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OBJECTIVES

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

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

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

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

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

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

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

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

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HEALTH PROGRESS
—1995-1996

P. P. CHAUHAN

SECRETARY (HEALTH)
Ministry of Health & Family Welfare

SIGNIFICANT improvements in the provision of health care have been possible because of vigorous implementation of different national programmes. In our endeavour to provide better health care, the National Health Programmes have been intensified to combat communicable diseases like TB, Leprosy, Malaria, Filaria, as well as non-communicable diseases like cataract-induced blindness, cancer and cardio-vascular diseases, etc. The emergence of AIDS, the absence of a cure, and social stigma attached to its nature, the dependence on professional blood donation have made control of the disease a daunting task. The threat of HIV transmission is being tackled through safe blood transfusion services, control of sexually transmitted diseases and information, education and mass communication. Poverty, illiteracy, low levels of sanitation, mal-nutrition and a growing population have made the task before us difficult but not insurmountable. The chalienge is being met by increasing financial allocations for disease control, upgrading the national institutions, promoting and strengthening institutional developments and providing technical assistance to the States.

The Department of Health steered the formulation and implementation of 10 National Health Programmes aimed at prevention, control and eradication of communicable and non-communicable diseases. The promotion of education, research and training and manpower development in various medical disciplines have continued with special emphasis on the delivery of health facilities to rural areas. Apart from administering the tertiary hospitals and other Central institutions, the production of vaccines and sera and strengthening of the drug and food quality organisations have been given impetus.

The AIDS control programme focused mainly on prevention of HIV transmission and reduction of impact of HIV/AIDS at the individual, societal and economic levels. The strategy is to ensure blood safety, control of STD, creation of awareness, surveillance and clinical management. The Supreme Court have directed that Councils will be set up at the Central and State levels to *inter-alia* coordinate the supply of safe blood and blood products and phase out professional blood donation in a time-bound manner. The matter is receiving special attention.

National Malaria Eradication Programme is a centrally sponsored scheme based on 50:50 cost sharing between the Centre and the States. Considering that the seven North-Eastern States are hard-core malaria endemicity and the States find it difficult to raise the required funds for intensifying malaria control activities, 100% Central assistance in the form of cash assistance and materials are being provided to these seven sister States. Further, in order to intensify malaria control activities, particularly, in the tribal and backward areas, a Malaria Control Project for obtaining World Bank and other external assistance is also currently under formulation.

Kala-Azar has been a major cause of large scale mortality in Bihar and West Bengal. 30 districts of Bihar and 9 districts of West

Bengal are affected by Kala-Azar. In view of the growing problem, special control measures have been launched to contain Kala-Azar and expert teams have been providing on the spot advice on how to strengthen surveillance and vector control.

The sporadic outbreaks of Japanese Encephalitis have caused concern as they largely affect children. The virus has been invading newer areas and recently, Kerala which was considered to be free of this infection, also faced an outbreak of Japanese Encephalitis. Action taken for the containment of the outbreak in Kerala includes Malathion fogging in affected areas, Larviciding in selected areas and adequate measures for proper case management at medical college/ hospitals.

The major activities also include identification of high-risk groups and epidemiological monitoring of the disease for effective prevention and control.

National Leprosy Eradication Programme (NLEP) aims to achieve the elimination of leprosy as a public health problem by 2000 AD.

The number of TB patients have been increasing over the years and currently around 14 million people are estimated to be suffering from the disease. The impending threat of HIV-TB, co-infection and emergence of drug resistance has added a sense of urgency to the situation. A TB control project with World Bank assistance is at an advanced stage of appraisal.

Blindness is a major public health problem in India. Out of an estimated 12 million affected people, cataract—an age related disease—accounts for more than 80% of the blindness. Government of India has intervened by initiating World Bank assisted projects at a total project cost of Rs. 554 crore aimed at conducting over 11 million sight restoring operations during 5 years.

We are deeply concerned about the growing problem of drug abuse in India, especially due to arrival on the scene of synthetic drugs and psychotropic substances. The situation in North-Eastern States is particularly grave due to consumption of drugs mainly by way of intravenous injections which is one of the contributing factor for the spread of AIDS. Steps are being taken to curb this menace through regulatory and educational efforts.

During the 8th Five Year Plan, efforts were made to strengthen Iodine Deficiency Disorders (IDD) monitoring and to achieve the goal of universal iodisation of salt. It is proposed to bring down the incidence of IDD by 10% level by 2000 AD. Already 20 States and Union Territories have banned the sale of non-iodised salt and efforts are underway to cover the country.

Cancer is increasing and becoming a major health problem. The policy places emphasis on primary prevention early diagnosis of cancer and augmentation of treatment facilities.

The country is now at the verge of achieving zero guinea worm status having achieved over 99% reduction in the annual incidence of guinea-worm disease in the country. In a span of 10 years, the number of cases have been reduced from 40000 to 363.

A Task Force was set up under the Chairmanship of Justice E. S. Venkataramaiah, Retd. Chief Justice of India to look into the efficacy and relevance of the provisions of Prevention of Food Adulteration Act, 1954, and Rules made thereunder. Its report is being examined in consultation with the State Governments. Meanwhile, efforts are being made to upgrade the prevention of food adulteration organisations at the Centre and the States through a project for which Central assistance is envisaged to be taken.

CGHS provides comprehensive medical facilities to the Central Government employees and members their families. Currently, it cover 40 lakh serving Central Government employees and 4.87 lakh pensioners throughout the country. Three new allopathic dispensaries were opened one in Delhi, two in Trivandrum; 43 new private hospitals including diagnostic centres in Pune and Calcutta were recognised during the year for extending services to the beneficiaries.

An Expert Committee has been set up to make a comparative study

on the reduction of tobacco use, *inter-alia* examining the tax revenue and foreign earnings, employment and consumer expenditure on the one hand, and cost of tertiary level medical care facilities for treatment of tobacco related diseases, losses due to fire hazards, ecological damage due to deforestation and disposal of tobacco waste on the other. This is being done with a view to making an economic study on the impact of tobacco consumption.

The Government accorded permission for starting three Medical colleges and one Dental college at Pariyaram (Kerala), Bhavanagar (Gujarat), Punchkula (Haryana) respectively.

A comprehensive plan for bringing the subject of environmental health and sanitation high on the National agenda was prepared in consultation with the Ministry of Rural and Urban Affairs and Employment and Environment and Forests.

The Fourth Conference of Central Council of Health and Family Welfare was held at New Delhi from October 11-13, 1995. This is the highest decision making body in the Ministry of Health and Family Welfare Sector with Union Minister of Health and Family Welfare as the Chairman and the Ministers Incharge of all the States/UTs and some eminent persons as members of this Council. The Council discussed many important issues concerning the Health and Family Welfare Sectors and made several recommendations which are in the process of implementation throughout the country.

Prime Minister of India inaugurated the Indira Gandhi Memorial Hospital at Male, Maldives on 15th April, 1995.

The Government of Japan agreed to give a grant of Yen 757 million for the improvement of medical equipments at the Osmania General Hospital in Andhra Pradesh.

The Andhra Pradesh Health Systems Project for the upgradation of secondary level hospitals was posed to the World Bank and negotiations completed successfully. The total cost of the Project is estimated at US $ 156 million out of which IDA's credit would be US $ 133 million (approx).

Negotiations for the Health Systems Development Projects for the States of West Bengal, Karnataka, Punjab were held with the World Bank in January, 1996 and IDA credit of $ 350 million for 3 States has been agreed to. The Project has commenced implementation.

Notes have been exchanged between the Government of India and the Government of Japan on 14th December, 1995 to provide grant-in-aid to the extent of Rs. 40 crore for construction and provision of equipment for upgradation and improvement of Kalavati Saran Children's Hospital and Urban and Rural Health Centres attached to LHMC, New Delhi.

The Minister for Public Health of the Russian Federation, D. Edvardo Anechayen visited India and called on the Minister of State for Health and Family Welfare on 10th March, 1995.

The Vice Minister for Public Health of the People's Republic of China, Dr. He Jiesheng led a delegation from her Ministry to India from 11-17 June, 1995. A plan of action was drawn up for further co-operation specially in the field of Yoga and Accupuncture.

A delegation from South Africa led by Minister of Health, H.E. Dr. N. C. Dlamini Zuma visited India from 7-11 November, 1995 to explore the areas and mechanism for future co-operation in the Health Sector.

Dr. Y. Praratz, Chief of International Health in Israel visited India from 15-21, November, 1995 as an official guest of the Government of India, Ministry of Health and Family Welfare.

The Plan outlay for the Health Sector in 1995-96 was Rs. 670 crore compared to Rs. 598 crore during 1994-95. In order to strengthen the medical and health services, the Department of Health sought external assistance from the World Bank, WHO and other international agencies to support the implementation of the major health programmes.

—Excerpts from the Introduction to the Annual Report of the Ministry of Health and Family Welfare for 1995-96.

Fourth Conference of Central Council of Health & Family Welfare

UNDER Article 263 of the Constitution, the President of India has constituted the Central Council of Health and Family Welfare. The Council consists of the Union Minister for Health and Family Welfare as Chairman, Minister of State/Deputy Minister in the Ministry of Health and Family Welfare as Vice-Chairman, Member (Health and Family Welfare), Planning Commission, Ministers incharge of the Ministries of Health and Family Welfare, Medical Education and Public Health from the States/ Union Territories with Legislatures, representatives from Union Territories without Legislature, Members of Parliament, Distinguished Non-Officials and Eminent Persons from Health and Family Welfare sectors and six senior officials from the Central Government are also its members.

The Council is an apex advisory body and in that capacity (i) considers and recommends broad lines of policy in regard to matters concerning Health and Family Welfare in all its aspects such as the provision of remedial, promotive and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research; (ii) makes proposals for legislation in the field of activities relating to medical and public health and family welfare matters; (iii) examines the whole field of possible inter-State cooperation on a wide basis in regard to health matters; (iv) recommends to Central Government regarding distribution of available grants-in-aid for Health and Family Welfare purposes to the States and review periodically the work accomplished in different areas through the utilisation of these grants-in-aid; and (v) establish any organisation or organisations invested with an appropriate functions for promoting and maintaining cooperation between the Central and State Health and Family Welfare administration.

The Fourth Conference of CCH & FW was held from 11th to 13th October, 1995. A comprehensive agenda consisting of Programmes concerning Family Welfare Health and I.S.M. and Homoeopathy Sectors was considered by the Council.

The Council noted the progress made by different States in achieving the goals of the Family Welfare Programmes set under the National Health Policy. While complementing the States which have already achieve the goal—Health for All—comprising of indicators, the Council also urged the other States to continue their affords in this direction by according a high priority to Population and Family Welfare Programmes. The Council resolved to support the modifications/ amendments in the MTP Rules and Regulations to increase the facilities for safe abortion services. It also recommended the expansion of safe abortion services especially in the rural areas in order to safeguard the health of women. The Council resolved that appropriate authorities be appointed and Advisory Committee be constituted immediately for effective implementation of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 and rules thereunder. The Council noted with concern the deficiencies in the implementation of the Family Welfare Programme as pointed out by the Parliamentary Standing Committee of Human Resources Development and resolved that suitable steps may be initiated for improvement of Rural Health Infrastructure. Involvement of Panchayats in the Management and Administration of Primary Health Care Institutions was also resolved by the Council.

The Council strongly urged the Central Government, Planning Commission and the State Governments to step up health allocation and also to encourage wider participation in health care by the private sector so that the direct investment by the Government can be raised to a minimum of 5% of the GDP and the total investment in health goes upto 10% of the GDP.

In order to provide effective financial and other assistance for NGO's involved in delivery of Health and Family Welfare Programmes at the field level, the Council urged the Government to set up a separate foundation with a minimum corpus of Rs. 300 crore at Central Government level in the Ministry of Health and Family Welfare. It also recommended the Government to initiate urgent measures to introduce health insurance and managed care in order to insure access to all to get the quality medical care.

With a view to harnessing all the available resources for the health care, especially for the poor and the disadvantaged, it is imperative that all efforts be made to develop public-private partnership through a joint sector approach in collaboration with Corporate Bodies, Non-Government Organisations and Public Sector Units, especially in favour of the poor.

After indepth discussion, the Council adopted resolution on on-going National Health Programmes viz. National AIDS Control Programme, National Malaria Eradication Programme, National Leprosy Eradication Programme, National TB Control Programme, National Programme for Control of Blindness, National Cancer Control Programme, Iodine Deficiency Disorders Control Programme, for strengthening and effective vigourous implementation of these programmes. Various measures for strengthening of Prevention of Food Adulteration Programmes in the States/UTs were also enunciated by the Council to ensure effective implementation of Prevention of Adulteration Act and Rules. The Council adopted the resolution with regard to Indian System of Medicine and Homoeopathy for strengthening of undergraduate colleges, departments of specialised treatment centres, drug control of Indian System of Medicine and development of medicinal plants etc. ○

ANTI-CANCER MICROBES FOUND IN SOIL

Microbes that commonly grow in mud, soil and water have been found to contain compounds with potent anti-cancer activity. The discovery comes from Dr Michael Shipman and his research team supported by the UK Cancer Research Campaign (CRC) at Loughborough University of Technology.

The compounds, known as azinomycins, have been shown to be effective against a range of cancers. The Scientific Director of the CRC, Professor Gordon McVie, says he hopes that azinomycins will be valuable in treating some of the most commonly fatal cancers, such as bowel, lung and breast.

Human trials are expected within two years. Meanwhile research at Loughborough will concentrate upon understanding how the compounds kill cancer cells, so as to develop drugs that are even more effective. (LPS) ○

— Medical News From Britain

NATIONAL HEALTH PROGRAMMES

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

NATIONAL MALARIA ERADICATION PROGRAMME

WITH the implementation of Modified Plan of Operation (MPO) the total malaria cases came down from 6.47 million in 1976 to 2.18 million cases in 1984. The malaria situation since then is contained around 2 million cases.

The trend of malaria cases, Plasmodium falciparum cases and death due to malaria during the recent past can be referred at figure No. 1(a) & 1(b). Statewise distribution of malaria cases, Plasmodium falciparum cases and deaths due to malaria during 1995 are given at figure No. 2, 3 and 4 respectively.

Control Strategy

Case Detection and Prompt Treatment: Case detection and prompt treatment is given more emphasis to reduce parasitic load in the community. Blood slides are being collected through active and passive agencies and presumptive treatment is given. All positive cases are given appropriate radical treatment.

Vector Control: Selective and judicious insecticidal spray is carried out in the areas registering two and more than two API in the preceding three years. In other areas only focal spray is being done. During 1995-96, 158.34 million population has been projected for, to be protected by insecticidal spraying.

Anti Larval Measure: In the urban areas anti larval measures are being used under which recurrent weekly larviciding with temephos, Fenthion, MLO and Paris green etc are used besides source reduction as well as bio-environmental measures wherever feasible.

Malariogenic Stratification: To prioritise endemic areas and judicious use of resources, stratification is in progress in a phased manner. It has been completed in the four States namely Karnataka, Maharashtra, Gujarat and Rajasthan and is in progress in the States of Andhra Pradesh and Madhya Pradesh.

Health Education: To increase awareness of the community and seek their active participation and cooperation for implementing control activities, health education is being undertaken.

Malaria in Urban Areas: Urban Malaria Scheme (UMS) was launched in 1971 with the objective to control malaria by reducing the vector population in the urban areas through recurrent anti larval measures and detection and treatment of cases through the existing health services.

In this scheme all the towns having more than forty thousand population are to be covered and the scheme was sanctioned for 181 towns distributed in 17 States and two UTs. It has so far been implemented in 131 towns. During 1993 about 2.3 lakh malaria cases have been reported from these towns and 60 towns (46%) showed a decrease in the number of malaria cases as compared to 1992. During 1994, 54 towns showed a decreased in malaria cases by 51% as compared to period of 1993.

Around 10% of total malaria cases in the country are being reported from urban areas.

Malaia in Tribal Areas: In view of the persistent transmission of malaria in the North-Eastern States which are almost entirely inhabited by tribal population are provided 100% central assistance for the control of malaria from December, 1994.

In addition about 44.5 million population of tribal areas in the 7 States namely, Andhra Pradesh, Madhya Pradesh, Gujarat, Maharashtra, Bihar, Rajasthan and Orissa are contributing 30% of total malaria cases and 50% of P. falciparum cases of the country. A proposal to intensify malaria control measures through World Bank assistance is under the consideration.

Outbreak of Malaria during 1995: During 1995 malaria outbreak has been reported from 2 States—Assam and Maharashtra. The Malaria epidemiological situation in these States are as follows:

EPIDEMIOLOGICAL SITUATION IN ASSAM

Year	Total Malaria	P.Falsiparum cases	Deaths
1993	1,18,403	78,504	48
1994	1.61,038	1,05,477	69
1995	2,12,741	1,37,157	300

EPIDEMIOLOGICAL SITUATION IN MAHARASHTRA

Year	Total Malaria	P.Falsiparum cases	Deaths
1993	2,52,475	71,529	15
1994	3,30,699	1,03,616	9
1995	3,60,613	1,28,231	219

The Ministry of Health and Family Welfare supplied insecticides, antimalarial drugs including quinine injections, microscopes as per the need and several central teams of experts visited the affected areas to review the situation and suggested effective control measures.

BUDGET AND EXPENDITURE

(*Rs. in lakh*)

Year	Budget Provision	Actual Expenditure
1985-86	8,868·00	8,856·91
1986-87	8,500·00	7,815·14
1987-88	8,200·00	8,456·95
1988-89	8,300·00	8,750·00
1989-90	8,900·00	8,862·15
1990-91	8,200·00	7,660·45
1991-92	8,960·00	8,793·04
1992-93	9,700·00	9,800·14
1993-94	11,000·00	11,054·28
1994-95	11,000·00	11,000·00
1995-96	14,200·00	14,200·00
1996-97	14,500·00	

National Filaria Conrol Programme

Filariasis is a major public health problem in many States of the country and about 420 million people are estimated to be living in known endemic areas of which about 109 million are in urban areas of which about 47 million urban population is being protected.

The National Filaria Control Programme was launched in 1955. Under the programme following measures are undertaken.

(i) Delimitation of the problem in hitherto unsurveyed areas.

(ii) Control in urban areas thorough recurrent anti larval measures and anti parasitic measures by 206 control units and 198 clinics giving treatment with diethyl carbamizine to clinical cases and microfilaria carriers.

During the 8th Plan it has been envisaged to distribute anti-filarial drugs through primary health care delivery system in the rural areas of endemic States.

Kala-Azar

Kala-Azar is a serious public health problem in Bihar and West Bengal. After its resurgence in Bihar in the early seventies the disease spread from the four districts to adjoining areas now about 30 districts of Bihar and 9 districts of West Bengal are affected by Kala-Azar. The increasing trend of the disease is evident from the fact that the total number of cases which were 17,806 with 72 deaths in 1986 rose to a total of 77,102 cases with 1,419 deaths in 1992. However, this trend has been arrested in 1993 with a total number of 45,459 cases with 710 deaths reported. During 1994, 25,652 cases and 384 deaths and during 1995 21,884 cases and 274 deaths were reported.

In view of the growing problem planned control measures were initiated to contain Kala-Azar. Until 1990-91 the assistance for the Kala-Azar control was being provided by the Government of India out of the National Malaria Eradication Programme budget provision. However, specific funds to the tune of Rs. 4.06 crore were made available during 1990-91 for control of Kala-Azar. Since then the Government of India has considerably enhanced the inputs to Rs. 15.38 crore in 1990-91. During 1992-93 Rs. 20.00 crore were provided against annual plan outlay of Rs. 15.00 crore. During 1993-94 Rs. 18.64 crore

and during 1994-95 Rs. 5.77 crore have been utilised by States as material assistance. In 1995-96 material assistance worth Rs. 3.11 crore have been provided to Bihar and West Bengal for Kala-Azar control. A budget estimate of Rs. 10.00 crore has been approved during 1995-96.

Strategy for Control: The strategy for Kala-Azar control broadly includes 3 major activities:

(i) Interruption of transmission for reducing vector population by undertaking in-door residual insecticidal spray twice annually.

(ii) Early diagnosis and complete treatment of Kala-Azar cases.

(iii) Health education for community awareness.

In view of the financial constraints, Government of India provides the total cost on medicine and insecticides for Kala-Azar in Bihar. To ensure optimum utilisation of available resources district action plan are prepared under which exclusive infrastructure is deployed for the Kala-Azar activities. Material and equipment with strict supervision is provided. Monitoring and concurrent and consecutive evaluation are regularly carried out.

Government of India Assistance: Assistance in terms of cash as well as kind has been provided approved during the initial years. 1993-94 onwards assistance in the form of kind has been given to Bihar and West Bengal. Material assistance included the insecticide DDT, Sodium stibo Gluconate and imported drug Pentamidine lsethionate.

In addition UNICEF assistance of Rs. 15.95 lakh has been provided in 1990-91 for information, Education and Communication activities and orientation of medical professionals.

As a result of concerted efforts there has been consistent decline in both cases and deaths. A decline of 43.47 per cent in cases and 50.78 per cent in deaths due to Kala-Azar has been recorded during 1994 as compared to 1993. During 1995 a decline of 14.69% and 28.65% morbidity and mortality respectively has been recorded as compared to 1994.

Japanese Encephalitis

The disease is caused by a minute virus and manifests as high fever, convulsions, confusion, stiffness of the neck and coma etc. The fatality rate of this disease is very high and those who survive do so with various degrees of neurological complications. This disease is spread by mosquito which usually breed in rice fields and swampy and marshy areas.

Of late, this disease has become a major public health problem and has been reported from 24 States/ UTs. There were a total of 4071 cases with 1530 deaths reported in 1991, 2432 cases with 888 deaths in 1992. In 1993, 2291 cases and 923 deaths and in 1994, 1243 cases and 640 deaths were reported. In 1995 (up to Dec.) 2027 cases and 622 deaths were reported.

Strategy for Control: Major activities to control Japanese Encephalitis includes:

(i) Care of the patient;

(ii) Development of a safe and standard indigenous vaccine;

(iii) Sentinel surveillance including clinical surveillance of suspected cases;

(iv) Studies to identify the high risk groups by measuring the blood level of anti bodies; and

(v) Epidemiological monitoring of the disease for effective implementation of prevention and control strategies.

No specific budget for Japanese Encephalitis has been approved. Assistance in terms of insecticides are being supplied to effected States out of NMEP supply as and when required.

National Leprosy Eradication Programme

Problem: Leprosy has always attracted high degree of social stigma. There are many superstitions around this disease even now in the various parts of the country. Many still believe that leprosy is highly infectious and contagious. This is all wrong. Disease is caused by a germ and effective cure is available.

Leprosy occurs in significant numbers in about 80 countries of Asia, Africa and Latin America. At one time, there were 10 to 12 million leprosy cases in the world. Now with effective treatment and relentless war against leprosy, there are still 1.8 million cases left in the world. Of these, .55 to 60% are contributed by India. Leprosy occurs in substantial numbers in 9 out of 11 countries of the South-East Asia Region. Next to India are Indonesia, Denmark, Bangladesh and Nepal who contribute Leprosy in substantial numbers.

Leprosy occurs in 11 States and UTs. However, the distribution of cases is uneven. Very high leprosy endemic areas are South-Eastern and Central Regions viz., States

of Tamil Nadu, Andhra Pradesh, Orissa, West Bengal, Bihar, Madhya Pradesh, Uttar Pradesh, Maharashtra and Karnataka. These States account for over 90% of cases. With successful implementation of MDT programme in some States now five States of West Bengal, Orissa, Bihar, Madhya Pradesh and Uttar Pradesh contribute to over 70% of the cases in India.

Declining Trend: With the extension of MDT services under the programme, a large number of leprosy cases are being discharged as disease cured. For the first time in 1987, the number of MDT cured cases was more than the number of new cases detected; with rapid further extension of MDT services to other endemic areas, the number of discharged cases has gradually increased during subsequent years. During the year 1994-95, the number of discharged cases was 6.35 lakh as against new case detection of less than 4.29 cases. So far the programme has been able to discharge, including those cured with MDT, about 9.0 million cases. Active caseload has come down to 0.61 million cases at the end of March, 1996. During 1995-96, the number of cases discharged are 4.71 lakh as against new case detection of 3.49 lakh.

There has also been a definite shift in the disease pattern and the type of cases. In States, where MDT has been extended to leprosy cases in the endemic districts for over 5 years, a substantial number of cases have one or two patches only. Multibacillary cases have come down to less than 10%. Smear positive cases are now rare in these districts. Over 70% of the current caseload is now in the States of Uttar Pradesh, Madhya Pradesh, Bihar, Orissa and West Bengal.

Programme: The present approach to the control of leprosy is based on early detection and their prompt treatment with MDT on a long term basis. Education of patients and community about the curability of the disease and their medico-social rehabilitation are other two key components of the programme activities.

The strategy adopted is to:

(i) Provide domiciliary treatment (MDT) in endemic districts through staff trained in leprosy.

(ii) Provide services through mobile leprosy treatment units and primary health care personnel in moderate to low endemic districts.

(iii) Intensive case detection and treatment activities through special surveys.

(iv) Organise health education to patients, their families and community, and

(v) To provide rehabilitation services to the needy patients.

Over the years a separate cadre of health workers were trained to provide anti-leprosy services. Treatment of leprosy cases with MDT has been taken up in a phased manner. All the registered cases in all the districts in the country are being provided free domiciliary MDT treatment.

Leprosy Profile and Progress of NLEP: On an average 0.4 million new cases are being detected annually. Number of cases discharged as cured is increasing progressively over the years. For the first time during the year 1987, annual case discharge was 10% more than the annual new case detection, this percentage increased to 25% in 1988, 38% during the year 1989, over 90% in 1990, 1991 and again over 90% in 1992. Discharge rate was again 75% more in 1993 and 1994. At the end of March, 1996, 0.61 million active leprosy cases remained on the programme records.

Plan for Elimination of Leprosy.

(i) Early detection of leprosy cases and their regular and free treatment with MDT;

(ii) Consolidation of MDT services in all the districts of the country;

(iii) Organization of Health Education and Special Public Awareness Campaigns;

(iv) Provision for leprosy ulcer and disabilities;

(v) Orientation training of PHC workers; and

(vi) Slow integration of leprosy services with PHC.

Overall Scenario: If the programme is implemented as per planned strategy and additional resources are made available there would remain just over 72,000 leprosy cases by the end of 1998 and not more than 40,000 cases at the end of 2000 AD. This would also bring in an effective break in disease transmission, thus achieving the goal of elimination of leprosy (10,000) as set by WHO for the year 2000 AD.

National Tuberculosis Control Programme

Problem: In India 14 million people are suffering from active tuberculosis of which 3-3.5 million are highly infectious. About 0.5 million die of the disease every

year. An estimated 2-2.5 million cases are added every year.

Programme: The programme is in operation since 1962 and is integrated with General Health Services. The programme aims to detect cases early and treat them effectively till they are cured. In the district, the programme is implemented through the District Tuberculosis Centre (DTC) and a number of Peripheral Health Institutions (PHIs). The District Tuberculosis Programme (DTP) is supported by State level organisation for coordination of the tuberculosis activities in the State and supervision of the DTPs. The programme provides free services to the community. The programme is run on 50:50 sharing basis between Centre and States in terms of drugs and logistics. Under the programme Voluntary Organisations are provided anti-TB drugs (100%).

Achievements: At present out of 496 districts in the country, District TB Centres (DTC) have been established in 446 districts. A team of medical and para-medical personnel duly trained at NTI, are available at these centres. Besides the District Tuberculosis Centres 330 TB Clinics, 16 TB Training and Demonstration Centres and about 47,600 TB beds are functioning in the country.

The National TB Control Programme has been accorded high priority by the Government. With the inclusion of NTP in the 20-point programme, a thrust has been given for the expansion of the essential activities under the programme. There has been considerable increase in the budgetary allocation to the programme e.g. from Rs. 1.80 crore in 1981, the outlay has been increased to Rs. 50.00 crore in 1994-95. Short Course Chemotherapy containing more effective drugs is being introduced in this country in a phased manner. So far 292 districts have been covered.

Training: Regular training (average 8 in a year) and one International Training Course are conducted by NTI, Bangalore for medical and para-medical personnel. Training has also been conducted in 15 RNTCP project sites with World Bank assistance under PPF.

International Assistance: The World Bank is supporting the implementation of Revised Strategy of NTCP in 15 project sites in the country. The strategy is proposed to be expanded in a phased manner with World Bank support.

DANIDA assistance has been sought to implement the Revised Strategy of National Tuberculosis Control Programme in the State of Orissa.

Monitoring and Review: Programme data is generated at the Peripheral Health institutions on monthly basis. Quarterly Reports are compiled in the districts and one copy is sent to the State level and the other to National Tuberculosis Institute, Bangalore. NTI furnishes quarterly and Annual Reports to the Central TB Division and sends feed backs to the districts. The feed back to the State level is also sent from the Central Division. The districts also send monthly information on case-detection, sputum examination and new sputum positive cases under 20 Point Programme directly to the Central TB Division.

The programme is periodically reviewed by the Minister of Health and Family Welfare (every quarter) and the Secretary (Health) and Director General of Health Services (every month) for appropriate action. Procurement of Anti TB drugs and expenditure is reviewed monthly.

Annual Review Meetings of the Programme Officers of all States and Union Territories are held regularly.

Review of NTCP and Formulation of Revised Strategy: Consequent to the National Review of the programme in 1992 a Revised Strategy for Tuberculosis Control has been evolved based on its finds and recommendations. The Salient features of this strategy are:

(i) Achieve at least 85% cure rate of infectious cases through supervised Short Course Chemotherapy involving peripheral health functionary;

(ii) Augmentation of case finding activities through quality sputum microscopy to detect atleast 70% of estimated cases; and

(iii) NGO Involvement, IEC, improved MIS and Operational Research.

Implementation of Revised Strategy: In 1993 the Revised Strategy was launched in five project sites viz. Bombay, Delhi, Calcutta, Bangalore and Mehsana district of Gujarat to cover a total population of 2.35 million. The initial results show a sputum conversion of over 85% and a cure rate of over 80%.

In October, 1994 and February, 1995 an IDA Preparatory Mission reviewed and commended the pro-

gress and achievements made in implementing the Pilot Phase of Revised NTP. With their assistance the Technical, Laboratory and Operational Guidelines were finalised. Encouraged by the performance of Pilot Phase-I the Government of India decided to extend the Revised Strategy to 15 project sites with one district each in Gujarat, Kerala, Himachal Pradesh, West Bengal and Bihar and 10 cities of Delhi, Bombay, Calcutta, Madras, Hyderabad, Bangalore, Jaipur, Lucknow, Bhopal and Pune covering a total population of 13.85 million. World Bank assistance as Project Preparation Facility has been provided to the extent of US $ 1.996 million for this.

A number of workshops were conducted in 1995-96 for drafting the strategy for Involvement of NGOs and Private Practitioners in NTP, developing MIS and IEC strategy and formulation of strategy for tribal areas under Revised NTP.

The World Bank Mission visited India in the month of January-February, 1996. In the Phase-III, it is proposed to extend the Revised Strategy to 102 districts over a period of 5 years with World Bank assistance. In the year 1996-97 itself 39 districts will be covered with a population of 124.74 million.

The Revised Programme is proposed to be extended in a phased manner throughout the country during the 9th Plan period.

National Programme for Control of Blindness

National Programme for Control of Blindness was launched in the year 1976 as a 100% Centrally Sponsored programme. Various activities of the programme include establishment of Regional Institute of Ophthalmology, upgradation of Medical colleges and district hospitals and block level Primary Health Centres, development of mobile units, recruitment of required ophthalmic manpower in eye care units for provision of various ophthalmic services. The goal is to reduce the prevalence of blindness from 1.4% to 0.3% by 2000 A.D.

Budget Allocation: The assistance provided to the service components under this programme has been enhanced during 1995-96, with the budget allocation raised from Rs. 40 crore during 1994-95 to Rs. 72 crore during the current year 1995-96. There is a provision of Rs. 75 crore during 1996-97.

Year	Budget Allocated (Rs. in crore)	Expenditure Reported (Rs. in crore)
1993-94	25	19·70
1994-95	40	38·26
1995-96	72(RE 63 crore)	57·51
1996-97	75	—

The infrastructure developed so far and targets for the same for the year 1995-96 are as follows:

Infrastrutucre	Developed Upgraded so far	Services sanctioned during 1995-96
State ophthalmic cell	19	
Medical Colleges	81	1
District Hospitals	418	3
DMUs	269	5
PHCs	5117	26
Eye Bank (Govt.)	166(tot)	3
Eye Bank (Pvt.)	—	—
DBCS	456	
CHC/SDH	—	30

Performance of cataract operations has gone up. Target for the year 1994-95 was 24.50 lakh and 21.56 lakh operations were performed. A target of 26.20 lakh operations has been set for the year 1995-96 and 19.73 lakh operations have been performed so far.

Performance of cataract operations

Year	Targets	Achievements
1992-93	20,00,000	80%
1993-94	24,30,000	79%
1994-95	24,50,000	88%
1995-96	25,50,000	86% (upto Feb. 96)
1996-97	26,20,000	

Voluntary organisations are playing an important role in this programme. With the success achieved and experience gained through the pilot districts, District Blindness Control Societies are being established throughout the country under the Chairmanship of District Magistrate/District Commissioner. Training of District Blindness Control Coordinator are being carried out in a phased manner. Till about, 456 DBCS have been established. During 1995-96, grants-in-aid in instalments to tune of Rs. 13.19 crore was released to the District Blindness Control Societies.

Commodity Assistance: Consumable items including sutures are procured centrally and are being distributed to States and DBCS. Grants to NGOs are now being released through DBCS to ensure timely payment. Equipments, vehicles, and other supplies are also procured centrally.

External Assistance: The following two organisations have been actively involved in assisting the development activities since 1980.

Danida International/Development Agency (DANIDA): In 1978, an agreement was signed between the Government of India and the Govt. of Denmark to provide support for the development of services under NPCB, viz. supply of equipments to Mobile Units, PHCs and District Hospitals and covering part of recurring costs. It is involved in the following activities:

(a) Manpower development;

(b) Establishment of Management Systems at State level;

(c) Establishment and development of monitoring and evaluation systems;

(d) Preparation of Health Education material, teaching and information aids; and

(e) Training.

During the first phase of Danish Assistance (1978-87), an assistance of Rs. 10.12 crore was provided by the Agency to supplement the programme. Danish Assistance for Phase-II (1989-94) as envisaged comes 34.53 crore.

World Bank Assistance: Apart from the external assistance provided by the above organisations, a World Bank Assisted Cataract Control Project is under implementation since 1994-95. The proposed expenditure of the project is Rs. 554 crore during the period of 7 years. The States of the country namely Andhra Pradesh, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu and Uttar Pradesh. Major inputs of the project are upgrading the ophthalmic service, expanding the coverage in rural and tribal areas, establishment and functioning of DBCS, training of ophthalmic manpower, improving the management information system and creating awareness about the programme in the masses.

Under the World Bank Project a sum of Rs. 21 crore was allocated for the year 1994-95. Assistance of 48.60 crore was allocated for the year of 1995-96. Assistance of Rs. 61.00 crore is anticipated for the year 1996-97.

World Health Organisation (WHO): WHO is assisting NPCB in organising workshops and seminars at National and State levels and sponsoring fellowships for Regional and extra regional countries, professional development of manpower and supply of sophisticated ophthalmic equipments.

National Iodine Deficiency Disorders Control Programme

Iodine Deficiency Disorders (IDD) affect a large number of population living in all the continents of our planet. Iodine is an essential micronutrient which is required 100-150 micrograms daily for normal human growth and development. There is an increasing evidence of wide-spread distribution of environmental iodine deficiency not only in the Himalayan region but also in Sub-Himalayan terai areas, riverine areas and even the coastal regions. Iodine Deficiency starts its impact from development of foetus to all ages of human beings. It results in abortion, stillbirth, mental retardation, deaf-mutism, squint, dwarfism, goitre of all ages, neuromotor defects etc. It is worth to mention that Iodine deficiency thus directly affects the "Human Resources Development" and which in turn greatly affects the human productivity as well as country's development.

Magnitude of the Problem: As per information available more than 1.5 billion population of the world are at the risk of Iodine Deficiency Disorders (IDD), out of which, it is estimated about 167 million people are in our country. The Survey conducted by the Central and State Health Directorates, ICMR and medical Institutes have clearly demonstrated that not even a single State/UT is free from the problem of Iodine deficiency disorders. It is estimated that 54.4 million population are suffering from endemic goitre and about 8.8 million people are ental/motor handicaps. Sample surveys have been conducted in 25 States and 4 Union Territories of the country which revealed that out of 255 districts surveyed so far IDD is a major public health problem in 222 districts.

Control Programme: Realising the magnitude of the problem the Government of India launched a 100 per cent centrally assisted National Goitre Control Programme (NGCP) in 1962 with the following objectives:

(i) Initial surveys to assess the magnitude of Iodine Deficiency Disorders;

(ii) Supply of iodated salt in place of common salt; and

(iii) Resurveys to assess the impact of iodated salt every 5 years.

In August 1992, the National Goitre Control Programme (NGCP) was renamed as National Iodine Deficiency Disorders Control Programme (NIDDCP) with a view of wide spectrum of Iodine Deficiency Disorders.

Policy: On the recommendations of Central Council of Health in 1984, the Government took policy decision to iodate the entire edi-

ble salt in the country by 1992. The programme started in April, 1986 in a phased manner. To date, the annual production of iodated salt in our country is 34 lakh metric tonnes per annum.

IDD Training Programmes: A three day Training Programme in Management and Monitoring of National Iodine Deficiency Disorders Control Programme for the Regional Director of Health and Family Welfare as well as the State level Technical Officers was organised in April 1995 by the Directorate General of Health Services at New Delhi.

A three day Training Programme for Laboratory Technicians from the State level IDD Monitoring Laboratories organised by the Directorate General of Health Services in February 1996 at New Delhi.

Information, Education and Communication: To intensify IEC activities posters/danglers and radio/TV spots have been prepared. TV Spots are being regularly telecast through the National Network of Doordarshan about the consequences of Iodine Deficiency and the benefits of consuming iodised salt. The Central Council of Health in its meeting held in 1995 has again called upon the remaining State Governments to urgently issue notification banning the sale of salt other than iodated salt. The State Governments have been advised to include iodated salt under Public Distribution System (PDS).

National Mental Health Programme

Considering the importance of this programme, it was decided to revamp and revitalise the NMHP in 1995-96. Earlier, in the Fourth Conference of Central Council of Health and Family Welfare meeting on 11-13th October 1995 at New Delhi, a decision was taken in this direction. Accordingly a national workshop was held at Indian Institute of Management, Bangalore in February 1996 under the aegis of WHO and NIMHANS, Bangalore with the Health Secretaries/Administrators of various States and UTs.

Its recommendations form a basis for future course of action. As per its recommendations, the emphasis has been laid on community based approach and reaching the poor and unreached at the District P.H.C. level.

The training programmes to train the members of the District Mental team at the grass-roots level have already been initiated in Assam, Rajasthan, Maharashtra, Andhra Pradesh and Tamil Nadu. Rs. 3 lakh each have been made available to Institutes of Mental Health/Medical Colleges located in these States for organising the training programmes. This is in addition to the efforts being made by NIMHANS, Bangalore in this direction.

Ministry of Health with the help of WHO also appointed two Consultants during this year to help it implement the National Mental Programme in various States and UTs and also assist in formation of Mental Health Authority at the Centre as well as in various States. The Central Mental Health Authority constituted in 1992 came into force in April 1993 giving effect to the Mental Health Act 1987. During the year Mental Health Authorities have also been constituted in several States who would have the mandate of developing and regulating mental health services in their respective States.

During the year 1995-96, there was an allocation of Rs. 15 lakh for NMHP which was utilised as above.

National Cancer Control Programme

Cancer has become a major public health problem due to increasing longevity and changing life style. There are about 1.5 to 2 million cases of cancer in the country at any given point of time. Therefore, to strengthen National Cancer Control Programme which was started in 1975, the programme was revised in 1984 with the objective of:

(i) *Primary Prevention*: Health education and prevention of intake of tobacco.

(ii) *Secondary prevention*: Early detection of common cancers—cervix, mouth, breast and other tobacco related cancers; and

(iii) *Tertiary*: Under this strengthening of the existing institutions is being done for comprehensive therapy, surgical, radio and chemotherapy, palliative treatment, i.e. providing free morphine tablets to the users.

To strengthen the National Cancer Control Programme the following steps have been taken:

Regional Cancer Centre: That the existing Regional Cancer Centres be further strengthened to act as referral centres for complicated and difficult cases at tertiary level, Rs. 50.00 lakh each year to 8 Regional Cancer Centres out of twelve.

Development of Oncology Wing: A scheme for development of oncology wings in medical colleges has been initiated to fill up the geographical gaps in the detection and treatment of cancer. It is expected that each of the assisted institutions would carry out outreach programmes for early detection and treatment of cancer and that more such institutions would be developed under the scheme in the coming years. Financial assistance has been given to twelve medical colleges during last three years for cobalt equipments and upgradation of institutions, Rs. 1.50 crore to each medical college.

District Cancer Control Programme: One time assistance of Rs. 15.00 lakh and a recurring assistance of Rs. 10.00 lakh for 4 years are provided to a district under a scheme for District projects for health education, early detection and pain relief measures. State Governments/UT Administrations should, therefore, bring up more such proposals for assistance under the programme. So far 33 districts have been provided with the required funds.

Voluntary Organisations: A scheme has been initiated for financial assistance of upto Rs. 5.00 lakh to voluntary organisations for purposes of undertaking health education and early detection activities in cancer. The council recommended involvement of NGOs on a large scale in the Cancer Control Programme.

Cobalt Therapy Installation: The efforts should be made to strengthen the Programme further during the coming years. Financial assistance for cobalt therapy units has further been increased to Rs. 1.00 crore per unit and other radiotherapy equipments have been brought under the ambit of the scheme. A sum of Rs. 18.15 crore (Plan) was spent on the Programme during the year 1993-94. A sum of Rs. 18.00 crore was spent on the Programme during the year 1994-95. For 1995-96 a sum of Rs. 16.00 crore has been allocated for National Cancer Control Programme for suitably augmenting the treatment facilities in the country. Effective monitoring of the programme, establishment of Cancer Control Boards at the National and State Levels should be set up and/or suitably strengthened. During the last 3 years, financial assistance has been released to 23 medical colleges/hospitals/institutions for installation of Cobalt therapy facilities.

Government of India has allocated Rs. 80.00 crore for VIII. Plan period as against Rs. 19.34 crore for the VII plan. As such more schemes are being launched in VIII Plan period under National Cancer Control Programme.

National AIDS Control Programme

National AIDS Control Programme including Blood Safety and STD Control: HIV infection has been reported from almost all States and Union Territories of the country but the emerging pattern of geographical distribution is not uniform. Though the dominant mode of transmission of HIV infection in the country still remain heterosexual contact, the pattern of transmission in North-Eastern States seems to be predominantly through sharing of infected needles by injecting drug users.

As per the HIV screening report available to us as many as 26.79 lakh persons have been screened for HIV of which 22,529 have been found sero-positive as on 31 March 1996. The sero-positivity rate per thousand works out to be 7.99. A total of 2,528 AIDS cases during the same period have been reported in India. These figures do not convey the actual magnitude of HIV/AIDS in the country and represents only a fraction of actual morbidity due to HIV.

Realising the gravity of epidemiological situation of HIV prevailing in the country, the Government of India launched a comprehensive scheme at an estimated cost of Rs. 222.6 crore during the 8th Plan with assistance from the World Bank to the tune of US $ 84 million and another US $ 1.5 million in the form of technical assistance from WHO. Another scheme for Rs. 45.22 crore was prepared for strengthening the Blood Banking System in the country. This scheme is now integrated with the scheme for Prevention and Control of AIDS in India being implemented with World Bank Credit.

Ministry of Health and Family Welfare has set up a National AIDS Control Organisation as a separate wing to implement the programme. The overall objective of the project is to arrest the spread of HIV/AIDS infections in the country with a view to reducing the future morbidity, mortality and infection of AIDS.

The project consists of the following components:

(a) *Strengthening Programme Management Capabilities*: National AIDS Control Organisation is primarily involved in planning, consulting, implementing and monitoring the various activities under the project through the AIDS Control Cells at the State/UT level. The programme is being implemented as a Centrally Sponsored Scheme through all the State/Union Territories, with 100% Central assistance;

(b) *Strengthening of IEC*: Since there is no cure for AIDS as of now, the project seeks to carry out intensive public awareness and community support campaigns through Mass Media and sustained dissemination of information and health education about HIV and AIDS to all level and categories of personnel;

(c) *Prevention of Transmission through Blood and Blood Products*: The project seeks to upgrade the blood banking capabilities in the public sector and expansion of HIV capabilities in the public sector and expansion of HIV screening of all blood used for transmission and blood-products in the country. With this end in view, all the 715 (already existing 608+newly identified 107) Blood Banks in the public sector are being strengthened. 31 Blood Component Separation Centres are being set up to promote rational use of Blood. Orders have been placed for the equipments required for all the 31 units. The equipment is expected to be received shortly.

(d) *Strengthening Clinical Management Capabilities*: The project seeks to strengthen the institutional capabilities at the State/UT level for monitoring the development of HIV and AIDS epidemic and planning and programming interventions to control such epidemic. 150 Zonal Blood Testing Centres and 62 Surveillance Centres have been set up where blood testing facilities for HIV are available. Linkages have been provided through the country. In addition to this, 9 HIV referral centres have also been set up. An exhaustive Plan has been drawn to train medical officers down the district and taluk levels in diagnostic skill and clinical management of HIV/AIDS cases. About 3,900 crore trainers have already been trained and with the help of these core trainers the States/UTs are training their medical officers of District Hospitals, Primary Health Centres etc.

Controlling STD: One of the predominant mode of transmission of HIV infection is through sexual contact. The project seeks to take up activities to strengthen the clinical services and case management activities in STD Centres in 97 Medical Colleges and 275 District level STD Clinics. Apart from this 132 new STD Clinics in various States/UTs have been identified and have been taken up for strengthening. About 400 medical officers have been trained as core trainers. Similarly, about 250 laboratory technicians were trained in the lab. diagnosis of STD. With the help of these trainers, the State Governments will arrange further training programmes to cover all the medical and para-medical staff in STD Clinics.

USAID APAC Project: The Scheme for Prevention and Control of AIDS (APAC) is being implemented in Tamil Nadu by a Non-Governmental Organisation named Voluntary Health Services, Madras. This project is getting 100% financial support from USAID. Government of India contribution is in the form of condom distribution in the State through Family Welfare Department. The assistance from USAID to the Voluntary Health Services, Madras is passed through Government of India budget.

National Diabetes Control Programme

National Diabetes Control Programme was started on pilot basis during 7th Five Year Plan in some of the districts of Tamil Nadu, J&K and Karnataka, but due to paucity of funds in subsequent years this programme could not be expanded further in remaining years. However, a sum of Rs. 20 lakh was allocated for this programme during 1995-96 which was reduced to Rs. 12 lakh at RE stage in the same year. A small expert group consisting eminent diabatologist had met in DGHS and assisted the DDG (NCD) in preparing a PIC note for this purpose. Thereafter, a Steering Committee Meeting consisting 7 eminent diabatologists from various institutions was organised at Planning Commission in September, 1995. ○

INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY

Y. N. CHATURVEDI
Secretary
Department of Indian Systems of Medicine & Homoeopathy

IN March 1995, the Government of India decided to create the new Department of Indian Systems of Medicine and Homoeopathy (ISM&H) by bifurcating the Department of Health in the Ministry of Health and Family Welfare. Thus, the Ministry of Health and Family Welfare has now three Departments, the Department of Family Welfare, the Department of ISM&H and the Department of Health. Operationally, the Department of ISM&H has become functional as a Department with the posting of a new Secretary in December, 1995.

While the ISM&H have always had the broad policy support of the Government, the manpower and financial resources have remained only modestly available because the allopathic system being looked after by the Department of Health, by its sheer size and current acceptability have inevitably dominated in claiming greater share of manpower and financial resources available to the Department.

BUDGET ESTIMATES

(*Rs. in crore*)

	1994-95		1995-96	
	Plan	Non-Plan	Plan	Non-plan
Family Welfare	1430·00	248·68	1581·0	314·51
Health	538·90	673·68	621·48	796·08
ISM&H	26·10	16·38	23·09	17·85

In 1995-96, the Non-Plan allocation for ISM&H was 5.6 per cent of the Non-Plan allocation for the Department of Family Welfare and 2.2 per cent for the Department of Health. In Plan allocation the provision for ISM&H was 1.4 per cent of the Plan budget allocation for the Department of Family Welfare and 3.7 per cent for the Department of Health. Sixteen States have a separate Department/Directorate of ISM&H. As far as dispensaries are concerned, out of 313 CGHS dispensaries (Central Government Health Scheme), 68 dispensaries have one or more ISM units. In the State Sector, while there are 235 allopathic dispensaries/hospitals, there are only 78 dispensaries/units/hospitals of ISM&H. At the District and super speciality level, the ISM&H practically have no hospitals in the country comparable to such hospitals on the allopathic side. Thus, while there is wide acceptance for the ISM&H systems of treatment, the resources thus far invested in the development of ISM&H systems have been disproportionately less and the Government resources for making available the treatment facilities to the patients have been invested much less in the ISM&H sector. ○

EDUCATION AND TRAINING

THE Central Council to Indian Medicine is a statutory body constituted under the Indian Medicine Central Council Act, 1970. The first Council was nominated by the Government of India in 1971. The Council was reconstituted in 1984, and functioned upto 13th March 1995. The Ministry of Health and Family Welfare reconstituted the Central Council of Indian Medicine which started functioning from 14th March 1995.

The main objectives of the Central Council are as follows:

(i) To prescribe the minimum standards of education for courses in Indian Systems of Medicine viz. Ayurveda, Siddha and Unani;

(ii) To advise Central Government in matters relating to recognition of medical qualifications of Indian Medicine;

(iii) To maintain the Central Register of Indian Medicine and revise the register from time to time; and

(iv) To regulate practice in Indian Medicine and prescribe standards of professional conduct, Etiquette and Code of Ethics to be observed by the practitioners.

The Central Council of Indian Medicine is responsible for laying down and maintaining uniform standards of education in the fields of Ayurveda, Siddha and Unani and regulating practice in these systems under the provisions of the IMCC Act, 1970. The uniform curriculum and syllabus for Under-graduate and Post-graduate education in these systems have already been prescribed. These are amended from time to time per requirements. The Council has also prescribed the standards of Professional Conduct, Etiquette and Code of Ethics for practitioners of Indian Systems of Medicine. The Council considers the issue for inclusion of medical qualification granted by the Universities in the Schedules to the IMCC Act, 1970.

Central Council of Homoeopathy

The Central Council of Homoeopathy is a corporate body established under the provisions of Homoeopathy Central Council Act, 1973 to maintain Central Register of Homoeopathy and matters connected therewith. The Council is also responsible for maintaining minimum standards of medical education in Homoeopathy.

The Central Council has allowed the upgradation of 9 colleges from Diploma to Degree level subject to certain conditions. It also extended the recognition of 5 new colleges, and has recognised 6 new colleges in Maharashtra State for starting BHMS degree course in Homoeopathy subject to certain conditions.

The Central Council has allowed H.K.E.'s Homoeopathic Medical College, Gulbarga to start M.D. (Hom.) Course for one year subject to certain conditions. The Central Council has inspected 2 more colleges in Maharashtra State namely Shree Bhagwan Homoeopathic Medical College, Aurangabad and Foster Development's Homoeopathic Medical College, Aurangabad on receipt the request from Marathwada University for assessing their viability to start M.D. (Hom.) Course.

Rashtriya Ayurveda Vidyapeeth

Rashtriya Ayurveda Vidyapeeth is an autonomous organisation under Ministry of Health and Family Welfare, Government of India. It is a registered Society under Societies Registration Act, 1860 and was established on 11th February, 1988. Presently, it is accommodated in the premises of Dhanwantri Bhavan, Road No. 66, Punjabi Bagh, New Delhi-110026.

Rashtriya Ayurveda Vidyapeeth was established with the aim to promote knowledge of Ayurveda through Guru Shishya Parampara in various subject of Ayurveda by appointing Gurus amongst its fellows and by imparting training to Ayurvedic Scholars possessing Postgraduate qualification in Ayurveda or Graduate in Ayurveda with three years teaching/research/professional experience by enrolling them as Shishyas.

The Vidyapeeth awards fellowships to the eminent scholars of Astnaga Ayurveda and practitioners of various techniques of Ayurveda. The Vidyapeeth has awarded 50 fellowships in the beginning who are foundation fellows. Thereafter the maximum of 30 fellowships are awarded every year.

National Institutes

The Four National Institutes viz. (i) National Institute of Ayurveda at Jaipur; (ii) National Institute of Homoeopathy at Calcutta; (iii) National Institute of Unani Medicine at Bangalore and (iv) National Institute of Naturopathy at Pune, have been set up under the Ministry of Health and Family Welfare.

DEVELOPMENT OF MEDICINAL PLANTS

The Ministry of Health and Family Welfare have initiated a number of steps for development of medicinal plants which have been the basic source of raw material for preparation of medicines of ISM and Homoeopathy. In this direction, a unit called 'Medicinal Plants Cell' was set up in the Ministry. Later in the year 1990-91, the Ministry implemented a purely Central Scheme under Plan known as 'Central Scheme for Development and Cultivation of Medicinal Plants'.

The objective of the scheme is to augment the production of raw herbs of plant origin by providing central assistance for their cultivation and development. As per present pattern of the scheme, central assistance is provided to Government/Semi Government organisations including ISM and Homoeopathy institutions, autonomous/statutory bodies etc. directly controlled by the Government for setting up/expansion of herbal gardens for growing of identified plants. The organisations seeking grant under this scheme should have basic infrastructure, expertise and minimum five acres of land.

The basic strategy to augment the production of these medicinal plants through this scheme is to involve concerned organisations in cultivation of these plants and thereby working out the cultivation techniques and also commercial viability in their cultivation, and then pass on this information to commercial growers.

AREAS OF PRIORITY

With the creation of new Departement of ISM and H in March 1995, higher expectations have been aroused for the development of these systems. These systems are facing a number of pressing problems which have to be redressed on priority.

Firstly, the availability of herbs and medicinal plants in the country is a serious problem. The forests have been traditionally the source of such plants, but increasing population and therefore increasing demand and shrinking forest areas availability is becoming very difficult to the point that a large number of Ayurvedic herbs and plants are not easily available. Because of this, the practising physicians feel large scale substitution is taking place in manufacturing of ISM medicines. Therefore, availability of herbs and plants needs to be increased sharply and fairly quickly.

Secondly, the standards of ISM and H medicines seems to be leave much to be desired. Partly the work of laying down standards and testing procedures has not been completed and because of this the system of testing for genuineness of the drugs is very weak and partly the regulatory control over the manufacturing system is weak. It is obvious that a good standards of drugs and medicines has to be ensured both in the interest of good health of the users and in the interest of credibility of these systems.

Thirdly, the treatment facility in the Government Sector in ISM and Health is proportionately much less particularly when one notices a much wider acceptance among the public for the ISM and Health systems.

Fourthly, while there are enough ISM and Health educational institutions, the infrastructure and manpower facilities there and the standards of teaching are grossly below acceptable levels. These institutions have remained very underprovided both in the Central and the State Sectors. It is urgently necessary that the facilities and standards in these institutions are improved without delay because otherwise they will keep on producing sub-standard graduates who in turn will continue to remain a liability rather than an asset to these disciplines.

Finally, the research effort in the sector has remained very weak even though the country has large body of research personnel and institutions. This has been largely due to nominal resources available for Research and Development in the past due to which the Central Councils for Research in ISM and H have refrained from reaching out to institutions outside the ISM & H sector in the country for collaboration in R&D.

HIGHLIGHTS OF FAMILY WELFARE PROGRAMME

Several important initiatives were taken by the Department of Family Welfare to increase the coverage of Family Welfare services in the country during 1995-96. Some of the highlights are:

THE Pulse Polio Immunization (PPI) was successfully implemented on 9th December, 1955 and 20th January, 1996. 8.7 crore children including 7.9 crore in the age group 0-3 years were given a dose of oral polio vaccine in the country on 9th December, 1995 and 9.3 crore children including 8.5 crore in the age group 0-3 years were given a dose of oral polio vaccine in the 2nd round on 20th January, 1996.

The response was overwhelming and unprecedented. Reports from States indicated that a festive atmosphere prevailed in the villages and towns with the mothers making a beeline for the immunization posts since early in the morning. At the country level more than 100% of the target was achieved in both the rounds. More than 100% target was achieved by the State/UTs of Arunachal Pradesh, Assam, Bihar, Haryana, J & K, Kerala, Manipur, Mizoram, Madhya Pradesh, Punjab, Rajasthan, Sikkim, Tripura, Uttar Pradesh, Delhi, D & N Haveli and Pondicherry.

Overwhelming response to PPI programme has prompted the Department of Family Welfare to prepare for a massive health check-up programme of about 10 crore primary school children in July, 1996, through the campaign mode of approach.

The Department of Family Welfare conducted a series of discussions, meetings and workshops by involving experts, representatives of States, NGOs etc. was held for rationalising training system and reduction in overlaps of services.

Workshops have been conducted in almost all districts for decentralised planning system in which the districts will be the organiser/coordinator/implementor of all training programmes with support from States and Centre.

Pilot projects without targets have been successfully implemented in 18 districts all over India and in two States, Kerala and Tamil Nadu. Encouraging results have led to the entire programme becoming free of targets from April 1, 1996.

For monitoring the work done, quality and impact indicators have been developed which will replace the targets.

Swasthya Melas have been implemented in many tribal and remote places in the country with the help of NGOs. Despite low cost initiative, Swasthya Melas have proved to be very effective.

To emphasise the need for close liaison with NGOs as they are the most competent means of addressing the needs of women and children, a one-day workshop of NGOs working in Jammu and Kashmir was held on February 5, 1996 under the Chairmanship of the Secretary (FW) to sensitise and promote NGOs from J&K to take up the challenging task of providing the interface between people and the Government schemes.

Intensive IEC activities were organised to generate massive awareness and mobilise the community for the PPI programme on 9th December, 1995 and 20th January, 1996.

ACHIEVEMENTS OF THE FAMILY WELFARE PROGRAMME

Parameter	1951–61	1981	
Birth rate	41·7	37·2	28.7 SRS 94
Death rate	22·8	15·0	9.3 SRS 94
Total Fertility Rate	5·97	4.5	3.5 SRS 93
Infant Mortality Rate (per 1000 live births)	146·0	110.0	74 SRS 94
Couple Protection Rate (Percent)	10·4 (1970–71)	22·8	45.8 (31-3-95)
Cumulative Number of Births Averted (in Million)	0·04 (1956–60)	44·19 (31-03-81)	182·76 (31-3-95*)

*Provisional

On the occasion of World Population Day, several thousand members of Mahila Swasthya Sangh of different States assembled at Gwalior and pledged themselves to work for the Family Welfare of the people of India.

The Family Welfare pavilion at the India International Trade Fair, 1995 was adjudged the second best among all State and Central pavilions for its excellent thematic display.

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

The data from the Sample Registration System (SRS) for 1994 indicate that the estimated annual live birth rate was 28.7 in 1994. Within this, however, the States exhibit a wide variation in the estimated live birth rates. The States of Kerala and Tamil Nadu have returned live birth rates of 17.4 and 19.2 respectively. The States of Assam, Bihar, Haryana, Madhya Pradesh, Rajasthan, Uttar Pradesh, Meghalaya and the Union Territory of Dadra & Nagar Haveli have returned live birth rates significantly in excess of the national average. In the rural areas, the birth rates are significantly in excess of the national average. In the rural areas, the birth rate continues to be higher (30.5), as compared to urban areas (23.1). The death rate has gone down to 9.3 in 1994. The Infant Mortality Rate for the 16 bigger States was 74 in 1994. Within this, however, the States again display a wide variation in the Infant Mortality Rates. The States of Assam (IMR 78), Madhya Pradesh (IMR 98), Orissa (IMR 103), Rajasthan (IMR 84) and Uttar Pradesh (IMR 88) display Infant Mortality Rate significantly in excess of the national average. The natural growth rate, which is the difference between birth rate and death rate, SRS data shows 1.94% in 1994.

If the averted births had taken place during 1981-91 the growth rate of population could have been 2.71% per annum as against 2.14% as enumerated in the Census.

The Eighth Plan document of the Planning Commission estimates that the growth rate of population should be 1.78% by the end of Eighth Plan, i.e. 1977 and should come down to 1.65% during 1996 to 2001. It has been reckoned that the NRR: 1 level may attained only in the period 2011 to 2016 A.D. India's fertility and mortality levels and the age distribution of the population are such that even after attaining NRR : 1 in the above period, the zero growth rate of population (stabilisation of population) may be achieved only after several decades. O

MATERNAL AND CHILD HEALTH PROGRAMME

Care of mothers and children—the most vulnerable sections of our society—occupies a paramount place in our health services delivery system. This is reflected from the fact that 9 out of the 17 goals listed in the National Health Policy (1983) relate to Maternal and Child Health.

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

(a) Universal Immunization Programme (UIP) for the control of vaccine preventable diseases namely, diphtheria, pertussis, neo-natal tetanus, tuberculosis, poliomyelitis and measles.

(b) Oral Rehydration Therapy (ORT) Programme for control of deaths due to dehydration caused by diarrhoea. It is estimated that about one million children die of diarrhoea every year and most of these deaths can be prevented if dehydration is checked.

(c) Prophylaxis Schemes against nutritional anaemia among pregnant and lactating mothers and against blindness due to Vitamin A deficiency among children of under 5 years of age.

The impact of the above interventions is becoming perceptible in the declining trends of disease incidence and Infant Mortality Rate. The Universal Immunisation Programme, started in 1985-86, has particularly succeeded in establishing a system of contact between the beneficiaries, mothers and children and the paramedical workers the ANMs located at the Susidiary Health Centres.

The access established under the immunization programme is now being utilized to extend and intensify other services related to maternal and child health under the Child Survival and Safe Motherhood (CSSM) Programme which was launched in the year 1992-93. The Programme, being implemented with the financial assistance of World Bank and UNICEF with an overall approved outlay of Rs. 1125.51 crore over a seven year period (1992-93 to 1997-98), has the following components:

(i) Sustaining and strengthening the ongoing Immunisation, Oral Rehydration Therapy (ORT) and prophylaxis schemes;

(ii) Improving maternal care at the community level by providing an enhanced reporting fee of Rs. 10.00 per case to the Traditional Birth Attendants (TBAs) and disposable delivery kits to the pregnant women;

(iii) Expanding, in a phased manner, the programme for control of Acute Respiratory Infections (ARI) for children below 5 years of age; and

(iv) Setting up, in a phased manner, a network of sub-district level First Referral Units (FRUs) for improving emergency obstetric care in the States of Assam, Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh.

The UIP, ORT, prophylaxis schemes of IFA and Vitamin A administration to pregnant women and children respectively, and Dais' training etc. are ongoing activities in all districts. Additional interventions relating to ARI control (along with training/retraining of medical

and para-medical staff) and setting up of First Referral Units in the six States, will be expanded in a phased manner. For convenience, these have been termed as "Child Survival" and "Safe Motherhood" components respectively. The phasing plan is as given below.

Year	Child Survival		Safe Motherhood	
	New	Cumulative	New	Cumulative
1992-93	51	51	21	21
1993-94	103	154	32	53
1994-95	101	255	51	104
1995-96	98	353	48	152
1996-97	113	466	67	219

ACHIEVEMENTS

Immunisation

6.2.1. Universal Immunisation Programme (UIP), declared as one of the Technology Missions in 1986, was launched in 1985 as part of the overall national strategy to bring down infant and maternal mortality in the country by providing immunisation to all infants against six vaccine preventable diseases and pregnant women against tetanus. Towards this, additional inputs in the form of cold chain equipment, vaccines, training of medical and paramedical staff and IEC material etc. were provided to all the districts, in a phased manner. Beginning with 31 districts in 1985-86, the Programme was expanded to all districts by 1989-90.

Under the UIP, every year about 25 million infants are to be vaccinated before they are one year old with three doses of DPT vaccine (Diphtheria. Pertussis and Tetanus), three doses of polio vaccine (orally administered) and one dose each of the measles and BCG vaccines. About 27 million pregnant women are also to be administered two doses of tetanus toxoide (TT) as prevention against tetanus to them and to their new born.

Diarrhoea causes dehydration through the excessive loss of water and salt (sodium chloride) in liquid stools. Dehydration can be prevented by replacing these losses as they occur by giving sufficient amounts of fluids and food (with salt).

Water is rapidly absorbed even during diarrhoea. In contrast, salt is absorbed only when food molecules are also present in the intestines and are also being absorbed. The ability to absorb food molecules remains normal during diarrhoea.

ORS solution provides water, glucose and salt, plus other electrolytes, in a single solution. Home therapy works in the same way by using fluids and food available at home.

At the beginning of the Programme in 1985-86 vaccine coverage levels ranged between 29% for BCG and 41% for DPT. By the end of March 1995 coverage levels have improved significantly and ranged between 81% for tetanus Toxoid for Pregnant Women to 97% for BCG. During 1995-96 upto (February 1996) coverage levels ranged from 67% for TT (PW) to 84% for BCG.

Impact on Infant Mortality Rate (IMR)

The impact of the programme is reflected in the significant drop in the infant mortality rate from 129 in 1976 to 104 in 1984 and has reached 73 in 1994. In the states of Bihar, Madhya Pradesh, Orissa and Rajasthan the IMR has come down specially during the last four years. In Uttar Pradesh, IMR has declined from 118 in 1989 to 88 in 1994. In Madhya Pradesh, it has declined from 117 in 1989 to 98 in 1994 and in Rajasthan, the IMR has declined from 96 in 1989 to 84 in 1994. The IMR in the State of Orissa is still above 100. Further, there is a wide difference in the IMR in 1994 in rural and urban areas which were 79 and 51 respectively.

Oral Rehydration Therapy for Diarrhoea Control among Children

The Oral Rehydration Therapy Programme was started in 1986-87 in a phased manner. The main objective of the programme is to prevent deaths in children caused by diarrhoeal diseases due to dehydration. Diarrhoea still remains one of the leading causes of death among children under 5 years. ORS has been used as a drug of choice for proper case management of diarrhoea cases.

ORS supplies are being organised by the Government of India centrally and 355.84 lakh packets were procured and supplied to the states and union territories during 1994-95. For 1995-96, provision has been made for supply of 546.53 lakh packets. In the CSSM districts, ORS is being supplied as a part of the sub-centre kits. In order to make ORS packets widely available, States have been advised for marketing of ORS packets through the Public Distribution System.

The programme emphasizes rational use of drugs for the management of Diarrhoea. Anti-diarrhoeals have no place in the treatment of Diarrhoea; while antibiotics are recommended only for specific indications like Cholera and Dysentery. A Gazette Notification, dated 30 Sep. 1994, now prohibits the manufacture, sale and distribution of anti-diarrhoeal drugs in public interest.

Interpersonal communication for promotion of ORT, through mother's meeting was started in 1990-91. During 1994-95, an amount of Rs. 232.80 lakh was allocated to the States for this activity. An allocation of Rs. 251.00 lakh has been made during 1995-96 for the States.

The Bharat Scouts & Guides are proposed to be involved to propagate the messages on the promotion of ORT. For this purpose an amount of Rs. 15 lakh has been sanctioned for training of scouts under this project. In addition single sheeters on 'Advise to Mothers' on ORT and 10 lakh ORS packets for Scouts/ Guides are also being made available.

Prophylaxis Schemes

Anaemia Prevention and Control among Pregnant Women: Anaemia, which accounted for 20% of the maternal deaths in the country in 1991, is one of the leading causes of maternal mortality and is an aggravating factor in haemorrhage, toxemia and sepsis. The CSSM Programme, therefore, has prioritised pregnant women for IFA administration. During 1994-95, 208 lakh (85.8%) pregnant women were provided with the recommended dosage of IFA tablets.

Prevention and Control of Vitamin A deficiency among Children: Vitamin A deficiency, which can lead to blindness, has been widely prevalent in the country, especially among the pre-school children. The CSSM Programme seeks to administer five doses of Vit 'A' to all children under 3 years of age. The 1st dose (100,000 units) is given at 9 months of age alongwith Measles vaccine. The second dose (200,000 units) is given along with DPT/OPV booster doses. Subsequent three doses (200,000 units each) are given at six monthly intervals. During 1994-95, 149.8 lakh (72.6%) infants were administered the measles-linked dose while the DPT/OPV booster linked dose was administered to 98.6 lakhs (54.8%) children in the age group of 1-2 years.

Acute Respiratory Infections (Pneumonia) Control

Pneumonia is a leading cause of deaths of infants and young children in India, accounting for about 20% of the under-five deaths. The ARI control strategy was developed during the period 1989 and implemented in 24 districts on a pilot basis. During 1990 pilot projects were taken up in 14 districts in 13 States and pilot projects were implemented in 10 more districts during 1991. The programme includes the training of peripheral level health workers on recognition of pneumonia and treatment with cotrimoxazole. An evaluation carried out in two districts in 1991 found that the trained health workers were able to correctly diagnose and treat pneumonia, Cotrimoxazole availability at subcentre level was also adequate.

The rational treatment of ARI and prevention of deaths due to pneumonia is now an integral part of CSSM and the health workers are being imparted practical skills training in ARI management. Cotrimoxazole is being supplied to the health workers through the CSSM drug kit. Communication messages focus on recognition of symptoms and referral and are channelled through mothers meetings, interpersonal communication with ANMs and other sectors such as ICDS.

Training Under CSSM

The CSSM training, to be expanded in a phased manner, beginning with 51 districts in 1992-93, has two objectives; (i) to retrain the medical and paramedical workers for the continuing activities viz. immunisation, ORT, prophylaxis schemes and (ii) to impart skill based training to the medical and para-medical personnel for pneumonia control activities. Thus, the training for the programme managers, medical officers and the paramedical staff has been integrated to include the entire range of maternal and child health care interventions.

Upto October, 1995, 34 regional training/orientation workshops for state core members have been organised in which 786 DIO/DHOs and principals of HFWTCs been trained. Upto April 1995, 20,492 Medical Officers and 68,382 Paramedical

workers have been trained in the Phase-I, Phase-II and Phase-III districts.

An integrated training on management of diarrhoea, ARI and newborn care, module for the clinicians has also been developed.

First Referral Units (FRUs) For Emergency Obstetric Care

Under the Child Survival and Safe Motherhood Programme support in the form of equipment to First Referral Units (FRU), Primary Health Centres and Sub-centres, from Government of India was envisaged for the districts in only six States viz, Assam, Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh. It has now been decided that equipment to strengthen Emergency Obstetrics Care (EOC) would be supplied to all districts in the country. Equipment for safe motherhood activities is being supplied in the form of Kits. Sub-centres and Primary Health Centres would be supplied Kit C (Sub-Centre Kit) and Kit D (Primary Health Centre Kit) respectively. Health facilities which can function as First Referral Units will receive Kit E to Kit P. Details of the kits are given below:

Kits for First Referral Units	
KIT E	Laparotomy set
KIT F	Minilaparotomy set
KIT G	IUD insertion set
KIT H	Vasectomy set
KIT I	Normal Delivery set
KIT J	Vacuum extraction set
KIT K	Embryotomy set
KIT L	Uterine evacuation set
KIT M	Equipment for anaesthesia
KIT N	Neonatal resuscitation set
KIT O	Equipment and reagents for blood tests
KIT P	Donor blood transfusion set

Strengthening of sub-district health facilities will improve the quality of maternal care. In districts where sub-district PP Centres exist, it has been decided that the sub-district PP Centres will function as FRU and would be supplied equipment Kits E to P. In addition, 1-3 additional sub-district health facilities are to be designated as FRUs. These would also receive Kits E to P. States will identify these additional health facilities (like CHCs or large PHCs with sufficient obstetrics case load), which are to function as FRUs.

In districts where there are no sub-district PP Centres, two health facilities which can function as FRUs will be supplied Kits E to P. States are to identify these health facilities.

With a view to establishing an effective referral system for Emergency Obstetric Care (EOC) in the districts, the Primary Health Centres and Sub-centres in the catchment areas of the FRUs will also be provided equipment. States have been requested to identify 5 PHCs and 36 sub-centres in the vicinity of the FRUs for supply of equipment Kits D and C respectively. States have been informed that personnel in the PHCs and sub-centres may be advised that patients requiring EOC from their services areas may be referred to the designated FRU of that area.

Financial Assistance to States

During the year 1994-95, a total assistance of Rs. 250.00 crores have been provided to the States/UTs. This includes commodity assistance of Rs. 28.00 crore and cash assistance has been released for meeting operational expenses, salary of additional staff, POL, contingencies, mothers meeting and maintenance of cold chain equipment etc. The kind asistance comprised of vaccines, cold chain equipment, Iron and Folic acid tablets, Vitamin A solution, Oral Rehydration Salts (ORS) packets, equipment kits and vehicles etc.

For the year 1995-96, the Programme has been provided with an outlay (BE) of Rs. 220.00 crore. Out of this outlay the cash and kind assistance earmarked for the States/UTs has been estimated at Rs. 218.00 crore. This will consist of Rs. 30.00 crore as cash assistance and Rs. 188.00 crore as kind assistance. The revised outlay is, however, estimated at Rs. 300.00 crore, which includes Rs. 80.00 crore for Pulse Polio Immunization (PPI) and Rs. 30.00 crore for procurement of cold chain equipment.

Pulse Polio Immunization (PPI)

Government of India decided to implement the strategy of National Immunization days i.e. Pulse Polio Immunization, beginning in 1995 to achieve polio eradication by the year 2000. In the first phase, Government decided to observe pluse polio Immunization on the two fixed days on 9th Dec, 1995 and on 20th January, 1996. On these two days, oral polio vaccine (OPV) was given to all children 0 to 3 years of age in the entire country regardless of previous immunization.

The Pulse Polio Immunization (PPI) was successfully implemented on the fixed days of 9th Dec, 1995 and 20th January, 1996. 8.7 crore children including 7.9 crore in the age group 0-3 years were given a dose of oral polio vaccine in the country on 9th Dec, 1995 and equal number of 9.3 crore children

including 8.5 crore in the age group 0—3 years were given a dose of oral polio vaccine in the 2nd round on 20th January, 1996. Coverage in urban areas was in general lower than in rural areas.

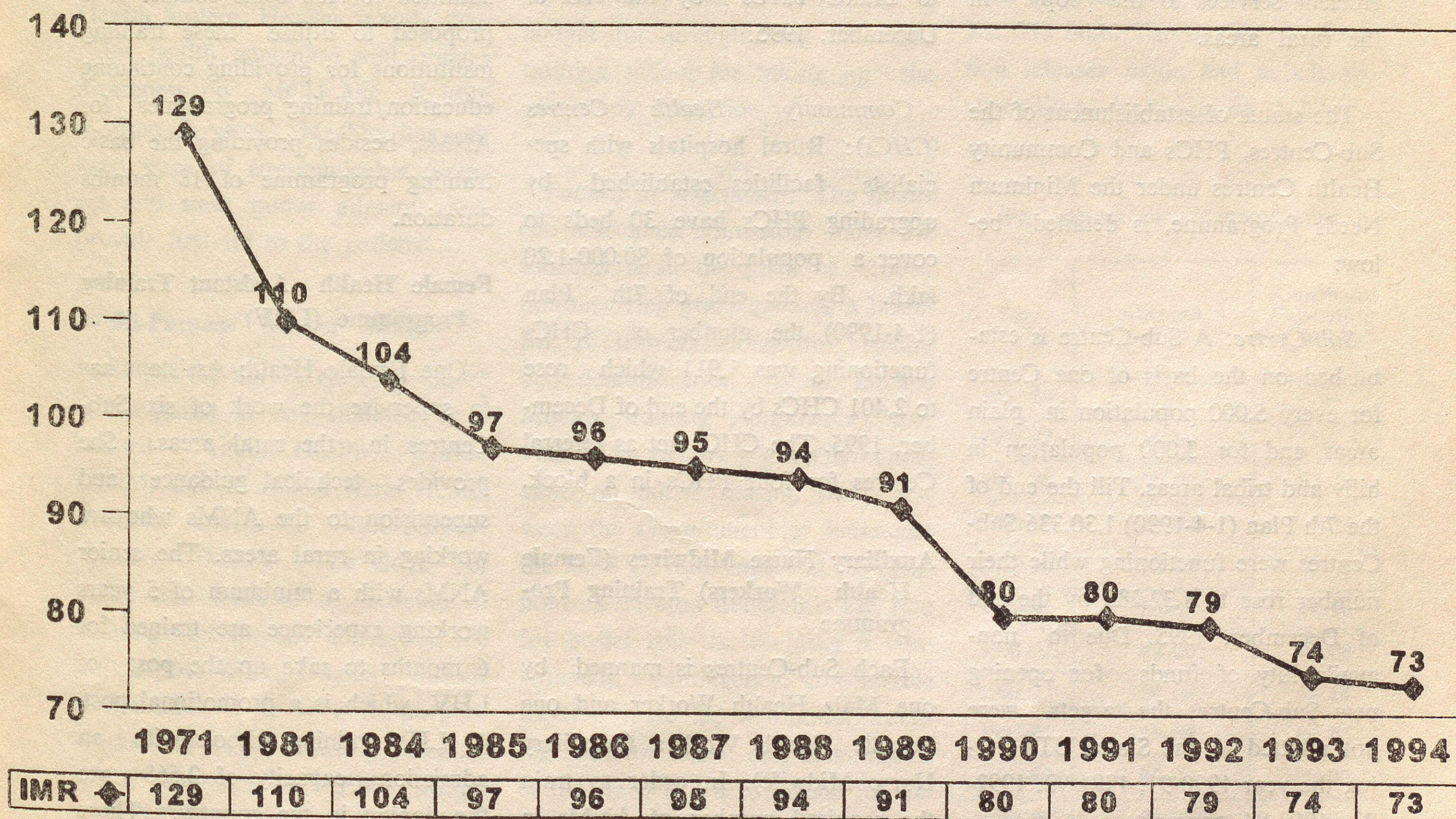
The response was overwhelming and unprecedented. Reports from States indicated that a festive atmosphere prevailed in the villages and towns with the mothers making a beeline for the immunization posts since early in the morning. At the country level more than 100% of the target was achieved in both the rounds. More than 100% target was achieved by the States/UTs of Arunachal Pradesh, Assam, Bihar, Haryana, J&K, Kerala, Manipur, Mizoram, Madhya Pradesh, Punjab, Rajasthan, Sikkim, Tripura, Uttar Pradesh, Delhi, D&N Haveli and Pondicherry.

Vaccines were received under proper cold chain conditions with vaccine carriers being used in the PPI posts. More than 85% of the posts had 4 or more persons at each post. 40% of the PPI coordinators were medical doctors, 50% were paramedical workers and government personnel from other departments and 5% each were teachers and NGOs. 50% of the posts visited were in urban areas, 35% rural, 5% urban slums, 5% transit points and the remaining were resettlement colonies and tribal areas.

PPI was the biggest public health intervention ever to be carried out in our country and the outstanding coverage achieved is commendable. All departments of the government and non-governmental organisations successfully coordinated and cooperated to achieve this.

It has been decided to implement 2nd phase of Pulse Polio Immunization on two days i.e. on 7th Dec, 96 and 18th January, 1997. ○

INFANT MORTALITY RATE



	1971	1981	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
IMR ◆	129	110	104	97	96	95	94	91	80	80	79	74	73

RURAL HEALTH SERVICES

Numerous programmes and schemes are being implemented under the Minimum Needs Programme to provide Primary Health Care relevant to the actual needs of the community in the rural areas.

HEALTH Infrastructure in rural areas is of prime importance for realisation of the objectives set forth in the National Health Policy and for attaining the goal of 'Health for All by the Year 2000 A.D.' Coordinated efforts are being made under various Rural Health Programme to provide effective and efficient services to the people in the rural areas.

The status of establishment of the Sub-Centres, PHCs and Community Health Centres under the Minimum Needs Programme, is detailed below:

Sub-Centre: A Sub-Centre is established on the basis of one Centre for every 5,000 population in plain areas and for 3,000 population in hilly and tribal areas. Till the end of the 7th Plan (1-4-1990) 1,30,336 Sub-Centres were functioning while their number rose to 1,32,285 by the end of December, 1995. Due to non-availability of funds for opening new Sub-Centres the targets were not allotted to the States/UTs during the year 1990-91, 1991-92, 1992-93, 1993-94 onwards.

Primary Health Centres: Primary Health Centres are established on the basis of one PHC for every 30,000 population in the plain areas and for every 20,000 population in hilly, tribal and backward areas. Numbering of PHC functioning in the country was 18,981 by the end of 7th plan (1-4-1990) which rose to 21,802 PHCs by the end of December, 1995.

Community Health Centres (CHCs): Rural hospitals with specialists facilities established by upgrading PHCs have 30 beds to cover a population of 80,000-1.20 lakh. By the end of 7th Plan (1-4-1990) the number of CHCs functioning was 1,911 which rose to 2,401 CHCs by the end of December, 1995. The CHCs act as referral Centres for four PHCs in a block.

Auxiliary Nurse Midwives (Female Health Workers) Training Programme

Each Sub-Centres is manned by one Male Health Worker and one Female Health Worker (Auxiliary Nurse Midwife). In order to train the required number of ANMs in the rural areas, there are 464 ANMs Training Schools functioning in the country with an annual admission capacity of 20,312. The duration of the training is 18 months. 10th pass girls preferably from the local villages where this services will be utilised later at the Sub-Centres and Primary Health Centres are admitted for the basic course. It is proposed to utilise these training institutions for providing continuing education/training programmes for ANMs, besides providing the basic training programme of 18 months duration.

Female Health Assistant Training Programme (LHV)

One Female Health Assistant has to supervise the work of six Sub-Centres in the rural areas. She provides technical guidance and supervision to the ANMs who are working in rural areas. The senior ANMs with a minimum of 5 years working experience are trained for 6 months to take up the post of LHV, which is a promotional post. 44 LHV training schools with an admission capacity of 2,568 are functioning in the country. These

training schools are utilised for giving continuing education for Female Health Assistance (LHV) besides providing training programme of six months duration.

Village Health Guide Scheme

The Village Health Guide Scheme was initially started as Community Health Workers Scheme on 2nd October, 1977 in all States except Tamil Nadu, J&K, Kerala and Arunachal Pradesh. The Scheme was re-named as Village Health Guide Scheme in 1981 when it was made 100% Centrally sponsored scheme under Family Welfare Programme. According to the scheme the village community selects a volunteer as VHG who after training acts as a link between the community and the Governmental Health System. He/She mainly provides health education and creates awareness on MCH and Family Welfare Services. He/She has to keep track of communicable diseases and treat minor ailments and provide first-aid to the patients.

Multi-Purpose Worker (Male)

As per the norms, each sub-centre is required to be manned by a trained Female Health Worker (ANM) and a trained Male Health Worker known as Multi-purpose Worker (Male). The Govt. of India had initiated a scheme of training and thereby converting the uni-purpose workers under various programmes to multi-purpose workers in 1978. However, because of the shortage of MPW's (Male) at Sub-Centre level, a scheme of basic training for MPW (Male) was initiated during the 7th Plan period. Under this scheme, 10th pass candidates are selected and trained for one year before they are inducted into services.

Orientation Training of Medical and Para-Medical Personnel

This is a Centrally Sponsored Scheme under the Family Welfare Programme. It was started in 1984 with the objective to train Medical and Para-Medical Personnel working at PHCs and Sub-Centres. Each category is placed to be imparted training in the same institution, where they had their basic training. The duration of the training is two weeks. Presently, the continuing education is being provided only at 44 HFWTCs due to constraints of budget for strengthening the basic training school for taking up the continuing education.

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

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

Progress of Expenditure: The 8th Plan allocation for the Scheme was Rs. 530 lakh. The details of allocation releases made and anticipated expenditure is as shown below:

PROGRESS OF EXPENDITURE

Year	Allocation	Anticipated Expenditur (Rs. in Lakh
1985-86	—	—
1986-87	50.00	—
1987-88	150.00	67.37
1988-89	100.00	43.74
1989-90	50.00	50.00
1990-91	50.00	49.90
1991-92	83.00	78.00
1992-93	80.00	65.14
1993-94	80.00	80.00
1994-95	80.00	80.00
1995-96	80.00	80.00

Health and Family Welfare Training Centres (HFWTCs)

Health and Family Welfare Training Centres are established in the country with the objective of giving in-service training to health personnel in the rural health sector. These Training Centres are set up with 100% financial assistance from the Central Government. There are 47 HFWTCs in the country at present.

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

Medical Officer	2 Weeks
Health Assistances (Male & Female)	2 Weeks
Health Workers	2 Weeks
Block Extension Educators	2 Weeks
Key Trainers of ANM School & M.W.P. (M) Basic Schools	2 Weeks

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

The recurring costs of one HFWTC comes to Rs. 9.5 lakh approximately.

Training of ISM Practitioners on Family Welfare Programme

The Scheme relates to the involvement of the practitioners of Indian System of Medicine (ISM) in the various Family Welfare Programme presently in operation in the country, by holding some Sensitisation Seminars. It was envisaged that the seminar would cover various aspects of the Family Welfare Programme with a view to motivate the practitioners of ISM to popularise small family norm, encourage use of contraceptives, assist in information and attitude building for higher age at marriage and to inform them of the demographic changes and impact of population explosion.

Keeping this in view, the Department of Family Welfare had started a scheme for involving ISM Practitioners with the Family Welfare Programme from 1992-93, in the State Sector on an experimental basis. Under the scheme Rs. 50,000/- per seminar was provided to the States for Sensitisation of private ISM practitioners only.

From the year 1995-96, the scheme has been transferred to the Central Sector with a Budget Allocation of Rs. 10 lakh. ○

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ensure that on the basis of experience gained, such programmes can be introduced nationwide.

National Illness Assistance Fund

A National Illness Assistance Fund is being set up to assist poor patients needing specialised medical treatment for major life threatening diseases but do not have the resources to meet the cost of the treatment. The Fund would be mainly financed by donations. The State Governments would be provided assistance for setting up medical relief fund/registered societies for providing special medical treatment to the poor. Assistance to poor patients would be provided from the Fund on the recommendation of the State/UT Governments in cases where treatment costs is excessive. A sum of $ 6.7 million has been provided for the purpose in the budget for 1996-97, $ 1.4 million for setting up of the National Illness Assistance Fund at the Centre and $ 5.3 million for Grants-in-Aid to State Governments for assistance towards expenditure on hospitalisation of the poor. The donations to the National Fund would be exempted from income-tax. This has been announced in the Budget, 1994.

National Blood Transfusion Council

The National Blood Transfusion Council has been set up and 19 States and Union Territories have also set up the State/Union Territory Council of Blood Transfusion in compliance with the Supreme Court Judgement in this respect. The programmes and activities of these councils will cover the entire range of services related to operations and requirements of blood banks including the launching of effective motivation campaigns and establishment of organisation of various services including civic bodies, training of personnel in relation to blood collection, storage and utilisation of all the basic essentials of the operations of blood bank. The donations made to these councils would also be exempted from income-tax. ○

Important Areas of Health Promotion

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DIRECTOR
Central Health Education Bureau

THE policy adopted for the health sector is primarily aimed at improving the health care services and access to health for all. Efforts have been made since the very inception of planning to create public health and other medical facilities, eradicate and control all vector borne and other communicable and non-communicable diseases, develop medical education and research facilities. In addition, attempts have also been directed in successive Five Year Plans to meet the training requirements of technical manpower, para-medics and other health workers—specially for health care services provided to the rural population. Considerable gains have been made in the health status of the people due to the implementation of these programmes as can be seen from an increase in life expectancy, reduction in infant mortality, death rate, and fertility rate. However, much more needs to be done to improve the quality of life of the people and we still have a long way to go before achieving the goal of "Health for All". In some parts of the country, especially in tribal and difficult terrain areas, infrastructure is still inadequate. Outbreak of diseases like malaria, cholera, gastroenteritis, which are easily preventable, are still occurring. Added to this, is the problem of non-communicable diseases like cancer, mental health problems, diabetes, cardio-vascular diseases, and the threat of new diseases such as AIDS. On one side is the burden of communicable diseases with already strained infrastructure at the primary, secondary, and tertiary levels, and on the other side the burden of non-communicable diseases requiring heavy secondary and tertiary level investment.

In view of the complex problems facing the health sector, it has been considered necessary to consolidate and improve health infrastructure, to continue to fund disease control programmes, to improve the quality of disease surveillance and health management information system, to upgrade laboratory support services and to give health education due importance.

Health Infrastructure

While an impressive infrastructure comprising of 2385 Community Health Centres, 21,693 Primary Health Centres, 1,31,900 Sub-Centres has been set up throughout the country for providing health care services to the public it has been found over the years that this infrastructure is working at sub-optimal capacity. **In order to upgrade it an ambitious project has been taken up with World Bank assistance of $ 547 million for providing better buildings, equipment support, funds for drugs, consumables, manpower to all district and sub-divisional hospitals in the States of Andhra Pradesh, Karnataka, West Bengal and Punjab.** The Project strategies are aimed at improving the efficiency and effectiveness of health care services and reducing overcrowding at tertiary facilities. It would provide the poor an opportunity to have less episodes of illness, death and disability which would improve productivity. It would improve the interface between the institutional staff and health seekers which would encourage patients to seek timely health care resulting in higher care rate at lower costs. Primary health system would get vital support and credibility for implementing various national and other health programmes as basic health care would now be available in rural areas. Finally the first referral health system would strengthen the linkages with private health care.

Disease Control Programmes

Some of the highlights of the disease control programmes being implemented by the Government of India are indicated below. In a number of these projects external assistance has been availed of and is being further sought so that in critical areas the Centre can assist the States in the containment and eradication of diseases.

(a) *National Leprosy Eradication Programme*

The National Leprosy Eradication Programme (NLEP) has shown tremendous success and is under implementation with a loan of $ 85 million from the World Bank. The Leprosy case load in the country has come down from 4 million cases in 1981 to 0.5 million cases at the end of March 1996. Under the Programme MDT drugs are supplied free of cost. The Leprosy Eradication Programme aims to achieve the elimination of leprosy by 2000 AD.

Health Education and IEC activities are important component of the NLEP and are being undertaken vertically. Sufficient funds are available for the same under the Programme. Under the Programme, most of the health education and IEC fund is being provided to District MDT Societies directly for conducting area specific IEC and Health Education activities as per plan of activities. For the endemic districts allocation for health education is Rs. 24,000 per annum while for non-endemic districts funds are earmarked on annual basis to the States and UTs along with guidelines on health education and IEC activities. A small quantity of the fund is kept central level to utilise the same for preparation of any innovative prototype for use under the Programme. On an average about Rs. 3 crores is being spent annually on health education and IEC activities under the Programme. Health Education material on leprosy are being developed extensively by specialised Voluntary Organisations.

(b) *National Tuberculosis Control Programme*

In India, today it is estimated that about 40 million are suffering from T.B. of which 3—3.5 million are highly infectious sputum positive cases responsible for spreading the disease in the community.

A Tuberculosis Control project which seeks to introduce short course chemo-therapy for the control of T.B. is at an advanced stage of appraisal of the World Bank covering 102 districts and an estimated 0.3 million T.B. patients in the first phase. Subsequently this revised strategy of T.B. Control is proposed to be extended to cover all T.B. patients in the whole country.

Revised strategy for IEC has been evolved at present with the technical assistance from WHO. The strategy addresses identified weaknesses including for IEC activities and emphasises increased budgetary outlay for the programme.

The important activities under the programme are Passive Case detection and Case holding besides direct observe therapy (DOT). The problems faced in the programme are inadequate availability of facilities for diagnosis and treatment. Health educational and IEC material also needs to be developed and disseminated in a phased manner.

More emphasis is being given to interpersonal communication at the treatment centre during DOT by health workers and para-medical supeprvisors. Empahsis is also being given for motivation of medical, paramedical personnel, private practitioners, medical colleges, local community leaders and grass-root workers by holding meetings, workshops, supply of educative materials in respect of T.B. and its cure.

(c) *National Programme for Control of Blindness (NPCB)*

Under the Blindness Control Programme an ambitious project for conducting 21 million sight restoring cataract surgeries in seven years has been taken up with a loan of $ 117 million from the World Bank. The project is under implementation in the States of Andhra Pradesh, Uttar Pradesh, Rajasthan, Maharashtra, Tamil Nadu, Madhya Pradesh and Orissa where the incidence of blindness is relatively higher. The remaining parts of the country are being covered under the National Programme and with DANIDA Assistance in Karnataka State. Already in the last year 22 lakh surgeries have been conducted which has been a record for the country.

A major aim of the NPCB is to increase the demand for eye care services through sustained IEC, with special emphasis on women and poor people. The institution of District Blindness Control Societies in 456 districts of the country has been a major achievement of the Programme and will permit greater flexibility in the IEC strategy of the Programme. Feeling the need for authoritative grass-roots information regarding

Communication Needs for the NPCB, the Programme Division had commissioned a Communication Needs Assessment study by the Operations Research Group. A number of publications and films have been prepared on 'Care of Eyes' and on treatment of ailments and diseases.

(d) *National Malaria Eradication Programme (NMEP)*

NMEP is a Centrally sponsored scheme based on 50:50 cost sharing between the Centre and the States. Since the seven North-Eastern States are high risk malaria areas, 100% Central assistance is being provided from December 1994 to intensify malaria control activities. In addition, a Malaria Control Project seeking World Bank and other external assistance is also currently under formulation which is aimed at tackling malaria particularly in the tribal areas of the country where the endemicity of the disease is very high. For the first time biocides, synthetic pyrethroids and medicated bednets are being supplied selectively under the Programme in view of the need to respond to special problems of areas, which do not respond to conventional strategies.

In tackling the problem of Malaria, Health Education serves two purposes : (i) to inculcate individual/community protective and preventive habits as a part of malaria control measure within a given socio-economic and environmental context; and (ii) to generate a demand for appropriate services from the health delivery system.

In the changing circumstances of epidemiology of the disease and the environment, the following broad strategy for Health Education activity has been adopted:

Objective: To create awareness among the members of the community about the causes, prevention treatment and management of malaria cases leading to the reduction in the mortality and morbidity (mortality—nil and morbidity—0.5 cases per 1,000 population per annum is planned by 2000 A.D.).

Specific Objectives:

— To create awareness on reduction in the frequency of contact between man and mosquito;

— To create awareness amongst the masses regarding methods which are likely to reduce parasite load in the community; and

— To create awareness on the methods which can bring about reduction in the mosquitogenic conditions leading to the lowering of the mosquito density in the area.

The following strategy has been adopted : The State Programme Officers keep in touch with the faculty of Regional Family Welfare Training Centres and State Health Education Bureaux under their guidance Malaria Inspector and other field workers keep the community members informed about the disease and the programme by personal contact. The target group consists of school children, housewives, mahila mandals, villagers, small factory workers and different members of community. The involvement of the community and opinion of non-formal leaders is of paramount importance in the spread of awareness on malaria in the community and in obtaining their co-operation in implementation and acceptance of control activities.

Electronic and print media and traditional methods such as folk dances, local drama, puppet show are extensively used for creating awareness and transmitting messages. At the peripheral level poster competition, essay competition, organisation of exhibitions at school level, hoardings and banners at *Melas* (Carnivals), clay models depicting malaria vector, life cycle, DDT spray, treatment, etc. are being carried out.

Training programme at various echelons are being organised by the States. Village head, NGOs and Panchayat level workers are being involved for distribution of drugs and reduction of mosquitogenic conditions in their surroundings. Training of shopkeepers who are literate enough to take blood smear is being provided by the State for administration of chloroquine. States develop their own IEC material in local language for distribution to Primary Health Centres and among the target groups.

'Malaria week' is being observed in the country since 1995. During the 'Malaria week' one full page advertisement was inserted in national newspapers with messages from Hon'ble Minister of Health, Secretary (Health), Ministry of Health and Family Welfare, and the Director General of Health Services. Information on malaria was publicized through newspapers. Meetings, Seminars were organised in different States with the help of State Health Education Bureau. Malaria Clinics were opened for slide examination and prompt treatment. Banners, posters in local language were displayed to sensitise the community.

The recent resurgence of malaria in many parts of the country has necessitated strengthening of health promotion component of the Programme. Therefore, it has been decided that in future 'Malaria Week' will be observed in the month of June as some of the States have suggested that the week should coincide with the onset of transmission. A set of guidelines have been formulated for observing 'Malaria Week' and posters, folders, and video cassettes on DDT spray, how to protect oneself from Malaria, prevention of malaria in pregnant women, war against vector borne diseases, diagnosis and management of malaria etc. have been prepared for dissemination. The guidelines have been framed keeping in mind the fact that success of the programme depends upon community participation.

(e) *National Mental Health Programme* (*NMHP*)

During 1996-97, it has been proposed to implement District Mental Health Programme. A draft plan of action has already been finalised in consultation with the States.

The District Mental Health team envisaged under the scheme is expected to provide :

— Running daily outpatient service and integrate it with general health care;

— Ten bedded indoor facility (for short-term treatment);

— Establish liaison through periodic visits and provide mental health service and training to the community;

— Follow-up service : Follow-up of discharged patients from the indoor facility and also those from the mental hospital and training institution;

— Referral service : Those needing specialised type of care will be referred to the appropriate institution in the State;

— Provide necessary counselling and teach families of patients and their significant relatives how to look after their patients in the community itself;

— Carry out a survey of mentally ill people in the entire district for which training institutions will extent necessary technical help; and

— Establishment contact with community leaders and take necessary steps towards creating awareness, removing stigma and change in attitude towards mentally-ill patients and take positive steps to rehabilitate persons cured.

The major components of the scheme are personnel; equipments, vehicles and other infrastructure; medicines and other contingencies; IEC components; and training programmes in identified institutions of various workers up to the grass-root level.

(f) *AIDS Control Programme*

The campaign on AIDS prevention was implemented with vigour and 608 blood banks were upgraded and more than 2200 doctors trained in clinical management of HIV/AIDS since the inception of the Programme. A loan of $82 million has been availed of from the World Bank. The strategy is to ensure blood safety, control sexually transmitted diseases, create awareness and improve surveillance. The Programme also aims at providing training of medical and para-medical personnel. At the Central Government level, the National AIDS Control Organisation (NACO) is the nodal agency for implementing the Programme. The Supreme Court have directed that Councils will be set up at the Central and State levels to inter-alia coordinate the supply of safe blood and blood products and phase out professional blood donation in a time-bound manner. The matter is receiving special attention.

IEC is seen as an essential component of HIV/AIDS Prevention and Control Programme in India. However, IEC in isolation cannot succeed unless supported by health and social services. IEC is to be planned in the context of the overall programme objectives and activities. With this in view, NACO has formulated IEC strategies.

Keeping in view the overall objective of the IEC of bringing about behavioural change, the priorities identified under the AIDS Control Programme include (i) Advocacy at all levels, (ii) NGO collaboration, (iii) capacity building of IEC institutions and IEC capabilities of the State AIDS Cell, (iv) Inter-sectoral collaboration, (v) innovative behavioural change interventions and (vi) Development of generic prototype package for adaptation at the State level to prepare group specific material and operation research for IEC.

The activities were planned through use of mass media (like TV, Radio, Newspaper) in consultation

with the State Governments for creating general awareness among the people. An effort was made to identify an advertising agency for launching a national mass media campaign. The rural out-door units and traditional arts form were also utilised. Exhibitions, public meetings and seminars, fairs and festivals form an important part of general awareness in the States. For further utilising TV and Radio, audio-visual material was prepared in the form of TV serials, video spots and audio spots. A genertic package of material for use among the injecting drug users, commercial sex workers, STD clinic attenders was prepared. The general material for utilisation for creating awareness among slum dwellers and truck drivers is in the process of development.

To obtain good data on assessing high risk behaviour patterns, an operational research i.e. high risk behaviour survey was planned and for that purpose 65 cities including States/UT capitals were identified. Out of these, the survey has been completed in 35 cities. The data on individual city/state-wise is being analysed which may help in advocacy with the State Government and city representative so that the intervention project may be started in the specific cities. To gather data on sexual health care seeking behaviour, a study was planned in West Bengal which has been completed and the data indicates that there is a well planned network of sexual activities outside the marriage system, even in rural areas which indicates that there is an urgent need of having intervention projects even in the rural areas.

The Department of Youth Affairs and Sports, Ministry of Human Resource Development, had taken a pioneering lead in AIDS prevention and control among college and university students with a programme called "Universities Talk AIDS" implemented through the National Service Scheme (NSS). Phase-1 of this programme commenced in October, 1991 with the objective of raising awareness regarding HIV/AIDS among college students and sensitising them on the issues so that they could initiate peer group and community discussions on AIDS prevention. The main activities under this phase was a two month campaign in 59 universities covering more than one lakh students. IEC messages were developed by the students themselves which were later used in the programme. A year later, in 1992, on the occasion of World AIDS Day over 250 colleges were involved in observing AIDS awareness week. In the current phase of the programme the project seeks to train 70,000 students, peer educators along with training, a permanent core team of 6,500 project coordinators at college level. A standardised training manual—"AIDS Education for Students Youth" was developed and later translated into eight regional languages for wider dissemination.

To create awareness among the non-student youth, National AIDS Control Organisation has involved Nehru Yuvak Kendra Sanghatan (NYKS). NYKS implemented a pilot project in 800 villages of Manipur State, by spreading AIDS awareness messages through youth groups in the villages. This pilot project has now been extended to other North-Eastern States. Besides a National Council Organisation called "Vishwa Yuvak Kendra" was started to train 150 NGOs working in the urban areas.

Action has been taken to introduce AIDS Education in the secondary schools. In this connection a curricular training package entitled, 'AIDS Education in Schools' has been brought out for use in training of teachers and organising students activities in schools. 15 State governments have developed proposal for initiating AIDS Awareness Activities in schools in a phased manner.

In order to reach the young children who are outside the formal education system, a series of AIDS related articles were included in distance education package of National Open Schools.

In order to facilitate larger involvement of NGOs in HIV/AIDS activities, a set of guidelines were developed and issued. In order to facilitate quick project appraisal and access to Govt. funding, 14 major States have been provided funds for providing financial assistance to NGOs.

The following inter-sectoral collaboration has been established:

— Linkages have been established with the Departments of Education, Youth Affairs and Sports and Women & Child Development. Two national level workshops on "Women and AIDS" were held. The recommendations/suggestions made in this workshop are being processed for follow-up action.

— HIV/AIDS/STDs issues are being integrated in MCH and family welfare activities.

— All the media units of the Ministry of Information & Broadcasting are fully involved in disseminating messages on AIDS awareness using various media of communication.

— The Federation of Indian Industry (CII) in collaboration with and assistance of NACO and WHO developed advocacy material for Chief Executive Officers of companies to undertake AIDS education at the work place.

— CII is now preparing option packages for developing interventions at the workplace and has undertaken to provide training and other technical assistance to the industry initiating interventions for their employees.

A training module of counselling has been developed with the help of exports. A reputed medical college has been identified as the apex institute to train master trainers selected from 5 other regional institutes in the country. The regional institutions will provide training to key-officials trained from various institutions. They would organise skilled counselling training for health and social workers.

To develop care and support facilities for the HIV positive and those living with AIDS, a pilot project was started in Manipur in which the health care functionaries and family members were trained in providing care and support. Based on the experience gained from the pilot project, generic guidelines have been developed for initiating similar project services in other States. The State Government of Maharashtra and Tamil Nadu have already developed a comprehensive plan and submitted their proposal to NACO for technical and financial support.

(g) *National Iodine Deficiency Disorders Control Programme (IDD)*

During the 8th Five Year Plan, efforts were made to strengthen the IDD monitoring and to achieve the goal of universal iodisation of salt. The lack of iodine in the diet causes serious physical and mental impairment leading to goitre, cretinism and mental retardation. It is proposed to bring down the incidence of IDD by encouraging consumption of iodised salt. Already 20 States and Union Territories have banned the sale of non-iodised salt and efforts are underway to cover the entire country.

It is estimated that, in India, 54.4 million population are suffering from endemic goitre and about 8.8 million people have mental/motor handicaps. Sample surveys have been conducted in 25 states and 4 Union Territories of the country which revealed that out of 245 districts surveyed so far IDD is a major public health problem in 211 districts.

To intensify IEC activities, posters/danglers and radio/TV spots have been prepared. T.V. Spots are being regularly telecast through the National Network of Doordarshan about the consequences of Iodine Deficiency and the benefits of consuming Iodised salt.

(h) *Guinea Worm Eradication Programme (GWEP)*

The GWEP envisages the efficient implementation of well defined strategies, namely (a) Guinea worm case detection and continuous surveillance through three active case search operations and regular monthly reporting (b) GW case management (c) Vector control by the application of Temephos in unsafe water sources eight times a year and use of fine nylon mesh/double layered cloth strainers by the community to filter cyclops in all the affected villages (d) Health education (e) Trained man power development and (f) Provision and maintenance of safe drinking water supply on priority in GW endemic villages (g) Concurrent evaluation and operational research.

At the beginning of the Programme i.e. in 1984, there were around 40,000 GW cases in 12,840 villages in 89 districts of seven endemic states. Till May, 1996 only six guinea worm cases have been recorded in two adjacent villages of Jodhpur district (Rajasthan), all of which were adequately contained.

Environmental Health and Sanitation

Environmental Health and Sanitation was found to have slipped from a place of prominence on the National agenda. Surveillance of diseases was inadequate and reporting systems were also not reliable. In the wake of the outbreak of plague, a number of Committees have given reports to augment the

surveillance system. A National Apical Advisory Committee for Diseases Surveillance and Response System was constituted in April 1996 with Union Secretary (Health) as its Chairman. The Committee will suggest the mechanism for setting up of a National Disease Surveillance and Response System and review periodically the progress in this regard including the epidemic preparedness of health care providers. In addition, the Committee would review various programmes, guidelines and mechanisms for prevention and control of communicable diseases with special reference to new emerging and re-emerging pathogens and epidemic prone diseases. Under the aegis of the National Institute of Communicable Diseases (NICD) efforts are being made to network Apex level institutions and set up centres of expertise which can disseminate information on specific diseases and also provide support to the States at a time of outbreak and epidemics. NICD has formulated a National Disease Surveillance Programme covering 100 districts of the country and it includes strengthening of laboratory capacities in the national, regional, zonal, medical colleges and district laboratories during the next five years in a phased manner.

Environmental Hygiene and Sanitation: Health Awareness:

A detailed report on a comprehensive National Programme on Sanitation and Environmental Hygiene on the lines of a Technology Mission was submitted to the Government in July, 1995 by a Committee under the convenorship of Shri M. S. Dayal, former Union Secretary (Health). The Committee of Secretaries also had detailed deliberations on the recommendations contained in the Dayal Committee Report which were pertaining to various Ministries/Departments concerned with Environment and Sanitation. The Committee of Secretaries recommended that the proposals contained in the Dayal Committee Report would form the basis for formulation of projects by the concerned Departments during the 9th Five Year Plan.

The Sub-Mission on strengthening of health surveillance and support services has to be implemented by the Department of Health as the nodal agency. One of the major components of this Sub-Mission is creation of health awareness and community participation in environmental health and sanitation activities. The proposed initiatives under this component are as follows. The Central Health Education Bureau should function as a nodal agency at the Central level for health education, health awareness and community participation programme in environmental health and sanitation. Therefore, its structure and organisation need to be strengthened.

For effective implementation of health education activities in environmental health and sanitation, multi-sectoral cooperation and coordination is necessary. Various Committees at Village, Block, District and State level need to be constituted as under with the representatives from Government and Non-Governmental Agencies:

(i) *Village level.* The Village Level Committee may have members from Water Supply, Health Education, Rural Development, Agriculture and Social Welfare Departments and should meet periodically to review the progress of health education activities in this regard.

(ii) *Block level*: The Block level Committee should be constituted under the chairmanship of the Chairman of the Panchayat Samiti or Block Development Officer and Members from PHED/Water Supply, Education, Rural Development, Agriculture, Social Welfare Department, Chief Executive Officer of the Primary Health Centre as Member-Secretary. This Committee should also meet periodically and review the health education activities at the Block level.

(iii) *District level*: The District Level Committee comprising of Collector/District Development Officer as Chairman, and Members from PHED/ Water & Sewerage Board, Pollution Control Board, Medical, Social Welfare, Education, Project Director of District Rural Development Agency, Ayurvedic Medical Officer/Health Officer of the

Municipal Corporation, and Chief Medical Officer as Member Secretary may be constituted. This Committee may also co-opt any other member either from Government or from Voluntary Organisation as the case may be. This Committee should meet quarterly to review and guide the activities relating to health education and awareness.

(iv) *State level*: The State Coordination Committee may be constituted under the Chairmanship of Health Secretary and Members from the Departments of PHED/Water and Sewerage Board, State Pollution Control Board, Medical, Health, Social Welfare, Education, and the Chief of the State Health Education Bureau as Member-Secretary. This Committee should meet periodically to plan, direct and review the health education activities in the State.

Discouraging the use of tobacco products in India

The Department of Health has been engaged in the formulation of a Bill called **'The Tobacco Products/Prohibition of Advertisement and Regulation of Production, Supply, Distribution and Consumption Bill'.** The proposed Bill provides for a complete ban on all forms of advertisements in respect of tobacco related products, statutory warning on all packages of tobacco and tobacco products, indication of permissible limits for nicotine and tar content on all packages of cigarettes, ban on sale of tobacco or taking tobacco products within a distance of 100 metres from schools, hospitals, etc., and ban on smoking in and around public places like hospitals, dispensaries, Government buildings, educational institutions, domestic air-flights, trains, buses, etc.

The proposed Bill, vetted by Ministry of Law was about to be referred to the Cabinet for clearance towards the end of 1994 prior to its introduction in Parliament. However, several Members of Parliament concerned with the employment and livelihood of workers/farmers engaged in the tobacco industry expressed apprehensions about the Bill. Meanwhile an Expert Committee has been constituted to study the economic impact of the earnings from tobacco industry vis-a-vis the cost of expensive tertiary care necessary to combat the health hazards and diseases caused by the use of tobacco.

Upgradation of Drug Control/Prevention of Food Adulteration Organizations

Over the years, the Drug Control and Prevention of Food Adulteration Organizations have not received due attention due to constant pressures for support for disease control programmes. The subjects were also accorded low priority by the States. There have been critical shortages of Inspectors both for Drugs and for Food at the State level. The Food laboratories both at the Central and State level have not been equipped adequately to be able to analyze sufficient samples commensurate with the need for enforcement of standards for drugs and food. There is critical need to spread consumer awareness about the ill effects of eating food of poor quality. In order to upgrade the organizations, a project is being formulated for seeking World Bank assistance.

During the 8th Five Year Plan, the following educational material have been developed and printed:

(a) Tips to Consumers (Hindi & English)

(b) Tips to Food Safety & Sound Diet (Hindi & English)

(c) Safe Food for Travellers (English).

Non-Communicable Diseases

India now shares a double burden of disease because of increased life expectancy. It is, therefore, necessary to also address new and emerging problems like Cancer, Cardio-Vascular diseases, Oral health, diabetes, Micronutrient deficiencies etc. A thrust has been given to these programmes and pilot projects have also been initiated from the last year to

(*Contd. on page 160*)

WORLD "NO TOBACCO DAY" OBSERVED

The Health Education Bureau, Jammu, observed 'No Tobacco Day' on 31st May 1996, the day dedicated by the World Health Organization and its members to the cause of ensuring a tobacco-free society. This year, World No Tobacco Day focused on Sports and Arts without Tobacco. The following Health Education activities on the matter were taken up by the Health Education Bureau:

1. Cloth banners with different slogans were displayed throughout the city of Jammu. All prominent places and busy crossings were covered.
2. Sticker compaign was launched in which two thousand stickers were displayed in various offices of public transport vehicles and other prominent places like bus stands etc.
3. **Print Media Coverage:**— Advertisements in Hindi and English were inserted in prominent local newspapers for general awareness among the people in 'DAILY EXCELSIOR' & 'DANIK KASHMIR TIMES' on 31st May 1996.
4. **Radio Coverage:**— A discussion on anti-smoking in local programme viz. Gojri and Dogri was broadcast by Radio Kashmir. All the programmes organised by the Health Education Bureau were well covered in local bulletins. Slogans were also broadcast in the Primary Services of Radio Kashmir, Jammu.
5. **T.V. Coverage:**— The Doordarshan Jammu Station also telecasted half hour programme regarding No Tobacco Day, and Siti Cable also covered the programme and informed people regarding the theme "Sports and the Arts without Tobacco—Play it Tobacco Free"
6. **Literature distribution:**— Copies of the literature on No Tobacco Day were distributed to the Medical Institutions/Non-Medical Institutions and also to the masses during the rally. Some posters and folders were also distributed.
7. The children's rallies were also organised by Health Education Bureau. The Divisional Commissioner, Jammu Shri B. R. Kundal, flagged off the rally from Mubarak Mandi. All the Officers and officials of the Health Services also participated in the rally. Twelve hundred children from 15 schools (Government & private) of Jammu City took out an impressive anti-tobacco rally on that day. Children were holding different placards depicting slogans of harms of smoking, passed through the main bazars of the Jammu city. They were also raising slogans for motivating the parents, relations and others to abstain from smoking which cause many fatal diseases. Prizes were distributed among those children whose work on placard were adjudged best by judges. Refreshments and prizes were given away in the compound of Health department complex by Dr. M. P. Gupta, Director Health Services, Jammu.
8. **Painting & display competition:**— Children's drawing & painting competition was organised by Health Education Bureau in which 15 schools participated. The topic was 'Harmful effects of smoking'. About 1200 children from different schools participated. These children were asked to bring their drawing/placards in the rally on 31st May, 1996. Some of the slogans are as under:—

— CANCER AND CIGARETTE MADE FOR EACH OTHER, STOP SMOKING FROM TODAY.

— SMOKING IS A SLOW MOTION SUICIDE, AVOID IT.

— PREVENT HEART ATTACKS—STOP SMOKING FROM TODAY.

They emphasized that cigarette is one of the major public health hazards facing the world to-day. Trophies were distributed to the best five students whose paintings were adjudged best by the judges. □

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The Central Health Education Bureau also observed the World No-Tobacco Day on 31st May 1996 at Rural Health and Training Centre, Najafgarh. The Day was organised with a view to involve the Rural Community & Youth. Besides, CHEB as a matter of strategy jointly organised World No-Tobacco Day with other organisations to sensitize them against Anti-Tobacco measures.

The Bureau carried out the following activities on the theme: Sport and the arts without tobacco—Play it tobacco-free:

1. *Backgrounder* on the theme was brought out.
2. *Swasth Hind*—Special issue of the monthly magazine in English was published.
3. *Race*—Races of the general public, trainees, faculty senior citizens were organised at R.H.T.C., Najafgarh.
4. *Poster Competition*—A poster competition was conducted. The participants were ANMs of Lady Reading Health School and Junior Nurses and Interns of Safdarjang Hospital. These posters were put up on display.
5. *Declamation Contest* in Hindi and English.
6. *Skit* on the theme.
7. *Exhibition* on the theme.
8. *Advertisement* in the newspapers was released throughout India.
9. *Seminar* on the theme was organised. It was addressed by Secretary (Health), AS(H), D.G.H.S., Director, CHEB, Chief Medical Officer-Incharge RHTC, WHO Representative in India. Addl. DGHS and JS (SB) also participated.
10. *Talk* by Secretary (Health) & Director (CHEB) was broadcast on AIR.
11. *Prize distribution*—Prizes to the participants of Poster competition/Declamation contest, skits & races were awarded by Secretary (Health).
12. *Pledge* was taken by the community. The participants offered to stop smoking. not to start smoking and motivate at least one member each to stop smoking. □

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