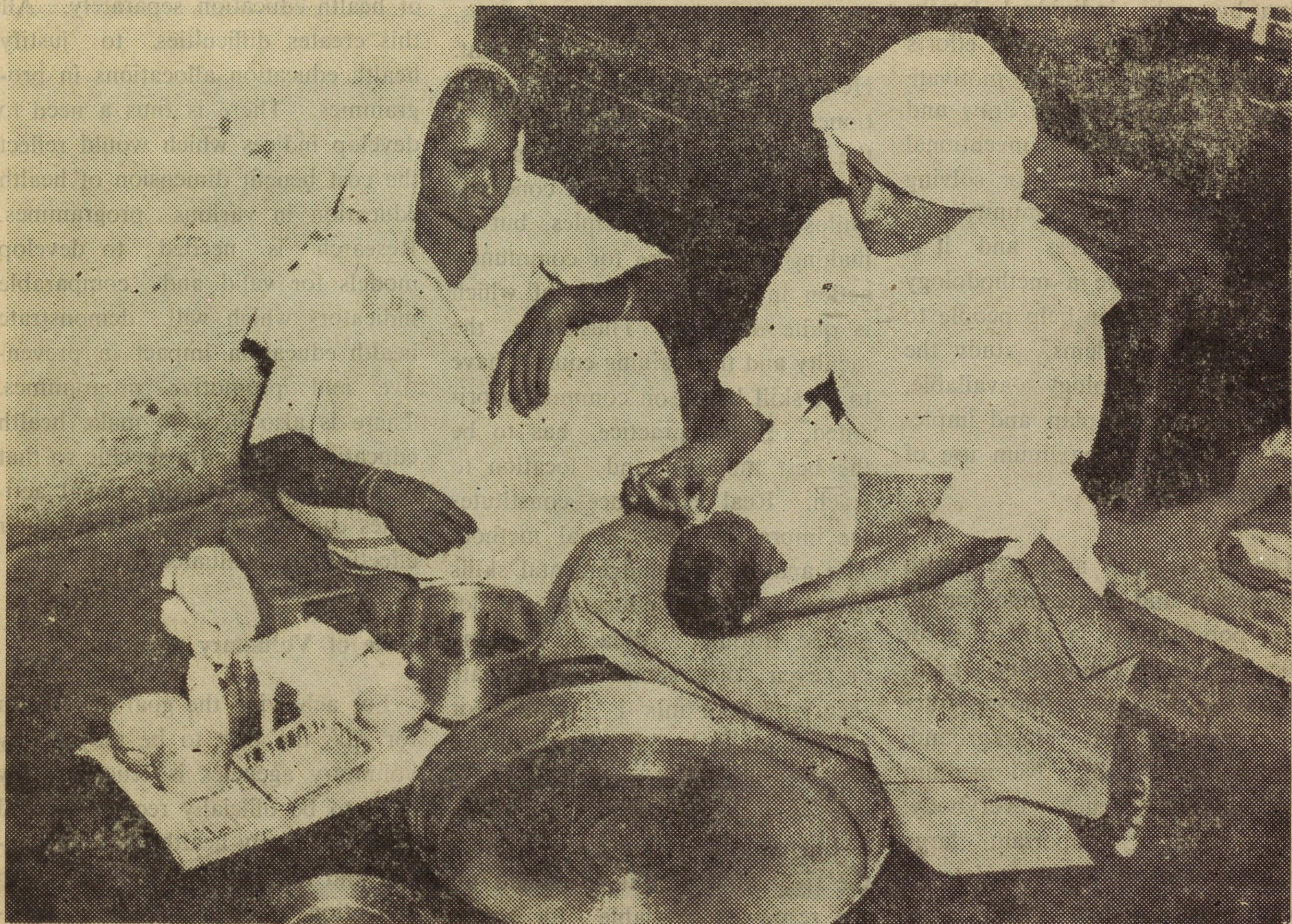
building construction or financial contributions to health services. In the new health policy of Primary Health Care, individuals and communities have to be involved in the whole process of programme planning and implementation with the ultimate aim to take its responsibility on the basis of self-reliance. This is entirely a new dimension of health development in which health education has a vital role to play. New health education approaches have to be evolved and integrated into the very fabric of the each programme activity. These approaches should be people-oriented both in terms of technology and delivery of services. People will need to know and understand their problems in the context of available resources and technology and carry out at the individual and community level specific activities to solve them. These are entirely new areas for which health administrators and field workers will have jointly to pool their wisdom for finding a solution.

HEALTH EDUCATION CHALLENGES

Understanding the complexity of Human Behaviour by Programme Planners and administrators:

All health and family planning programmes aim to achieve certain measurable goals many of which are time-bound. To achieve these goals people are expected to adopt new ways of living. The most serious health hazards like malnutrition, gastro-enteritis, tuberculosis, etc., are embedded in the way people live. Customs, poverty and ignorance contribute to the maintenance of these diseases.

Human behaviour is the net result of a series of factors—psychological,



A large majority of health functions can be effectively handled and resolved by the people themselves with the organised support of volunteers, auxiliaries, trained birth attendants and multi-purpose workers of various grades of skills and competency.

socio-cultural or situational. To change traditional beliefs and practices, mere conveying of messages based on scientific facts and modern technology are not enough. To change people we do not need knowledge alone, but a process has to be initiated in which people can be made to go through an experience related to the new habit in the context of their socio-cultural setting. Such an experience should be a satisfying one and should include complete information on the benefits

and limitations of the particular innovation or technology used.

The challenge, therefore, is to develop health technology based on people's understanding and preferences and not something based on scientific criteria alone. Health educators, therefore, should develop procedures and tools by which a peripheral field worker can collect, compile and interpret what the people know, feel and do about a particular health problem. This will

help in providing an educational base from which a strategy and plan could then be decided upon and developed.

Clarification of the concept of Community Involvement for Programme responsibility and self-reliance.

In the new policy of health development, people and the health professionals have to work as partners in tackling local problems. Acquir-

ing good health will need specific action by each individual, family or community. Educational efforts to inform, educate and motivate people will be needed to draw and utilize the community's conventional wisdom and resources for solving these problems. Community involvement is a process and it is necessary to evolve a methodology and steps which can help people to identify their problems, study the options and technology available, choose a suitable plan and implement it, making maximum use of community resources.

The provision of adequate health information and education for an entire population is a task of great difficulty. Every community is composed of several groups having different socio-cultural background, interests and needs. No medium can possibly reach everybody. Identification of important large groups is essential to formulate a realistic educational plan. Their present knowledge and practices along with their perception of the advantages of the new practice should be collected and used in planning educational activities.

If community involvement envisages people's own responsibility in programme planning and implementation, then it should be clearly specified with well-defined objectives and adequate resources be provided for it in the programme budget. Health education activities will be the single largest input in helping people organise and implement any health plan.

The Dilemma of Training

Whenever one is planning a programme, Training of Staff is usually

identified as the first need. It is always a question of large numbers, limited resources and time constraint. Health education being a practitioners discipline cannot be taught in the class-room alone. It is not just a question of learning concepts, philosophies and principles, but of making use of these for community action in situations, each of which is quite different. Thus both the faculty and the training courses have to be skill based on community oriented. Field practice has to be the best method and location to teach. Real experience constitutes the impressive educational method. The analytic and judgemental skills needed by health educators are not gained through didactic teaching or even discussions. A delicate theory-practice mix is needed for all courses in health education and a living practice demonstration field is a must for all institutions giving health education training. Without the right kind of trained people, all the resources available for health education get wasted. Training people to help community self-reliance and organise and support inter-sectoral cooperation are matters which need ingenuity, knowledge and experience. Faculty selection and its preparation is, therefore, a challenge which must be met. Resistance of the faculty to modify training curricula and programmes should also be tactfully handled.

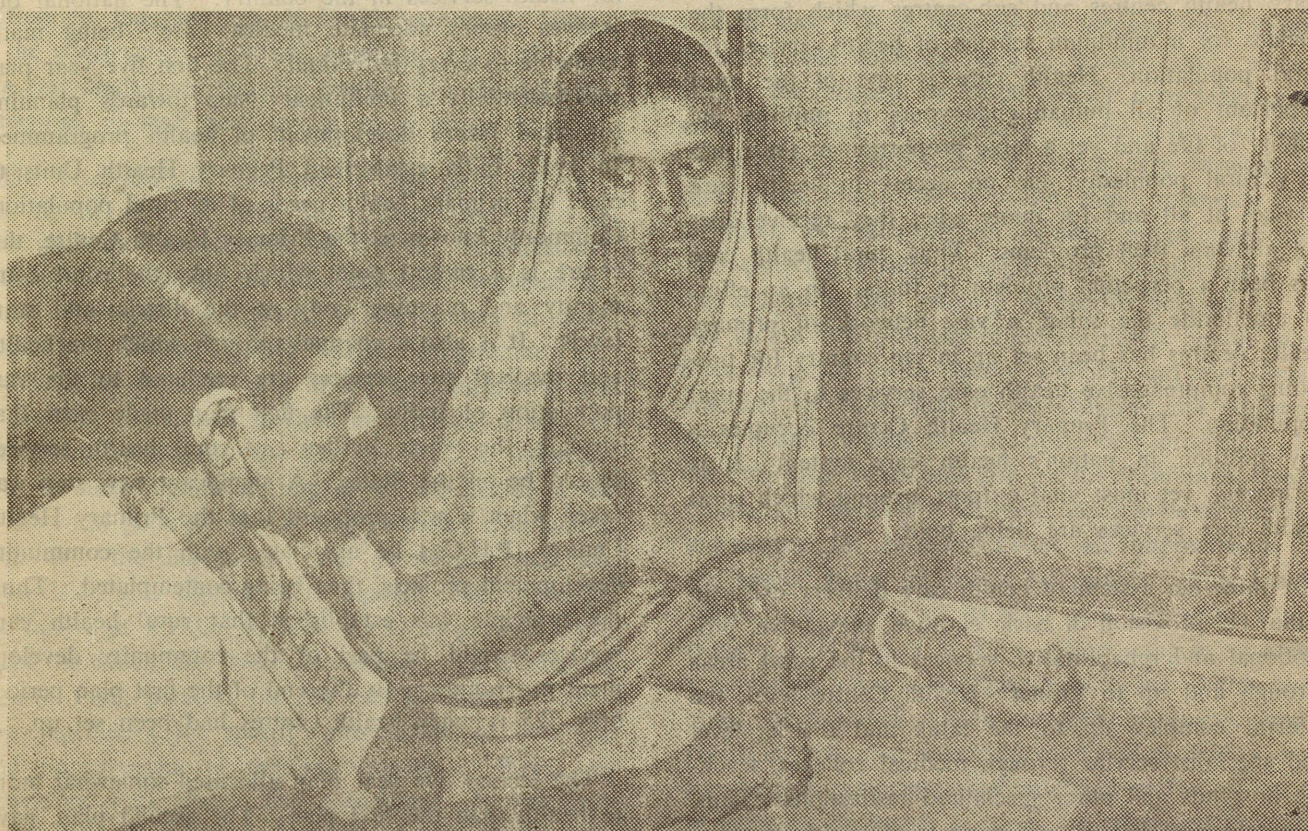
Problem of measuring impact

Since behaviour change is the result of a large number of factors in a person's environment, measuring impact of health education is sometimes rather difficult. In community activities as well health education cuts across a number of sectors and agencies resulting in

difficulty of assessing contributions of health education separately. All this creates difficulties to justify health education allocations in programmes. There is thus a need to develop indices which would reflect the cost benefit dimension of health education in various programmes. Research is needed to develop models for valid and comparable indicators which will demonstrate health education impact in preventive and promotive programmes. There is also need to make health education sufficiently specific so that implementation of educational activities can be monitored and their effectiveness evaluated.

Role of Voluntary agencies

For achieving the goal of 'Health for All', the part to be played by voluntary agencies is crucial. They need to be officially recognised and involved in any health plan. Financial and technical support for health education through voluntary agencies can pay rich dividends as those agencies are an expression of the will of the people to use their own initiative in improving their own lifestyles. Voluntary agencies to be associated should be the one's working in the community and should include religious groups or bodies as well. Sufficient attention has not been paid to involving them in health education work so far. The ultimate success of any programme is invariably linked to the extent of voluntary agencies, active involvement. Education, support and trust are the key elements in developing collaboration with voluntary agencies. Health educators need to know and practice it.



CHANGING PERSPECTIVES ON RURAL HEALTH CARE : AN OVERVIEW

S. SRINIVASAN

The primary goal of any health delivery system to organise the health services in such a manner as to optionally utilise the available resources, knowledge and technology with a view to prevent and alleviate disease, disability and suffering of the people. For making the health care services more meaningful to our people, it is necessary, the author feels, to bring about fundamental changes in focus and approach to the entire health care delivery system of the country in general and above all rural care services in particular.

THE HEALTH CARE SYSTEM is intended to deliver the health care services. It operates in the context of the socio-economic and political system of the country. India is one of the very few countries that had from the very beginning planned health services as a part of general socio-economic development. Accordingly, a health delivery system was evolved in independent India on the lines suggested by the Bhore Committee (1946). The broad objectives of health plan are to strengthen the health infrastructure and to complete eradication of diseases and their integration into the basic health services. In realisation of the need for social reconstruction, health care

system was coordinated with the other nation-building activities and was part of community development programme administered through a network of primary health centres and sub-centres which form the nucleus for a minimum scheme of health services for rural population. Health care is one of the most important of all human endeavours to improve the quality of life and yet a large proportion of the country's rural population has no access to health care services at all and for many what they receive does not alleviate their problems. Thus, rural health care has been a perpetual problem in India. In an effort to ameliorate the same, a vast network of primary health centres has been set up in the country for providing comprehensive health care services to the rural population. The Primary Health Centre occupies a key position in nation's health care system. It is peripheral, yet most vital outpost, around which rural health care services are being built.

A three-tier system of health care delivery exists in India, i.e. provision of basic curative, preventive, promotional and rehabilitative services to the rural areas through and up to Primary Health Centre level, the referral complex up to the taluk and district level and specialist service through medical colleges, teaching hospitals and other specialised institutions. Thus, comprehensive health care consists of health care delivery at the primary, secondary and tertiary levels.

The primary goal of any health delivery is to organise the health services in such a manner as to optionally utilise the available resources, knowledge and technology with a view to prevent and alleviate diseases, disability and sufferings of the people.

There are three types of health resources that exist in the rural areas of India, namely, formal, informal and folk health care systems. The formal health system consists of the governmental network of primary health centres, sub-centres and dispensaries (the P.H.C. complex). This system is highly formalised and organised bureaucratically. The informal system consists of a network of private clinics of the full-time private medical practitioners of various systems of medicine such as Ayurveda, Siddha, Unani and Homoeopathy. The folk health care system consists of a variety of part-time health workers who function within the context of folk traditions and village organisation. All these systems fulfil the health needs of the rural population in India, to a varying degree.

Rural health services and five-year plans

The Five year plans defined the national objectives for health services in the country. The national objectives ensure adequate medical care being made available to every individual. The first five year plan was essentially a preliminary step towards planning for rapid future development of health programmes. In 1952, India established Primary Health Units to meet the primary health needs of its rural population. Commonly known as the Primary Health Centre, this centre is a central point which links the rural community and planning body at the district and state levels. It is also a channel through which the health and medical care services are rendered to the vast population of India. The first plan made clear that virtually the whole burden of rural health services should be on the States. A significant new step was taken when it was proposed that the Primary Health Centres (P.H.Cs.) be associated with the community development projects, then being contemplated. Thus, the principle was established that rural health care services would be part of the community development programme. By the end of the first plan period, only 725 primary health centres had been set up.

The second five year plan allocated somewhat more to health than the first plan. The second plan, gave the highest priority for the need to establish more primary health centres and a regional system of district and taluk hospitals. The plan called the provision of adequate health services for the rural populations 'by far the most urgent need'. By the end of the second plan, 2800 P.H.Cs. were established, covering most of the development blocks. The two succeeding five year plans served only to highlight shortfalls in implementation of health programmes and the deficiencies of their logistics.

The broad objective of the health and family planning programme in the third plan was to expand health services to bring about progressive improvement in health of the people ensuring a certain minimum physical well-being and to create conditions favourable to greater efficiency and productivity. The third plan saw the launching of the nationwide extension approach to family planning as an integral part of the rural health services to educate and persuade the rural population to accept the small family norm. The third plan accorded very high priority to family planning and due importance to nutrition.

By the end of third plan it was intended to establish one P.H.C. each in C.D. blocks. By March 1966, 4631 P.H.Cs. were set up. The third plan directed attention to the shortage of health personnel, delays in the construction of P.H.C. buildings and staff quarters and inadequate training facilities for the different categories of staff required in rural areas.

The Fourth Plan emphasised the need for creation of an effective base for health and medical care such as strengthening of P.H.Cs., subdivisional and district hospitals, the integration and implementation of programmes related to the control of communicable diseases, family welfare programme, etc. The P.H.Cs. form the base of the integrated structure of medical and health services in the rural areas. It was a widely shared view that the P.H.Cs. were not able to make significant impact on the health status of the rural populations. It may be stated that factors such as the inadequacy and insufficient supplies, supervision and support were equally responsible for the failure of P.H.Cs. to fulfil the ideological commitment for which they were established. Therefore, the Fourth Plan, pleaded for the establishment of effective machinery for speedy construction of buildings and improvement of the performance of P.H.C. by providing staff, drugs and equipment. It was proposed during the Fourth Plan, to establish 508 P.H.Cs. covering 340 blocks which did not have a P.H.C. so that there could be, at least, one P.H.C. in each block. By March 1974, 5283 primary health centres were set up throughout the country. During the Fourth Plan, the P.H.C. complex was further strengthened for providing preventive and curative services and also for ensuring the maintenance phase of the communicable diseases control and eradication programme. Yet despite the fact that health programmes which were initiated during the first four five-year plans had brought about some definite improvement in the health status of the people, they fell short of the expectations because they did not meet the laid down objectives adequately.

The Fifth Plan reformulated the health programme in order to 'consolidate past gains in various fields of health such as communicable diseases, medical education and provision of infrastructure in rural areas' (Planning Commission 1974, Vol. II, p. 234). This consolidation of the past gains was envisaged in the context of the new Minimum Needs Programme (M.N.P.) introduced by the plan.

The approach of the fifth five-year plan was modified to integrate health and family planning services, maternal and child health services, and nutrition in such a way that a package of services was offered to the people enabling them to accept family planning in the context of better health expectancy and services. Thus, the emphasis in the fifth plan was on increasing availability of health care services in rural areas, integration of health, family planning and nutrition, augmentation of training programmes for multi-purpose workers, qualitative improvement in the education and training of health personnel. It was in the fifth plan the minimum public health facilities integrated with family welfare and nutritional practices for vulnerable groups, children and pregnant women and nursing mothers were first provided. In the fifth plan, stress was laid on the 'Minimum Needs Programme' because it was considered to be of singular importance for bringing about an improvement in the health status of the rural people. The health related components of M.N.P. were (Planning Commission, 1974 Vol. 1, p. 87): (i) ensuring in all areas a minimum uniform availability of public health facilities, which would include preventive medicine, family planning and the detection of early morbidity and adequate arrangements for referring serious cases to an appropriate higher echelon; (ii) supplying drinking water to villages suffering from chronic scarcity or having unsafe sources of water, and (iii) carrying environmental improvement of slums.

The Minimum Needs Programme was the main instrument through which health infrastructure in the rural areas was expanded and further strengthened to ensure primary health care to the rural population. The Minimum Needs Programme alongwith the training of multi-purpose health workers and a more rigorous pursuit of communicable diseases control and eradication was considered as the core of the health care programme. The Minimum Needs Programme in the State sector would continue to be the main instrument for the development of the rural health care delivery system. Primary Health Centres at the rate of one for each C.D. block had been established by the end of the fifth plan. By the end of March 1978, 5430 P.H.Cs. were set up. Thus, the number of P.H.Cs. was only 67 at the end of the first plan; it increased to 2800 and 4631 at the end of the second and third plans, respectively. After third plan, the strategy was to establish sub-centres around

each P.H.C. This, too, was pursued vigorously. As a result, in 1978, the infrastructure for institutional facilities for health care comprised 5430 P.H.Cs., 38,594 sub-centres, 126 rural hospitals, 258 subsidiary health units and 124 mobile units mostly attached to medical colleges. It was also proposed to have one sub-centre for 10,000 population and upgrade one out of every four selected P.H.Cs. to a 30 bedded rural hospital to serve as a first link in the chain of referral services. A community health centre, a modified form of the upgraded 30 bedded hospital is being established for a coverage of one lakh population with 30 beds and specialised medical care services in gynaecology, paediatrics, surgery and medicine. Thus, rural health infrastructure would be further strengthened in order to achieve the goal of 'Health for all by 2000 A.D.' The rural health component of the Minimum Needs Programme was the main instrument for strengthening adequate infrastructure for health care services in rural areas but the achievements during the fifth plan period fell short of its targets.

The M.N.P. is supported by the Centrally-sponsored schemes of community health volunteers, employment and training of multi-purpose workers and reorientation of medical education which are all continuing schemes.

New rural health policy

(i) Community Health Volunteers' Scheme : In the evolution of countrywide health and medical infrastructure, the first significant departure from the approach to rural health pursued since the beginning of planning was made only in 1977, when the Community Health Volunteers' Scheme was launched. In October, 1977, a new rural health policy was announced in the country, advocating a multidimensional approach which could bring about significant change in the country's health status in the near future. The introduction of the Health Guides Scheme, formerly known as the Community Health Volunteers' Scheme in rural areas, forms an important part of the new rural health policy. Thus, Rural Health Scheme was launched in 777 selected P.H.Cs. spread over the country. This scheme concentrates the government's endeavour to place 'people's health in people's own hands'. With the twin objectives of providing adequate medical care where it is needed and simultane-

ously educating the people in the matter of preventive and promotive health, the Rural Health Scheme was formulated. The people, particularly the rural masses, have to be conscious of what they themselves can do and not merely wait for assistance from outside like government agencies to achieve better health. This scheme intends to make them aware of the services and at the same time educates them about the contribution they could make. This scheme was introduced with the objective of preparing a cadre of voluntary health workers selected by the community.

The scheme began with the training of community health workers (C.H.Ws.). It envisages provision of one CHW for every village or community with a population of 1,000. The CHW is selected by the village panchayat, the medical officer and the Block Extension Educator and the male and female health assistants of the Primary Health Centre are mainly responsible for his training. The training of CHW is arranged at the P.H.C. The training period is of 200 hours to be completed normally within a three-month period. He is taught the basic elements of health care and family welfare. He is trained in both modern and traditional medicine popular in the local region. The trainees receive a stipend of Rs. 600 in three instalments of Rs. 200 each during the training period. After completing the training, each CHW is provided with a kit containing simple medicines and remedies, educational aids and a work manual. The CHW receives an honorarium of Rs. 50 per month to meet out pocket expenditure, and drugs worth Rs. 50 per month.

This scheme envisages achieving the aims by allowing the people themselves to select their own health workers. This scheme as envisaged will go a long way in fulfilling a long-felt need of the rural populations in India by providing minimal medical facilities. For the successful implementation of this scheme, it is imperative that the selection of CHWs should be made with care. However, the introduction of the scheme is not the only solution to the health problem prevailing in rural areas. The extent to which this endeavour succeeds depends upon various factors like the awareness status of the villagers towards this scheme, the expectation of trained CHWs.

This scheme was evaluated by a number of institutions. The conclusions of these evaluation studies were : (i) it has been mostly welcomed by the vill-

agers; (ii) the CHW has emerged as a vital carrier for the family welfare programme; (iii) the CHW acts as a link between the government health functionaries and the villagers; (iv) misgivings do exist amongst the medical profession about the success of the scheme. One of the major findings of the Ministry of Health, Government of India is that while the new tribe of 'barefoot doctors' enjoy greater degree of recognition and acceptance within the rural community, their assistance is mostly sought for minor illnesses and first-aid needs. Their usefulness in the field areas is very much limited.

(ii) Multipurpose Workers' Scheme : Multipurpose Workers' Scheme provided health package to the rural masses at their doorstep to meet the growing needs of intensifying rural health services. This scheme was recommended by the Kartar Singh Committee (1973). The objectives of the scheme were : (i) to increase the accessibility of medical facility in rural areas; (ii) to achieve a good rapport with the community; (iii) to reduce the area and population allotted per worker to improve the quality of health services by trained para-medical personnel and to extend services at the periphery. Thus, the main objective of Rural Health Scheme is to ensure a minimum uniform availability of public health facilities which would include preventive medicine, family welfare, nutrition and referral services. Instead of a number of health workers belonging to different national programmes like malaria, smallpox, tuberculosis etc. operating vertically without any coordination, it was proposed to setup a multipurpose health workers' cadre (both male and female) at the sub-centre level and Block Extension Educator and a Health Assistant at the block level under the supervision of a medical officer at the P.H.C. The area of operation of the multipurpose worker was reduced to 10,000 and maternal and child health was to be integrated with family welfare. But all these efforts have not made much difference in the execution of health services in the villages.

Sixth plan strategy on rural health

The strategy advocated in the Sixth Plan is as follows: (Planning Commission, 1981, p. 368).

- (i) A rural health care system based on combination of preventive, promotive and curative health care services would be built-up starting from the village as the base;
- (ii) The infrastructure for rural health care would consist of primary health centres each serving a population of 30,000 and sub-centres each serving a population of 5,000. These norms would be relaxed in hilly and tribal areas. The village or population of 1,000 would form the base unit where there will be a trained health volunteer chosen by the community;
- (iii) Facilities for treatment in basic specialities would be provided at community health centres at the block level for a population of one lakh with a 30 bedded hospital attached and a

system referral cases from the community health centre to the district hospital/medical college hospitals will be introduced;

- (iv) various programmes under education, water-supply and sanitation, control of communicable diseases, family planning, maternal and child-health care, nutrition and school health implemented by different departments/agencies would be properly coordinated for optimal results;
- (v) Adequate medical and paramedical manpower would be trained for meeting the requirements of a programme of this order and all education and training programmes will be given suitable orientation towards rural health care;
- (vi) The people would be involved in tackling their health problems and community participation in the health programmes would be encouraged. They would be entitled to supervise and manage their own health programmes eventually.

The Sixth Five Year Plan envisages the implementation of a 'Minimum Programme of Rural Health Care'. In this programme, the schemes which are included are : (i) Multipurpose workers' scheme; (ii) Health Guides' Scheme; (iii) components of the Revised Minimum Needs Programme; (iv) Training and Promotional Training Programmes for Birth Attendants (Dais), ANMs/Health Workers (Female), community health officers and the setting up of Regional Teachers' Training Institutes. These schemes are expected to ensure availability of adequate infrastructure and medical and paramedical manpower to make the universal provision of primary health care a reality.

Minimum rural health care programme

1. Multipurpose workers' Scheme : It aims to establishing a health delivery system in the rural areas through a team of multipurpose workers, one male and a female for 5000 population.

2. Training : (a) Seven Central training institutes conduct training programme for the key trainers and the district-level medical officers, (b) 47 Health and Family Welfare training centres impart training to medical officers and block extension educators of P.H.Cs; (c) Trained MOs and BEEs organise training at their own PHCs/selected PHCs for their paramedicals.

3. Health Guides Scheme : This is introduced with the objectives of preparing a cadre of voluntary health workers selected by the community who will undergo training in promotive, preventive and elementary health care at the grass-root level. The Primary Health Centres (PHCs.), upgraded PHCs,

(Contd. on page 224)

40 Years of Independence

HEALTH IN 1986-87 EMPHASIS ON COMMUNITY PARTICIPATION

S. S. DHANOA



The Ministry of Health and Family Welfare continued its efforts towards 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. Sustained efforts were made to activate the people through health education and family welfare communication to avail of the services being provided. The communication strategy has been revamped to obtain greater community participation in the health and family welfare programmes.

DURING the year 1986-87, the Ministry of Health and Family Welfare continued its efforts towards attaining the twin goals of 'Health for All' and a 'Net Reproduction Rate of Unity' by the year 2000 AD. through the universal provision of comprehensive primary health care services. During this second year of the Seventh Five Year Plan, concerted efforts were made for raising the health status of our people. The preventive and promotive aspects of health services augmented, steps for child survival widened and the educational component of the family welfare programme strengthened. All this was, of course, backed with service support. The services were extended closer to the door-steps of the people by increasing and improving primary health care facilities in rural and tribal areas and the areas inhabited by the weaker sections of the society. Sustained efforts were made to activate the people through health education and family welfare communication to avail of these services. The communication strategy has been revamped to obtain greater community participation in the health and family welfare programmes.

The focus has been on maternal and child health care in general and on reducing the infant mortality in particular by protecting children against the six common childhood diseases—Diphtheria, Tetanus, Poliomyelitis, Tuberculosis, Measles and Whooping cough—all preventable through vaccination. The Universal Immunization Programme launched in November 1985, is operating in 92 districts. Additional 90 districts will be taken up in 1987-88. Our aim is to cover all the districts in the country by 1989-



The focus has been on maternal and child health care

90. The Universal Immunization Programme is expected to further reduce infant mortality which is 95 per thousand live births at present.

At the same time, stress is being laid on Oral Rehydration Therapy (ORT) with the aim of reducing diarrhoeal mortality by 90% by the year 1990. Most of the diarrhoeal

deaths are in below five age group. For this purpose, health education and training programmes have been intensified and ORT salts are being made available to people.

Primary health care approach

We have adopted a primary health care approach that seeks to provide universal, comprehensive health care

services relevant to the actual needs and priorities of the community. The health and family welfare services are being provided to the people through the length and breadth of the community via 12,314 primary health centres; 89,815 sub-centres; 1.85 lakh multi-purpose workers of which about 1 lakh are females; 3.9 lakh trained health guides and 5.45 lakh trained dais.

In order to remove the imbalances and to provide better health care and family welfare services to the Scheduled Tribes, the population coverage norms have been relaxed. For the tribal areas, a sub-centre is sanctioned for a population of 3,000 instead of 5,000 and a primary health centre for a population of 20,000 instead of 30,000. Similarly, in order to benefit Scheduled Castes, attempts are being made by the State Governments to locate Health and Family Welfare Units in or around the areas adjacent to the localities inhabited by Scheduled Castes. Villages and basties having more than 20% scheduled caste population will be covered under this scheme. An additional 215 primary health centres and 660 sub-centres have been established in the tribal areas. Thus, the number of primary health centres and sub-centres functioning in the tribal areas has increased to 1,542 and 10,489 respectively.

Today, the expectation of life at birth is 54.4 years. The death rate has declined to 11.7 per thousand. This is a direct result of better health services now available to the community. Besides taking up of ambitious Universal Immunization Programme, well co-ordinated national programmes for the control of communicable diseases including

Leprosy, Malaria, Filaria and T.B. have been going on. Facilities for early diagnosis and treatment of the killer disease like Cancer are being provided throughout the country.

Incidence of Goitre has shown a decline in many areas following the supply of iodized salt under the National Goitre Control Programme. Nearly 40 million persons are estimated to be suffering from Goitre while a total of about 145 million live in the endemic regions. The entire country is to be covered under the scheme for providing iodized salt by the year 1992. The production of iodized salt is being stepped up in view of this objective.

The Indian Medical Council Act, 1956 being amended to confer adequate power on the Medical Council of India to enable it to enforce the various provisions of the Act more effectively and ensure maintenance of minimum standards of medical education. In pursuance of the Supreme Court direction, a scheme has been evolved in consultation with the State Governments, Universities and Medical Council of India for holding an all-India Entrance Examination for admission to 15% seats in undergraduate and 25% seats in postgraduate courses; these examinations would be conducted by the Central Board of Secondary Education and All India Institute of Medical Sciences respectively. Both these organizations have been provided adequate funds for this purpose.

Assessing health manpower requirements

An expert Committee has been established to, *inter-alia* assess the existing and projected national health manpower requirements for the primary and intermediate level health care programmes and to identify the

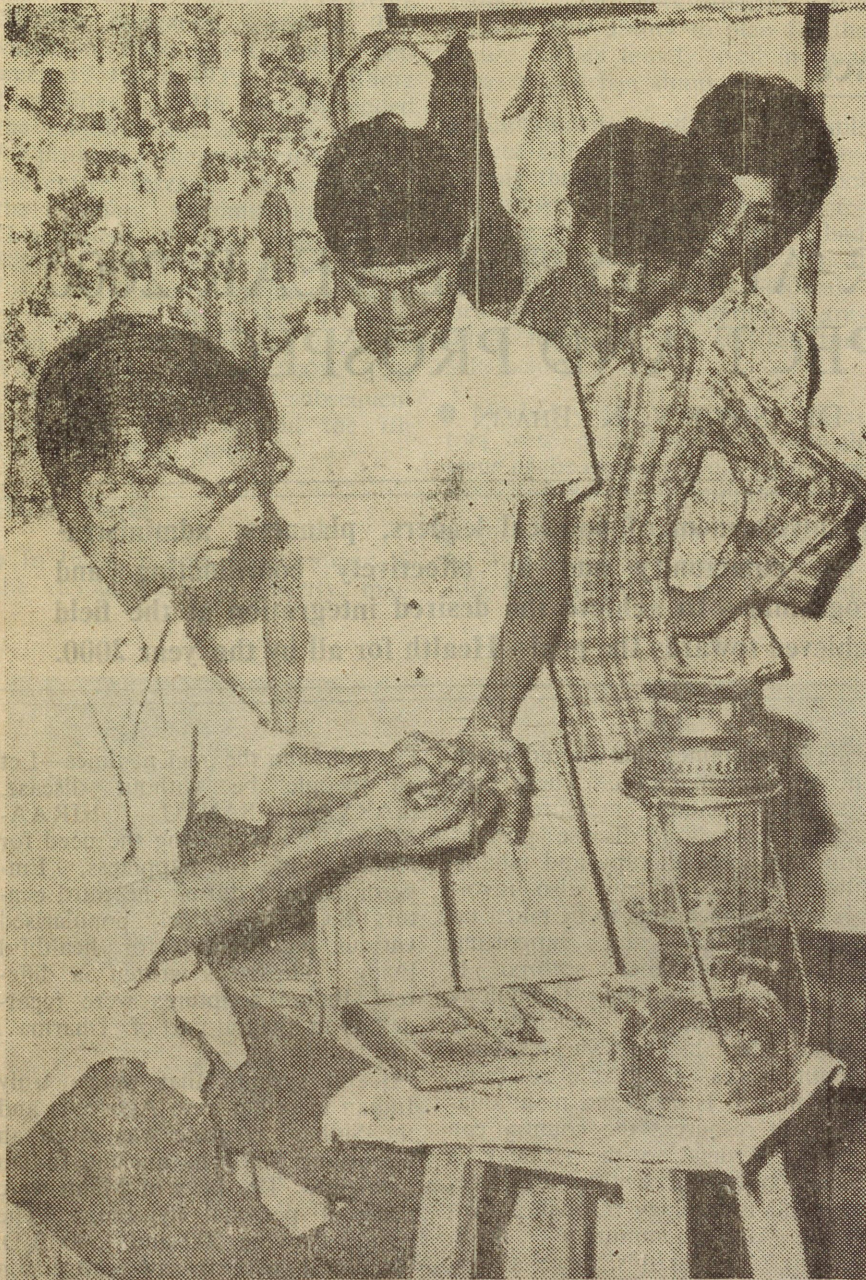
type of health related courses which could be incorporated at the +2 stage of the vocational education. Besides, it is also proposed to establish a central body on the lines of the University Grants Commission to lay down broad policies and coordinate programmes and activities in the field of medical education including the Indian Systems of Medicine.

The Indian Systems of Medicine and Homoeopathy which have a great role to play in the spread of health services in the country are receiving, as ever, due attention from the Ministry. Four separate Research Councils for these systems are now functioning with financial and technical support from the Ministry. Training and research in Yoga received a fillip during the period.

New thrusts to family welfare programme

The Ministry has been involved in an exercise of giving a new thrust and a multi-disciplinary orientation to the family welfare programme and in this direction a Revised Strategy was mooted. The Revised Strategy gives family planning programme the broadest possible dimensions of social engineering which include not only Health and Family Welfare, but also child survival, women's status and employment, literacy and education and socio-economic development programmes including anti-poverty programmes. It also seeks to streamline the entire spectrum of programme management and formulate for family welfare multi-disciplinary agencies. Its ultimate aim is to elevate the programme into a genuine and voluntary people's programme.

The basic health and family welfare services are being provided under the Rural Health Scheme through a network of Primary Health Centres and sub-centres. It is proposed to



Well-coordinated national programmes for the control of communicable diseases including leprosy, malaria, filaria, T.B. have been going on. Photo shows a Filaria worker taking blood samples.

select more and more women as Health Guides for villages as women have come forward in a big way to accept the family planning programme. The Health Guides and the women volunteers are to serve as links between the community and

the governmental infrastructure. They have to work with opinion leaders of the community to form the base of the rural health services. Popular committees at District level in all States are being formed. A pilot project for village level women

volunteer corps in a primary health centre block is being launched. The women volunteers will promote the small family norm through interpersonal communication.

In order to meet the varied needs of the people, a 'Cafeteria Approach' is being applied to family planning services. The people are left free to choose from a number of methods of contraception which are explained to them and made available. The fact that the programme is people's own programme and, hence, absolutely voluntary has been underlined time and again. More than 300 voluntary organisations are also working in different areas to popularise and promote this programme.

The population of India was estimated to be 761 million as on 1st March 1986. It is estimated that nearly 76 million births have been averted since the inception of the programme. The total number of acceptors of different family planning methods in 1985-86 was 18.92 million—an all time high. We have at present couple protection rate of 34.9 per cent. In terms of numbers—we had a total of 13.26 million acceptors of different family planning methods during April to December, 1986. This was higher by a little over 1.67 million over the same period last year. However, we have to strive harder as we have to reach a couple protection rate of 60% by 2000 AD if we want to achieve our target of Net Reproduction Rate of Unity-1 by then, as laid down in our Health Policy. We envisage to achieve the goal of reducing the present birth rate of about 33 to 21 per thousand and death rate to 9 from around 12 per thousand today. (Excerpted from the Introduction to the Annual Report of the Ministry of Health and Family Welfare 1986-87.)

HEALTH FOR ALL BY THE YEAR 2000 RETROSPECT AND PROSPECT

DR (SMT.) V. K. BHASIN

With the motivation, intensive involvement of political leaders, planners, administrators, health workers and the community and by effectively coordinating and implementing the existing programmes to achieve the desired integration at the field level tangible results will be achieved towards the goal—Health for all by the year 2000.

ON May 1977, the Thirtieth World Health Assembly decided that the main social target of Governments and the WHO should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them lead a socially and economically productive life.

In 1979, the Thirty-second World Health Assembly launched the global strategy for Health For All by the year 2000 by adopting a resolution W.H.A. 32.30. In this resolution the World Health Assembly endorsed the Report and the Declaration of the International Conference on "Primary Health Care" held at Alma-Ata, U.S.S.R. in 1978 and invited the Member-States of the WHO to act individually in formulating national policies, strategies and plans of action for attaining this goal.

The strategy that followed described the broad plans of action to be undertaken at policy and operational levels nationally and internationally in the health sector and other social and economic sectors. The main thrusts of the strategy would be development of the health system starting with primary health care for the delivery of the country-

wide programmes that should reach the whole population. These programmes include measures for health promotion, disease prevention, diagnosis, therapy and rehabilitation. The strategy also involves specific measures to be taken up by the primary and supporting levels and by other sectors. It also involves selecting technology that is appropriate, scientifically sound, adaptable to various local circumstances, acceptable to those for whom it is used and maintainable with resources the country can afford. Crucial to the strategy is social control of health infrastructure and technology through a high degree of community involvement. Besides this, there is need to spelling of international action to be taken to support the above strategy through information exchange and management, promoting research and development.

India is committed to the goal of providing "Health For All" by the year 2000. At this point of time, a view in retrospect understanding the prospects of achieving the goal we look at the past, *i.e.*, retrospect.

Retrospect

The history of India shows that she had realised this concept of Health

For All from the ancient times—Let all people be without disease. (SARVAI SANTU NIRAA-MAYA). Recognizing the need for regulated life for happiness, Emperor Ashoka during the third century B.C. had widely popularised various prescriptions for healthful living. The rules written in different Indian scriptures were regarded as an integral part of "Dharma".

Health systems that were truly Indian in origin were Ayurveda and the Sidha. Hygiene was given an important place in ancient Indian medicine. The laws of Manu were code of personal hygiene. The period between 500 and 1500 A.D. (Medieval period) saw reversion back to primitive medicine dominated by superstition called the "Dark Ages of Medicine". The period following 1500 A.D., *i.e.*, modern period was marked by the revival of medicine to it. With the commencement of the period of discoveries, development of public health made rapid strides. The science of preventive medicine marked the beginning of a new era. The concept of "health centre" as an establishment combining medical care and preventive services was established in the first half of this century. Seven model health units

were set up with assistance from the Rockefeller Foundation in Delhi, Madras, Bangalore, Lucknow, Trivandrum, Pune and Calcutta between 1931 and 1939. The Bhore Committee in 1946 recommended the establishment of health centres for providing integrated curative and preventive services. Subsequently, the Planning Commission of the Government of India endorsed the Bhore Committee recommendations for establishment of primary health centres right from the 1st Five Year Plan (1951-56), to the 7th Five Year Plan, (1985-1990). This trend will continue in subsequent Five Year Plans beyond the 7th Five Year Plan, too.

Health Status

- In India, people were trapped in the vicious circle of poverty, mal-

nutrition, disease and despair that reduced their work-capacity and limited their ability to plan for the future. They mostly lived in rural areas and urban slums.

- Undernutrition affected and still afflicts millions of people, undermining their performance in school and at work and reducing their resistance to disease. People had food intake much below the critical nominal level, i.e., below 1400 calories. Though this situation is gradually improving it is still far from satisfactory.

- Morbidity and mortality indicators were quite high even though some of the diseases could have been prevented by timely immunization.

- Diarrhoeal diseases, transmitted by human faecal contamination of soil, food and water were rampant.

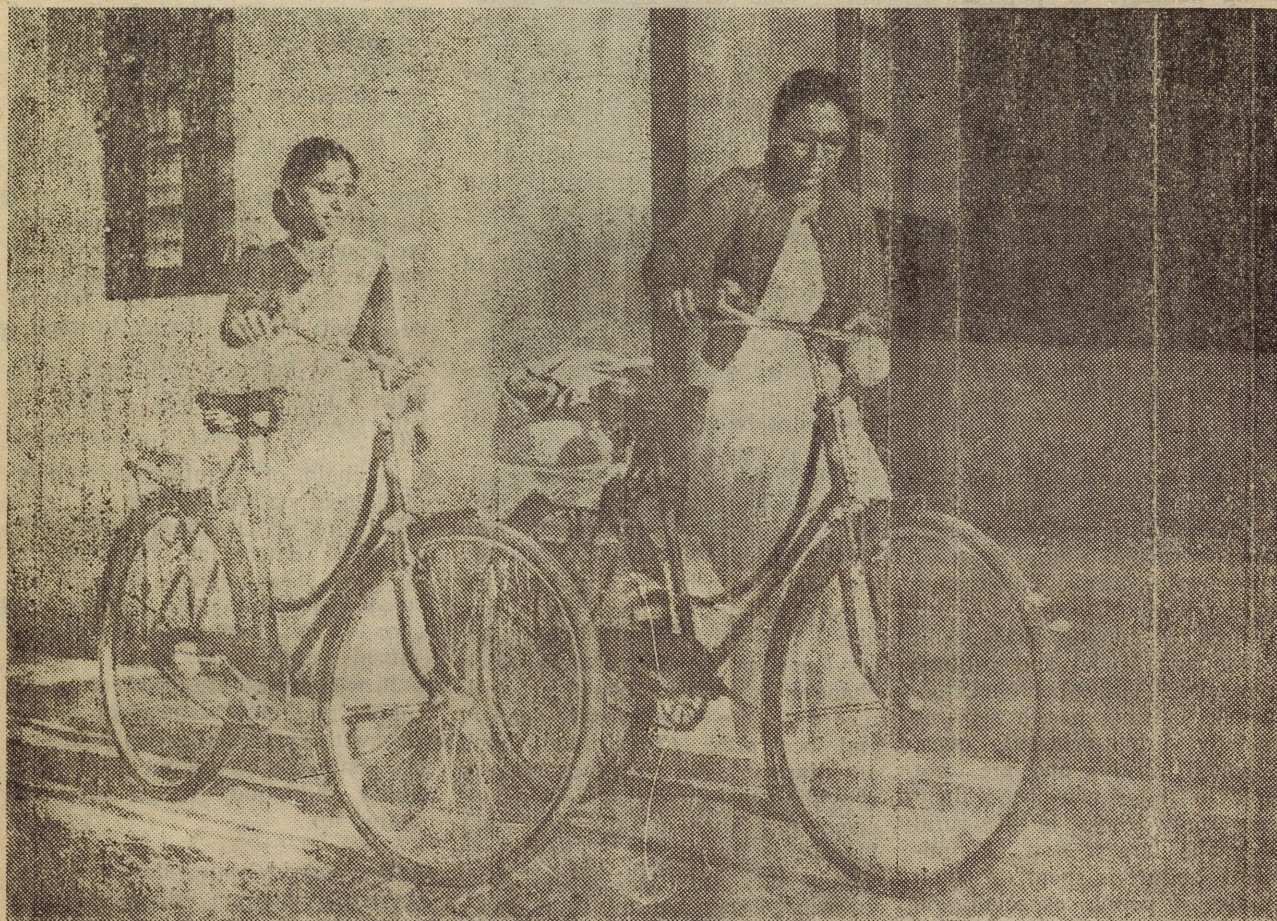
- Diseases transmitted by insects and other vectors were widespread.

- Malaria, filaria and other vector-borne diseases remained the most prevalent diseases.

- Environmental health problems due to industrialisation and urbanisation have assumed great importance. Accidents, cardiovascular and mental diseases, alcohol, drug abuse, smoking and cancer have started becoming common diseases for the last three decades.

- High illiteracy rate was also a strong barrier for healthy living as literate people could have understood their health problems and ways of solving them.

- Health delivery system was concentrated in large cities. Highly sophisticated technology served only a small minority of people.



Training programmes for health functionaries have been modified to give them a special orientation and technical skills to meet the health needs of the population they are to serve.

- Deficient planning and management including cooperation with other social and economic sectors, multiple health care delivery system resulting in duplication of health care services in some areas and deprivation of health care services in others, inadequate training in health management and insufficient use of good managerial practices all lead to inefficient use of resources.

- Health personnel were not appropriately trained for the tasks they were expected to perform. They were not provided with the equipment and supplies they required.

- Community was the passive recipient of health care delivery system.

- Realising the adverse effects of increasing numbers of population, the National Family Planning Programme was started during the 1st Five Year Plan. Despite increasing budget allocations from the first Five Year Plan to the Seventh Five Year Plan and adopting various approaches, *i.e.*, clinical extension, integration with package of services including maternal and child health, immunization, nutrition and health education and changing the nomenclature to family welfare, the infant mortality rate, perinatal mortality rate, maternal mortality rate and crude birth rate still remain fairly high.

Health services after Alma Ata Declaration—1978 to new challenges, *i.e.*, health problems are being recognised as components of socio-economic systems. This means raising the level of people's health is possible by making changes in their economic, social and cultural environments. The other challenge is that the existing health services are mostly urban-oriented, over-sophisticated, costly and are not available to those who need them most especially those in the rural areas. The largest part of limited health budget is spent on small percentage of people especially on those living in urban areas. This is termed as "Social injustice". To overcome this imbalance, equity of services is given the greatest importance.

It was observed that socio-economic problems were intimately inter-linked with health problems.

Prospect

India has set two major goals to achieve. These are—

- (1) To attain health for all by the year 2000 through primary health care approaches and

- (2) To attain a net reproduction rate of one by the turn of the century.

Health Services

The main objective would be to provide better health services to rural areas and urban slums. Keeping in view the birth rate, the population projection indicates that the country's population would increase to about 917 million by 2000 A.D. And as a signatory to the Alma-Ata Declaration, the Government of India is taking steps to provide Health For All by the year 2000 through the National Health Policy, which aims at solving "Social injustice" by providing primary health care supported with referral services and community participation. Communities are encouraged to take the initiative in identifying their own health problems and in seeking solutions for them. It has been found that a wide range of illnesses can be prevented/cured at the community level, not by a professional expert but by a person from the village Health Guide who is selected by village panchayat/pradhans from the local village community. The Health Guides are given training for three months. They provide mostly promotive, preventive services and sometimes rehabilitative services also. Another area in which changes are taking place is with regard to the traditional leaders and local *dais*. (Traditional birth attendants). The role they play in providing the services are being recognised. They are the important "Health Resource". They can play a very important role if their knowledge can be improved.

- It has been agreed to have a health sub-centre with one male and one female multipurpose health worker for every 5000 population.

At present, the functions of a sub-centre are limited and it is not able to meet even some basic needs. It is proposed that the facilities in future would be provided at all the sub-centres for IUD insertion and simple laboratory investigations like urine examination.

- There will be one primary health centre for 30,000 population (20,000 in hilly terrain).

- Every primary health centre area has 2 or 3 or even more dispensaries of the allopathic/ayurvedic/homoeopathic systems. All the dispensaries functioning in rural areas would be involved in the delivery of primary health care (PHC) by upgrading them into subsidiary health centre and alternatively into primary health centres. This centre would be equipped to provide basic laboratory services, facilities for basic surgical procedures like vasectomy, tubectomy, medical termination of pregnancy and facilities for the treatment of ailments of infancy and childhood.

- The existing primary health centres or a sub-district hospital will be upgraded into rural hospitals with 30 beds and specialities in surgery, medicine, obstetrics and gynaecology and paediatrics with X-ray and laboratory facilities. The next referral point will be the district hospital.

Medical colleges and apex institutes will be the referral centres for superspecialities.

- A chain of sanitary-cum-epidemiological stations will be set up to take care of environmental health problems, detect and control epidemics and communicable diseases and check up the quality of food and water.

- Provision of safe drinking water supply and improvement of sanitation with rural and urban with special emphasis on proper disposal of liquid and solid waste are being geared up.

- Due to widely prevalent malnutrition, the nutrition education programme and special nutrition programme with concerted efforts are being put in with regard to food production, distribution and consumption.

● Promote family planning on a voluntary basis as a people's movement.

● Special efforts are being made to gear up Maternal and Child Health Care Programme and Family Welfare Programme to bring down perinatal, infant, child and maternal mortality and crude birth rate by providing 100 per cent health coverage to this vulnerable segment of the population.

(a) Maternal Care: To provide antenatal care, prophylaxis against nutritional anaemia and tetanus and make available trained personnel for antenatal, natal and post-natal care.

(b) Infant and child care programme consists of health education of mothers, prophylaxis against diphtheria, whooping cough, tetanus, polio, tuberculosis and measles, extensive use of oral rehydration therapy in case of diarrhoeal diseases and special programmes to take care of nutritional deficiency diseases.

● A comprehensive school health programme will be launched as onward programme of integrated child development scheme.

● The primary health care programme would be fully coordinated with other socio-economic programmes like integrated child development scheme (ICDS) and national adult education programme, which have been launched by different Ministries/Departments of the Government.

● The main emphasis would be on promotive, preventive and rehabilitative aspects of all those institutions which at present are providing only curative services.

● Medical education would be restructured to give community health care bias.

● Training programmes for health functionaries have been modified to give them a special orientation and technical skills to meet the health needs of the population they are to serve.



Special efforts are being made to gear up maternal and child health care programmes and family welfare programme to bring down perinatal, infant, child and maternal mortality. Photo shows health check-up of a pregnant woman.

● The National Programmes on Family Welfare, Malaria Eradication, Tuberculosis Control, Leprosy Eradication, Goitre control, Diarrhoeal Diseases Control, Blindness control are being geared up.

● Mental Health Services would be adequately provided.

● Provision of medical and social rehabilitation to those in need is an essential component.

● All out efforts would be made to make all essential drugs available and at a cost the community can afford.

● Efforts to set up a dynamic health management information system to support the health planning, decision-making and programme implementing machinery is being geared up.

● Legislative support is provided wherever needed.

Managerial Support

Managerial support to primary health care programme at present is provided by the Central Institutes, particularly by the National Institute of Health and Family Welfare, New Delhi, the All India Institute of Hygiene and Public Health, Calcutta, Central Health Education Bureau, New Delhi, Rural Health and Family Welfare Training Centre, Gandhigram and Health Family Welfare Training Centres. In addition, support is also available to the health sector from the national institutes in the manpower development and training.

Health Budgetary Provision

Financial and material resources are being enhanced by higher budgetary provision for health sector in subsequent Five Year Plans. Preferential allocation of funds for rural and urban slums involving the community, coordinating with voluntary agencies, utilising the trained manpower and facilities available under the various Indian Systems of medicine for the delivery of primary health care utilising assistance available from foreign services and international agencies are some of the means of generating resources.

Monitoring and Evaluation

—Steps are being taken to improve the monitoring and evaluation so that set targets are attained within the stipulated time.

—To gear health information measurement system by improving maintenance of records and reports, standardisation of reporting procedures, storage retrieval and data handling.

—Provision of inservice training to health statistical personnel.

—Health Service Research, sample surveys, special studies and evaluation studies of different programmes are being geared up.

All these well planned efforts with proper implementation monitoring and evaluation will change the health status of the country to achieve the set goal as mentioned below.

| | Retrospect up to 1979 | Prospect by 2000 |
|---|--------------------------|---------------------|
| (1) Health Status Indicators | | |
| (a) Infant mortality rate | 125 | Below 60 |
| (b) Crude death rate | 14.1 | 9 |
| (c) Pre-school (1-5 years) child mortality rate | 30-40 | 10 |
| (d) Life expectancy at birth : male | 52.6 | 64 |
| female | 51.6 | 64 |
| (e) Birth weight below 2500 g | 30% | 10% |
| (f) Crude birth rate | 33.2 | 21 |
| (g) Net reproduction rate (NRR) | 1.51 | 1 |
| (2) Provision of Health Services | | |
| (a) % of couples protected by modern methods of contraception | 22.8 | 60 |
| (b) % of pregnant women receiving antenatal care | 40-50 | 100 |
| (c) % of deliveries by trained staff | 25 | 100 |
| (d) Immunization | | |
| —% of coverage of pregnant women by T.T. | 20 | 100 |
| —% of school children covered by T.T. | — | 85-100 |
| —% of infants covered by D.P.T. | 25 | 85-100 |
| —% of infants covered by Polio | 5 | 85-100 |
| —% of new entrants to schools covered by D.T. | 20 | 85-100 |
| (e) Nutrition Supplement | | |
| —% of coverage by Vit. A prophylaxis (0-5 years) | 25 | maintenance at 100% |
| —% of expectant mothers covered by iron folic acid supplement. | 25-30 | maintenance at 100% |
| —% of children up to 12 yrs. covered by iron folic acid supplement. | 10 | maintenance |
| (f) Malaria A.P.I. | 4.6 | Below 0.5 |

Lastly with the motivation, intense involvement of political leaders, planners administrators, health workers and community by effectively coordinating and implementing

the existing programmes to achieve the desired integration at the field level, tangible results will be achieved by the year 2000.

EVALUATION

STRATEGY ADOPTED BY INDIA TO ACHIEVE HEALTH FOR ALL

COL. K. K. VADHERA (RETD)

THE International Conference on Primary Health Care in Alma-Ata, USSR (1978), a historic event, was a dawn of a new era as it declared that the health status of hundreds of millions of people in the world was unacceptable and called for a new approach to achieve a more equitable distribution of health resources and to attain a level of health for all the citizens of the world that would permit them to lead a socially and economically productive life.

It is a holistic concept calling for efforts in agriculture, industry, education, housing, communication just as much as in medicine and public health. Active involvement of the people was also stressed as it raises their self esteem, mobilises their social energies and helps them to shape their own social and economic destiny.

In 1979, a global strategy for Health for All by 2000 AD was launched.

It was the most novel and exciting idea when the target for health was laid. India undertook this commitment by signing the Alma-Ata declaration and in the context of achieving the objective, set the following important goals to be reached by 2000 A.D.

- (1) Reduction of Infant mortality from the present level of 125 (1978) to below 60.
- (2) To raise the expectation of life at birth from the present level of 52 years to 64 years.
- (3) To reduce the crude death rate from the present level of 14 to 9 per 1000 population.
- (4) To reduce the crude birth rate from the present level of 33 to 21 per 1000 population by 2000 AD.

(5) To reduce the maternal mortality rate from 3-4 to below 2 per 1000 live births.

(6) To provide potable water to the entire rural population by 1990.

Health Situation in India

At the time of Independence, some of the important indicators of the health status of our people were almost at a shocking level. The average expectancy of life at birth was 32 years, infant mortality rate was 157 per 1000 live births. Malaria accounted for 75 million cases and 7.5 lakh deaths per year.

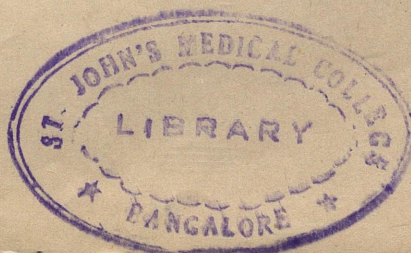
There is no denying the fact, that during the last 40 years, a lot of development has taken place. Infant mortality rate for the first time, has declined to a two-digit level and at present stands at 85 whereas it is below 50 in Sri Lanka and Thailand.

There has been a colossal increase in the number of health institutions and both medical and para-medical manpower.

Despite all this, the health status of our people, particularly in far-flung villages, in the tribal and hilly areas continues to be at a low level. There are still pockets in the country where infant mortality rate is about 150 per 1000 live-births.

The maternal mortality rate in certain pockets is at a level of 6-7 per 1000 live-births.

According to one study, 77% of children in the rural and 73% in tribal area are malnourished. About 30,000 children become blind due to Vit. A deficiency



each year, Iodine deficiency diseases like goitre, cretinism, mental and physical subnormality threaten the well-being of 27 million children.

The major causes of morbidity and mortality are directly or indirectly associated with infectious and parasitic infestations diarrhoeal diseases, respiratory diseases, tuberculosis, leprosy, vaccine, preventable diseases of childhood are our major health problems.

A comparative statement of the present status and our goals, by 2000 AD is given in the Table below:

TABLE

A COMPARATIVE STATEMENT OF PRESENT HEALTH STATUS AND TARGETS BY 2000 AD

| Indicator | Present Status | Target by 2000 AD |
|--|----------------|-------------------|
| 1. Crude death rate | 11.9 | 9.0 |
| 2. Crude birth rate | 33.8 | 21.0 |
| 3. Perinatal mortality | 53.2 | 30.35 |
| 4. Infant mortality | 104.8 | Below 60 |
| 5. Maternal mortality | 3.4 | Below 2 |
| 6. Life expectancy both for male and female | 54.4 | 64 |
| 7. Babies with birth weight below 2500 gm | 30% | 10% |
| 8. Pregnant mothers receiving antenatal care | 50.6% | 100% |
| 9. Deliveries by trained birth attendants | 50% | 100% |

From the above, it is clear that though there has been an improvement in health manpower, the services do not seem to reach where the need is the greatest, i.e., malnourished children, eligible couples, pregnant and lactating mothers. The health services have failed to trickle down from various institutions to the community.

Outlook for the future

It is evident that positive start has been made by our country in its quest for health for all. The health sector will, however, face unprecedented strain from a rapidly growing population, diseases associated with under development and poor environmental conditions. Rapidly increasing urban population has already started presenting a lot of social and economic problems and will require an important place in the health spectrum.

Very little time is left to achieve the targets. In order to ensure that 'Health For all' becomes a reality, and not an empty slogan and an unrealistic ideal based on romantic ethics, it is important that all-out efforts are made.

The following factors need our urgent attention:

(1) We need more coordination in achieving an inter-sectoral health action.

(2) We are weak in areas of training and education. Many countries in the world report lack of skilled managerial staff. Suitable institutions in the country have to be identified, strengthened and stimulated to innovate critical managerial areas, including policy and decision-making, planning and evaluation. There is a growing recognition that technical capabilities of health workers must be strengthened if their full potential is to be mobilised.

* We are lacking an ideal information management system. Health programmes do not yield the type of results they are intended for and this area requires strengthening.

* We work without active participation of the people.

* Despite of significant increase in food production, hunger is still a stark reality and malnutrition is aggravated by inequitable distribution of food.

* Industrialisation and urbanisation are taking place more rapidly than the preventive measures being planned to counter its adverse health consequences.

* Our life-style is changing and we are becoming prone to cardio-vascular and other stress diseases.

* Growing population is masking our developmental activities.

* Due to unemployment and change in social values, our young people are becoming drug addicts.

* May be we are spending less on health. ○

NATIONAL HEALTH & FAMILY WELFARE PROGRAMMES

Achievements during 1986-87

In a mixed economy such as ours, any programme of investments embodying the pattern of allocation laid down in the Plan, calls for effective implementation so as to achieve objectives for which the outlay is provided. The revised 20-Point Programme containing the basic action plans before the country in the socio-economic fields accords a crucial role for health and family welfare. Health is at once a means as well as an end in the process of development. For speedy and effective execution of approved Plan programme, the 7th Plan envisages that while the efforts are made to complete integration of the organisational set up under health, family welfare and MCH programmes, financial integration has also to be taken up towards the objective of funding of the services as a package programme. The 7th Plan outlay for health sector is Rs. 3,392.89 crore out of which Rs. 2,495.55 crore is for State and Union Territories, Rs. 557.75 crore for Centrally-sponsored programmes and Rs. 339.59 crore for the Central schemes.

During the year 1986-87 Rs. 200,00.00 lakh for the Centrally sponsored and purely Central schemes and Rs. 494,24.00 lakh for States and Union Territories for the Plan programmes and Rs. 244,55.73 lakh for the Non-Plan programmes have been allocated. As such a total outlay of Rs. 444,60.13 lakh has been provided.

Communicable diseases account for more than two-third of the total morbidity and mortality in the country. For the control and eradication of Communicable diseases, the programme implementation at all levels is being strengthened. The Primary Health Care system is being utilised for delivering comprehensive front line care and for better diseases surveillance and control.

National Malaria Eradication Programme

During 1986, as per reports upto 31 October, 1986 there is decline of 8.98% in total cases and increase of 6.94% in P.f. infection as compared to the corresponding period of 1985. However, the situation is not uniform everywhere. In some States total malaria cases and P.f. cases have shown increase during 1986.

Surveillance Operations: An analysis of the malaria situation during 1981 to 1985 shows that number of blood smear examination varies between 67.84 million and 68.13 million annually. There was an increase in blood smear examination in the year 1985.

In-depth evaluation of the Programme and action taken thereon: Realising the need for reviewing the Modified Plan of Operations under National Malaria Eradication Programme, the Government of India, Ministry of Health and Family Welfare appointed a

Committee comprising national and international experts. The Committee had submitted its report in October, 1985 with recommendations.

Taking into consideration, the recommendations of the Committee, the Government of India, Ministry of Health and Family Welfare have—

- (i) constituted a Committee to undertake the malariogenic stratification of problem areas in the country. The findings are awaited.
- (ii) constituted an expert Committee to draw up a plan of action for active community participation and health education to check the growing public indifference towards malaria control programme.
- (iii) approached the various Ministries/Departments concerned for creating in-built infrastructure in developing coal-mines, steel, oil projects, irrigation projects, water supply projects, urban housing projects etc. for undertaking anti-malaria measures.
- (iv) reviewed the position for augmentation of facilities for training in malariology and allied fields within available time schedule and resources.
- (v) Planning and epidemiological assessment divisions are already functioning at Dte. N.M.E.P. Operational field research schemes are functioning at present. For augmentation of research activities, a Committee of national and international experts has been constituted to suggest new schemes/areas for operational field research. The Report has been received and appropriate action is being initiated.

National filaria control programme

Present estimates indicated that about 342 million population is living in known endemic area of which about 82 million are in urban areas and the rest in rural areas.

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

| | |
|---------------------------|-----|
| Control Units | 198 |
| Survey Units | 27 |
| Clinics | 158 |
| Rural Filaria | |
| Control Project | 2 |

Progress: At present about 33 million Urban Population is being protected through antilarval measures by 198 control units. Another 5 million rural population is being protected by 2 Rural Filaria Control Projects through detection and treatment of Filaria

cases. Use of common salt medicated with Diethyl-carbamazine citrate powder for the control of filariasis was implemented with success in Lakshadweep during 1976-78. The method has been carried out in Karaikal district of Union Territory of Pondicherry from April, 1982 to December, 1985. 98 per cent reduction has been observed in microfilaria rate and infection and infectivity rate has been brought down to Zero. During 1986-87 one control unit, one survey unit and eight clinics have been established so far.

Achievement: 300 districts are situated in endemic areas. Of which 238 districts have been surveyed for delimitation of filaria problem and 173 have been detected to be endemic for filariasis. 27 Survey Units are carrying out delimitation survey in equal number of districts. 94 per cent of the towns where control measures are in operation for more than five years have shown marked reduction in microfilaria rate.

Kala-azar

Directorate of N.M.E.P. is monitoring the kala-azar situation in India. The kala-azar unit of Dte. N.M.E.P., is regularly collecting kala-azar incidence reports and is keeping a close vigil over the situation. The kala-azar incidence in India for the last three years is given below:

| Year | Cases | Deaths |
|--|-------|--------|
| 1983 | 14406 | 135 |
| 1984 | 16459 | 65 |
| 1985 (Prov.) | 15265 | 33 |
| 1986 (As per reports received upto 27-10-86) | 4800 | 16 |

Kala-azar is endemic in the States of Bihar and West Bengal and they have been requested to spray DDT in the affected areas for effective control. At present, there is no separate budget for kala-azar control. However, insecticide for kala-azar control is supplied from N.M.E.P. budget. A "Group of Experts" on kala-azar constituted by the Govt of India to explore the possibilities of integration of kala-azar control activities with N.M.E.P. has submitted its report which is under consideration.

National leprosy eradiation programme

Over 400 million population is covered with an infrastructure created under National Leprosy Eradication Programme (N.L.E.P.). The important existing physical set up is Leprosy Control Units-449. Urban Leprosy Centres-715, Survey Education Treatment Centres-7028, Temporary Hospitalisation Wards-266, District Leprosy Offices-197, Leprosy Training Centres-45. A total of 23.6 lakh leprosy cases have been discharged after treatment.

A total of 1.87 lakh new cases were detected till September, 1986, against the annual target of 4.20 lakhs, 1.74 lakh new cases detected were put on treatment, and 1.59 lakh cases were discharged against the annual target of 4.30 lakh. Effective and short term Multi-drug treatment of leprosy cases introduced under the programme in selected districts has replaced the

less effective, prolonged dapsone monotherapy. The Multi-drug Treatment Project is proposed to be extended to 32 more districts during 1986-87 under NLEP own funds. D.A.N.I.D.A. will be supporting for introduction of M.D.T. in 4 districts by 1986-87. Thus a total of 47 districts with a population of about 70 million are expected to be under multi-drug treatment by the end of 1986-87. About 7.0 lakh cases are estimated to be in these districts.

A total outlay of Rs. 14.0 crores has been provided to the programme during 1986-87. It has been proposed to increase this amount upto 15.63 crores at RE stage to meet the enhanced cost of physical components and also to extend multi-drug treatment in highly endemic districts. Continuity of treatment of leprosy patients has been maintained by way of adequate supply of anti-leprosy drugs to the State Government.

The programme has been subjected to Independent Evaluation jointly by the Government of India and World Health Organization in February, 1986. At the aggregate level the performance of the programme was considered to be very satisfactory. Weaknesses/shortfalls in some States were identified and suggestions to remedy them were made.

National T.B. control programme

At present there are about 431 districts in the country and of these, up to the end of September, 1986, 366 districts have been provided with District T.B. Centres equipped with essential equipments and manned by trained staff. These Centres are undertaking T.B. Programme in association with general health and medical institutions. In addition, there are about 300 T.B. 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 45,800 beds are available in the country for treatment of seriously sick 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 new strategy short course chemotherapy drug regimens containing Rifampicin and Pyrazinamide were introduced on pilot study basis in 18 selected districts of the country which will reduce the duration of treatment from 18 months to 6-8 months. The result of detailed study is awaited. It has now been proposed to introduce drug regimens of 6-8 months' duration in 26 districts of the States of Tamil Nadu, Gujarat and Maharashtra in phased manner during the current financial year.

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.

There was a significant improvement during 1984-85, and about 17.31 lakh sputum examinations were conducted by the Primary Health Centres. During 1985-86 about 19.77 lakh sputum examinations were conducted.

Targets for 1986-87: The target for detection of new TB Cases in 1986-87 has been raised to 14.50 lakhs, and Primary Health Centres continued to be involved in case finding activity. Upto the end of 1st Quarter of 1986-87, nearly 3.38 lakh new TB. Cases have been reported to be detected by the States/U.Ts. with 93.23% and nearly 4.22 lakh sputum examinations were reported to be conducted at the Primary Health Centres.

Future Plan of Action: With a view to meeting the increased requirement of Freeze Dried BCG Vaccine under the E.P.I., the Government has sanctioned one crore of rupees under the VII Five Year Plan for the expansion of the BCG Vaccine Laboratory.

National programme for control of blindness

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.

Plan of Action: 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 Government 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.

Infrastructure: The following infrastructure has been developed upto now.

| | Target | Achievement |
|--|--------|-------------|
| Strengthening of PHCs | 2000 | 2000 |
| Central Mobile Units | 80 | 80 |
| Strengthening of Distt. Hospitals | 400 | 404 |
| Upgradation of Department of Ophthalmology in Medical Colleges | 60 | 60 |
| Establishment of Regional Institutes | 10 | 9 |
| Ophthalmic Asstt. Training Centre | 37 | 37 |
| Setting up of Distt. Mobile Units | 30 | 30 |
| Setting up of State Ophthalmic Cells | 18 | 18 |

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 the country as a whole has been reported as under:

| | Target (in lakhs) | Achievement |
|-------------------|-------------------|-------------|
| 1982-83 | 13.03 | 9.04 |
| 1983-84 | 12.54 | 10.69 |
| 1984-85 | 12.78 | 11.34 |
| 1985-86 | 13.84 | 12.09 |

National diarrhoeal diseases control programme

National Diarrhoeal Diseases Control Programme

during Sixth Plan was started mainly to bring down diarrhoea related mortality through promotion of Oral Rehydration Therapy.

An intensified programme has been launched during the Seventh Plan to reduce diarrhoea mortality by 50% by the year 1990. This is proposed to be achieved through short and long term objectives.

Plan of action: The plan of action will be as under:

(a) Oral Rehydration Salt: The oral rehydration therapy is envisaged in 3 stages. The first stage is managing diarrhoeal situation with home made/home available liquids.

In the second stage, oral rehydration salt is to be encouraged.

In the third stage, the primary health centres and hospitals will be treating the severe cases of diarrhoea having dehydration and which fail to respond to home available/ORS solution with I.V. therapy.

(b) Training Programme: It is proposed to include diarrhoeal management with ORS in the course curricula of multi-purpose workers, village health guides, medical and nursing students and paediatricians. It is also necessary to cover the medical and para-medical personnel involved in the primary health care at the district hospital/PHCs/Sub-centres and village level. Private practitioners are also to be involved by arranging suitable training programme through I.M.A. The M.C.I., Nursing Council are also to be approached for including the same in the curricula for the various professional and training courses. Ministry of Education and N.C.E.R.T. will be approached for training the teachers, introducing them to the ORT and the need for control of Diarrhoeal Diseases in the country.

(c) Health Education: The community education in the prevention and control of diarrhoea through the use of home available/home made ORS is absolutely essential. It is proposed to organise mass educational programme through advertisement, radio programme, T.V., Cinema slides etc. It will also be necessary to approach all voluntary organizations particularly women to support the effort for popularising ORS.

(d) Research: Despite efforts we are still unaware of the organisms which causes diarrhoea and remains undetected. It is, therefore, proposed to encourage different research activities in relation to the isolation and diagnosis of ethological agents, epidemiological features, preventive and control measures and drug response. Operational research and clinical considerations need to be specially promoted and thereby should be accorded due priority.

National goitre control programme

Nearly 145 million people are estimated to be living in the known goitre endemic regions of the country which exist in the entire sub-Himalayan region and in almost all the States viz. entire State of Jammu & Kashmir, Himachal Pradesh, Arunachal Pradesh, Assam, Manipur, Nagaland, Meghalaya, Sikkim,

Tripura, Mizoram U.T. of Chandigarh and Delhi, 20 districts of Uttar Pradesh, 5 districts of West Bengal, 13 districts of Bihar, 13 districts each of Gujarat and Punjab, 6 districts of Maharashtra, 12 districts of Madhya Pradesh and 1 district each of Haryana, Andhra Pradesh and Kerala. Nearly 40 million persons are estimated to be suffering from goitre in these regions.

To augment the existing production of iodised salt, the Government of India have liberalised its production under the Private Sector. Licences have been issued by Salt Department to 400 manufacturers for production of iodised salt and nearly 109 of them have started production as on September, 1986.

The Government of India have approved the scheme to iodise all the edible salts in the country by the year 1992 in the following phased manner:

| Year | Production of iodised salt in lakh MT |
|---------|---------------------------------------|
| 1986-87 | 15.00 |
| 1987-88 | 16.00 |
| 1988-89 | 22.00 |
| 1989-90 | 30.00 |

An outlay of Rs. 20.00 Crores has been approved for the National Goitre Control Programme during the 7th Five Year Plan. During 1986-87 an outlay of Rs. 350 lakhs has been approved.

During the current financial year, 19 States and 3 UTs have been identified for implementation of the scheme.

The State Governments have been addressed by the Ministry of Health and Family Welfare to set up goitre control cells and also for taking up necessary Health Education measures. Necessary funds have also been earmarked for the purpose to be released as grant in aid. The scheme is a purely central scheme.

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

1. Production of iodised salt vis-a-vis targets.
2. Quantity of iodised salt despatched to the goitre endemic States against the allocated quota.

Production and Distribution of iodised salt: A quantity of 3.63 lakh MT of iodized salt was supplied to the goitre endemic areas from April to September, 1986.

Establishment of State level goitre control units: The States of Gujarat, Sikkim and Maharashtra have established a state level goitre control cell. The States of Uttar Pradesh, Mizoram, Arunachal Pradesh, Nagaland Haryana and UTs of Chandigarh and Delhi are expected to set up the same by the end of current financial year. The other endemic states are being requested to expedite similar action.

Expansion of the National Goitre Control Programme: 11 additional districts each of Uttar Pradesh and Bihar, 9 districts of Madhya Pradesh, Mizoram, entire State of Punjab, one district of Andhra Pradesh have also been brought under the purview, of National Goitre Control Programme for supplies of iodised salt. The States of Assam, Tripura, Meghalaya and entire State of West Bengal and UT of Delhi are expected to do so by the end of the current financial year.

Sexually transmitted diseases control programme

Sexually Transmitted Diseases Control Programme which was instituted as a Centrally aided scheme in 1956 with the objective of reducing morbidity and mortality associated with S.T.D., initially emphasised opening up of S.T.D. clinics throughout the country during the successive Plan periods. During the Sixth Plan as a purely Central sector scheme the Programme envisaged establishment of (i) Five Regional Teaching-cum-Training Centres; (ii) Five Regional S.T.D. Reference Laboratories and (iii) five Regional Survey-cum-Mobile S.T.D. Units to cater on a zonal basis.

Group Educational Activities in S.T.D. for Medical Officers were held during 1985 at Mysore in Karnataka and at Trivandrum in Kerala State. A Group Educational Activity for the Laboratory Technicians was conducted at Cuttack in Orissa State. During 1986, workshops on YAWS were conducted at Puri in Orissa and at Raipur in Madhya Pradesh.

During the 7th Plan, the scheme functions as a purely Central scheme with an approved outlay of Rs. 100 lakhs. The present Plan envisages to continue the ongoing/unaccomplished components of the 6th Plan. A sum of Rs. 20.00 lakhs have been provided for the financial year 1986-87 for the S.T.D. Control Programme. An amount of Rs. 6.89 lakhs has been incurred so far towards the programme and the balance is expected to be exhausted by the close of the current financial year.

Achievements: The details of achievements under S.T.D. Control Programme are as under:

| Item | 1985-86 | 1986-87 |
|---|---------|---------|
| 1. Training of Medical Officers | 25 | 75 |
| 2. Training of Para-Medical Personnel | 52 | 150 |
| 3. Inter-Laboratory Evaluation of V.D.R.L. Test (No. of distt. Hospitals) | — | 63 |

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 have tentatively allocated a sum of Rs. 1.00 crore for implementing the programme during the 7th Five Year Plan period. A Committee under the Chairmanship of Dr. G. N. Narayana Reddy, Director, National Institute of Mental Health and Neuro Sciences, Bangalore has been constituted to work the details for taking up an appropriate programme.

National Family Welfare Programme

Seventh Five Year Plan 1985-90

The approach to Sixth Five Year Plan is being adopted in the Seventh Five Year Plan for attaining the long-term goal for reaching 120 million couples in the reproductive age group. For effective implementation of the programme a larger allocation of Rs. 3,256 crores has been earmarked for the purpose.

Responding to increased demand for Laparoscopic sterilisations, availability of laparoscopes, facilities for training of personnel in this technique have been stepped up. In addition to existing 8 central laparoscopic training centres, 4 new centres have been established in 1986-87—one each in the State of Orissa, Bihar, M.P. and U.P. A scheme has also been sanctioned for training of members of IMA in Laparoscopic sterilisation, followed by a subsidy to the ceiling of Rs. 20,000, subject to the condition that 500 sterilisations will be done in 3 years after the availability of the laparoscope. Another scheme has been sanctioned for free supply of laparoscopes to the hospitals, maintained by the Trade Unions, Co-operative Societies, and voluntary organisations etc. This scheme will be implemented through the State Governments. Imaginative and innovative measures have been adopted in order to make conventional contraceptives and oral pills freely and widely available through an effective distribution system and a social marketing mechanism. To achieve the long-term demographic goals, educating and enlightening the people on the benefits of late marriage and its social enforcement are being greatly emphasised.

For achievement of 'two-child family norm' it is essential that child survival rate in our country is enhanced. As more than half of infant mortality takes place in the neonatal period, the Mother and Child Health Programmes have been considerably strengthened recognising the potential of immunization as a low cost effective technique for child survival, an intensified programme of immunisation against vaccine preventable infectious disease namely diphtheria, pertussis, tetanus, poliomyelitis, tuberculosis and measles, to all eligible infants and pregnant women by 1990. This programme provides for additional supply of vaccines, reinforcement of cold chain equipment and provision of staff at Central, State and district levels.

Programme Implementation

In keeping with the democratic traditions of the country, the F.W. Programme seeks to promote on a voluntary basis, responsible and planned parenthood with 'two-child norm', male, female or both, through independent choice of family planning method best suited to the acceptors. Family Planning services are offered through the total health care delivery system.

People's participation is sought through all institutions, voluntary agencies, opinion leaders, people's representatives, Government functionaries and various other structures and influential groups. Imaginative use of the mass media and inter-personal communication is resorted to for explaining the various methods of contraception and removing socio-cultural barriers wherever they exist. As a result of this approach, the number of acceptors of various methods of family planning has started to register progressive increase over the years.

Performance under the Programme

The family welfare programme in India has gone through several phases in its evolution. It started in a small way in 1952 but continued to receive greater emphasis in successive five year Plans. It is estimated that the crude birth rate declined by about 8 points in 16 years—from 41 per 1000 population in 1966 to 33 in 1983 which accounts for an average decline of 0.5 per cent per year. Approximately 7.6 crore births have been averted since the inception of the programme so far. The programme performance touched a fairly high level in the mid seventies. During the year 1976-77 about 12.5 million acceptors of family planning methods were enrolled. Subsequently, in the three years that followed, the programme received a severe set-back and the number of acceptors steeply declined to 4.5 million during 1977-78. During the 6th Plan the programme started gaining momentum once again with renewed political commitment and performance under the programme has been continuously improving since 1980-81.

During 1985-86, nearly 4.90 million sterilisation operations were performed and a total of 3.27 million IUD insertions were done. In addition 9.39 million users of conventional contraceptives and 1.36 million users of Oral Pills were enrolled. The total number of acceptors of different family planning methods in 1985-86 was of the order of 18.92 million an all time record since the inception of the programme. In relation to targets at all India level, achievement in sterilisation was 88.1 per cent and that under IUD insertions was 100.9 per cent. The achievement of targets with respect to Conventional Contraceptives (C.C.) users and Oral Pills (O.P.) users were respectively about 98.6 per cent and 141.3 per cent.

About 45.16 million couples (34.9 per cent of the total eligible couples in the reproductive age-group whose wives were in the age-group 15-44 years) were effectively protected against conception by one or the other approved family planning methods, as on March, 1986. Of these, 26.5 per cent were protected by Sterilisation alone.

The performance under the programme during the VI Five Year Plan is as follows.

| Family Planning | 1980-85 (in million) | % of targets achieved |
|--|-------------------------|--------------------------|
| Sterilisation | 17.45 | 79.2 |
| IUD | 7.17 | 81.7 |
| C.C. & O.P. Users (Couple year Protection) | 32.50 | 85.4 |
| Total acceptors | 57.12 | |
| Increase in couple protection rate 9.8% points | | |

Family Planning Targets for 1986-87 and the VII Five Year Plan

The Family Planning targets for 1986-87 and during the 7th Five Year Plan are given below:—

| | Sterili- sation | IUD | C.C. Users | O.P. Users |
|-----------------------------|--------------------|-------|---------------|--------------------|
| (Figures in million) | | | | |
| 1986-87 | | | | |
| (a) Plan targets | 6.00 | 3.75 | 10.5 | 1.0 |
| (b) Addl. targets | 2.00 | 1.25 | 9.5 | 1.0 |
| 1985-90 | 31.00 | 21.25 | 62.5 | (CC & OP Users) |

The achievements from April to December, 1986 were 2.77 million sterilisations and 2.53 million IUD insertions. During the period April to November, 1986, 7.11 million CC users and 0.85 million Oral Pill users have been recorded. The total number of acceptors of different Family Planning methods recorded during the period (April to December, 1986) was 13.26 million.

Rural Health Services

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 31st March, 1985 was 82946, as against the estimated total requirement of 1.30 lakh.

The progress is as under:

| | |
|--|-------|
| Functioning on 1-4-1985 | 82946 |
| 7th Plan Target | 54883 |
| Functioning on 1-4-1986 | 88967 |
| Target 1986-87 | 8766 |
| Achievements during 1986-87 (April-September, 1986) | 848 |
| No. Functioning on 30-9-1986 | 89815 |

PRIMARY HEALTH CENTRES: It is envisaged to establish the primary health centres on the basis of one PHC for every 30,000 population in the plains' area 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 to the existing building, the rural dispensaries which are providing curative service only will function as primary health centres and shall be providing package of promotive, preventive and curative services. The existing position in respect of PHCs is given below:

| | |
|---|-------|
| Functioning on 1-4-1985 | 11029 |
| 7th Plan Target | 12390 |
| Functioning on 1-4-1986 | 12269 |
| Target 1986-87 | 1554 |
| Achievement during 1986-87 (April-September, 1986) | 5 |
| Functioning on 30-9-1986 | 12274 |

UPGRADED PHC: It is proposed to establish rural hospitals with specialists' 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 upgrading PHC/CHC is given below:—

| | |
|---|------|
| Functioning on 1-4-1985 | 675 |
| 7th Plan Target | 1553 |
| Functioning on 1-4-1986 | 710 |
| Target 1986-87 | 278 |
| Achievement during 1986-87 (April-September, 1986) | NIL |
| Functioning on 30-9-1986 | 710 |

During the year 1985-86, 32,529 dais have been trained against a target of 25,000 dais. The target for the year 1986-87 is 20,000 dais. Total number of dais trained from 1974 to-date is 5.44 lakhs. Our objective in the Seventh Plan is to train 1 lakh dais. Efforts are also being made to start re-orientation training for Dais similar to that of village health guides.

Continuing Education of Primary Health Care Staff

This Scheme is of continuing education programme for each category of the health functionaries working at the PHC and sub-centre level, for a duration of 2 to 3 weeks at least once in five years, at the training institute where they get their basic training. Accordingly selected ANM Schools (40), LHV schools (14), HFWTCs (50), RHTC (1) and one college of Nursing and Medical Colleges are proposed to be strengthened for undertaking continuing education. The HFWTC's are already in the process of being strengthened. Lady Reading Health School of Delhi has also been strengthened for training key trainers of ANM & LHV schools. Government of India would be bearing 100% non-recurring and 50% of recurring cost.

The Scheme was sanctioned in the last year of the sixth plan. The States and UTs were asked to draw out a complete proposal for the scheme indicating non-recurring and recurring grants required for the purpose. Proposals have been received from the States of Maharashtra, West Bengal, Gujarat, Andhra Pradesh, and Jammu & Kashmir. The Scheme has already been sanctioned for the State of Maharashtra where the training is in progress. The proposal in respect of other States is under active consideration.

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. The health infrastructure is gradually being expanded to reach the population as close to their doorsteps as possible. As child-survival is a key factor contributing to promotion of Planned Parenthood, Ministry of Health and Family Welfare, Government of India have sponsored in a big way the immunization schemes for infants and children and mothers against common vaccine preventable diseases, prophylaxis schemes against nutritional anaemia among mothers and children and prophylaxis against blindness due to Vitamin 'A' deficiency.

Targets and achievement upto November, 1986 and financial outlays are given below:

| Scheme | Target (financial Rs. in lakhs) | (Figures in lakhs) | | |
|---|---------------------------------|--------------------|-------------------------------|---|
| | | Target 1986-87 | Achievement upto Nov-ber 1986 | %age achievement of annua physical target |
| Prophylaxis against nutritional anaemia among : | | | | |
| Mothers | 430.00 | 186.38 | 104.56 | 56.1 |
| Children | | 194.33 | 88.49 | 45.5 |
| Prophylaxis against blindness among children due to Vitamin 'A' deficiency | | | | |
| | | 289.70 | 176.84 | 61.0 |

Immunization programme : Expanded Programme of Immunization

The major causes of sickness and death of children in India are infectious diseases, many of which are preventable by immunization. Neonatal tetanus remains a major cause of neonatal mortality in the country, especially in the rural areas. Poliomyelitis is the single major cause of lameness in children under five years. A large number of cases of diphtheria, pertussis, tetanus, measles, poliomyelitis, tuberculosis and typhoid fever are reported annually.

The coverage at the end of 5th and 6th Plan period and the proposed coverage at the end of 7th Plan is given at Table No. 1. The figures relate only to services provided by Government centres and do not include performance by the voluntary organizations or private medical practitioners.

TABLE 1

Reported vaccination performance in 1979-80 and 1984-85 and proposed coverage in 1989-90.

(Figures in millions)

| Year | Pregnant women | | | Infants | | |
|---------|----------------|--------|-------|---------|---------|--|
| | TT | DPT | POLIO | BCG | MEASLES | |
| 1979-80 | 47.5 | 68.8 | 6.70 | 140.9 | — | |
| 1984-85 | 93.65 | 124.27 | 98.93 | 123.25 | — | |
| 1989-90 | 239.0 | 183.0 | 183.0 | 183.0 | 183.0 | |

The performance under Expanded Programme on Immunization during 1986-87 (upto November, 1986) is given below:—

Targets 1986-87 & Achievement during 1986-87 & 1985-86

(Figures in lakhs)

| Activity | Target 1986-87 | *Achievement | | % in-crease (+) or decrease (-) of performance 1986-87 as compared to 1985-86 | % achievement of target |
|------------------|----------------|-------------------------|--------------------------|---|-------------------------|
| | | 1986-87 (April-Nov. 86) | 1985-86 (Corres-ponding) | | |
| TT(PW) | 152.00 | 61.48 | 57.31 | (+)-7.3 | 40.4 |
| DPT | 153.00 | 61.16 | 63.88 | (-)-4.3 | 40.0 |
| POLIO | 153.00 | 55.03 | 49.45 | (+)-11.3 | 36.0 |
| BCG | 153.00 | 46.85 | 35.11 | (+)-33.4 | 30.6 |
| DT | 121.00 | 52.65 | 54.32 | (-)-3.1 | 43.5 |
| TYPHOID | 121.00 | 39.82 | 38.91 | (+)-1.7 | 32.9 |
| TT (SC 10 Years) | 67.00 | 27.23 | 22.98 | (+)-18.3 | 40.6 |
| TT (SC 16 years) | 41.00 | 16.77 | 13.75 | (+)-21.3 | 40.9 |

*Figures are provisional. Source (E & I) Division, Ministry of Health & Family Welfare.

The performance in respect of all EPI activities have shown progress during the period under review as compared to the corresponding period last year except Typhoid vaccination.

Universal Immunization Programme

Performance under Universal Immunization 1986-87: Under the Universal Immunization Programme (UIP), it is aimed to achieve 100% coverage of the pregnant women with two doses of TT at least 85% of infants in the 92 districts with the six preventable diseases under this programme. The annual vaccination targets are the coverage of 61.02 lakh women with 2 doses of TT and 46.10 lakh infants with 3 doses each of DPT and Polio Vaccine and 1 dose each of BCG and measles vaccine. According to plan, 65% of annual targets were expected to be achieved by the end of December, 1986.

Vaccine-wise achievement are given below:—

| Vaccines | Annual Target | Achievement upto December, 1986 | %achievement Annual Target | % Prop. Target |
|----------|---------------|---------------------------------|----------------------------|----------------|
| TT (PW) | 61.02 | 18.63 | 30.5 | 47.0 |
| DPT | 46.10 | 19.22 | 41.7 | 64.1 |
| Polio | 46.10 | 17.34 | 37.6 | 57.9 |
| BCG | 46.10 | 18.49 | 40.1 | 61.7 |
| Measles | 46.10 | 8.12 | 17.6 | 27.1 |

Monitoring of the programme: The programme is being monitored regularly. The officers in the wing are allotted districts under Universal Immunization Programme for visits and for supervisory holding discussions on the subject with the State Authorities to keep the pace of immunization programme.

CHANGING PERSPECTIVES OF RURAL HEALTH CARE: OVERVIEW

(Continued from page 205)

subsidiary health centres and sub-centres of PHCs are health institutions meant for the most vital functions of the health schemes in the rural areas of the country.

The scheme of training of multi-purpose workers has been completed in 329 districts by the end of March, 1983, and the training is continuing in 41 districts. The quality of implementation of the multi-purpose workers' scheme has not been satisfactory except in some States like Karnataka, Gujarat and Maharashtra.

The objectives of MNP under sixth plan for Rural Health Component are : (i) to provide one community health volunteer for a population of 1,000 or a village by 1990; (ii) to establish one sub-centre for a population of 5,000 in plains and 3,000 in tribal and hilly areas by 2000 A.D.; (iii) to provide one Primary Health Centre for 30,000 population in plains and 20,000 in tribal and hilly areas by 2000 A.D. and (iv) to establish one community health centre for a population of 1,00,000 or one community development block by 2000 A.D.

In the Sixth Plan, the M.N.P. is being intensified. The programme has an outlay of Rs. 5,770 millions during the sixth five year plan period, approximately 10 per cent of M.N.P. budget. These funds are provided merely for creating the infrastructure, while salaries of health staff as well as supply of drugs and medicines would be met out of regular health budget.

Sustained efforts towards promotion of health infrastructure during the past three and half decades have resulted in significant improvement in the health status of the rural population. The M.N.P. has contributed to creation of 16,431 sub-centres, 560 primary health centres and other infrastructure during the sixth plan period. However, the progress is said to be slow in many States, as the state public works departments have not been able to handle the construction of health infrastructure effectively. Shortage of doctors, nurses and trained auxiliary nurses and midwives is another constraint in the way of rural health care services. Scarcity of construction materials is reported to be causing delay in creating health infrastructure. Another important issue is that unless the regular health budget is made to support the functioning of these facilities by providing adequate staff and supply of medicines and drugs, the health

infrastructure would remain unproductive investment.

There is considerable unmet felt-need for curative, preventive and promotive health services among rural population of India at a time when there is considerable under-utilisation of even the very limited rural health care services that have been made available to them. Some of the main reasons why the health care delivery system in our villages has not been able to strike roots are the inaccessibility of services to the majority especially women and children who cannot avail them due to transport problems and time constraints, greater emphasis on curative care rather than preventive medicine; hospital facilities which override primary health care, so people rush to hospitals rather than to the PHC, clinical rather than community orientation of physicians, insufficient training of health workers posted at the PHCs; inadequate and erratic supply of medicines, non-availability of certain services due to lack of social acceptability and non-participation of the community in the health delivery system. The indifferent attitudes of doctors and para-medical staff has further discouraged the villagers from optimally utilising the health care services provided by the health centres. The location of the health centre is another important factor for its under-utilisation, as villages located away from P.H.Cs cannot receive the services.

Conclusion

In concluding remarks, we can therefore, only say that the problem of providing primary health care to the rural population of India, is as difficult today as it has ever been in the past. Transport system and communication facilities have greatly improved the outreach of public delivery systems of health, education, social welfare, rural development, etc. In this process, the expectations of the rural people have greatly increased, leading to greater demands for hospitals, health centres, clinics, etc. This trend is not at all conducive to the development of a primary health care system. It is this context that lends great importance to the introduction of the community health guides scheme and multi-purpose health workers' scheme which brought a ray of hope to the rural people in the countryside. Moreover, for making the health care services more meaningful to the population of the country, it is necessary to bring about fundamental changes in focus and approach to the entire health care delivery system of the country in general and above all rural health care services in particular.

Courtesy : KURUKSHETRA, April, 1987.

Sixth Five Year Plan, 1980-85, Mid-Term Appraisal, Government of India, Planning Commission, August, 1983, p. 101.

BOOKS

Controlling Diarrhoea

Nutritional & Diarrhoeal Disease Control—Report of an International Conference held at the West Dean Conference Centre, U. K. from August 12-16, 1985:

Concrete actions in nutrition alongwith other interventions, constitute integral parts of a comprehensive approach to the control of diarrhoeal diseases in children through primary health care (PHC). Nutrition interventions not only are effective means of disease prevention themselves but also are key elements in case management for the prevention and recuperation of the nutrient depletion accompanying diarrhoea and in the improvement of the nutritional status of those surviving diarrhoeal disease. Unfortunately, the implementation of diarrhoeal disease control (DDC) often relies overly on selective, isolated distribution and use of oral rehydration solutions (ORS), to the neglect of the nutritional aspects of control.

In view of this problem, the third International Conference was convened by the International Nutrition Planners Forum on the topic of Nutrition and Diarrhoeal Disease Control to focus attention on the current status of programme implementation, identification of existing constraints to effective programme integration and the formulation of practical recommendations for a more comprehensive approach to DDC through PHC.

The Conference held in West Sussex, UK from 12 to 16 August, 1986, was attended by 27 experts from 20 developing countries and five representatives of three international organisations (WHO, UNICEF and USAID).

Given the cumulative deterioration in nutritional status associated with repeated episodes of acute diarrhoeal disease, survivors tend to become progressively malnourished if their nutritional needs during and after bouts of the illness are not adequately met. Hence, preventing deaths from diarrhoeal dehydration by means of oral rehydration therapy (ORT) is not enough to ensure long-term health benefits and significant reduction of overall child mortality. Infants and children saved by rehydration alone will continue to be malnourished and exposed to high risk of morbidity and mortality from other infections and diarrhoea itself. Therefore, integrating dietary actions with ORS and other DDC interventions is fundamental for an effective prevention and control of both diarrhoeal and protein-calorie malnutrition.

The principal interventions selected as part of a comprehensive approach to nutrition and diarrhoeal

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disease control, constraints to its implementation and the approaches recommended by the conference for integration of nutrition and DDC actions form part of the Report.

—S. Venkatesh

