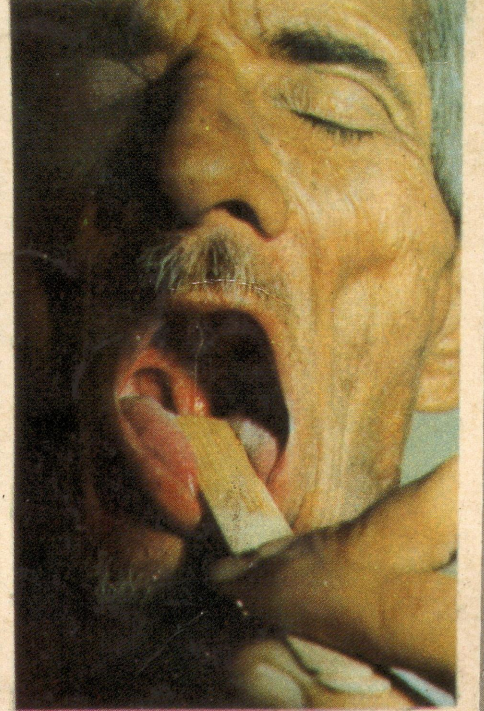
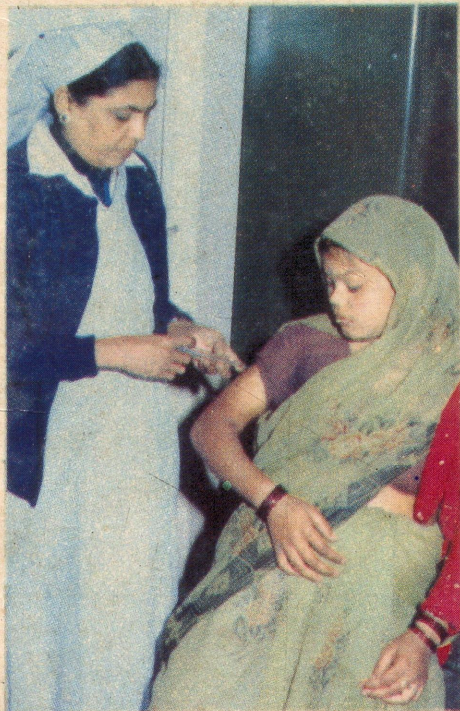
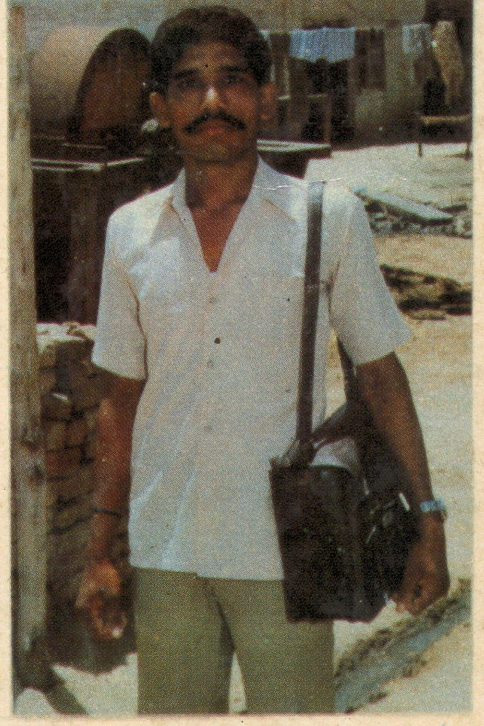
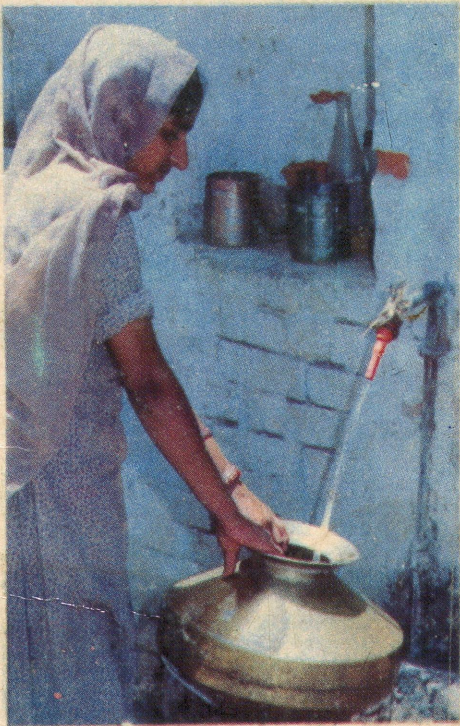


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HEALTH PROGRESS IN INDIA

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OBJECTIVES

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

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

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

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

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

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

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Editorial and Business Offices

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

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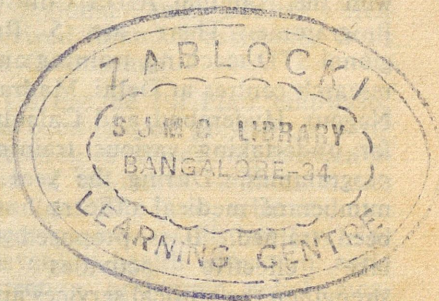
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HEALTH PROGRESS

—1993-94

M.S. DAYAL
SECRETARY (HEALTH)

Ministry of Health & Family Welfare



The public expenditure in the health sector both Centre and States put together has been a little over 1.5% of GDP. The WHO had recommended that public health care expenditure should gross at least 5% of GDP if equity and universal coverage are to be realised. The plan outlay for the central health sector in 1993-94 is Rs. 483.30 crore which is a marginal increase against the previous year's outlay of Rs. 447 crore.

THE health problems being faced by us are highly complex and challenging. While we are still struggling to meet the health hazards of communicable diseases like leprosy, TB and malaria, we also have to now cope with the challenge of post transitional diseases like cardiovascular and cancer. On top of all these, we have to reckon with the horrendous implications of AIDS. The complexity of the health problems is further aggravated by widespread poverty leading to malnutrition, unhygienic sanitation, illiteracy and ignorance; these negative forces are reinforced by the rate at which our large population is growing.

While the health problems are indeed complex and daunting, the importance of the state of health of our people can scarcely be over-emphasised. As a matter of fact, the ultimate objective of all socio-economic development is to bring about a meaningful and sustained improvement in the well-being and welfare of the people and there is no better index of the well being of a people than the state of their health.

The public expenditure in the health sector both Centre and States put together has been a little over 1.5% of GDP. The WHO had recommended that public health care expenditure should gross at least 5% of GDP if equity and universal coverage are to be realised. The plan outlay for the central health sector in 1993-94 is Rs. 483.30 crore which is a marginal increase against the previous year's outlay of Rs. 447 crore.

National AIDS Control Programme: Realising the gravity of epidemiological situation of HIV prevailing in the country, the Government of India has launched a comprehensive scheme at an estimated cost of Rs. 220 to Rs. 222.6 crore during the 8th plan with assistance from the World Bank to the tune of US \$ 84 million and another US \$ 1.5 million from WHO. The World Bank loan became effective from September, 1992.

With the objective to arrest the HIV/AIDS infections in the country and to reduce the future morbidity, mortality and infection of AIDS, the Ministry of Health and

Family Welfare has set up a National AIDS Control Organisation as a separate wing to effectively implement and closely monitor the various components of the Programme. The National AIDS control Programme envisages the planning, counselling, implementing and monitoring of the various activities of the Project, carry out an intensive public awareness and community support campaign through mass media and sustained dissemination of information and health education about HIV and AIDS, upgradation of the blood banking capabilities in the public sector and expansion of HIV screening of all blood used for transfusing and blood-products in the country, strengthening of the institutional capabilities at the State/UT level for monitoring of HIV and AIDS epidemic planning and programming interventions to control such epidemic and strengthening the clinical services and case management activities in STD centres.

National Sexually Transmitted Disease Control Programme (STD): Recognising STD as one of the major factors for transmission

of HIV infection, the National STD Control Programme has merged with the National AIDS Control Programme. There are 5 Regional STD teaching, training and research centres at Delhi, Madras, Nagpur, Hyderabad and Calcutta for undertaking various training programmes. During the year a number of medical officers have been trained. It is proposed to take effective activities to strengthen the clinical services and case management activities in STD centres in 97 medical colleges (including 5 Regional STD Centres) and 275 District level STD clinics.

Blood Safety Programme: A scheme on prevention of infection and strengthening of Blood Banking System in the country has been under implementation since 1989 under which State Governments were provided assistance for setting up to testing facilities including HIV in the Blood Banks, strengthening and modernisation of State managed blood banks and development of manpower and rational use of blood.

Under the Blood Safety Programme, it is proposed to upgrade all the 608 State managed blood banks in the country. During 1992-93, assistance has been given for modernising 90 blood banks under the World Bank assisted National AIDS Control Programme, while 138 blood banks were upgraded till March, 1992. The remaining 380 blood banks are proposed to be taken up for upgradation in a phased manner during the 8th Plan period. During the year 1993-94, 100 blood banks are being upgraded. 10 Training institutions have been operationalised at regional level for training of Doctors and technicians working in the blood banks. The rules under the Drugs and Cosmetics Act have been made more stringent providing for mandatory testing of blood for blood transmissible diseases including HIV and the approval of licence by

the licence approving authorities has been made compulsory. It also provides that the whole human blood and components shall conform to standards as prescribed under the Indian Pharmacopoeia.

National Malaria Eradication Programme: The organised public health programme to control malaria was launched in India in the year 1953. The number of confirmed malaria cases increased during 1976 which necessitated renewed vigorous anti-malarial activities and modification in the existing strategies. With the implementation of the Modified Plan of Operation (MPO) which was based on a two-tier stratification, the total malaria cases decreased from 6.47 million in 1976 to 2.18 million cases in 1984. However, since then the malaria situation in the country has remained more or less static (contained) around two million cases a year.

The NMEP is category II Centrally Sponsored Scheme on 50:50 sharing basis between the Centre and the State. The budget provision and estimated expenditure under the 50% central share which is in the form of drugs and insecticides during 1993-94 is to the tune of Rs. 11000 lakh.

In view of the persistent transmission of malaria in the seven North-Eastern States which are almost inhabited by tribal population, a plan to provide 100% central assistance for the control of malaria is being worked out. The Urban Malaria Scheme came into effect in 1971 with the objective to control malaria by reducing the vector population in the urban areas through recurrent Anti-larval measures. The Scheme was sanctioned in 181 towns distributed in 18 States and 2 Union Territories. It has so far been implemented in 128 towns.

National Filariasis Control Programme: Filariasis is a major public

health problem in many States of the country and about 396 million people are estimated to be living in 175 known endemic districts of which about 109 million are in urban areas. The National Filariasis Control Programme which was launched in 1955, provides for delimitation of the problem in hitherto unsurveyed areas, control in urban areas through recurrent antilarval measures and antiparasitic measures. There are 206 control units and 195 clinics giving treatment with Diethylcarbamazine to clinical cases and microfilaria carriers.

Kala Azar: Kala Azar is a serious public health problem in Bihar and West Bengal. About 30 districts of Bihar and 9 districts of West Bengal are affected by Kala Azar. The increasing trend of the disease is evident from the fact that the total number of cases which were 17806 with 72 deaths in 1986, rose to a total of 77101 cases with 1419 deaths in 1992. However, this trend has been arrested in 1993 with total number of 26752 cases with 439 deaths reported till July 1993.

Assistance in terms of cash as well as kind has been provided during the last three years. In 1992-93, about Rs. 20 crore worth of assistance in kind has been given to Bihar and West Bengal. Material assistance included the insecticides, DDT and the imported drug Pentamidine Isthionate.

Japanese Encephalitis: This disease is caused by a minute virus and manifests as high fever, convulsions, stiffness of the neck and coma etc. The death rate due to the disease is very high and those who survive do so with various degrees of neurological complications. Of late this disease has become a major public health problem and has been reported for 24 States/UTs. As against 4071 cases with 1530 deaths in 1991, 2432 cases with 888 deaths in 1992, cases reported till September 1993 were 189 with 126 deaths.

National Programme for Control of Blindness: The approach under the NPCB consists of intensive health education for eye care through the mass media and extension education methods; extension of ophthalmic services in the rural areas through mobile units and eye camps and establishment of permanent infrastructure for eye health care as an integral part of general health services.

It has been estimated that there is an annual incidence of 2 million cataract induced blindness in the country. At the rate of 1.5 million cataract operations annually, we are adding to the backlog rather than reducing it. In order to strengthen the Programme and to reduce the backlog of blindness, it has been decided to establish District Blindness Control Societies (DBCSS) under the Chairmanship of the District Collector. So far 267 DBCSSs have been formed. A sum of Rs. 6 crore at the rate of Rs. 3 lakh each has already been released to 200 of these DBCSSs to make them financially and operationally autonomous. Under the Programme, the equipments and vehicles are also provided to District Mobile Units and Primary Health Centres. The NPCB is being assisted by the Royal Danish Government. The Phase-II of the assistance spans the period 1989-96 and so far a sum of Rs. 3.86 crore has been reimbursed by the DANIDA to NPCB on the basis of actual expenditure incurred by the various State Governments on stipulated components of NPCB.

The World Bank has been approached for Rs. 554 crore assistance for an intensive blindness control programme in the seven States of Tamil Nadu, Andhra Pradesh, Maharashtra, M.P., U.P., Rajasthan and Orissa. One of the strategies of the project is the formation of District Blindness Control Societies in all districts of the Project States and to make them financially and operationally autonomous. Dedicated eye care infrastructure is proposed to be created and strengthened in the District Hospitals and selected sub-divisional Hospitals. Medical colleges are also proposed to be upgraded with the modern ophthalmic equipment and provision of special-

ised training to the faculty members to perform IOL surgery.

National Iodine Deficiency Disorders Control Programme: Iodine is one of the essential elements for human growth and development. The spectrum of Iodine Deficiency Disorders affects each and every stage of life from foetus to adult. It is estimated that in India alone, more than 54.3 million people are suffering from endemic Goitre and about 8.8 million from different grades of mental/motor handicaps. The surveys conducted indicate that out of 235 districts surveyed, IDD is a major public health problem in 193 districts. Goitre is not restricted only to the Himalayan belt of India but also widely prevalent in the plain, plateau, riverine areas and near the sea coast.

The achievement of the programme so far has been that 23 States/UTs have completely banned the use of salt other than Iodised salt while another 6 States have banned partially in the endemic areas only. The Chief Ministers of remaining States have been requested to urgently issue notification banning the use of salt other than iodised salt. Testing kits for on the spot qualitative testing have been developed in collaboration with UNICEF and they were distributed to all the District Health Officers in endemic States for regular monitoring. 23 States/UTs have set up Iodine Deficiency Disorder Control Cells to ensure effective implementation of the Programme. It has been proposed to set up the monitoring labs in the States of Arunachal Pradesh, Assam, Gujarat, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, Sikkim, U.P. and West Bengal. A tentative allocation of Rs. 75,000/- per lab has been provided for this purpose.

National Cancer Control Programme: The Government of India started the Cancer Control Programme in a limited form during the year 1975-76 when central assistance at the rate of Rs. 2.5 lakh was provided to institutions for purchase of Cobalt Therapy Units for treatment of cancer patients. This Scheme continued during the 6th and 7th Plan period with the

increase of rate of assistance to Rs. 12.00 lakh. At the same time, ten major institutions were recognised as Regional Cancer Centres which received financial assistance from the Government.

During the 8th Plan, emphasis, has been laid on prevention, early detection of cancer and augmentation of treatment facilities in the country. The new scheme envisages projects at district level for preventive health education, early detection and pain relief measures. Under the scheme, financial assistance of Rs. 15.00 lakh is provided to the concerned State Government for each district project selected under the scheme with a provision of Rs. 10.00 lakh per year for each district for the remaining four years of the project period. During the years 1990-91 to 1992-93, 17 district projects have been undertaken in Gujarat, Karnataka, Madhya Pradesh, Kerala, Orissa, Punjab, Tamil Nadu and West Bengal. Financial assistance upto Rs. 1 crore (in phases) is provided to the State Government for development of Oncology Wings in the medical colleges/hospitals and for purchase of equipments which includes Cobalt Unit. So far financial assistance has been provided for development of Oncology Wings in 16 Medical Colleges/Hospitals in the country. Financial assistance upto Rs. 5.00 lakh is also provided to the registered voluntary organisations for the purpose of undertaking health education and early detection activities in cancer. So far 15 voluntary organisations have been provided the assistance under the scheme.

National Mental Health Programme: The National Mental Health Programme was launched by the Ministry with a view to ensure availability of mental health care services for all specially the community at risk and under-privileged section of the population. 11 institutions have been identified for training of health workers under the programme. This training will consist of basic knowledge on mental health to the Primary Health Care physicians and paramedical personnel. During 1993-94, Rs. 18 lakh have been allocated for this programme.

National Leprosy Eradication Programme: India ranks foremost among the countries saddled with the burden of leprosy sufferers. Out of 2.7 million cases of leprosy in the world, 1.3 million are estimated to be found in India (1993). At the time of the launching of National Leprosy Eradication Programme in 1983, the disease was highly prevalent in the States/UTs of Tamil Nadu, Andhra Pradesh, Lakshadweep, Pondicherry, West Bengal, Maharashtra, Karnataka, Bihar, Nagaland, Sikkim, Andaman & Nicobar. Now the problem of leprosy has been reduced in many of these States.

The National Leprosy Eradication Programme was started in 1983 with the objective to arrest transmission of disease by the year 2000 A.D. The programme provides for the provision of domiciliary multi-drug treatment coverage in 135 districts having problem of 5 or more cases per 1000 population and introduction of MDT services through existing general health care services in the low endemic districts. Currently about 60% of leprosy patients are getting the benefit of MDT in the country. Available information indicates that MDT is well accepted by the patients, the tolerance is good and side effects are minimum. There is marked reduction of over 90% in the prevalence rate in the 40 districts which have completed MDT of 5 years or more. MDT coverage has been expanded to all the 201 endemic districts which includes 135 districts on vertical pattern and 66 on modified pattern. During the 8th Plan, it is proposed to provide MDT coverage to all the districts with endemicity of 2 to 4.9 per 1000 population on Modified Pattern and MDT services will also be extended through primary health care in other low endemic districts.

A comprehensive proposal for financial assistance of Rs. 302 crore has been agreed to by the World Bank in order to spread MDT in the uncovered areas and to further intensify efforts for reduction of Leprosy. World Bank assistance would also be utilised for strengthening the monitoring information system and to embark on deformity care and rehabilitation programme.

National T.B. Control Programme: Tuberculosis continues to be a major public health problem in the country with an estimated 1.5% of the population suffering from Radiologically active Tuberculosis and with about 1/4th of the cases being sputum positive or infectious. It is estimated that there are 5 lakh deaths annually on account of this disease while a similar number of persons achieve cure.

A joint evaluation of the TB Programme by the Government of India, WHO and SIDA revealed that it was necessary to shift the emphasis from monitoring, detection and treatment to monitoring of the number of cases cured, to bring TB effectively under control. Case holding and monitoring for cure is beset with difficulties on account of need to follow-up patients for a long period of 18 months in the case of conventional therapy and 6 to 8 months in the case of short course chemotherapy. Often patients tend to stop taking drugs when the symptoms of the disease disappear initially.

In order to reduce the burden of disease in a medium term perspective, it is estimated that about 10 lakh sputum positive cases need to be treated and cured each year. The cost of drugs alone for ensuring such coverage would amount to Rs. 150 crore per year. Added to this would be the cost of strengthening the organisational structure in the Centre, State and districts for introducing effective supervised

administration of drugs. Although the central Plan outlay has been enhanced to a level of Rs. 35 crore in 1993-94 from Rs. 28 crore in 1992-93, it is not considered practicable to avail further enhanced outlays without external assistance. A project proposal has, therefore, been made for obtaining World Bank financial assistance based on short-term course chemotherapy for sputum positive cases while the non-infectious cases continues to be on cheaper conventional therapy.

Indian Systems of Medicine: A lot of concern has been expressed about over exploitation of Medicinal Plants as a result of which rare species are facing extinction. Ministry took initiative in calling a meeting which was presided over by Deputy Minister of Health wherein Secretary, Environment and representatives of CSIR and ICMR participated. A Task Force has been constituted for promotion, development and appropriate exploitation of medicinal plants under the Chairmanship of Secretary, Ministry of Environment.

International Health: Government of India is assisting the Government of Nepal to establish the BP Koirala Institute of Medical Sciences in Dharan. The Post-graduate training requirements of Nepalese MBBS students year-wise and discipline wise has been worked out. 7 Nepalese students are being imparted training in Indian institutions in the current year itself.

The Department of Health has been performing the agency role for the Ministry of External Affairs in connection with the establishment of Indira Gandhi Memorial Hospital at Male.

A Protocol was signed with the Government of Russia on 16th September, 1993 at St. Petersburg in which 13 areas were identified for mutual cooperation.

—Excerpts from the Introduction to the Annual Report of the Ministry of Health and Family Welfare for 1993-94. □

NATIONAL HEALTH PROGRAMMES

The Centre takes concerted measures to combat communicable, non-communicable and other major diseases. For this purpose, several National Health Programmes are directly run by the Ministry which can have a bearing in the reduction of mortality and morbidity and also have a salutary effect on efforts to improve the quality of life of the common man. These programmes also reinforce the delivery of primary, secondary and tertiary health care throughout the country. Here we detail the progress made in the conduct of these programmes during the year 1993-94.

National Malaria Eradication Programme

Control Strategy: Case detection and prompt treatment are emphasised so as to reduce the parasite load in the community. Blood slides are collected through Active and Passive Agencies and presumptive treatment is given. All positive cases are given appropriate radical treatment.

Selective and judicious insecticidal spray is done in areas registering an API of 2 and above in the preceding three years. In other areas, focal spray and surveillance are carried out. During 1993-94 about 160 million people were projected for being covered by spraying.

In urban areas, anti-larval measures are in the form of recurrent weekly larviciding with chemicals including Temephos, Fenthion, MLO, Parisgreen. Source reduction as well as other bio-environmental measures are being applied wherever feasible to control the breeding of mosquito vectors.

Malariogenic stratification to prioritize endemic areas into high, medium and low risk areas is being undertaken. This exercise has been completed first in Karnataka, and has been in operation since 1991. During 1993-94, revised strategies based on stratification have been launched in Maharashtra, Gujarat and Rajasthan.

Health Education to awaken the community and seek their active

involvement and cooperation in dealing with disease control is being undertaken.

Budget: The NMEP is a category II Centrally Sponsored Scheme on 50:50 sharing basis between the Centre and the States. The budget provision and estimated expenditure under the 50% central share which is in the form of drugs and insecticides is given below.

BUDGET AND EXPENDITURE

Year	Budget Provisions	Actual Estimated Expenditure (Rs. in lakh)
1985-86	8868.00	8856.91
1986-87	8500.00	7815.14
1987-88	8200.00	8456.98
1988-89	8300.00	8750.00
1989-90	8900.00	8862.17
1990-91	8200.00	7660.45
1991-92	8960.00 (final)	8793.04
1992-93	9700.00	9800.14
1993-94	11000.00	

Tribal Areas: In view of the persistent transmission of malaria, in the seven North-Eastern States which are almost entirely inhabited by tribal population, a plan to provide 100% Central assistance for the control of malaria is being worked out.

As about 30% of the total malaria cases and about 50% of the *P. falciparum* cases are reported from the tribal areas of the country, comprising about 44.5 million population of Andhra Pradesh, Madhya Pradesh, Gujarat, Maharashtra, Bihar, Rajasthan and Orissa, a proposal to provide 100% assistance for the control of malaria in these areas is being initiated for posing to the World Bank in due course for funding.

Control of Malaria in Urban Areas: The Urban Malaria Scheme (UMS) came into effect in 1971 with the objective to control malaria by reducing the vector population in the urban areas through recurrent anti-larval measures. Though the scheme was sanctioned in 181 towns distributed in 18 States and 2 Union Territories, it has so far been implemented in 128 towns. About two lakh cases of Malaria were recorded in 120 towns in 1992. It is observed that 120 towns from where comparative data was available, 62 showed a decrease while 58 showed an increase in malaria cases in 1992 as compared to 1991. The metropolitan cities of Delhi, Calcutta, Bombay and Madras recorded 12331, 17893, 11879 and 48447 cases of malaria respectively during 1992 compared to 8491, 13354, 5334 and 66,937 during 1991.

Kala-Azar

In view of the growing problem, planned control measures were initiated to contain Kala-Azar.

Until 1990-91 the assistance for the Kala-Azar Control was being provided by the Govt. of India out of the National Malaria Eradication Programme budget provision. However, specific funds to the tune of Rs. 4.06 crore were made available during 1990-91 for the control of Kala-Azar. Since then, the Govt. of India has considerably enhanced the inputs to Rs. 15.38 crore in 1990-91. During 1992-93, Rs. 20.00 crore were provided against the Annual Plan outlay of Rs. 15.00 crore. For 1993-94 a provision of Rs. 20.00 crore has been approved in the Annual Plan.

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

- (i) Interruption of transmission for reducing vector population by undertaking indoor residual insecticidal spray twice annually;
- (ii) Early diagnosis and complete treatment of Kala-Azar cases; and
- (iii) Health Education for community awareness.

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

Assistance Provided by the Government of India: Assistance in terms

of cash as well as kind has been provided during the last three years. In 1992-93, about Rs. 20 crore worth of assistance in kind has been given to Bihar and West Bengal. Material assistance included the insecticides DDT and the imported drug Pentamidine Isethionate.

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

National Filaria Control Programme

The National Filaria Control Programme was launched in 1955. Under the Programme the following activities are undertaken:

- (i) Delimitation of the problem in hitherto unsurveyed areas; and
- (ii) Control in urban areas through recurrent anti-larval measures and anti-parasitic measures.

There are 206 control units and 195 clinics giving treatment with Diethylcarbamazine to clinical cases and microfilaria carriers.

Japanese Encephalitis

This disease is spread by mosquitoes which usually breed in rice fields and swampy and marshy areas.

Strategies for Control: Major activities to control Japanese Encephalitis include:

- (i) Care of the patients;
- (ii) Development of a safe and standard indigenous vaccine;

- (iii) Sentinel surveillance including clinical surveillance of suspected cases;
 - (iv) Studies to identify the high risk groups by measuring the blood level of antibodies; and
 - (v) Epidemiological monitoring of the disease for effective implementation of prevention and control strategies.
- (c) Introduction of MDT services through existing general health care services in the low endemic districts. Treatment with combination of drugs include treatment with 3 drug viz. Rifampicin, Clofazimine and Dapsone. Education of the patients and the community about the curability of disease and their socio-economic rehabilitation are other two key components of the control strategy.

National Leprosy Eradication Programme

Problem: The disease is widely spread all over the country. The prevalence rate of leprosy exists above 5 per 1000 population in 201 districts out of 468 districts of the country. About 15% of the leprosy sufferers are children below 14 years of age. The proportion of infectious cases varies from 15 to 20% and equal number of patients suffer from deformities.

Programme Objectives: The Government of India launched National Leprosy Eradication Programme in 1983 with the objective to arrest the transmission of the disease by 2000 AD. It is a 100% Centrally Sponsored Programme.

Strategies: The adopted strategy under the programme involves:

- (a) Provision of domiciliary multi-drug treatment coverage in 135 districts having problem of 5 or more cases per 1000 population, by specially trained staff in leprosy;
- (b) Shifting of 66 endemic districts on Modified MDT pattern to regular vertical pattern; and

Infrastructure: Over the years, a vast infrastructure of leprosy workers has been developed in the country, specially trained for providing leprosy services. In the endemic rural areas, these services fan out from Leprosy Control Units (one for 0.4 to 0.5 million population) while its urban counterpart called Urban Leprosy Centre caters to a population of about 30 to 40 thousand. Temporary hospitalization ward having 20 bed capacity has been established, at least one in each endemic district to render hospitalization services. Under the Programme, 49 Leprosy Training Centres are engaged in providing training to various categories of health workers in leprosy. Following infrastructure exists at the end of March, 1993. Leprosy Control Unit-758, Urban Leprosy Centre-900, Survey Education and Treatment Centre-6097, Temporary Hospitalization Ward-291, District Leprosy Unit-285, Leprosy Training Centre-49, Reconstructive Surgery Unit-75, Leprosy Rehabilitation and Promotion Unit-13, Sample Survey cum Assessment Unit-39.

Infrastructure thus created has been predominantly established by the State in the endemic districts. In the district with

endemicity of less than 5/1000 population, the general health care provide the services. However, there are still gaps in the 66 endemic districts due to financial constraints. To extend the benefit of MDT to over 7 million patients living in these 66 districts, Government of India sanctioned a modified MDT approach in these districts from January, 1991. This modified approach include the involvement of PHC in the delivery of services to leprosy patients. Now all these 66 districts are proposed to be covered on regular vertical pattern of MDT scheme, 18 such districts have already been sanctioned vertical MDT scheme.

Achievements: Currently about 60% of leprosy patients are getting the benefit of Multi Drug Therapy in the country. Available information indicates that MDT is well accepted by the patients, the tolerance is good and side effects are minimum. There is marked reduction of over 90% in the prevalence rate in the 40 districts which have completed MDT of 5 years or more. MDT coverage has been expanded to all the 201 endemic districts which includes 135 districts on vertical pattern and 66 on modified pattern.

Target & Achievement in 1992-93: During the year 1992-93 against the target of 289600 for new case detection and treatment, a total of 547686 new cases have been detected out of which 541078 cases have been put under treatment.

The target for cases discharged was 573900 during 1992-93 against which 1052823 cases have been discharged.

The objectives of target allocated for 1993-94 consists of 265200 cases for detection and treatment and 525300 for case discharge. The expenditure of 1992-93 was Rs. 3338 lakh and for 1993-94 the BE allocated is Rs. 3380 lakh.

YEAR-WISE PERFORMANCE OF TARGETS DURING SEVENTH PLAN ARE INDICATED BELOW

(Figures in Lakh)

Year	Case Detection		Case Treatment		Case Discharge	
	Target	Achievement	Target	Achievement	Target	Achievement
1985-86	3.82	4.77	3.82	4.56	3.75	4.46
1986-87	4.20	5.08	4.20	4.90	4.30	5.07
1987-88	4.20	5.19	4.20	4.99	5.03	5.75
1988-89	3.90	4.75	3.90	4.65	5.94	6.01
1989-90	3.50	4.67	3.50	4.62	6.55	6.69
Total						
(7th Plan)	19.62	24.46	19.62	23.72	25.57	27.98
1990-91	3.69	4.82	3.69	4.74	8.81	9.85
1991-92	3.35	5.13	3.35	5.10	6.12	8.26
1992-93	2.89	5.48	2.89	5.41	5.74	10.53

The target allotted for 1993-94 is 2.65 lakh cases for detection and treatment and 5.25 lakh cases for discharge.

8th Plan : During the 8th Plan it is proposed to provide MDT coverage to all the districts with endemicity of 2 to 4.9 per 1000 population on modified pattern and MDT services will also be extended through Primary Health Care in other low endemic districts.

World Bank Assistance : To spread the MDT coverage to uncovered areas and to further intensify the efforts, the Government have sent a comprehensive proposal to World Bank for financial assistance of Rs. 302 crore which has been agreed by them. In the proposed World Bank Project, it is envisaged to provide the leprosy services with separate workers in the 66 remaining endemic districts. The 77 moderately endemic districts would be taken up for introducing the Modified MDT Programme. MDT will also be extended in the endemic pockets of all low endemic districts on modified pattern. The monitoring information system would be strengthened

and a foundation laid to embark on deformity care and rehabilitation programme.

National T.B. Control Programme

Tuberculosis continues to be a major public health problem in the country with an estimated 1.5% of the population suffering from Radiologically active Tuberculosis and with about 1/4th of the cases being Sputum positive or infectious. It is estimated that there are 5 lakh deaths annually on account of this disease, while a similar number of persons achieve cure. This is balanced by an addition of one million Sputum positive cases annually.

District TB Centres have been established in 390 out of 459 districts in the country for supervising the programme of TB Control in these districts. These are meant to provide necessary support to Primary Health Centres and other peripheral institutions

engaged in TB Control in terms of drugs, consumable, training and supervision. They are also responsible for monitoring progress. At the State level, State TB Control Officers working under the Directors of Health Services are responsible for coordination of efforts and they in turn are supported at the Central level by a Cell in the Directorate General of Health Services which looks after the TB Control. This cell has been upgraded in 1993-94 and is headed now by a Deputy Director General. TB training and demonstration centres have been established in many States to undertake basic training of medical and para-medical personnel. The National TB Institute carries out training of all district level functionaries.

Although, around 47,000 beds are available for treatment of seriously sick TB patients, the emphasis in TB control, however, has now been shifted to ambulatory treatment; and conventional therapy lasting about 18 months is

being gradually replaced by short course chemotherapy, (for the sputum positive cases) which lasts only 6 to 8 months.

The Conventional Therapy is based on treatment with INH and Thiacetazone while short course chemotherapy consists of an intensive multi-drug phase involving Rifampicin, Pyrazinamide, Ethambutol and INH generally lasting 2 to 3 months followed by a maintenance phase of INH/Rifampicin lasting 4 to 5 months. While acute symptoms of disease generally disappear within a month of start of multi-drug therapy, more time is required to achieve a non-infectious or sputum negative status and the full course of 6 months or so is important from the point of ensuring complete cure with avoidance of the possibility of relapse.

Anti-TB drugs for free treatment are being supplied to the TB clinics run by the State Governments through a Centrally Sponsored Scheme with 50% of the cost being borne by the Central Government and 50% by the States. 100% grants-in-aid is given for supply of materials, equipments and drugs for the programme in Union Territories, as well as in the case of grants to certain voluntary bodies.

Often patients tend to stop taking drugs when the symptoms of the disease disappear initially. This may be on account of work and social pressures, ignorance or inability/unwillingness to complete the full course of treatment. The drugs alone would cost around Rs. 1500 per patient in case of short course chemotherapy. Non-availability of drugs in peripheral health institutions would also lead to stoppage of treatment. In other countries of the world emphasis is being laid on supervision of drug administration in the 2 month intensive phase of short course chemotherapy.

A project proposal has been made for obtaining World Bank Assistance for TB Control Project based on short course chemotherapy for sputum positive cases while the non-infectious cases continue to be on cheaper conventional therapy. Pilot Projects based on this new strategy are proposed to be implemented in 5 States namely, Bihar, Gujarat, Himachal Pradesh, Kerala and West Bengal and 6 metropolitan cities, Bombay, Calcutta, Hyderabad, Madras, Bangalore and Delhi in order to test and obtain experience with the proposed new strategy. This is being initially done with SIDA assistance. It is proposed to extend coverage of these Pilot Projects after gaining further experience and building of the necessary expertise. The proposed Pilot Project has been initiated in 3 cities viz. Gujarat, Delhi and Bombay.

So far the stress in the National TB Control Programme has been on detection and since this has not helped significantly in the reduction of the disease, the new project has, therefore, a revised strategy. However, during 1992-93, there were 15.39 lakh new TB cases detected against a target of 17.50 lakh. In the current year (1993-94) about 3.63 lakh cases have been detected against the annual target of 18 lakh till July, 1993. The budget allocation for 1993-94 has been raised to Rs. 35 crore from Rs. 28 crore in 1992-93. The amount allocated in the budget is mostly used for the procurement of drugs.

National Programme for Control of Blindness

The National Programme for Control of Blindness was launched in the year 1976 as a 100% centrally sponsored programme. The approach under the NPCB, consists of intensive health education for eye care

through the mass media and extension education methods; extension of ophthalmic services in the rural areas through mobile units and eye camps and establishment of permanent infrastructure for eye health care as an integral part of general health services.

The budgetary allocations for NPCB have been as follows:

Year	Rs. in crore
1991-92	9.70
1992-93	20.00
1993-94	25.00

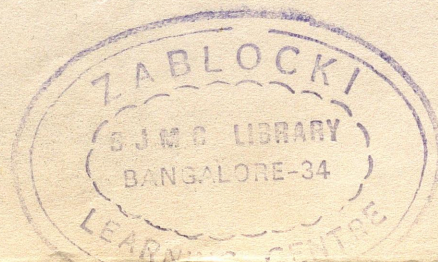
The infrastructure developed so far and the targets for the same for the year 1993-94 are as follows:

	Target for 1993-94
Regional Institutes of Ophthalmology	10
Upgradation of Medical Colleges	60 8
Upgradation of Distt. Hospitals	402 21
Estt. of DBCS	267 200
Central Mobile Units	76
Development of Distt. Mobile Units	162 27
Upgradation of PHCs	4096 413

The State Governments have to send proposals in respect of these items.

As a result of the programme the number of cataract operations has gone up from a level of 5.5 lakh cataract operations in 1981-82 to 1.6 million operations in the year 1992-93. The target for the year 1993-94 is 24.30 lakh cataract operations.

Voluntary Organisations have played a very significant role in this programme. They have been



active in providing Eye Health Education, Preventive, Rehabilitative and Surgical Services for Control of Blindness.

The Need to Step up the Programme: The NPCB-WHO Survey (1986-89) has shown that there is a backlog of 22 million blind eyes or 12 million cases of blindness. Out of this 80.1% is on account of cataract.

It has also been estimated that there is an annual incidence of 2 million cataract induced blindness in the country. At the rate of 1.5 million cataract operations annually we are adding to the backlog rather than reducing it. As such the programme needs to be strengthened considerably if we have to reduce the backlog of blindness.

Steps Taken: It has been decided to establish District Blindness Control Societies (DBCSs) under the Charimanship of the District Collector. The structure of the DBCS is:

Chairman : District Collector
Members : Chief Medical Officer
District Ophthalmic Surgeon
District Education Officer

Nominated members (from NGOs, Private Sector)

Member Sec- District Blindness
retary : Coordinator

So far, 267 DBCSs have been formed. A sum of Rs. 6 crore @ Rs. 3 lakh each has already been released to 200 of these DBCSs to make them financially and operationally autonomous. The first Orientation Workshop for District Collectors was held in Delhi to orient the District Collectors in the functioning of DBCSs. Steps have also been initiated to train the District Blindness Control Coordinators to enable them to effectively run the DBCSs.

The purchase of equipment and vehicles meant for the District Mobile Units and Primary Health Centres is now being done centrally and the assignment is also being done accordingly. 85 vehicles were procured and distributed centrally for the various Mobile Eye Care Units in the country. Simultaneously the process of central procurement and distribution of Ophthalmic Equipment has also been taken on hand.

Danish Assistance for NPCB: The National Programme for Control of Blindness is being assisted by the Royal Danish Government. The Phase-II of the assistance spans the period 1989-96. So far a sum of Rs. 3.86 crore has been reimbursed by DANIDA to NPCB on the basis of actual expenditure incurred by the various State Governments on stipulated components of NPCB. DANIDA had also taken up 5 Pilot Districts for implementation of NPCB through the formation of District Blindness Control Societies in each of three districts. The performance in cataract surgery has gone up by 2 to 300% with the formation of DBCSs in these pilot districts. Encouraged with this success and on the basis of the recommendations of the Mid-Term Review Report DANIDA has now taken up the entire state of Karnataka for replication of the model for Control of Blindness developed in the 5 Pilot Districts.

World Bank Project for Control of Blindness: The World Bank has been approached for a Rs. 550 crore assistance for a intensive Blindness Control Programme in the Seven States of Tamil Nadu, Andhra Pradesh, Maharashtra, Madhya Pradesh, Uttar Pradesh, Rajasthan and Orissa. As per the NPCB-WHO Survey (1986-89) these seven States have the highest prevalence of blindness after the State of Jammu & Kashmir. One of the strategies of the Project is the formation of District Blindness Control Societies in all districts of the

project States and to make them financially and operationally autonomous. Dedicated Eye Care infrastructure is proposed to be created and strengthened in the District Hospitals and selected subdivisional hospitals. Medical Colleges are also proposed to be upgraded with the modern ophthalmic equipment and provision of specialized training to the faculty members to perform IOL Surgery. Ophthalmic Staff is proposed to be trained under the programme to provide quality Eye Care Services. The project envisages the involvement of NGOs and the use of modern monitoring systems to keep stock of the performance.

National Iodine Deficiency Disorders Control Programme

Iodine is one of the essential elements for human growth and development. Due to various factors there has been iodine depletion of the soil, as a result of which an average balanced diet and water does not take care of the total daily iodine requirement of 150 micrograms. Earlier only goitre was associated with Iodine deficiency. It is now well established that goitre is only "a tip of the iceberg" of the manifestations of Iodine Deficiency Disorders (IDD). The spectrum of Iodine Deficiency Disorders affects each and every stage of life from foetus to adult.

The National Iodine Deficiency Control Programme (NIDDCP) is the new name given to the erstwhile National Goitre Control Programme. The title has been changed in view of the wide spectrum of Iodine Deficiency Disorders like mental and physical retardation, deaf-mutis, cretinism, high rate of abortion etc., and the Government's commitment to overcome all other Iodine Deficiency Disorders apart from Goitre through Universal Iodisation of Salt.

Achievements: The achievements made under the Programme from its inception to date are as under:

- (i) 641 private manufacturers have been licensed by the Salt Commissioner, out of which nearly 532 units have commenced production so far;
- (ii) Annual production of iodised salt has been raised from 5.0 lakh Mt in 1985-86 to 26.0 lakh Mt in 1991-92 and in 1992-93, the production was 28.34 lakh Mt. This is expected to be further raised to 50.00 lakh MT in near future;
- (iii) 23 States/UTs have completely banned the use of salt other than Iodised Salt while another 6 States have banned partially in the endemic areas only;
- (iv) Testing Kits for on the spot qualitative testing have been developed in collaboration with UNICEF and they were distributed to all the District Health Officers in endemic State for regular monitoring;
- (v) 23 States/UTs have set up Iodine Deficiency Disorder Control Cell to ensure effective implementation of the Programme;
- (vi) To intensify IDD activities, a project has been finalised with UNICEF assistance for intensive IDD monitoring in 4 States viz. Uttar Pradesh, Madhya Pradesh, Himachal Pradesh and Assam;
- (vii) A National Reference Lab for monitoring of IDD has been set up at the Biochemistry Division of National Institute of Communicable Diseases, Delhi for training both medical and para-medical personnel and monitoring salt and urinary iodine;

(viii) An evaluation of Salt Iodisation Programme was also carried out in some districts. The results of evaluation have shown that the prevalence of goitre has declined from 41.2% to 31.8% in Hamirpur and from 49.53% to 16.9 in Buldhana;

(ix) It has also been proposed to set up the monitoring labs in the States of Arunachal Pradesh, Assam, Gujarat, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, Sikkim, U.P. and West Bengal. A tentative allocation of Rs. 75,000/- per lab. has been provided for this purpose;

(x) GOI-UNICEF Project 1993-95 has been approved in 13 selected endemic States for the extensive monitoring and IEC activities of NIDDCP. The activities are to be strengthened in 106 selected districts of the 13 States including North Eastern region;

Review: After a review of the Programme in 1991 the Chief Ministers of remaining States were advised to urgently issue Notification banning the sale of salt other than iodised salt. The State Governments have been advised to include iodised salt as a non-compulsory item under Public Distribution System.

The Salt Commissioner has been advised to take action to instal iodisation plants in consuming areas in States/UTs and to improve packaging of iodised salt to prevent iodine losses during transit.

Information, Education and Communication: To intensify the IEC activities, a communication package by way of video films, posters/danglers and Radio/T.V. has been finalised with UNICEF.

VIII Plan Proposals: It is proposed to strengthen IDD Monitoring and to achieve the goal of

Universal Iodisation of Salt. IDD monitoring will be carried out at the district level both through regular checking of iodised salt as well as urinary iodine excretion. With this, it is also proposed to bring down the incidence of IDD to below 10% level by 2000 A.D.

Problems: Surveys in the remaining districts, ban notification in the remaining States and setting up of Control Cell in some States are yet to be completed.

National Sexually Transmitted Disease Control Programme (S.T.D.)

S.T.D. was introduced as a National Control Programme during the second Five Year Plan by the Government of India. The programme was then primarily a Centrally Aided Scheme concerned mainly with (i) establishing S.T.D. clinics throughout the country; (ii) supply of drugs to the earlier existing and newly established clinics; and (iii) conducting orientation training courses in S.T.D. for the inservice medical and para-medical personnel.

The scheme was converted into a Centrally Sponsored Scheme during the fourth five year plan and the Central Government assistance was limited to (i) giving grant-in-aid to States for establishing new S.T.D. clinics and (ii) supplying of drugs (Benzathine Benzyl Penicillin) to the S.T.D. clinics.

The scheme was again reviewed and during sixth and seventh five year plan it was decided to establish five Regional S.T.D. Teaching, Training and Research centres at Delhi, Madras, Nagpur, Hyderabad and Calcutta.

Recognising S.T.D. as one of the major factors for transmission of HIV infection the programme has been merged with the AIDS Control Programme. The existing

components of the programme viz. Teaching, Training, Research and Epidemiology, however have been retained outside the World Bank assisted activities of the National AIDS Control Programme. Under the National S.T.D. Control Programme following achievements have been made:

As on July 1993 the Regional S.T.D. centres have trained as many as 98 medical officers and 112 para-medical personnel like Laboratory Technicians, Nurses, Health Educators and Social Workers etc.

About 56 medical colleges, hospitals, laboratories/public health laboratories had participated in the inter laboratory evaluation programme of VDRL test being conducted by the Regional STD reference laboratory at Madras and Hyderabad.

The Crash programme for the training of Medical Officers working in Primary Health Centres in Tamil Nadu, Andhra Pradesh, Maharashtra, West Bengal and Delhi at the 5 Regional S.T.D. Training Centres was launched and under this 274 Medical Officers were trained.

S.T.D. Planning Workshops for the State Programme Officers of STD, AIDS and Epidemiologist of various States were held at Delhi, Madras and Bhubaneswar.

S.T.D. Treatment Workshop was held at Delhi on 6-7 July, 1993 to develop standard treatment guidelines for Sexually Transmitted Diseases and STD syndrome.

The Project seeks to take up activities to strengthen the clinical services and case management activities in STD centres in 97 medical colleges (including 5 Regional S.T.D. Centres and 275 District level STD clinics).

Blood Safety Programme: A Scheme of Prevention of Infection

and Strengthening of Blood Banking System in the country has been under implementation since 1989 under which State Governments were provided assistance for setting up of testing facilities including HIV in the Blood Banks. Strengthening and modernisation of State managed Blood Banks and development of manpower and Rational Use of Blood.

A Programme for the Prevention and Control of AIDS has been currently under implementation since 1992. One of the major components of this Programme is Blood Safety and Rational Use of Blood.

Modernisation of Blood Banks: Under this Programme it is proposed to upgrade all the 608 State managed Blood Banks in the country with provision of equipments and recurring assistance of consumables in a phased manner. During 1992-93 assistance has been given for modernising 90 Blood Banks under the World Banks assisted National AIDS Control Programme, while 138 Blood Banks were upgraded till March 1992. The remaining 380 Blood Banks are proposed to be taken up for upgradation in a phased manner during the 8th plan period. During the year 1993-94, 100 Blood Banks are being upgraded.

Training and Manpower Development: 10 Training Institutions have been operationalised at Regional level for training of Doctors and Technicians working in the Blood Banks. Institutional facilities have already been upgraded. Doctors and Technicians have been imparted Training in blood banking technology, through short term orientation course.

Training modules for training of various categories of personnel working for the blood banks are being prepared and modular training will be introduced shortly.

Legal Frame Work: Schedule FXII-B provides the necessary legal frame work as per Drugs and Cosmetics Act. The Rules have been made more stringent providing for mandatory testing of blood for blood transmissible diseases including HIV. Approval of license by the Central license approving authorities has been made compulsory. It also provides that the whole human blood and components shall conform to standards as prescribed under the Indian Pharmacopia.

Promoting Rational Use of Blood: It is proposed to establish 30 Component Separation Centres in Blood Banks handling more than 10,000 units of blood per annum in phases. Six centres were identified during 1992-93 and 9 more Centres have been identified for component laboratory during 1993-94. The remaining centres shall be taken during 1994-95.

National AIDS Control Programme

HIV infection in the country has been reported from as many as 23 States/UTs and of these Maharashtra, Tamil Nadu, Manipur have reported the highest incidence of the disease. In the Maharashtra and Tamil Nadu, the pattern of HIV infection is that of Sub-Saharan type *i.e.*, through sexual transmission and in the North Eastern State, the pattern of HIV infection follows the course similar to South European and Thailand *i.e.*, through drug abuse.

As per the epidemiological reports available as many as 18,98,670 persons have been screened for HIV of which 13,254 have been found to be sero-positive as on 30-09-93. The sero-positivity rate per 1000 among the samples screened is 698 and the total number of full blown AIDS cases reported from different States is 459. The reported prevalence of infection represents a fraction of actual morbidity and this amounts to just

the probial tip of ice-berg of the whole problem. According to the estimates made, the number of infected persons by the end of 1990-92 was about 1 million and the total full blown AIDS cases to be somewhere between 5,000 to 10,000.

Realising the gravity of epidemiological situation of HIV prevailing in the country, the Government of India has launched a comprehensive scheme at an estimated cost of Rs. 220 to Rs. 222.6 crore during the 8th Plan with assistance from the World Bank to the tune of US\$ 84 million and another US\$ 1.5 million from WHO. The World Bank loan became effective from 21-9-1992.

Ministry of Health & Family Welfare has set up a National AIDS Control Organisation as a separate wing to implement and closely monitor the various components of the programme as documented in the Staff Appraisal Report of IDA (World Bank). The overall objective of the project is to arrest the HIV/AIDS infections in the country with a view to reducing the future morbidity, mortality and infection of AIDS.

The project consists of the following components:

Strengthening Programme Management Capabilities: National AIDS Control Organisation is primarily involved in planning consulting, implementing and monitoring the various activities under the project through the AIDS Control Cell at the State/UT level. The programme is being implemented as a Centrally Sponsored Scheme through all the State/ Union Territories who have given letter of Undertaking to implement the programme. During 1992-93 grants aggregating Rs. 11.55 crore have been released to the State/UTs. During 1993-94 first instalment of 25% of the total grant proposed for the current year has been released.

Strengthening of IEC: Since there is no cure for AIDS as of now, the

project seeks to carry out an intensive public awareness and community support campaign through mass media and sustained dissemination of information and health education about HIV and AIDS to all level and categories of personnel. For launching media campaign at a large scale throughout the Country, a proposal has been finalised on the selection of an Advertising Agency. Limited media campaign has already been launched with the help of DAVP at an approximate cost of Rs. 54 lakh.

Prevention of Transmission Through Blood and Blood Products: The Project seeks to upgrade the blood banking capabilities in the Public Sector and expansion of HIV screening of all blood used for transfusion and blood-products in the country. During 1992-93 financial assistance has been given for modernising 90 blood banks. During the year 1993-94 another 100 blood banks are being modernised under the scheme to modernise all the 608 blood banks in Public Sector.

Strengthening Clinical Management Capabilities: The project seeks to strengthen the institutional capabilities at the State/UT level for monitoring the development of HIV and AIDS epidemic and planning and programming interventions to control such epidemic. 180 Zonal Blood Testing Centres (inclusive of 62 Surveillance Centres) have been set up where blood testing facilities for HIV are available. Linkages have been provided throughout the country. In addition to this, 9 HIV reference centres have also been set up. An exhaustive plan has been drawn to train medical officers down the district and taluk levels in diagnostic skill and clinical management of HIV/AIDS Cases. So far about 425 medical officers have been trained; and

Controlling S.T.D.: One of the predominant mode of transmission of HIV infection is through sexual

contact. The project seeks to take up activities to strengthen the clinical services and case management activities in STD Centres in 97 medical colleges and 275 District level STD Clinics.

National Cancer Control Programme

In India it is estimated that there are 1.5 to 2 million cancer patient at any given point of time with about 0.6 million new cases coming every year. The Government of India started the Cancer Control Programme in a limited form during the year 1975-76 when Central assistance @Rs. 2.5 lakh was provided to institutions for purchase of Cobalt Therapy Units for treatment of cancer patients. This scheme continued during the 6th and 7th Plan Period with the increase of rate of assistance to Rs. 12.00 lakh. At the same time ten major institutions were recognised as Regional Cancer Centres which receive financial assistance from the Government.

New Schemes Under National Cancer Control Programme: During the 8th Plan, emphasis is on prevention, early detection of cancer and augmentation of treatment facilities in the country. The following new schemes have been initiated starting from the year 1990-91.

Scheme for District Project: The scheme envisages projects at district level for preventive health education, early detection and pain relief measures. Under the scheme financial assistance of Rs. 15.00 lakh is provided to the concerned State Government for each district project selected under the scheme with a provision of Rs. 10.00 lakh per year for each district for the remaining four years of the project period. The project is linked with a Regional Cancer Centre or an institution having reasonably good facilities for treatment of cancer patients. During the years 1990-91 to 1992-93, 17 district projects have been undertaken in

Gujarat, Karnataka, Madhya Pradesh, Kerala, Orissa, Punjab, Tamil Nadu and West Bengal.

Development of Oncology Wings in Medical Colleges/Hospitals: This scheme has been initiated to fill up geographical gaps in the availability of cancer treatment facilities in the country. According to the scheme, financial assistance upto Rs. One crore (in phases) is provided to the concerned State Govt. for purchase of equipments which includes one Cobalt Unit. The civil works and manpower are to be provided by the concerned State Govt./Institution. So far financial assistance has been provided for development of Oncology Wings in sixteen medical colleges/hospitals in the country.

Scheme for Financial Assistance to Voluntary Organisations: Under the

scheme, financial assistance upto Rs. 5.00 lakh is provided to the registered voluntary organisations recommended by the State Government for the purpose of undertaking health education and early detection activities in cancer. So far assistance has been provided to fifteen voluntary organisations under the scheme.

Utilisation of Funds by the State Governments: It has been observed that in a number of cases, there is a long time-gap between release of the amount by this Ministry and utilisation of the same by the concerned State Govt. At times State Govts. provide the amount or part thereof to the concerned Medical Colleges/Hospitals after a considerable time. This hampers the effective implementation of the programme.

Government of India intends to strengthen the Programme further during the coming years. The schemes for grant-in-aid to Regional Cancer Centres and for financial assistance for cobalt therapy units have been continued. The rate of financial assistance for cobalt therapy units which was increased to Rs. 20.00 lakh, has further been increased to Rs. 50.00 lakh per unit w.e.f. 20th January, 1993. Other radiotherapy equipments like Brachytherapy and Linear Accelerator have also been brought under the ambit of the scheme. A sum of Rs. 19.00 crore was spent on the Programme during the year 1992-93 as against the total allocation of Rs. 19.34 crore during the entire seventh five year plan. A sum of Rs. 20.00 crore has been earmarked for the National Cancer Control Programme in the current year. □

Drug Patches Help Prevent Premature Births

Drug-releasing skin patches similar to those used by heart patients and people trying to wean themselves off cigarettes could now have a role in preventing premature births, according to researchers.

A team from King's College Hospital School of Medicine in London, has found that applying the patches to the abdomens of women in premature labour rapidly stopped their contractions. The patches contain the glyceryl trinitrate (GTN) drug that has long been used to relieve chest pains. In this case, it relaxes the womb muscles and improves blood flow to the womb.

Over a period of three months, the patch was used on 13 women who were at high risk of imminent delivery and in preterm labour. A single patch delivering 10mg of GTN was applied to the abdomen and this treatment was continued until the contractions completely subsided, which was usually achieved within 24-48 hours. As a result, the pregnancies were prolonged by an average of 28 days.

King's College team member Dr. Christoph Lees, reporting the development to The Lancet medical magazine, commented: "GTN patches appear to be a safe, well tolerated and non-invasive method of suppressing uterine contractions in preterm labour."

—Medical News From Britain

Prevention of Adulteration of Food and Drugs

The Prevention of Food Adulteration Act, 1954: Food is a basic need for survival. It is, therefore, imperative to ensure that whatever we consume is pure and wholesome. With this objective, the Prevention of Food Adulteration Act, was enacted in 1954. The aims envisaged under this Act are:

- (i) To ensure quality food to the consumers;
- (ii) To protect the Consumers from fraud and deception; and
- (iii) To encourage fair trade practices.

The Act, which came into effect from 1st June, 1955, has been amended thrice in 1964, 1976 and 1986 for plugging the loopholes and for making the punishments more stringent and empowering the Consumer and Voluntary Organisations to take samples.

Constitutional Status and Enforcement of the Act

The subject of Prevention of Food Adulteration is in the concurrent list of the Constitution. However, in general, the enforcement of the Act is done by the State/U.T. Governments. The Central Government primarily plays an advisory role in its implementation besides carrying out various statutory functions/duties assigned to it under the various provisions of the Act.

Main Functions of the Central Government

The Central Committee for Food Standards (a statutory committee constituted by the Central Government under the Act) is responsible for considering amendments to various provisions of the Act, Rules and Standards. The Central Government conducts examination for the chemists for their appointment as Public Analyst under the Act. It approves the State Prevention of Food Adulteration Rules under the Act and is also

Adulteration of food and drugs can cause serious damage to human life. This anti-social menace is sought to be countered by making the legal provisions more stringent and deterrent, even entailing life imprisonment for adulterations causing grievous hurt and danger to human life. This malpractice is also being tackled through effective health education measures. The drug de-addiction centres are being strengthened to provide treatment facilities for the drug abuse problem and drug dependence disorders.

required to examine and approve the labels for infant food. The Central Government evaluate and monitor the working of the PFA Act in the States/UTs by collecting periodical reports and visits and collects analytical data from Food Laboratories for Standardisation purpose. It also arranges training programmes for various functionaries under the Act and creates consumer awareness through workshops/seminars etc. The Central Government ensures the quality of food imported into the country under the Act and also deals with matters relating to international agencies namely CODEX/FAO/WHO.

Central Food Laboratories

Four Central Food Laboratories have been established/specified under the Act, which work as Appellate Laboratories for the purpose of samples lifted by Food Inspectors of States/UTs and Local Bodies. The two laboratories viz (i) Food Research and Standardisation Laboratory, Ghaziabad and (ii) Central Food Laboratory, Calcutta are under the Administrative control of the Directorate General of Health Services and the other two, viz (iii) Central Food Laboratory, Pune and (iv) Central Food Laboratory, Mysore are under the Administrative control of Government of Maharashtra and Council of Industrial and Scientific Research, Government of India respectively.

State Food Laboratories

There are 78 Food Laboratories under the Administrative control of State/UT Governments and Local Bodies.

Steps Taken to Improve the Programme

During the year, steps have been taken to strengthen the PFA set up. 48 training programmes were conducted by the Hq. PFA division in collaboration with various Institutions/Organisations under which more than 500 different types of officials/functionaries under the Act were imparted training, 11 examinations were conducted in which 225 chemists qualified to hold the post of Public Analyst under the Act. Consumer Education Programmes were organised involving Voluntary Organisations for exposing them to the Programme of Food Safety and Quality.

The Central Council of Health and Family Welfare which met in July, 1993 recommend *inter-alia* that the State Governments should take appropriate measures to update and simplify procedures for licensing, augment enforcement machinery and laboratory facilities and give emphasis to sampling and analyses of commonly used food commodities.

Centrally Sponsored Scheme

The Ministry has launched a Centrally Sponsored Scheme for providing funds to the State Governments for purchase of equipments for strengthening their Food Laboratories, during the Eighth Five Year Plan. The financial assistance is in the form of a one time grant. Under this scheme, an amount of Rs. 151 lakh was given to 17 States/UTs during 1990-93. During the year 1993-94, Central assistance amounting to Rs. 50 lakh was provided to Andaman and Nicobar Islands, Jammu & Kashmir, Maharashtra, Pondicherry and Rajasthan.

Central Drug Standard Control Organisation

Quality control of imported drugs, introduction of new drugs in the country and framing of the Rules under the Drugs and Cosmetic Act are some of the important activities of the Central Drug Standard Control Organisation (CDSCO). However, the State Governments are responsible for issuing licenses for manufacture and marketing and monitoring the quality of drugs and cosmetics in the country. The State Licensing authorities are the enforcement agency for the Drugs and Cosmetics Act in their respective States.

Functions of the Central Drug Standard Control Organisation

The statutory control over the import of drugs is exercised through the port and airport offices

of the CDSCO located at Bombay, Nhavashava, Madras, Calcutta, Cochin and New Delhi. Close co-ordination is maintained with the State Drug Control Authorities so as to maintain a uniform standard of inspection and enforcement of the Drug rules, by the offices located in Bombay, Madras, Calcutta and Ghaziabad besides sub-zonal offices at Lucknow and Patna.

Permission for trial of new drugs is given after due examination of all technical material and related pharmacological literature. The clinical trials are evaluated before granting marketing approval to a new drug.

Import of 19 new drugs and 23 new drug formulations were allowed during the period April to September, 1993.

The Central Drugs Laboratory at Calcutta tests samples of imported drugs and also functions as the appellate laboratory under the Drugs and Cosmetics Act and Government Analyst for 21 States/UTs. Similar function is carried for 8 States/UTs by the Central Indian Pharmacopoeia Laboratory at Ghaziabad and the Biological Laboratory and Animal House, Madras tests drug samples drawn from the Southern Zone. Another Central Drug Laboratory was inaugurated at Bombay and it will be in a position to test 5000 samples per year when fully functional. Regional laboratories are also being established at Guwahati, Chandigarh and Hyderabad. They would be in a position to

analyse 3000 samples each year. Rs. 85 lakh were allotted to Haryana, Punjab, Kerala, M.P., J. & K., Maharashtra, Karnataka and Tamil Nadu for strengthening their State Drug Testing Laboratories during 1992-93.

A Statutory Drug Technical Advisory Board advises the Central and State Governments on technical matters arising out of the administration of the Drugs and Cosmetics Act.

During the period April to September, 1993, 93 amendments were issued and 140 monographs were finalised. In order to provide for a more effective mechanism to ensure the quality of blood products, the Central Government has assumed concurrent licensing powers for Blood Banks, I.V. Fluids, Sera and Vaccines. Standards of Condoms have also been revised as per the specifications of the WHO, keeping in view its importance in controlling sexually transmitted diseases and AIDS.

Seventyone additional posts have been sanctioned for strengthening the CDSCO. Recruitment action is at hand. This will enable the CDSCO to have two additional sub-zonal offices at Ahmedabad and Hyderabad.

Drug De-addiction Programme

Ministry of Health and Family Welfare is basically responsible for providing treatment facilities including preventive health and after care service in the field of drug-addiction.

For coordination of functioning of various Ministries/Depts., some high powered committees have been set-up including a Cabinet sub-Committee and High Level Committee consisting *inter-alia* of some members of Parliament.

The Govt. of India have set-up De-addiction Centres in Central Govt. Institutes/Hospitals at AIIMS, New Delhi, P.G.I., Chandigarh, JIPMER, Pondicherry Lady Hardinge Medical College and Hospital, New Delhi and Dr. R.M.L. Hospital, New Delhi.

In addition, Centres with the assistance of UNDCP have also been developed at Deen Dayal Upadhyay Hospital, New Delhi, AIIMS, KEM Hospital, Bombay and Institute of Post Graduate Medical Education and Research, Calcutta.

The above Institutes, besides providing treatment services also provide training of Medical/Para-medical personnel prepare Health Education Material, and render Community Outreach Services.

Steps Initiated to Develop the Programme in States

During 1992-93, a new strategy was developed to strengthen the infrastructural facilities in the States by way of providing them assistance to establish Drug-De-addiction Centres in the identified Medical Colleges/District Level Hospitals. A vast trained manpower of doctors is being developed who will serve at the peripheral level after obtaining the training on basic techniques of de-toxification from the identified training Institutes. So far 27 Centres have been established in various Medical

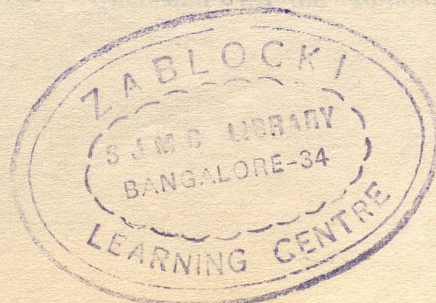
Colleges/Distt. Level Hospitals. About 500 doctors have been trained under the Scheme in 20 courses conducted so far. The training of para-medicals has also been undertaken at some Institutes which will be further strengthened.

Special Measure for North Eastern States

Keeping in view the acute problem of drug abuse in North Eastern States, particularly in Manipur and Nagaland, additional assistance in terms of equipment, vehicles and for construction of buildings is being provided to these States. Special arrangements have been made to train the Medical/Para-medical personnel of North Eastern States. □

ACHIEVEMENTS OF THE FAMILY WELFARE PROGRAMMES

Sl. No.	Parameter	1951-61	1981	1991
1.	Birth Rate	41.7	37.2	29.0 SRS 92
2.	Death Rate	22.8	15.0	10.0 SRS 92
3.	Total Fertility Rate	5.97	4.5	3.8 SRS 90
4.	Infant Mortality Rate (per 1000 live births)	146.0	110.0	79.0 SRS 92
5.	Couple Protection Rate (percent)	10.4 (1970-71)	22.8	43.4 31-3-93
6.	Cumulative Number of Births Averted (in million)	0.4	43.4	155.0 31-3-93



NATIONAL FAMILY WELFARE PROGRAMME

The National Family Welfare Programme was launched in India in 1951 with the objective of reducing the birth rate to the extent necessary to stabilise the population at a level consistent with the requirement of the national economy. In keeping with the democratic traditions of the country, the Family Welfare Programme seeks to promote responsible and planned parenthood through voluntary and free choice of family planning methods, best suited to individual acceptors. People's participation is sought through local self-government including voluntary organisations and opinion leaders at different levels. Imaginative use of mass media and interpersonal communication is made for highlighting the benefits of small family norm and removal of socio-cultural barriers for adoption of family limitation programmes.

THE long-term demographic goals, as laid down in the National Health Policy (1983), is to achieve a Net Reproductive Rate of Unity (NRR-1) by the year 2000 A.D. This corresponds to achieving a birth rate of 21 per thousand, death rate of 9 per thousand and natural population growth rate of 1.2%. The National Health Policy also envisages reducing infant mortality rate to below 60 per thousand live births by the turn of the century.

The Seventh Plan Document visualised that the goal of reaching NRR-1 may be achievable only in the period 2006-2011 A.D.

Keeping in view the present levels of achievement, it has been stated in the Eighth Five Year Plan Document that NRR-1 would now be achievable only in the period 2011-16 A.D. The goals to be achieved by the end of the Eighth Plan under the Family Welfare Programme are :

Indicator	Goal to be achieved by end of Eighth Plan
(a) Crude Birth Rate (per 1000 population)	26.0
(b) Infant Mortality Rate (per 1000 live births)	70.0
(c) Couple Protection Rate	56%

The Sample Registration System for 1992 brings out the marked inter-State variation points to the need for differential strategies and greater efforts on the part of States, which have recorded Infant Mortality Rates and live birth rates significantly above the national average.

Policy Initiatives

Action Plan : To impart dynamism to the Family Welfare Programme, a result-oriented Action Plan has been evolved by the Ministry of Health and Family Welfare in close consultation with the States/UTs. It was unanimously endorsed in the conference on Health Ministers held at New Delhi on 6-7 January, 1992. The Action Plan highlights the need for evolving a national consensus in support of the Family Welfare Programme and to obtain the willing participation of all sections of the society. Its key features include, (i) improving the quality and outreach of family welfare services; (ii) differential strategy for special focus on 90 poor performing districts (birth rate of 39 per thousand population and above as per 1981 census); (iii) developing a mecha-

nism to make available funds to States/UTs on the basis of reduction of actual birth rate; (iv) increasing the coverage of younger age couples through vigorous promotion of spacing methods; (v) introducing new contraceptives and improving the quality of contraceptives; (vi) strengthening family welfare schemes in urban areas, especially in slum pockets; (vii) revitalising training activities of medical/para medical personnel with emphasis on motivational and counselling aspects; (viii) sustaining the good work done under the Universal Immunisation Programme and strengthening of other interventions for Maternal and Child Health Care; (ix) re-orientation of information, education and communication efforts to focus on the quality of life issues and inter-personal communications; (x) involving voluntary and non-governmental organisations in a big way to promote active community participation in the Programme; (xi) gearing up of the implementation machinery in the States/UTs; and (xii) evolving high level inter-sectoral coordination mechanism at the national, State and district levels, etc. All the States/Union Territories have

been requested to operationalise the different components of the Action Plan. The progress of implementation is being periodically reviewed by the Department.

Constitution of NDC Committee on Population: It was stated in the National Health Policy (1983) that in view of the vital importance of securing a balanced growth of population, it is necessary to enunciate, separately, a National Population Policy. A National Population Policy has yet to be evolved. The National Development Council (NDC) in its meeting held on 23-24th December, 1991 gave broad approval to the strategies calling for demonstrating strong political will, evolving a national consensus in support of the population control programme, sustained administrative efforts and adopting population stabilisation measures based on a holistic and multi-sectoral approach. In pursuance of the decisions taken in the NDC, a Committee of the NDC on Population was constituted by the Planning Commission under the Chairmanship of Chief Minister, Kerala in February, 1992. The Committee was, inter alia entrusted with the task of recommending appropriate formulations for a National Population Policy, identifying effective intervention strategies, both at macro and micro levels, on a holistic and multi-sectoral basis and suggesting mechanisms for securing commitment and support of leadership of all denominations and at all levels, for a National Population Policy and the implementation of the population control programme. The report of the Committee was endorsed by the NDC in its meeting on 18th September, 1993.

National Population Policy: A group of experts has been set up under the Chairmanship of Dr. M.S. Swaminathan to prepare a draft of the National Population Policy. The group has met twice on 14th August and 23rd and 24th October, 1993.

Prescription of Policies through Legislation, Rules and Regulations: (i) *Introduction of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Bill, 1991:* With a view to curbing the abhorrent practice of misuse of pre-natal diagnostic techniques, for determination of the sex of the foetus leading to female foeticide, a Draft Bill entitled 'Pre-natal Diagnostic Techniques' (Regulation and Prevention of Misuse) Bill, 1991 had been introduced in the Lok Sabha on 12-9-1991. It was subsequently referred to a Joint Committee under the Chairpersonship of Smt. D.K. Thara Devi Siddhartha, ex-Minister of State for Health and Family Welfare. The Committee has submitted its report during the Winter Session of the Parliament in December, 1992. The Bill, as reported by the Joint Committee, could not be taken up for consideration and will now be taken up in the Winter Session.

Introduction of the Constitution (Seventy-ninth Amendment) Bill, 1992: With a view to demonstrating strong political will and commitment for population control, the Constitution (Seventy-ninth Amendment) Bill, 1992 has been introduced in the Rajya Sabha on 22-12-1992. The Bill stipulates amendment of the Directive Principles of State Policy to provide that the State shall endeavour to promote population control; and inclusion in the Fundamental

Duties, a duty to promote and adopt the small family norm by the citizens. It is also proposed that a person shall be disqualified for being chosen and for being a Member of either House of the Parliament or either House of the Legislature of a State, if he has more than two children. These amendments will, however, have prospective effect and will not apply to any person who has more than two children on the date of commencement of the proposed amendment or within a period of one year of such commencement. The Bill could not be taken up for consideration in the last Session.

Action on the Constitution (Seventy Third Amendment) Act: The Constitution (73rd Amendment) Act, 1992 has come into force with effect from 24-4-93. The Constitutional amendment stipulates constitution of panchayats at the village, intermediate and district levels. Under Articles 243 (G) of the Constitution, State Legislatures may endow the panchayats with powers and authority in respect of the subjects shown in the Eleventh Schedule to the Constitution, which include family welfare as well as related subjects like women and child development, health and sanitation, social welfare, education and maintenance of community assets.

A suggestive list of activities connected with family welfare that could be entrusted to the panchayats at various levels has been drawn up in consultation with the State Health Secretaries in a meeting held on 3rd September, 1993. □

MATERNAL AND CHILD HEALTH PROGRAMME

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

As part of the overall strategy for reduction of infant mortality to below 60 per thousand live births; child mortality to below 10 per thousand; child population and maternal mortality to below 200 per 100,000 live births by 2000 AD, following specific programmes have been under implementation in the country as 100% Centrally sponsored family welfare schemes:

- (i) Universal Immunization Programme (UIP) for control of vaccine preventable diseases namely, diphtheria, pertussis, tetanus, childhood tuberculosis, poliomyelitis and measles.
- (ii) Oral Rehydration Therapy (ORT) Programme for control of deaths due to dehydration caused by diarrhoea. It is estimated that about one million children die of diarrhoea every year and most of these deaths can be prevented if dehydration is checked in time.
- (iii) Prophylaxis Schemes against nutritional anaemia among pregnant women and against blindness due to Vitamin A deficiency among children of under 3 years of age.

The impact of the above interventions is becoming perceptible in the declining trends of disease incidence and Infant Mortality Rate. The Universal Immunisation Programme started in 1985-86,

has particularly succeeded in establishing a system of contact between the beneficiaries—mothers and children—and the paramedical workers—the ANMs located at the Sub-Centres.

The access established under the immunization programme is now being utilised to extend and intensify other services related to maternal and child health under the Child Survival and Safe Motherhood (CSSM) Programme which was launched in the year 1992-93. The programme, being implemented with the financial assistance of World Bank and UNICEF with an overall approved outlay of Rs. 1,125.51 crore over a seven year period (1992-93 to 1997-98), has the following components:

- (i) Sustaining and strengthening the ongoing Immunization, Oral Rehydration Therapy (ORT) and Prophylaxis Schemes;
- (ii) Improving maternal care at the community level by providing an enhanced reporting fee of Rs. 10.00 per case to the Traditional Birth Attendants (TBAs) and disposable delivery kits to pregnant women;
- (iii) Expanding in a phased manner, the programme for control of Acute Respiratory Infections (ARI) for children below 5 years of age;
- (iv) Improving newborn care; and

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

The UIP, ORT, Prophylaxis Schemes of IFA and Vitamin A administration to pregnant women and children respectively, and Dais Training, etc. are ongoing activities in all districts. Additional interventions relating to ARI control (alongwith training/retraining of medical and paramedical staff) and setting up of First Referral Units in the six States, will be expanded in a phased manner. For convenience, these have been termed as "Child Survival" and "Safe Motherhood" components respectively.

Achievements

Immunization

Universal Immunization Programme (UIP) declared as one of the Technology Missions in 1986, was launched in 1985 as part of the overall national strategy to bring down infant and maternal mortality in the country by providing immunization to all infants against six vaccine preventable diseases and pregnant women against tetanus. Towards this, additional inputs in the form of cold chain equipment, vaccines, training of medical and paramedical staff and

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IEC material, etc. were provided to all the paramedical staff and IEC material, etc. were provided to all the districts, in a phased manner. Beginning with 31 districts in 1985-86, the programme was expanded to all districts by 1989-90.

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

At the beginning of the Programme in 1985-86, vaccine

coverage levels ranged between 29% for BCG and 41% for DPT. By the end of March 1993, coverage levels have improved significantly and was above 85% for all vaccines

for infants. Coverage of pregnant women with 2 doses was 79%. The year-wise and antigen-wise achievement during 1985-86 to 1992-93 is shown in Table II.

TABLE II
YEAR-WISE AND ANTIGEN-WISE ACHIEVEMENT
DURING 1985-86 TO 1992-93

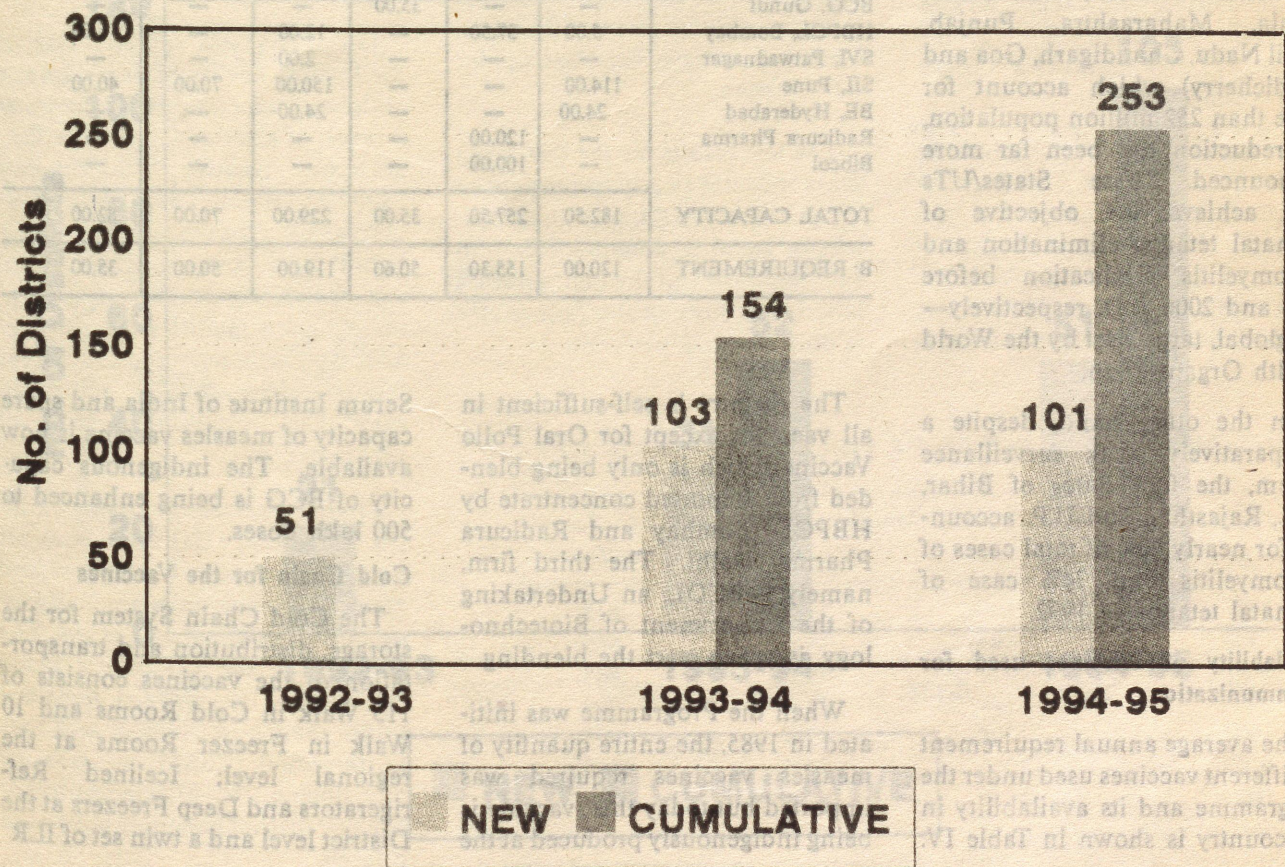
YEAR	DPT	OPV	BCG	MSL	TT(PW)
1985-86	41.12	35.66	28.84	1.34	39.85
1986-87	56.55	48.41	52.19	16.17	45.27
1987-88	72.23	60.46	70.70	44.06	56.48
1988-89	79.61	74.83	79.29	55.17	65.15
1989-90	82.93	82.30	89.04	69.32	58.83
1990-91	100.72*	101.54*	102.99*	90.85	79.70
1991-92	90.89	91.26	92.83	84.99	77.57
1992-93	90.19	90.81	96.41	85.75	79.40

Note: Measles vaccine was introduced in the programme from 1985-86.

* : Over 100% figures due to inclusion of children over one year age under immunisation.

State wise details of 1992-93 given in the Appendix I at the end of this chapter.

DISTRICTS UNDER CSSM CHILD SURVIVAL



Considerable efforts have gone into developing a reliable surveillance system. The immediate reporting of cases of neonatal tetanus and poliomyelitis has been made mandatory. Nil reporting by hospitals and health facilities has been introduced to confirm that cases are not being missed due to incomplete reports. Active surveillance for suspect cases of poliomyelitis and neonatal tetanus has started. Line lists of cases of poliomyelitis and neonatal tetanus are maintained and cases of poliomyelitis are followed up 60 days after the onset of paralysis to confirm diagnosis. The decline in the reported disease incidence, under this background, is encouraging.

Reported incidence of vaccine preventable diseases in India are shown in Table III.

In ten States/UTs (Haryana, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Chandigarh, Goa and Pondicherry) which account for more than 252 million population, the reduction has been far more pronounced. These States/UTs may achieve the objective of neonatal tetanus elimination and poliomyelitis eradication before 1995 and 2000 A.D. respectively—the global targets set by the World Health Organisation.

On the other hand, despite a comparatively weak surveillance system, the four States of Bihar, M.P., Rajasthan and U.P. accounted for nearly 40% of total cases of poliomyelitis and 74% case of neonatal tetanus in 1992.

Availability of Vaccines used for Immunization

The average annual requirement of different vaccines used under the Programme and its availability in the country is shown in Table IV.

TABLE III
REPORTED INCIDENCE OF VACCINE PREVENTABLE DISEASES : INDIA

Year	Dip	Per	Tet	NNT	Pol	Mea	Total
1980	39231	320109	43837		19051	124036	546264
1981	26315	359288	39175		38090	197129	659997
1982	17191	279635	39955		26302	146196	509279
1983	13776	211282	32870		24727	129639	412294
1984	17058	189148	29965		23250	190881	450302
1985	15686	184368	37647		22584	160216	420501
1986	9426	167225	30994		20169	155076	382890
1987	12952	163786	31844		28264	247519	484365
1988	17146	145469	24343	11849	24257	157800	380864
1989	9790	137374	17763	11114	13866	162560	352467
1990	8425	113016	14043	9313	10408	87446	242651
1991	12550	73520	15036	11241	6028	79655	198030
1992	8115	119854	11268	6626	9440	92185	247488

*Tet—includes cases in adults. Cases of NNT also included upto 1987.

TABLE IV

AVAILABILITY OF VACCINES USED FOR IMMUNIZATION

(Million doses)

A: CAPACITIES	DPT	OPV	BCG	TT	MEASLES	DT
CRI, Kasauli	23.00	—	—	30.00	—	25.00
PII, Coonoor	16.50	—	—	11.00	—	11.00
BCG, Gundi	—	—	35.00	—	—	—
HBPCL, Bombay	5.00	37.50	—	12.00	—	6.00
SVI, Patwadnagar	—	—	—	2.00	—	—
SII, Pune	114.00	—	—	150.00	70.00	40.00
BE, Hyderabad	24.00	—	—	24.00	—	—
Radicura Pharma	—	120.00	—	—	—	—
Bibcol	—	100.00	—	—	—	—
TOTAL CAPACITY	182.50	257.50	35.00	229.00	70.00	82.00
B: REQUIREMENT	120.00	155.30	50.60	119.00	50.00	35.00

The country is self-sufficient in all vaccines except for Oral Polio Vaccine which is only being blended from imported concentrate by HBPCL, Bombay and Radicura Pharma, Delhi. The third firm, namely BIBCOL, an Undertaking of the Department of Biotechnology, is yet to start the blending.

When the Programme was initiated in 1985, the entire quantity of measles vaccines required was imported but today this vaccine is being indigenously produced at the

Serum Institute of India and spare capacity of measles vaccine is now available. The indigenous capacity of BCG is being enhanced to 500 lakh doses.

Cold Chain for the Vaccines

The Cold Chain System for the storage, distribution and transportation of the vaccines consists of 113 Walk in Cold Rooms and 10 Walk in Freezer Rooms at the regional level; Icelined Refrigerators and Deep Freezers at the District level and a twin set of ILR

Freezer at the PHC level. From the PHCs, the vaccines are taken in vaccine carriers as no storage is envisaged at the Sub-Centre level.

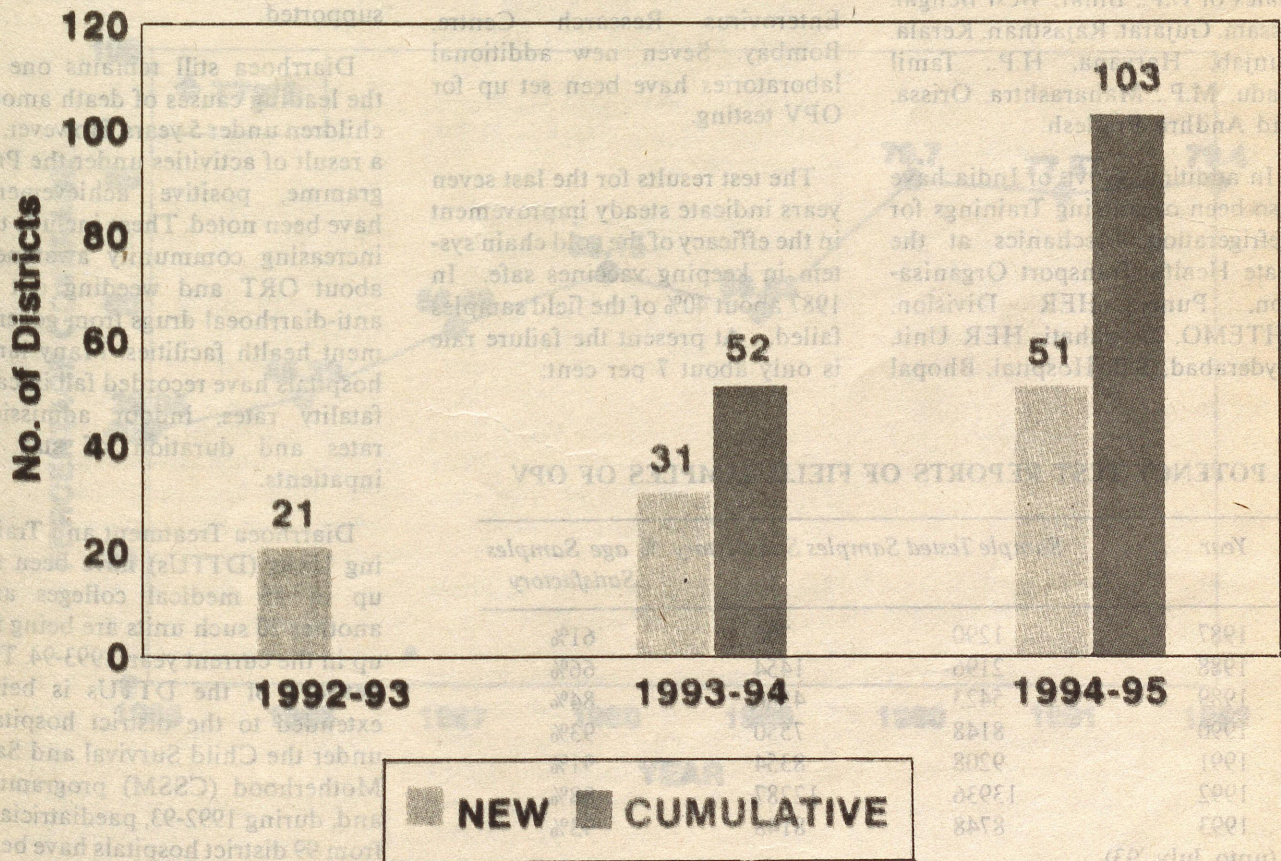
The above basic cold chain system is supported by (a) Cold boxes for transportation of vaccines from the regional storage points to the districts and from the districts to the PHCs; (b) Sterilization equipment for the PHCs and Sub-Centres; and (c) Needles and syringes every year calculated on the basis of estimated beneficiaries.

Overall supplies made to the State/UTs since the inception of the programme till September, 1993 in respect of major items are given in Table V.

TABLE V
CUMULATIVE SUPPLIES TILL SEPT. 1993

ITEM	
ILR-240 Ltr.	3041
ILR-300 Ltr.	653
Chest Freezer-300 Ltr.	1755
Chest Freezer-140 Ltr.	16184
Chest Refrigerator-140 Ltr.	16196
Cold Box-22 Ltr.	17916
Cold Box-5 Ltr.	22582
Vaccine Carriers	191360
Vaccine Day Carriers	173515
Autoclaves	15235
Sterilizing Drums	163646
Steam Sterilizer Pressure Cookers (DR.)	130327
Stove Kerosene	179046

DISTRICTS UNDER CSSM SAFE MOTHERHOOD



Maintenance of Cold Chain Equipment

Till 31-3-1991, the maintenance of cold chain equipment was under contract between UNICEF and commercial agencies. With effect from 1-4-1991 all the States/UTs have taken over the responsibility of maintenance of cold chain equipment. In January 1992, the States were requested to review the existing arrangement for maintenance of cold chain equipment with a view to identify the strengths and weaknesses of the existing system and take remedial action in this regard.

To assist the States to formulate Action Plans for maintenance of cold chain, workshops are being held in States jointly by Ministry of Health & Family Welfare and UNICEF. So far (upto Sept. '93), workshops have been held in the States of U.P., Bihar, West Bengal, Assam, Gujarat, Rajasthan, Kerala, Punjab, Haryana, H.P., Tamil Nadu, M.P., Maharashtra, Orissa, and Andhra Pradesh.

In addition, Govt. of India have also been organising Trainings for Refrigeration Mechanics at the State Health Transport Organisation, Pune; HER Division, SHTEMO, Guwahati, HER Unit, Hyderabad, T.B. Hospital, Bhopal

and HER Training Centre, Madras. During the year 1993 (upto Oct. 1993) 52 trainees have been trained in Refrigerator Repair Training Course, 78 trainees have been trained in WIC Repair Training Course and 42 have been trained in Voltage Stabiliser Repair Training Course.

Quality of Cold Chain

Statutory testing of vaccines is done by the National Quality Control Laboratory at Kasauli. The protocols of all vaccines are scrutinized before use and are released only after declared standard by this laboratory. In addition, samples of OPV are picked up from various levels of storage and sent to designated laboratories for potency testing to ensure effectiveness of the Cold Chain System. Earlier there were only three testing laboratories, i.e. CRI, Kasauli; NICD, Delhi and Enterovirus Research Centre, Bombay. Seven new additional laboratories have been set up for OPV testing.

The test results for the last seven years indicate steady improvement in the efficacy of the cold chain system in keeping vaccines safe. In 1987 about 40% of the field samples failed. At present the failure rate is only about 7 per cent:

POTENCY TEST REPORTS OF FIELD SAMPLES OF OPV

Year	Sample Tested	Samples Satisfactory	% age Samples Satisfactory
1987	1290	790	61%
1988	2196	1454	66%
1989	5423	4580	84%
1990	8148	7550	93%
1991	9208	8354	91%
1992	13936	12287	88%
1993 (upto July '93)	8748	8148	93%

Oral Rehydration Therapy for Diarrhoea Control among Children

The Oral Rehydration Therapy Programme was started in 1986-87 in a phased manner. The main objective of the programme is to prevent diarrhoea-associated deaths in children due to dehydration. The training programmes and health education material highlight the rational management of diarrhoea in children, including increased intake of home available fluids, breastfeeding and continued feeding of the child. ORS is promoted as the first line of treatment and rational use of intravenous fluids and antibiotics are recommended. Preventive measures to reduce disease incidence by measles immunization, exclusive breastfeeding, health and hygiene practices, safe water supply and improved sanitation are supported.

Diarrhoea still remains one of the leading causes of death among children under 5 years. However, as a result of activities under the Programme, positive achievements have been noted. These include the increasing community awareness about ORT and weeding out of anti-diarrhoeal drugs from government health facilities. Many large hospitals have recorded fall in case fatality rates, indoor admission rates and duration of stay of inpatients.

Diarrhoea Treatment and Training Units (DTTUs) have been set up in 55 medical colleges and another 20 such units are being set up in the current year, 1993-94. The network of the DTTUs is being extended to the district hospitals under the Child Survival and Safe Motherhood (CSSM) programme and, during 1992-93, paediatricians from 99 district hospitals have been trained.

ORS supplies are being organised by the Govt. of India Centrally and 2.25 crore packets were procured and supplied to the States and UTs during 1992-93. For 1993-94, provision has been made for supply of 3.47 crore packets. In the CSSM districts, ORS is being supplied as a part of the Sub-Centre kits.

In order to make ORS packets widely available, States have been advised for marketing of ORS packets through the Public Distribution System.

A National Standard for ORS packets has been developed. The

standard consists of a logo, a packet design and instructions (written and graphic) for use on ORS packets.

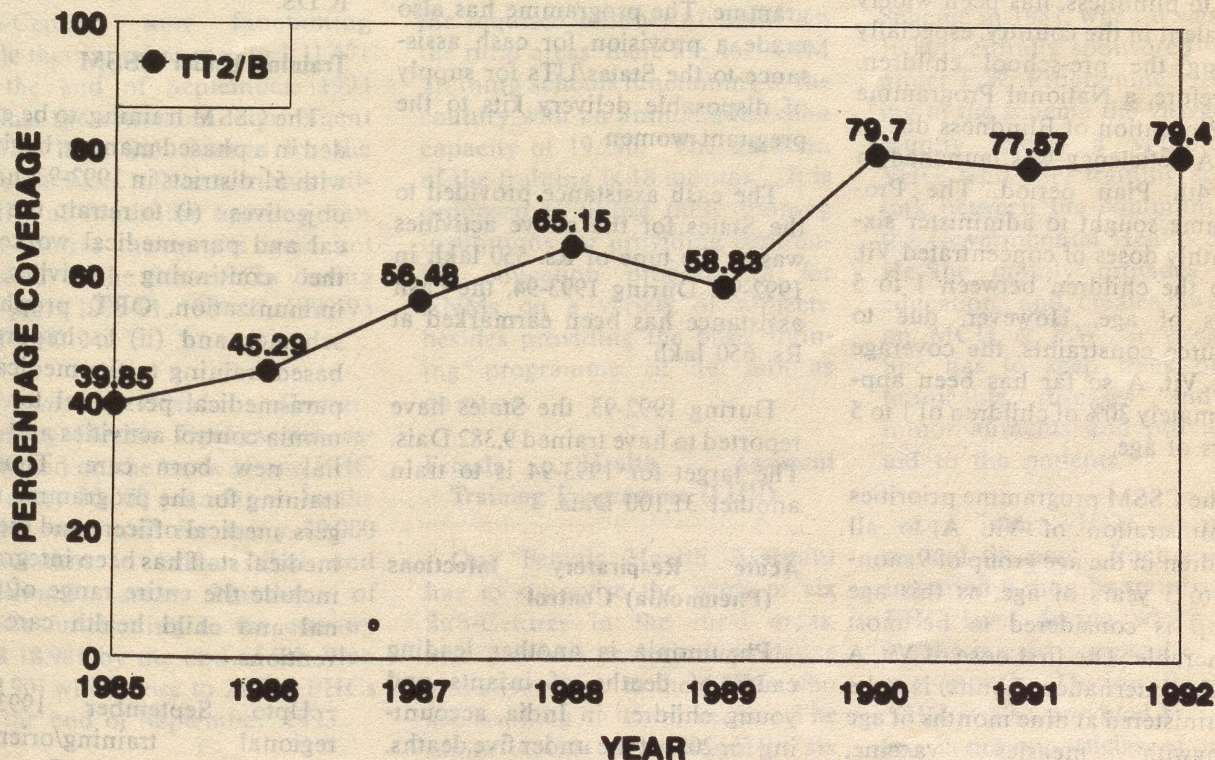
The Programme emphasises rational use of drugs for the management of diarrhoea. Anti-diarrhoeal drugs have no place in the treatment of diarrhoea; while antibiotics are recommended only for specific indications like Cholera and Dysentery. States have been advised to delete anti-diarrhoeal drugs from their procurement lists.

A Committee of Experts in the Office of Drug Controller, India

has recommended banning the sale of paediatric anti-diarrhoeal. Action to ban these formulations is now being taken by the Drug Controller, India.

Inter-personal communication for promotion of ORT through mother's meeting was started in 1990-91. During 1992-93 an amount of Rs. 231.31 lakh was released to the States for this activity and the States have reported to have trained 11.06 lakh mothers in home management of diarrhoea. An allocation of Rs. 232.90 lakh has been made during 1993-94 for the States.

UNIVERSAL IMMUNIZATION PROGRAMME TETANUS FOR PREGNANT WOMEN



Prophylaxis Schemes

Anaemia Prevention and Control among Pregnant Women: Anaemia, which accounted for 19% of the maternal deaths in the country in 1990 is one of the leading causes of maternal mortality and is an aggravating factor in haemorrhage, toxæmia and sepsis. Although administration of IFA tablets to pregnant and lactating women was started in the 4th Plan period, its effective coverage remained due to resource constraints, around 30 per cent of the total eligible target group. The CSSM programme, therefore, has prioritised pregnant women for IFA Administration. During 1992-93, 158.61 lakh (58.9%) pregnant women were provided with the recommended dosage of IFA tablets.

Prevention and Control of Vitamin A Deficiency among Children: Vitamin A deficiency, which can lead to blindness, has been widely prevalent in the country, especially among the pre-school children. Therefore, a National Programme for Prevention of Blindness due to Vit. A deficiency was launched in the 4th Plan period. The Programme sought to administer six-monthly doses of concentrated Vit. A to the children between 1 to 5 years of age. However, due to resource constraints, the coverage with Vit. A so far has been approximately 30% of children of 1 to 5 years of age.

The CSSM programme priorities administration of Vit. A to all children in the age group of 9 months to 3 years of age, as this age group is considered to be most vulnerable. The first dose of Vit. A (1 lakh international units) is to be administered at nine months of age alongwith measles vaccine, followed by another dose alongwith the booster dose of DPT/OPV vaccine. During 1992-93, 106.07

lakh (43.7%) infants were administered the measles-linked dose while the DPT/OPV booster linked dose was administered to 56.48 lakh (28.7%) children in the age group of 1-2 years.

Essential Maternal Care: Dais Training, Their Reporting Fees and Disposable Delivery Kits for the Pregnant Women

The SRS data for 1990 indicates that the proportion of deliveries attended by untrained hands is still very high, particularly in the rural areas of States of Assam, Bihar, M.P., Orissa, Rajasthan and U.P. The CSSM Programme, therefore, accords a high priority to speeding up the training of Traditional Birth Attendants (Dais) in all States/UTs, particularly in the above mentioned States. The reporting fee to the Dais has also been enhanced from Rs. 3.00 per case to Rs. 10.00 per case under the CSSM programme. The programme has also made a provision for cash assistance to the States/UTs for supply of disposable delivery kits to the pregnant women.

The cash assistance provided to the States for the above activities was to the tune of Rs. 550 lakh in 1992-93. During 1993-94, the cash assistance has been earmarked at Rs. 650 lakh.

During 1992-93, the States have reported to have trained 9,382 Dais. The target for 1993-94 is to train another 31,100 Dais.

Acute Respiratory Infections (Pneumonia) Control

Pneumonia is another leading cause of deaths of infants and young children in India, accounting for 20% of the under five deaths. The ARI control strategy was developed during the period 1989 and implemented in 24 districts on

a pilot basis during 1991. The Programme includes training of peripheral level health workers on recognition of pneumonia and treatment with cotrimoxazole. An evaluation carried out in two districts in 1991 found that the trained health workers were able to correctly diagnose and treat pneumonia. Cotrimoxazole availability at Sub-Centre level was also adequate.

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

Training Under CSSM

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

Upto September 1993, 24 regional training/orientation workshops for State Core Members have been organised in which
(Contd. on Page 204)

SWASTH HIND

RURAL HEALTH SERVICES

Health Infrastructure in rural areas is of prime importance for realisation of the objectives set forth in the National Health Policy and for attaining the goal of "HEALTH FOR ALL BY THE YEAR 2000 A.D." Co-ordinated efforts are being made under various Rural Health Programmes to provide effective and efficient services to the people in the rural areas.

NUMEROUS programmes and schemes are being implemented under the Minimum Needs Programme to provide Primary Health Care relevant to the actual needs of the community in the rural areas. The status of establishment of the Sub-Centres, PHCs and Community Health Centres under the Minimum Needs Programme, is detailed here:

Sub-Centres: A Sub-Centre is established on the basis of one Centre for every 5,000 population in plain areas and for 3,000 population in hilly and tribal areas. Till the end of the 7th Plan, 1,30,336 Sub-Centres, were functioning while their number rose to 1,31,471 by the end of September, 1993 against the estimated requirement of 1.38 lakh Sub-Centres for the Seventh Plan. Due to non-availability of funds for opening new Sub-Centres the targets were not allotted to the States/UTs during the years 1990-91, 1991-92, 1992-93 and 1993-94.

Primary Health Centres: Primary Health Centres are established on the basis of one PHC for every 30,000 population in the plain areas and for every 20,000 population in hilly, tribal and backward areas. Number of PHCs functioning in the country was 18,981 by the end of 7th Plan (1.4.90) which rose to 21,024 PHCs by the end of September, 1993.

Community Health Centres (CHCs): Rural hospitals with specialist facilities established by

upgrading PHCs have 30 beds to cover a population of 80,000-1.20 lakh. By the end of 7th Plan (1.4.90) the number of CHCs functioning was 1,911 which rose to 2,293 CHCs by the end of June, 1993. The CHCs act as referral Centres for four PHCs in a Block.

Auxilliary Nurse Mid-wives (Female Health Worker) Training Programme

Each Sub-Centre is manned by one Male Health Worker and one Female Health Worker (Auxilliary Nurse Midwife). In order to train the required number of ANMs in the rural areas, there are 462 ANM Training Schools functioning in the country with an annual admission capacity of 19,290. The duration of the training is 18 months. It is proposed to utilise these training institutions for providing continuing education programmes for ANMs on a variety of subjects, besides providing the basic training programme of 18 months duration.

Female Health Assistant Training Programme (LHV)

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

capacity of 2,758 that are functioning in the country. These training schools are utilised for giving continuing education for Female Health Assistants (LHV) besides providing basic training programme of six months duration.

Village Health Guide Scheme

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

4.15 lakh VHGs have been trained till now. Each trainee is imparted 3 months training at the PHC level during which period he/she is paid a stipend of Rs. 200 per month. During training, a VH.G. is also provided kit containing common articles of use and medicines and a manual. At present 3,24,727 VHGs are on the role of State Governments/UTs. Each

VHG is paid an honorarium of Rs. 50 per month.

Appendix I

Multi-Purpose Worker (Male)

As per the norms, each Sub-Centre is required to be manned by a trained Female Health Worker (ANM) and a trained Male Health Worker known as Multi-Purpose Worker (Male). The Govt. of India had initiated a scheme of training and thereby converting the uni-purpose workers under various programmes to multi-purpose worker in 1978. This training was continued till 1990. However, because of the shortage of MPW's (Male) at Sub-Centre level, a scheme of basic training for MPW (Male) was initiated during the 7th Plan period. Under this Scheme, the 10th Pass candidates are selected and trained for one year before they are inducted into the service.

The basic training of MPW (Male) has been initiated by opening 44 such schools in various States. Against the sanctioned strength of 50 schools, out of which 40 schools are functioning at present. As these schools were found to be inadequate to meet the requirements of training of MPW's (Male), this training was also initiated in 36 HFWTCs. Additional staff was sanctioned for training of MPW's (Male) in HFWTCs.

Orientation Training of Medical and Para-Medical Personnel

This is a Centrally sponsored scheme under the Family Welfare Programme. It was started with the objective to train Medical and Para-Medical Personnel working at PHCs and Sub-Centres. Each category is placed to be imparted training in the same institution, where they had their basic training. The duration of the training is two weeks.

Pattern of Assistance: The financial assistance admissible under the scheme is in the form of 100% non-recurring grant towards a

PROGRESS OF EXPENDITURE

Year	Allocation	Anticipated expenditure (Rs. in Lakh)
1985-86	Nil	Nil
1986-87	50.00	Nil
1987-88	150.00	67.37
1988-89	100.00	43.74
1989-90	50.00	50.00
1990-91	50.00	49.90
1991-92	83.00	78.00
1992-93	80.00	39.96

hostel for 20 trainers alongwith lecture and demonstration room, kitchen articles, training equipment and aids. The recurring grant is admissible on 50:50 sharing basis between the Govt. of India and the State Governments and the components covered under this are: rent for hostel (till the building is constructed), contingency, consumable training material; additional teaching staff for hostel and class rooms of the HFWTCs and stipend for the trainees. For HFWTCs, which have been

augmented under the scheme of orientation training of medical and para-medical personnel only stipend is admissible to trainees. Regarding UTs, as they do not have enough training facilities available with them, they will seek the assistance of adjoining States to train their personnel.

Progress: The Scheme is in operation in the States of Andhra Pradesh, Assam, Bihar, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Karnataka,

Appendix II

FUNDING PATTERN OF HFWTCs

Non-recurring

- | | |
|--|---|
| 1. Vehicles (one bus, one mini bus and one jeep or two mini buses and one jeep) and equipments including duplicating machine, projector, typewriter and furniture. | Rs. 1,36,500.00 (old expenditure as no training centre has been sanctioned after 1975). |
| 2. Construction | Cost of 20,350—20,450 sq. ft. plinth area as per the blue print of Government of India. |

Recurring (per annum)

- | | |
|---|---|
| 3. Pay & allowances, etc. of the staff (as per pattern). | Rs. 8.5 lakh at present (approx.) |
| 4. Contingencies including purchase of educational materials, books for library, periodicals, postage, telephone charges, electricity and water charges, printing and stationery and other items. | Rs. 6,000.00 (per annum) |
| 5. Cost of petrol and maintenance of vehicles at the rate of Rs. 12,000/- and Rs. 9,000/- (for petrol & diesel drive vehicles respectively). | Rs. 36,000.00 per annum. (Revised from time to time). |
| 6. Rent for training centre and hostel for trainees in case Govt. accommodation is not available. | Rs. 18,000.00 per annum |
| 7. Payment to Guest Faculty | Rs. 1,500.00 per annum |

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ADVICE TO THE MOTHER OF A CHILD WITH DIARRHOEA

THE cooperation of the mother is important to prevent diarrhoea-associated deaths. She is the one who is looking after the child, who even if hospitalised, will largely be cared for by her. Lack of information on the part of the mother can put the life of the child at risk. Appropriate management of diarrhoea is not complete if the mother has not been counselled about the home available fluids, ORS, continued feeding and when to seek immediate help.

While the accessibility of ORS has improved and ORS packets are available in all health facilities and also through outreach sites in the villages, it is also important that the mothers and other health care providers are aware about the quantities of ORS to be given to prevent diarrhoea-associated dehydration. A child under 6 months of age needs approximately 50 ml (quarter glass); 7-12 months—50 to 100 ml (quarter to half glass) and above 12 months—100 to 200 ml (half to one glass) of ORS or home available fluids for each stool loss to prevent dehydration.

About 100 ml of ORS solution per kg body weight are required to be given in the first 4 hours if the child has any signs of dehydration such as increased thirst, restlessness, irritability, decreased skin turgor, dry mouth and tongue, no tears and sunken eyes. If the child is thirsty and wants to drink, more solution should be given.

Most fluids that a child normally takes and are usually prepared with salt should be promoted such as salted rice water, dal ka pani, salted lassi or soups. These fluids should

be prepared in the usual way and since they are safe when given to healthy children, it is not likely that a child with diarrhoea will get too much salt. Plain water should always be recommended as a home available fluid although it contains no salt. However, soft drinks, sweetened fruit juices and sweetened tea should not be used as they are potentially dangerous due to their high osmotic activity which can aggravate dehydration and cause hypernatraemia.

In majority of the cases, diarrhoea is self limiting and the children will recover in a few days if they are given adequate fluids and food. Some children, however, will need medical care and others may have to be hospitalized and the mother must be able to recognize the signs when to seek immediate help. Cases of dysentery (blood in the stools), for example, require to be treated with antibiotics. Children who are floppy or

IMPORTANT INFORMATION FOR THE MOTHER

- Increase intake of fluids-ORS or HAF
 - How to prepare an ORS solution
 - Continue feeding the normal diet
 - Recognize signs when to seek help
-

In addition to fluids, food is also important to prevent dehydration, other complications and malnutrition. The child's diet should be what is appropriate for the age and to which the child is accustomed. If the child is undernourished, advice can be given on improving the diet by simple measures such as giving food of thicker consistency (for infants), preparing milk based cereals and addition of small amounts of oil. Food prepared with salt should be encouraged. As the child may have a poor appetite, food should be given frequently about 6 times a day. If the child is taking animal milk, this should be given in the normal amount and be undiluted. Breastfeeding should continue if the child is on breastmilk.

unable to drink have severe dehydration and need to be given intravenous fluids. Severely malnourished children have high case fatality rates and are at a higher risk of persistent diarrhoea. These children need careful management. Some children may have other infections such as pneumonia. Children who get diarrhoea following an episode of measles may have a more severe illness and vitamin A deficiency. The mothers must be encouraged to bring the child for medical checkup if the condition of the child has deteriorated or if she is worried or anxious. She must be able to recognize the danger signs when to

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

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

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

seek medical care. The signs include the following:

- Blood in the stools
- Many watery stools, repeated vomiting
- Unable to drink and refusal of breastfeeds
- Floppy, difficult to wake, unconscious
- Increased respiratory rate or chest indrawing
- Diarrhoea within 6 weeks of measles.

—CSSM Review, Oct, 1993

FACTS ABOUT EYE DONATION

1. Almost anyone of any age can pledge to donate eyes after death. This can be done even if the donor wears glasses, has cataract or has undergone eye surgery successfully. All that is needed is a clear, healthy cornea.
2. The eyes have to be removed within six hours of death. So the nearest Eye Bank or Eye Collection Centre must be informed immediately.
3. The Eye Bank itself will rush a doctor to donor's home. There is no charge to the family.
4. Eye removal takes only 10-15 minutes and leaves no scar for disfigurement of the face.
5. Your donation gives sight to two blind persons. One blind person is given one eye.
6. The eyes of the deceased can be donated whether he has pledged the eye or not. The law provides that one is authorised to the donations of the eyes of a deceased relatives if he or she had never said anything against eye donation.
7. On reaching the eye bank eyes are examined, treated (processed) and used for cornea transplant operation within 7 hours.
8. The donated corneas are transplanted with to patients eyes who are on waiting list in accordance with the priority base on guidelines to avoid malpractices.
9. The recipient of cornea will always remain anonymous but the family should be satisfied knowing that the eyes have been used to restore vision to two blind persons.
10. The eyes can be pledged to an Eye Bank and can be actually donated to the nearest Eye Bank at the time of death.
11. The donated eyes are never bought or sold. The eye donation is never refused.

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Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Orissa, Punjab, Tamil Nadu, UP and West Bengal.

Progress of expenditure: The 7th Plan allocation for the Scheme was Rs. 1,000 lakh. The details of allocation releases made and anticipated expenditure is as stated in Appendix I.

During 1993-94, Rs. 80 lakh has been allocated for this Scheme.

Health and Family Welfare Training Centres (HFWTCs)

Health and Family Welfare Training Centres are established in the country with the objective of giving in-service training to health

personnel in the rural health sector. These training centres are set up with 100% financial assistance from the Central Government. There are 47 HFWTCs in the country at present.

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

Medical Officer	2 weeks
Health Assistants (Male & Female)	2 Weeks
Health Workers	2 weeks
Block Extension Educators	2 weeks

Key Trainers 2 weeks of ANM School

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

Funding Pattern of HFWTCs: The HFWTCs are funded under 100% Central assistance from the Family Welfare Budget. The different components which are funded are as shown in Appendix II.

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

Elimination of Neonatal Tetanus will save 1 million newborns annually

THE number of infants dying each year from tetanus in the first three weeks of life has been cut in half since 1980 and is now estimated at 500,000 worldwide. In addition, over 30,000 deaths of women from the same cause are being prevented each year.

This achievement, outlined in a report on elimination of neonatal tetanus and control of measles, EB 93/21, prepared for the WHO Executive Board meeting currently in Geneva, is mainly the result of the effective immunization of women with tetanus toxoid vaccine before or during their pregnancy.

Immunization at this stage provides long-term protection against tetanus for the mother, but, critically, also protects her newborn child during the early weeks of life. It is during this period that tetanus spores, implanted in the infant's umbilical cord as a result of unhygienic birth practices, can lead to the disease. Poor birth hygiene and harmful traditional practices pose an ever-present threat both to mothers and infants.

"The initiative to eliminate neonatal tetanus will ensure better protection of the mother and the child, and, by its emphasis on training birth attendants, will also lead to safer childbirth", says Dr Ralph Henderson, Assistant Director-General of the World Health Organization.

In 1989, the World Health Assembly committed WHO to achieving the elimination of the disease by 1995, which in many countries accounted for up to 25% of all infant deaths in the early 1980s. Elimination is defined as less than one case of tetanus for every 1000 births occurring in each administrative district throughout the world.

In a statement adopted in January 1994, WHO's Executive Board encourages Member States to demonstrate the political will and provide the resources for neonatal tetanus elimination. Priority support should be given to countries accounting for 80% of the estimated global neonatal tetanus cases: Bangladesh, China, Ethiopia, India, Indonesia, Kenya, Nepal, Nigeria, Pakistan, Somalia, Sudan, Uganda, Viet Nam, Zaire.

"With two years to go, we are facing the most dangerous stretch of the road with warning signs Complacency Ahead. We simply must focus on the situation in the 14 countries responsible for 80% of all cases worldwide", stressed Dr Henrik Zoffmann, Acting Director of WHO's Expanded Programme on Immunization (EPI).

In 1980, fewer than 5% of women in developing countries had received the recommended course of at least two vaccinations against tetanus, a figure that by 1993 had risen to 43% in spite of the steady increase in the total population.

As public health workers extend immunization programmes to reach the most needy populations—including the poor, the least educated, those living in remote areas, overcrowded and unhygienic conditions—the opportunity is taken to educate mothers and birth attendants on how to conduct hygienic births. Improved hygiene during and after delivery makes for a safer childbirth both for mothers and infants.

Cases of neonatal tetanus do not occur evenly throughout the world. WHO estimates that only 25 countries have more than five cases of tetanus per 1000 births. Within a country, cases tend to occur in clusters, in areas with poor birth hygiene and harmful traditional practices. It is true to say that neonatal tetanus affects mostly the poorest of the poor in countries in greatest need.

Public health workers use clusters of the disease as the basis for an effective control strategy. Detecting cases helps to determine areas with low immunization levels and poor birth hygiene. This approach yields better results than blanket countrywide immunization of all women of childbearing age, whatever the risk of contracting the disease.

The progress achieved is promising but there is still much to be done. Reliable supplies of potent vaccine, sterile syringes and needles are needed to enable affected countries to conduct regional immunization days backed up by health education campaigns. These needs are vital. Without their provision, not only will the 1995 target of neonatal tetanus elimination be missed, but the potential of safer childbirth and the possible 25% cut in infant mortality will also be unnecessarily delayed.

"Tetanus is but one among many problems associated with childbirth which threaten the lives of mothers and their newborns", says Dr Henderson. "Eliminating this one problem will not solve them all. But tetanus is a warning beacon. Wherever it occurs, it demonstrates abject failure of the health system. So eliminating this disease automatically requires health workers to recognize and respond to the problems which have generated it, ensuring that all mothers have access to the basics of good maternal care. Tetanus elimination does indeed provide a powerful strategy for improving maternal care more generally." —W.H.O.

ANTIBIOTIC HOPE FOR CANCER SUFFERERS

Doctors at University College London (UCL) have found that once they have used antibiotics to eliminate the bacterium causing stomach cancer, the tumours also disappear. As a result, thousands of stomach cancer sufferers could soon be successfully treated.

The first person treated in this way was Mr Stephen Hope, a betting shop manager from Warrington in Northern England, who was diagnosed as suffering from a lymphoma of the stomach two years ago. On the advice of Dr Peter Isaacson, of UCL, he was treated with the antibiotics at Warrington hospital and a month later the cancer had gone.

So far, Dr Isaacson's team has treated only stomach lymphomas, which represent about 600 of the 12,000 stomach cancers diagnosed in Britain each year.

Five other patients have been treated, all of them successfully. Dr Andrew Wotherspoon, of UCL, said that the team had been "gratified rather than surprised" that the treatment had worked. He continued: "Over the past two or three years, a fair bit of evidence had been building up for a link between this type of cancer and a bacterium called *Helicobacter pylori*. We thought it made sense to eliminate the bacterium and see what would happen to the tumour".

Dr Isaacson's team uses a cocktail of common antibiotics and two weeks treatment is enough to kill the bacterium.

Medical News from Britain

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511 DIO/DHOs, Principals of HFWTCs and other medical officers have been trained. Training of para-medical workers in the 51 districts taken up in 1992-93 (Phase I) has already been completed, while training of Medical Officers and para-medical workers is in progress.

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

First Referral Units (FRUs) for Emergency Obstetric Care

Selected rural health facilities, with a sanctioned post of a gynaecologist and an operation theatre, are being upgraded by providing essential equipment and

skill based training, where required. About 6 to 12 such FRUs (for 300,000 to 500,000 population) are expected to be established in each district and will be in addition to the district hospital. Easier accessibility to adequate medical care is essential for an effective referral system and for promoting timely and early referral under the CSSM. Since the CSSM outlays are limited, in this regard, the States of Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa and Assam, other States are to mobilise their own resources for upgrading health facilities for providing emergency obstetric care and medical treatment of maternal complications.

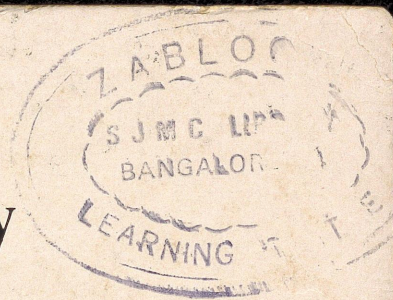
Assistance to States in 1992-93 & 1993-94

During the year 1992-93, the estimated cash and commodity

assistance to the States/UTs has been calculated at Rs. 100.73 crore. This consists of Rs. 26.54 crore as cash assistance and Rs. 74.18 crore as kind assistance. The kind assistance comprised of vaccines, cold chain equipment, iron and folic acid tablets, Vit. "A" solution, Oral Rehydration Salt (ORS) packets for all districts and medicine kits for the 51 districts.

For the year 1993-94, the programme has been provided with an outlay of Rs. 125.00 crore. Out of this outlay the cash and kind assistance earmarked for the States/UTs has been estimated at Rs. 123.93 Crore. This will consist of Rs. 27.80 crore as cash assistance and Rs. 95.00 crore as kind assistance. □

One Earth, One Family



On the occasion of World Environment Day, following is the message from Elizabeth Dowdeswell, United Nations Under-Secretary-General and Executive Director, UNEP

THE global village. The new world order. The peace dividend. These are all buzzwords of the 90s that reflected an optimistic outlook for the dawning of the next century. Each idea represents a sense that finally we had reached a point in time when we could progress from the dysfunction caused by the lack of understanding of the simple idea that we are one family.

Unfortunately, it has become obvious that the corner turned did not lead to a smooth road where racism, nationalism and a plethora of insular attitudes take a backseat. In fact, it seems that we have entered a period where many of the demons of the Cold War era—whether economic, environmental or social—are looming still like an ominous cloud on the horizon.

This foreboding sense has become all the more apparent by the numerous reports of the past year outlining the global security problems we face as due to environmental and development woes. At the Earth Summit two years ago there was a lot of talk about a doomsday if action was not taken. And, if anything, some of those scenarios seem all the more imminent.

Indeed we know the problems. And, in fact, we know some of the solutions. It is only a matter of political will if we are to implement them.

Politics aside, there is a more basic approach each individual can take. We must recognize our responsibilities to the planet. What this means is quite simple: **We are one earth and one family. This concept is the theme of this year's World Environment Day: One Earth, One Family.**

The family is the backbone of any society and it should provide the necessary moral foundation that we build on. But families all over the world are under heavy stress. Disease, war, poverty, crime and drugs are tearing the fibers that bind families and subsequently societies together. So it is vital that all of use no matter what age or gender help make the family a refuge from these problems.

If each individual can embrace that concept half the battle is won. As human beings we are a unique. Unfortunately that uniqueness has often proven more of a handicap. If we can embrace a collective sense of spirit in the name of the human family, the shortsightedness of the

past will be put in perspective as a necessary learning curve.

Working at the United Nations, it is a bit easier for thousands of our employees to appreciate the concept of the human family. That's because everyday we are in contact with people of all creeds, colour and religions.

But what about the herder in Mongolia, the farmer in Africa, the fisherman in the South Pacific, the hunter in the Arctic, the civil servant in Europe or the financier on Wall Street. How do these people transcend what is in some cases an isolated existence or in others an all encompassing occupation.

One way is to break things down to basics. Think about the water we drink, the energy we use and the food we eat. All are finite resources and the way we use one of them affect the life of someone on the other side of the planet in our global village. In a very practical manner everyone from adolescent to octogenarians can take action. Reducing water and energy consumption or volunteering in community-based organizations are others. —U.N. Newsletter

