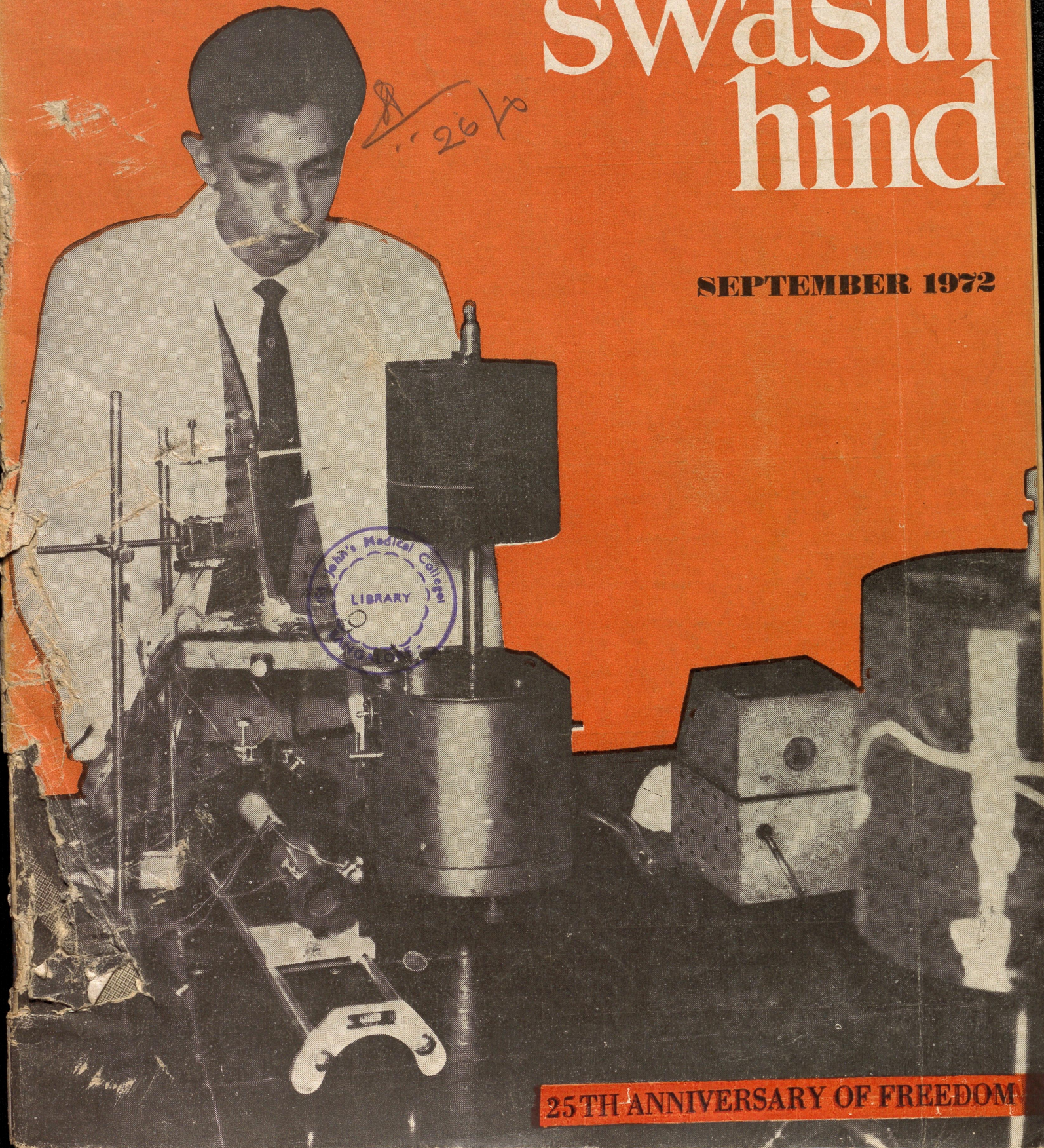


swasth hind

SEPTEMBER 1972



25TH ANNIVERSARY OF FREEDOM

Swasth hind

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

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

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TOWARDS BETTER HEALTH

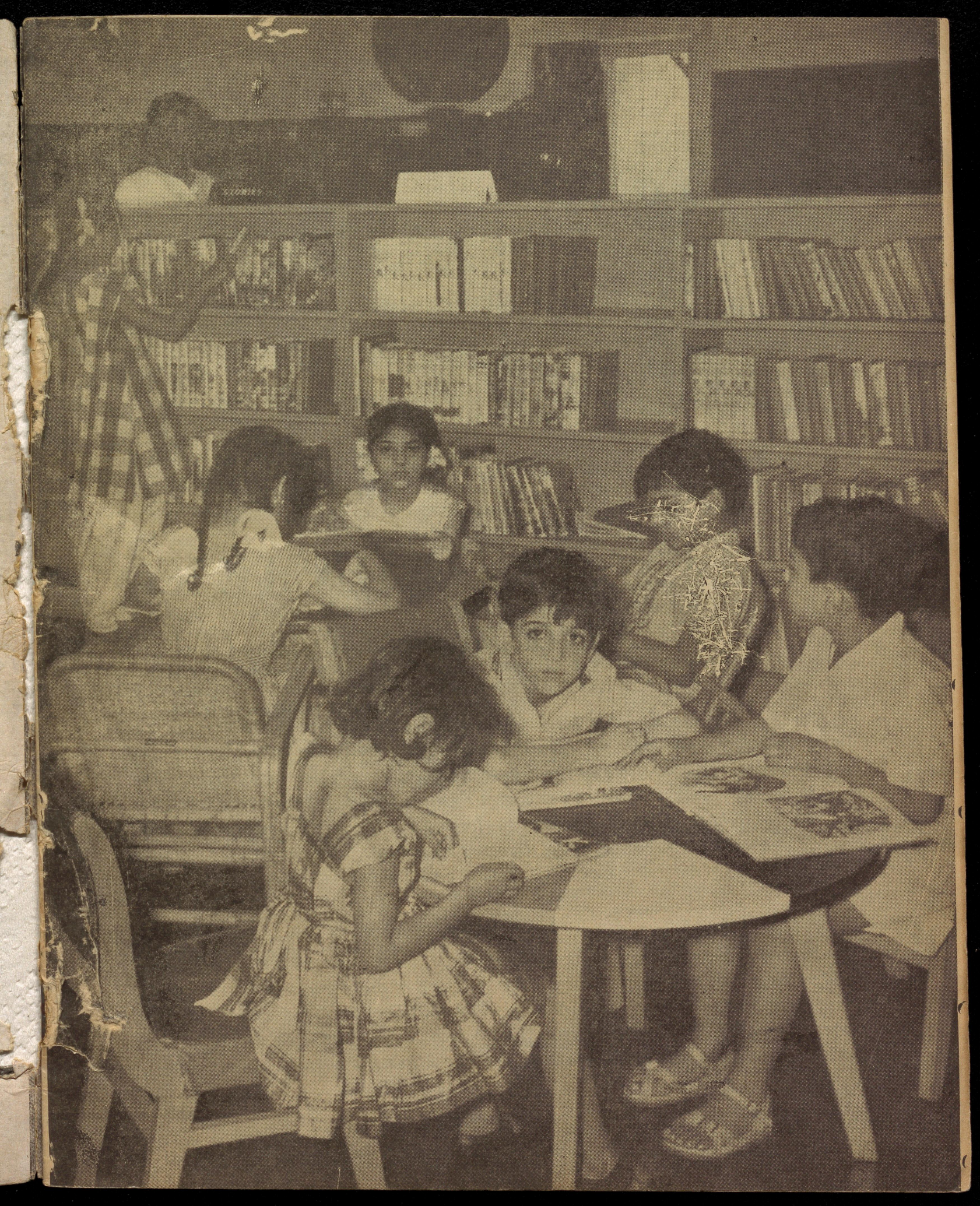
TWENTY-FIVE years of India's Independence has witnessed a remarkable growth in the expansion of medical and health facilities.

There are unmistakable trends of improvement in the health of the people. And vital statistics which are an index for a nation's health speak for themselves. The death-rate which was 27.4 per 1000 population in 1941-50 has come down to 15.9 in 1970 because of the number of programmes launched for the control and eradication of communicable diseases. The birth-rate which was 39.9 per 1000 population in 1941-50 has come down to 37 in 1970. Today the infant mortality rate—a sensitive index to the health status of any nation—is 139 per 1000 live births in the rural sector. It has registered a steep fall from 183 per 1000 live births in 1941-50. *These figures are based on the Sample Registration System of the Registrar-General of India.*

People in India enjoy healthier and longer life span than ever before. Today, an infant can hope to live to an estimated 50 years as against 32 years in 1941-50.

Swasth Hind reviews the progress of health on the 25th Anniversary of Freedom. India has evolved a national strategy for health to achieve the over-all objective of "Health for All".

Our Covers (1st and 4th) show young students engaged in laboratory work. Increasing medical manpower and its maximum utilization is of vital importance for providing comprehensive community health care.





Smt. Indira Gandhi

HUMAN ENVIRONMENT

—A New Design for Living

During the recent years there has been a growing awareness of the finite resources and complex natural relations of the biosphere on which man depends for his survival. The problem has been aggravated by the unprecedentedly fast growth of population, accelerating impact of technology, rising consumption, increasing urbanization, problem of pollution and deterioration of the quality of human environment. There is also the alarming pace of depletion of natural resources. These are posing a major threat to the well-being of man.

Over-shadowing all these, there is the problem of "sense of values of the contemporary world which ignores the rights of others and is oblivious of the longer perspective" as the Prime Minister, Shrimati Indira Gandhi, said while addressing the Plenary Session of the United Nations' Conference on Human Environment at Stockholm on 14 June, 1972. 'SWASTH HIND' reproduces the text of the Prime Minister's address.

It is indeed an honour to address this Conference—in itself a fresh expression of the spirit which created the United Nations and its concern for the present and future welfare of humanity. It does not aim merely at securing limited agreements but at establishing peace and harmony in life—among all races and with nature. This gathering represents man's earnest endeavour to understand his own condition and to prolong his tenancy of this planet. A vast amount of detailed preparatory work has gone into the convening of this Conference guided by the dynamic personality of Mr Maurice Strong, Secretary-General of the Conference.

I have the good fortune of growing up with a sense of kinship with nature in all its manifestations. Birds, plants, stones were companions, and sleeping under the star-strewn sky, I became familiar with the names and movements of the constellations. But my deep interest in this our "only earth" was not for itself but as a fit home for man.

One cannot be truly human and civilized unless one looks upon not only all fellow-men but all creation with the eyes of a friend. Throughout India, edicts carved on rocks and iron pillars are reminders that 22 centuries ago the Emperor Ashoka defined a king's duty as not merely to protect citizens and punish wrong doers but also to preserve animal life and forest trees. Ashoka was the first and perhaps the only monarch until very recently to forbid the killing of a large number of species of animals for sport or food, fore-shadowing some of the concerns of this Conference. He went further, regretting the carnage of his military conquests and enjoining upon his successors to find "their only pleasure in the peace that comes through righteousness".

Deterioration of Flora and Fauna

Along with the rest of mankind, we in India—in spite of Ashoka—have been guilty of wanton disregard for the sources of our sustenance. We share your concern at the rapid deterioration of flora and fauna. Some of our own wild life has been wiped out, miles of forests with beautiful old trees, mute witnesses of history, have been destroyed. Even though our industrial development is in its infancy, and at its most difficult stage, we are taking various steps to deal with incipient environmental imbalances. The more so because of our concern for the human being—a species which is also imperilled. In poverty he is threatened by malnutrition and disease, in weakness by war, in richness by the pollution brought about by his on prosperity.

It is sad that in country after country, progress should become synonymous with an assault on nature. We who are a part of nature and dependent on her for every need, speak constantly about "exploiting" nature. When the highest mountain in the world was claimed in 1953, Jawaharlal Nehru objected to the phrase "conquest of Everest" which he thought was arrogant. Is it surprising that this lack of consideration and the constant need to prove one's superiority should be projected onto our treatment of our fellow-men? I remember Edward Thompson, a British writer and a good friend of India, once telling Gandhiji that wild life was fast disappearing. Remarkd the Mahatma—"It is decreasing in the jungles but it is increasing in the towns"!

We are gathered here under the aegis of the United Nations. We are supposed to belong to the same family sharing common traits and impelled by the same basic desires, yet we inhabit a divided world.

Prejudices and Tensions

How can it be otherwise? There is still no recognition of the equality of man or respect for him as an individual. In matters of colour and race, religion and customs, society is governed by prejudice. Tensions arise because of man's aggressiveness and notions of superiority. The

How can we speak to those who live in villages and in slums about keeping the oceans, the rivers and the air clean when their own lives are contaminated at the source? The environment cannot be improved in conditions of poverty. Nor can poverty be eradicated without the use of science and technology.

power of the big stick prevails and it is used not in favour of fair play or beauty, but to chase imaginary windmills—to assume the right to interfere in the affairs of others, and to arrogate authority for action which would not normally be allowed. Many of the advanced countries of today have reached their present affluence by their domination over other races and countries, the exploitation of their own masses and their own natural resources. They got a head start through sheer ruthlessness, undisturbed by feelings of compassion or by abstract theories of freedom, equality or justice. The stirrings of demands for the political rights of citizens, and the economic rights of the toiler came after considerable advance had been made. The riches and the labour of the colonized countries played no small part in the industrialization and prosperity of the West. Now as we struggle to create a better life for our people, it is in vastly different circumstances, for obviously in today's eagle-eyed watchfulness, we cannot indulge in such practices even for a worthwhile purpose. We are bound by our own ideals. We owe allegiance to the principles of the rights of workers and the norms enshrined in the charters of international organizations. Above all, we are answerable to the millions of politically awakened citizens in our countries. All these make progress costlier and more complicated.

On the one hand the rich look askance at our continuing poverty—on the other they warn us against their own methods. We do not wish to impoverish the environment any further and yet we cannot for a moment forget the grim poverty of large numbers of people. Are not poverty and need the greatest polluters? For instance, unless we are in a position to provide employment and purchasing power for the daily necessities of the tribal people and those who live in or around our jungles, we cannot prevent them from combing the forest for food and livelihood, from poaching and from despoiling the vegetation. When they themselves feel deprived, how can we urge the preservation of animals? How can we speak to those who live in villages and in slums about keeping the oceans, the rivers and the air clean when their own lives are contaminated at the source? The environment cannot be improved in conditions of poverty. Nor can poverty be eradicated without the use of science and technology.

A Strange Question

Must there be conflict between technology and a truly better world or between enlightenment of the spirit and a higher standard of living? Foreigners sometimes ask what to us seems a very strange question, whether progress in India would not mean a diminishing of her spirituality or her values. Is spiritual quality so superficial as to be dependent upon the lack of material comfort? As a country we are no more or less spiritual than any other but traditionally our people have respected the spirit of detachment and renunciation. Historically, our great spiritual discoveries were made during periods of comparative affluence. The doctrines of detachment from possessions were developed not as rationalization of deprivation but to prevent comfort and ease from dulling the senses. Spirituality means the enrichment of the spirit, the strengthening of

Will the growing awareness of "one earth" and "one environment" guide us to the concept of "one humanity" ? Will there be more equitable sharing of environmental costs and greater international interest in the accelerated progress of the less developed world ? Or will it remain confined to a narrow concern, based on exclusive self-sufficiency ?

one's inner resources and the stretching of one's range of experience. It is the ability to be still in the midst of activity and vibrantly alive in moments of calm; to separate the essence from circumstances; to accept joy and sorrow with some equanimity.

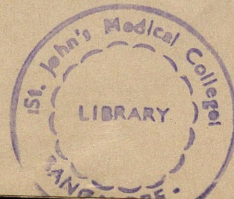
I am reminded of an incident in one of our tribal areas. The vociferous demand of elder tribal chiefs that their customs should be left undisturbed found support from noted anthropologists. In its anxiety that the majority should not submerge the many ethnical racial and cultural groups in our country, the Government of India largely accepted this advice. I was amongst those who entirely approved. However, a visit to a remote part of our North-East Frontier brought me in touch with a different point of view—the protest of the younger elements that while the rest of India was on the way to modernization they were being preserved as museum pieces. Could we not say the same to the affluent nations ?

Multi-dimensional Approach

For the last quarter of a century, we have been engaged in an enterprise unparalleled in human history—the provision of basic needs to one-sixth of mankind within the span of one or two generations. When we launched on that effort our early planners had more than the usual gaps to fill. There were not enough data and no helpful books. No guidance could be sought from the experience of other countries whose conditions—political, economic, social and technological—were altogether different. Planning in the sense we were innovating, had never been used in the context of a mixed economy. But we could not wait. The need to improve the conditions of our people was pressing. Planning and action, improvement of data leading to better planning and better action, all this was a continuous and over-lapping process. Our industrialization tended to follow the paths which the more advanced countries had traversed earlier. With the advance of the 60's and particularly during the last five years we have encountered a bewildering collection of problems, some due to our shortcomings but many inherent in the process and in existing attitudes. The feeling is growing that we should re-order our priorities and move away from the single-dimensional model which has viewed growth from certain limited angles, which seems to have given a higher place to things rather than to persons and which has increased our wants rather than our enjoyment. We should have a more comprehensive approach to life, centred on man not as a statistic but individual with many sides to his personality. The solution of these problems cannot be isolated phenomena of marginal importance but must be an integral part of the unfolding of the very process of development.

People's Welfare Top Priority

The extreme forms in which questions of population or environmental pollution are posed, obscure the total view of political, economic and social situations. The Government of India is one of the few which has an officially sponsored programme of family planning and this is making some progress. We believe that planned families will make for a healthier and more conscions



In poverty man is threatened by malnutrition and disease, in weakness by war, in richness by the pollution brought about by his own prosperity.

population. But we know also that no programme of population control can be effective without education and without a visible rise in the standard of living. Our own programmes have succeeded in the urban or semi-urban areas. To the very poor, every child is an earner and a helper. We are experimenting with new approaches and the family planning programme is being combined with those of maternity and child welfare, nutrition and development in general.

It is an over-simplification to blame all the world's problems on increasing population. Countries with but a small fraction of the world population consume the bulk of the world's production of minerals, fossil fuels and so on. Thus we see that when it comes to the depletion of natural resources and environmental pollution, the increase of one inhabitant in an affluent country at his level of living, is equivalent to an increase of many Asian, Africans or Latin Americans at their current material levels of living.

The inherent conflict is not between conservation and development, but between environment and the reckless exploitation of man and earth in the name of efficiency. Historians tell us that the modern age began with the will to freedom of the individual. And the individual came to believe that he had rights with no corresponding obligations. The man who got ahead was the one who commanded admiration. No questions were asked as to the methods employed or the price which others had had to pay. The industrial civilization has promoted the concept of the efficient man, he whose entire energies are concentrated on producing more in a given unit of time and from a given unit of man-power. Groups or individuals who are less competitive and, according to this test, less efficient are regarded as lesser breeds—for example the older civilizations, the black and brown peoples, women and certain professions. Obsolescence is built into production, and efficiency is based on the creation of goods which are not really needed and which cannot be disposed of, when discarded. What price such efficiency now, and is not reckless a more appropriate term for such behaviour?

All the 'isms' of the modern age—even those which in theory disown the private profit principle—assume that man's cardinal interest is acquisition. The profit motive, individual or collective, seems to overshadow all else. This over-riding concern with self today is the basic cause of the ecological crisis.

Pollution is not a technical problem. The fault lies not in science and technology as such but in the sense of values of the contemporary world which ignores the rights of others and is oblivious of the longer perspective.

Problems of War and Poverty

There are grave misgivings that the discussion on ecology may be designed to distract attention from the problems of war and poverty. We have to prove to the disinherited majority of the world that ecology and conservation will not work against their interest but will bring an improvement in their lives. To withhold technology from them would deprive them of vast resources of energy and knowledge. This is no longer feasible nor will it be acceptable.

We should have a more comprehensive approach to life, centred on man not as a statistic but individual with many sides to his personality.

The environmental problems of developing countries are not the side effects of excessive industrialization but reflect the inadequacy of development. The rich countries may look upon development as the cause of environmental destruction, but to us it is one of the primary means of improving the environment for living, or providing food, water, sanitation and shelter, of making the deserts green and the mountains habitable. The research and perseverance of dedicated people have given us an insight which is likely to play an important part in the shaping of our future plans. We see that however much man hankers after material goods, they can never give him full satisfaction. Thus the higher standard of living must be achieved without alienating people from their heritage and without despoiling nature of its beauty, freshness and purity so essential to our lives.

The most urgent and basic question is that of peace. Nothing is so pointless as modern warfare. Nothing destroys so instantly, so completely as the diabolic weapons which not only kill but maim and deform the living and the yet to be born; which poison the land, leaving long trails of ugliness, barrenness and hopeless desolation. What ecological project can survive a war? The Prime Minister of Sweden, Mr Olaf Palme has already drawn the attention of the Conference to this in powerful words.

It is clear that the environmental crisis which is confronting the world, will profoundly alter the future destiny of our planet. No one among us, whatever our status, strength or circumstance, can remain unaffected. The process of change challenges present international policies. Will the growing awareness of "one earth" and "one environment" guide us to the concept of "one humanity"? Will there be more equitable sharing of environmental costs and greater international interest in the accelerated progress of the less developed world? Or will it remain confined to a narrow concern, based on exclusive self-sufficiency?

The first essays in narrowing economic and technological disparities have not succeeded because the policies of aid were made to subserve the equations of power. We hope that the renewed emphasis on self-reliance, brought about by the change in the climate for aid, will also promote a search for new criteria of human satisfaction. In the meantime, the ecological crisis should not add to the burdens of the weaker nations by introducing new considerations in the political and trade policies of rich nations. It would be ironic if the fight against pollution were to be converted into another business, out of which a few companies, corporations, or nations would make profits at the cost of the many. Here is a branch of experimentation and discovery in which scientists of all nations should take interest. They should ensure that their findings are available to all nations un-restricted by patents. I am glad that the Conference has given thought on this aspect of the problem.

Life is one and the world is one, and all these questions are interlinked. The population explosion, poverty, ignorance and disease, the pollution of our surroundings, the stockpiling of nuclear weapons and biological and chemical agents of destruction are all parts of a vicious circle. Each is important and urgent but dealing with them one by one would be wasted effort.



INDIA AND THE U.N. ENVIRONMENT CONFERENCE

PRIME MINISTER INDIRA GANDHI said at a press conference on 16 June at Stockholm that the U.N. Conference on Human Environment has been "a success". "The main thing", she said, "is that this problem has caught the attention of the people and governments everywhere and the conference has promoted a better understanding on it". Shrimati Gandhi also hoped that this understanding would lead to the evolution of concrete plans to resolve the environmental crisis.

A major recommendation made on behalf of India for the establishment of an international fund to assist in strengthening national programmes for environmental improvements for human settlements was accepted by the U. N. Conference on Human Environment, which concluded its two-week session at Stockholm on 16 June. The recommendation which calls for "provision of seed capital and extension of technical aid for effective utilization of domestic resources for housing and environmental improvement of human settlements", was supported by 58 countries, with 15 in opposition and 13 abstentions.

The conference also accepted two important suggestions by India relating to management of natural resources. They were : (1) research on different aspects of forest in

relation to environment should be strengthened by Food and Agriculture Organization, and (2) water regions and watershed management in relation to forests should be included in the international coordination programme for research and exchange of information.

Earlier, on 13 June the conference adopted an Indian amendment ensuring that the pre-occupation of developed countries with their own environmental problems would not affect the flow of economic assistance to developing countries.

The conference also adopted a declaration of principles to guide governments in their approach to the environmental crisis.

The conference recommended that the U.N. Secretary General give priority to request of governments for the establishment or improvement of natural disaster research programmes and warning systems. The programme is intended to prevent death and damage where possible and minimize them. The conference has condemned nuclear weapons tests, "specially those carried out in the atmosphere" and called on all States planning such tests to abandon them.

—*Indian & Foreign Review*, July 1, 1972.

It serves little purpose to dwell on the past or to apportion blame, for none of us is blameless. If some are able to dominate over others, this is at least partially due to the weakness, the lack of unity and the temptation of gaining some advantage on the part of those who submit. If the prosperous have been exploiting the needy, can we honestly claim that in our own societies, people do not take advantage of the weaker sections?

Unfinished Revolution

We must re-evaluate the fundamentals in which our respective civic societies are based and the ideals by which they are sustained. If there is to be change of heart, a change of direction and methods of functioning, it is not an organization or a country—no matter how well intentioned—which can achieve it. While each country must deal with that aspect of the problem which is most relevant to it, it is obvious that all countries must unite in an overall endeavour. There is no alternative to a cooperative approach on a global scale to the entire spectrum of our problems.

I have referred to some problems which seem to me to be the underlying causes of the present crises in our civilization. This is not in the expectation that this Conference can achieve miracles or solve all the world's difficulties, but in the hope that the opinions of each nation will be kept in focus, that these problems will be viewed in perspective and each project devised as part of the whole.

On a previous occasion I have spoken of the unfinished revolution in our countries. I am convinced that this can be taken to its culmination when it is accompanied by a revolution in social thinking. In 1968 at the 14th General Conference of UNESCO the Indian delegation, along with others, proposed a new and major programme entitled "A Design for Living". This is essential to grasp the full implications of technical advance and its impact on different sections and groups. We do not want to put the clock back or resign ourselves to a simplistic natural state. We want new directions in the wiser use of the knowledge and tools with which science has equipped us.

And this cannot be just one upsurge but a continuous search into cause and effect and an unending effort to match technology with higher levels of thinking. We must concern ourselves not only with the kind of worlds we want but also with what kind of man should inhabit it. Surely we do not desire a society divided into those who condition and those who are conditioned. We want thinking people, capable of spontaneous self-directed activity, people who are interested and interesting and who are imbued with compassion and concern for others.

It will not be easy for large societies to change their style of living. They cannot be coerced to do so, nor can governmental action suffice. People can be motivated and urged to participate in better alternatives.

It has been my experience that people who are at cross purposes with nature are cynical about mankind and ill-at-ease with themselves. Modern man must re-establish an unbroken link with nature and with life. He must again learn to invoke the energy of growing things and to recognize as did the ancients in India centuries ago, that one can take from the earth and the atmosphere only so much as one puts back into it. In their hymn to Earth, the sages of the Atharva Veda chanted: I quote.

"What of thee I dig out, let that quickly grow over,
Let me not hit thy vitals or thy heart.

So can man himself be vital and of good heart and conscious of his responsibility.

There is an urgent need for expansion of medical care and health services in the country in the shortest possible time. Apart from meeting a minimum welfare commitment, improvement of public health besides enriching the quality of human material also maintains their productive efficiency and thereby contributes significantly towards programmes of economic development. A minimum package of health services covering curative and preventive medicine, maternal and child health care, family planning, health education, etc., must be made available within a reasonable reach of the population. New strategy for health is a bold and major effort in this direction.

NATIONAL HEALTH STRATEGY

INDIA has made considerable progress in health programmes since Independence. Striking results have been achieved in bringing down the death and infant mortality rates. The expectation of life at birth has risen considerably. The number of medical colleges, available health manpower and beds in the country have also increased appreciably. Measures for the eradication of malaria and smallpox, and control of T.B., leprosy, filaria, etc., have resulted in a marked decline in their incidence.

The achievements, though significant, are not enough. There is wide disparity in the spatial spread of the health infra-structure—the concentration of health services and manpower is mostly in the urban areas. The primary health centres and sub-centres, the focal points for provision of medical facilities in the rural areas, have too large a coverage to be adequate. With the growth of population over the years, their effectiveness has gradually deteriorated,

particularly at the peripheral level. Due to lack of adequate finances and non-availability of the full complement of medical and para-medical personnel, the standard of the services has become diluted. At the district and sub-divisional levels, referral services have not expanded or improved significantly. The programmes for vector control and eradication of major diseases have considerably reduced the incidence. But the incidence of the diseases has not yet been reduced to the level where they cease to be a major public health hazard. The ratio of health manpower of doctors, dentists, nurses, etc. to the population in the country continues to remain below the recommended norm. The emphasis has been mainly on curative medicine and the preventive aspects of health care have not received much attention. Programmes of health education have lagged behind and unless health consciousness is created in the people, lasting improvement in the health status cannot be secured.

There is, thus, an urgent need for expansion of the medical care and health services in the country in the shortest possible time. Apart from meeting a minimum welfare commitment, improvement of public health besides enriching the quality of human material also maintains their productive efficiency and thereby contributes significantly towards pro-

grammes of economic development. A minimum package of health services covering curative and preventive medicine, maternal and child health care, family planning, health education, etc., must be made available within a reasonable reach of the population. A bold and major effort is crucial during the Fifth Five Year Plan.

OBJECTIVES OF THE STRATEGY

For formulating a long-term national strategy for health and specifically, the goals to be pursued during the Fifth Plan, the following are the broad objectives:

- expanding the net-work of the medical facilities and health services in the country for providing a package of services including curative and preventive medicine, nutrition, maternal and child health care, family planning and health education;
- increasing the accessibility of health services and medical facilities in the rural areas, particularly at the periphery, by increasing the number of primary health centres/sub-centres per block, and by involving the practitioners of indigenous systems of medicine in the rural health services;
- removing the disparities in providing health services and medical facilities between the urban and the rural areas and also between one area and another;
- intensification of effort under the national programmes for control and eradication of major diseases to bring down their incidence to a level where they will not be a serious public health hazard;
- laying greater emphasis on preventive medicine and public health measures through schemes for provision of adequate potable water supply, disposal of wastes and nightsoil, improvement of environmental sanitation and nutritional status of the people comprehensive immunization, and promotion of health education;
- improving the quality of the health services by securing the full complement of trained medical and para-medical personnel at primary health centres and ensuring adequate financial provisions for drugs and other requirements of the primary health centres, hospitals, etc.;
- ensuring the quality, through rigorous measures for drugs control, and the availability of the various drugs, pharmaceuticals, surgical instruments, etc. by gearing the production and supply and by achieving self-sufficiency in the country;
- achieving total prevention of food adulteration and securing hygienic production, distribution and sale of food by setting up a network of public health laboratories and a stringent system of inspection and prosecutions;
- progressively improving the quality of and providing the necessary rural orientation to the medical and para-medical personnel by continued emphasis on the standards of medical education, training and research;
- improving the ratio of medical and para-medical personnel and other health infra-structure (referral hospitals, beds, laboratories, etc.) to the population;
- intensifying efforts, through schemes which have large potentials, for generation of employment opportunities particularly for the educated unemployed.

Assessment of Expected Fourth Plan Progress

For achieving the broad objectives, the programme has to be based on the assessment of the progress likely to be made under the various on-going programmes during the Fourth Plan. On its appraisal it has to be viewed whether objectives of different schemes have been secured. If the objectives have been achieved, the particular schemes would be discontinued and the expenditure on maintenance of the services and facilities created by the end of the Fourth Plan will, as usual, have to be met from the general resources as non-Plan expenditure. Schemes not achieving the impact must also be discontinued. And efforts need to be concentrated on the effective and feasible schemes.

Modifications in the Continuing Schemes

On the basis of the need for continuance of the various schemes, the approach for intensification of efforts would be indicated. Based on the examination of the reasons, if any, for their slow progress of different schemes in general, and specific regions in particular modifications in the approaches of the schemes will have to be considered. And necessary changes in the administrative and institutional arrangements for financing, implementation, coordination, supervision, review, etc. would have to be suggested. Keeping in view the priorities for different programmes the increase in inputs under various schemes, in terms of resources, personnel, material and equipment etc., would be suggested.

New Schemes

Besides the on-going schemes to be continued in the Fifth Plan, the need for certain new schemes would be examined. New schemes would fill the gaps in the infra-structure of public health services and medical facilities and make it more broad-based. They would help secure coordination among various agencies and bring into focus the needed emphasis on certain aspects of the health and medical care services

Coordinated Effort

For achieving the objectives of the Fifth Plan, appropriate schemes, continuing and new ones, would be formulated. Coordination and dovetailing of the efforts of the Centre, States, Union Territories, voluntary organizations and even institutions in the private sector, must be given utmost emphasis.

The support of other programmes which contribute towards improvement of public health should also be secured. Thus, provision of protected drinking water supply, environmental hygiene and sanitation, sewerage, removal of garbage and wastes, creation of hygienic conditions of living and work, removal of congestion, slum clearance, prevention of industrial and other accidents, etc., must also receive high priority.

Support from Voluntary Organizations

The building up of voluntary and other philanthropic organizations for providing medical care, and spreading health consciousness in the people through health promotion and health education, has to be considered. Similarly, the organizations in the public and the private sectors engaged in the manufacture and supply of various drugs, pharmaceuticals instruments, etc., will have to gear up their activities to meet the growing needs of the programmes and achieve self-reliance.

Categorization of Schemes

At the beginning of the Fourth Plan, the categorization of various schemes under Central, Centrally-sponsored and State sectors as also the pattern of Central assistance had been considered. And the following criteria was adopted for classification of a programme as Centrally-sponsored during the Fourth Plan:

- (a) that they relate to demonstration, pilot projects, surveys and research ;
- (b) that they have a regional or inter-State character ;
- (c) that they require lump-sum provision to be made until they can be broken down territorially ; and
- (d) that they have an overall significance from the all-India angle.

It was also decided that the Centrally-sponsored programmes would carry Central assistance as 100 per cent grants.

Support for State Sector Programmes

By and large, these criteria and the pattern of assistance should continue during the Fifth Plan also. But it needs to be considered that such State Sector programmes that are likely to affect those of

nationwide importance, should be provided support in terms of resources, material, staff, etc., if the States had experienced difficulty in their implementation. For instance, an inadequate implementation of the malaria eradication programme in blocks which are in the maintenance phase may result in focal outbreak or even reversion of the blocks to the attack phase. The manner and the extent of support needed should be spelt out.

Increasing the Resources

The resources made available under the various Plans for the health programmes have not been enough for a rapid expansion of the medical care and health services in the country. The States have also experienced difficulty in allocating adequate non-Plan funds for the running of hospitals, dispensaries, primary health centres, etc. Due to lack of financial support, the quality of services had suffered. The Bhole Committee's recommendation that "no individual should fail to secure adequate medical care because of inability to pay for it" has been considered by various States in the matter of recovering charges for the medical care services. Efforts are to be made for getting larger allocations of Plan and non-Plan funds in future for the health programmes. But the possibilities of considerably increasing the total availability of resources, which alone could support a bold and ambitious programme for the expansion of the services in the shortest possible time, have to be examined. It should be considered whether health services provided by the Government should be continued as free or a nominal charge could be made if that would improve the availability and the quality of services. If the services provided by the Government are deficient in both these respects, people have to fall back upon private sources and perhaps incur a much larger expenditure. The introduction of a system of graded charges for all medical care and health services, except in the case of genuinely indigent patients, may go a long way in rapidly improving the quality of the services provided and their availability within a reasonable reach of the population.

Building-up Organizational Capabilities

Based on the experience of the Fourth Plan the existing administrative and institutional structure would be strengthened. This organizational apparatus besides improving the efficiency might be able to support and sustain a much larger programme in the

Fifth Plan. For better coordination and implementation of the programmes, establishment of regional organizations should also be considered. Coordination Committees at the Centre and State levels could be set up for securing the needed support for the health programmes from the activities of other Central and State Departments.

Health Statistics

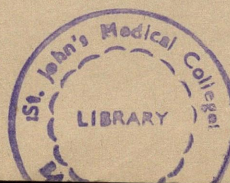
A well organized system of reporting of morbidity, mortality and other statistical health data, its proper recording, analysis and utilization is essential for planning. But the inadequacy of health statistics is perhaps the weakest link in our planning process. The deficiencies should be identified and removed.

Planning and Evaluation Cells

Continuous appraisal of the progress for ascertaining the bottlenecks, shortfalls, etc. for remedial action in time is an integral part of the process of planning. Implementation of a number of schemes has been slow in the absence of adequate arrangement for regular feed-back of progress data and its prompt evaluation. Planning and Evaluation Cells at various levels should be created/strengthened for collecting, analysing and evaluating the progress data and other statistical information for concurrent appraisal of the various programmes. For Centrally-sponsored programmes of nation-wide importance, prompt and regular feed-back of information is of crucial importance. This would enable in taking corrective measures for overcoming the bottlenecks and avoiding short-falls besides considering modifications in the approach and strategy in the light of the experience of working of the programme in the various areas. The Planning Commission has agreed in principle for strengthening the staff structure at various levels for this purpose for securing better implementation of the programmes. The available staff for collection, analysis and reporting of progress data should, however, be further organized and work coordinated for avoiding duplication of effort or personnel.

Suggested Approaches and Targets

Taking into consideration the broad objectives, their *inter se* priorities and the other approaches for integrated health planning, suitable schemes will have to be implemented during the Fifth Plan with adequate outlays. The facilities and services which are languishing



for want of resources must be utilized by providing necessary support. Following approaches are suggested in this regard :

Rural Health Services

Correction of the regional disparities and heavy concentration of health infra-structure and manpower in the urban areas is the imperative of social justice in the Health Sector. A reorientation of the health programmes and policies was, therefore, envisaged in the Master Plan considered by the Health and Family Planning Conference held in Delhi in December, 1970. (Please see *Swasth Hind*—March 1971). The consensus was that a minimum infra-structure for the entire country, particularly in the rural areas, should be set up with the resources available in the Fourth Plan for delivery of an integrated package of four-fold services, viz., health care, medical treatment, family planning and maternal and child health care. The schemes included in the Master Plan which was subsequently recommended by the Central Council of Health need to be pursued more vigorously in the Fifth Plan. These schemes are :

- (i) Revised pattern of sub-centres attached to primary health centres—provision of auxiliary nurse-midwives and basic health workers.
- (ii) Establishment of primary health centres in blocks which are without them and addition of family planning wings to each of the primary health centres—completion of buildings of primary health centres and staff quarters—augmentation of staff and provision of drugs and equipment.
- (iii) Development of referral services—upgradation of primary health centres/dispensaries to 25-bed hospitals.
- (iv) Mobile training-cum-service hospitals and dispensaries on contributory basis.
- (v) Involvement of hospitals and dispensaries in preventive and promotional care.
- (vi) Involvement of voluntary organizations in running medical institutions.
- (vii) Special camps.
- (viii) Village sanitation.

In the Fifth Plan, the target would be for providing one primary health centre for 30,000 population

and a sub-centre and one basic health worker for every 5,000 population.

Bed-population ratio to be increased to provide one bed per thousand population by the end of the Fifth Plan and more beds would be created in the rural areas than in the urban. Of the total beds to be added, only 20 per cent of them should be added in the urban areas and the remaining 80 per cent in rural areas and at Taluka levels.

Expansion of the medical facilities in the rural areas has also to be accelerated by involvement of the large number of available trained practitioners of indigenous systems of medicine including homoeopathy, in the rural health services.

Control and Eradication of Major Diseases

The continuing control and eradication programmes would be intensified/completed during the Fifth Plan.

The national smallpox eradication programme is to be completed during the Fifth Plan.

The national malaria eradication programme would envisage eradication of malaria at least from 75 per cent of the areas in the country by the end of the Fifth Plan.

The 50 per cent of the population at risk under filaria to be covered by the end of the Fifth Plan.

Anti-leprosy control programme is to be intensified. All hyper-endemic areas with a population of about 42.0 million are to be covered and further 50 per cent of the remaining population of the moderately endemic areas (about 90 million) would also be brought under control by the end of the Fifth Plan.

At least 50 per cent of the tuberculosis infectious cases to be diagnosed and brought under treatment through the national tuberculosis control programme by the end of the Fifth Plan.

Entire country to be covered under the national trachoma control programme during the Fifth Plan.

The peak incidence of cholera would be truncated. And all the cholera endemic area would be brought under the national cholera control programme.

All areas endemic for goitre be brought under effective control by the end of the Fifth Plan.

Preventive Health Measures

Water Supply : In rural areas 70 per cent of the diseases are preventable. Of these, 50 per cent

are transmitted through water. Provision of safe water supply is, therefore, vital in organizing preventive health measures. The goal is to attain a coverage of the entire urban and rural population in the country with assured drinking water supply by the end of the Fifth Plan.

The highest priority, therefore, would be given to the programme of rural water supply. Within this overall strategy effort in the rural sector would be directed at providing a source of assured water supply to villages in difficult and scarcity affected areas. Equally high priority would be accorded to providing protected water supply to villages suffering from health hazards, namely, cholera endemicity, guinea-worm and filaria infestation, and where water contains high chloride or iron contents.

In the urban sector, all the towns would be provided with piped water supply.

Sanitation: Sewerage, an important method for sanitation, would be given very high priority. Towns with a population of one lakh and above would be provided with sewerage. In States, where the towns are of smaller size, sewerage proposals would cover the few main urban centres.

A sanitation scheme would be introduced in the rural areas, too.

The scheme would provide for: (i) surface drainage and disposal of waste water; and (ii) popularization of sanitary latrines to individual householders. Community sanitary latrines, if found acceptable, could also be tried.

The villages situated in areas with high rainfall would particularly be covered with rural sanitation. The prosperity brought about in the rural economy by the green revolution has raised expectations of the rural population. And many areas in the rural sector would be having the necessary motivation for taking up rural sanitation schemes.

The training of public health engineers and personnel engaged in the water supply and sanitation sector would be expanded. Facilities for training the general cadres of the operational and maintenance staff would be made available in the State itself. Wherever the number of candidates is not much, a few States might combine together and they could be served by one Centre.

Since the technical institutions of various standards have multiplied all over the country, there was no need for setting up new institutions for training purposes. The training facilities might be stepped up in the faculties of the technical/academic institutions by devising suitable courses. State public health engineering departments or some other departments where expertise and necessary facilities exist would also be developed for such training facilities.

The States might identify the personnel for which training facilities should be developed and quantify the need for such facilities and their phasing over the Fifth Plan.

Disposal of Urban Wastes: The scheme for disposal of urban waste would receive high priority. Apart from making the cities clean, the garbage would be converted into compost which will become a source of income to the municipalities. A Committee has been constituted for the purpose. An ambitious programme for garbage disposal would be based on the recommendations of the Committee and other studies. The scheme would particularly aim at (a) suitable collection, transportation and disposal of urban waste; and (b) administration and maintenance of the programme on a continuing basis.

Water and Air Pollution Control Programme: The Water Pollution Control Bill is before Parliament and the Air Pollution Control Bill is likely to be introduced soon. These two enactments are likely to come into force before the Fifth Plan starts. Suitable infra-structure would be established at the Centre and in the States for enforcement of these Acts. With the help of the institutional set up backed by laboratory facilities and enforcement organization, a substantial programme of controlling water and air pollution is envisaged.

Improvement of Nutritional Status: Provision of adequate nourishment for the pregnant women in the last trimester and infants from 0-3 years of age would be considered for promoting health of the most vulnerable sections of the population.

Immunization Programme: Comprehensive immunization programme, particularly for the vulnerable segment of the population, viz., pregnant women

and children in the early age-groups to begin with would be introduced in the Fifth Plan. The immunization would be against diphtheria, pertussis and tetanus. The production of the required vaccines would also be stepped up.

Medical Care

By 1968-69, the country had achieved a ratio of 0.49 beds per thousand only as against the ratio of 0.24 at the beginning of the First Five Year Plan. The Mudaliar Committee (1960) had set a modest target of one bed per thousand population with the next fifteen years. This target might not be achieved by 1975. But it is likely to be reached during the Fifth Plan. During the Fourth Plan, 25,900 beds were to be added to the existing bed-strength of 2,55,700. More beds in medical and orthopaedic departments would be added to reach the norm of one bed per thousand population during the Fifth Plan. The bed facilities are mostly concentrated in the urban area. The new beds would, therefore, be planned mostly in the rural and semi-urban areas to correct this imbalance.

Because of the existing shortage of beds and likely delay in reaching the minimum norm of one bed for one thousand population, convalescent homes would be set up for patients who require prolonged observation, treatment and nursing care. This would reduce the pressure on beds in hospitals which can be utilized for serious cases. One such convalescent home might be provided in each big city to begin with.

The district hospitals would be further strengthened by providing eye specialists, ENT specialists and dentists.

The incidence of mental diseases is on the increase. Efforts would be made to provide adequate facilities for psychiatric services in the hospitals; existing hospitals would be strengthened and more mental hospitals established.

Adequate number of posts for nursing and other categories of para-medical personnel would be provided to improve the standard of services. The aim would be to achieve the minimum norm of one nurse for three beds in teaching hospitals and one nurse for five beds in other hospitals. Various

categories of personnel would be provided for development of existing hospitals, etc.

Medical Education and Training

The knowledge and skills necessary for the expanding health system have to be developed according to a pre-determined schedule. Broadly speaking, the health manpower planning should provide for generation and utilization of skills.

New medical colleges would be established in those States only where the medical training facilities are inadequate.

It is felt that the increased number of medical colleges within a period of 25 years of Independence has created the problem of maintenance of standards of medical education at least to the minimum level recommended by the Medical Council of India. Some of the institutions, particularly private medical colleges, are ill-equipped, poorly staffed and have insufficient accommodation. The accent during the Fifth and the subsequent Plans would, therefore, be on the improvement of the standards of medical education in existing medical colleges.

Basic Doctors

This would be based on the recommendations of the Medical Education Conference for orientation of medical teaching for training of basic doctors conversant with the basic health problems of the rural and urban communities. Basic doctors would be trained for increasing the number of doctors in the rural areas. The emphasis would be on training of basic doctors rather than expansion of facilities for post-graduate medical education. The post-graduate education would meet the needs of various speciality posts in the teaching and non-teaching spheres in the Government and private organizations.

Medical Research

Sufficient research facilities are available in the country. The various departments of the medical colleges are, by and large, equipped not only for teaching but also for research. A number of private institutions are also equipped for research. These research facilities have to be fully exploited through coordinated policies and programmes for promotion of research. More emphasis would be on applied than on fundamental research. □

25th ANNIVERSARY OF FREEDOM

HEALTH TODAY

India has launched a relentless war against deadly diseases with the overall objective: "health for all". During the past twenty-five-year battle, a number of programmes have been launched for the control and eradication of communicable diseases which had been sapping the vitality of our people.

Indeed, a commendable success has been achieved in our fight against diseases like malaria, smallpox, cholera, tuberculosis, leprosy, filaria, plague, venereal diseases, etc. Plague is non-existent and malaria no longer claims any life. Deaths due to cholera and smallpox have registered a significant decline.

But, the nation does not rest on its laurels. The battle is still on.

HEALTH TODAY

Malaria Eradication

THERE has been an enormous reduction in malaria cases. By 1971 malaria incidence had come down to 1.09 million cases from 75 million cases in 1952 before launching of the National Malaria Control Programme. A steep fall, indeed! It has brought many collateral benefits in its wake including eradication of plague and kalazar.

India's 547 million population is covered in 393.25 NMEP units under the National Malaria Eradication Programme. The phasing of the programme during 1972-73 is— Attack phase: 98,429 units covering 132 million population; consolidation phase: 68,365 units covering 93 million population; maintenance phase: 226,456 units covering 322 million population.

Upto 1964, the progress of the programme had been very satisfactory. But, unfortunately, there had been set-back to the programme since 1965. Therefore a realistic phasing of the programme was done in 1968. And 71,385 unit areas were reverted to attack phase to ensure once again a timely insecticidal coverage overlapping the transmission period.

Filariasis Control

THE National Filaria Control Programme was launched in 1955 to control filariasis. At present, 110 filaria control units in various endemic States/Union territories are carrying out anti-larval operations in urban areas. Besides, 10 specialized units called the Headquarters Bureau are also operating for co-ordinating the control activities. By 1972-73, another 25 filaria control units and two headquarters bureaux will be set up and give protection to over 13 million people.

Fight Against Smallpox

THERE is a substantial reduction in the mortality and morbidity from smallpox, thanks to present strategy of giving top priority to primary vaccination (including neonatal vaccination) and intensification of surveillance and outbreak containment measures. The technique of vaccination has been changed from rotary lancet to multiple puncture.

Under the National Smallpox Eradication Programme, launched in the last quarter of 1962, systematic primary vaccination and revaccination with potent freeze-dried smallpox vaccine and intensification of surveillance and containment measures are under way on nationwide basis.

Trachoma

THE National Trachoma Control Programme was launched in 1963 to wage a war against the disease. Till March 1972, a population of about 42.68 million has been brought under the control programme, spreading over 531 community development blocks in various States. The programme is in operation in Assam, Bihar, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Madhya Pradesh, Meghalaya, Mysore, Punjab, Rajasthan, Uttar Pradesh and Manipur. By the end of the Fourth Plan, about 141 million people will be covered under the scheme within the present Plan ceiling.

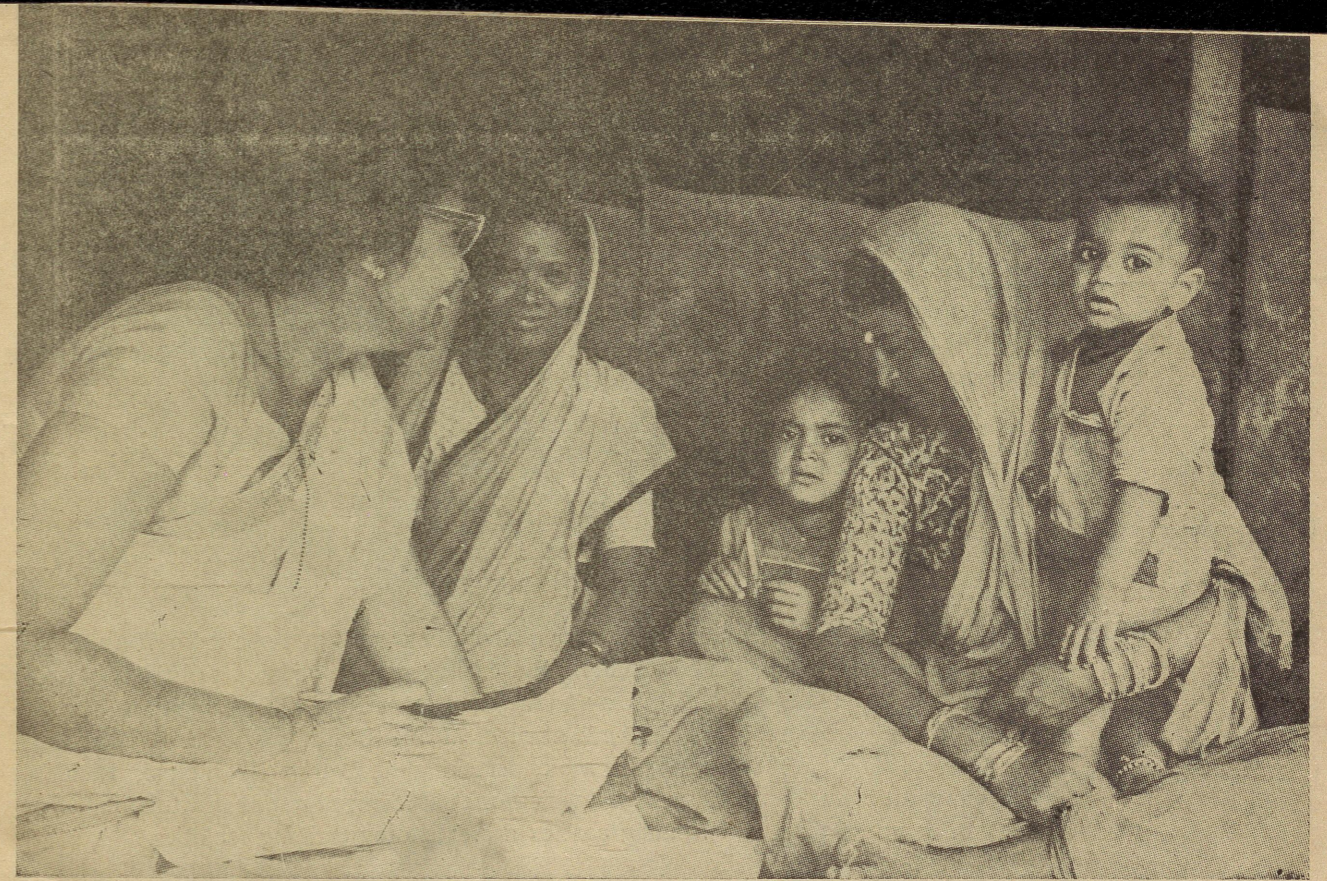
Significant success has been achieved in our fight against malaria. Photo shows DDT spray operations by an anti-malaria team in a village. →





EXPANDING RURAL HEALTH SERVICES : Primary health centres and sub-centres form a nucleus from which all health services radiate in the rural area. Correction of the regional disparities and of heavy concentration of health infrastructure and manpower in the urban areas is imperative for social justice. A reorientation of health programmes and policies envisaged in the Master Plan provide for a minimum infrastructure for the entire country particularly in the rural areas for delivery of an integrated package of health services, for health care, medical treatment, family planning and maternal and child health care and also for provision of safe water supply.

HEALTH FOR ALL



TOWARDS BETTER MATERNAL AND CHILD HEALTH : The maternal and child health services have been integrated with the family planning programme. This, in fact, is a prelude to the total integration of this national programme with the general health services. Home visits and building rapport with the people are vital for the success of maternal and child welfare programmes.



CAMPAIGN AGAINST COMMUNICABLE DISEASES : Trachoma—a communicable eye disease—is a major public health problem. In fact, trachoma and associated infections are responsible for 60 to 80 per cent of the blindness in the country. The main reservoir of infection is in the pre-school age group.

HEALTH TODAY

THE main plank of the National Tuberculosis Control Programme, launched in 1949, is early case-detection and domiciliary treatment and mass BCG vaccination of the people in the 0-20 years age-group.

Campaign Against Tuberculosis

Nearly, 250 million people have been tuberculin-tested and about 150 million BCG-vaccinated by 272 BCG teams. The number of BCG teams has risen from 15 in the First Plan to 272 by the third year of the Fourth Plan.

To meet the demand of the vaccine for the mass campaign, a BCG-vaccine laboratory was established in 1949-50 at Guindy, Tamil Nadu.

The number of T.B. clinics for domiciliary treatment has risen from 70 in 1947 to 532 by the third year of the Fourth Plan. Emphasis is now being laid on district control programme. It envisages that T.B. case-finding treatment and BCG vaccination facilities should be integrated with the general medical and health services. Of the 532 tuberculosis clinics in the country, 253 are undertaking the district programme. Besides other institutions and medical colleges which offer specialized courses in tuberculosis, 17 T.B. demonstration and training centres are extending training facilities.

Combating Cholera

To meet the cholera menace the National Cholera Control Programme has been launched. It aims at eliminating the endemic foci through surveillance and timely remedial action supported by provision within our limited resources of protected water supply and sewerage systems. The programme has been started since 1970-71 in the States with large endemic areas, namely, Andhra Pradesh, Bihar, Maharashtra, Mysore, Orissa, Tamil Nadu and West Bengal.

From the year 1972-73, the programme has been extended to cover all the endemic areas including the States of Assam, Madhya Pradesh, Uttar Pradesh, Rajasthan and the Union Territory of Pondicherry.

WITH a view to provide modern treatment to leprosy patients, the National Leprosy Control Programme was undertaken in 1955. The programme is now operating in 23 States/Union Territories covering almost all the pockets of high and moderate endemicity.

Leprosy Control

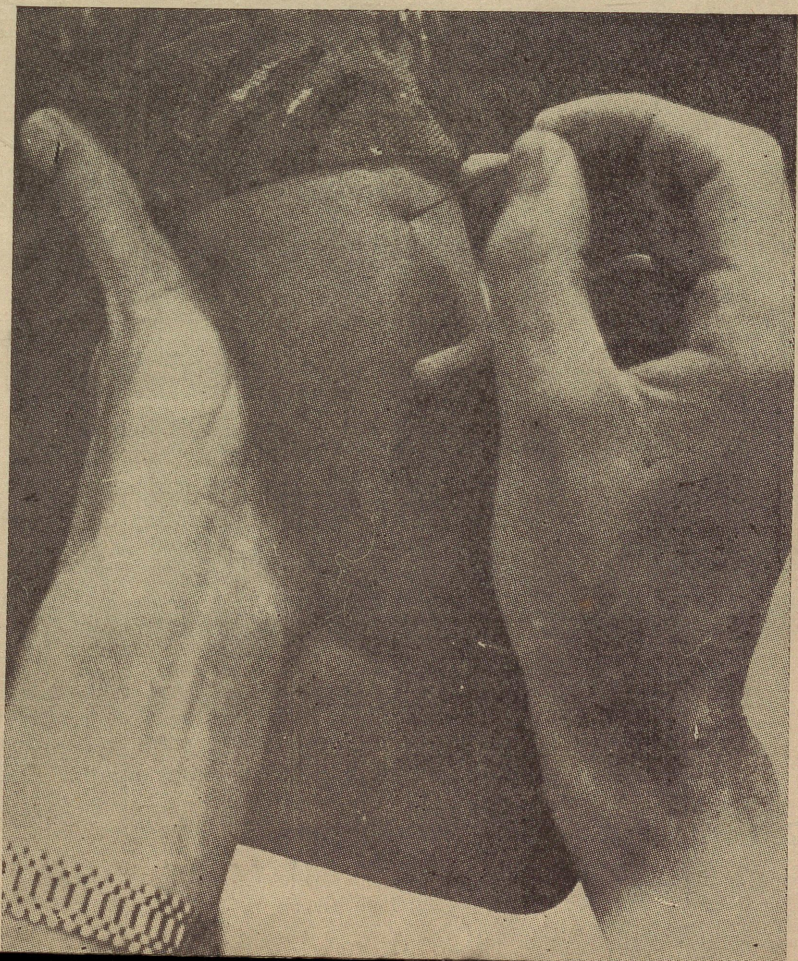
Under the programme, 227 control units and 1,422 Survey, Education and Treatment (S.E.T.) Centres are functioning in the country. Thirty voluntary organizations and five control projects run by the international agencies are also participating. To integrate leprosy control work with the general health services the S.E.T. centres are attached to the primary health centres, hospitals and dispensaries.

Research, too, forms part of the leprosy work. The Central Leprosy Teaching and Research Institute, Chingleput, Tamil Nadu, set up in 1955, conducts research in leprosy.

Thirty hospitals offer facilities for reconstructive surgery for the deformities of hands, feet and face.



Tuberculosis eats into the vitals of the nation and often takes the best of us. The main plank of the National Tuberculosis Control Programme, launched in 1949, is early case-detection and domiciliary treatment and mass BCG vaccination of the people in the 0-20 years age-group.



Smallpox—a dread disease wiped out from many countries—continues to show its ugly head in India. There is a substantial reduction in the mortality and morbidity from smallpox. Considerable progress has been made in smallpox vaccination coverage. Photo shows vaccination with bifurcated needle.

HEALTH TODAY

Venereal Diseases

DUE importance has been given in the Fourth Plan, as in earlier Plans, to check V. D. A. headway has been made in the establishment of V.D. clinics to fight the menace. A total of 288 clinics (up to 1 July, 1972) are working in different States and about 22 more clinics would be opened during the Fourth Plan.

Goitre

THE goitre survey teams are engaged in estimating the prevalence of goitre in the country. For producing iodized salt 10 iodization plants have been set up at Sambhar, Khargoda and Calcutta. Two more plants would be installed soon. Yet another pilot plant has been installed at Mandi near saltmine.

At present, iodized salt is being supplied to three districts of Punjab; one district each of Haryana and Bihar; nine districts of Uttar Pradesh, Himachal Pradesh, Nagaland and Manipur and Union Territories of Chandigarh and Arunachal Pradesh.

During the Fifth Plan the entire endemic belt will be supplied with iodized salt.

Rural Health Services

FOR providing health services in rural India, primary health centres were the right answer. It was in 1952 that an integrated comprehensive scheme of establishing primary health centres in the community development blocks was heralded.

Since 1952, as many as 5,183 primary health centres and 28,167 sub-centres have been set up in the country till 31 March, 1972. Some States have more than one primary health centre in a block. But 200 blocks in various States are without primary health centres. There is one doctor each in 2,553 and two doctors each in 2,455 primary health centres. But 175 primary health centres are without a doctor.

Health Insurance

To build India into a Welfare State nothing is of higher importance than the health of its people. The Central Government Health Scheme is functioning at four places in the country—Delhi (since 1954), Bombay (since 1963), Allahabad (since 1969), and Meerut (since 1971). The Scheme has been extended to two more cities, viz., Kanpur and Calcutta. It is meant for the benefit of all categories of the Government of India employees and their families in these six places. Indeed, it is a step towards introducing the National Health Insurance Scheme for the furtherance of the objective of a Welfare State.

The Scheme has gained considerable popularity as is evidenced by the increase in the number of beneficiaries covered by it.

The Scheme has been extended to the Members of Parliament, certain semi-Government Organizations, pensioners and those widows who receive family pension and the general public in some areas of Delhi.



Veneral diseases can be controlled by the application of modern techniques of control and treatment. Photo shows blood sample being taken from a suspected V. D. case.

HEALTH TODAY

Indian Systems of Medicine

INDIAN Systems of Medicine now enjoy the same status as the Modern System of Medicine in the development of the National Health Services.

The Central Council for Research in Indian Medicine and Homoeopathy (CCRIMH) was set up to initiate, guide, develop and co-ordinate scientific research in different aspects—fundamental and applied—of Ayurveda, Siddha, Unani and the Homoeopathic Systems of Medicine and Yoga. At present 172 research units including five central research institutes and six regional research institutes are functioning under the CCRIMH. The CCRIMH, which has started work on 1 September, 1971, would ensure minimum standards of training in Indian Systems of Medicine and maintain an all-India register of qualified practitioners of these systems.

At present, about 9,000 dispensaries, 115 colleges and 180 hospitals of Indian Systems of Medicine are functioning in India.

A SIGNIFICANT feature for combating malnutrition is the creation of State nutrition divisions in 15 States and two Union territories. These divisions define the areas of nutritional backwardness in their own States and Union Territories.

To combat malnutrition, two important action programmes, viz., Applied Nutrition Programme and School Meal Programme were started in early 60's. The Applied Nutrition Programme is operating in 924 community development blocks in the States for improving the nutrition status of the rural community. The School Meal Programme aims at preventing irreparable damage to primary school children. As many as 11 million primary school children are given nutritious mid-day meals in 14 States/Union Territories.

Nutrition

Two prophylactic programmes against blindness due to vitamin A deficiency among children and anaemia among expectant mothers and children have been taken up during the Fourth Plan. On similar lines endemic goitre caused by the iodine deficiency is being tackled through iodized salt.

Supplementary feeding programme as an emergency measure to overcome malnutrition among the vulnerable segments of the population, namely, infants and pre-school children, expectant and nursing mothers are also being undertaken. Crash feeding programme caters to the nutritional needs of the infants and pre-school children and expectant and nursing mothers in slum and tribal areas. Whereas *Balwadi* feeding programme aims at improving the nutritional status of the pre-school children of rural areas.

Adequate provision of safe water and improvement in environmental sanitation are essential in disease prevention and health promotion. →





A well-organized contingent of medical manpower is essential to achieve the objective of comprehensive health services for all. Medical education has been receiving constant attention in India.

Augmenting

A number of measures have been taken to expand the training facilities. Today, there are 97 medical colleges with an admission capacity of about 12,000 as against 25 medical colleges in 1947 with barely 1,933 admissions. Six more colleges would be opened during the Fourth Plan.

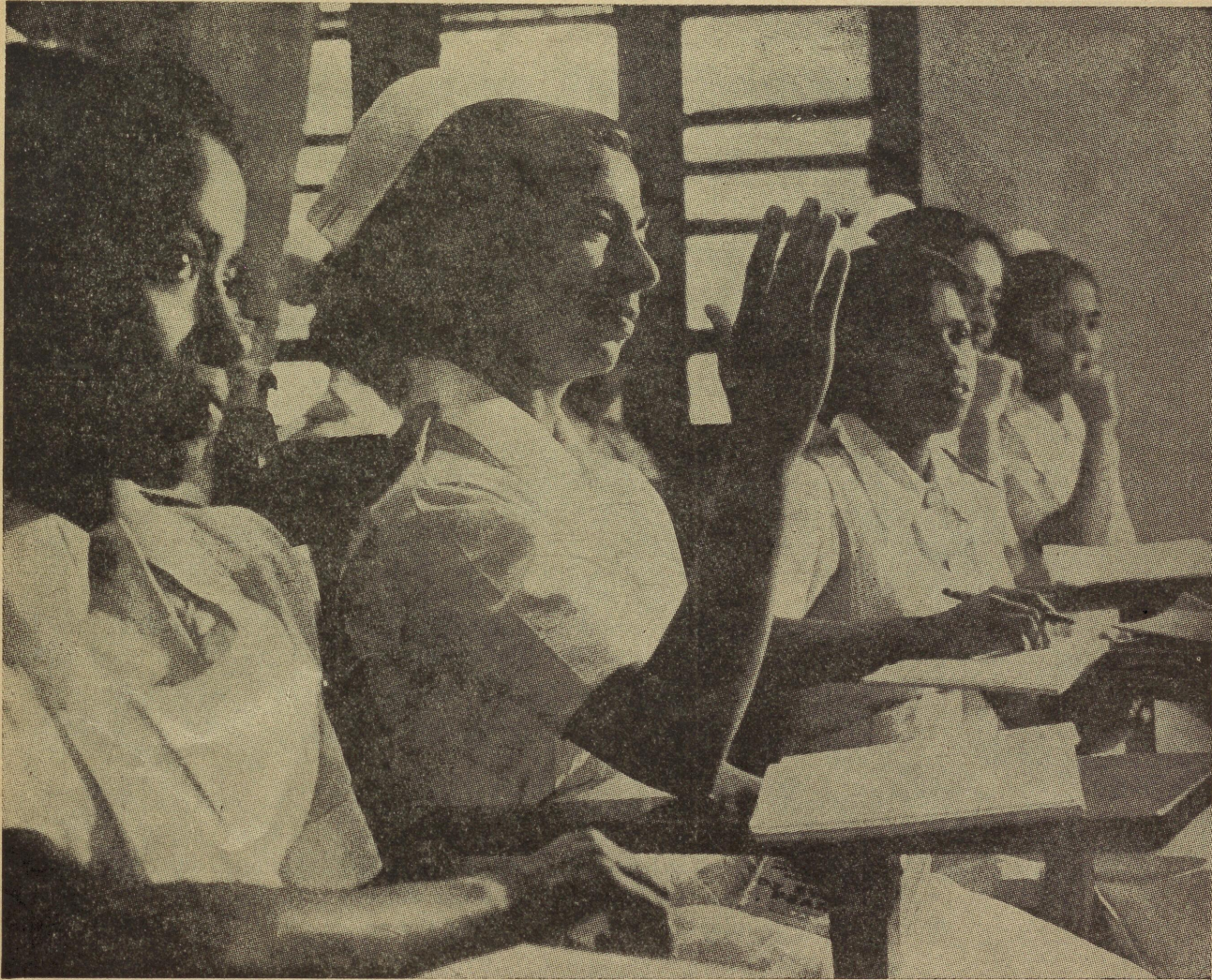
Medical

The main handicap in the opening of new colleges is shortage of teachers which is about 16 per cent. This void will become even greater when six more colleges are to be opened during the Fourth Plan.

Manpower

There has been a rapid increase in the number of doctors. But many more doctors are still needed to meet the increasing demands of population growth.

The number of doctors has increased from 47,524 in 1946 to 1,15,725 in 1970-71 taking the doctor-population ratio to 1:4730. The number of doctors is expected to rise to 1,37,930 by the end of Fourth Plan.



Nursing

THE changing health needs have been always kept in view for the education of nurses. Recently, the emphasis has been on community nursing and family planning. There are 15 colleges (basic and post-basic) which award B.Sc. degree in Nursing. Two colleges provide nursing education at the post-graduate level (M.Sc. in Nursing). Efforts are made to help the nurses through these post-graduate courses in specializing in various branches of clinical areas, viz., medical-surgical nursing, paediatric nursing, public health nursing. This will help in providing quality nursing service to the patients.

There are also 253 schools of nursing engaged in the training of nurses and qualify about 5,000 nurses yearly. Today, there are 66,000 nurses in the country. By the end of the Fourth Plan, 88,000 nurses will be trained. This will mean a ratio of one nurse for five beds and nurses for health centres and family planning work.

HEALTH TODAY

THE problem of food adulteration is viewed with great concern. The Prevention of Food Adulteration Act 1954 and the Prevention of Food Adulteration Rules 1955 prohibit the import, manufacture, stock, exhibit and sale of adulterated food in the country.

Food Adulteration

The Central Food Laboratory at Calcutta is being suitably strengthened to undertake analysis of pesticide residue and microbiological work. And a scheme for training of analysts from the State food laboratories has been started.

Work is under way to establish a Food Standardization and Research Laboratory at Ghaziabad for analysing the samples of food collected by the Central Food Squad. This laboratory would also undertake studies for fixation of standards of food articles.

SAFE water supply and proper disposal of community wastes are a crying need in India for bringing down the incidence of preventable water- and filth-borne diseases like cholera, typhoid, diarrhoea and dysentery, hookworm, etc. These diseases are responsible for a large number of deaths in the country. In fact, provision of safe water would help raise the health standards of the people.

Water

Supply

And

Sanitation

The launching of the National Water Supply and Sanitation Programme in 1954 was a landmark. Under this integrated Scheme not only the urban areas are being provided with protected water supply and sewage system but also increasing number of villages are getting such facilities. Priority has been given to those villages which do not have this basic amenity.

During 1954-72, 1,348 urban water supply and sanitation schemes costing Rs 4878.1 million and 3,227 rural water supply schemes costing Rs 886.5 million have been approved under the programme.

Up to 31 March 1971, as many as 1,281 towns were having partial or full water supply and 188 towns had sewerage facilities out of 2,452 towns. And 19,892 villages were having piped water supply catering to 133 lakh people.



Health Education of the People

MANY a time health services provided at a considerable cost and effort to the people are not fully utilized. Health programmes do not always secure public participation. To bridge the gap, health education seems to be the answer.

The Central Health Education Bureau (CHEB) came into being in 1956 with a view to organize health education campaigns in the national health programmes. Today, 15 States and two Union Territories have set up health education bureaux as envisaged in the Central Scheme to carry out health education work. Other States, too, are on their way to establish health education bureaux and thereby strengthen this vital component of the health programmes.

The commencement of the course, Diploma in Health Education from July 1971 by the Central Health Education Bureau under the auspices of the Delhi University was a landmark in the history of growth of the Bureau.

The State Health Education Bureaux with their own units for training, Student health education, field study and demonstration, material production carry out health education at the State level. □

FAMILY WELFARE PLANNING

DR (MISS) L.V. PHATAK

THE official family planning programme in India was initiated about twenty years ago. In these two decades in the different approaches in its technical and motivational aspects the programme has undergone a series of changes. They have only highlighted the philosophy underlying the programme from time to time.

Massive publicity, enlarged service facilities and a door to door extension approach have led to a widespread awareness of family planning. Mere knowledge of the methods or of its utility, however, is not always enough to induce an individual to practise family planning and there has not yet been a matching response in respect of practising it in real life. This seems to be our biggest challenge for the present.

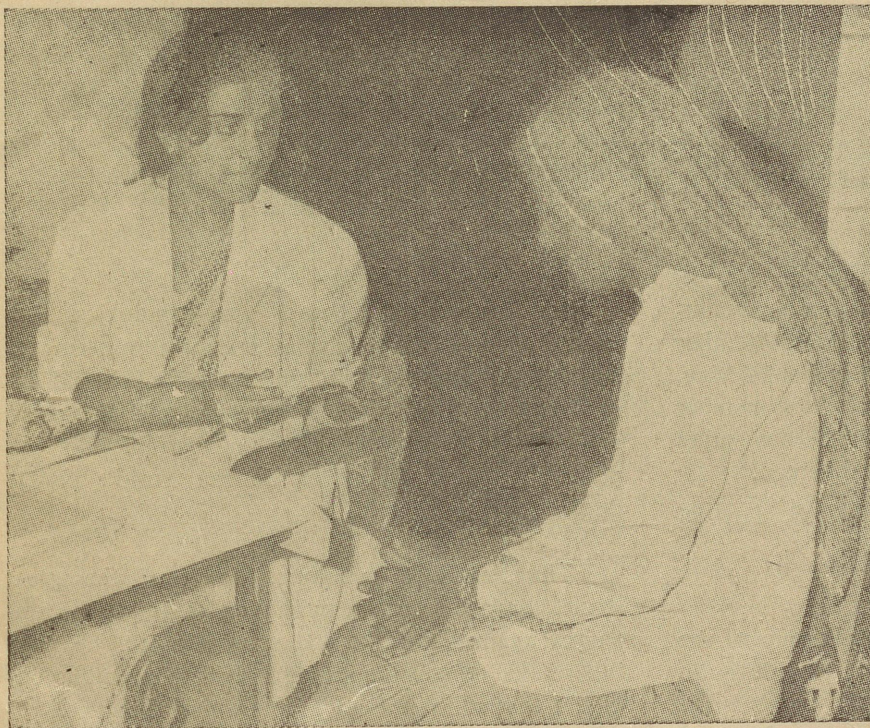
Multi-pronged Strategy

While a multi-pronged strategy is being evolved to bridge this gap, I have a feeling that the root cause of this anomaly may perhaps be traced in the very Indian attitude towards life. They have learnt to live with diseases, natural disasters and even external aggression, acting only when an emergency stares hard on their faces. This, a kind of stoic complacency, is what prevents a determined action to eliminate the factors which may spell disaster in future. Even when the fast moving events of the recent past have largely shattered their composure, our people are yet hesitant to come out and grapple with the realities. It is necessary that it has to be a movement of the people for the ultimate socio-economic uplift of every individual and the society.

This is evident in the positive health programmes also. While our ancient books had much to say and suggest about taking positive action to maintain and improve health, what most of us do in real life is to fight the symptoms or take action when we are afflicted with a disease. Epidemics like smallpox and cholera, which used to take a heavy toll of lives, were not so much taken as deadly diseases as manifestations

Education of women is of utmost importance for the acceptance of family welfare planning programmes





As many as 1,903 urban and 5,204 rural family welfare planning centres are providing family planning services in the country besides 32,157 sub-centres in the rural areas. Further 2,369 institutions like hospitals and dispensaries in urban and 8,861 in rural areas are doing family planning work. Also, 399 mobile sterilization and 428 mobile IUCD units attached to the district family planning bureaux are rendering services.

of the wrath of some malevolent goddess. People depended as much on vaccination or inoculation as on appeasing the deities. In such circumstances, it is not easy for the people to feel convinced of a dynamic and progressive programme like family planning, which does not promise any immediate benefit or relief, and accept its practice which requires continued motivation.

Programme Related to Cultural Pattern

The idea of family planning has to be wedded to the cultural pattern of our people so that the programme never appears to be an official whim imposed on them. For this, we need deep and detailed studies of the cultural history of our people in general and in different regions. Alongside these studies and researches, we have to take several other social measures which help adoption of the idea of family planning. I would rate spread of women's education as the most important programme in this respect. With spread of education status of our women in the society will be enhanced. She has to understand that since it is she who bears a child, it should also be her decision when to have one or not. Her wishes must be respected and honoured, as that of an equal partner in family life. This would come when she is educated and can think for herself.

There are hopeful signs of changes in the outlook of our people. One encouraging report says that rural people are now going in for family planning in increasing numbers. There has to be a sustained effort to impart family planning education to our rural people. This education should primarily be based on health requirement.

Bringing out the very Best

Acceptance of sterilization is now gaining momentum due to different reasons even in rural areas; but that is a remedy not for all and not for all times. Thus, spacing, I stress, is of basic importance to this national programme which touches one of the most important and delicate areas of human life. Whatever we try to say to our rural people must be in the language of the people to carry conviction with them. They understand health and spacing earlier than the impact of a small family on the economy.

These are some of the random thoughts that come to my mind as a result of my experience in the family planning programme, during the past few years. Great though are the problems, our programme personnel should rise to the occasion. □

Twenty-fifth World Health Assembly

THE Twenty-fifth World Health Assembly, (composed of delegates of 129 of WHO's 135 Member States) concluded its session in Geneva on 26 May, 1972 after nearly three weeks' work. Non-member States, the United Nations, and numerous other international organizations were represented.

The Assembly elected Dr Basil D.B. Layton, Canada, as its President.

New Members

Bangladesh was admitted to membership of the World Health Organization. Qatar, previously an Associate Member, acceded to full membership. Papua New Guinea was elected an Associate Member of WHO. Membership now stands at 135 Member States and one Associate Member.

1973 Budget : \$93 Million

An effective working budget of \$93,174,400, to finance the work of the World Health Organization in 1973, was adopted. This figure represents an increase of 8.3 per cent over the 1972 budget as revised during the Twenty-fifth Assembly.

President's Inaugural Address

Dr Basil Layton, in his inaugural address, stressed that it had become important for the Organization to "conduct a self-examination and an appraisal of where it stands and where we are going".

"We are, admittedly, not the international policy makers who attempt to resolve and untangle the problems which can and sometimes do lead to conflict—be it widespread or localized, overt or undercover, seemingly justifiable or openly aggressive. Whatever the underlying cause and extent, the resultant common denominators are suffering, both physical and mental, destruction, desolation, human disability and death. And it is at this stage that we, as physicians, become personally involved to try to repair the damage to body and mind."

Dr Layton added that it was paradoxical that WHO, founded on principles set forth in terms of health, happiness, peace and security "should all too frequently have its work impeded, frustrated and perhaps even negated by the disruption of the peaceful way of life which all the world's people desire".

The President mentioned some of the great strides made forward in public health as in the campaigns against malaria and smallpox but, he said, "there still remain the killing and disabling afflictions of old that still represent a continuing threat to two-thirds of the world's population, and these plus the developing challenges to all societies: the degradation of our environment, explosive population growth and the ever-increasing occurrence of the degenerative diseases which will call for a further and even more forceful thrust into these areas."

Speaking of world tension and how it affects the work of WHO, Dr Layton said: "My belief is that this Organization, collectively through its annual assemblies, individually in its regional groupings and in the Member countries themselves, can demonstrate to the world at large, in unmistakable and positive terms, our continuing concern with the health of people and the improvement of their way of life. This, I feel, cannot help but have a profound influence on world opinion and affairs, and hopefully even alleviate the chronic tensions which can generate hostile outbursts."

"We see before us many avenues for attacking the old afflictions which have plagued mankind for untold centuries and we seek the means and modalities with which to anticipate, prevent, minimize or, hopefully, to overcome the modern challenges to our society and thus the health of our peoples", Dr Layton said.

Director-General's Report

Developing countries should not become recipients of dangerous manufacturing processes and bye-products not desired in the developed countries, Dr M.G. Candau, Director-General of WHO, told the World Health Assembly while submitting his Annual Report on the work of WHO in 1971.

Dr Candau continued, "they should not be expected to adhere to environmental standards that are promulgated by and for developed countries and that would impede their own economic development".

After referring to the UN Conference on the Human Environment in Stockholm, Dr Candau emphasized that developing countries should define for themselves their own minimal environment standards in line with their needs and possibilities. With reference to the highly developed countries Dr Candau said, "clearly we must look to technology to help us solve the environmental problems that technology has created. WHO has been playing its part in these efforts, notably in matters of air and water pollution."

Biological Pollution

"In the midst of present pre-occupations with environmental problems, we must not lose sight of our central concern for human health here and now; we must not forget that only about 20 per cent of mankind live in a highly developed technological environment. Among the health hazards of the underdeveloped environment, biological pollution stands out at present in contrast to the predominantly chemical pollution, associated with high industrialization. Millions still live in places where the basic human needs for unpolluted water supply and safe waste disposal are not satisfactorily met. Poor sanitation forms part of the vicious circle linking poverty, disease, ignorance and hunger. The Stockholm Conference can help to bring into sharper focus the question of how to break this circle without further degrading the environment of man."

Health Pays

Dr Candau then spoke of the economic importance of health work.

"Personally I have never been able to see how there could be much hope for appreciable economic development among populations where nutritional deficiencies and communicable diseases—especially some of the major parasitic diseases—remained widespread."

Malaria: Progress Slowed

"In the malaria eradication campaign", Dr Candau said, "there has been a slowing of the pace of progress of past years due to technical problems as well as administrative and financial shortcomings. Many governments of developing countries are facing serious financial difficulties and, without additional international or bilateral assistance, progress in malaria eradication must continue to be relatively slow. The report notes that 275 million people live in malarious areas where formal programmes against this disease are not yet in operation. These areas are mostly in the African Region where every effort should be made to reduce the intensity of malaria transmission. This I believe to be essential for the social and economic development especially of rural areas."

Smallpox : No Complacency

"The smallpox eradication programme has been making steady progress, but there certainly are no grounds for complacency as recent events have shown. A great amount of work still needs to be done in order to interrupt transmission in the endemic countries and to achieve greater vigilance in preventing the re-introduction of the disease in areas free of smallpox. Clearly an intensification of effort is essential at this time if we are to achieve the goal of global eradication."

Heart Disease

"The heavy loss of human life from ischaemic heart disease, cerebral stroke and rheumatic heart disease could be substantially reduced if all the means now available were effectively applied. Yet even then, cardiovascular diseases would remain the foremost public health problem in many countries. But, before we can make scientifically justified efforts in mass prevention, much further research will be needed."

"Cancer is another area where progress can be made with present means but where our knowledge

of causes and hence of possible preventive action is inadequate.

Extension of Health Services

Dr Candau referred to problems relating to the strengthening of health services:

"The extension of health service coverage has been slow, too slow I would say, especially in rural areas. Secondly there has been a lack of progress in the use of available resources to improve the health status of groups already covered by services. The third problem concerns the effects on established health programmes of new responsibilities—for example those related to family health or the environment—which by competing for resources may actually decrease existing possibilities unless the new activities can be planned and developed in an integrated way. To these challenges WHO must seek to respond effectively in the coming years."

Family Health: Research and Field Programmes

"It was no doubt in part because of WHO's concern with the *quality* of human life that it has received such generous support from a variety of sources for the further strengthening of family health services. Of note is the expanded programme of research in human reproduction, which has now become the financially largest research effort undertaken by WHO. Several lines are being followed, basic research in reproductive biomedicine, clinical trials of fertility-regulating agents, and collaborative research by scientists in different disciplines. This programme also has a strong research training component. As regards our assistance to governments in family health, a few points will indicate the general trend. In Asia where in some countries the primary aim was originally to influence population size, family planning has turned out to be a long-term, complex process the success of which depends in large measure on the confidence people have in the health services and on the commitment of personnel to their health service tasks. In countries of the Americas, the dangers to mother and child health of high pregnancy rates including induced abortions, maternal depletion and infant malnutrition are clearly recognised and are being met by integrated maternal and child health and family planning programmes. In the African Region, requests are being received

for assistance in all aspects of family health including pregnancy spacing as part of health care and also problems of infertility which is a cause for concern in some countries."

Educational Planning Needed

"In many WHO areas of work, progress is still impeded by a lack of trained health manpower. One of the ways to overcome this is by better planning, but health manpower planning is still something of an innovation in most parts of the world. The relationship between the education institutions for the health professions and the agencies providing health care is often exceedingly weak or even non-existent. Yet the principle that educational planning must be geared to meet manpower requirements is being gradually accepted. It means that education must be linked and adapted to operative systems."

Recommendations and Suggestions

Smallpox Eradication

The Assembly called for intensified efforts in the world-wide smallpox eradication campaign. The discussion centred on the need for the rapid detection and reporting of cases, and the maintenance of vaccination. Numerous delegates stressed the continued importance of maintaining a high degree of immunity in the population as an effective barrier against the spread of smallpox.

Malaria Programme

In addition to the overall progress of malaria eradication programmes, the Assembly learned that there had been a very significant reduction in the malaria mortality rate in countries where eradication had not been achieved within the time-limit originally planned. For example, in countries of Central America the general mortality rate in the period 1955-1968 indicated a reduction of 30-40 per cent, the reduction in the malaria death-rate for the same period ranging between 70 per cent and 100 per cent. A reduction of the same order in the malaria death-rate was achieved in countries in Asia. In Thailand, the malaria death-rate dropped from 63.2 per cent to 10.4 per cent.

Prevention of Blindness

There are between 10 and 15 million blind people in the world. More than half could have

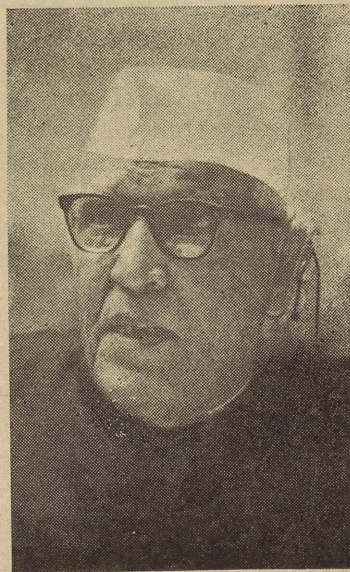
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LIFE FREE FROM WANT AND WORRY

As a nation which shelters a seventh of humanity we are very conscious of the duty of our Government to create conditions in which all our people can live a life free from want and worry. Prompt medical attention and programmes which improve the level of health of our people occupy a key place in our design of national development. The main ingredients of the public health programmes of India and most other developing nations, at the present time, are the prevention of communicable diseases, provision of safe water, nutritious food and medical care for the masses, and the regulation of the growth of population.

As a result of our endeavours during the last two and a half decades, the general death rate has come down from 27.4 per thousand population in 1946 to 17.0 in 1971. The infant mortality rate has also declined considerably. A child born today in the country can expect to live for 52.6 years as compared to 32 years during 1941-50.

Our public health programmes have resulted in an appreciable reduction in morbidity and mortality caused by communicable diseases. There has been a steady decline in the number of cases and deaths due to smallpox. Malaria has once been our principal killer, but malaria cases have shown a reduction by 99 per cent. But our malaria eradication programme has taught us that in matters of health there should be no complacency or premature relaxation of effort. In some places, we have found that new mosquito strains resistant to D.D.T. and other insecticides have made their appearance. As a result we have rephased our programme. I would suggest that international research organizations should also take up an earnest study of the problem of malaria recrudescence. Our programmes on control of tuberculosis, leprosy, filariasis, trachoma, etc., have started yielding dividends. In regard to cholera and other gastro-intestinal diseases, our emphasis has been on the improvement of environmental sanitation and safe water supply under the National Water Supply and Sanitation Programme.



Shri Uma Shankar Dikshit

One of the most complex challenges that face us is that of a fast expanding population. This tends to dilute the results of our economic development and leads to other social tensions. Family planning has, therefore, been accepted as a national imperative and is an acknowledged objective of national policy. The programme has been integrated with the basic health services and maternal and child care. Both in urban areas and in our half million villages, the people have come to recognize that smaller families make for improved levels of living and also for greater opportunities for education and employment of the younger generation. We have succeeded in breaking through traditional psychological barriers and we now expect a fairly rapid acceleration of the programme.

—Excerpts from the Speech of the Union Minister of Health and Family Planning at the 25th World Health Assembly held in May, 1972 in Geneva.

been spared their fate if the cause of their blindness had been detected in time. According to the available and incomplete data, blindness rates are in general around or below 200 per 100,000 persons in America and Europe. In the developing countries, especially in Asia and Africa, the rates at times are above 1,000. Trachoma and associated infections are still the main causes of eye disease in most of the developing countries. In cases of serious complications they may lead to partial or total loss of vision. It is estimated that there are four to five hundred million cases of trachoma in the world, and of these 125 million are in India alone. In a resolution, the Assembly requested the Director-General to endeavour to obtain additional data on visual impairment and blindness and their prevention with special emphasis on the situation in developing countries, keeping in mind the need for a generally accepted definition of blindness and visual impairment.

New Problems of the Pharmaceutical Revolution

The Assembly decided it was time to adopt a comprehensive approach to ensure the quality, safety, and efficacy of drugs, and to assist governments in this field. The Director-General was asked to present a report to the next World Health Assembly: (1) on the feasibility of an international information system providing data on the scientific basis and the conditions of registration of individual drugs; (2) on practicable minimum requirements for a comprehensive approach to ensuring the quality, safety and efficacy of drugs. He was also requested to undertake a study of the possible ways of marking the limits of shelf life of pharmaceutical products under the conditions of their storage, as well as the date of manufacture and batch number, and the maintenance of records which facilitate tracing of distribution.

Health and Environment

With regard to the Stockholm Conference on the Human Environment, WHO's responsibility for international health aspects of environmental problems was underlined. In a resolution, the Director-General was asked to continue to pursue the Organization's long-term programme on the human environment, "stressing the permanent need for the World Health Organization and member governments to secure appropriate means for the protection of human health against adverse affects from environmental influences".

SHOUSA PRIZE TO DR EL HALAWANI

Dr Ahmed Abdel Salam El Halawani, of Egypt, received from the World Health Assembly the medal and prize of the Dr A.T. Shousha Foundation for his most significant contribution to public health, and especially his outstanding research in the field of communicable diseases.

Formerly Under Secretary of State for Health in Egypt, Dr El Halawani is at present Director of the Medical Research Centre of Baghdad University, Iraq.

Dr El Halawani is well-known for his extensive research and publications on malaria, schistosomiasis, amoebiasis, filariasis and leishmaniasis.

Leon Bernard Prize awarded to Sir George Godber

The World Health Assembly awarded the Leon Bernard Medal and Prize to Sir George Godber for his outstanding contributions to the development of social medicine and international public health. The presentation was made by Dr Basil Layton, President of the Assembly, in plenary session.

Sir George Godber, born in 1908, studied medicine at Oxford University and the London Hospital Medical School, and public health at the London School of Hygiene and Tropical Medicine. He spent almost his entire professional working life in the Ministry of Health of the United Kingdom and its successor, the Department of Health and Social Security. Since 1960 he has been Chief Medical Officer of the Department, and also of the Department of Education and Science, and of the Home Office.

Sir George has been chief of the United Kingdom delegation to the World Health Assembly since 1961 and, at the same time, a member of the Executive Board on numerous occasions as well as a member of the WHO Expert Panel on Public Health Administration.

After thanking the Assembly, Sir George Godber presented the prize money of 1000 francs to the WHO Director-General, as a "small British contribution" to the Voluntary Fund for Health Promotion.

Occupational Health

Most workers are employed under inadequate conditions. They are exposed to work stresses and strains of all kinds in addition to their exposure to the health hazards common to the population as a whole. Occupational diseases and injuries in the United States of America cost nearly \$9,000 million in 1969. In the United Kingdom in 1967, there were 9,00,000 compensated cases of occupational diseases and injuries in industry, agriculture and commerce, which resulted in a loss of 23 million workdays, compared to 3 million lost through strikes. A resolution was passed recommending that Member States give appropriate attention to occupational health programmes, in particular to the provision of an adequate infra-structure in the national health services to enable them to undertake their responsibilities in occupational health with sufficient trained personnel; and to the strengthening of co-ordination among all the agencies, national and private, and trade unions, involved in the health problems of the working population.

Brain Drain

WHO is to undertake a comprehensive study on the emigration of qualified health personnel, the Assembly decided, because of the complexity and magnitude of the problem. □

BANGLADESH ASSIGNED TO S-E REGION OF WHO

BANGLADESH has been assigned to the South-East Asia Region of the World Health Organization with its headquarters in New Delhi by the World Health Assembly meeting in Geneva. It had already become a member of WHO on 19 May, 1972. This will bring the total membership of the South-East Asian region up to nine. These countries are: Bangladesh, Burma, India, Indonesia, Maldives, Mongolia, Nepal, Sri Lanka and Thailand.

IMPLEMENTATION OF ABORTION LAW

ADMINISTRATIVE Medical Officers and Family Planning Officers discussed operation of the Medical Termination of Pregnancy Act and the problems encountered by the States in its implementation. Since 1 April this year when the Act came into force, over 1,100 abortions have been performed all over the country.

Largest number of abortions have been reported from Tamil Nadu (274) followed by Delhi (235) and West Bengal (230).

A number of States and Union Territories including Andhra Pradesh, Assam, Haryana, Madhya Pradesh, Maharashtra, Mysore, Tamil Nadu, Uttar Pradesh, West Bengal, Manipur, Tripura, Chandigarh, Delhi and Andaman and Nicobar Islands, have since constituted boards as required under the Act for approving institutions where abortions could be performed and the medical practitioners for this work.

Shri K.K. Dass, Secretary, Ministry of Health and Family Planning, said that the main purpose of the Act was to provide to a large number of women abortion facilities by qualified and approved medical practitioners and thus save them from the quacks.

Shri Dass reiterated that abortion was in no way a substitute for family planning and the women coming in for it had to be advised on suitable methods for spacing the children and limiting the family. In no case more than three abortions could be permitted.

Shri Dass asked the State Secretaries to furnish prompt information about the number of abortions done and other characteristics of the cases to enable the Ministry to have a proper evaluation of the Act and also to assess additional financial and other assistance asked for by them. Several State representatives asked for Central assistance for increasing number of beds in the maternity wards for abortion cases. In this context the Health Secretary said that the States should endeavour to find funds from their own resources; however, a sum of ten million dollars was being provided under the United Nations Family Planning Fund for expansion of maternity wards in hospitals and another sum of one million pounds for providing additional beds under the post-partum programme. The need for having a Pregnancy Service was highlighted by most of the State representatives.

HEALTH IN FIVE YEAR PLANS

DURING the Fourth Plan period efforts are being made to provide an effective base for health services in rural areas by strengthening the primary health centres. These centres will undertake the preventive and curative health services, besides taking over the maintenance phase of communicable diseases and various national control programmes.

Medical education and para medical personnel will be expanded to meet the manpower requirements.

The Family Planning Programme will be pursued with great vigour and a sense of urgency during the Fourth Plan to ensure the economic health of the nation.

Under the First Plan, out of the total investment of Rs 23,600 million (Rs 2,360 crores), the outlay for health was Rs 1,400 million (Rs 140 crores)—about 5.93 per cent.

The health outlay was further distributed as under: Rs 903 million (Rs 90.30 crores) for health programmes, Rs 490 million (Rs 49.00 crores) for water supply and sanitation, and Rs 7 million (Rs 0.70 crores) for family planning.

During the Second Plan, out of a total outlay of Rs 46,000 million (Rs 4,600 crores), the investment on health was Rs 2,250 million (Rs 225 crores)—about 4.90 per cent. This outlay was utilized thus: Rs 1,460 million (Rs 146.00 crores) for health programmes, Rs 760 million (Rs 76.00 crores) for water supply and sanitation, and Rs 30 million (Rs 3.00 crores) for family planning.

The total outlay for the Third Plan was Rs 82,000 million (Rs 8,200 crores), the allocation for health being Rs 3,418 million (Rs 341.80 crores), about 4.20 per cent. The sum is allocated as under: Health programmes—Rs 2,095 million (Rs 209.50 crores), water supply and sanitation—Rs 1,053 million (Rs 105.30 crores), family planning—Rs 270 million (Rs 27.00 crores).

Under the Fourth Plan, out of the total investment of Rs 1,59,020 million (Rs 15,902 crores), the outlay for health is Rs 11,555.30 million (Rs 1,155.53

crores)—about 7.27 per cent. This was split as under: Health programmes—Rs 4,335.30 million (Rs 433.53 crores), water supply and sanitation—Rs 4,070 million (Rs 407 crores) and family planning Rs 3,150 million (Rs 315 crores).

Medical Care

Medical care facilities have been considerably expanding since Independence. Reliable index for medical care for any country is its hospital bed-population ratio. By 1968-69, a ratio of 0.49 beds per 1,000 population was achieved against a ratio of 0.24 at the beginning of the First Plan. Nearly 26,000 beds would be added during the Fourth Plan, but the ratio will still be around 0.49 because of the present population growth rate. An attempt has been made to provide the service right into the rural areas by establishing five to ten rural beds per primary health centre.

As many as 248 dental clinics at district level, 130 at taluk level, 85 in primary health centres and 55 in various other hospitals have been established during the first three plan periods. Five mobile hospitals also serve the rural areas.

There are at present 38 mental hospitals in the country with a bed strength of 18,000. In addition, 2,000 beds for the mentally retarded are also available in other general hospitals, etc. On the recommendations of the Central Council of Health for improving mental health services of the 54 psychiatric clinics to be set up during the Fourth Plan, 20 have been established in various states.

Research activities form an important component in every sphere of the health programmes. Research work being conducted by various institutions is coordinated by the Indian Council of Medical Research, New Delhi.

One of the significant achievements of the Council is the organization of research projects on collaborative basis. These are mostly in the field of epidemiology and involve studies on blindness, diabetes mellitus, epilepsy, and oral, cervical and breast cancer, environmental carcinogenesis, peptic ulcer and subarachnoid-haemorrhage. □



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