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# Swasth Hind

*Dr. J. S. ...*

VOLUME V

NOVEMBER 1961

NUMBER 11

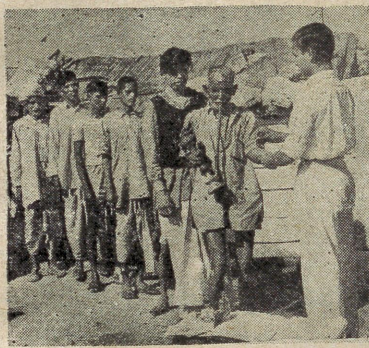
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### OUR COVER

Smallpox pilot projects undertaken with the object of assessing the manpower and financial requirements and other problems in connection with the Smallpox Eradication Programme came to an end in March last. Of the total population of the pilot project areas of about 23 million, 14.4 million had been approached and 12 million covered. Our cover shows a mass vaccination programme in progress.

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## COMPULSORY OR VOLUNTARY VACCINATION\*

ALTHOUGH a century and a half have elapsed since vaccination was introduced by Jenner, it does not yet seem to have been universally accepted. It is easy enough to understand why isolated peoples, living as their ancestors have for generations and being as yet untouched by modern civilization, fail to grasp the reason for vaccination and are hostile to it. It is less easy to understand why civilized people, even doctors themselves, should still form anti-vaccination leagues.

Just how strong is this hostility to vaccination? In the USA, when the campaign to have the susceptible population immunized with Salk vaccine against poliomyelitis had been in progress for some months, it was decided that the response was inadequate. A survey was, therefore, carried out in 1957 to ascertain why more people had not offered themselves for vaccination<sup>1</sup>. The inquiry showed that people were on the whole well-informed about vaccination, and not specifically opposed to it. However, there were no direct, positive influences acting upon them to make them go and have themselves vaccinated. Thus, many adults did not undergo vaccination simply because they kept on putting it off. Some also had the feeling that they were not susceptible to the disease—a feeling that was related to the belief that victory over poliomyelitis had been achieved—and many parents of teenagers thought that their children were less susceptible to the disease than younger children. Those with more education and higher economic and social standards were more aware of the need met by the vaccine and the threat presented by poliomyelitis, and were accordingly more likely to have themselves immunized. The doctor's influence was of prime importance. Many people said that they would have had themselves vaccinated if their doctors had recommended it;

but they then admitted that they seldom visited their doctors.

A separate survey in California in 1956<sup>2</sup> elicited some additional information about the attitude of the public to vaccination against poliomyelitis. Families that had not had their children vaccinated against other diseases tended not to have them vaccinated against poliomyelitis, and usually belonged to a lower social and economic level. The attitude of other families in their immediate circle exercised a great influence. Of the 11 per cent. of mothers who were unfavourable to vaccination, most mentioned fear, their disapproval of all injections, or the opposition of someone else, as the reason for their attitude. Among mothers who were favourable to vaccination but who had not had their children vaccinated, the chief reason for this omission was simple negligence. A point that confused a certain number of people was that in the early stages of the campaign vaccination had been limited to children aged 5-9, the reason being simply a shortage of vaccine. Later on, when the vaccine became more plentiful, many people did not realize that other age-groups might avail themselves of vaccination and were, in fact, being urged to do so.

It may be surmised that some of the opposition to vaccination is based on the feeling that animals are made to suffer in order to provide vaccine; it is thus allied to the opposition to vivisection. Some may be due to the fear engendered by the headline reporting of accidents or serious side reactions, always more sensational than news about the tens of thousands of people who have been vaccinated safely. Some may be due to fear of the vaccination procedure itself, of the pain of the needle and the later pain at the site. In some people an obstinate

\* Based on: Moerloose, J. De (1961) *Compulsory or voluntary vaccination*. In: World Health Organization, *The role of immunization in communicable disease control*, Geneva, p. 85 (*Public Health Papers*, No. 8).

<sup>1</sup> Glasser, M.A., (1958) *Amer. J. Publ. Hlth*, 48, 141.

<sup>2</sup> Merrill, M.H. (1958), *Amer. J. Publ. Hlth*, 48, 146.

refusal to conform will make them hostile to any general measure, even one benefitting them, particularly if it is compulsory. More important than genuine opposition are apathy, indifference, procrastination, the feeling that the disease, whatever it is, may affect other people but not oneself. Among more abstract reasons adduced against vaccination, especially compulsory vaccination, are the individual's right to his own personal freedom and the right to religious freedom—compulsory immunization being considered by members of certain sects as contrary to their beliefs.

In favour of compulsory vaccination it is argued that if a vaccine against a disease threatening the community is effective, anyone who does not have himself vaccinated is committing an offence against the community. He is thus abusing his right to individual freedom by endangering other people, and he should be compelled to undergo vaccination so that the community may be protected. This argument is applied to all members of the community, whether they have religious scruples about vaccination, or are too apathetic to have themselves vaccinated, or exhibit a "doltish prejudice" against vaccination. It follows that if a vaccination campaign runs the risk of failure because not enough people have had themselves vaccinated to ensure a level of immunity high enough for control of the disease concerned, compulsion should be employed.

Does compulsion achieve all it is supposed to achieve? If the experience of the United Kingdom with smallpox vaccination is to be regarded as typical, it seems not. Smallpox vaccination was made compulsory in that country in 1853. In 1897 and 1907 the inclusion of a conscientious objection clause led to a progressive decline in the number of vaccinations, and in the years 1940 to 1949—a period during which several other countries were intensifying vaccination—the average annual percentage of children under one year vaccinated in the United Kingdom did not exceed 35 per cent. Compulsion was abolished in 1948, and in the age-group under one year the percentage of vaccinations then fell to less than 20 per cent. Since 1951, however, intensive health education in favour of vaccination has led to a rise in the number of vaccinations in this age-group—in 1958 it reached 44.5 per cent. in England and Wales.

Smallpox vaccination in the United Kingdom is perhaps not a very good example to choose as an illustration of the defects of compulsion. In the United Kingdom and most of Europe, smallpox is now not endemic, the occasional outbreaks being the result of infection imported from outside, especially from the main reservoir of the disease in South-East Asia. These outbreaks can be controlled by strict quarantine of contacts and vaccination of all concerned with the patients. Consequently, the question whether compulsory vaccination for the whole population is necessary when isolated outbreaks are the only possible or likely manifestations of the disease had been exercising the minds of the medical profession in the United Kingdom for some considerable time before compulsion was abolished. Moreover, infant vaccination alone, even when done successfully, will not protect the whole population or control the spread of smallpox in the community. To maintain a high level of immunity in the population, re-vaccination at suitable intervals is essential, and there was much controversy about whether the amount of vaccination required could be justified. Some of these arguments had become reasonably well-known to the general public. It can hardly be doubted that they had their effect in swelling the numbers of those who claimed the benefit of the conscientious objection clause or succeeded in one way or another in evading vaccination for their children. They must also have led to diminished zeal on the part of the medical authorities in seeing that vaccination was enforced.

The situation with regard to vaccination against diphtheria in England and Wales provides an interesting comparison with that of smallpox vaccination. Vaccination against diphtheria has never been compulsory, and in the decade before large-scale immunization—*i.e.*, 1933-42—the annual average of cases was 55,125, of deaths 2,783. A campaign was launched in 1941 to educate the public to the desirability of having children vaccinated against this disease, with the result that the number of vaccinations soared and the number of cases and deaths fell rapidly. In 1956, there were 53 cases, with three deaths; in 1957, 37 cases, with four deaths; and in 1958, 80 cases with eight deaths. Although diphtheria morbidity rises and falls and there have been sharp falls in the incidence in some countries since the epidemic of 1943-45, "the close

correlation between the initiation and widespread application of active immunization and the steady fall of both morbidity and mortality rates can leave no doubt about the effectiveness of vaccination"<sup>3</sup>—and, it may be added, of the health education drive in favour of diphtheria vaccination in England and Wales.

The various groups taking part in the Technical Discussions at the Thirteenth World Health Assembly came to the conclusion that there is no simple solution to the controversial problem of whether vaccination should be compulsory or voluntary.

"The decision whether to adopt compulsory or voluntary vaccination", says the report of these discussions,<sup>4</sup> "has to be made according to experience of or opinion about which would result in the most effective vaccination programme, and these vary greatly in different countries. However, the consensus in all groups was that the ultimate aim should be voluntary vaccination, depending for its success on the development of a spontaneous demand by the population for vaccination through health

education both of the population at large and—especially important in some countries—of the medical profession itself, which should, but often does not, play a leading role in stimulating a proper attitude to immunization."

While voluntary vaccination is the ideal, it is obviously an ideal that cannot be attained overnight.

"The aim that vaccination programmes should become 'the people's programme with government participation' rather than 'the government's programme with people's participation' can only be achieved by gradual stages. . . . In the words of one group of participants: 'In under-developed areas compulsory vaccination is essential. As education improves so compulsion can be relaxed. However, it is stressed that for the success of all programmes it is essential to inform the populations with great care *how, when, and where* the programmes are to take place and explain *why* as the ability of the population to understand such explanations improves. Health education should be undertaken in all programmes, whether compulsory or not.'"

—WHO Chronicle

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<sup>3</sup>. Cruickshank, R. (1961) *The background to immunization*. In: World Health Organization, *The role of immunization in communicable disease control*, Geneva, p. 33 (*Public Health Papers* No. 8).

<sup>4</sup>. World Health Organization (1961) *The role of immunization in communicable disease control*, Geneva, p. 101 (*Public Health Papers* No. 8).

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No physician, insofar as he is a physician, considers his own good in what he prescribes, but the good of his patient. For the true physician is also a ruler having the human body as a subject, and is not a mere money-maker.

—Plato

# PROGRESS IN IMMUNIZATION

THE following immunization schedules were accepted by the participants in the technical discussions at the Thirteenth World Health

Assembly as being suitable for areas with adequate and areas with inadequate medical services, respectively.

## For areas with adequate medical services

Age	Proposed schedule
2-6 months	Diphtheria-pertussis-tetanus triple vaccine : three doses with one month's interval between each dose.
6-7 months	Smallpox vaccination.
7-10 months	Poliomyelitis vaccine (inactivated) : Two doses with one month's interval.
15-18 months	Booster dose of triple vaccine ; simultaneously, third dose of poliomyelitis vaccine.
2-4 years	Fourth dose of poliomyelitis vaccine.
5-6 years	Booster dose of diphtheria-tetanus vaccine ; simultaneously, smallpox re-vaccination.
10-15 years	Booster dose of diphtheria-tetanus vaccine if Schick test positive ; no injection of diphtheria prophylactic in Schick pseudo-reactors. BCG vaccination (in tuberculin-negative reactors).

## For areas with inadequate medical services

Age	Proposed schedule	Visit
0-4 weeks	(1) BCG vaccination	1st
3-9 months	(2) Smallpox vaccination. (3) Diphtheria-pertussis-tetanus (triple vaccine with alum) ; two doses at an interval of one month. The first injection could be given at the time of smallpox vaccination. Smallpox vaccination is verified at the second visit. Failures of smallpox vaccination are re-vaccinated.	2nd and 3rd
School entry or soon thereafter	(4) Diphtheria/tetanus booster (plain or with alum) (5) TAB vaccination (where necessary) : Two doses at an interval of one month. (6) Smallpox re-vaccination : at the time of second TAB injection.	4th and 5th
10-14 years	(7) BCG re-vaccination (in tuberculin-negative reactors) (8) Smallpox re-vaccination (9) TAB booster	6th and 7th

--Extracts from an article in the  
*WHO Chronicle*



# HEALTH HAZARDS AND PRECAUTIONS IN USE OF PESTICIDES\*

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THE use of pesticides and other agricultural chemicals is posing an increasingly important occupational health problem in California. Reported occupational disease attributed to these chemicals has increased three-fold since 1954.

Three-fourths of the 1,100 cases reported last year occurred among farm workers. The rest occurred primarily among those who manufacture, transport, or otherwise handle pesticides. Only 12 cases concerned structural pest control operators—those who handle pest control in buildings such as homes and offices.

Considering the hazardous chemicals which they may use, structural pest control operators appear to have a comparatively good occupational safety record. However, neither the amounts of hazardous pesticides used nor the number of workers actually exposed are known so this apparently good record could reflect a lesser number of exposed workers.

As a basis for discussion of safe handling of pesticides, I would like to list nine rules for safety...

Although these safety rules... were prepared for the information of structural pest control operators, these data are applicable to the safe handling of pesticides by other workers and by householders as well.

## Safety Rules for Handling Pesticides\*\*

1. All operators handling pesticides should be informed of the risks involved to themselves

and others and should receive instructions for handling chemicals safely.

2. There should be adequate technical and medical supervision of operators with advance plans for handling any accidents or casualties. New employees particularly, and those not trained in handling chemicals, need adequate supervision.

3. No one should work alone with a hazardous chemical.

4. Pest control equipment should be of proper design, well-maintained and regularly cleansed so as to minimize the likelihood of accidental spills or other pesticide exposure to operators or others.

5. Whenever there is a choice, effectiveness being equal, the less hazardous chemical should be used and no more of any chemical than is necessary, even when it is considered fairly harmless.

6. Washing facilities should be readily available and any spills or splashes of chemicals should be immediately washed from the skin and clothing changed. Hands should be washed before smoking or eating. Lunches and tobacco should be kept away from the chemicals. Showers and a change of clothing after each day's work should be mandatory. Work clothes should be separate and not taken home for laundering.

7. The employer should provide, maintain and clean whatever protective clothing or equipment is needed for safe work with chemicals.

\*Presented at the Eighth Annual Cal Poly Pest Control Conference, California State Polytechnic College, Pomona, December 1960.

\*\*Eighth report of the Expert Committee on Insecticides, Insect Resistance and Vector Control, World Health Organization Technical Report Series No. 153. 1958 (Above safety rules based on information on Page 47).

8. Special care is necessary in handling concentrated pesticides. It is in this operation that the greatest hazards lie, particularly if the chemical is readily absorbed through the skin. In the transferring of concentrates from drums, either threaded taps or drum pumps should be used.

9. All pesticide containers should be properly labelled and stored in a locked place. No pesticide chemicals or their containers, empty or otherwise, should be left where children or pets have access.

Of the twelve cases of occupational disease due to pesticides reported among structural pest control operators in 1959, five were some kind of illness and two of these were potentially serious. The other five cases concerned skin rashes attributed to pesticides.

Any physician in California who treats a worker for an occupational injury or disease must file a report with the Department of Industrial Relations of the State of California. Those doctors' reports concerning occupational disease are forwarded to the Bureau of Occupational Health of the State Department of Public Health. This information is the source of our reported cases among pest control operators.

### Recommendations

I would like to.....emphasize some points which appear to me to be neglected or misunderstood by those who work with hazardous chemicals. The first point concerns the two kinds of supervision—operating and medical. Both are too often neglected or slighted. It is not enough to tell an employee about safe practices; he must be supervised closely to be sure that he takes the proper precautions and knows why. Too often the work involving the most exposure to chemicals is handed to the new man or to the least skilled employee.

Another important matter is the proper care of emergencies which could be related to the effects of pesticides. Recommended procedure is for the employer to arrange with a physician or a group of physicians beforehand to provide emergency care, if necessary. The physician can be kept apprised of the chemicals being used and can advise on the need

for medical examinations and laboratory tests which workers should have periodically to detect early any adverse effects of certain chemicals. (Carbon tetrachloride, methyl bromide and certain organic phosphates are examples of chemicals where such medical examinations are indicated). Workers can be advised to report to the physician when any questions arise concerning the effects on them of chemicals. Labels of pesticides to which a worker is exposed should be taken to the physician along with any ill worker. The name and phone number of the physician should be posted, and carried by each employee.

Another point is the confusion regarding the difference between hazard and toxicity. Hazard is a summation of a number of factors which may result in injury by a chemical. Toxicity is just one of these factors and has to do with the ability of a chemical to produce damaging effects once it gains entrance into the body. Persons handling chemicals often become confused because they concern themselves with a lot of minor details about toxicity or the signs and symptoms of poisoning by a chemical. At the same time, they do not know more important facts about the hazard a chemical poses in their work. For example, some toxic pesticides are hazardous primarily because they can travel right into the body through the unbroken skin. It is very important that the worker knows he needs a barrier in the form of protective clothing between him and the chemical and that frequent washing is very necessary to his safety. Other pesticides are highly toxic but not much of a hazard to workers because they don't travel readily through the skin. These same chemicals may be very hazardous to children who are apt to swallow them. Arsenic is an example.

The last point is a discussion of "susceptibility". Many times employers hopefully try to explain or excuse their lack of safety supervision by stating that a sick employee must have been "more susceptible", or "sensitive", to a pesticide which poisoned him. Among healthy workers, there may be minor degrees of difference as to how much it takes to affect them, but for all practical purposes, these minor differences can be ignored. If the worker was not well in the first place, he should not work with toxic chemicals and it is the employer's responsibility through proper medical supervision

to be sure of this. For example, alcoholics are at special risk working with carbon tetrachloride.

On the other hand, true allergic reactions are an entirely different matter and are not related to the toxicity of a chemical. Some materials are such powerful allergens (poison oak, castor bean meal) that most people if exposed to them eventually will produce an allergic response (asthma, hay fever, skin rashes or hives, etc.). Other materials such as pollens are milder allergens and produce a response only in persons who are particularly susceptible. Occasionally pesticides, particularly the botanicals, may produce allergic reactions in some workers.

Usually employees who become allergic to something in their working environment may have to change jobs because of the allergy. Such responses are not a major problem among persons working with pesticides.

In closing, I would like to leave you with the idea that working safely with chemicals requires a carefully worked out plan known to everyone involved in the operations. The elements of the plan are keeping chemicals out of and off of people, and providing emergency care for workers who accidentally contact a chemical or become ill.

—*California's Health*  
Vol. 19, No. 2, July 15, 1961

## HEALTH SURVEY & PLANNING COMMITTEE REPORT SUBMITTED TO GOVERNMENT

The Health Survey and Planning Committee, at its meeting held in New Delhi on 27th October last finalized its reports on the developments in the field of medical relief and public health since 1946 and recommendations for formulating health programme in the country during the Third and subsequent plans. The Report has been submitted to the Government of India.

The Committee appointed by the Union Ministry of Health in June 1959 consists of 17 members with Dr A.L. Mudaliar, Vice-Chancellor, Madras University as its Chairman. The other members of the Committee are, Shri Tirumal Rao, M.P. ; Dr G.S. Melkote, M.P. ; Lt-Col. V. Srinivasan, Director-General of Health Services; Lt-Gen. D.N. Chakravarti; Major K.N. Rao ; Dr (Miss) H.M. Lazrus ; Dr C.O. Karunakaran ; Lt-Gen. B. Chaudhri ; Lt-Gen. B.M. Rao ; Dr R.V. Sathe ; Dr P.M. Mehta ; Dr K.C.K.E. Raja ; Dr Dukhan Ram ; Dr C.G. Pandit and Dr T.R. Tewari.

The Report covers the entire field of health activities in the country, including professional education and research, medical relief (rural and urban), public health, communicable diseases, drugs and medical stores, population problem and family planning and the Ayurvedic and other indigenous systems of medicine.

In order to collect the basic data, the members of the committee issued questionnaires, interviewed people, and visited representative institutions in all parts of the country. The Committee also took the opportunity of securing the views of a number of distinguished medical men from abroad who came to India for the 14th World Health Assembly held in February this year.

## 9TH MEETING OF CENTRAL COUNCIL OF HEALTH

THE three-day Ninth Meeting of the Central Council of Health at Hyderabad, beginning on 10th September, 1961, recommended, among others, that family planning orientation camps should be held throughout the country and that a corps of voluntary workers—*Pariwar Kalyan Sahayaks*—should be raised in each State. In its resolution on medical research, it recommended to the State Governments and Universities that in making budgetary allocations for the medical colleges and post-graduate centres, specific amounts might be set apart for the promotion of research as an integral part of the activities of such institutions. Considering the working of the Primary Health Centres Programme, it recognised the extreme inadequacy of the existing set-up to provide any reasonable health coverage to the population and the area expected to be covered by each centre.

The meeting was opened by the Union Minister of Health, Shri D.P. Karmarkar. Shri P.V.G. Raju, Minister for Health and Medical, Andhra Pradesh, welcomed the participants of the meeting, which was also addressed by the Chief Minister, Shri D. Sanjeeviah.

### Shri Raju's Address

Welcoming Shri Karmarkar and others, Shri Raju said that the inadequacy of the provision under Health in the Plan was obvious. The Central Council of Health in its previous meetings had laid stress on the fact that the Health Plan should not be less than 10 per cent. of the total Plan. The actual allotment under Health in the Plan was, however, even less than five per cent.

Reviewing the progress his State had made in the health field, the Minister said that the medical and public health administrations had made rapid strides during the Second Plan period.

In 1947, there were only two medical colleges in the State, whose number had gone up to eight now

(six government and two private). The number of admissions to M.B.,B.S. degree course had been raised from 155 in 1947 to 850 in 1960.

A college for general practitioners had been started in Hyderabad in 1961 to bring home to the busy practitioners the recent developments in the field of medicine and health. The State Government had also started a dental college and a college of nursing and was trying to multiply other training facilities for para-medical and auxiliary workers to meet the demands of the schemes to be taken up during the Third Plan period.

Turning to medical facilities in the rural areas, he said that so far, 193 primary health centres had been established in the State. A sum of Rs 65.54 lakhs had been provided for the construction of buildings for the centres and their maintenance. Besides the centres, there were 247 rural dispensaries, 104 local fund dispensaries and municipal institutions and 59 private medical institutions, totalling in all 649 medical institutions catering medical facilities to the rural population. There were 15 mobile medical units functioning in the State for the benefit of the rural population.

To further augment medical facilities even in the remotest corners of the State, a scheme was proposed to be implemented which envisaged the supply of one medicine chest costing approximately Rs 80 to 100 to each of the 26,000 villages in the State. The supply would be spread over five years in the Third Plan and all the villages would be covered according to a phased programme. These boxes would be filled up periodically so that every village at every time might have some basic medicines available for emergencies.

Speaking of family planning, Shri Raju said that the Government of Andhra Pradesh was keen to encourage pharmaceutical industries to come

forward for the manufacture of contraceptives on a large scale to enable the State Government to buy them cheap and distribute them free or at nominal cost.

The Second Plan, he said, offered many perspectives towards promotion of health measures in the country. The enormous possibilities that open up in building the health of the people with the co-operation of the people themselves seemed to have been adequately realised in the Plan as was evidenced by the incorporation of this principle in the ideology of community projects. However, with all the efforts that were being made, it seemed that the principle of self-reliance had not yet taken root and, to that extent, the results achieved had fallen short of expectations. The probable principle reason for this situation, the Minister thought, was that the bulk of the rural population was still deficient in initiative and lacking the vital spark of helping themselves. The solution seemed to lie in the introduction of a new method of health insurance scheme. He announced that the State Government was proposing to take up two sets of health insurance schemes to be started in rural and urban areas as pilot projects.

He referred to the zonal meetings of State Health Ministers and said that the first Southern Regional Conference met, at the invitation of the Government of Andhra Pradesh, in Tirupati in January 1961, in which Andhra Pradesh, Madras, Mysore and Kerala participated. The Conference, among other things, had been able to evolve a uniform structure of pay scales for the services, pattern of inter-State facilities for post-graduate medical education and admission of patients in specialised hospitals.

Shri Raju referred to the Expanded Nutrition Programme in the State, with the technical and financial assistance from UNICEF, FAO and WHO, as education-cum-demonstration project on food and nutrition in rural areas. Dietary and nutrition surveys would be carried out in all the 200 villages selected for the programme in 20 *panchayat samithi* blocks distributed in 20 districts all over the State.

In collaboration with the Government of India and the Indian Council of Medical Research, the Government of Andhra Pradesh had launched a

Polio Project in Krishna and Guntur districts and the city of Hyderabad in order to arrest the spread of epidemics of polio, sporadic incidence of which was reported in the first two districts in late 1960 and early 1961 and to study the efficacy of oral polio vaccine, of which two lakh doses were supplied by the Russian Government and one lakh doses by the Canadian Government, free of cost for the field trial.

The Andhra Pradesh branch of the Indian Council of Child Welfare had sponsored and prepared a scheme for a pilot project for the total welfare of the child. The State Government had accepted the scheme and a pilot project had been launched in Pattancheru, 15 miles from Hyderabad city. It would cover about 30 villages with a population of 22,000, the child population being about 8,500. The pilot project was expected to be in full operation by the middle of 1962. It would serve as an experimental ground and demonstration and training centre for other similar projects to be taken up in other parts of the State, Shri Raju added.

#### **Shri Karmarkar's Address**

Shri Karmarkar, in his opening address, said that the allocation for Health in the Third Plan was Rs 341 crores. Besides, Rs 30 to 40 crores were likely to be made available for rural water supply from other sources. Reviewing the progress of the various health schemes under the First and Second Plans, he said that with the help of the resources in the First and Second Plans, what had been accomplished could not by any means be considered a mean achievement. "Even if we were not to take into account anything else, the manner in which malaria has been controlled and is now at the point of eradication, would by itself be a worthwhile achievement. Programmes for the control of other communicable diseases have been set on a firm footing. The largest BCG vaccination programme in the world has been undertaken. The stage is set for the eradication of smallpox. We have come to grips with the problem of leprosy. Measures are in hand for the liquidation of the perennial sources of cholera. Water supply and sanitation facilities in the cities as well as the villages have been largely extended. A network of primary health centres has been brought into existence. The training potential has been greatly enlarged, there having been a

phenomenal increase in the number of medical colleges in the last 10 years. By no means exhaustive, this list is all the same impressive, and my only purpose in drawing your attention to these is to invite you to share with me the feeling of optimism and confidence in regard to the future. With the experience, knowledge and team-work we have developed in the course of two Five Year Plans we can confidently look forward to an increasing tempo of activity and achievement in the Third Plan in all fields of our endeavour," he said.

Shri Karmarkar said that the major portion of the Third Plan outlay, namely, about Rs 296 crores out of the total of Rs 341 crores, figured in the State Plans. This did not exclude the possibility of Central financial assistance being given for many of the schemes but this would be against the amount included in the State Plan. He added that the emphasis continued to be placed on the preventive and public health aspects. It was, therefore, in the fitness of things that more than half of the provision was earmarked for water supply, sanitation and control of communicable diseases, even if this had necessitated the stepping down of the programmes of institutional medical care and projects of training.

The Minister then reviewed the progress of some of the major health programmes.

#### MALARIA

Dealing with the National Malaria Eradication Programme, he said: "Judging from the progress achieved we are obviously progressing towards complete eradication," and added, "we have yet to go a long way and there is much harder work ahead."

There had been a steep decline in malaria incidence and malarionometric indices as against 1953. The percentage of cases found to be suffering from malaria to the total number of cases treated in hospitals and dispensaries in 1960 was 1.3 per cent. as against 10.8 per cent. in 1953. There had thus been a reduction of 88 per cent. in the incidence of malaria between this short period. During the same period, child spleen, child parasite and infantile parasite rates had also been reduced by 93 per cent. to 97 per cent.

#### FILARIA

Turning to the filariasis problem, he said it was on the increase as newer areas were becoming filarial. This was chiefly attributable to rapid urbanisation and industrialisation that are taking place in the country. Both the above factors contributed to an increased breeding of *Culex fatigans*, the vector mosquito of the disease, while migration drew people from the endemic areas.

An analysis of the work under the National Filaria Control Programme during the last five years had revealed that the basic measures for the prevention of this infection were necessarily long-term ones. Of the short-term measures, the available synthetic insecticides had proved ineffective in the control of this infection. Mass distribution of Hetrazan had shown several limitations as a control measure. Wherever adequate oiling of the breeding surfaces had been carried out, the results had been promising.

Shri Karmarkar said that a committee had been set up in 1960 under the Indian Council of Medical Research to review the programme as a whole and make recommendations for the future. The report had been received and was under the scrutiny of the Government.

#### LEPROSY

In the field of leprosy control, the Minister said that in addition to the 33 leprosy control centres established during the First Plan, it had been proposed to establish 100 leprosy subsidiary centres in the various States during the Second Plan period and that this target had been exceeded. During the Plan, 104 centres had been established giving a total of 137 centres. Up to the 31 March, 1961, 65.63 lakh persons had been examined out of which 1.04 lakh cases were registered for treatment. The Government of India, in collaboration with the Maharashtra Government, had started an All-India Leprosy Training Centre at the Medical College, Nagpur, which, up to the end of March 1961, had trained 56 medical officers from various States. He regretted that this training centre had not been fully utilised by the State Governments and urged upon them the urgent need for sending medical officers for training. Another training course of four months' duration had also been

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started at the Gandhi Memorial Leprosy Foundation Centre at Chilakalapalli in Andhra Pradesh. This Training Centre was specially meant for a senior medical officer from the Public Health Department of each State. Eight medical officers had been trained by this Centre.

During the Third Plan period, the Minister said, a sum of Rs 424.40 lakhs had been provided for leprosy control.

#### TUBERCULOSIS

Speaking of the control of tuberculosis, he said that 168.3 million persons had been tested and 59.1 million BCG-vaccinated up to June 1961. Though the original target had been nearly achieved, he called for a better level of performance by the technical teams and closer supervision and watch.

During the Third Plan, the mass campaign would be continued but the emphasis would be on the vaccination of the younger groups, especially those below the age of 15 years. There was also a scheme for integrating the BCG Vaccination Programme with the normal work of the district TB clinics when these were established or upgraded according to the national plan.

Though 180 clinics were to be established during the Second Plan period and the State Governments had been supplied laboratory equipment for 60 clinics, all of them had not yet started functioning in the anticipated manner. The equipment had been installed in only 55 clinics but even some of these were not working to full capacity. Hence, the progress in this respect had been far from satisfactory.

He referred to the National Tuberculosis Institute at Bangalore, whose main object was to train the key personnel—doctors, home visitors, X-ray and laboratory technicians and BCG workers. He said that the training facilities offered by the Institute needed to be widely utilised in the interest of giving the required public health orientation to the TB Control Programme.

#### SMALLPOX

Shri Karmarkar spoke of the smallpox pilot projects which came to an end on 31 March, 1961.

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Of the total population of the pilot project areas of about 23 million, 14.4 million had been approached and 12 million covered. The percentage of the people covered was thus approximately 52. No case had been reported from amongst those who had been successfully vaccinated in the project areas. He also made a reference to the Report of Smallpox Pilot Projects Committee. He drew the particular attention of the Council to the observation of the Committee regarding delays that occurred in the States in giving financial sanctions to their Health Directorates for incurring expenditure on staff and equipment for the Pilot Projects. He hoped that all procedural delays would be reduced to the barest minimum when the Eradication Programme was launched.

#### WATER SUPPLY AND SANITATION

Up to the end of the Second Plan, 396 urban water supply schemes and 100 sewerage schemes costing Rs 88 crores and rural water supply and sanitation schemes for 14,700 villages costing Rs 19 crores were approved under the Programme. A majority of these schemes had either been completed or brought to an intermediate stage of beneficial use.

In the Third Plan, a provision of about Rs 89 crores for the urban schemes and about Rs 16 crores for the rural schemes had been made under the National Water Supply and Sanitation Programme. In addition to this, another Rs 30 to 40 crores were likely to be available for water supply schemes in rural areas, out of the grants for local development works, backward areas, etc.

In the rural phase, apart from the allocation made under the National Water Supply and Sanitation Programme, the Third Plan envisaged an increase in the tempo of activity for rural water supplies under the community development programme and the local development works. While rural water supply programmes under the Five Year Plans had made some progress, rural sanitation as such had not received the attention it deserved. Any significant and lasting improvement in the public health field would largely depend upon the improvement of environmental sanitation in rural areas, Shri Karmarkar said.

The expanding programme of water supply and sanitation works, both urban and rural, envisaged in the Third and the succeeding Plans, the Minister said, called for the training of public health engineering staff as a continuous measure so that they might be better equipped to handle their everyday problems in public health engineering. A specific provision for the training of public health engineers and auxiliary personnel had been made in the Third Plan.

#### INDIGENOUS SYSTEMS OF MEDICINE

With reference to Indigenous Systems of Medicine, the Health Minister said that in the Third Plan a provision of about Rs 10 crores had been made for the development of the systems.

Stating that the question of introducing uniformity in standards of training and qualifications in Indigenous Systems of Medicine had been coming up for consideration frequently during the recent years, Shri Karmarkar observed that the several committees appointed by the Government of India had all been unanimous on the need to enforce uniformity in this matter.

#### MEDICAL EDUCATION

In his reference to medical education, he said that progress had been made in this sphere in recent years at a pace which even the Bhole Committee did not visualise, "even though we are still far short of our needs." From 25 medical colleges in 1947 to 61 in 1960 was a remarkable achievement. More than three times as many students were entering medical colleges annually now as compared to 1947, the present capacity being about 6,000 admissions. Apart from the increase in the numbers, a great deal of thought and attention had been paid to the question of standards of education and their orientation to present day needs. It was hoped that 15 more medical colleges would be added during the Third Plan.

Referring to the proposal of training an auxiliary health worker whose services could be utilised in a manner as to give a wider health care coverage to the rural population with the limited medical manpower at our disposal, he thought that medical assistants, as envisaged in the scheme, would serve a useful purpose as it had been done in the USSR.

"We have reached a stage at which the urgent demands for post-graduate education can no longer be ignored without imperilling the future of medical education as a whole in this country," Shri Karmarkar said. He also spoke of the importance of training para-medical personnel. He admitted that one of the important and main bottlenecks in the way of the implementation of the various schemes was the lack of personnel at the level of nurses, health visitors, midwives, sanitarians, etc., and added that very considerable advances had been made in the two Five Year Plans, in setting up the training facilities for these various categories of health workers. He also said that facilities for training public health engineers, sanitarians, laboratory technicians, physiotherapists, dietitians, health educationists, etc., had been created and enlarged.

#### FAMILY PLANNING

The Minister then touched on the 1961 Census figures, which put the population at about 438 million, an increase of about 2.15 per cent. per year.

Speaking of the family planning programme's progress, he stated that family planning advice and assistance was available today through nearly 4,000 centres, including family planning and other health clinics. About 1.5 lakh sterilization operations had been carried out. About 4,000 workers of different categories had been given training. Family Planning Boards and family planning officers had been appointed at the Centre and in almost all States. He also mentioned the research and other connected programmes going on in the country. Shri Karmarkar said that a financial ceiling of about Rs 27 crores and programme ceiling of about Rs 50 crores had been laid down.

He had no doubt that a demand in varying degree in different parts of India for the services had been created and stressed the need to provide services to meet this demand and continue the efforts to make family planning a way of life of the people.

#### HEALTH EDUCATION

Speaking of health education as one of the best ways of enlisting active participation of the people

in the implementation of public health programmes, he briefly described the growth and work of the Central Health Education Bureau, which started functioning in 1957. He said that the Bureau had conducted orientation and training courses in health education methods and media for 436 health and social workers. Studies in the health behaviour of people had been initiated during the last year and that health education had been included in the curriculum of teacher-training courses and that the health education syllabus for primary and secondary schools had been formulated.

Under the scheme for establishment of State Health Education Bureaux sanctioned in 1959, eight States had started the Bureaux. The UNICEF, WHO and TCM, he said, proposed to provide technical and material assistance for promoting health education during the coming year.

#### INDIAN COUNCIL OF MEDICAL RESEARCH

Next came a review of the activities of the Indian Council of Medical Research, which, the Minister said, had made good progress during the year. He spoke of the research findings of the Council in the fields of nutrition, goitre, communicable diseases, tuberculosis, rehabilitation in leprosy, environmental sanitation, etc. Under the Council's coordinated drug research programme, several indigenous drugs claimed to be of medicinal value had been investigated on a scientific basis and, as a result, active principles had recently been isolated, some of which appeared to possess tranquilising properties of high potency. He said that the Council had chalked out programmes of research for the Third Plan period on some important problems like infantile diarrhoeas, filariasis, chemoprophylaxis of leprosy, heart disease, mental and dental disorders, etc.

Concluding, the Minister commended the example of the Regional Conference of the Health Ministers of Andhra Pradesh, Madras, Mysore and Kerala to the Health Ministers of other States. He thanked the international organizations and bilateral agencies for extending their moral and material support in the endeavour to achieve a higher standard of health and living and hoped that aid, technical advice and the assistance of the organizations would continue to be available.

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## Resolutions

Following are some resolutions passed by the Council :

The Central Council of Health took note of the patterns of financial assistance prescribed for Centrally-aided and -sponsored schemes and recommended, among others, that the Central subsidy for the smallpox eradication scheme should be 100 per cent.

It recommended that early steps should be taken by each State Government to secure the maximum amount for rural water supply schemes, from out of the allotments placed at the disposal of the States for local development works and to ensure that this allocation was fully utilised for water supply and sanitation schemes in the rural areas.

### Family Planning

It considered that the objective of stabilizing the growth of population over a reasonable period must be the focal point of planned development and re-emphasised that the pace of implementation of the programme should be accelerated, and recommended that—

- (a) family planning orientation camps should be held throughout the country especially in rural areas and a corps of voluntary workers—*Pariwar Kalyan Sahayaks*—should be raised in each State;
- (b) continuous and regular supplies of contraceptives should be facilitated through all medical and health centres and other approved agencies;
- (c) the sterilization programme should be intensified;
- (d) local bodies and voluntary organizations should be induced to participate actively in the programme; and
- (e) family planning officers to be subsidised 100 per cent. by the Centre should be appointed at the level of each district.

It noted with satisfaction that, for the family planning programmes, 100 per cent. financial assistance would now be available to local bodies and voluntary organizations and similar 100 per cent. assistance would be available to State Governments

for providing sterilization facilities, contraceptive supplies, education, training, and research programmes, and hoped that the assistance would be fully and expeditiously utilised.

### **Ayurveda**

In regard to Ayurveda, the Council recommended provision of facilities for acquaintance with Ayurvedic medicine in modern medical colleges; of orientation courses in public health aspects of modern medicine for Ayurvedic practitioners; of adequate facilities for training at post-graduate level so as to produce the required number of fully-qualified teachers; promotion of study of Ayurveda at post-graduate level by awarding stipends and prizes for research work and preparation of theses; provision of facilities for the utilisation of qualified Ayurvedic practitioners in the health services; further intensification of research in Ayurvedic medicine to the extent possible, and continued Central assistance for education and research in Ayurvedic medicine to the training and research centres, as at present.

### **Medical Research**

The role played by the Indian Council of Medical Research in the promotion of research activity in the country, was noted with satisfaction. It noted further that due emphasis on research as a part of the activities of the under-graduate and post-graduate training centres was not being given, and recommended to the State Governments and Universities that in making budgetary allocations for the medical colleges and post-graduate centres, specific amounts might be set apart for the promotion of research as an integral part of the activities of such institutions.

### **Health Education**

Reviewing the progress made in establishing Health Education Bureaux during the Second Plan period and recognising the urgent need for intensifying health education activity to enlist active participation of people for successful implementation of the health programmes, it urged upon the State Governments the need for further extending and strengthening health education services with emphasis on pre- and in-service training of all health and welfare personnel and research in health education methods and media.

### **Primary Health Centres**

Having considered the working of the Primary Health Centre Programme, it recognised the extreme inadequacy of the existing set-up to provide any reasonable health coverage to the population and area expected to be covered by each Centre, and recommended that the position be examined carefully with the object of emphasising the preventive and educative aspects of health care activity, defining the size and population of the area to be covered by a health centre and its staffing pattern. The Council resolved that a committee consisting of Health Ministers of Madras (as Chairman), Maharashtra and Gujarat (with Dr P. R. Dutt of the Directorate General of Health Services as Secretary) may examine and report to the Council before the end of December 1961, their proposals for the reorganization of the Primary Health Centre Programme.

### **TB Programme**

The Council recorded its appreciation of the report of the Sub-Committee on Tuberculosis under the Chairmanship of the Health Minister, Maharashtra, set up at the meeting of the Council held in Jaipur in October 1960, and commended the recommendations made by that Committee to the Central and State Governments for their consideration, more particularly for the enlistment of the support and enthusiasm of voluntary and non-official organizations.

The Council was deeply concerned with the unsatisfactory progress made in the Tuberculosis Programme in the matter of setting up of tuberculosis clinics, domiciliary chemotherapy programme and the provision of institutional facilities for the treatment of patients of tuberculosis. It urged upon the Governments the need for giving a high priority to the entire range of anti-tuberculosis schemes in the Third Plan period, and that the campaign against tuberculosis should be worked as a National Programme.

### **Malaria Eradication**

The steady progress of the National Malaria Eradication Programme so far was noted with satisfaction by the Council. It drew the attention of the State Governments to the serious financial and other repercussions consequent on any dislocation

of existing schedule and urged that the tempo of the programme be raised further in a way so as to ensure withdrawal of spray operations in 1962-63 as planned and recommended that the budget provision for 1961-62 may be revised in accordance with the requirements of the National Malaria Eradication Programme as approved by the Central Government and necessary adjustments made accordingly in the budget for 1962-63.

#### **Leprosy Control**

In its resolution on the leprosy control programme, it appreciated the WHO/UNICEF assistance in this programme, and requested the State Governments to make adequate provision for this scheme in their budgets to ensure full utilisation of the amount allocated for leprosy in the Third Plan.

#### **Smallpox Eradication**

The Council appreciated the efforts put in the Smallpox Pilot Project Programme, and hoped that the results of the pilot projects would serve as the base for the implementation of the Smallpox Eradication Programme to be undertaken by the States without further loss of time and completed within the period of not more than two to three years. It drew attention again to the inescapable necessity of a comprehensive eradication programme on a uniform basis throughout the country.

#### **Water Supply and Sanitation**

After reviewing the progress of the National Water Supply and Sanitation Programme in the two five year plans, it drew the attention of the State Governments to the recommendation of the Council for the early completion of water supply schemes. It suggested that proposals for water supply schemes for the Third Five Year Plan should be prepared and processed expeditiously in order to complete the spillover schemes and to initiate new water supply and drainage projects. It recommended that designs divisions be set up in the Public Health Engineering Directorates to facilitate the expeditious preparation of sound water supply designs, and that piped water supply schemes for individual villages might also be made eligible for grants under the National Water Supply and Sanitation Scheme.

#### **Compulsory Rural Service for Medical Graduates**

Considering the proposal for compulsory period of service for medical graduates in rural areas after graduation, it agreed broadly with the principle of the proposal. It felt that a more detailed examination of the implications of this proposal appeared to be necessary. It considered that so long as the required period of pre-registration service in the rural areas did not exceed the period of one year, where compulsory internship formed a part of the training programme, there should be no difficulty in implementing the proposal.

I desire not kingdoms, Heaven or even freedom from re-birth ;  
I desire to end the suffering of beings that are in anguish.

—An ancient Indian prayer

## WHO REGIONAL COMMITTEE FOR S.-E. ASIA

**T**HE seven-day Fourteenth Session of the WHO Regional Committee for South-East Asia came to a close in Ootacamund on 25th September last after approving the programme and budget for 1963 and adopting the Regional Director's annual report for July 1960-August 1961.

The final report of the committee expressed grief at the tragic death of Mr Dag Hammarskjöld, UN Secretary-General, who died in a plane crash in Congo on the eve of the meeting.

The meeting, which was inaugurated by His Excellency the Governor of Madras, Shri Bishnu Ram Medhi, was attended by delegates from Afghanistan, Burma, Ceylon, India, Indonesia, Nepal, Thailand and UK. Representatives of UNTAB, UNICEF, FAO and a number of bilateral agencies and non-governmental organizations in official relationship with WHO, were also present. Lt-Col. V. Srinivasan (India) was elected Chairman and Dr A.R. Hakimi (Afghanistan) Vice-chairman.

The Government of India acted as the host Government for the session.

### Indian Health Minister's Address

"It is heart-warming to see delegates from so many neighbouring countries assembled under the aegis of WHO to discuss health problems of mutual interest and consider a concerted region-wide programme to fight disease and promote health", Shri D.P. Karmarkar, Minister for Health, Government of India, said in an address of welcome to the session. The Minister was unable to attend the meeting and the address was read on his behalf by Lt-Col. V. Srinivasan, Director-General of Health Services, Government of India, and the country's chief delegate to the Regional Committee.

Shri Karmarkar referred to India's policy of supporting international cooperation for world peace

and well-being of the people everywhere, and recalled the Indian Prime Minister's tribute to WHO for its "single-minded devotion to the purpose for which it was created" in his address to the 14th World Health Assembly held in New Delhi.

"This meeting is important to us, therefore," Shri Karmarkar said, "not only because of its positive contribution to our own national health efforts but also as an example of inter-governmental cooperation in which our Region of South-East Asia has been so successful ever since its work started in 1948-49".

Surveying the WHO activities in the recent past, the Minister said: "Today most of the member countries are receiving WHO assistance in nation-wide efforts to control disease and to promote general health services. The vast malaria eradication programmes in every one of the countries in the Region, the national tuberculosis control programmes in India, Indonesia, and Thailand, the leprosy programmes in India, Indonesia, Burma and Thailand, the tremendous yaws projects in Indonesia and Thailand are some examples.

"Inter-country and inter-Regional conferences have been held to ensure the necessary exchange of scientific and operational information between countries.

"WHO's and my Government's efforts in tuberculosis research and development of methods for home treatment of the disease, have opened up the prospect of a future free from this disease.

"Many of the countries have been enabled to start or improve production of vaccines. Campaigns against smallpox are in varying stages of progress. Medical education has expanded and improved. Preventive and social medicine is today recognized as an important discipline in the curricula of medical colleges."

WHO assistance to its member-countries today covered every aspect of public health, the Minister added. It had made an immense contribution in programmes to train various categories of health workers in all the countries of the Region. It had given momentum to the Region-wide movement for better health and its timely advice and support had greatly helped member-governments in the proper utilization of their resources.

In a message to the Committee on behalf of the Director-General of WHO, Dr F. Grundy, Assistant Director-General, drew attention to the important role of the Regional Committees in the activities of WHO.

Mr Poul F. Larsen, representing UNICEF, referred to the close ties between governments of South-East Asia and UNICEF. He expressed satisfaction that the subject for this year's Technical Discussions related to nutrition on which UNICEF placed great stress in all its programmes.

Mr K.A. Bennet, representing the Food and Agriculture Organization, referred to numerous activities in which FAO and WHO had closely cooperated. He drew attention of the Committee to the "Freedom from Hunger" campaign started by FAO and expressed the hope that the Committee would bear it in mind in the course of its deliberations.

#### **\$8.5 Million Health Aid**

According to the programme proposals and budget estimates approved by the committee, the cost of WHO assistance in health programmes in South-East Asia during 1963 will be 8.5 million dollars. The amount includes funds to be provided, mainly for supplies and equipment, by UNICEF and the UN Special Fund. The estimates will be forwarded for incorporation in WHO's world budget and final adoption by the World Health Assembly after consideration by WHO's Director-General and Executive Board.

Two important projects in the 1963 programme are to be financed by the UN Special Fund which realizes that investment in health is investment in economic prosperity. These are the first projects in which WHO will assist as an executive agency for

the Special Fund. The amount involved—one million dollars—is to be spent on a survey of water supply and sewage for Greater Calcutta and on assistance to the Central Public Health Engineering Research Institute, Nagpur.

During discussion of the Regional Director's annual report, the committee expressed satisfaction with WHO's policy of giving priority to communicable disease control and training of health personnel in its aid programme. Some members stressed the need for an accelerated programme for smallpox eradication and greater assistance in the control of filariasis. Small plague outbreaks in India and Indonesia were regarded as dangerous pointers and it was felt that the situation needed to be watched carefully.

Statements on filariasis control, enteric disease and the use of freeze-dried BCG vaccine were made by the Regional Director in accordance with resolutions passed by the thirteenth Regional Committee asking for information and action related to these subjects.

#### **Outlook on Filariasis**

In regard to filariasis control, it was stated that "the present studies or knowledge does not justify any target of eradication". WHO was, however, giving close attention to the subject. In the South-East Asia Region, a consultant had visited Burma and Ceylon for establishing pilot studies in the near future.

Under WHO's medical research programme continuing studies on filariasis were proposed and preliminary planning had started on a study of the influence of malaria eradication on other insect-borne diseases. It was felt that anti-malaria operations could not be expected to benefit the filariasis programme.

#### **Intestinal Diseases**

The committee was informed that a WHO diarrhoeal advisory team was proposed to be assigned to Ceylon in 1962. The team will help assess the nature and extent of this problem and to study the manner of spread of the enteric group of diseases.

Without exact knowledge of the epidemiology of these diseases, it was stated, it was difficult to

formulate anything more than general recommendations for the improvement of health education, water supplies and sanitation. WHO had, therefore, been assisting member-countries in the development of public health laboratory services and epidemiological and health statistical units. The WHO Advisory Committee on Medical Research had strongly supported a proposal to establish a scientific group on cholera research.

The committee was also told that the Indian Council of Medical Research proposed to organize two pilot studies, one in the north and the other in the south of India, to obtain detailed knowledge on the prevalence of diarrhoeal and other associated diseases. In each study a population group of about 500 families will be followed up for a period of 12 months.

#### **Freeze-dried BCG Vaccine**

The committee was informed that field and laboratory investigations carried out under the auspices of WHO had clearly established that freeze-dried BCG vaccine offered certain advantages in use in the hot countries of South-East Asia. Its better keeping qualities, resistance to heat and amenability to laboratory control tests, provided the solution to many difficulties faced by mass BCG programmes in certain parts of the tropics with slow communications and high temperatures, where liquid vaccine was difficult to transport. It was hoped that it would be possible now to assist member-countries in procuring dry vaccine.

The committee heard a report on the new Regional office building in New Delhi and thanked the Government of India for the progress made. It urged member-Governments to contribute generously items of decoration and furnishings for the new building so that it will reflect the skills and culture of the Region.

#### **Malaria Eradication Stamps**

Simultaneous issue of malaria eradication postage stamps by the member-States of WHO was recommended by the committee as a sound publicity measure. It was felt that in addition to awakening world-wide public interest in the programme it would be possible to collect some money by the sale of the

special stamps to be used in the national and global war against malaria.

The question of improvement of nutrition throughout South-East Asia was considered in its many aspects when the committee met as a group for Technical Discussions on the subject: "The Role of the Public Health Department in the Improvement of Nutrition". The recommendations of the group will be sent to all the member-Governments. "Community Water Supply" was the subject selected for Technical Discussions during the 1962 session of the Regional Committee to be held in New Delhi.

The committee accepted an invitation of the Government of Thailand to hold its sixteenth—1963 session—in Thailand.

#### **WHO Regional Director's Review**

"Funds for public health, although gradually increasing, still remain very inadequate", said Dr C. Mani, WHO Regional Director, in a review of health progress in South-East Asia, which formed part of his Annual Report to the Session. The Report covered the period July 1960–August 1961.

#### **Warning Note**

Conceding progress in two vital spheres—control of communicable diseases and training of health workers—Dr Mani warned that training of personnel was still much behind the actual requirements of new programmes and stressed the need for careful advance planning.

In the sphere of communicable diseases, the great effort against malaria had begun to pay good dividends but if the gains made were not to be forfeited, the tendency to slacken financial and administrative support during the present crucial stage of malaria eradication must be controlled.

The mass of communicable diseases directly related to poor environmental sanitation—such as cholera, children's diarrhoeas, enteric fevers, dysenteries and diseases caused by intestinal parasites—continued to maintain their stronghold. There was so little prospect of an early improvement in sanitary conditions in the Region that the reduction

of this vast reservoir of avoidable infections was unlikely in the near future.

WHO-assisted pilot projects had pointed the way towards meeting two outstanding needs of rural areas: a protected water supply and safe means of excreta disposal. But implementation would be possible only through dynamic and well-supported extension schemes.

Difficulties facing the development of rural health services had not been solved. These were mainly the shortage of staff and the general reluctance of professional staff to serve in rural areas.

#### **WHO Assistance**

WHO in South-East Asia, the Report said, continued to give high priority to communicable disease control programmes in the Region. During 1960, 52.7 per cent. of the total regional budget was spent in this field. Assistance in malaria accounted for 66.4 per cent. of 1.8 million dollars spent on all communicable diseases.

WHO, in close collaboration with other international and bilateral agencies, gave technical and financial assistance in the malaria eradication programmes of member-governments, assisted with the training of malaria workers and arranged conferences of countries with common borders to facilitate exchange of scientific information of common interest.

The programmes recorded steady progress in most of the countries. In Ceylon, eradication seemed more nearly in sight than anywhere else in the Region. Evidence of mosquitoes becoming resistant to the insecticide used was recorded in two States of India (Gujarat and Maharashtra) highlighting the need for rapid achievement of eradication.

#### **Home Treatment of TB**

In the field of tuberculosis the studies undertaken in the WHO-assisted Indian Council for Medical Research Project at Madras aimed at finding suitable methods of treating patients in their homes (without isolating them in clinics and hospitals), attracted world-wide interest.

Thirteen WHO specialists worked in the Indian National Tuberculosis Institute in Bangalore along

with national staff on a programme to work out and test suitable methods for a nation-wide tuberculosis control campaign based on a policy of home treatment. The Bangalore and Madras centres provided an excellent training field for tuberculosis workers and the results of the studies being carried out there would be reflected in national control programmes in the Region and elsewhere.

#### **Progress Against Leprosy**

National leprosy control campaigns assisted by WHO and UNICEF continued in five countries of the Region. While case-finding and treatment continued to take priority in these programmes, the governments of the Region showed increasing interest in re-constructive surgery and physiotherapy to prevent and cure deformities caused by this disease.

In Indonesia and Thailand, the leprosy control campaigns moved further towards their goal of integration into the general health services. The WHO/UNICEF-assisted project in Thailand was started in 1956. By the end of 1960, nine provinces with a population of over six million had been provided with case-finding and treatment services. More than 40,000 patients were under treatment in 1961 and nearly 200 treatment units had been established.

WHO and UNICEF agreed to give assistance to the Government of India in a programme for the development of leprosy control services, for which the Government had allocated Rs 45 million (\$ 9.45 million) under its Third Five-Year Plan (1961-66).

#### **Fight Against Smallpox**

National smallpox vaccination campaigns were strengthened in most of the countries in accordance with calls made by successive World Health Assemblies and Regional Committees for efforts to eradicate the disease. WHO continued its support to programmes for the production of vaccine.

An international conference on smallpox, sponsored by WHO, was held in New Delhi in November 1960. Sixteen pilot projects set up in various States of India in 1960 completed their vaccination programmes and collected a great deal

of valuable information for a nation-wide attack on smallpox.

### Unexpected Outbreak of Cholera

Seventeen thousand cases of cholera, a perennial problem in South-East Asia, were reported during 1960 with an alarming outbreak in Afghanistan (885 cases with 199 deaths) where the disease had not been reported for many years. This highlighted the risk to other countries of the reservoir of infection in India and Pakistan. WHO had expressed its interest in assisting with water supply projects because provision of safe water will do more for control of this disease than anything else.

### Plague—Hidden Danger

A salutary warning against sudden eruption of plague was issued through a special number of the WHO Bulletin (Vol. 23, No. 2-3 of 1960). It said: "Though almost extinct according to the latest statistics, plague may at any moment erupt again. . . . The present manifestations of plague, insignificant though they may appear at first glance, should not be considered local events of little importance. . . . but should be given continued attention by those interested in global health".

This warning became highly relevant with a significant increase in the number of plague cases in India in 1960, as compared to the figures for the earlier two years, and a total of 18 cases with 10 deaths reported from Burma.

### Filariasis—Dark Spot

The Report described filariasis as a "serious problem in the Region to which no practical answer has yet been found", and added: "It is assuming

greater prominence as a public health problem as malaria becomes less and less so. This situation needs to be watched very carefully".

Other fields in which assistance was given during the period related to trachoma control, building up of epidemiological services, health statistics, development of health services in community development areas, mother and child health services and paediatrics, development of nursing services and training, environmental sanitation with emphasis on safe water supplies and sanitary latrines, nutrition, mental health and strengthening of public health laboratories.

During the period, assistance was given in 123 health projects in the Region, utilizing 259 internationally-recruited specialists. A total of 102 fellowships were awarded and assistance given in nearly 450 training courses for various categories of health workers involving more than 10,000 trainees.

During discussions on the annual report of the Regional Director (for the period July 1960–August 1961) several delegates referred to subjects needing careful attention. The Indian delegation made special mention of the danger of plague outbreaks in certain areas. Some speakers emphasized the need to expedite national programmes for the eradication of smallpox and expressed concern at the stubborn problem posed by filariasis. Others called for greater attention to environmental sanitation, streamlining statistical services and improvement of the health of the pre-school and school child. (Based on the press releases of the WHO Regional Office for South-East Asia, New Delhi).



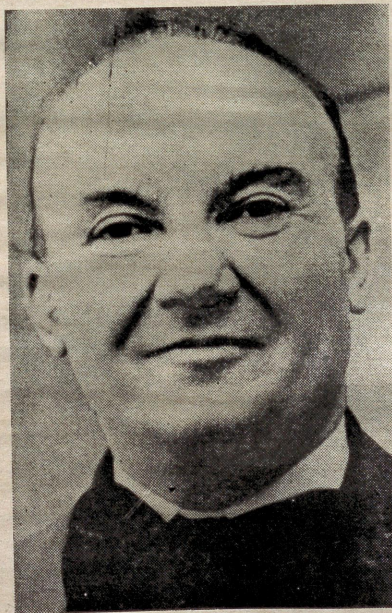
# News from States

## DELHI

### *Count Raoul Follereau in the Capital*

COUNT Raoul Follereau, President of the Order of Charity, Paris, who was on a visit to India between 10 and 29 October last delivered an impassioned address to an audience of those interested in leprosy work at a meeting organized by the Hind Kusht Nivaran Sangh, New Delhi, on 14 October, 1961.

Count Raoul Follereau



Mr Follereau's address was a passionate plea for ending the age old ignorance and superstitious fear concerning leprosy. Recalling the circumstances which challenged him to enter the fight on behalf of leprosy sufferers, he said that in 1932 he paid a visit to Sahara as a Press correspondent. During his tour, his car broke down on the outskirts of a

Nigerian village. Soon a crowd gathered round him, mostly people with swollen faces, thickened ears and other symptoms which we associate with leprosy. Not having known so far what leprosy is, he asked his driver who they were. The driver with an air of complete indifference said, "lepers". Mr Follereau asked: "Who looks after them, where are they?" The driver said: "I don't know. I don't care." From that day onwards, Mr Follereau decided to shatter this cruel indifference of the world to leprosy patients and has been waging a war against the universal injustice to leprosy patients for the last three decades. Mr Follereau said that he had travelled round the world 30 times visiting even the remotest leprosaria. But he added that he was spending half the time with leprosy sufferers and another half with those who do not have leprosy, including high dignitaries. For, he felt that if the patients needed cure for the disease, the public were even more in need of a cure for their fear and prejudice. He said that the tragedy of a leprosy patient today is that he suffers really from two diseases, the physical disease of leprosy for which he has now a certain cure in the sulphone drugs and the intolerable cruelty and injustice he has to endure from an ignorant and frightened public. He was not a doctor, but he had attended the International Congress at Tokyo and he was just then coming from a Regional Conference of the WHO at Istanbul. Now the experts were all of the opinion that today leprosy is curable and that it was among all diseases the least contagious. The experts should be believed and our fear cast off. He referred to Mahatma Gandhi's example of abundant love and

personal service to the leprosy sufferer. He was sure that under Gandhiji's inspiration India was marching on right lines in its leprosy relief and control campaign.

Mrs Raksha Saran, the Chairman of the Delhi Central Social Welfare Board, who presided over the occasion, introduced Count Raoul Follereau to the audience as the "Vagabond of Charity" who had travelled incessantly all over the world to bring relief to the suffering and to awaken the conscience of the world to the needs of this neglected group of human beings—the leprosy patients.

Shri T.N. Jagdisan, the Organizing Secretary of the Sangh, who proposed a vote of thanks, said that Mr Follereau's address was a wonderful demonstration of the power of words when they were united with sincere feelings and abundant love. Mr Follereau was amongst the greatest champions in the cause of leprosy and his World Leprosy Day, observed in 112 countries last year, had become a powerful means for removing the horror attached to leprosy and promoting a sympathetic understanding of the disease and its victims. Shri Jagdisan hoped that the end of this century would mark the end of leprosy as a problem.

#### MADRAS

##### *Madurai Conference on Ophthalmic Surgery*

THE latest advancement made in the field of ophthalmic surgery and its applicability to cure severe eye diseases in India were subjects discussed by experts at the Ninth Madras State Ophthalmic Conference held at Madurai Medical College in September last. Professor T.S. Sadasivan, Director, University Botany Laboratory, Madras, inaugurated the Conference.

Dr R.P. Dhanda of Indore, who presided over the Conference, and spoke on "Keratoplasty in India", said that 50 per cent. of cases of blindness in the country was corneal blindness and half of them could be cured by surgery called Keratoplasty. Stating that recent experiments had proved that the corneas removed from dead bodies within 24 to 48 hours could be effectively used for penetrating and lamellar surgery respectively, Dr Dhanda said that the latest experimental studies had yielded

fruitful results regarding the possibility of using eyes and corneas as donor material for Keratoplasty.

Professor Sadasivan called for specific efforts to organize a team with initiative and enterprise to break through the new scientific problems facing them in the country. He dwelt on the importance of studying biological control of insect vectors and in this field much fundamental work remained to be done before we could manipulate biological control agents and press them into service in the field of public health.

#### MAHARASHTRA

##### *Due Approach to Mentally Ill*

THE Maharashtra Minister for Health, Shri Homi J.H. Taleyarkhan, said at Nagpur on 5 September last that lack of sympathy towards the mentally imbalanced and a tendency to disown even the cured mental patients posed serious problems for hospitals.

Inaugurating the first meeting of the State Board for Mental Health, Shri Taleyarkhan said, such a tendency led to a large number of mental patients staying on in overcrowded hospitals even after being cured.

Maharashtra had made advancement during the Second Plan in respect of increased consciousness and improved facilities. He urged the Board to give due consideration to schemes for reducing congestion in the existing hospitals and to extend training facilities.

#### MYSORE

##### *Homoeopathy System*

THE Mysore legislature passed the Mysore Homoeopathic Practitioners Bill, 1960 as amended seeking to regulate the qualifications and practice of Homoeopathic medicine and to provide for the registration of practitioners of the Homoeopathic system of medicine in the State. The bill, moved by the Health Minister, Dr K.K. Hegde, received a general welcome. In his reply, the Minister said that the Bill would now confer statutory recognition of the practitioners of that system of medicine and also certain institutions imparting training in it.

## WEST BENGAL

### *Medical Relief to Middle Income Group*

THE State Minister for Health Dr A.B. Ray, announced in the West Bengal Assembly on 26 September last, a scheme called "Zonal Out-patients and Emergency Services and Contributory Domiciliary Treatment Scheme" for the middle income group in Calcutta. The Scheme seeks to decentralise the medical facilities and reduce overcrowding in Calcutta hospitals and ensure prompt attention, treatment and medical relief.

The whole of the city, consisting of 80 wards, has been divided into 11 zones, each served by a big hospital, where expert medical, surgical, gynaecological and obstetrical and specialised diagnostic services will be provided. Each hospital will have under it five sub-zonal hospitals or clinics.

## UTTAR PRADESH

### *Cholera/Gastro-enteritis Epidemic*

SPORADIC cases of cholera/gastro-enteritis were reported in U.P. since January this year. There was considerable increase in incidence during the month of April, and the disease assumed epidemic proportions in the last week of August. The infection spread in the first instance to the districts neighbouring Varanasi, through pilgrims returning from the Panch Koshi Yatra held in Varanasi district during April-May. Subsequently, the infection spread to other districts. The epidemic reached its peak during July-August and showed decline in the month of September.

The month-wise figures of cases and deaths from cholera, including gastro-enteritis, reported are given below :

<i>Month</i>	<i>Cases</i>	<i>Deaths</i>
January	29	—
February	28	3
March	414	37
April	1,560	150
May	2,796	848
June	5,484	1,624
July	8,304	2,357
August	8,855	2,785
September	4,920	1,859

The Districts of Azamgarh, Jaunpur, Ghazipur, Mirzapur, Banda, Hamirpur, Allahabad and Hardoi and the cities of Lucknow and Varanasi were the worst affected.

The State Government enforced compulsory anti-cholera schemes in all the major fairs and on the pilgrim routes to Badrinath and Kedarnath as a preventive measure against outbreak of epidemics, greater attention was also paid to the sanitation and water supply of the fair areas and pilgrim routes. Vigorous steps were taken to combat the outbreaks in all epidemic-affected areas. Temporary isolation hospitals were opened wherever necessary, and the existing facilities in the permanent infectious diseases hospitals were augmented. Domiciliary treatment facilities were provided to patients who could not be removed for isolation in hospitals. The other measures taken consisted of disinfection of infected houses and material, sterilization of water supplies, anti-fly measures, and mass anti-cholera inoculations. Nearly, 49 lakh inoculations were performed during the year up to September. Epidemic diseases regulations relating to control over manufacture and sale of articles of food and drink were enforced.

The affected districts were provided with adequate staff and funds in order to enable them to meet the epidemic situation.

The State Government took vigorous steps to control the explosive outbreak which occurred in Lucknow city in the last week of June, on account of the large religious gathering held in certain areas of the City on the occasion of Moharrum.

The existing isolation and treatment facilities in the local Infectious Diseases Hospital were augmented, and an additional hospital was opened temporarily to provide isolation and treatment facilities to the patients. The local Medical College and the Health School provided the extra doctors and nurses needed to attend on patients. The Blood Bank provided large quantities of saline needed.

Eight senior medical officers of health were detailed along with trainee sanitary inspectors and medical students for taking epidemic control measures in the City. On account of the immediate and vigorous steps taken by the Government, the explosive situation in the City was brought under control in a matter of few days.

# SMALLPOX AND CHOLERA

## MORBIDITY & MORTALITY

THROUGHOUT India, 2,116 cases of smallpox with 568 deaths were reported during August 1961. The cases and deaths due to cholera were respectively 14,877 and 5,151. Forty-two cases of plague with five deaths were reported during the month.

STATE	CHOLERA		SMALLPOX		PLAGUE	
	<i>Cases</i>	<i>Deaths</i>	<i>Cases</i>	<i>Deaths</i>	<i>Cases</i>	<i>Deaths</i>
Andhra Pradesh	486	217	208	54	—	—
Assam	—	—	9	1	—	—
Bihar	8005	2866	—	—	—	—
Delhi	—	—	10	6	—	—
Gujarat	—	—	76	18	—	—
Himachal Pradesh	—	—	5	2	—	—
Jammu & Kashmir	†	†	†	†	†	†
Kerala	—	—	57	18	—	—
Madhya Pradesh	288	106	154	37	—	—
Madras	1	—	987	249	8	2
Maharashtra	1843	529	62	9	—	—
Mysore	277	98	161	43	34	3
Manipur	—	—	—	—	—	—
Orissa	301	89	23	1	—	—
Pondicherry	—	—	37	18	—	—
Punjab	—	—	66	13	—	—
Rajasthan	3	2	29	7	—	—
Tripura	—	—	—	—	—	—
Uttar Pradesh	3024	988	202	80	—	—
West Bengal	649	256	30	12	—	—
TOTAL :	14877	5151	2116	568	42	5

†Information not received.

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Issued by

CENTRAL HEALTH EDUCATION BUREAU  
Directorate General of Health Services, Ministry of  
Health, Government of India, Kotla Road, New Delhi-1.