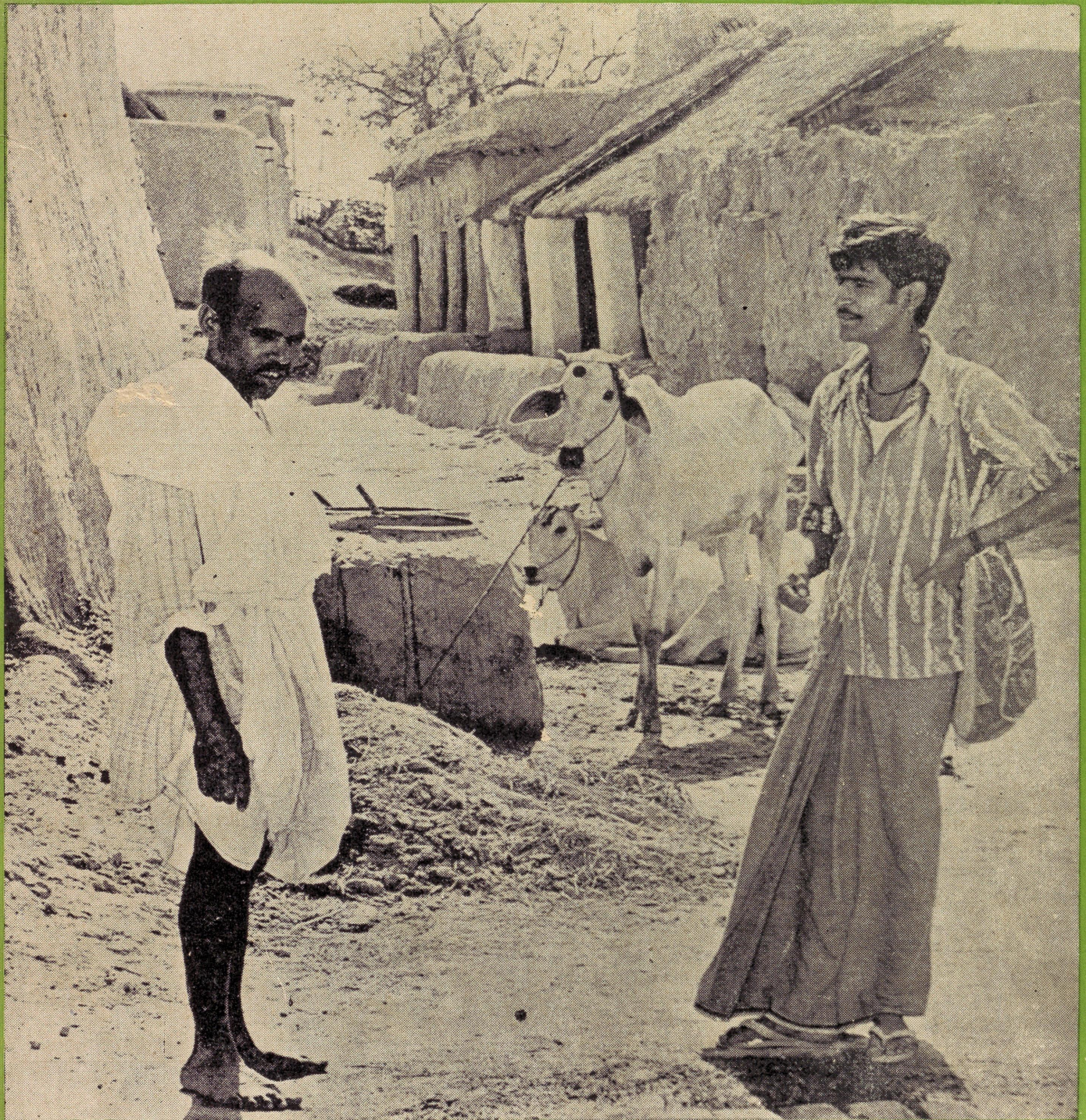


12/26/4

Swasth hind



December 1978



Swasth hind

Readers Write

The magazine is very educative and useful to laymen and the medical profession. I am very much interested in the branch of Medicine and I am a homoeopath.

G. R. Sethuraman
3/373-C Bunderkar Road
Bombay-400 019

* * * *

I have to request you to start a permanent column of "Mental health" in your journal. This will provide information regarding mental illness and mental health to the general public and medical personnel. This is necessary to remove many misconceptions regarding mental illness.

Dr Raj Nath Sahay
Psychiatrist,
Bhagalpur Medical College Hospital
Bhagalpur-812 001

* * * *

We are very much interested with all the articles that appear in most of the issues of your magazine. In this regard we wish to subscribe for three years.

Dr J. Tariang
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Shillong.

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Health Situation In India

DR B. SANKARAN

The health of the nation has always been a major concern of the Government and the Planning Commission. Within the limitations imposed by resources availability, they have accorded high priority in the allocation of funds for the various health care programmes which benefit the community at large.

IN India, 'Health' is more than a problem. It is a challenge that has been well-met and is progressively nearing fulfilment.

When the National Government took over in 1947, the situation that confronted was appalling. The infant mortality rate was alarmingly high and the life expectancy of Indians was among the lowest in the world with the epidemics taking a heavy toll. Unaccounted numbers of people were suffering from endemic diseases.

Bringing about a speedy improvement in public health was a major challenge that the national Government took up 30 years ago. The success of the Government's efforts in meeting the challenge in the past 30 years can be measured by the remarkable improvement that has been brought about in the health of the nation.

The following are some of the measurable indications of that remarkable improvement in the short span of just 30 years.

1. Life expectancy has shot up by as much as 20 years.
2. Infant mortality rate has been cut by 40 per cent.
3. Death rate has been slashed by almost one half.

This improvement in health standards is the combined result of many factors. These include improved sanitation and water supply, early detection and treatment of diseases, better hospital facilities, widespread adoption of preventive measures, better diagnostic procedures and increased availability of modern medicine.

Modern medicines have reduced the need for hospitalization; cure diseases faster than even before; and have revolutionized the science of therapy.

These achievements have been creditable but they represent only a fraction of what needs to be done to give our people a fuller life and our country a health care system that measures up to the minimum demands of a welfare State. A great deal remains to be done even now.

1. The average life expectancy in India is 52 years now. It is still very low compared to 70-80 years in advanced countries.
2. Infant mortality in India, despite the recent reduction, is yet very much higher than in other countries.
3. The death rate, in spite of the successful control of epidemics is still very high.

4. About half of all recorded deaths are amongst children under five from the combined effects of communicable diseases and under-nourishment and/or malnutrition.

5. More than 25 per cent of all villages in the country are without safe drinking water.

6. The majority of the rural population which constitute 80 per cent of the total is still beyond the catchment area of health facilities.

7. The availability of health facilities in the country is inadequate and generally lopsided.

The same is true of basic health facilities. The number of hospital beds available at present is only 3,13,800 for a population of over 600 million, a ratio of one bed per 2000 population. The number of doctors available is about 2,20,000 at the end of 1976-77 giving a doctor population ratio of 1: 40,000. The norms recommended by the Health Survey and Planning Committee (Mudaliar Committee) are one bed per 1000 population and one doctor per 2,000-3,500 population. We have still a long way to go to reach these norms.

It is true that health is not merely a matter of medicines, doctors and

hospitals, the importance of nourishing food, proper clothing, housing, sanitation, etc., is obvious. The Government is no doubt doing its utmost to solve the problem. But the problem is far too big to be handled effectively by any single agency. It needs the active assistance and cooperation of everyone concerned with the health of the nation whether as individual or as institutions.

Life expectation and mortality rates

One of the most important indicators of health is the expectation of life at birth. The expectation of life at birth, which was 32.1 years during the decennium 1941-50 increased to 52.6 years by 1971.

Equally significant is the trend of birth and death rates. The birth rate which was 39.0 per 1000 in 1941-50 declined to 38.6 in 1966-70. It is estimated to have come down further to around 35.0 during 1971-75.

The death rate fell from 27.4 per 1000 in 1941-50 to 14.0 during 1966-70 and further to 11.3 during 1971-75. Control of communicable diseases and expanded medicare facilities have about this striking reduction in the death rate over the last two decades.

No less significant has been the declining trend of infant mortality. The rate of infant mortality was as high as 183 per 1000 live births in 1941-50; it declined steeply to 113 during 1961-70. But there is a long way to go before infant mortality trend in India can stand comparison with the low rates in many advanced countries.

COMMUNICABLE DISEASES

The Government's health programmes, particularly those relating to

control of communicable diseases, have played a major role in raising the health status of the people of India. The trends of morbidity (affliction) and/or mortality caused by the major communicable diseases are revealing in this respect.

Cholera on way out

The death rate due to cholera, for instance, declined from 93 per 100,000 in 1945 to 0.6 in 1970. It is well on the way to eradication. Because morbidity and mortality due to the diseases are being constantly reduced by the National Cholera Control Programme with its accent on preventive and control measures in the highly endemic areas. The disease is to be wiped out from the country through all round improvement of environmental sanitation as envisaged under the National Water Supply and Sanitation Programme.

Smallpox eradicated

The mortality rate due to smallpox was 50 per 100,000 in 1945 only about 14,000 cases, with nearly 2,400 deaths, were reported in the entire country during 1971, as against 84,000 cases and 26,000 deaths in 1967. This remarkable reduction in both morbidity and mortality rates can be mainly attributed to the 173 million primary vaccinations and 718 million revaccinations done up to the end of 1971 by the National Smallpox Eradication Units established in all the States by the end of 1962. Since 1975, the incidence of the disease has further declined and no case has been reported till then. And Smallpox has been eradicated from India.

Deaths due to dysentery and diarrhoea have also declined.

A similar trend was noticed about respiratory diseases, the combined mortality rate in their case having come down by nearly one-half—from 150 per 100,000 in 1945 to 83 in 1960. In particular, pulmonary

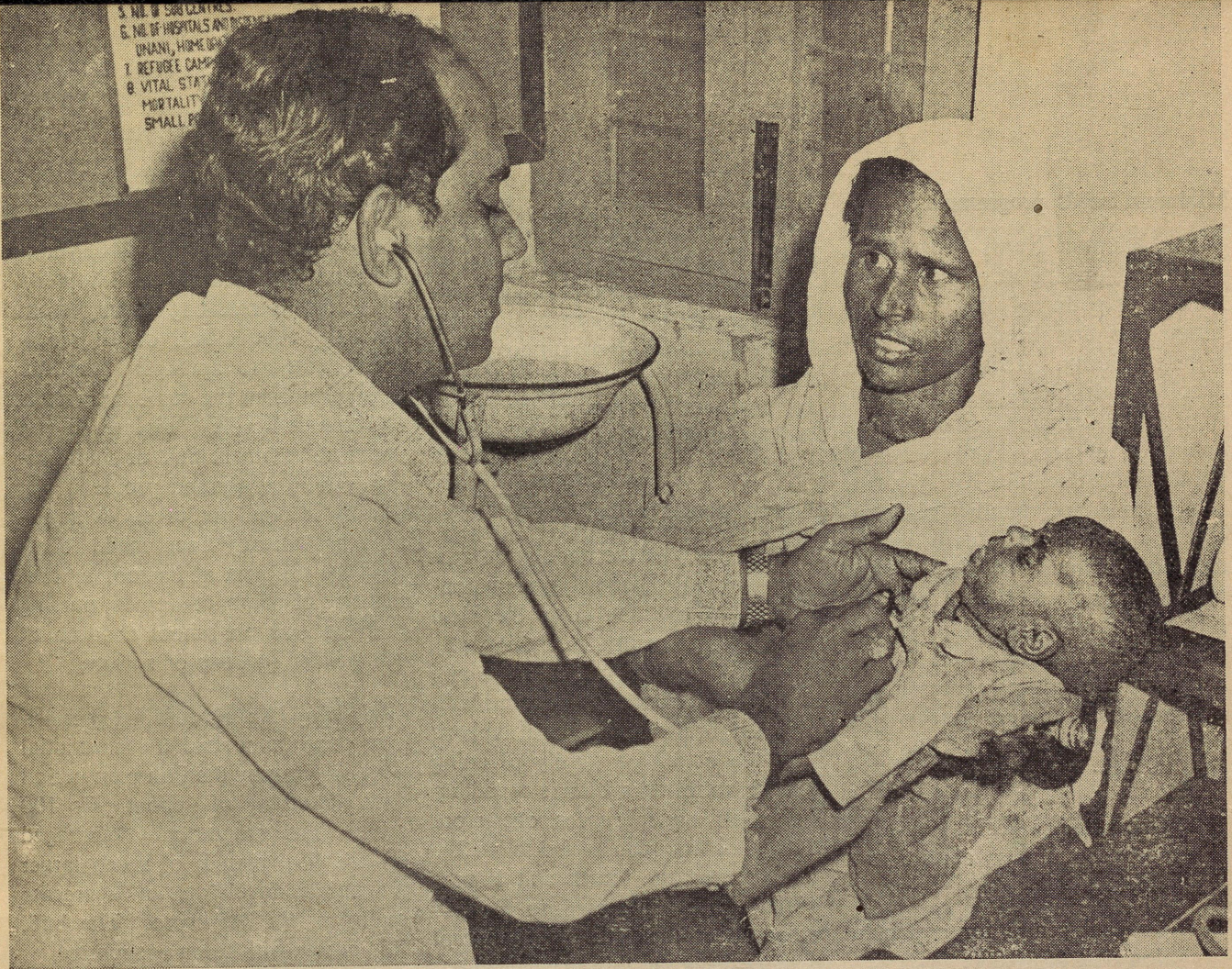
tuberculosis—the most widely prevalent form of that dreaded disease—has to be contained under the National T.B. Control Programme though the number of infectious cases—two million out of eight million active cases—is yet to be reduced to a level at which tuberculosis would no longer constitute a serious public health hazard. As the incidence of this disease is greatly influenced by the socio-economic factors, its more effective control and ultimate eradication would partly depend on improvements in living standards, particularly in respect of food and nutrition, housing and environmental sanitation.

Malaria control

Another scourge—malaria—has, however, been more effectively controlled since Independence. In 1947, the morbidity rate of malaria was more than 20 per cent—representing 75 million cases—which resulted in 1.6 million deaths due to both direct and indirect effects of the disease. This rate was nearly halved by 1953 to 10.8 per cent. Thanks to the National Malaria Control Programme launched in 1953, the case morbidity rate declined further to 4.4 per cent over the five years that followed. Indeed, the control programme was so effective that there were only 0.15 million cases during 1966. It has been the biggest single-factor in the reduction of the death rate over the last two decades. However, the recent recrudescence of malaria again poses a major public health challenge.

Filaria control

Filaria is an endemic disease next only to malaria and tuberculosis in its incidence. As many as 136 million people live in the filarious areas of the country and they are, therefore, exposed to the risk of infection. There are eight million chronic cases with different manifestations of the disease and about 12



HEALTH OF THE NATION—Remarkable improvement has been made in the health of the people in a short span of just 30 years since independence. Infant mortality rate has been cut by 40 per cent, death rate has been slashed by almost one-half, life expectancy has shot up by as much as 20 years. But, they represent only a fraction of what needs to be done to give the people a fuller life.

million people have micro-filaria in their blood. Control of this disease is a slow, long-term process because filarial infection has peculiarly complex features. The filaria control programme aims at reducing transmission of infection and also prevent subsequent recrudescence by bringing about continued reduction in the reservoir of infection.

Control programmes for other communicable diseases such as leprosy, trachoma and venereal diseases have also been in operation on a continuing basis under successive plans. Expenditure for the control of these and other communicable diseases

mentioned earlier increased more than fourfold from Rs 23 crores during the first plan to Rs 99 crores during the fourth plan.

Public outlays on health care programmes such as those relating to control of communicable diseases, hospitals and dispensaries, medical education and research, indigenous systems of medicine and homoeopathy and training of health workers have increased substantially from plan to plan. The expenditure was about Rs. 90 crore during the first plan period, Rs 146 crores during the second, Rs 226 crores during

the third, Rs 140 crores under the 1966-69 Annual Plans and Rs. 344 crores during the fourth plan period. The outlays proposed for the fifth plan period are as much as Rs. 796 crores.

Programmes for control of communicable diseases absorbed, especially since the second plan, the largest share of allocations for health care. Hospitals, dispensaries and primary health centres claimed the next largest share. Medical education, research and training of health workers occupied the third place in allocations.

Minimum needs programme

The Minimum Needs Programme, which will involve an outlay of Rs 291.5 crores during the fifth plan period, has now been accorded the highest priority. This programme, in so far as it relates to rural health, is of wider scope; it envisages a minimum uniform availability of public health facilities covering preventive medicine, family planning, nutrition, detection of early morbidity and reference of serious cases to an appropriate higher echelon; supply of drinking water to villages suffering from chronic scarcity or having unsafe sources of water; and environmental improvements of slums. The targets of the programme are:

1. One primary health centre for each community development block.
2. One sub-centre for a population unit of 10,000.
3. Making up the backlog and deficiencies in buildings, staff, equipment, etc.
4. Provision of drugs at the enhanced level of Rs 12,000 per annum per primary health centre and Rs 2,000 per annum per sub-centre; and
5. Upgradation of one in four primary health centres to 30-bedded rural hospitals.

It will, thus be seen that the Minimum Needs Programme is designed to supplement the other health care programmes by strengthening the primary health centre complex and by integrating health, nutrition and family planning services.

Related health plans

These health care programmes are not the only ones relevant to public health. In fact, health planning in India has acquired an increasingly wider scope covering as it does

(i) family planning, (ii) nutrition, (iii) water supply and sanitation, and (iv) environmental improvement of slum areas. Thanks to the greater accent on these aspects since the fourth plan, the programmes relating to them involve a much larger aggregate outlay than on the health care programmes proper.

Family planning

The urgency of the population problem has called for a bigger nationwide effort to bring down the birth rate, so as to neutralize significantly the impact of the fall in the death rate brought about by modern medicine and health care. This explains why the outlay on family planning (birth control) has been stepped up from just under rupees one crore during the first plan period to Rs 276 crore during the fourth and is proposed to be increased to Rs 518 crore under the fifth plan. Actual achievements in this crucial sector have fallen short of the fourth plan targets.

The family planning programme will continue to be a Centrally-sponsored programme up to 1983-84. As family planning services will be increasingly integrated with those for health, maternity and child health and nutrition, it would be more appropriate to describe it as a 'family welfare planning programme'. The supreme objective of the programme is to reduce the birth rate to 30 per 1,000 by 1978-79 and further to 25 per 1000 by 1983-84.

Nutrition

It is well known that under-nourishment in India is a widespread phenomenon resulting mainly from poverty. About half of all recorded deaths are amongst children under five from the combined effects of communicable diseases and under-nourishment and/or malnutrition. It is a gigantic problem requiring colossal resource. A beginning has already been made to attack the problem at its root by taking care of pregnant women, nursing mothers and pre-school children of the weaker sections of society.

Anything like a coordinated nutrition programme had a substantial start only during the fifth plan period with an outlay of about Rs 100 crore. The programme envisaged for the fifth plan is of much larger magnitude involving an aggregate outlay of Rs 745 crore. The bulk of this outlay will be on account of

- the mid-day meals programme for school children—Rs 312 crore (including Rs 200 crore of CARE assistance expected in the form of food);
- the supplementary feeding programmes for children in the age group 0-6 and pregnant women and nursing mothers in tribal, slum and drought-prone areas—Rs 218 crore.
- integrated child care services in the social welfare sector—Rs 140 crore.

The idea of people's participation as far as health service are concerned have not been adequately implemented and this vast resource has hardly been tapped to the desired extent. As people's expectations from health services increased, the need for strengthening country's health services was recognized and subsequently the need for enlisting people's active participation assumed greater importance.

HEALTH PROGRAMMES : PROGRAMME-WISE BREAK-UP OF
PLAN OUTLAYS (Rs. in Crores)

Programme	I Plan	II Plan	III Plan	IV Plan	V Plan
Control of communicable diseases	23.1	64.0	70.5	99.3	168.6
Hospitals, dispensaries and public health centres	25.0	36.0	61.7	82.7	155.5
Medical education, research and training	21.6	36.0	56.3	86.0	111.8
Indigenous systems of medicine and homoeopathy	0.4	4.0	9.8	15.1	28.1
Minimum Needs Programme	..	..	..	34.3	291.5
Other programmes	20.2	6.0	27.6	26.6	40.8
TOTAL	90.3	146.0	225.9	343.9	796.0

Health related Programmes	I Plan	II Plan	III Plan	IV Plan	V Plan
Family planning	0.7	0.3	27.0	276.5	516.0
Nutrition	..	..	..	100.0	745.0
Water supply and sanitation	49.0	76.0	105.3	650.0	1095.6
Environmental improvements in slum areas	..	..	..	30.0	94.6
TOTAL	49.7	79.0	132.3	1,056.5	2,451.2

N.B. Figures have been rounded off to the first decimal point; they do not add up exactly to totals.

Source: Planning Commission.

Water supply and sanitation

Safe drinking water is of great importance to public health. It reduces substantially the incidence of water-borne diseases. Sanitary facilities for the proper disposal of wastes have also the same objective. Between these, they constitute the principal environmental control measures against the transmission of most water-borne diseases. Given the magnitude of the problem and the constraint of resources, only a small dent has been made on the overall problem.

Thus, whilst four-fifths of the urban population have piped (protected) water supply now, nearly 1.2 lakh villages with a population of more than 60 million do not still have even the most elementary water supply system. As for sewerage, only 40 per cent of the urban population

have the requisite facilities. Most medium and smaller towns have no sewerage systems. In the rural areas, implementation of proper sewerage and drainage schemes has hardly begun.

It is in view of this appalling situation that the magnitude of effort has been lately enlarged. As against the modest outlay of Rs 49 crore during the first plan period the outlay

during the fourth plan period was as much as Rs 650 crore—Rs 455 crore (including Rs 75 crore of expenditure by the Calcutta Metropolitan Development Authority) for urban water supply and sanitation and Rs 573 crore for rural water supply and sanitation are proposed for the fifth plan. In addition, some part of the provision of Rs 250 crore made for integrated urban development in the Central sector would be available for water supply and sanitation in urban projects of national importance.

The scheme for environmental improvement in slum areas has been in operation only since 1972-73. Provision for improvement of water supply, sewerage and community latrine facilities in slums (which are not likely to be cleared during the next 10 years) is the object of this scheme. It may help in the control of communicable diseases prevalent in and transmitted from such slums. A three-fold increase in outlay on the scheme—from Rs 30 crore in the fourth plan period to nearly Rs 93 crore in the fifth plan is envisaged.

The size of the health plan as a whole covering health care programmes proper, family planning, nutrition, water supply and sanitation and environmental improvement of slums will have increased twenty-three fold—from Rs 140 crore during the first plan to about Rs. 3,250 crore during the fifth plan period.

INFRASTRUCTURE FOR HEALTH CARE AND RELATED SERVICES INFRASTRUCTURE FOR HEALTH CARE

(As at the end of plans)

	I Plan	II Plan	III Plan	IV plan anticipated	V Plan targeted
Hospitals & Dispensaries	10,000	12,000	14,600	..	..
Hospital beds	1,23,000	1,85,000	2,40,100	2,81,000	3,21,600
Primary health centres	725	2,800	4,900	5,250	5,400

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Primary Health Care

JAGDAMBI PRASAD YADAV

“We must concentrate on primary health care and give top attention to promotive and preventive aspects of health care. In this objective our concept of primary health care will find its true translation into action through the help of vast human resources available in our country. . . . in order to make the health services a reality, we have to place the responsibility on the shoulders of the people”.

PRIMARY health care is now receiving its appropriate priority. There is no doubt that it is quite natural and timely. The essentiality of primary health services has always been felt but we have to be more conscious of its role in the present day health problems. In spite of the great strides which the world has made in the field of health services, a great majority of the people on this earth are still outside the reach of the basic minimum health services. This is more obvious and acute in our country where 80 per cent of the population live in the rural areas. Though during the last 30 years, a network of primary health centres (PHCs) and sub-centres have been set up, these are not enough keeping in view the size and sparseness of population. We have to do a lot more. So far about 5,400 primary health centres and 38,000 sub-centres have been set up in our country. A PHC serves a population of about every 80,000 to 1,00,000 and a sub-centre every 10,000 population. In a PHC, there are two to three medical officers and about 40 para-medical staff. There is a provision of medicines also in these centres, but these are not adequate.

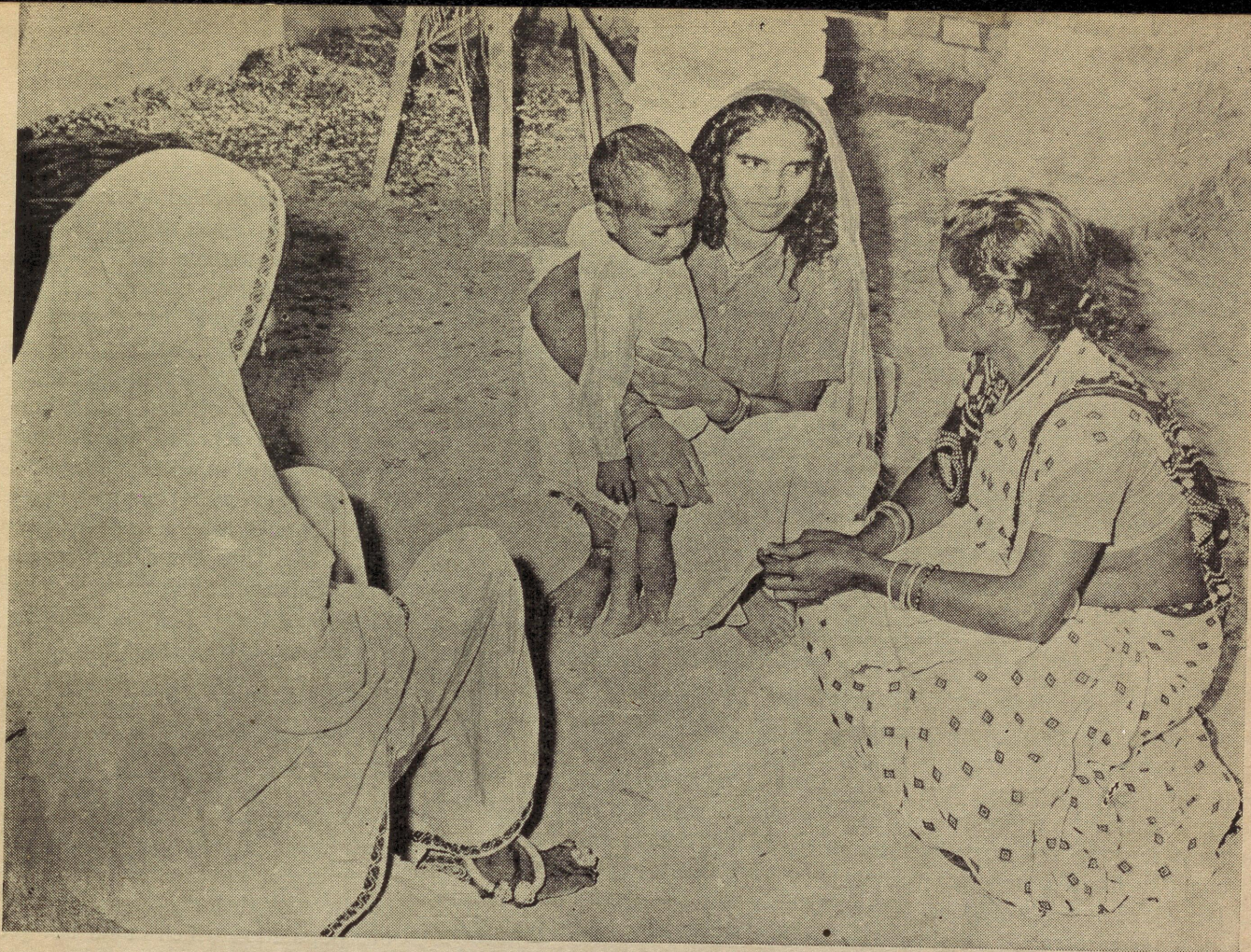
Medical education

Medical education in our country and generally elsewhere also has been so oriented that the community health services have not received adequate attention. Medical education and medical institutions have been urban-oriented. Most of the doctors are inclined to stay and practice in cities. They are not inclined towards the villages for many reasons, one of which may perhaps be lack of community orientation in medical education. It is possible that the doctors are not inclined to go to the villages for lack of facilities there. Though it is partly true. The indifference of the doctors towards the rural area is largely because of their attitude. Further, in our medical education more emphasis has been given on curative aspects and the doctors have come to feel that to cure is their primary function. Obviously, because of this attitude the preventive aspect of medical education becomes secondary and this leads to difficult problems. The diseases occur and spread in the villages. Our resources, namely, availability of doctors and para-medicals in villages, medicines, communication,

etc., are limited and they make our effort to curb and eradicate the diseases in the villages still more difficult.

The reorientation of medical education is very essential to bring about desired improvement in community health services. To begin with, we decided to make the medical colleges responsible for PHCs. Initially, each medical college will be responsible for three PHCs. Each college will be provided with three mobile clinics for the three PHCs. In these mobile clinics, the students, the teachers and the members of the faculty of the college will be visiting the villages. They would not only deliver expert health care to the people in the remote areas but would also acquaint themselves with community health problems. Thus, community health aspect will get its rightful place and emphasis in medical education. This would lead to radical change in the knowledge and attitude of the students as well as the doctors. In due course, they will not be disinclined to serve in the villages.

We must, therefore, concentrate on primary health care and give



Primary health care is now receiving its appropriate priority. Its essentiality has always been felt but we have to be more cautious of its role in the present-day health problems.

top attention on promotive and preventive aspects of health care. In this objective, our concept of primary health care will find its true translation into action through the help of vast human resources available in our country. We have accepted that we cannot be able to take health services to the doorsteps of the people in the villages only through the PHCs. For this we have to involve the people in their health services. What I mean to say is that we have to place people's health into their hands. We may think of extending technical and financial help to them but in order to make the health services a reality, we have to place the responsibility on the shoulders of the people.

Community involvement

With the above objective in view we have taken some significant

steps in the recent past. For the first time, our Government formulated a programme to involve the community in the delivery of health care. On 2 October, 1977, we introduced the scheme of Community Health Workers (CHWs) in the selected PHCs. About 42,000 CHWs have already received training and gone back to their villages. They are now in the field of the service of the people. Another batch, which is the fourth batch, of 14,000 CHWs is undergoing training. In the present phase of the Scheme, which will be over by March 1979, about 90,000 CHWs will have received training. Our plan is that every village in the country should have a CHW by the end of the present plan ending by 1982-83.

With a view to streamlining the working of the Scheme and also to

expanding it, evaluation of the Scheme had been undertaken by a few institutions. Reports of these institutions have since been made available to us. As expected, the scheme has been received very well in the countryside. It has been proved that the scheme provides the only answer to the health problems facing the rural areas. The performance of the workers who have gone back to the villages has been generally satisfactory. No doubt, the evaluation reports have also brought out certain deficiencies in the implementation of the Scheme. These deficiencies, as we were already conscious of, mainly relate to the understanding of the Scheme, selection of the CHWs, supply of medicine and teaching aids, teaching procedure, etc. We have already initiated measures to remove these deficiencies and some more measures are contemplated.

We are confident that our country which is rich in human resources will be able to present an ideal of people's participation in health services.

In a big country like India, which has such a vast rural population, health services with the help of Government resources as also people's endeavour would need cooperation and participation of the voluntary organizations in a big way to succeed fully. Not only such voluntary organizations which have keen interest in health activities and who are doing significant work in this field should expand their activities but also many more voluntary organizations who have tremendous potentialities and resources for doing work in health services should also come forward and contribute their might to the welfare of the people. The Government would be prepared to give them all possible encouragement and cooperation.

The international organizations with their contribution and significant work in the field of health services have done a great service to the teeming millions. I am sure that they will involve themselves in a

bigger way in the Community Health Programmes which would prove epoch-making.

Indian systems of medicine

Our country has been rich in traditional systems of medicine. In order to bring about radical improvement in the health services in the rural India, we have to encourage and promote growth and use of these systems of medicines. Unfortunately, during the last 30 years, we could not do much to give these systems their due. If we could restore these systems their rightful place in our health services, much of our problems will automatically go. It is well-known that these systems have significant treasures which need to be brought to light through research and practice. It is our duty not to get biased towards any particular system of medicine. All systems are sisters and should move towards the achievement of the goal—service of the community.

In the rural health services, we have taken a few more steps. We have decided that there should be two workers—one male and one female—for every 5,000 population.

We have also decided to cover the entire country under the multi-purpose workers scheme by 1981-82 so that workers of all categories in the field of health and family welfare services are fully utilized. There has been significant progress in the implementation of the multi-purpose workers scheme which has been completed in about 80 districts. It is also our endeavour that every village should have a trained midwife (*Dai*). This would help in ensuring delivery at the expert hands. They would also help in reducing the rate of infant mortality and would contribute to better care of mothers. Significant progress has been achieved in the field of training of midwives.

There are a few steps which have been taken to improve health services in the rural areas. We, sincerely, wish that the 80 per cent of our population which could not get adequate health care in the past, should now get its due.—*Based on the speech by the Union Minister for Health and Family Welfare at the Workshop on Primary Health Care held in New Delhi from 2-4 August 1978.* ○

What is Health?

A healthy individual is a man who is well balanced bodily and mentally, and well adjusted to his physical and social environment. He is in full control of his physical and mental faculties, can adapt to environmental changes, so long as they do not exceed normal limits; and contributes to the welfare of society according to his ability. Health is, therefore, not simply the absence of disease: it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual.

From : Sigerist, H. E. *Medicine and human Welfare*, New Haven, Yale University Press, 1941 p. 100

Family Welfare Programme —A Few Steps

SMT SERLA GREWAL

The principal difference between the New Population Policy placed before the people in June 1977 and the earlier one enunciated in April 1976 is the voluntary basis of new policy. Secondly, conception control is not to be treated as an end but as a means to achieve a higher purpose—the quality of life. Thirdly, the package of family welfare is to be integrated more meaningfully with other programmes, particularly in villages.

INDIA has travelled a long distance since 1952 when the family planning programme was launched in the country by the Government. With no roads, no signboards to guide us, the first few steps were more or less exploratory in nature. Some service clinics—their number was 147—were established in the rural areas. The principal aim was to give through these service clinics, as well as through the existing Government hospitals, advice on family planning methods to those who came to seek it. Another aim was to conduct research on a modest scale in areas connected with family planning, viz., medical, technical and motivation.

Over the years, the programme has expanded immensely (though not adequately enough considering the size of India) particularly in rural areas. There are 5,400 primary health centres with 38,000 sub-centres in villages. In urban areas, about 1,800 family welfare centres and 324 postpartum centres have been established. The programme has acquired new dimensions. It touches almost all aspects of family life. Maternal and child health care is the principal basis on

which it rests. Education and motivation are the main channels through which it seeks to draw people to the health and family welfare infrastructure. Research has become more meaningful and it today covers a variety of areas—from biomedical research in human reproduction to indepth studies into the relationship between fertility behaviour and socio-economic levels of the society. The training infrastructure has also been strengthened to meet the demands of the programme and today it consists of nearly 60 Regional Centres and about half a dozen Central Institutes.

Population education

Keeping in mind the long-term perspective and the need to impart population values to students in schools and colleges, population education has been introduced in the school system. It is expanding gradually. The University Grants Commission has accepted our request to persuade the Universities to take up a series of lectures on population education for students in colleges. We are at the moment engaged in dialogues with various

Institutes to develop this series. It is also our endeavour, and we are succeeding in it to certain extent, to introduce population education in the training programme of workers in the organized sectors of industry. Similar exercises are on with the authorities concerned for induction of population education in the training of agricultural extension workers. We are also associated with the National Adult Education Programme launched on 2 October, 1978 which aims at imparting functional literacy to 65 million adults in the 15-35 years age-group during the current Plan period. The functional literacy to be imparted to the people under this programme will have a good component of health and family welfare subjects.

Salient features

The salient features of the new population policy which has emerged as a result of our long experience and which we placed before the people in June 1977 are:

- (i) The family welfare programme embraces all aspects of family welfare particularly

DELAY THE FIRST SPACE THE SECOND STOP THE THIRD

Family Planning Month: January 1979

January 1979, will be observed as the Family Planning Month throughout the country. The new slogan for the family planning campaign is: "Delay the first, Space the second and stop the third," in keeping with the needs of the time. This slogan has been chosen from 40,000 entries in all languages received in the competition from the general public.

The month is being observed in view of the success achieved in focussing public attention on the seriousness of the population explosion problem as a result

of the activities during the national family welfare fortnight in October 1978. One of the encouraging aspects of this fortnight was the remarkable increase in the request for sterilization. As many as one lakh people are reported to have offered themselves for sterilization. This is a clear indication that people realize the need and usefulness of family planning.

The purpose of observing the family planning month is two-fold: to take advantage of the good popular response

during the family welfare fortnight and to utilize the favourable climate for imparting speed and substance to the programme. The effort will be to involve all sections of the society, particularly voluntary organizations and development departments of the Government and public sector undertakings in the formulation and implementation of the programmes.

The State Governments, it has been suggested, may organize orientation training camps of opinion leaders in the villages during December 1978. Many service camps will also be organized during the month and in the following weeks. A larger package of maternity and child health services will also be provided to emphasize the welfare aspect of family planning. At the same time, this fortnight will be on the limitation of family size without which the whole philosophy of family welfare can fall to pieces. ○

those which seek to promote the health of mothers and children. Maternal and child health care, as a matter of fact, now forms the very basis of the programme.

(ii) Family planning continues to be accorded the same importance as it used to receive in the past. The difference is that compulsion, coercion or pressures of any sort have been ruled out from the programme for all times to come. The approach is educational and wholly voluntary.

(iii) All methods of contraception are being offered to the people and it is left to a couple to decide what method it may like to adopt.

(iv) Sterilization continues to be an important method. Those who ask for it can get it free of cost.

(v) Monetary compensation for sterilization and IUD has been retained in the new policy. This is because the brief stay in hospital which these methods, particularly sterilization, may entail can result in possible loss of wages which the majority of our people cannot easily afford.

(vi) Any medical complication resulting from a voluntary sterilization will be attended to free of cost; if in an unfortunate case recanalization becomes necessary, this facility will be offered to the individual concerned under the best possible professional care available without any charge.

(vii) Adequate ante-natal, natal and post-natal care must be made available to mothers. The programme of immunizing children against child-

hood diseases of whooping cough, diphtheria and tetanus should be expanded further.

(viii) Higher priority should be given to women's education both through formal and non-formal channels.

(ix) The age of marriage has been raised from 15 to 18 years for girls and from 18 to 21 years for boys.

(x) Population education should be given due importance in the educational system.

(xi) In all cases where population is a factor for Central assistance to State Plans, devolution of taxes, duties and grants-in-aid, the population figures of 1971 should continue to be followed till the year 2001.

(xii) To ensure purposeful implementation of the programme, eight per cent of the Central



The Family Welfare Programme has expanded immensely, particularly in rural areas, since its inception in 1952. There are 5400 primary health centres with 38,000 sub-centres in villages. In urban areas, about 1800 family welfare centres and 324 post-partum centres have been established. The programme touches almost all aspects of family life.

assistance to the State Plans should be linked with the States' performance and success in family welfare.

- (xiii) All sectors of the society should be involved in the implementation of the programme.
- (xiv) Special attention should be given to research inputs in the field of reproductive biology and contraception.

The principal difference between the new Policy and the old one which was enunciated in April 1976 is the absolutely voluntary basis of the former. Secondly, conception control, even though highly important in itself, is not to be treated as an end but as a means to achieve a higher purpose—bringing about improvement in the quality of life. Thirdly, the total package of family welfare has to be integrated more meaningfully with other programmes, particularly in villages.

The birth rate at the moment is estimated to be 33 per thousand live births. We have to bring it down to 30 per thousand by 1982-83. To achieve this, an operational plan has been drawn up in consultation with the State Governments, according to which it will be necessary for the country to have 25 million more persons opting for voluntary sterilization and five million women for insertion of IUD during the next five years. The number of users of conventional contraceptives, includ-

ing Nirodh and the oral pill, has simultaneously to go up from the present 2.8 million to six million. In the area of maternal and child health care, we expect that during the next five-year period, prophylaxis against nutritional anaemia will be provided to 73 million mothers and an equal number of children. Protection against childhood diseases of diphtheria, whooping cough and tetanus will be extended to 132 million children and against tetanus to 33 million expectant mothers. In addition, about 125 million children of pre-school age will be covered under the scheme of prevention of blindness due to vitamin 'A' deficiency. The infrastructure responsible for maternal and child health care services, particularly in villages, is being strengthened and it is our hope that family planning acceptance will go up as more women and children avail themselves of M.C.H. services.

We have held several conferences with the State Governments, voluntary bodies and organizations representing various sectors of the society; and we have their assurance that they are deeply concerned about the programme and will take all possible steps to enable the people to understand its importance and to adopt it. We have energized all media, including extension education, to restore to the programme the credibility that rightly belongs

to it and to increase its acceptance by the people. Early this year, some 2,000 orientation camps of opinion leaders were organized in the rural areas. These camps helped greatly in dispelling misgivings that had cropped up in the minds of the people in the recent past. As many as 10,000 more such camps would be organized during the remaining part of the year. Each camp is attended on an average by 40 leaders from villages. From every village, a group of three or four persons comes. It is our hope that this group at the end of an orientation camp will become an important catalytic agent in the rural society in relation to the family welfare programme.

Rural health scheme

We are pinning great hopes on the rural health scheme not just in relation to creation of some degree of self-reliance in the area of health in the villages but also in relation to voluntary acceptance of the family welfare programme by the people. The two are as a matter of fact vitally interlinked. Success in enabling people to meet their basic health needs should induce them to take to the small family norm more easily. Similarly, success in the family welfare programme should on the one hand, help parents to provide better care to their children and on the other reduce the pressure of

population on the limited resources. Both the programmes—the rural health scheme and family welfare—are part of the total package of welfare and we can legitimately hope that in the coming years these programmes will play a notable role in bringing about improvements in the living standards and styles of our people.—Based on the paper presented at the Workshop on Primary Health Care held in New Delhi from 2-4 August, 1978.

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Health care planning : strategy and tactics—ends and means

Much health and health care planning has been preoccupied with tactical minutiae at the expense of overall strategic thinking. Plans are made for training new types of health care manpower or for designing new laboratories, with no consideration being given to what each is to do, whether it meets a perceived need, or how it is to be related to other modalities of care. Health and health care planning, particularly with respect to resource allocation, is much more a matter of strategy than of tactics; *what* to do should take precedence over *how* to do it. A clear ordering of the objectives of a health care system provides a guide to the planning of solutions. Every major objective can be thought of in terms of a set of immediate objectives that are a series of necessary steps towards achieving that major objective. If immediate objectives are properly formulated and carefully planned, the allocation of resources and the implementation of measures will probably be effective, as immediate objectives are usually more realistic and more easily attainable within a specified time than are higher-level objectives.

From : White, K. L. et al., *Health Services : concepts and information for national planning and management* (Public Health Papers No. 67). Geneva, World Health Organization, 1977, p. 113.

Health Status In The Third World

The new thinking of the 1970's reinforced in all the important world conferences asserts that it is not only possible, but becoming increasingly more urgent to change the established order so as to release the energies of the people of the third world for more productive activities.

HUNDREDS of million of men, women and children in the Third World carry a massive burden of preventable ill-health. The majority (upwards of 80 per cent of the population in some countries) live in the vast rural areas of Africa, South Asia, and parts of Latin America as yet untouched by progress. Others flee the countryside in search of better life in the cities, only to swell the ranks of the impoverished in burgeoning peri-urban slums.

In the rural areas peasant farmers, both men and women, have limited access to the technology, services and institutions which would sustain higher levels of productivity in agriculture, the mainstay of their existence. The urban poor lack both the skills required in the modern sector and the services and technological innovations that would bolster the informal sector on which they depend, with resultant unemployment and under-employment. Widespread illiteracy, ignorance, insanitary and crowded living conditions and the social ills that afflict urban slums, characterize the lot of the poor, rendering them easy prey to ill-health and apathy.

Women of child-bearing age, infants and young children are the most severely affected. Infant mortality remains as high as 200 per 1000 live births in some developing

countries, and one-third of the children die before the age of five from diseases, such as, diarrhoea, pneumonia, malaria, measles and tuberculosis—all preventable. Among those who survive (and there are growing numbers) the debilitating effects of chronic under-nutrition and lack of early social stimulation are clearly visible.

This depressing picture must of necessity be painted. The privileged, both in the industrialized countries and in the upper echelons of society in developing countries have become too insensitive to this appalling situation. It is necessary for all to be reminded that:

- (i) reality for countless numbers of fellow human beings is stark, unrelieved poverty, compounded by ill-health.
- (ii) these conditions did not come about by accident but have evolved out of the highly skewed pattern of development that has prevailed in "modern times", the benefits of which have accrued to the peoples of the developed countries and a minuscule portion of those in the developing countries, and
- (iii) the situation can and must be corrected, not out of a sense of guilt or charity, but in the enlightened self-interest of all humanity, and

with the full participation of both rich and poor in bringing about a more just order.

In the past 25 years both developed and developing countries have achieved, in global terms, impressive rates of overall growth and development. But it is only recently (not until the end of the 1960's) that it began to be widely realized that much of the development taking place was uneven, both between and within countries. The gap dividing rich and poor countries has widened progressively with people in the rich countries having an average *per capita* income eleven to twelve times higher than those in the developing countries as the table below reveals:

Real product in 1975 prices. per capita US\$

	1950	1975
Developed market economy countries.	2350	5140
Developing countries	240	463
Socialist countries of Eastern Europe	540	2660

Source : UNCTAD

The difference in *per capita* real product (measured in 1975 prices) between developing countries and territories and developed market economy countries, which in 1950 was of the order of \$ 2110, had in 1975 increased to US \$ 4680. During the same period the analogous gap dividing the Third World and the Socialist countries of Eastern

Europe had increased from US \$ 300 to US \$ 2200. Per capital income in developing countries increased from a low US \$ 240 to only US \$ 460 by 1975, most of which was realized in oil-rich developing and middle income countries.

In the least developed among developing countries and in some of those most seriously affected by the economic crisis of 1970's, the rate of growth of *per capita* income has slowed to one per cent or less. Equally disturbing is the gap dividing income groups within these and other developing countries which show the widest disparities between the top 20 per cent and the bottom 40 per cent of the population. The fruits of growth and development accrue to a few, usually urban-based people. It is this highly skewed pattern of development which has left countless millions in under-development and poverty, the primary causes of ill-health. Simultaneously, a weighty disease burden and accompanying apathy result in low performance levels and continuing under-development.

The health sector has tended to be treated outside of these realities,

with health viewed largely as an end in itself. The traditional medical care approach and conventional pattern of delivery of health services—relying mainly on gradually extending coverage out from the centre using a disease centred model—has proved highly irrelevant to the health needs of the majority of people. Organized around high-cost, urban, hospital-based and private practitioner technology, a kind of medical industry has evolved in both developed and developing countries which benefits for the most part the more affluent in society. It is psychologically removed and largely inaccessible to those most in need of health care. In some countries it is estimated that less than 20 per cent population have access to centrally financed, government provided health care services. The majority of people remain dependent upon traditional healers who have not been brought within the orbit of the organized health sector. What is more, the underserved in some countries contribute large sums (mainly in the form of taxes) for services they do not enjoy. Even programmes such as malaria control, smallpox eradica-

tion and world-wide immunization are open to question. While theoretically of benefit to everyone, they are of greater significance to well-nourished, well-housed and less exposed people.

The new thinking of the 1970's, reinforced in all the important world conferences—the sixth and seventh special sessions of the General Assembly, and the conferences sponsored by the United Nations or agencies of the UN system on environment, population, food, women, employment, habitat and water—asserts that it is not only possible, but becoming increasingly more urgent to change the established order so as to release the energies of the people of the Third World for more productive activities. The International Conference on Primary Health Care at Alma Ata will no doubt engage in similar discussion and highlight the need for health-promotive development policies at national and international levels.—*Excerpts from a paper prepared for N.G.O.'s Conference on Primary Health Care, Canada, May 1978.* ○

Appropriateness of health services

Health services need to be appropriate to the circumstances. Hazardous and expensive tests are inappropriate for a common symptom such as sporadic headache for which the risk of a serious outcome is extremely low without treatment. On the other hand, intramuscular antibiotics for a person living in an inaccessible area who has a serious fever commonly associated with bacterial infection would appear to be an inexpensive solution in the face of the high risk of a debilitating illness or worse. The solutions in one country or area, at one level of care or one type of facility, or for one kind of problem are not valid for all settings and for all problems. Inappropriate solutions may involve both unacceptable costs and undesirable outcomes.

From: White, K. L. et al., *Health services: concepts and information for national planning and management* (Public Health Papers No. 67), Geneva World Health Organization, 1977, pp. 112-3.

COMMUNITY HEALTH SERVICE SCHEME LAUDED

THE fifth joint Conference of the Central Council of Health and the Central Family Welfare Council has welcomed "the extension of the Community Health Workers' Scheme to the second set of Primary Health Centres". The Council which met in New Delhi on 6, 7 and 8 October, 1978 made it clear that "the C.H.W. Scheme has now come to stay and has to be consolidated". The conference welcomed the Karnataka's decision to adopt the scheme in 106 PHCs and said that it was essential that all people involved in the implementation of the CHW Scheme including the community should be fully and properly educated about the impact of the scheme". The people should be taken into confidence and explained all the facts of the Schemes before it was put in operation, the conference noted.

The Conference noted "with gratification" appreciation of India's experience at the International Conference of Primary Health care held at Alma-Ata (USSR) in September 1978. It welcomed the recommendation and declaration adopted at Alma-Ata and said that efforts should be intensified to ensure primary health care for all the people of India by the year 2000.

Shri Jagdambi Prasad Yadav, Union Minister of State for Health and Family Welfare, inaugurated the Conference on 6 October. He referred to the heavy damages caused by the flood and that "this year in

spite of their magnitude we have been by and large able to prevent the widespread outbreak of communicable diseases. The preventive measures which were taken by the state governments supported by the Centre, have on the whole proved effective and one hopes that the country will not have to face the usual phenomenon of diseases following floods." He referred to the high incidence of malaria and said steps should be taken to bring down its incidence and eradicate the disease as quickly as possible.

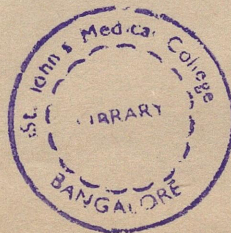
The Minister referred to the population explosion and said: "We cannot possibly achieved the expected success in our health care programmes or, for that matter, in all other programmes of socio-economic development, unless we are able to tackle the problem of population explosion."

The Minister said: "We have held several conferences. We have passed several resolutions expressing our determination to bring down the population growth rate with the willing cooperation of the people the Prime Minister has spoken so many times on the importance of reducing the birth rate. A large infrastructure is in existence. More than 110 crores of rupees are being invested in the family welfare programme every year. In addition, we have the cooperation of other ministries and organizations like the Ministry of Information and Broadcasting and voluntary bodies in im-

plementing this programme. Why is it that the programme is not picking up? The Press and enlightened public opinion have been focusing attention on the dangerous situation to which we are exposing ourselves. There is evidence of the people themselves asking for services. At many places these are not being made available to them. Why should it be so? Why should we who led the family planning movement all over the world be now lagging behind the other developing countries?"

"We cannot go on discussing this question every year and every month without finding an effective solution to it. At the present rate of progress, I do not see how we can achieve the levels of performance which were fixed early during the year. If these levels are not achieved, there is no possibility of our bringing down the birth rate to 30 per thousand by 1982-83. Of the 108 million estimated number of couples in the eligible age group, those covered under the programme constituted 24.4 million at the end of June 1978 as against 25 million at the end of 1977-78. The protected couples coverage is going down fast. The lowest performance is in relation to sterilization. This is a situation which we cannot possibly ignore."

Shri Rajeshwar Prasad, Secretary, Ministry of Health and Family Welfare, presented a report of the deliberations of the meeting held with



the State Secretaries of Health and State Directorates of Health Services.

RESOLUTIONS

The Conference emphasized the importance of political commitment to the family planning programme. It said: "The Family Planning Programme is vital to the country's socio-economic survival and progress. In recognition of this, all political parties should eschew any adverse reference to this programme. All of them on the other hand should dedicate themselves to propagation of the small family norm as a sacred national duty".

"The Conference was happy to note that Parliament has already raised the age of marriage for girls to 18 years and for boys to 21 years. The Conference also noted with satisfaction that National Awards have been recently announced. The constitution of a Working Group on Population Dynamics by the Planning Commission is also a welcome step. The Conference noted the principle of linkage of resource allocation for development to the State Governments to their performance in family planning."

".....While at the State and Central Government levels there is increasing awareness of the importance of the programme, considerable misgivings still exist in the minds of the people about the commitment of the government to the programme. The only manner that the programme could be rejuvenated would be through the expression of clear, total and continuous commitment from all political levels, from the grassroot to the national level. The conference felt such political commitment has not been adequately voiced in public."

It urged the public leaders, who are the most important builders of

public opinion, should unreservedly and perseveringly come out in favour of the programme in their frequent public appearances and utterances. This should apply to panchayat leaders, legislators, parliamentarians, ministers and others.

Concerted efforts towards creation of awareness and motivation would demand intensive measures in the field of information, education and communication directed at all age groups. Extended mass media and communication efforts, including revamping of existing machinery, are necessary in this connection.

A nominal charge of 25 paise be levied in respect of all new cases attending the outpatient department of Government Hospitals and dispensaries excepting the cases of accidents, emergencies, medico-legal cases and those below the poverty line—From a resolution of the fifth joint Councils of Health and Family Welfare.

Among other resolutions adopted were:

Health Education

In disease control, prevention is better and more economical than cure, and prevention is only possible with full public cooperation and that public cooperation can be assured by proper health education. Health education should form an integral part of all educational activities—both formal at school level and non-formal adult education.

Malaria

"Operational research work should be intensified to evolve alternate strategy for controlling the disease (malaria) and ultimately eradicating it. The Government should make adequate funds available for carrying out such research activities.

"Special emphasis should be laid on controlling the spread of *p. falciparum*—which is the main cause of death in malaria—additional operational inputs available with the help of SIDA/WHO for this purpose should be effectively utilized."

With a view to making anti-malarial drugs freely available as near to the door-steps of the people as possible, the number of Fever Treatment Depots, Drugs Distribution Centres and Malaria Clinics should be increased and their proper functioning should be ensured through increased supervision.

Entomological studies at the zonal tier should be stepped up so that adequate data regarding the susceptibility status of the vector mosquito and their bionomics becomes available for selecting appropriate types of insecticides.

To the extent possible, new techniques for antilarval work, like Ultra Low Volume spray and thermal fogging should be introduced under the Urban Malaria Programme.

Adequate arrangements should be made under the 'Modified Plan of Operations' for examination of blood smears in the urban areas.

Leprosy Control

The National Leprosy Control Programme be continued as target oriented one and 100 per cent Centrally-sponsored during the sixth plan period so that the tempo of early case-detection and treatment which has been achieved with much efforts and inputs overcoming many difficulties in the field during the 5th period is not lost.

At least 90 per cent of the Leprosy cases in the country be detected and brought under regular treatment during the sixth plan by suit-

Swasth Hind

able annual targets and achievements so that almost all the grossly positive cases are treated with multi-drug therapy, made non-infectious and maintained so to interrupt the transmission of the disease.

Sufficient number of Temporary Hospitalization wards should be created expeditiously in the existing leprosy institutions and District Hospitals.

Training of all categories of staff, whether uni-purpose or multi-purpose be augmented and strengthened in understanding of leprosy problem, its diagnosis, treatment, health education and socio-economic problem concerning the patients of leprosy so that under the integrated general health service pattern, they can render an effective medical care in this field.

The medico-surgical rehabilitation of leprosy patients should be initiated through establishment of rehabilitation promotion units in suitable leprosy institutions and referral centres (Government or voluntary) and facilities for reconstructive surgery, physiotherapy, prosthesis, jobs and tools adaptation and training of technicians are created so that these patients are made fit to be rehabilitated socio-economically by their own efforts or through the help of government or voluntary organizations.

Important anti-leprotic drugs like DDS, Lamprone, Rifampicin, should be allowed customs free entry in the country for free treatment of leprosy patients, particularly by voluntary organizations, who receive this drug out of the public charity funds collected in foreign countries.

Tuberculosis

The National Tuberculosis' Control Programme should continue during the sixth plan as a centrally sponsored scheme as it was in the fifth plan.

The States should take urgent steps for revitalization of the T.B. programme by ensuring involvement of all-multi-purpose workers posted in primary health centres and sub-centres in both T.B. case-finding and treatment and BCG vaccination programme as per recommendations and guidelines provided by the Government of India.

Since there are still several districts in the country where District T.B. Centres are yet to be established, States should take expeditious action in this regard so that

The draft national health policy be widely circulated for inviting comments, opinions, etc., and thereafter the matter be further considered prior to approval of Cabinet and Parliament—from a resolution of the fifth joint Councils of Health and Family Welfare.

additional sets of X-ray equipment with Odelca cameras for new District T.B. Centres when received from SIDA/WHO can straightaway be allocated to them for installation.

One of the deficiencies of the programme is lack of monitoring, supervision and training at district and State levels. For this, it is essential that the Training and Demonstration Centres should be reorganized as State T.B. Centres on recommended lines and the personnel of these centres trained at the National Tuberculosis Institute.

The number of T.B. beds in each Dist. should be increased to provide necessary treatment to patients requiring hospitalization.

Filaria Control

The operational activities of the National Filaria Control Programme should stand merged with the Urban Malaria Programme at the State level as resolved in the last meeting of this Council.

In order that National Filaria Control Programme units also become responsible for anti-malarial activity in their areas, additional inputs by way of staff material and equipment from NMEP (urban) should be provided by the Central Government.

Control of STD

To provide diagnostic and therapeutic services to patients suffering from sexually transmitted diseases, facilities should be improved by opening more S.T.D. clinics in the States, especially in the backward, tribal, industrial and educational centres. The basic target should be at least one S.T.D. clinic per district.

To pick up blood samples of patients suffering from syphilis and also to screen pregnant women attending primary health centres/taluka hospitals/dispensaries, V.D.-R.L. test needs to be instituted in the District laboratories wherever this facility does not exist so that these samples are sent to them for VDRL test.

States should encourage the laboratories located in their domain to participate in the inter-laboratory evaluation of S.T.S. with the S.T.D. Reference Laboratory at Madras.

States should nominate a medical officer who could coordinate with the centre for the S.T.D. control

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BETTER HEALTH FOR WORLD'S PEOPLES

C. R. KRISHNAMURTHI

Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford.

EVERY human being has a right to realize his full potential and health is basic to the realization of this ideal. So health is fundamental to human progress. This is clearly brought out in ancient Sanskrit saying,

**'Dharmartha kama mokshanam
arogyam moolam uttamam'**

The World Health Organization has defined health as state of complete physical, mental and social well being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.

Despite impressive advances in the fields of science, medicine and technology, the vast majority of the population, particularly in rural areas, have little or no access to health services. It is stated that only 15 per cent of the rural population are able to avail of this benefit of health services and only 10 to 15 per cent have access to safe drinking water. After India attained Independence in 1947, there has been increase in the number of medical colleges and hospitals and

medical care institutions. To look after the millions of people in rural areas a series of Primary Health Centres and Sub-centres numbering 5,400 and 38,000 respectively have been set up since then. These steps and other health measures have brought in a steep increase in the life expectancy of the people and a small but significant reduction in the infant mortality and maternal mortality. However, morbidity due to various diseases continues to haunt the nation. The nation has

been able to eradicate smallpox and bring under control a number of diseases. However, more than these the population is plagued by common ailments which can be cured by simple remedies. Further, if a sense of cleanliness, hygiene, good health habit in relation to eating, sleeping etc., can be inculcated in children as well as adults, the health status of the people will improve considerably.

Therefore, the nation has to achieve an acceptable level of health within foreseeable future as part of social development and in a spirit of social justice. In addition to these the disadvantaged population living in tribal and remote areas have to be provided greater access to conventional forms of health care. There is further need for new strategy to provide simple and primary health care at doorsteps of the population.

In the light of these the International Conference on Primary Health Care held at Alma Ata at Soviet Kazakhstan in September last assumes importance. This Conference jointly sponsored and organized by WHO and UNICEF addressed itself to the issues of how better health care can be provided for all the world's peoples. It provided an opportunity to exchange experience

Indian Delegation

The Indian delegation to the Alma-Ata Conference on Primary Health Care was represented by the following.

1. Shri Jagdambi Prasad Yadav, Minister of State for Health and Family Welfare.
2. Shri C. R. Krishnamurthi, Joint Secretary, Ministry of Health and Family Welfare.
3. Shri B. K. Sharma, Joint Secretary, Ministry of Agriculture and Rural Development.
4. Shri M. M. Rajendran, Joint Secretary, Ministry of Education and Social Welfare.
5. Dr B. C. Chosal, Asstt. Director General (HA), Ministry of Health and Family Welfare.
6. Shri B. D. Tekriwal, S. A. to Minister of State for Health and Family Welfare.

and information on the development of primary health care within framework of comprehensive national health systems and services and national effort. The Conference defined primary health care as essential health care made universally acceptable to individuals and families in the communities by means acceptable to them through their full participation and at cost with the community and the country can afford. It stated that the primary health care forms an integral part of the country's health care system of each nucleus and of the overall social and economic development of the community.

Naturally, India's community health workers' scheme was well appreciated. Consequently the WHO requested Shri C. R. Krishnamurthy, Joint Secretary, Ministry of Health and Family Welfare and member of the Indian delegation along with Dr Sharmanovich of the Kazakhstan Socialist Republic, and Dr Madam H. Labelle, Director General of Department of Indian and Northern Affairs, Canada to explain their individual country's primary health care programme to the staff of the World Health Organization at Geneva.

The Conference expressed the need for urgent action by all governments to protect and promote health of peoples of the world and made a declaration known as Declaration of Alma Ata. This declaration laid accent on self-reliance and people's participation in the planning, organization and promotion of primary health care making full use of the local resources. It says that the primary health care should rely at local and referral levels of health workers including physicians, nurses, midwives, auxiliaries and community workers as well as traditional practitioners. It requested all the governments to formulate national policies,

strategies to launch primary health care as part of comprehensive national health system and in coordination with other sectors. Indeed, the Alma Ata declaration can be called Magna Carta of health which can lead to provision of health to all the peoples of the world.

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We give below a report of the Alma-Ata Conference on Primary Health Care based on the WHO Press releases.

The International Conference on Primary Health Care held in Alma-Ata, capital of the Kazakhstan Socialist Republic, between 6 and 12 September, 1978 has called for urgent and effective international and national action to develop and implement Primary Health Care throughout the world, and particularly in developing countries. The plea was part of the 10-point 'Declaration on Alma-Ata' adopted by delegates from 140 nations and number of non-governmental organizations. The Conference was jointly sponsored and organized by the World Health Organization and the United Nations Children's Fund.

The Declaration called for new approaches that would end the inadequate and inequitable distribution of health personnel between and with countries. The Declaration had among other things stated that the inequality in the health status of the people, particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries".

The Conference, the first convened on a global scale to consider the issues of how better health care can be provided for all the world's people, was called in pursuance of a resolution by the World Health Assembly, in May 1975. UNICEF,

through a decision of its executive Board, subsequently joined the WHO as co-sponsor.

The Conference's objectives were:

- exchange of experience and information on the development of primary health care, within the framework of comprehensive national health systems and services, and overall national development.
- promotion of primary health care; and
- preparation of a report including recommendations to governments, which will be submitted to the WHO World Health Assembly, and UNICEF's Executive Board.

Some 700 participants attended the Conference either as delegates from Member States or as representatives of international agencies and non-governmental organizations. Delegations included ministers of health, planning, national development and finance. A key area of the Conference's work was to see how health can promote the broad range of development activity. Programme in agriculture, water resource development and education, for example, could all be involved in raising awareness and providing technical inputs for improved health care—both for specific groups, like children and general population.

Dr Halfdan Mahler, Director-General of World Health Organization, urged World Governments to make an unequivocal political commitment to primary health care as a means of providing essential health care to every citizen.

He urged that all governments formulate, or review national policies and plans for primary health care within the next two years, as an essential component of their development efforts. National Health budgets should be based upon these

plans, and national health systems reshaped, if necessary, in urgent response to the world health situations.

These comprehensive national plans would permit WHO to draw up a world-wide plan of action as "unique manifestation of international health solidarity", he said.

He said each country must develop its own health systems in the light of political, social and economic realities. However, primary health care is the key to achieve an acceptable level of health throughout the world in the foreseeable future, although it will take a wide variety of shapes in accordance with each country's political, social and economic systems.

Dr Mahler said he hoped the Conference would reach agreement on the main principles of primary health care and on national and international action so that it may be introduced or strengthened systematically.

Delegates should ask whether their governments were ready to address themselves seriously to narrow the gap between health 'haves' and 'have-nots', and whether they would make preferential allocations of health resources to the social periphery as an absolute priority. An affirmative answer to these and related questions, he said, would make the Conference a success by demonstrating the readiness of world governments to mobilize the resources necessary to provide greater equity in health care.

Global plans of action

In urging governments to formulate or review national policies and plans for primary health care within the next two years, Dr Mahler said, these plans and related budgets will be highly useful in mobilizing bilateral and multi-lateral support for primary health care. Also, such

planning will permit the World Health Organization to draw up, not later than 1981, regional and global plans of action. These action plans are crucial components of the strategy now being developed by WHO for attaining an acceptable level of health for all the world's peoples by the year 2000.

Different Approach to Health Care Needed

Mr Henry R. Labouisse, Executive Director of UNICEF, addressing the Conference said that a number of societies, both rich and poor, have reached 'a sort of impasse' in the field of health care.

Mr Labouisse said the organization has emerged from 'our deep conviction that the scandalous disparities between health opportunities in different parts of the world, and also within countries, can no longer be tolerated.

"The developing countries have come to realize that the conventional approach inherited from industrialized countries was hopelessly inappropriate when it came to meeting within a reasonable period of time, the health care needs of their vast populations", he said.

Also, however, the industrialized countries themselves, after spectacular advances in the field of medicine and the building up of services with costly facilities, sophisticated technology and highly specialized personnel, are now finding themselves burdened with ruinously expensive medical care and unable to provide proper health protection to their own poor, Mr Labouisse said.

UNICEF, which allocated some 50 per cent of its programme expenditure to the health sector, has over the past three decades helped supply with equipment, drugs, or both, hundreds of thousands of health centres, most of them in the populous but underserved rural areas of

some 100 developing countries. The Children's Fund also has supported the training of more than a million health workers.

These efforts are multiplied many times by the financial, technical and human efforts of the government with which UNICEF cooperated and by other assistance from bilateral sources and from numerous international organizations.

Yet more than 80 per cent of people in rural areas and poor urban neighbourhoods still lack access to any health services.

And demographers calculate that this 15.5 million infants and young children would die before their fifth birthday and that 15 million of these deaths would be in developing countries.

As an answer to this situation, Mr. Labouisse says, one of the most significant developments of recent years has been the recognition by governments and most aid-giving organizations that simpler, more direct and much more decentralized actions—the primary health care approach must be taken promptly to bring to the most needy the essential health services they so far had never known.

"A report by WHO and UNICEF in 1974-75 identified some of the components of this alternative approach", he said.

The two organizations had not invented this primary health care approach, he added. "We were recognizing a necessity apparent to many and which was already leading to new patterns of services."

"A number of countries have had experience with this approach and are applying it either nationwide or in some limited areas. They do so each in their own way, depending on their political systems, their cultural patterns, their social philosophy and their financial resources".

Mr. Labouisse said the primary health care approach requires first "a drastic re-ordering of priorities and a change of attitudes at all levels of governments and legislatures, beginning at the very top where the crucial political decisions are made".

It will also require the training or re-training of many professionals used to concepts and routines no longer and it will require increased budgetary allocations to expand and ensure effective use of health supporting services.

"The problem", said Mr Labouisse, is not just to extend the existing infrastructure of health services, generally very limited: it is to begin building at the other end, at the village end and in the city slums—and to mobilize in the process the interest and creative spirit of the people whose health will be improved and lives transformed by the services to come".

UNICEF stands ready, Mr Labouisse said, to intensify its cooperation to the very limit of available resources with support for planning of new programmes and inter-country exchanges of key personnel or information; provision of supplies and equipment support for training, particularly of paramedical personnel and community health workers; and increased cooperation in health related fields such as safe water supply; sanitation, nutrition, formal and non-formal education, and local production and effective storage of food-stuffs.

Alma-Ata Declaration

In adopting the ten-point "Declaration of Alma-Ata", and in drawing up 22 specific recommendations, the Conference stated that governments had made "an historic collective expression of political will." It urged all nations, at all levels of government and society, to now commit themselves to the achievement of

primary health care for all citizens. Primary health care was the key to attaining for all peoples, by the end of the century, level of health that would permit them to lead socially and economically productive lives, the Conference stated. This should be a major social objective of governments, international organizations and the world community in the coming decades, it declared. At present more than half the world's people did not have adequate primary health care. The existing "gross inequality" in health status, particularly between developed and developing countries as well as within countries, was politically social and economically unacceptable. Development based on a new international economic order was of basic importance in closing this gap, and would at the same time contribute to a better quality of life and to world peace.

The translation of principles into practice would require the priority allocation of budgetary resources to primary health care, the conference pointed out. The better distribution of existing resources, plus improved management in planning, implementing, monitoring, supervising and evaluating health programme was also required.

Primary health care was defined as "essential health care based on scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development, in a spirit of self-reliance and self-determination". It formed an integral part of both the country's health system, of which it is the central function and of overall social and economic development.

Primary health care, the conference continued, included at least

health education, the promotion of proper nutrition, adequate safe water, basic sanitation, maternal and child health care including family planning, immunization programmes, endemic diseases prevention and control, treatment of common ailments and injuries, and the supply of essential drugs. The system relied on physicians, nurses, midwives, auxiliaries and community workers, as well as on traditional practitioners where available. All should be trained to work as a team and to respond to the communities' expressed health needs. All training, the conference recommended, should include field activities. Physicians and other professional health workers should be urged to work in underserved areas early in their careers.

Each country must interpret and adapt primary health care within its own social, political and developmental context. However, all systems should provide promotive, preventive, curative, rehabilitative and emergency care. The Conference emphasized the importance of developing comprehensive national health systems, of which primary health care should be an integral part. Governments were urged to coordinate the work of different ministries in health-related fields, and to delegate appropriate responsibility and authority to intermediate and community levels.

Health was inter-dependent with social and economic development, the conference stated. Health led to, and at the same time depended on, a progressive improvement in quality of life. Thus health activities must be coordinated at all levels with those of other social and economic sectors including education, agriculture, animal husbandry, household water supply, housing, public works, communications, industry and others, there must also be related measures to improve nutrition, increase production and

DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential of sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attain-

ing this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally

endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, *détente* and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

employment to achieve a more equitable distribution of income and protect the environment.

Primary health care, the conference emphasized, required and promoted maximum community and individual self-reliance and participation in the planning, organization, operation and control of programmes. It made fullest use of local, national and other available resources. The promotion of primary health care should enhance the capacity of people to solve their own problems. It required a close relationship between health workers and the communities they served.

It stressed the importance of continuous supply of essential drugs

and urged governments to formulate national policies for the import, local production, sale and distribution of drugs, making them available at the lowest feasible cost. Proven traditional remedies should be incorporated.

The needs of women, children, the under-privileged and working populations at high risk were emphasized. Special attention was essential for remote and neglected areas. While service in these areas required dedication, incentives were also needed to attract health personnel. These included opportunities for further training and support for the education of health workers' children. The conference recommended that governments quickly

work out well-defined goals and action plans to ensure that primary health care be accessible to the entire population. It called for increased technical and financial support from international organizations, multilateral and bilateral agencies, non-governmental organizations, funding agencies and other partners in international health. It further recommended that WHO and UNICEF on the basis of national programmes, draw up concerted regional and global plans that would facilitate mutual support between countries in the primary health care field. WHO and UNICEF were also urged to continuously promote the mobilization of other international resources.

HEALTH SITUATION IN INDIA *continued from page 309*

	I Plan	II Plan	III Plan	IV Plan anti- cipated	V Plan targeted
Sub-centres of PHCs	..	..	..	33,000	44,025
Rural hospitals	..	..	..	..	1,293
Medical colleges	42	57	87	99	106
Annual admissions in medi- cal colleges	3,500	5,000	10,625	12,500	13,000
Doctors in practice	65,000	70,000	86,000	1,38,000	1,76,000
Nurses	18,500	27,000	45,000	88,000	1,23,000
ANMs	12,780	19,900	35,000	64,600	..
Health visitors	300	1,500	4,200	..	..
Nurse-Dais	6,400	11,500	28,000	..	..
Sanitary inspectors/Health assistants	4,000	6,000	18,000	32,000	..
Pharmacists	..	42,000	48,000	66,000	..

Thanks to the greatly increased outlays on health care, related institutional facilities and trained manpower required for the most effective administration of such programmes have increased very considerably.

Thus, the number of hospitals and dispensaries in the country increased from 10,000 at the end of first plan to 14,600 at the end of the

third. It must be considerably more now, though the exact figure is not available. The number of hospital beds has more than doubled from 125,000 to 281,600 at present. Primary health centres at present number 5,250 as against 725 at the end of the first plan and the number of the sub-centres has reached a total of 33,000 by now.

MEDICAL AND PARAMEDICAL MANPOWER NORMS—REQUIREMENTS AND AVAILABILITY

Category	Ratio to population	Require- ments	Actual position (1972-73)	Ratio to pop. (1972-73)	Actual position (1973-74) anti- cipated	Ratio to pop. 1973-74 (end year of IV Plan)
Doctors	1 : 3,500	170,870	130,530	1 : 4,366	138,000	1 : 4,239
Dentists	1 : 30,000	19,900	8,400	1 : 67,845	..	..
Nurses	1 : 5,000	120,000	82,330	1 : 6,922	88,000	1 : 6,648
ANMs	1 : 5,000	120,000	50,000	1 : 11,398	64,000	1 : 9,066
Sanitary Inspect- ors	1 : 10,000	59,000	30,060	1 : 18,959	32,600	1 : 17,94

Source: "Report : 1972-73" Ministry of Health and Family Planning, Government of India.

Likewise, the number of medical colleges has increased from 42 to 106. Annual admission in these colleges have nearly quadrupled from 3,500 to 12,500. There are now 138,000 doctors and 88,000 nurses as against 65,000 and 18,500 respectively, at the end of the first plan.

Substantial increases have also been recorded in the number of paramedical personnel such as auxiliary nurse-midwives, health visitors, sanitary inspectors and pharmacists.

Impressive though these achievements are, they still fall short of the

requirements based on the norms suggested by the Health Survey and Planning Committee as the table indicates.

Mention should also be made of the infrastructure facilities available for the control of tuberculosis and for the family planning programme. As for TB control, there are now 278 district TB centres, 17 demonstration training centres and 36,500 T.B. isolation beds, as against 170, 15 and 35,000 respectively at the end of 1968-69.

In the field of family welfare planning, the rural centres and sub-centres are part of the PHC Complex of Centres and Sub-Centres. So there are, and will be as many family welfare planning (FWP) centres and sub-centres. For the urban areas, there are nearly 2,000 FWP centres. The number of sterilization beds has increased more than sixfold over the last five years. Inadequacy of transport has been one of the serious bottlenecks in the family planning programme. The number of vehicles in use represents less than 50 per cent of the estimated requirement of 8,000. The outlay of Rs. 24 crore proposed in the fifth plan for procurement and maintenance of vehicles may make good the larger part of the deficiency.

A broad measure of the facilities required for the family planning programme is provided by the the anticipated expenditure on service and supplies, training, mass education, evaluation and organization, amounting to nearly Rs 260 crore during the fourth plan period, and the proposed expenditure of Rs. 480 crore for the fifth plan period.

Rural health services

Since 80 per cent of the population in our country lives in rural areas and in view of the existing wide disparities in the availability

of health care facilities between the urban and the rural areas, steps are now urgently being taken to train a special functionary, namely, a multi-purpose health worker. He will deliver integrated health care services in the countryside. The object of having the multi-purpose workers programme is to train unilevel health workers engaged in various communicable disease control/eradication programmes like malaria, smallpox, T.B., family welfare, etc. Hitherto, this programme was mostly vertically conceived and was being implemented at the field level by the staff separately deployed to implement it, with little consideration for integration of these services. This was primarily because, various health programmes, and later on the family planning programme were launched at different times and each such programme was conceived to run vertically with its own staff. There is at present a great need for integrating medical, public health, nutrition and family planning services.

In a concerted drive to extend health care to the rural out-reaches, as many as 5,400 primary health centres and about 38,000 sub-centres have been set up in the country since independence serving the rural population of about 500 million in 5,247 community development blocks.

The integrated approach for the delivery of a package of health, family planning, MCH and nutrition services to the community has been accepted in the fifth plan. It has been decided to introduce multi-purpose approach on phased programme throughout the country in the fifth plan. The adoption of multi-purpose approach has added a new dimension to the training programme hitherto conducted separately for family planning personnel and workers engaged in various other health programmes.

Under this scheme a comprehensive health and family welfare care will be provided through a team of two workers (one male and one female) at the sub-centre level. It is now envisaged that by the end of the sixth Plan, there would be one sub-centre for every 5,000 population with a team of one female and one male worker. However, taking into consideration the existing one male and one female workers and the workers that will be available by the end of the fifth plan, it is envisaged that there will be one female worker for every 8,000 population. In addition to their duties of providing health and family welfare and nutrition education, these workers will also be responsible for providing first-aid treatment for minor ailments.

There will also be a team of one male and female health supervisors to supervise the male and female health workers under the scheme. All those supervisory personnel will be designated as health assistants who will highlight their role of assisting the doctor. They will also be trained and equipped to give specific remedies for simple day-to-day illnesses but at high level of competence. They will carry a medical kit for the curative services that they will perform. While the health assistants do have a supervisory role, they should also function as health workers in their own area carrying out the same duties and responsibilities, but at a higher level of technical competence. They will be specially responsible for the promotive and preventive health measures and all the national health programmes. The female health assistants will take particular care of children, expectant and nursing mothers.

Very few developing countries have been successful in developing their health delivery network to achieve a wide coverage of their popula-

tion. Although there are variances between different successful country schemes, several common features exist. For instance in each country or area the government started with the formation, reinforcement or recognition of a local community organization and treated it as a part of the enterprise. It organized community action for problems that could be resolved by individuals, it controlled the primary health worker; it assisted in financing services and it linked health action with broader community goals.

Since the initiation of developmental activities, planners have always given importance to the need of enlisting people's participation in this direction concerning all aspects of developmental programmes. Health programmes are no exception.

However, during the intervening period the idea of people's participation as far as health services are concerned have merely remained on paper and this vast resource has hardly been tapped to the desired extent. As people's expectations from health services increased, the need for strengthening country's health services was recognized and subsequently the need for enlisting people's active participation assumed greater importance.

Under the Multi-purpose Health Workers Scheme, each worker will hopefully deliver minimum health care to the rural communities. However, the desire of extending these services to every village may not be feasible in the near future. It is keeping this in view that the idea of Community Level Health Workers was mooted by the Report of the Group of Medical Education and Support Manpower which was appointed by the Government of India in 1974. Their report stressed the need to provide health services

(Continued on page 312)



RURAL HEALTH SCHEME Implementation and Evaluation

Some press reports and editorials have appeared in a section of the Press commenting on the scheme of Community Health Workers launched by the Ministry of Health on 2 October, 1977. These are based mostly on certain portions of the assessment report of the Institute of Economic Growth. The Institute of Economic Growth was requested by the Ministry of Health to undertake an appraisal of the Rural Health Scheme.

The Institute of Economic Growth had studied the scheme in operation in five PHCs in Punjab and Haryana and 94 community health workers trained in these five PHCs. Presently, the Scheme is in operation in 741 PHCs covering about 74,000 villages and about 42,000 CHWs are in position. While the defects of the Scheme as pointed out in the assessment report have been highlighted, the positive aspects of the Scheme mentioned in the report itself have not been found any mention. Dr Ashish Bose himself had written to the Union Health Minister stating "I am glad to report to you that the rural masses have welcomed your scheme. We have also argued in the report that the misgivings of the doctors are not justified."

It is but natural that in any Scheme of this much dimension which, in the initial phase, is spread over 741 PHCs, there are bound to be initial difficulties. Unlike other Schemes, an evaluation of this Scheme has been undertaken not only by the Institute of Economic Growth but also by five other demographic research centres and a group of other academic and management institutes consisting of the National Institute of Health and Family Welfare, All-India Institute of Hygiene and Public Health, Calcutta, Indian Council of Medical Research, Indian Institute of Management, Ahmedabad, Indian Institute of Population Studies, and the Gandhigram Institute of Rural Health. This latter group have conducted a more extensive evaluation covering a sample of over 10 per cent of the PHCs in which the training of the Scheme has been in operation compared to the only five PHCs which had been taken up by the Institute of Economic Growth.

All the reports so far received, including the Report of the Institute of Economic Growth, indicate that the Rural Health Scheme has been generally "welcomed by the rural masses." While in some States like Punjab and West Bengal, the community has not been fully involved in the selection of CHWs, the awareness of

the community in many of the States has been of a very high order. Most of the reports indicate that the quantum of honorarium of Rs. 50 per month and quantum of medicines worth Rs. 50 per month may not be sufficient. The Scheme itself lays very great emphasis on preventive and promotive aspects of health care. Since some of the reports show that these have not been adequately emphasized during the training programme, necessary corrective measures would be undertaken.

Scheme deserves fair deal

Likewise, there are some misgivings about the Scheme on the part of the medical profession. The report of the Institute of Economic Growth devotes a whole chapter on the misgivings of the medical profession, their fear that the CHWs would turn to be quacks, stress on indigenous systems, lack of control over CHWs; and finally concludes that having examined all the major misgivings on the part of the medical profession, "our team is not convinced that their misgivings are warranted. The new rural health scheme certainly deserves a fair trial." The report concludes that by and large, "the new rural health Scheme is benefitting the Scheduled Castes and low income groups." It does mention that it kits, manuals, medicines, etc., are not reached in time, the Scheme is likely to fail. The Government are entirely in agreement with this observation and extraordinary efforts are being made to ensure timely supply of kits, manuals, medicines, honorarium to the thousands of CHWs. There is constant liaison with the State Governments that the entire training programmes are efficiently organized, that sufficient teaching aids are made available and that the involvement of the community is imaginatively pursued. It is not the intention or desire of the Health Ministry that it should remain a mere administrative programme without effective participation of the community.

In the report, a number of suggestions for improvement of the Scheme regarding effective communication with the panchayats, formation of village health committees, orientation courses for panchayat members, upgradation of the CHWs, timely payment of stipend, honorarium, medicines, reduction in content of training, realistic training for solving all local health problems, refresher courses, working group to suggest alternatives, need to monitor and review of such a massive programme have all been given. These suggestions and those which will emanate from the evaluation being done by the National Institute of Health and Family Welfare (NIHFW) and other institutes, would be examined and necessary correctives introduced.

Rural Bias from bottom

The report has also said that "rural bias is to be given to medical infra-structure of health and medical services from the bottom and not from the top. The introduction of the CHW on a mass scale for every community of 1000 persons in every village is a very desirable *first step* in this direction." The report further states: "Finally, we do believe that there has been more talk than action in the field of rural health for at least 40 years in this country and the Janata Government certainly deserves congratulations on actually launching a Rural Health Scheme soon after taking over."

The Government, therefore, welcome every positive suggestion which would enable greater involvement and participation by the community.

The study carried out by the Gandhigram Rural Institute has brought about that the work of CHWs has been appreciated by the people and that they (the CHWs) have further shown willingness to carry on the same even if no honorarium is given to them. The interim report of the NIHFW indicates that the scheme of CHWs was acceptable to a large majority of community leaders, staff of primary health centres, etc.

From the very outset, starting with the formulation of the scheme, every section of opinion has been involved by inviting public comments and open discussion. Immediately after the implementation began, evaluation by external, independent and scientific bodies has been purposely made an integral part of the scheme so as to ensure its evolution as a genuine people's movement. The Scheme will also be put to a thorough screening through the Planning Commission.

The Scheme has evoked world-wide interest. The Director-General of the World Health Organization (W.H.O.), Dr H. Mahler, after his visit to Punjab where he saw the community health workers in operation, called this a revolutionary Scheme in providing primary health-care to the people.

Opinion Survey on Family Welfare Programme

In pursuance of the Union Cabinet decision for conducting a survey of public opinion on methods for a more effective implementation of the new Family Welfare Programme, the National Institute of Health and Family Welfare conducted a study on the subject in which replies from 7,271 respondents were received and processed. These people represented practically all sectors of national life and all religions, occupations, tribes and castes. The conclusions of the report are that the people generally favoured a voluntary approach to family planning, but groups of people who are termed as 'informed groups' recommended some compulsion through statutory measures, particularly in cases where couples had two or three living children. There was a recognition of fear of after-effects in sterilization and IUD. The respondents gave two more suggestions for overcoming the fears. These were extensive education of people and intensification of follow-up services. The informed groups of respondents supported the idea of compensation to those accepting sterilization and wanted additional incentives to couples who accepted terminal methods of family planning.

Another important conclusion of the report was the universal approval of the people for raising the minimum age for marriage of boys and girls. There was a demand for enforcement of the Child Marriage Restraint Amendment Act and for providing education on sex and about the hazards of a large family. Several suggestions have been made in the report for intensifying information and education through mass media, personal contacts and mobilization of Panchayats, voluntary agencies and the Rural Health Services network for this purpose.

A meeting of the National Family Welfare Awards Committee was held here on 21 November, 1978 under the Chairmanship of Shri Jagdambi Prasad Yadav, Union Minister of State for Health and Family Welfare. The survey report was considered in detail at the meeting. The various State Governments had also been requested to send their suggestions on ways and means for giving strength and speed to the Family Welfare Programme. Detailed suggestions have been received from the Governments of Bihar, Arunachal Pradesh, Gujarat, Tamil Nadu, Kerala, Nagaland and Sikkim and the Union Territories of Andaman and Nicobar Islands, Lakshdweep, Goa, Daman and Diu, Pondicherry and Chandigarh. The suggestions included various incentives as well as disincentives. The recommendation will be considered and a final decision taken at the next meeting of the Committee. ○

News from States

ANDHRA PRADESH

In-service training to Deputy Inspectors of Schools in Health Education

A three-week in-service training to Deputy Inspectors of Schools in Health Education was organized by the State Health Education Bureau, Andhra Pradesh at Hyderabad.

Inaugurating the training course, Shri P. Audinara-yana, Director of School Education, emphasized that health education had an important place in school curricula. He said that the supervisors of primary schools were also being trained so that they would train the teachers.

Dr S. N. Mathur, Director of Medical and Health Services, in his presidential address, stressed the need for inclusion of health education as a subject in schools. He also favoured the production of short films on health education for screening in the schools.

Dr T. John Phillip, Assistant Director of Medical and Health Services (Health Education), said that teachers could influence the society and community, and play a significant role in the implementation of national health programmes.

Speaking on the importance of primary health care, Dr Sanjeevi, paediatrician and Consultant in UNICEF, New Delhi, said that irrespective of the economic background and geographic domicile, every citizen should be provided with the modern medical facilities. He stated that good referral system was necessary for primary health care. Dr Sanjeevi said that the mother was very important, dependable and reliable source of information regarding health.

Addressing the trainees on heart diseases among children, Dr U. Brahmaji Rao, Cardiologist of Osmania General Hospital, said that 0.5 to one per two thousand infants suffered from congenital heart diseases. Ten per cent of the children of the age-group of five to twelve years usually suffered from high blood pressure, he added. Dr Rao further said that 10 out of 1000 children studying in various schools were detected to be suffering from rheumatic fever and rheumatic heart diseases. He observed that teachers must take keen interest in imparting health education and creating good habits among the children.

Dr R. Patnayak, Skin Specialist of Gandhi Hospital, Secunderabad, speaking on skin diseases among school children said that 80 per cent of the out patients attending the hospital were suffering from scabies. He added that skin diseases among children were due to parasite, bacteria, virus and vitamin deficiencies. Emphasizing the need for early diagnosis of leprosy among school children, Dr Patnayak informed that an infective case of leprosy could be converted into non-infective type within a week by proper treatment.

Dr Y. R. Reddy, Superintendent, Niloufer Hospital, Hyderabad, said that School Health Services were very important for health of the school-going children. The deficiencies in the children should be detected, diagnosed and corrected in the early age, Dr Reddy added.

Valedictory function

Awarding the certificates to the trainees at the valedictory function, Dr S. N. Mathur, Director of Medical and Health Services, said that health education would be taught as a subject in primary schools in Andhra Pradesh. He asked the State Health Education Bureau to help in preparation of syllabus, production of instructional material, etc. He called for a

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close liaison between the functionaries in making the school health services more effective and beneficial.

Speaking on the occasion Dr H. S. Nayak, Resident Programme Officer of UNICEF, said health education was extension of simplified knowledge without complicated medical terms for healthful living.

Dr P. Siva Reddy, Director of Ophthalmology, said that the teachers could play an important role in prevention of blindness. He emphasized the need of imparting proper education and knowledge for preservation of eyesight and early detection of defects and treatment on time.

Dr S. Ramachandra Reddy, Training Officer, State Health Education Bureau, proposed a vote of thanks. ○

KARNATAKA

Rural Health Care Scheme Launched

LAUNCHING of the new scheme of the Primary Health Care for villages marked the Gandhi Jayanti Celebrations in Karnataka on 2 October, 1978. The Scheme aims at involving the community in providing health care to individuals and families. The scheme was launched in one sub-centre consisting of 10,000 population in each of the 19 districts of the State.

Shri K. H. Ranganath, Karnataka's Minister for Agriculture and Parliamentary Affairs, inaugurating the scheme at the Suradhenpura village, underlined the need for paying greater attention to preventive aspects of health.

Shri M. Mallappa, Minister for Health and Family Welfare, Karnataka, appealed to the people to give their wholehearted support to the Scheme.

MAHARASHTRA

Leprosy Control Programme

IN Maharashtra, the estimated prevalence rate of leprosy is seven to eight patients per 1000 population and there are about 3.5 to 4.0 lakh patients. Where-

as the national average is five patients per 1000 population. Ninety per cent of the endemic population has been brought under the National Leprosy Control Programme and the remaining 10 per cent would be covered during 1978-79.

The first survey conducted shows that nearly 25 to 30 per cent leprosy patients have deformities. In re-surveys, only 10 per cent of the new patients show early deformities. Where two or three surveys have been done, the deformity has come down to five per cent. Now many patients seek voluntary diagnosis in the early stage.

Of the total estimated patients—3,01,548, as on 31st January 1978—50 per cent of them take treatment. Of these, about 30,000 patients are children below 15 years of age.

Dr Jivraj N. Mehta

We regret to report the death of Dr Jivraj N. Mehta, the first Director-General of Health Services, in Bombay on 4 November, 1978. Dr Mehta was 91. He was appointed Director-General of Health Services in 1947 and he was also Secretary of the Ministry of Health.

Studies undertaken in some old centres showed that 40 to 50 per cent of old recorded patients were free from disease, though with some residual deformities.

A 14-member Leprosy Advisory Board for the State has been formed to advise for improving the management of Leprosy Control Units, Urban Leprosy Centres and S.E.T. Centres; to study the grievances of the public relating to the leprosy hospitals, Control Units; suggest measures to remedy them etc.

District Leprosy Advisory Boards have also been constituted at the districts of Wardha and Amaravati with similar functions. ○

DELHI

Project for Optical Counters

Under the National Plan, each of the 106 medical colleges are to be upgraded and provided equipment worth Rupees five lakhs each to convert their departments of ophthalmology into departments of community ophthalmology to enable them to offer good ophthalmic care to the community. But there is no provision for supply of spectacles, low vision aids (LVA) and contact lenses, etc.

The project was approved by the Executive Committee of the National Society for the Prevention of Blindness held on 4 August, 1978, in New Delhi.

Under this project optical counters would be opened at all the upgraded departments of community ophthalmology of all the 106 medical colleges, 15 State eye hospitals and seven regional institutes totalling to 128 by providing all qualities of frames and glasses, L.V.A. and contact lenses. The staff required to run each of their optical counters would consist of refractionist or optician and one peon *cum* despatcher to prescribe and evaluate the opticals, L.H.A.'s, contact lens, etc., and to do the research work at the regional institute level.

All other facilities such as detection of visual defects, examining of the patients, performing operations, etc., will be extended by their own staff and on extra payments will be provided from this project funds. Meanwhile, no counter will be opened or staff appointed at the 400 district hospitals. Orders for spectacles and low vision aids in these cases will be received through the doctors already working there.

The Society would be willing to grant loan up to Rs. 10,000 to the needy organizations to make optical counters, showcases and maintain a minimum of frames and glasses. The supply of frames and glasses can be obtained from the Central office on 15 days credit by sending regular orders. Attempts have been made to execute orders within three days of the receipt of the respective order and despatch the same to the ordering institutions immediately. The centralization of the supplies of frames and glasses at the Central office of the National Society for the Prevention of Blindness is advantageous. Because, the Society will be able to procure the material on the minimal cost, even less than the whole-sale prices, and supply the same to the said sale counters at much cheaper rates than the market rates. All that is needed is a show-case exhibition. One or two persons thus employed shall

book orders for spectacles from the patients and send the orders to the headquarters. They will then receive dispensed spectacles, L.V.As or contact lenses from the Headquarters and deliver them to the patients and visually handicapped. Hence, no separate arrangement will be required for detection/refraction work. Also, duplication of efforts will be avoided besides economical execution of the spectacles, L.V.A. and contact lens distribution.

However, all necessary technical guidance and supervision will be assured by the National Society for the Prevention of Blindness and the Dr Rajendra Prasad Centre for Ophthalmic Sciences, All-India Institute of Medical Sciences, New Delhi for which no expenditure will be required to be paid by the institution starting the Optical Counters. ○

Colourful Capping Ceremony of Nurses

At a colourful function here, Smt. Renuka Devi Barkataki, Minister of State for Education, performed the capping ceremony of the nursing students of Dr Ram Manohar Lohia Hospital on 6 December 1978 in New Delhi.

Speaking on the occasion, Smt. Barkataki said that Dr Ram Manohar Lohia Hospital which was easily one of the best equipped hospitals in India, had so far trained about 300 nurses. The hospital took 25 students every year for a three-year course. The professional standard of these nurses was so high that a large number of them had found lucrative jobs in the U.S.A., England, Europe, West Asia and many other foreign countries.

Welcoming the Minister, Dr L. R. Pathak, Medical Superintendent, stated that the Dr Ram Manohar Lohia Hospital treated almost eleven lakh patients in the outdoor patients department and about 1,50,000 patients in the Emergency Ward every year. The hospital which had at present about 800 beds was hoping to increase them to 1,000 beds in the coming years.

Dr Pathak said that it was proposed to expand the nurses' school and adjoining plot had already been earmarked for its new building and a hostel for the nurses. The new building would have all the modern facilities including a creche for children of the married nurses. He said although the hospital discouraged going abroad of nurses trained by it, the quality of training imparted was rated so high internationally that many nurses could not resist the offers from abroad. ○

BOOK REVIEW

STERIOD CONTRACEPTION AND THE RISK OF NEOPLASIA. Report of a WHO Scientific Group. World Health Organization Technical Report Series, 1978 No. 619 (ISBN 92 4 120619 5). 54 pages. Price: US \$ 3.

Steroid contraceptives first became available for general clinical use in the United States of America in 1960 and were rapidly adopted in other countries. Some 80 million women around the world are now thought to be using "the pill", and the fact that large numbers of healthy young women are taking potent steroid drugs for prolonged periods of time has aroused concern about the safety of the preparations.

The present report of WHO Scientific Group that met in December 1977 is mainly devoted to a review and analysis of the many studies of steroid contraceptive use and the risk of developing neoplastic disease. An extensive reference list is given.

The report first considers the research problems involved, and then

describes the four main epidemiological approaches used to determine whether there is an association between drug use and the development of disease: clinical case reports, vital and morbidity statistics, case-control studies, and cohort studies. The report discusses neoplasias of the breast, genital tract and liver, and the possible role in their etiology of combined oral contraceptives and contraceptives containing progestogens without oestrogen. The report suggests that combined oral contraceptives may increase the risk of cervical neoplasia in certain subgroups of women who have other predisposing factors. Also, it is suggested that there is a marked association between the use of these drugs and the development of very rare benign tumours of the liver.

The Scientific Group emphasizes that research on the use of oestrogen for non-contraceptive purposes may not be relevant to possible contraceptive effects since there are major differences in the steroids used for the two purposes. Reference is made

to the relationship between diethylstilbestrol and the development of vaginal cancer among the daughters of mothers who used this drug to treat threatened miscarriage.

Next comes methodological issues to assist the reader to interpret the results of observational studies and to conduct further research. The Scientific Group discusses how to estimate the relative risk of developing neoplasia associated with drug exposure. It points out that knowledge of such risk in relation to the use of steroid contraceptives is almost exclusively derived from studies in the more developed countries, and examines the relevance of this knowledge to other areas of the world, in which very different conditions obtain.

The report concludes with a series of recommendations, dealing specifically with epidemiological research, the question of developing countries, clinical and laboratory studies, clinical practice and information exchange. ○

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programme as well as superwise the S.T.D. control programme in his State.

Cancer Control

Each State should be encouraged to develop its own Cancer Registry.

The Central Government should take appropriate steps for ensuring easy availability of anti-cancer drugs in the country.

The Central and the State Governments should provide all possible assistance in the screening and development of indigenous anti-cancer drugs in the country.

Every district hospital and hospitals attached to the medical colleges should have a properly equipped Cell for early cancer detection.

Blindness Control

As the Mobile Units which are being provided to the State Governments at the rate of one such Unit for every five districts for

holding Eye Camps remain under-utilized, a comprehensive programme for utilization/functioning of each Mobile Van should be finalized well in advance by the State/District Ophthalmic Officer and targets of operations indicated to each District and attempts made to achieve them. While doing so it should be ensured that there was no overlapping and duplication of places where camps being held by voluntary organizations and mobile eye vans.

The State Governments may allocate at least 10 per cent of the total beds with a minimum of 15 in a District Hospital for eye work under the programme. Wherever a number of beds are presently in the voluntary sector, the same may also be utilized for the programme.

In view of the fact that most of the blindness in the country is due to lack of awareness and education

regarding eye-care, it is important that all media of mass communication be geared up to educate the community and people's support and participation enlisted in the programme.

For ophthalmic assistants/technicians to be posted at Primary Health Centres, the Central Government may consider sharing the expenditure on their salaries, etc., as a part of the Centrally-sponsored scheme.

Grant-in-aid money at the rate of Rs. 40 per cataract operation for holding eye camps by voluntary organizations may be advanced to the State Governments on the basis of number of operations carried out by such voluntary organizations in the previous year as may be certified by the State Government. Its utilization/appropriation will, however, be subject to certificates as prescribed under the programme.

CATARACT

This is eighth in the series of the feature. The Community Health Workers, among others, are to educate the community on preventive, curative, promotive and rehabilitative aspects of health. Cataract is a common eye disease of old age. Given below are a few tips for CHWs to educate the community.

CATARACT is a common eye disease of old age. It may, however, affect young persons, children and even newborns. It is one of the few eye diseases, which, if treated properly in time, can be completely cured and a patient can have full vision to see and read even the minutest prints.

Many of us know that eye is like a camera. Just as a camera has a powerful lens that condenses the light coming from an external object and casts its image on a photo-sensitive plate, the eye has a transparent powerful lens which helps to cast the image of an external object on sensitive coat of the eye, the retina, from where the image is transmitted through the nerve of the eye (optic nerve) to the brain. This is how we perceive the image of any object seen by the eyes.

When this lens loses its transparency due to any cause, and becomes opaque, it is known as cataract. The process by which the lens becomes opaque can be compared to the formation of curd from milk. Just as the process of conversion of milk into curd is irreversible, in the same way once the cataract has started forming in the lens, it cannot be checked by any means whatsoever.

What Causes Cataract

The exact cause of cataract is not fully known. Among the known fac-

tors may be counted old age, deficiency of different dietic factors, such as proteins, Vitamins A, B and C, sun-rays and some toxic drugs. General diseases like diabetes (sugar in urine) and congenital syphilis are other important contributory factors. Inflammation within the eye and injuries can also cause cataract at any age. Children may be born with cataract from hereditary influences or because their mother had German Measles during the first three months of her pregnancy.

Signs and Symptoms

Early symptoms of cataract may be blurring of near and distant vision. Gradually and progressively, the eyesight is affected for distant objects though the near-vision may improve in the beginning. There is no headache, pain or redness of the eyes. In the beginning, an object such as lamp or light or moon appears more than one and often the patient complains of some watering. In the course of years the eyesight is considerably affected and the patient finds it difficult to move out for his daily routine. Due to poor sight he often strikes against objects. A time comes when he can see only the light of a lamp or torch. This condition is known as mature cataract (ripe cataract). If untreated, the mature cataract may cause discomfort and increase the pressure in the eye, or produce inflammation of the interior or both.

Do not Confuse Cataract with Glaucoma

It is very important to understand that deterioration of eyesight in old age is not always a cataract but may be one of the more serious diseases like Glaucoma (Kala Motia) or atrophy of the nerve of eye. The eye should always be got examined by a qualified doctor in the beginning and several times, subsequently to detect the possibility of such diseases and to treat them, if present. Many patients do not consult eye doctor but are satisfied with the advice of an old person who considers every loss of vision in old age as cataract. They advise the patient to wait till the cataract becomes mature. In a number of such patients it is actually Glaucoma or some other eye disease. The patient waits till he loses his sight completely and when he consults a specialist he finds to his horror that he is incurably blind because of Glaucoma.

Prevention

Following precautions should be followed to prevent or at least delay the onset of cataract.

- (1) A good and nourishing diet, rich in proteins and vitamins such as milk, papaya, mango, carrots, *palak*, egg and fish, should be taken.
- (2) Protect the eyes from excessive exposure to sun rays, in-

tensive heat, X-rays and injuries.

- (3) Diseases such as diabetes and syphilis should be effectively treated early. These diseases not only lead to cataract but also are responsible for many complications during cataract operation.
- (4) Cataract cannot be cured by application of any medicine to the eye or by taking medicine orally. In the beginning eyesight can be improved with glasses. Suitable glasses should be obtained after getting the eyes tested. The power of glasses changes with the progress of cataract. These are required to be changed every six months or so till no glasses are found useful.

Operations: Only Treatment

The only treatment of cataract known so far is operation. If there is a marked deterioration of vision and disability in going about one should undergo such an operation

without waiting for total maturity of cataract.

Cataract operation means removal of cataractous lens from the eye. It ensures full vision after operation. Such operation is simple. Operation should be performed by a qualified eye specialist in an eye hospital or eye camp organised by such agencies. It should never be got done by quacks, who go about in rural areas. Many of them claim to cure cataract without operation right on the spot. The village people are scared of operation and the expenses for staying in hospital and fall a prey to the Satiya (quack surgeon).

Precautions after Operation

The science is so advanced that immediately after the operation, the patient need not lie on his back. He can turn to unoperated side. The urine should be passed while lying. Only fluid diet is to be taken on the first two days. Cough or sneezing has to be suppressed. Sneezing can be stopped by pressing at the junction of soft and hard

parts of the nose close to the tip or pressing on the roof of the mouth cavity from within.

The head should not be bent to lift anything from the ground. Don't strain in passing stools. Don't chew anything hard. Do not smoke.

After the patient is discharged from the hospital, he has to observe all the above precautions. He has to carry out instructions regarding use of medicines, etc., and should go for a regular check-up as may be advised by the surgeon. In case there is pain and persisting redness, no time should be lost in consulting an eye specialist and carrying proper treatment.

Last of all it may be explained here that as the lens of eye has been removed by operation, every operated case has to use powerful spectacles to have useful vision for seeing distant object or for reading. Spectacles are advised after four to six weeks of the operation, and should be taken only from qualified opticians on a prescription of the eye specialist. ○

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within the community itself by organizing a large number of para-professionals who are drawn from the community and who enjoy their confidence.

In pursuance of the decision of Health Ministers' Meeting, the scheme was introduced from 2 October, 1977, the birth anniversary of Mahatma Gandhi. The objective of the scheme is to make primary health care facilities, both preventive and promotive, alongwith treatment of common ailments, available to every villager. It is proposed that for this purpose one community health worker (CHW) will be provided for every thousand population of approximately per village.

Community health workers scheme

The central philosophy of placing "people's health in the people's hands", the scheme envisages the provision of one CHW for every village or community with a population of one thousand. India has 5,80,000 villages served by 5,400 primary health centres. The scheme is programmed to train 5,80,000 CHWs selected by the respective villages to be in position by 1981-82.

The CHWs scheme is a compromise between the health needs of the rural population of our country and the resources as available to meet them. In reality, it combines the good features of modern system of medicine with the system

of providing minimum of health services through part-time self-employed persons drawn from the community itself.

It may be indicated that introduction of the CHWs in the rural areas is not expected to replace the existing and proposed system of the delivery of health services to the rural population. These workers on the other hand are expected to supplement the activities of health workers in the way that they will create an agency which is close to the people and would create a pattern of medical and health services which are qualitatively better and remain within the financial resources of the country which are likely to be available in the near future. ○

1979

INTERNATIONAL YEAR OF THE CHILD

On December 21, 1976, the General Assembly, having considered the recommendation of the Economic and Social Council of the United Nations and the two reports of the Secretary General, passed by consensus resolution 31/169 proclaiming 1979 the 'International Year of the Child'.

General Objectives of the IYC

(a) "To provide a framework for advocacy on behalf of children and for enhancing the awareness of the special needs of children on the part of decision-makers and the public.

(b) To promote recognition of the fact that programmes for children should be an integral part of economic and social development plans, with a view to achieving, in both the long-term and the short-term, sustained activities for the benefit of children at the national and international levels."

Meaning of these Objectives

The following points make explicit some of the premises underlying the general objectives:

(a) The Resolution is addressed to all countries. Therefore IYC is concerned with children in both industrialized and developing countries. Governments have to decide how they wish to respond to the Resolution and how they wish to "participate in the year", "participating countries" or "participating organisations".

(b) The special needs of children do not arise only out of their right to develop optimally in the physical sphere. They arise also out of their need to develop their full potential psychologically, intellectually, morally, socially and culturally.

(c) The special needs of children include defining and safeguarding their rights, especially as set out in the declaration of the Rights of the Child.

(d) Advocacy includes the spread of education and awareness of the special needs and potentials of children to families, communities, decision-makers at all levels, and to those responsible for services to children. It also includes awareness of new or expanded actions to improve the situation of children.

(e) "Sustained activities" need to be used on a commitment to children at the national and international levels beyond the Year itself, deep and persistent enough to produce necessary progress over the courses of the long-range future.