COM H 10.1

RF_COM_H_10_SUDHA

Directorate of Rural Health Services
and Training Programmes

St John's Medical College, Bangalore

DRHSTP-ACC-81 28 Nov 1981

Dear

Seasons Greetings for Chirstmas and the New Year from all of us in the Department of Community Medicine at St John's!

1982 is going to be a special year for us since a long standing plan to meet all of you in the field has finally materialised. Thelma and I are on special leave for a year starting December 1981 and during this year we plan to visit as many of you as possible in your own areas of work to re-establish contact, share experiences, reflect together and grow in our understanding of our people and our work. We have already been in touch with many of you and we shall be writing to others as the weeks go by. We thank all those who have so promptly and enthusiastically received this news and welcomed us to their villages in 1982. We hope to hear from many others amongst you soon.

In order to get some common information from all of you in the field we have drawn up a simple questionnaire taking ideas from many of your own letters. Please fill these up and add any other comments, information, suggestions you would like to send us. Those of you, who have already sent us some details of your work recently fill in only those sections which you did not cover in your personal letters. We would like very much to hear from each of the 150 Community Health Workers we have trained. Even a blank questionnaire with only your latest address and information on how to meet you next year would be most welcome.

Meeting you and seeing your programme will be a good experience for us but in case you feel there are any other ways in which our visit could be mutually beneficial please suggest this in Section C (b).

In preparation for this visit many other materials are being organized which we hope to send you soon - a list of Community Health Workers addresses, news bulletins, list of new handouts and educational materials and so on. So please keep in touch.

Hoping to hear from you soon and also meeting you next year.

With best wishes and regards,

To

Yours sincerely,

PS: Please post this to Drs. Ravi & Thelma Narayan, D-10 Staff Quarters,

Directorate of Rural Health Services &
Training Programmes

FOLLOW-UP EVALUATION OF COMMUNITY HEALTH WORKERS TRAINED IN ST JOHN'S MEDICAL COLLEGE

PROFORMA

Instructions : Section A and C to be filled in by all Community Health Workers
Section B to be filled in by those who are doing health work at present.

(Please keep us informed regarding change of Address)

SECTION – A – GENERAL INFORMATION

a) Name :

b) Age:

c) CHW Course No.:

d) Name of Congregation:

e) Diocese:

f) Permanent Address
(Mother House/Superior) :

g) Present Address
(For future correspondence) :

h) What have you been doing after the course ?
(If you have changed from place to place give us some details of your work in each place).

i) Give us a short description of the present team you are working with and what each member does (not only health activities)

j) Have you attended any course/meetings/workshops since you completed the Course ?

k) Are you in touch with any of the other Community Health Workers? If so give us their recent address.

l) Give in a few sentences a description of the poeple you are working with (rural, urban, tribal, non-tribal, main occupation, other characteristics etc). How many villages? Total population, what distances apart ?

SECTION B

a) Give a short description of the health activities you are involved in.

b) How many hours are allotted for this daily/weekly ?

c) Are you functioning independently or with a team of workers? If so, how is the health work shared amongst you ?

d) Do you get any assistance from the local Primary Health Centre? If so, specify ?

e) Do you get any assistance from a Taluk/Mission Hospital? If so, specify?

f) Do you work with any special groups in the village (young farmers, youth, mothers, harijans etc.)?

g) Do you participate in training of local people ? Grihinis, village level worker, mothers etc.

h) Do you have any of the following programmes?
Food for work, Health Insurance, CRS- MCH programme, any others

i) Are you part of any Diocesan Society or Health Team ? If so, specify.

SECTION C (Regarding 1982 project)

a) Give us detailed information on how to reach your village/project/centre? (By bus and train, also from station and bus stop)

b) Are there any forms of support which a visiting team can give you next year ?

Date:

Signature:

Please use the remaining blank space to give any further details for which there was not adequate space in the questionnaire.

COM H 10.2

ST. JOHN'S MEDICAL COLLEGE, BANGALORE 560 034
Department of Community Health

Dated:

Dear Sister/Father/Brother,

Greetings from St. John's Medical College, Department of Community Health!

We have received your present address from the superior of the convent from which you had come to us for the Community Health Workers Training course.

We had promised informative material & Consultatory help. However, before that we would like to have a few more details regarding your present work and address as also some of your view-points on our training. This would enable us to improve on our training as well as to help you in relevant aspects.

Enclosed herewith is a questionnaire with most of the answers provided. Tick or underline the answer you find most appropriate. You may use the space on the last page for any other details you like us to know.

Kindly fill in the questionnaire and mail it back to us as early as possible preferably before November 30th 1991.

Thanking you,

Yours sincerely,

R. G. Washington

DR REYNOLD WASHINGTON

Countersigned:

D. S. Amar

DR. DARA S AMAR
Prof. & Head

P.S. : Please post this to:

Dr. Reynold G. Washington
Dept. of Community Health
St. John's Medical College
BANGALORE 560 034

DEPARTMENT OF COMMUNITY HEALTH

GENERAL PROFILE: COMMUNITY HEALTH WORKERS

I a) Name: b) Age: c) Sex:

d) Year Attended CHW Course:

e) Religion: f) Caste: SC/ST

II 1) What was your educational qualification before joining the course?

a) Below S.S.L.C. (Xth Std)

b) S.S.L.C.

c) P.D.C./P.U.C.

d) Higher qualification: Medical
(specify) Degree/Diploma: Non Medical

e) Technical Training

2) Have you improved your educational qualification since then?

Yes/No

3) What is your educational qualification at present?

Below SSLC/SSLC/PDC/Higher Degree/Technical Training/Professional

III i) Have you done any other course related to health or Community Development after the course? (Please tick or underline)

Laboratory Technician/Auxiliary Nurse Midwife/Nursing/Community Health & Development/Integrated Rural Development/Diploma course for mentally retarded/ Bachelor of Education/ Teacher's Training/ Theology, Philosopher/ Multipurpose Worker's Course/Social Awareness Course/ Adult Education/Bachelor in Social Science/Naturopathy, Ayurveda, Unani, Siddha, Herbo-Mineral, Magnetotherapy Course/Small industry & Co-operative course/Leprosy Training Course/Any other/ Acupressure & Acupuncture.

ii) Have you attended any seminars or workshops as a process of continuing education such as?

- Diocesan meeting on Health Development
- Natural Family Planning
- Maternal & Child Health
- Vocation Seminar
- Youth Seminars
- VHAI Conventions
- Social Work meetings
- Adhoc mission hospital-based training

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Countersigned:

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DR. DARA S AMAR
Prof. & Head

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Yes/No

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- Youth Seminars
- VHAI Conventions
- Social Work meetings
- Adhoc mission hospital-based training

IV i) What area do you stay in ?

Rural Urban Tribal Others

ii) What type of people do you serve?

Rural Urban Tribal Others

V)i) Specify the year in which you were involved in any one of the following type of works

	YES/NO	Year	Duration of Experience in years
- Dispensary			
- Mobile Clinic			
- C.R.S. Programme			
- Maternal & Child Health			
- Creche/Balwadi			
- Immunization			
- Health Education			
- Natural Family Planning			
- Adult & Non-formal education			
- Malaria Surveillance			
- Leprosy work			
- School Health work			
- Nutrition Education			
- Home for the Aged			
- Major hospitals			
- Village level worker's training			
- Mahila Mandal			
- Youth club			
- Grihini Course			
- Agricultural Extension			
- Animal Husbandry			
- Vegetable gardens			
- Environmental Sanitation			
- Community Organisation			
- Conscientisation			

ii) Did you at any time work as any one of the following? Specify the year:

Teacher in a school -

Parish Priest -

Rehabilitation Centre/
Hostel -

Superior -

Parish Fr. parish work -

Manager of Estate -

Information/Matron -

VI) Did you integrate Community Health Work in these roles?

YES/NO

VII) Has the Community Health Workers Training helped in your work?
(i)

YES/NO

(ii) What aspects of field training/visits do you find relevant?

- Family studies
- Chlorination of well
- Immunization sessions
- Natural Family Planning
- Health Education
- MCH Services
- School Health
- Training of TBA's
- Training of Teachers
- Mobile Clinic
- Leprosy Survey
- Nutrition Demonstration
- Child to Child
- Family Role in Illness
- Spastic Society/Physically Handicapped
- Visit to the Blind
- Child guidance clinic/
  Speech & Hearing/
  Food preservation & Canning

iii) What teaching methods helped you the most?

- Lecture
- Lecture with Audio-Visual Aids
- Discussion
- Demonstrations/practicals
- Supervised field work
- Simulation games (Monsoons, Chikkanahalli)
- Learning by doing (Nutrition demonstration, child to child)

iv) Did you have difficulty in learning any of these areas during the course?

YES/NO

- Content;
- language:
- duration;
- Method of teaching used :
- timing of sessions:
- sequence of sessions:
- Last minute changing of time-table:

v) Was any action taken to help you learn better? YES/NO

vi) If so what action?

Extra classes/withdrawal from course/report to supervisor/

personalised attention by trainer/others.

vii) With respect to your objectives in joining the course, were you satisfied immediately after the course? YES/NO

viii) Do you think refresher course are necessary? YES/NO
On what aspects ?

- Control of Communicable diseases
- MCH
- Nutrition
- Immunization
- First Aid
- Health Education
- Environmental Sanitation
- Planning, Management
- Evaluation of Health Status
- Curative care for minor ailments
- Community Development Activity
- Vital event registration
- Referral
- Other systems of medicine
  (Ayurveda/Homeopathy/Unani)

VIII) What problems do you encounter in your work at present?

- Lack of self-confidence
- Lack of technical guidance
- Lack of support - personnel/money/material
- Restriction imposed by superior
- Lack of interest
- Lack of community participation
- Lack of co-operation with other groups (Govt.)
- Lack of cooperation with other groups (Private)
- Lack of continuing education from St. John's.
- Any others

COMMUNITY HEALTH WORKERS QUESTIONNAIRE
WORK OF THE COMMUNITY HEALTH WORKERS

I. CONTROL OF COMMUNICABLE DISEASES:

1.a) Do you screen patients for common communicable disease? Yes/No

b) How often do you screen patients for disease?
Once/year once/6 months once/3 months once/month

c) What common communicable diseases have you screened patients for?
TB/Leprosy/Malaria/skin diseases/Vitamin'A' deficiency/others(specify)

d) Do you screen any particular age group more often? Yes/No
Under 5/ 5- 15 school going/ 15-45/ 46-60/more than 60 yrs.

2.a) Do you impart health education concerning common communicable diseases in your area? Yes/No

b) How often?
Once/year once/6 mths once/3 months once/month
once/week every opportunity

c) What diseases have you taught or informed people about?
T.B./Leprosy/Malaria/V.D./Skin diseases/AIDS/Diarrhoea/Acute Respiratory Infections/Worm Infestations/others(specify)

3.a) Do you perform any laboratory tests Yes/No

b) If you do so, What?
Malaria slide/Stool examination/Sputum for AFB/Urine Sugar and Albumin/Hb. / Leprosy smear.

4.a) Do you treat patients with communicable diseases? Yes/No

b) What communicable diseases do you commonly encounter?
Measles/Polio/Jaundice/Malaria/TB/Leprosy/Diarrhoea/Dysentry/
Others(Specify)

c) What do you use to treat them?
Home remedies/Allopathic Drugs/Other systems (eg. Ayurveda, Homeopathy)
specify

d) Do you follow-up patients with chronic communicable diseases? Yes/No

5. What is your level of involvement in the following programmes:

a) Diarrhoeal Disease Control Program

b) ARI Control Program

c) Tuberculosis Control Program

6. What is your level of
7. How will you manage:
   a) An infant with ARI
   b) A young adult with malaria
   c) A child with diarrhoea

II. MATERNAL AND CHILD HEALTH

1.	Do you identify pregnant women from with/in the community?	Yes/No
2.a)	Do you identify high risk cases?	Yes/No
b)	Are the high risk cases referred for appropriate care?	Yes/No
3.	Do you arrange for T.T. Vaccination for Pregnant women?	Yes/No
4.	Do you educate them on general care, nutrition an immunization during pregnancy?	Yes/No
5.	Do you assess weight gain regularly in pregnant women?	Yes/No
6.a)	Do you conduct laboratory investigations for pregnant women?	Yes/No
b)	What? Hb/Urine/Blood group and type/VDRL	
7.	Do you distribute Iron and Folic Acid tablets to pregnant women?	Yes/No
8.a)	Have you assisted delivery at any time?	Yes/No
b)	At Home/hospital	
9.	Have you trained Traditional Birth Attendants (TBA) (eg: Dais) at any time?	Yes/No
10.a)	Do you inform and motivate pregnant women for family planning?	Yes/No
b)	What methods? NFP/others (specify)	
11.a)	Do you visit the newly delivered mother at home?	Yes/No
b)	How many visits usually? One/two/three/more than three	
12.	Is the weight of the new born child recorded?	Yes/No
13)	Do you advise on child care?	Yes/No
14)	Are you involved in any pre-school (Balwadi/Creche) activity	Yes/No
15)	Do you distribute Vitamin-'A' drops/capsules for children who need it?	Yes/No
16)	Have you organised any MCH programs (Mahila Mandal/Non-formal functional literacy groups for girls etc)	Yes/No.

5) What preventive steps in communicable disease control have you taken?

17. Do you maintain registers? Yes/No

a) Birth Register

b) Pregnant Women Register

c) Family Planning Register

18. Local MCH Indicators

a) No. of expectant mothers who received ante-natal care in the last year.

b) No. of mothers identified as high risk

c) No. of deliveries terminated as abortions or still births

d) No. of deliveries conducted at home/at hospital

e) No. of post-natal check-ups

f) No. of infants attending immunization clinic

III. IMMUNIZATION

1.a) Do you educate groups on vaccine Preventable Diseases? Yes/No

b) To whom? Mothers/School-going children/AWW/others(specify)

2.a) Do you motivate mothers and children to utilise immunization services? Yes/No

b) How?

3.a) Have you assisted at giving immunization? Yes/No

b) Where?

c) What vaccines? Polio/Measles/DPT/BCG

4. Have you organised any out-reach programmes for immunization? Yes/No

5. Do you evaluate your immunization programmes? Yes/No

6. Can you do a survey to assess immunization coverage in your area? Yes/No

7. Do you maintain an immunization register? Yes/No

8. Do you hand over immunization cards to the recipients? Yes/No

9. What facilities for the maintenance of 'cold Chain' do you have?

10.a) D.P.T. is given: Orally/Sub-cutaneously/intra-dermal/ intra-muscular

b) Measles Vaccibe is given: Orally/Sub-cutaneously/intra-dermal/ intra-muscular

IV. NUTRITION

1.a) Do you support promotion of breast feeding in your area? Yes/No

b) If breast feeding is insufficient, do you suggest bottle feeding/pallida feeding/spoon & glass/others (specify) buffale's milk/tinned milk/ cow's milk

2.a) When do you advise mothers to introduce weaning foods?

b) What type of weaning food do you advise?

3.a) Do you conduct sessions on nutrition education/nutrition demonstration? Yes/No

b) For whom?

4. Do you promote kitchen gardens? Yes/No

5. Do you maintain growth charts of children in your area? Yes/No

6. Do you identify the malnourished and render them special care Yes/No

7.a) Are you involved in any supplementary feeding programs? Yes/No

b) Name them

8. What are your local findings on diet practices?

a) In pregnancy

b) In infancy

V. FIRST AID

1. Have you come across cases of
   Burns/Wounds/Fractures/Bites/Accidents/Poisoning

2. What have you done for such cases ?
   Nothing/First-Aid and Referral/First-Aid and Curative Care/
   Referral straight away/First-Aid only

3. What is the first step you take:

a) In a case of dog bite
   i) give rabies vaccine
   ii) stitch the wound
   iii) Wash the wound with soap and water
   iv) dress the wound

b) In a case of burns
   i) Pour cold water
   ii) apply oil
   iii) apply burnol
   iv) dress the wound

VI. ENVIRONMENT

1.a) Do you educate the community on:
   - Safe water supply
   - Sanitary latrines: construction and use
   - Waste disposal
   - Food protection & food hygiene
   - vector control (insects)
   - personal hygiene

b) Who do you educate:
   - School children
   - Mothers
   - families

2. Do you motivate the community to use

- Safe drinking water
- Sanitary latrines
- Soakage pits
- protected food
- vector control measures (eg. DDT spraying)
- smokeless chullas

3. Have you arranged for -

- Chlorination of water source
- DDT spraying
- Construction of - soakage pits
  - smokeless chullas
  - sanitary latrines

4. How has the community involved itself in these areas

Good/Fair/Poor

- Maintenance of water supply
- use of sanitary latrines
- waste disposal
- food protection
- vector control

5. What are the diseases transmitted by mosquitoes?

a) Diarrhoea (b) Malaria (c) Filaria (d) Pneumonia

VII. IDENTIFICATION OF COMMUNITY HEALTH PROBLEMS WITH A VIEW TO SOLVE THEM:

1. Have you identified any Community Health problems in your community?

2. What type of problems have you, come across?

3) Do you take steps to solve them? Yes/No/sometimes

VIII. MEASUREMENT OF HEALTH STATUS OF A COMMUNITY:

1. Have you measured the 'health status' of your community? Yes/No

2. Commonly used Indicators of Health ~~are~~

- Infant Mortality Rate
- Life expectancy at birth
- Disease - specific mortality
- All the above
- None of the above

IX. COPING WITH COMMON HEALTH PROBLEMS: (Treating/Referring -when necessary)

1) What type of cases do you commonly come across?
Pains/Worm infestations/eye diseases/ear diseases/skin diseases/
Dental problems/Venereal disease/Mental disease/fits/others(specify)

2) Have you treated them?

3)a) Have you referred any cases? Yes/No

b) What type of cases have you referred?

c) To whom do you refer?
Private Hospital/Govt.Hospital/Pvt.Doctor/Govt.Doctor/ANM/
Others(Specify)

d) How far is the referral centre?
Less than 5 Km/6 - 10 Km/ 11 - 15 km/ 16 - 20 Km/ More than 20 Km

e) What is the common mode of transport for such patients?

- Motorised vehicle - Pvt. Vehicle
  - Ambulance
  - Public Transport Service
- Bullock Cart
- Walk

4) Do you follow-up referred patients? Yes/No

X. HEALTH EDUCATION

Yes/No

1) What aspects have you dealt with?

- Nutrition
- Immunization
- Communicable disease Control
- First Aid
- Environmental Sanitation
- Family Planning
- Others (specify)

2) What methods have you used?

	Very Often	Often	Rare	Not at all
- Lectures				
- Lectures with Audio-Visual Aids				
- 'Professional' Talks				
- Group Discussions				
- Demonstrations				
- Simulation Games				
- Child-to-Child/Youth-to-Child				

3) What Audio-Visual Aids do you use?

	Very Often	Often	Rare (occasionally)	Not at all
- None				
- Charts/Flannel graph				
- Chalk/Black-board				
- Slides				
- Overhead Projector				
- Films				
- Tape-recorder				
- Video films				

4) Have you used folk-media?

	Very Often	Often	Rare	Not at all
- Song				
- Dance				
- Drama & skits				

5) Do you use the Mass-media ?

	Very Often	Often	Rare	Not at all
- Radio				
- T.V				
- Newspapers				
- Magazines				

6) Do you organise mother-groups for health education? Yes/No

7) Do you utilise school-children/contact mothers for conveying health education messages? Yes/No

8) Have you organised training camps for youth/children/women/men/others (specify) or involved yourself in them to teach Health? Yes/No

9) Have you organised any health exhibitions/Baby shows? Yes/No

10) Do you utilise the opportunity of home-visits for inter-personal communication on health? Yes/No

11) a) Do you evaluate your Health Education Programs? Yes/No

b) How?

12) Do you document the program & its evaluation? Yes/No

XI. COMMUNITY DEVELOPMENT ACTIVITY

1) Have you been involved in training for any Community Development Activity?
Animal Husbandry/Horticulture/Piggery/Poultry/Tailoring/Arts & Crafts/
Weaving/Sericulture/Agriculture/Formal or In-formal education/
Others(specify)

2) Do you motivate the Community to involve themselves in any of these activities? Yes/No

3) Is health & Community development related? Yes/No/Don't know

4) Does the Community participate in these activities? Yes/No
   a) - in perceiving the need Yes/No
   b) - in decision making Yes/No
   c) - in planning Yes/No
   d) - in implementation Yes/No
   e) - in evaluation Yes/No
   f) - in bringing about changes Yes/No

5) What steps have you taken to improve community participation?

XII. MAINTENANCE OF VITAL STATISTICS

1) What are Vital Statistics?

2) Do you collect & convey information regarding Births, Deaths & Marriages in your area?

XIII. PROVIDING FOR CONTINUING EDUCATION

1) What steps have you taken to increase your knowledge & skills in your work?

2) Who do you approach in case of:

- lack of 'technical' guidance in you community health work

- for increasing your knowledge and skills in you community health work

XIV. PRACTICE OF OTHER SYSTEMS OF MEDICINE

1) What other systems of medicine do you practice?

2) Have you received formal training in them?

3) Where did you receive such training?

SYSTEMS	PRACTICE Yes/No	TRAINING Yes/No	PLACE OF TRAINING	DURATION OF TRAINING
- Ayurveda				
- Homeopathy				
- Accupressure & Accupuncture				
- Herbo-Mineral				
- Herbal Therapy				
- Home Remedies				
- Magnetotherapy				
- Siddha				
- Unani				
- Naturopathy				
- Others (specify)				

4) What percentage of your patients are treated with these other systems only?

less than 25% / 26 - 50% / 51 - 75 % / more than 75 %

5)a) Do you combine allopathy with these systems in any one given patients? Yes/No

b) What combinations do you commonly use?

6) Do you document such treatment? Yes/No

7)a) Have you evaluated the efficacy of such treatment? Yes/No

b) How?

c)What are your findings?

COMMUNITY QUESTIONNAIRE

I CONTROL OF COMMUNICABLE DISEASE :

1) a) Is is necessary to screen patients for disease ? Yes/No

b) How often should one screen patients for disease ?

once/year once/6 mths once/3 mths once/month

c) What common diseases require frequent screening?

TB/Leprosy/Malaria/Skin Disease/Vit 'A' Deficiency/Cancer/DM/others

2) a) Is Health Education regarding Common Communicable diseases necessary Yes/No

b) How often?

Once/yr once/6 months once/3 moths once/mth once/week

every opportunity

c) What diseases do people need to be taught about?

TB/Leprosy/Malaria/VD/Skin Diseases/AIDS/Diarrhoea/ARI/Worm Infestation

3) Is it necessary to do blood, Urine, Sputum or stool tests for communicable diseases ? Yes/No

Grade by degree of importance, the relevance of the following tests in your area:

	V.relevent	Relevent	not relevent
- Malaria slide - Malaria			
- Stook examination - Worm infestation/ Amoebiasis			
- Sputum for AFB - TB			
- Urine - Sugar - Diabetes			
- Hb - Anemia			

4) Importance of the following programmes in your areas:

	V.relevent	Relevent	not relevent
- Diarrhoel disease control program			
- ARI Control Program			
- National Tuberculosis Control Program			
- National Lperosy Eradication Program			
- Malaria Control Program			

../2

II MATERNAL & CHILD HEALTH:

1. Is is necessary to identify pregnant women in the community? Yes/No
2. Is it important to identify 'risk' cases & refer them ? Yes/No
3. Is T.T. vaccination essential for pregnant women? Yes/No
4. Is education of women on general care, nutrition & immunization during pregnancy relevent? Yes/No
5. Is regular assessment of weight gain of a pregnant women essential? Yes/No
6. Are blood and urine examination needed for a pregnant mother? Yes/No
7. Are Iron and Folic Acid supplements necessary for pregnant women? Yes/No
8. Do women in the community need assistance of a trained person during delivery? Yes/No
9. Is it necessary to train 'Dais' (TBAs) in Safe delivery practices ? Yes/No
10. Is family planning information & motivation relevant for pregnant mothers? Yes/No
11. Is it necessary for a newly delivered mother to be visited and advised by a health worker? Yes/No
12. Is it necessary to weigh the new born child? Yes/No
13. Is it important for the Community Health Workers to advice on child care ? Yes/No
14. Do children in Balvadis/creches need health care? Yes/No
15. Are Vit 'A' drops/capsules needed for small children? Yes/No
16. Does the Community Health Worker have to integrate his/her work with other programmes of women & children ? Yes/No
17. Is it necessary to maintain:
    - Birth Register - Yes/No
    - Pregnant Women (Antenatal) Register - Yes/No
    - Family Planning register - Yes/No

../3

III. IMMUNIZATION

1. Is there a need for people in your area to be educared & made aware of V.P.D.(s)? Yes/Np
   - Who needs this education most ?

2. Is it necessary for mothers & children (in your area) to be motivated to utilise immunization services? Yes/No
   How can they be motivated?

3. Are immunization sessions by a Community Health Worker necessary? Yes/No

4. Are 'outreach' programs for immunization required? Yes/No

5. Is monitoring & evaluation of immunization programs essential? Yes/No

6. Has immunization coverage survey been undertaken in your area? Yes/No

7. Is it necessary to maintain immunization registers? Yes/No

8. Is it necessary to hand over immunization cards to the recipients? Yes/No

VI. NUTRITION

1. Is it advantageous to promote breast feeding? Yes/No
2. Do mothers need to be eucated on "weaning foods" ? Yes/No
3. Are sessions on Nutrition Education & Mutrition Demonstration important & useful? Yes/No
   Who should be the recipients at such sessions?
4. Are kitchen gardens useful? Yes/No
5. Is it necessary to monitor a child's growth? Yes/No
6. Should the Malnourished be identied & rendered special care? Yes/No
7. Yes/No

V. FIRST AID

1) Is it necessary for a person to be trained to administer First Aid in your area for:

	V.Relevant	Relevant	not relevant
- Burns			
- Fractures			
- Wounds			
- Bites			
- Accidents			
- others			

VI. ENVIRONMENT

1)a) Does the community need to be educated on :

	V.Relevant	Relevant	not relevant
- Safe Water supply			
- Sanitary Latrines			
- Waste disposal			
- food protection & hygiene			
- Vector control			
- personal hygiene			

b) Who should this education be targeted at?

	V. Good	Good	not good
- School going children			
- Mothers			
- Families			
- Patients in hospital			
- others			

) Should the community be motivated to use?

	V.relevant	Relevant	not relevant
- Safe drinking water			
- sanitary latrines			
- soakage pits			
- protected food			
- vector control measures			
- smokeless chullas			

3) Does the community need a facilitator for:

- Chlorination of water
- DDT spraying
- Construction of soakage pits
- Smokeless chullas
- Sanitary latrines

4) Grade Community participation in :

	Good	Fair	Poor
- Maintenance of water supply			
- use of sanitary latrine			
- waste disposal			
- food protection			
- Vector control			

VII. IDENTIFICATION OF COMMUNITY HEALTH PROBLEMS WITH A VIEW TO SOLVE THEM:

- should the community health worker play a role to:
  - identify - health problems : Yes/No
  - solve - health problems Yes/No

VIII. Measure the health status of the community: Yes/No

IX. COPING WITH COMMON HEALTH PROBLEMS:

- Treating them
- Refereing them (when necessary)

1. What are the common ailments seen in this area?
   Pains/worm infestation/eye diseases/ear diseases/skin diseases/
   Dental caries/Venereal disease/Mental disease/Fit/Diarrhoea/ARI

2. Who can treat these common ailments?
   Self/Witch doctor/Pharmacist/ANM/CHW/Nurses/Doctors

3. Do difficult cases need referral?

To whom:	Hospital Pvt/Govt	Doctor Pvt.	ANM/Nurse	Others

4. Is follow-up of referred patients important? Yes/No

X. HEALTH EDUCATION

1. Are health messages on the following useful or not?

	Very useful	Useful	Not useful
- Nutrition			
- Immunization			
- Malaria			
- Diarrhoea			
- ARI			
- Environmental Sanitation			
- Family Planning			
- AIDS			

2. What methods of health education are useful?

	V. useful	Useful	Not useful
- Lectures			
- 'Professiona' Talks			
- Discussions (Group)			
- Demonstration			
- Simulation Games			
- Child to Child/ Youth to child			

3. Is it beneficial to use the following for conveying health messages:

- Audio-visual Aids - Yes/No

	V. Good	Good	Not useful
- Chests, Flannel-graph			
- Chalk - Black Board			
- Slides			
- Over Head Projector			
- Film reels			
- Tape recorder			

4. Folk media - Yes/No

	V. Good	Good	Not useful
Song			
Dance			
Drama			
Story telling			
proverbs			

5. Electronic Media: Yes/No

	V. Good	Good	not useful
Radio			
T.V.			
Video			
Films			

6. Mother groups

7. School children/contact mothers

8. Training camps:
Men/Youth/Women/Children

9. Health Exhibitions/Baby shows

10. Home visits

XI. Community Development Activity:

1. What types of Community Development Activity could be incorporated or advanced in your area?

- animal husbandry/horticulture/piggery/poultry/tailoring/arts & crafts/ weaving/sericulture/agriculture/others.

2. Is 'motivation' of the community necessary for involvement in such activity? Yes/No

3. Is health and community development related? Yes/No

4. Grade Community participation in these endeavours in general:

Good Fair Poor

5. Should steps be taken to increase the level of Community participation?

Yes/No

What steps?

XII. MAINTENANCE OF VITAL STATISTICS

Is it necessary for the CHW to

1) - Know Yes/No

2) - Maintain Yes/No

Vital statistics related to his/her area of work?

XIII. Continuing Education:

XIV. PRACTICE OF OTHER SYSTEMS OF MEDICINE

1. What other systems of medicine do people (of your area) believe in and are they useful?

2) Is training of practitioners in these systems important?

	V.useful	useful	not useful	Training Yes/No
- Ayurveda				
- Homeopathy				
- Accupressure& Accupuncture				
- Hebro-mineral				
- Home remedies				
- Magnetotherapy				
- Siddha				
- Unani				
- Naturopathy				
- Others				

3) Should allopathy be combined with other systems of medicine in a given patient?

Com H 10.3

A PROJECT PROPOSAL

A short term consultancy, to consolidate some of the past efforts of the Ross Institute Unit of Occupational Health, in the Plantations in South India, in the areas of continuing Education and Research.

Duration: 6 months in 1988

Venue : Coonoor/Bangalore

Background

In the first ten years since its inception the Ross Unit of Occupational Health evolved a series of plantation-based and medical college based continuing education programmes for plantation health staff, as an adjunct to the Comprehensive Labour Welfare Programme organised by the United Planters Association of Southern India. In addition it also undertook a pilot study on the Health Status of Tea Plantation workers with special reference to their occupation, in collaboration with the Regional Occupational Health Centre, Bangalore (ICMR Unit).

Since 1984 the unit's activities have been somewhat restricted, with a slowing down of the initial momentum of its development due to multiple factors outlined in the discussion document circulated by Professor Bradley in May 1986 entitled "The Future policy for the Ross Institute" and the paper "The Ross Institute Unit of Occupational Health 1974-84 - an Overview, and assessment and some thoughts about the future", by Dr Ravi Narayan in April 1987.

The short term consultancy outlined in this note is a process, suggested to consolidate some of the past efforts of the Unit in continuing Education and Research and to explore the feasibility of some of the ideas and future possibilities outlined in the above mentioned documents with all the institutions associated with the Unit in the past.

Objectives

A - Definitive

a) Compilation of a Reference manual on Plantation Health from the reports/hand outs/teaching materials/studies generated by the UPASI-CLWS and the Ross Unit continuing education programmes.

b) Organisation of 3-4 District level workshops in the Plantations on "Occupational Health and Research in the Plantations".

These workshops will be an occasion to share the findings of the ROHC/RIUOH Tea plantation pilot study as well as other studies identified by the recent assignment on "Health and Agriculture - Inter-relationships". Apart from keeping the Plantation medical officers informed about recent developments in Plantation Health around the world it would also be an opportunity to ascertain the interests of medical officers in research.

B - Explorative

c) The Feasibility of a comprehensive evaluation and analysis of trends in Health Status from the data collected on estates participating in the CLWS Scheme from 1971-86.

d) The feasibility of the evolution of a Plantation Study group (consisting of researchers from the different institutions and research units in India who were in touch with the Ross Unit), which would organise and support collaborative research programmes with plantation medical officers.

Dynamics of Consultancy

i) The consultancy will be undertaken over a period of six months in 1988 in close collaboration with UPASI and St John's Medical College.

ii) The consultant will be assisted by a full-time research project assistant for the duration of the consultancy. In addition one staff member each from the Medical Unit of UPASI and from the Department of Community Medicine at St Johns would be involved in the project, and would contribute to specific tasks and participate in continuity of efforts beyond the consultancy.

iii) The consultant and research project assistant will both base in Bangalore and Coonoor alternatively depending on the plan of the

consultancy drawn up in the initial week of the consultancy. Apart from Coonoor the consultant and research assistant will also travel to other plantation district headquarters for workshops and discussions with plantation medical staff.

iv) One of the purposes of this consultancy is to explore the feasibility of a broad-based support to Plantation Health work from all institutions in touch with or initially linked to the Ross Unit project. Hence 2-3 weeks of visits to different institutes will have to be an important component of the consultancy. Apart from centres in Bangalore, visits will have to be made to CMC, Vellore (especially the Epidemiology Resource Unit in its Community Health and Development Department), Institute of Research in Medical Statistics and Regional labour Institute in Madras, National Institute of Occupational Health Ahnedebad and the ICMR and other units in New Delhi. It may be worthwhile to establish links with the Regional Occupational health Centre at All India Institute of Hygiene and Public Health in Calcutta and contact some of the Ross Units (pre -1972) contacts in Assan and West Bengal Tea Gardens as well.

v) The consultancy is an adhoc step meant to consolidate some of the past efforts and explore future alternatives. The budget provision for it will therefore have to be adhoc as well - From Ross Institute sources with some inputs supported locally by UPASI and or St Johns. eg. UPASI could provide for travel and local hospitality for consultant and research assistant while in

Coonoor or travelling/visiting in the plantation districts. St Johns may help provide secretarial assistance for compilation of reference manual including xeroxing and audiovisual facilities.

vi) The research project assistant will need to be well versed in the use of a word processor and will undertake the necessary editorial assistance and other supportive actions for the consultancy in a participatory way along with the consultant. For the preparation of the manual particularly the use of a word processor is crucial, especially to cut on the time of repeated typing of drafts.

vii) Appendix A presents an approximate budget estimate for the short term consultancy, subject to further modification after general format of consultancy is approved and any suggestions received for modification incorporated.

viii)The note on the consultancy may be circulated to the Secretary UPASI; Director, Principal and Head of Department of Community Medicine at St Johns Medical College, and anyone elsoe whose suggestions may be considered valuable.

ix) A detailed schedule of the Consultancy in terms of programme, time schedule, tasks and deadlines will be planned once the consultancy is accepted in principle and finalised in the first two weeks of the consultancy. Some broad components are however outlined in Appendix B.

x) The consultancy will result in three documents.

a) The manuscript of a Reference Manual on Plantation Health.

b) A report of 3-4 district level workshops on "Occupational Health and Research" in the plantations.

c) A feasibility report on the Plantation Health Study Group.

xi) These documents can be discussed at an extended meeting in 1987 between all the units/institutions concerned and a more meaningful follow up action on the future of the links can be explored. Publication of the Reference Manual will be an important matter on the agenda.

xii) The consultancy project proposal is planned in such a way that certain definitive outputs (the reference manual and district workshops) would justify the project investment. Additionally the explorative objectives may help to make a breakthrough in the present status quo situations of the three institutional link (Ross London-UPASI-St Johns) with evolution of feasible alternatives for the future.

APPENDIX B

Component Steps of Definitive objectives

I. Reference Manual on "Plantation Health"

a) Collation of documents/reports/handouts from archives which will include:

i) Assam and Bangalore Ross Units
ii) UPASIS-CLWS
iii) Papers of Dr Donald Mackay
iv) Papers presented at District level plantation medical officers meetings
v) Reports/studies on plantations identified during background reference work undertaken for "ICMR Tea study" and "Health and Agriculture relationships" assignments

b) An outline plan of objectives/contents/formats/visuals for the manual.

c) An editorial review and selection.

d) Compilation and finalisation of chapters and draft manuscript.

e) Circulation of draft manuscript to an editorial collective and some key advisers.

f) Incorporation of comments/changes and finalisation of manuscript for publication.

Note

i) Items (a) to (d) will be attempted during the project period while (e) and (f) will be followed up beyond the project schedule of 6 months.

ii) It is suggested that an editorial collective be formed specifically for the manual. The manuscript could be sent

to Dr C M Francis, Professor David Bradley and Dr C R Ramachandran (ICMR) for additional comments.

II District Workshops

a) An outline of the scope and dynamics of the district workshops on "Occupational Health and Research in the Plantations" to be drawn up.

b) An exploratory questionnaire and some initial discussions with plantation medical officers to be undertaken to evolve the workshop programme in a participatory process.

c) Identification of resource persons in addition to project consultant.

d) Handouts and reading lists to be prepared for the sessions.

e) Organisation of workshops

f) Compilation of workshop reports

g) Compilation of an Overview from the 3-4 district based workshop reports.

III Study of UPASI - CLWS Data base 1971-86

a) Perusal of available data generated or collected from participating estates through CLWS-86.

b) Documenting nature, phasing, components of surveys and routinely monitored data.

c) Outlining the possible methods of analysis of data.

d) Outlining a more detailed research protocol if a) to c) establish feasibility of study.

COM H 10.5

36/14

ST JOHN'S MEDICAL COLLEGE, BANGALORE 560034
Directorate of Rural Health Services and Training Program e

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE - 560 001

NEWSLETTER 3
MAY 1982

Dear Friends,

Greetings from Bangalore! We returned home after over hundred days of travel covering approximately 10,600 kilometres in the States of Karnataka, Tamilnadu, Haryana, Delhi, Rajasthan, Gujarat and Maharashtra. It was an eventful journey and the modes of transport included train, bus, jeep, rickshaw, jutka and cycle. It was a wonderful experience of observing work at the grass-root level. Rural India is so diverse in scenery, development, life style and culture!

During the tour we met twelve CHWs, fourteen alumni doctors of St John's, staff from three departments of Community Medicine and members of V.H.A.I., C.H.A. and the Medico Friends Circle. We also visited centres and projects like Social Work Research Centre (Tillonia), Centre for Science and the Environment (New Delhi), Sewa Mandir (Udaipur), VIKAS, ASAG, Safai Vidyalaya and Behavioural Science Centre in Ahmedabad, Prayas (Mangrol), Tapovan (Amravati) and so on. The learning experience was much richer than we had imagined!

NEWS OF CHWs

It would be impossible to share with you all the details of the work of those we met among the CHWs but here are a few salient points:

(a) Sunanda Project (KGF)

The name means 'The Bringer of Joy' and the team which includes two of our CHWs--Sr Jude (BC5) and Sr Nalini (BC8) are dedicated to bringing joy and liberation through programmes which include a temporary relief home for children, schools of tailoring and typing, savings scheme, health and nutrition programme, non-formal education through trained animators, resource farm and community organisation in the villages near KGF. Two striking features of this team were the gradual acceptance of a simple 'ashram' life style and the use of street theatre medium in non-formal rural education involving animators who also belonged to the Dalit movement.

(b) Deepti Bhavan, Vimalalaya and Jyotirvikasa (Mandya)

These centres are run by the Missionary Society of St Thomas with the assistance of the Sisters of the Sacred Heart Congregation. The team includes three of our CHWs--Fr Joseph Purayidom (BC6),

Sr Elsy (BC7) and Sr Francilla (BC7). The work includes living among the people of the village, survey, dispensary, nursery school and classes for non-school going children and extension clinics. The project is in the formative years but the team has a holistic plan and is committed to sharing, simplicity, manual labour and team work. One of their dispensaries has been designated a Fever Treatment Depot by the Government under the National Malaria Eradication Programme and is acknowledged as the best one in the area!

(c) Kamagere Health Centre (Mysore Diocese)

Sr Ancilla (BC6) who works at this centre was away on leave but we visited the centre and its two outreach sub-centres at Hannur and Prakashpalayam along with Dr Ravindran, a St John's Doctor who works in the main hospital. In addition to the MCH programme based on the CRS plan, the community health team also does home visiting, clinics for leprosy and TB patients and runs a savings scheme for local people.

(d) Kalathipura Mission (Chickmagalur Diocese)

This little mission station and dispensary nestled amidst coffee and cardamom plantations is run by Franciscan brothers. Br Wency (BC8) came here after his course in December 1981, to join a senior Brother who is well known through his dispensary for miles around. The team also does survey work, home visiting, catechism and night classes for non-school going children and adults. After getting quite a comprehensive picture of the life and problems of plantation workers through home visiting, Br Wency is gradually beginning to work 'among' and 'with' them rather than only 'for' them. He also has good contacts with the local government PHC.

(e) Tamil Nadu VHA Meeting (Madras)

On 19th Februray, we both attended this meeting on the theme 'Health through People'. In addition to meeting many members keenly interested in Community Health Work we got the opportunity to have a short group discussion with three of our CHWs-- Sr Justina (BC3) working with a team involved with MCH programme, non-formal education and dispensary in Devikapuram (North Arcot), Br Xavier Amal (BC3), now a warden of a boy's hostel in Trichy,

COM.H 10-4

August 17, 1982.

C.B.C.I. Secretariat for Medical Education
St. John's Medical College
Bangalore - 560 034.

To: The heads of the departments, teaching and non-teaching and others concerned.

Dear friends,

Already a few months ago the former Dean and Secretary of the Evaluation Committee, Dr. C.N. Francis had sent you a circular regarding the proposed Evaluation of our College. In this connection Dr. Ashok Sahni, Director of Indian Institute of Management and Prof. Krishnayya of Systems Research Institute, Pune have prepared their respective questionnaires with a view to collecting the necessary data for the process of the Evaluation. Dr. Sahni has already sent his questionnaires out but the response so far has not been adequate.

I request all of you therefore to fill up the questionnaires supplied to you and place it in the boxes kept with the Receptionist in the Hospital and the Dean's Secretary in the College office. In soliciting this co-operation from you, I feel confident that your contribution to this Evaluation is going to be of immense value and will enable the Evaluation Team and the authorities concerned to arrive at satisfactory conclusions.

In case any one wishes to meet Dr. Ashok Sahni and discuss matters with him, he will be available in our College in Room No. 101 E, (next to the Administrative Officer's chambers) on Thursday and Friday the 19th and 20th instant between 2.00 and 5.00 P.M.

Once again, I earnestly request you to fill up your questionnaire and deposit it in the box meant for this purpose by the 23rd instant at the latest.

Thanking you,

Yours sincerely,

Ignatius Pinto

(Fr. Ignatius Pinto)
Secretary
C.B.C.I. Society for Medical Education

Dr. Thelma Narayan

INDIAN SOCIETY OF HEALTH ADMINISTRATORS
136/20, 7th Cross, Wilson Garden, Bangalore - 560 027
Cable: "HEALTHADMN" Phone: 226237

August 16, 1982

To: a) All faculty
b) Academic Departmental Heads
c) Key administrative officials
d) Senior administrative staff.

Dear Sirs:

Sub: Evaluation Study of St.John's Medical College

1. Kindly refer to our letter of July 15, 1982 enclosing four questionnaires (five questionnaires for categories b,c, and d above) requesting you to kindly fill out the same and return to Mrs.Ryan by August 1, 1982.

2. We are sorry to note that we have received very low response so far. Your candid reactions and suggestions are extremely important in establishing the goals, programmes and organizational systems as well as position responsibilities and corresponding authorities and powers.

3. Please do not write your name on any part of the questionnaire. All information will be statistically analyzed as a group and not presented on an individual basis. Copies of the report will be available for your reference. Should you like me to meet you personally, I shall be gald to do so.

4. Please fill out the questionnaires and return to us by August 23, 1982.

Thank you very much and with kind regards,

Cordially yours,

Ashok Sahni, Ph.D.
Executive Director

C.B.C.I. Secretariat for Medical Education
St. John's Medical College
Bangalore - 560 034.

August 20, 1982.

To: The Members of the faculty and others concerned.

Dear friends,

In connection with the Evaluation of our College, Mr. S.K. Sharma of Systems Research Institute, Pune has come to St. John's and will be available in Room No:101E, next to the Administrative Officer's chambers between 10.00 A.M. and 1.00P.M. and 2.00P.M. and 5.00P.M. on all working days from today upto 3.9.1982. You are requested to furnish him any necessary information he asks for orally or through a questionnaire. If during the hours mentioned above you are unable to meet him you can contact him at our Guest House in the campus and meet him there. Tel.No:52349.

Mr. Sharma will be going round and having a look at the departments in the College and Hospital whenever he is free.

Please extend your full co-operation to Mr. Sharma.

Thank you,

Yours sincerely,

Ignatius Pinto

(Fr. Ignatius Pinto)
Secretary
C.B.C.I. Society for Medical Education.

Dr. Thelma Narayan,
Community Medicine Dept.
SJMC.

COM H 10.5

36/14

ST JOHN'S MEDICAL COLLEGE, BANGALORE 560034

Directorate of Rural Health Services and Training Program e

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
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and Sr Constance (BC2) working in Vikravandi (South Arcot) with the MCH programme of Pondicherry Diocesan Society.

(f) Jagadhri (Haryana)

It was quite a change to see the agricultural development of the Haryana villages when we visited the project run by Sr Corcena (BC4) of the Sacred Heart Convent in Jagadhri. The team of sisters run a balvadi, dispensary and tailoring centre in the nearby village. Their primary involvement in the area is English Medium Convent, from which they have started this extension work.

(g) Kalambi-Vihar (Shilonda, Maharashtra)

Br Tommy Kuruvilla (BC8) who was completing his regency in this tribal area of Maharashtra, shared with us the experience of living out among the people, home visiting, conducting adult education classes and health work. A weekly clinic is run at this centre by a St John's doctor--Sr Vilma Nazareth--who is in-charge of the Mission Hospital at Talasari.

(h) Shanti Sadan (Borsar, Maharashtra)

After a one-day Seminar on 'Community Health' organised by the Bishop for priests, sisters, teachers and parish workers of the diocese in Aurangabad, we visited the mission stations of Borsar, Vaijapur and Ghogergaon along with Swami Sevanand (BC8) who is himself the parish priest of Borsar and is involved with a very holistic health effort of counselling and spiritual healing. We also visited St Luke's Hospital in Srirampur but were unable to meet Sr Tresa Jose (BC1) who is a Nursing student.

It was encouraging to see CHWs 'living among the people, learning from them and serving them'.

KEEPING TRACK

Catholic Hospital Association (refer address Newsletter 2) has drawn up Diocesan Level Health Plans. Contact the Delhi office for names of your regional animators and for more information about the programme.

Safai Vidyalaya, Harijan Ashram, Mahatma Gandhi Ashram Marg, Ahmedabad 380027. Write to them if you have any questions or problems regarding rural sanitation programmes. They have done pioneering work in this field and have also produced health education materials. They also run short practical courses for field workers.

With best wishes and regards,

RAVI AND THELMA NARAYAN

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

9 Aug 1982

Dear Doctor,

I am enclosing a questionnaire planned by the Systems Research Institute of Pune. The Review Commission set up by us to go into the question of whether the objectives for which this College was instituted are being achieved in order that the agencies that have helped us in the past may continue to do so, have asked for certain expert analysis to be made. Systems Research Institute is one of the expert organisations that has agreed to undertake this work.

I shall be grateful if you would kindly fill in the questionnaire and if you are not in the campus, kindly send it directly to Prof. J.G. Krishnayya, Systems Research Institute, 17-A Gultekdi, Pune 411 009, India, at an early date so as to reach him before the end of August 1982.

If you are in the campus, you may either hand it over personally to the Systems Research Institute people when they come here in the third week of this month or deposit it in the boxes placed for this purpose in Mrs. Ryan's office in the College or at the Reception of the Hospital.

Thanking you,

Sincerely yours,

Percy

(Fr. Percival Fernandez)
Administrative Officer

DRUGS - USE AND MISUSE:

From this issue we are publishing a series of articles on improper use of drugs for a country like India. The material has been from the Medico Friends Circle. We start with an article putting the problems in perspective.

HOW TO COMBAT MISUSE OF DRUGS ?

"The greatest danger to Health in India is the over medicalising of our Health Care System. Eternal vigilance is required that the Doctor-drug producer axis does not exploit the people and that the 'abundance' of drugs does not become a vested interest in health".

-ICMR/ICSSR study on "Health for all"
- an alternative strategy.

(1) 1500 branded drugs are on sale in India but a Government Committee believes that Health needs would be met by only 116 drugs.[2,3]

There is now an overproduction of drugs (often very costly) meant for the rich and well to do, while the drugs needed by the poor people (and these must be cheap) are not adequately available !

The real purpose of an essential drug list must be seen as taking drugs to those who need them most, not as reducing the drugs bill.[2]

Could we accept an essential drug list for ~~our practice in~~ which cost would be an important criteria in selection in addition to efficacy, safety and quality?

(2) All UN agencies and governments involved in preparing a list of essential drugs are convinced that prescriptions should be through the generic names of drugs only.6

Generic name is not chemical name but official, international, non-proprietary name e.g., not Acetylsalicylic acid but Aspirin.[2]

Branded named products cost higher because they include promotional costs and cost of claims of additional ingredients in formulation e.g. Librium by Roche is available for Rs.16/-[6] per 100 tablets but generic equivalents are available for Rs.1.50.

A study of UNCTAD has shown that bio-availability argument for branded drugs i.e., therapeutic difference based on formulation is not very valid for most drugs.[6]

Could we accept Generic Prescribing ? i.e., By Aspirin not plusprin, B Disprin, etc.

(3) ICMR/ICSSR and the Hathi Commission have recommended that the small scale sector, cooperative sector should be encouraged. Hospital and dispensary based formulations should be promoted. 1,3

Can we prescribe drugs which are Indian rather than foreign, Government rather than private industry, small scale and cooperative sector rather than large sector ?

Cont'd ../6

(4) Multiple drug combinations often containing drugs in amounts far in excess of what is required are presently marketed in India. There is a colossal national wastage of drugs because of such combinations.[3]

Packaging increases the cost of drugs very greatly becuase the trend is to make it attractive and highly elegant and to add cosmetic embellishments to promote sales. 1

The drugs Consultative Committee examined 34 categories of fixed dose combinations and concluded that in the case of 23 categories of these formulations, there was no therapeutic rationale for their marketing.

Could we stop prescribing drugs whose only additional advertised values are - cosmetic embellishment, Elegant packing Irrational combination Imitative drugs Inadequate evidence of greater value ?

(5) An ICMR/ICSSR study observed that production of INH and Dapsone are a third and a quarter respectively, of the minimal requirements of the country. On the other hand, tonics and vitamins which are mostly alcoholic preparation and spin money are produced in wasteful abundance! 1

A study by Kamala Jaya Rao on tonics has shown that most of the high potency or 'Forte' preparations of multi-vitamins are a sheer economic waste.[4] These are not only a drain on the patients 'purse' but also help only to vitaminise our sewage systems.

Can we stop this 'tonic' practice ?

(6) A study by WHO has revealed that Doctors misuse drugs in 75 ways. The commonest is overuse of drugs. Drugs are prescribed in too large quantities, for too long durations and too many drugs at the same time. 6

Drugs are prescribed when none are needed to retain the patient's good will- Most patients believe (and many doctors would like them to do so) that a good doctor prescribes large number of costly medicines.6

Drugs are prescribed to prove that one is up to-date.[6]

Can we adopt a rational drug therapy which is (a) necessary (b) Efficient (c) low cost and (d) easy to administer ?

(7) A WHO report notes that drug advertising and contacts with representatives of pharmaceutical firms are often the main sources of information for a physician on drugs and sometimes the only one. Such information is largely influenced by commercial interest.6

Drugs are often being prescribed by many doctors not because they think a particular one is best suited for the situation but because the company which produced it gives the maximum monetary and material advantages and inducements to them. These range from free samples (often sold in practice), pens, calendars, diaries, teas, lunches, travel and conference attendance costs. 1,6

Cont'd../7.

Medical training in Colleges does not train future physicians to judge a preparation critically ..... nor does it include conscious immunization against the half truth of persuasive industrial advertising.6

Can we stop accepting physicians samples and other forms of inducements from Medical Companies ?

(8) Many medicinal herbs and roots that are used by grandmothers, local dais and village medicine men have been scientifically tested and research and known to have therapeutic value. Their descriptions in journals collect dust in reference libraries . 2.6

Herbal medicines and home remedies are not only low cost and easily available but their popularisation will help in breaking the doctor-drug producer axis for over 80% of the common minor ailments which are now being over-treated.

China has integrated over 50 herbal medicines and home remedies in their armamentariums not only as a drug policy but as an expression of local participation in health care. 2,6.

Can we propagete simple home remedies and locally available herbal medicines after studying their efficacy ?

(9) A very large number of techniques of healing are being researched tiday in which diseases are tackled and cured without drugs. Non-drugs therapies include Yoga, Pranayama, Meditation, Accupuncture, Acupressure and Chiropractice among others. Traditional systems of Medicine such as Ayurveda, Unani, Homeopathy which use drugs but of a different sort are being researched in various places and the therapeutic effectiveness of many of their products are being discovered and documented.

Can we adopt a more open-policy of enquiry and use of traditional medicine and non-drug therapies ?

(10) Health Care is becoming increasingly a quest for priorities, "Clean water before antibiotics, food before vitamin pills, vaccination before kidney machines, mothers milk before powdered baby foods mixed with dirty water, health for villagers and slums before more hospitals for the affluent suburbs of capital cities"2

Inspite of our preoccupation with Drug Prescribing policy could we commit ourselves to other more important Health Care Priorities ?

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3. Hathi Committee: Report of the Committee on Drugs and Pharmaceutical Industry, Ministry of Petroleum and Chemicals, Govt. of India (1975)

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4. In Search of a Diagnosis MFC book containing reprints from bulletin

5. The Selection of Essential Drugs, WHO Expert Committee. WHO TRS No.615 (1977) and 641 (1979)

6. Medicines as if people mattered - Health for the Millions (VHAI bimonthly) Vol.VII No.2 & 3, April-June 1981.

News & Correspondence:-

I am publishing below a long letter by Dr. G.D. Ravindran. The first paragraph refers to a short course he attended in SJMCH, in blood banking and in his attempts to register and study for the MNAMS & FCGP general practice examinations.

Dear Sir,

I received your letters dated 11th Dec and 7th Jan. I thank you for the greetings which you sent.

I reported to Sr. Chanthal on 30th of January. Since the staff was going for a blood donation camp organised by the youth Congress, I did not spend much time in the lab. The next day Sr. Chanthal taught me everything about grouping, cross matching, about blood collection and about preparation of packed cells. I spent a fruitful day learning everything about blood transfusion. The next day i.e., January 1st, 1982 I spent revising all that I learnt. Thank you very much for the excellent arrangements, that you made.

Our new hospital at Prakashpalayam was opened on 3rd of January. The hospital has 24 beds. I visist the hospital every Saturday. I have to see about 60 - 70 patients between 3 - 6 p.m. I have to take care of in-patient also. If they have a serious case I visit the hospital. These days I am extremely busy. Only this Sunday I am getting some free time. Hence I am writing to you. I hope you will excuse me for the delay. I wrote another letter to Dr. B.C. Rao requesting him to enroll my name for the coaching classes being organised for MNAMS & FCGP exams. So far I have not heard anything from him.

The sisters requested me to stay for few more years here. I have agreed to stay till December 1983. By the end of 1983 I will be eligible for Part I MNAMS exams. Moreover I enjoy working here and I derive lot of joy and personal satisfaction. I think it is better than coming back and becoming frustrated and bitter trying for PG. Hence I have decided to stay for one more year. I hope that I will still receive the rural newsletter and also help from you and the Liaison Office.

When I was in Bangalore I could not meet you. I met Dr. Ravi. He is coming here this Friday. I will be coming to Bangalore in the month of April. I am attending a weeks course on Psychiatry organised by NIMHANS. I hope that I will be able to meet you then.

Regarding the newsletter I have a few suggestion to make:

1. Please ask the Dean to write a special column in every issue. Th

2. You publish only the success stories in the newsletter. I am sure there are many of us who have failures and frustration. I am sure that they write to you about it. Please try to publish some of it. While I was in Bangalore few of the seniors whom I met commented that the newsletter was a means of propaganda by the college. If you publish some stories of failure our students will realise that the newsletter is meant for sharing rather than an instrument of propaganda.

3. Working in the villages we tend to forget laboratory medicine. Please try to publish small articles on laboratory medicine especially the prodecures involved.

(G.D. RAVINDRAN)

NAMES & ADDRESSES OF OUR RURAL DOCTORS:

NAMES & DATE OF PEOPLE FINISHING SOON:

1. Dr. Donald Fernandes - Finished is Rural Bond Scheme on 15th February, 1982.
2. Dr. Maries Jose - Will be finishing on 1st June, 1982.
3. Dr. Anthony Fernandez - Will be finishing on 10th May, 1982.
4. Dr. Jose Joseph - Will be finishing on 1st June, 1982.
5. Dr. G.D. Ravindran - Will be finishing on 1st June, 1982.

COLLEGE & ALUMNUS NEWS:

One fallout of the problems between S.J.M.C. and Bangalore University is that this year the final M.B.B.S. clinicals for St. John's students will be held in Victoria Hospital. There is much suspense over the effect this will have on our results.

The Alumnus Association had a get together, sports & dinner on 14th February, 1982. The event went off

We are proud when we hear that one of our students completed two years of rural service. The name of students serving in rural areas is made known every where, (e.g. it appears in the journal of C.H.A.); so much propaganda is made about the people who go to rural areas. In this process we are forgetting the majority of our students.

Fr. Ignatius Pinto writes, "reports have also reached us that quite a few, chiefly our religious sisters, have so adapted themselves to the life style of the villagers that they feel like spending their whole life time in the service of the poor, helpless rural folk. This is because of the training imparted to them in their houses of formation APART FROM THE EMPHASIS LAID BY THE COLLEGE ON RURAL ORIENTATION AND DEDICATED SERVICE". If this statement is really being implemented then why is there so much apathy and indifference among our students to serve in rural areas?

Reflecting on the time I spent at S.JM.C. I feel that I did not get any orientation towards rural health care. All of us were made to feel that the only salvation for us was to become specialists and super specialists. It was a degrading thing to be a basic doctor. Very few people have emphasised that we were to be basic doctors. Most of the teachers have forgotten that they are basic doctors first, only then super specialists, and that they have to train basic doctors and not super specialists.

I remember how our medicine clinics used to end up in neuro - ophthalmology (the person who took these clinics was a neurologist) some how every patient whether suffering from GIT, CVS, or R.S. disorders used to end up having a neurological abnormality. So much so that we used to look for a neurological abnormality in every patient (somehow cook up a finding to please him) we examined.

This disease of specialisation is not limited to clinical departments alone. I remember how we mugged larynx for anatomy exams, when we heard that one of the examiners had done some research work on larynx (unfortunately not a single question was asked on the larynx).

I am mentioning these instances to show how much the idea of specialisation is prevalent in SJMC. Any number of instances can be given when we are exposed throughout to the idea of specialisation. How can we all of a sudden think of becoming basic doctors?

We are exposed to rural health through the Department of Community Medicine. Most of us have an impression that the rural health care is a complete monopoly of the Community Medicine Dept. There is not much glamour attached to Community Medicine. The same thing is added on to rural health.

After working for one and a half year in rural areas I have come to the conclusion that we cannot practice any preventive medicine unless we have a good educative base. It is no use speaking to the villagers about sanitary latrines if you cannot treat his diarrhoea. Clinical staff should get actively involved in rural health. Present day involvement of the clinical staff in rural work is by conducting one day camps in the villages. It does not serve

and asking them to come for investigations to a major hospital. Most of the villagers have that much common sense to come to a major hospital when they are really sick. It is only their economic conditions which prevent them from coming.

Instead of these one day picnics, teachers should be made to spend atleast a month in rural areas every year. This type of programme will make them give rural orientation to their teaching and also will make them realise that they are basic doctors first.

REGARDING INTERNSHIP

Seven of us were posted at Mallur. Since it was a big group there was not enough work for all (Doctors patients ratio 1:300) It was our first posting as interns. The medical Officer was on leave, we used to run the clinic. Each one of us choose a minor-speciality and studied it in detail. If a patient came with skin complaint, he was refered to somebody, if he came with ENT complaint to someone else. This way even in our rural posting we becaome minor specialist.

How is the assessment of rural posting done? It is not assessed by the service rendered to the community. It is assessed by the project report. This emphasis on project reports makes the students concentrate on projects and neglect the people.

Reflecting on all the above mentioned instances, I wonder whether any of us had any rural orientation in S.J.M.C. It is a wonder that INSPITE of St. John's, our students venture to work in rural areas. I hope that their tribe increases.

Dr. Ravi Narayan has written that the Dept. of Community Medicine has organised a rural camp for the 1st year students. At last some change is seen in SJMC. It is not enough if a 1 month camp is held during the 1st year. Most of the students are immature. 1st year is the transition period from a regular college to a professional one. Hence these camps are bound to become like N.S.S. Camps. The college should post students for a month in rural areas every year. I am sure that if our students get in contact with the rural masses during clinical year most of them will go to rural areas.

Instead of posting interns for one month in their chosen speciality, post them for 15 days each in all the minor specialities. This way our students will have a working knowledge of all the specialities.

I hope a day will come when most of the students of S.J.MC. will go willingly to serve in rural areas.

G.D. RAVINDRAN.

S Y S T E M S R E S E A R C H I N S T I T U T E

J.G.Krishnayya
Executive Director

President
J.S.Lall

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Dear Alumnus,

We would like to introduce ourselves as Prof. JG Krishnayya and Mr. SK Sharma of Systems Research Institute, Pune. SRI is a non-profit centre of policy & management research involved in study of public services including rural medical services, hospitals, etc. In 1979-80 we worked closely with the CMCH Vellore in the development of their forward plan. We have now been asked by the St. John's Evaluation Team to assist in their study of the college:

St. John's has several unique features which make this study a very interesting one. We plan to meet individual members of the faculty very soon, but before that we thought it would be useful to send you this questionnaire which identifies the questions we have. We would greatly appreciate your filling it out carefully, making your own comments wherever necessary.

Kindly post it back to us in the envelope provided. The individual questionnaires will be treated as confidential, of course, but we hope the Evaluation Team will find our Analysis useful.

Thank you,

J.G. Krishnayya
S.K. Sharma

SYSTEMS RESEARCH INSTITUTE SRI/SJMC/July 1982

QUESTIONNAIRE FOR ALUMNI DOCTORS

Note : Please answer the questions as freely and fully as you can. The answers to these questionnaires will be kept at SRI, and only the analysis supplied to the Evaluation Team. Some of these questions are factual a nd some ask for your opinion or impression; they are equally important for the success of this Survey.

1. Name (optional) : 2. Sex: M/F

3. Place of birth & Age :

4. Father's Occupation & Education :

5. Grandfathers' Occupation & Education: 1 (Maternal)
2 (Paternal)

6. Religion :

7. Approximate annual income today :

Duplicate

8. Educational background (High School and above) :
(Please give names of the institutions, places, and dates)

Name of the Institution and Place	Degree etc.	Date

9. Work Experience (Please give names of the Institutions, places & dates) :

Name of the Institution and Place	Nature of duties	Designation	Dates

10. How many years were you at St.John's and in what capacities? Please give details.

Dates	Designation	Nature of Duties

11. Other family members at St.John's (Past and Present) : Please mention relation, role at St. John's, and approx.dates.

12. How did you first hear of SJMC? From parents/friends/relatives/ Others ... (please specify)

13. Why did you decide to join Medicine?

    a) Parents' encouragement
    b) All friends were also joining Medicine
    c) Other reasons (please specify)

14. Your current place of work is
    Rural/Small town/City/Abroad : Third World Country/Developed Country

15. Did you go in for higher studies after St. John's?
    Yes / No Where? Which discipline?

16. You are working in:

Private Practice	Mission Hospital	Mission Management	Government Hospital	Private Hospital	How many beds?

17. In which of the following activities (one or more) are you involved? Please give a percentage breakdown, if possible (in terms of the time spent)

    a) Curative medicine : ▱
    b) Preventive/Community Health Care : ▱
    c) Teaching : Medical ▱ Nursing ▱ Paramedical ▱
    d) Research ▱
    e) Rural Development ▱
    f) Administration ▱

18. (DO NOT ANSWER this question if you are a full-time salaried employee)
    What percentage of your work, in terms of time, is charity, i.e. without getting any monetary reward?

19. Does St.John's Medical College have the following major objectives? (Your impression please)

    A) "Training Doctors for Rural Health Service". Yes / No

    What has SJMC done to achieve this objective?
    (List actions you know about)

    How well have they succeeded? Very well/So-so/Not at all

    What could they do to improve in this area?

B) "Inculcate 'Catholic' values in Doctors". Yes / No

What has SJMC done to achieve this objective?

How well have they succeeded? Very well/So-so/Not at all

What could they do to improve in this area?

C) "Training for Medical excellence". Yes / No

What has SJMC done to achieve this objective?

How well have they succeeded? Very well/So-so/Not at all

What could they do to improve in this area?

D) "Provide professionals for Catholic Health-care institutions". Yes / No

What has SJMC done to achieve this objective?

How well have they succeeded? Very well/So-so/Not at all

What could they do to improve in this area?

20. In which fields do you think St.John's should strive to become a professional leader? (The hospital has 400+beds now and is going to grow - in which departments or in which direction, do you think this growth should take **place.**)

21. St. John's has tried to be innovative in the following areas. Kindly indicate the success of these innovations. Please also make explanatory comments indicating whether the innovation is desirable and suggesting improvements.

Innovation		Result	Comments.
a) Selection process (including attitudinal tests etc.)	i) ii) iii)	Totally successful Partially do Failed	
b) Integration and sequencing of courses (e.g. clinical and non-clinical)	i) ii) iii)		
c) Orienting students to rural practice	i) ii) iii)		
d) Teaching Medical Ethics	i) ii) iii)		
e) Teaching First aid and Nursing procedures	i) ii) iii)		
f) Teaching Bio-statistics	i) ii) iii)		
g) Internship with 6 months' community health including 3 months in villages	i) ii) iii)		
h) Tutors (Guides) for small groups of students	i) ii) iii)		
i) Electives and Research for students	i) ii) iii)		
j) Curriculum Planning Committees with student representatives	i) ii) iii)		
k) Full-time and non-practising faculty	i) ii) iii)		
l) Bond to serve at a place designated by the college	i) ii) iii)		

22. What is the average social stratum of your own patients? (Please also give a rough percentage breakdown ifpossible)

- very rich
- rich
- upper middle class
- lower middle class
- poor
- destitute

23. St. John's graduates are, by and large (please tick one):

1. The best in the country
2. As good as the best in the country
3. Not as good as the best in the country

24. If 23(3) why?

25. St. John's graduates command (please tick one)

1. great respect in your field
2. average respect in your field
3. poor respect in your field

26. If 25(3), please give reasons why?

27. St. John's Medical education is

1. the best in the country
2. as good as the best in the country
3. not as good as the best in the country

28. If 27(3), where are the gaps?

29. What are the research outputs of St. John's that you have heard of?

30. St. John's research is

31. If 30(3), please give reasons why?

32. Do you find your present place of work as good as St. John's?
Not as good As good Better

33. Please state why?

34. Would you like to go back to and work at St. John's? If so, under what conditions?

35. Please list 3 major shortcomings of St. John's.

1.

2.

3.

36. How relevant is the St. John's training to the Indian 'health' environment? Please tick all the statements you agree with.

- is as relevant as any other medical college in the country
- trains doctors suitable only to work in large hospitals
- produces graduates who go out and work in the rural areas
- St. John's education tends to orient students towards specialisation rather than in a General Practitioner's role
- produces graduates who want to work with the most sophisticated equipment
- produces graduates who believe in humbly serving the people
- produces doctors who are urban-oriented and want to work as consultants
- produces doctors with driving ambition to do well
- produces doctors who can work in any environment

37. Having been trained at St. John's has helped you (please tick those that you agree with)

- in just getting a job
- in getting a professionally satisfying job
- in getting good remuneration
- to gain respect from professional colleagues
- in treating very complicated cases
- to develop a good rapport with your patients
- to help the poor
- in charting a lifetime career
- in selecting a field of specialisation

38. Have you faced any disadvantages because of your training at St. John's? Please explain:

39. In your professional capacity, which International/National/ Regional Organizations, Committees, Panels etc. do you belong to?

40. If you are <u>practising now</u> or <u>have practised</u>, in a rural area (if not, please go to Question 41) - Did the St.John's training equip you well for this field? Yes / No

What gaps in your training do you now perceive?

<u>Personal aspects</u>:

a) What are thedeprivations you experienced/are experiencing while living in the village?

b) What is the minimum level of amenities a doctor in your position would expect to have in the village?

c) Do/Did you feel hopeful about improving the general conditions in the village through your personal initiative?

d) How important was/is it for you to have the company of people with similar status and intellectual capacity? Very important/Somewhat important/Not important

e) How serious were the problems of adjustment faced by your family (if any) in the village? Very serious/Somewhat serious/ No problems
(Please give some examples)

f) Do you think being able to serve the people overcomes all the disadvantages of village life? Yes / No

Professional aspects

g) What suggestions do you have for overcoming the problems faced by doctors in the villages?

h) How does the work in rural areas affect your career prospects?

i) Can you please (briefly) describe the deficiencies which you have observed in the villages in both curative and preventive medicine?

j) What particular efforts did you make to remedy these deficiencies? How successful were these efforts?

41) What kind of training courses would you like to attend now?

42) What do you think the role ought to be, in India, of other systems of medicine - Homeopathy, Ayurvedic, Unani etc.?

43) Did you sign the rural-service bond on taking admission at St. John's? Yes / No

44) If yes, did you fulfil the bond or repay the bond amount?

45) What size of bond would have dissuaded you from repaying? (Tick one)
Smaller/10,000/20,000/30,000/50,000/75,000/larger

46) To what extent would you be willing to accept professional weaknesses in a religiously devout person? Quite a bit/A little/Not at all

47) Do you think that being a doctor is
a professional calling/like any other occupation for earning

48) In comparison with an IAS officer of your
like your income

50. What would be the special advantages to St. John's (and the disadvantages) of university recognition for PG courses?

51. Do you agree with the 'No Private Practice' policy for faculty? What are its advantages and disadvantages?

52. Which are the 3 major strengths of St. John's?

53. In your opinion should St. John's future efforts be directed towards training doctors in

a) Modern high-technology medicine
or
b) Community health/Rural medicine

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ST. JOHN'S MEDICAL COLLEGE, BANGALORE-560034.

RURAL HEALTH SCHEME - NEWS LETTER

January-March 1982

Vol.2 No:1

30.15

EDITORIAL:

Dear Friends,

In the first issue of this newsletter (Jan-March 1982) I had written that I hoped that all of you would use the newsletter to air your views and that we would soon have a vigorous debate conducted through our correspondence column. It has taken a little over a year to set the ball rolling. In this issue you will see a a letter by G.D. Ravindran and also an article by him. I will say no more about either of them except on a few points:-

1. Dr. Ravindran is one of our success stories. He is happy where he is and in fact intends to stay on at his hospital even after his bond period expires. Hence his views need special attention.

2. He has asked the Dean to write a column regularly. The Dean has promised to do so.

3. He writes that there is a feeling that the newsletter is "a means of propoganda by the College" as only success stories are published. Here I must disagree with him strongly. Firstly, the college authorities have never tried to influence what is published in the newsletter. That is solely my responsibility. In fact a copy is sent to the Dean & Fr. Pinto after it is posted to all of you, and that is the first they see of it. I must ask you to believe me when I say that I have no interest in "Propoganda". On the other hand, I cannot publish the darker side of the picture unless you write and tell me your complaints of the system.

So please, feel free to write what you feel and you can be sure that your views will be aired.

PREM PAIS.

FROM THE DEAN'S DESK

Greetings to all from St. John's!

The problems and issues of St. John's Medical College with Bangalore University remain unresolved. A time has now come when action is called for.

Cont'd../2.

We have been waiting patiently for long for the Bangalore University and the Government of Karnataka to bring a solution to these issues. Everyone agrees as to the excellence of our institution whether it be in the field of training or patient care or research. The achievements of the students at the various examinations speak for the excellence in teaching and learning. In the recently announced list of Rank-Holders for the first ten ranks, 8 out of 11 (1 was bracketted) were from St. John's, including the First and Second. The hospital in the campus has been doing very well in giving good patient care and in expanding its services. During the year, the sanctioned bed strength has gone up from 250 to 401. The institution is carrying out quality research in the fields of Malaria, Diahorrea, Cytogenetics in Mental Retardation and other areas. Inspite of all these achievements the University has not given Affiliation for the institution from 1981-82 onwards! Sanction for starting Post-graduate Course of study has not been given even though this matter has been pending from 1971 and the college has all the necessary facilities for Post-graduate studies!! The St. John's Medical College Hospital built, equipped and staffed at great expense to be a model teaching hospital has not been recognised by the Bangalore University for teaching purposes!!!

Hopes of a solution for these problems came when the Chief Secretary to the Government of Karnataka called a meeting on December 17, 1981 at which the Government Secretaries for Education, Health and Law, the Secretary to the Governor, the Vide-Chancellor of Bangalore University and the Director of Medical Education, Karnataka State were present. The college was represented by Bishop Patrick D'Souza, Chairman of the Executive Committee, Archbishop Henry D'Souza, Secretary General CBCI, Bishop Alphonsus Mathias, Bishop of Chickmagalur, Fr. Ignatius Pinto, Administrative Officer and the Dean. At this meeting it was resolved that early steps will be taken by the University and all formalities completed with respect to all these 3 pending issues, such that Government Orders could be passed before 28th February 1982. This date has now come and gone away but the University has not even moved to appoint a local inspection committee which according to them had to be appointed as the first step. The Government has failed to keep its promise.

Two members of the Minorities Commission, Mr.Giani Sujan Singh and Mr. Dorai Sebastian along with Mr. G.S. Sial, IAS, the Secretary visited Bangalore from the 15th to 17th February 1982 to go into the Complaints of the college with respect to the harassment by Bangalore University. The Commission was very much impressed by the facilities provided in the College and the Hospital. They met all the concerned authorities of the University and the Government including the Governor and the Chief Minister. All of them promised that action will be taken soon but nothing has happened. The strategy would appear to be to go along with the arguments and to praise the institution but do nothing about it pushing the institution to a situation where they will be forced to agree to the unjust demands. The Commission has issued a press release in which they have praised our College, but it had no desired effect. Meanwhile the Institution is going on doing its very best combining excellence and social concern.

We need your help.

Wishing you all the best,

Yours sincerely,

(C.M. FRANCIS, MBBS, Ph.D)
DEAN

MEDICAL CORNER

HEART DISEASE & PREGNANCY

Pregnancy can effect the heart in 3 ways:

1. Diagnosis of heart disease where none exists.
2. Aggravation of pre-existing heart disease.
3. Pregnancy per se, as a cause of heart disease.

Circulatory Adjustments in Pregnancy:

1. Cardiac output increases by 40% mainly due to increase in blood volume.
2. During labour, each uterine contraction is associated with increased cardiac output and increase in blood pressure.
3. Soon after delivery, there is a dramatic increase in blood volume as uterus involutes.

All changes regress by 2 - 3 weeks after delivery.

Signs which do not necessarily mean heart disease in a pregnant women:

1. Pedal oedema
2. False sense of cardiomegaly due to elevated diaphragm.
3. Ejection systolic flow murmer at the base of the heart. This flow murmer usually appears around 12th week and disappears by 1 week after delivery.
4. Mammary Souffle - a continuous soft murmer at sternal border due to dilated mammary vessels. It appears late in 2nd trimester and is easily obliterated by pressure.

Supine hypotensive sundrome:- episodes of syncope and dizziness if patient lies supine. It is due to uterus compressing IVC and is treated by telling the patient to lie on her side.

Rheumatic heart disease and Pregnancy:- In India RHD is the Commonest form of heart disease associated with pregnancy. Mitral stenosis is the commonest non obstretric cause of death in pregnancy.

Heart disease must be suspected where there is

a) History of pre existing heart disease or murmer.
b) Systolic murmer associated with a thrill.
c) Any diastolic murmer.
d) Atrial fibrillation.
e) True cardiomegaly.

Effects of pregnancy on RHD:

a) Murmers of MS and AS increase becuase of large blood volume murmers of AR and MR decrease because of low peripheral resistance.

Cont'd.../4.

b) MS does particularly badly as increased blood volume is associated with decreased diastolic time because of Physiological tachycardia of pregnancy.

c) Pulmonary oedema is especially liable to occur at or soon after labour. It must be treated with intravenous morphine (4-5-mgm) lasix (40-160mgm), lanoxin (0.5 mgm) and in severe cases by venesection of 1 pint of blood.

Antenatal care of patient:

a) Periodic (monthly) evaluation.
b) To offset increased cardiac work, rest is essential- 2 hours in afternoon and 8 hours at night, with mild sedation if required.
c) Correct aggravating factors- anaemia, respiratory infections hypertension (PET), recurrent rheumatic fever.
d) mild salt restriction and diuretics- do not overdo this as placental insufficiency may result.
e) If pulmonary oedema develops, advice hospitalisation till term.
f) Admit patient a few days prior to due date.

Management of labour:

Vaginal delivery with forceps to shorten 2nd stage. Keep patient's shoulders and head elevated. Additional diuretics and digoxin may be given to cover stress of labour.

Prophylaxis against SBE - Procaine penicillin 6 lakhs i.m. BD + streptomycin 1 gm 1.m. OD from onset of labour to 3 days after delivery.

On discharge advise delay or prevention of next pregnancy and surgical correction if possible.

Role of Cardiac Surgery:

Very rarely required. An occasional patient with MS and refractory pulmonary oedema may need early surgery.

Termination of Pregnancy:

Also very rarely required. Indicated if patient develops pulmonary oedema in 1st trimester. Thereafter, it is better to carry the patient through to term.

Sign of poor prognosis:

- Maternal age over 35 years.
- history of heart failure in the past.
- episode of acute rheumatic fever in previous 6 months
- atrial fibrillation.

PREM PAIS.

Com H 10.7

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COMMUNITY HEALTH CELL
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BANGALORE - 560 001

St JOHN'S MEDICAL COLLEGE, BANGALORE 560034

Directorate of Rural Health Services and
Training Programmes

O-O-O--O-O-O-O-O--O-O-O--O-O-O-O-O-O-O-O-O

N E W S L E T T E R - 2

FEBRUARY 1982

Dear Friends:

We have been planning out our travels in response to your letters. The prospects are becoming more interesting day by day. It now includes a 35 km trek in Orissa, a meeting on Health in Aurangabad, a Health Education Seminar in Mizoram, a sojourn through the North East and the tribal regions of Andhra, Bihar and Madhya Pradesh and so on. We are also visiting some alumni doctors of St John's working in rural areas and some health and development projects run by other groups. It will not be possible, therefore, to visit all the CHWs in their place of work, as we have less than 300 days for our travels. We hope that we will be able to meet some of you in small groups at Central places for a day eg., Mangalore, Goa, Karwar region, Mananthavady, Calcutta, Hazaribagh, Varanasi etc. You will soon get letters from the organizers. The first phase of our travel starting from last week of January till end of April will include Kolar, Salem, Mandya, Kollegal, Chickmagalur, Madras, North Arcot. Then to Delhi, Rohtak, Jagadhri, Chandigarh, Ludhiana, Tillonia, Udaipur, Ahmedabad, Vadodara, Rajpipla, Zankhvar, Talasri, Thane, Talegaon, Pune, Jamkhed, Nasik, Aurangabad, Amaravati, Wardha, Nagpur and back. We shall be writing letters to individuals giving further details.

In Madras, on 19/20 February, the Tamilnadu Voluntary Health Association have arranged a meeting and we hope to meet many of our CHWs there. Do keep in touch with us particularly if you change your address or your work. Our contact address will be D-10, Staff Quarters, St John's Medical College, Bangalore 560034 till June. You will have to excuse us for delays in replying since we shall be on wheels most of the time. If the matter is very urgent, please mark 'urgent' and 'redirect' on the cover of the letter; otherwise they will await our arrival.

"Many problems can be resolved when people work together and give each other help and support"

(2) Keeping contact with the Department

While we are away on our travels, if you are interested in the following -

a. List of latest addresses of CHWs of your batch and those working in your area;

b. Letter to your PHC doctor or DMO (Dist Med Officer) introducing you and requesting them to encourage you and include you in their programmes (send name and address of doctor/s);

c. Details of next Basic Course or Refresher Course;

d. Any other information

please write to Professor SV Rama Rao, Head of the Department of Community Medicine, St John's Medical College, Bangalore 560034.

(3) Keeping track

We have no news recently from the following. If you are in touch, please send us their latest addresses and news about what they are doing.

BC6 - Sr Paula, Sr Stella Mary, Sr Betcy

BC5 - Sr Annette, Sr Genevive, Sr Nirmala, Sr Anna Joseph, Br Sebastian Dung Dung, Br Francis Tiru

BC4 - Sr Anastasia, Sr Egidia, Sr Evangeline, Sr Servia, Sr Josetta, Br George MM

BC3 - Br G Victor

BC2 - Sr Shuba Minj and Br Nirmal

News of any of your other colleagues will also be always welcome.

(4) Contacts with VHAI/CHA

Hope you are in touch with VHAI (Voluntary Health Association of India, C-14 Community Centre, Safdarjung Development Area, New Delhi 110016) and CHA (Catholic Hospital Association of India, CBCI Centre, Goldakkhana, New Delhi 110001). They will keep you in touch with new concepts in health, audio-visual education materials and contacts with others working in the field in your States.

(5) Newsletter

We would like you to share some of your experiences with the others through short articles on your work. Please write and we shall put them in. If you have not written to us or to the Department after November 1981, please acknowledge receipt of the newsletter giving latest address to continue getting further issues.

With best wishes and regards,

RAVI & THELMA NARAYAN

"Primary Health Care is not just medicine. It means ditches, water pipes, nutrition, latrines, family welfare. Health is development". -- Earthscan

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ST JOHN'S MEDICAL COLLEGE, BANGALORE 560034

Directorate of Rural Health Services and
Training Programme

NEWSLETTER 3
MAY 1982

Dear Friends,

Greetings from Bangalore! We returned home after over hundred days of travel covering approximately 10,600 kilometres in the States of Karnataka, Tamilnadu, Haryana, Delhi, Rajasthan, Gujarat and Maharashtra. It was an eventful journey and the modes of transport included train, bus, jeep, rickshaw, jutka and cycle. It was a wonderful experience of observing work at the grass-root level. Rural India is so diverse in scenery, development, life style and culture!

During the tour we met twelve CHWs, fourteen alumni doctors of St John's, staff from three departments of Community Medicine and members of V.H.A.I., C.H.A. and the Medico Friends Circle. We also visited centres and projects like Social Work Research Centre (Tillonia), Centre for Science and the Environment (New Delhi), Sewa Mandir (Udaipur), VIKAS, ASAG, Safai Vidyalaya and Behavioural Science Centre in Ahmedabad, Prayas (Mangrol), Tapovan (Amravati) and so on. The learning experience was much richer than we had imagined!

NEWS OF CHWs

It would be impossible to share with you all the details of the work of those we met among the CHWs but here are a few salient points:

(a) Sunanda Project (KGF)

The name means 'The Bringer of Joy' and the team which includes two of our CHWs--Sr Jude (BC5) and Sr Nalini (BC8) are dedicated to bringing joy and liberation through programmes which include a temporary relief home for children, schools of tailoring and typing, savings scheme, health and nutrition programme, non-formal education through trained animators, resource farm and community organisation in the villages near KGF. Two striking features of this team were the gradual acceptance of a simple 'ashram' life style and the use of street theatre medium in non-formal rural education involving animators who also belonged to the Dalit movement.

(b) Deepti Bhavan, Vimalalaya and Jyotirvikasa (Mandya)

These centres are run by the Missionary Society of St Thomas with the assistance of the Sisters of the Sacred Heart Congregation. The team includes three of our CHWs--Fr Joseph Purayidom (BC6),

Sr Elsy (BC7) and Sr Francilla (BC7). The work includes living among the people of the village, survey, dispensary, nursery school and classes for non-school going children and extension clinics. The project is in the formative years but the team has a holistic plan and is committed to sharing, simplicity, manual labour and team work. One of their dispensaries has been designated a Fever Treatment Depot by the Government under the National Malaria Eradication Programme and is acknowledged as the best one in the area.

(c) Kamagere Health Centre (Mysore Diocese)

Sr Ancilla (BC6) who works at this centre was away on leave but we visited the centre and its two outreach sub-centres at Hannur and Prakashpalayam along with Dr Ravindran, a St John's Doctor who works in the main hospital. In addition to the MCH programme based on the CRS plan, the community health team also does home visiting, clinics for leprosy and TB patients and runs a savings scheme for local people.

(d) Kalathipura Mission (Chickmagalur Diocese)

This little mission station and dispensary nestled amidst coffee and cardamom plantations is run by Franciscan brothers. Br Wency (BC8) came here after his course in December 1981, to join a senior Brother who is well known through his dispensary for miles around. The team also does survey work, home visiting, catechism and night classes for non-school going children and adults. After getting quite a comprehensive picture of the life and problems of plantation workers through home visiting, Br Wency is gradually beginning to work 'among' and 'with' them rather than only 'for' them. He also has good contacts with the local government PHC.

(e) Tamil Nadu VHA Meeting (Madras)

On 19th Februray, we both attended this meeting on the theme 'Health through People'. In addition to meeting many members keenly interested in Community Health Work we got the opportunity to have a short group discussion with three of our CHWs-- Sr Justina (BC3) working with a team involved with MCH programme, non-formal education and dispensary in Devikapuram (North Arcot), Br Xavier Amel (BC3), now a warden of a boy's hostel in Trichy,

and Sr Constance (BC2) working in Vikravandi (South Arcot) with the MCH programme of Pondicherry Diocesan Society.

(f) Jagadhri (Haryana)

It was quite a change to see the agricultural development of the Haryana villages when we visited the project run by Sr Corcena (BC4) of the Sacred Heart Convent in Jagadhri. The team of sisters run a balvadi, dispensary and tailoring centre in the nearby village. Their primary involvement in the area is English Medium Convent, from which they have started this extension work.

(g) Kalambi-Vihar (Shilonda, Maharashtra)

Br Tommy Kuruvilla (BC8) who was completing his regency in this tribal area of Maharashtra, shared with us the experience of living out among the people, home visiting, conducting adult education classes and health work. A weekly clinic is run at this centre by a St John's doctor--Sr Vilma Nazareth--who is in-charge of the Mission Hospital at Talasari.

(h) Shanti Sadan (Borsar, Maharashtra)

After a one-day Seminar on 'Community Health' organised by the Bishop for priests, sisters, teachers and parish workers of the diocese in Aurangabad, we visited the mission stations of Borsar, Vaijapur and Ghogergaon along with Swami Sevanand (BC8) who is himself the parish priest of Borsar and is involved with a very holistic health effort of counselling and spiritual healing. We also visited St Luke's Hospital in Srirampur but were unable to meet Sr Tresa Jose (BC1) who is a Nursing student.

It was encouraging to see CHWs 'living among the people, learning from them and serving them'.

KEEPING TRACK

Catholic Hospital Association (refer address Newsletter 2) has drawn up Diocesan Level Health Plans. Contact the Delhi office for names of your regional animators and for more information about the programme.

Safai Vidyalaya, Harijan Ashram, Mahatma Gandhi Ashram Marg, Ahmedabad 380027. Write to them if you have any questions or problems regarding rural sanitation programmes. They have done pioneering work in this field and have also produced health education materials. They also run short practical courses for field workers.

With best wishes and regards,

RAVI AND THELMA NARAYAN

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ST JOHN'S MEDICAL COLLEGE, BANGALORE 560034

Directorate of Rural Health Services and
Training Programmes

NEWSLETTER 4
JUNE 1982

Dear Friends,

With great sorrow we inform you of the passing away of Major General B Mahadevan, Ex-Director of Rural Health Services and Training Programmes on 7th June 1982, after a heart attack. 'Papa' as he was affectionately called by all of you, was responsible for the development of the CHW course and we all remember with great gratitude the interest and enthusiasm with which he planned each course and guided each group of participants. Among the many contributions he made to the college during the six years that he was associated with it, as Professor of Community Medicine and Director, he will be remembered particularly for his commitment to re-orienting the college to Rural Health Work.

COMMUNITY HEALTH CELL
(First Floor) St. Marks Road
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May his soul rest in peace!

"Yes, all men are dust, but some are gold dust"
- John A. Shedd

For those of you, who would like to communicate with his family, the address is:

MRS C. MAHADEVAN
187 Defence Colony
Indira Nagar, Bangalore 560038

(2) NEWS FROM THE COLLEGE

(a) Affiliation : The college has finally been granted affiliation for two years by the Karnataka Government. We thank you for your prayers! We are continuing the dialogue to get permission to start post-graduate courses, which has still not been given.

(b) Dr C M Francis, Dean left the college in May to take up his new assignment as the Director of Salgaocar Medical Research Centre in Goa.

(c) Dr G M Mascarenhas, Professor of Cardio Thoracic Surgery at St John's Medical College Hospital has taken over as the new Dean.

(3) NEWS FROM THE DEPARTMENT

(a) Professor SV Rama Rao will complete his term as Professor of Community Medicine on 30th June 1982 and will take over as the new Director of Rural Health Services and Training Programmes from 1 July 1982. So please keep in touch with him regarding your work.

(b) The next Basic Course for Community Health Workers (CHW BC9) will commence on 30 Aug 82. The last date for applications is 30.7.82.

(c) The next Refresher Course for Community Health Workers (CHW RC-4) will commence on 22 Nov 82. The last date for receipt of applications is 10 Oct 82.

4. OUR PROJECT PLANS

As planned earlier, we shall be spending the summer and monsoon months - MAY-JUL - writing out our experiences of the CHW courses and analysing all the letters and questionnaires that you have sent to us since 1979. We also hope to complete other writing commitments.

Our extensive travel undertaken in January-April made us realise that it would be unrealistic to try and cover the whole country in a year. Many of our friends and CHWs are working in interior areas and getting to each of them takes a lot of time and travelling.

We feel that such a field contact can be undertaken by us over a longer period of time and need not be completed by December 1982. Also other faculty could be involved as well. We also feel that getting CHWs together at a central place for a one-day meeting would not only cut down travel time but also give opportunities for them to meet each other. The TNVHA meeting (NEWSLETTER 3) was one such opportunity. Places where this seems possible are the Nilgiris, Mangalore region, Karwar region, Goa and Wynad.

We have decided now to give the Southern States lower priority since we can continue to keep in touch with them in later years from St John's. The next trip will probably cover the Eastern region since this is a much neglected area. We are awaiting letters before we finalise details.

With best wishes and regards,

RAVI & THELMA NARAYAN

"If everyone of us could drink pure clean water, keep our surroundings free from flies and dirt, and make the best use of the food we grow and buy, we could protect ourselves against diseases and many of our health problems will disappear. For pure water, good sanitation and adequate nutrition are the world's best medicine"

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ST. JOHN'S MEDICAL COLLEGE, BANGALORE

RURAL HEALTH SCHEME - NEWS LETTER

April - June 1982

Vol:2 No:2.

EDITORIAL:

My Dear Friend,

This issue of the newsletter, comes at a time of changes for the college. First the good news. The Karnataka Government has granted affiliation to St. John's Medical College for the years 1981 to 1982 and 1982 to 1983. At last the college appears to be getting justice and our stand has been vindicated. One can now hope that recognition for post graduate courses will not be far behind.

Secondly we have to inform all of you, that Dr.C.M. Francis is no longer the Dean. The Government Body regretfully accepted his resignation in April. All of you know "C.M." and it will not be necessary for me to sing his praises. His interest in rural medicine and especially in all of you out there in the villages is also well known. We hope he will continue to take an interest in our affairs. The new Dean, is not new to the college, and is a person of eminence. I am sure most of you know him - Dr. Gerry Mascarenhas. With all his experience in administration both in Government service and as Medical Superintendent of S.J.M.C.H. , I am sure he will make an excellent Dean. For the first time we have a clinician at the top. You will shortly be getting your copies of the Alumnus bulletin which tells more of the matter.

Finally on a personal note, this will be the last issue of the newsletter that I am editing. From the 1st of July I will be on the staff of St. Martha's Hospital. Let me assure you that although I may not have official connections with the college and with all of you, I remain a Johnite always. Anytime I can be of any help, in any way, please don't hesitate. I will look forward to meeting any of you when you come to Bangalore.

PREM PAIS

A change from the old guard to the new - taken from the Alumnus Bulletin.

It is on a sad note that we bid farewell to Dr. C.M. Francis. After much procrastination and with great reluctance the Bishops of India have finally accepted the resignation of Dr. Francis as Dean of St. John's Medical College and Hospital.

A Physiologist with specialisation in Neuroendocrinology in Cambridge, Dr. Francis became Dean of the St. John's Medical College in July 1974.

Cont'd..../2.

He was selected to this important post mainly becuase of his experience and widely acclaimed ability as an academician cum administrator. Previous to joining St. John's, Dr. Francis had been Principal of the Trivandrum Medical College and later Principal of the Kottayam/Calicut Medical College. He was Executive Director of the Sree Chitra Thirunal Medical Centre for advanced studies in specialities when he was approached for Deanship at St. John's. The Kerala Government released him on deputation for a three year period. But, able that he was, Dr. Francis soon became indispensable and had to continue in St. John's. His stay here could have been longer but for his decision to call it a day, and being firm in his request, the Governing body regretfully accepted his resignation.

St. John's owes a lot to Dr. Francis. When one thinks of his approach to a problem one cannot but comment on his immense knowledge of the subject, his honesty in dealings, his hard work, his concern for details. The campus hospital is what it is today in large measure due to the untiring efforts of Dr.Francis who also ensured that the hospital would be able to afford a great deal of free and concessional care to the poor and needy. With his personal commitment, rural orientation of medical education became 'the' feature of training at St. John's. The institution continued to claim laurels in the field of academics, research, sports. Fruits of his labour are evident in various spheres and one can truthfully say that his efforts have not been in vain.

We, alumni, will miss our dear Dr. Francis. He has been a friend, philosopher and mentor to many of us. Though he leaves St. John's we do hope that our association with him will continue for many many years to come.

On this occasion we wish Dr, and Mrs. Francis continued success and happiness in their every endeavour.

Good Bye Sir and God Bless!

The Chairman and members of the Executive Committee of the Alumni Association congradulate Dr. Gerard Martin Mascarenhas on his appointment as Dean of the St. John's Medical College and take this opportunity to wish him a long and effective term in Office.

Dr. Gerry (as he is amiably known) graduated from the Madras Medical College in 1948 and joined the Hyderabad Medical Services. With the States reorganisation, he was allotted to the Mysore Medical Services. Dr. Mascarenhas worked as a Registrar in Thoracic Surgery, University of Edinburgh and obtained his F.R.C.S. in 1955. As an US AID Fellow, he underwent training in open heart surgery at the University of Kentucky and in 1968 he became a Fellow of the American College of Surgeons.

Dr. G.M. Mascarenhas is well known in Government Service for his pioneering work in Thoracic Surgery. He was responsible for setting up the Department of Cardio-Thoracic Surgery in Karnataka State in January 1968. Closely associated with SDS Sanatorium for T.B. and chest diseases since 1957, he was the medical Superintendent of that institution till 1976.

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In July 1976 Dr. Gerry retired voluntarily from the Karnataka Government Service after 26 years of service.

St. John's Medical College Hospital, then a newly opened and budding hospital, was fortunate to have the services of Dr. Gerry. He joined the institution in December 1976 as Professor and Head of the Department of Thoracic Surgery. Because of him, the unit at St. John's has become a leading referral centre for Heart Surgery and Thoracic Surgery. So much confidence did the Management repose in Dr. Gerry that in January 1977 he was appointed the Medical Superientendent of the campus hospital.

As alumni, we extend our warm welcome to our new President. We are confident that Dr. Gerry will take our Alma Mater many steps forward in the realisation of her objectives.

Medical Corner:- Recently Dr. A.R.A. Fernandez from Chickmagalur has written asking for clarification on a number of medical questions. We can tackle the first this time. He wishes to know something obout the interpretation of blood counts in a rural setting.

Anaemia :- Normal value of Hb is 13 - 15 gms. A low haemoglobin (i.e. anaemia) can be due to excessive destruction of blood or reduced formation. The next step in the investigation is to make a peripheral smear examination and a total and differential W.B.C. count.

a) In excessive destruction (haemolytic anaemia) peripheral smear will show RBC of abnormal shapes such as spherocytes (RBCs which are smaller than usual and lack the central pallor) or fragmented pieces. There is usually a leucocytosis. Urine will show urobilinogen in excess. Further work up requires tests like reticulocyte count, fragility test and haemoglobin electrophoresis which are usually not available in small hospitals.

b) Reduced production could be due to

i) Defficiency disorders - Iron deficiency. Peripheral picture shows the well known microcytic hypochromic picture. WBC count is usually normal. Peripheral signs of iron dificiency are usually present. A cause must be looked for

- B_{12} and Folate deficiency produce a macrocytic anaemia with large oval RBC. WBC count is on the low side and the polymorphs show a "hyper segmentation" i.e. the number of lobes of the nucleus are five or six instead of the usual 3 or 4. B_{12} deficiency can be caused by pernicious anaemia. Folate deficiency is caused by malabsorbtion and malnutrition.

- Dimorphic anaemia - seen in states of poor nutrition when there is deficiency of both folate and iron. There is a mixed picture of large cells with a hypochromic appearance.

Cont'd.../4.

ii) Reduced production due to infiltration of the bone marrow.

- Leukaemias can be diagnosed from the WBC count and peripheral smear.
- infiltration by secondary deposits of cancers or lymphomas in the marrow. Peripheral picture is one of general reduction of cells like an aplastic marrow. A bone marrow aspiration, if possible will show the cancer cells.

iii) Aplastic Anaemia : There is reduction in all the elements of the marrow. Thus besides anaemia, the WBC especially polymorphs are markedly reduced and the platelets are also reduced. On a peripheral smear there should be 8 - 10 platelets per oil immersion field. . The number of platelets per oil field X 10,000 gives the approximate platelet count. Aplastic anaemia may follow infections especially viral infections, drugs(chloramphenical, phenyl butazone, anti-cancer drugs) irradiation or may be idiopathic.

W.B.C. Count in infection:- If a patient has an infection whose aetiology is not clear, a WBC count is often of great use. Combine it with a differential count and study the morphology of the WBC.

a) Viral infections:- Generally give a low or normal WBC count with relati- lymphocytosis. An exception is infectious mononucleosis where the WBC count is elevated upto 50,000 to 60,000 oer cubic mm, most of the cells being lymphocytes of an abnormal type - large cells with large folded nuclei. The picture may resemble a lymphoblastic leukemia.

b) Bacterial infections - Most acute bacterial infections give rise to a polymorphonuclear leucocytosis. The more acute the infection the higher the count. The WBC are young - they have few lobes and band forms are seen. These are young cells where the nucleus has not yet divided into lobes. Very severe, overwhelming infection, when the patient is in shock, may be associated with a suppressed WBC count but the polymorphs will show increased band forms and and their granules will be coarse and prominent - toxic granulation.

Sub acute infection with gram negative bacilli especially especially typhoid fever have a suppressant effect on the marrow and may be associated with a decreased or normal WBC count.

PREM PAIS

Treatment of Diarrhoea:

Diarrhoea is defined as frequent passage of unformed stoods. It is one of the most common diseases and certainly the commonest-alimentary disorders in our Country. The underlying cause may be very simple and benign or a serious disorder. Most episodes of acute diarrhoea are infective in nature, are self limiting and easy to manage.

Occassionally however, etiological diagnosis may not be easy.

Recent researches have facilitated clearer understanding of the pathophysiology. It has been shown that approximately 7-9 litres of fluid are poured as secretions into the alimentary system everyday; 100-200 ml of this is excreted, the reminder being reabsorbed. Normal stools result from a balance between the process of secretion and reabsorption. Excessive secretion or d diminished reabsorption may result in diarrhoeas.

Etiology - Bacterial infection account for the majority of cases. Shigella and Escherichiae are common organisms which infect the gut. They invade the epithelial cells of the ileum and colon and cause out pouring of large volume of fluid into the bowel. The Vibrio Cholerae produces an enterotoxin which binds to the epithelial cells, Stimulate adenylcyclase and cyclic AMP activity leading to secretion of protein free isotonic fluid into the gut. Protozoa and flagellates or other helminths may be responsible for an episode of acute diarrhoea.

Enteroviruses are frequently cited as cause of epidemic or sporadic gastroenteritis and diarrhoea. Several studies have revealed that enteroviral infection is common in children but less as compared to E. Coli infection. (Cecil 1979).

From treatment point of view, it is advisable to find out the underlying cause and treat it. Spicy fatty food should not be allowed. Oral rehydration is the most effective therapy. Oral rehydration agents containing Sodium, Pottassium, Bicarbonates, and sugar have been increasingly used with good results. They are of particular value in infants and young children. Their use may be life saving in rural setting. The fluid can be prepared at home by disolving 3.5 grams of sodium Bicarbonate, 1.5 grams of Potassium chloride, 2.5 grams of socium Bicarbonate and 20 grams of glucose in a litre of water. General condition of the patient, his skin and tongue give evidence indicating the State of hydration. Fluids should be given to ensure a urinary out-put of 1200 - 1500 ml. in 24 hours.

Coming to the role of antibiotics, they may be required only in selected cases. Ampicillin 500 mgms orally QDS x 7 days for adults (100 mg per kg in 4 divided does in children), Cotrimexazole tablets 2 BDS for 7 days, tetracycline 500 mg four times a day for seven days or Sulfaguanidine 250 mg QDS for 7 days can be used. Tetracycline should be avoided in children.

COMMERCIAL PREPRATIONS:-

Let us come to the role of commonly available antidiarrhoeal mixtures which are frequently used in general practice. The following chart gives the name of the preparation, contents and their cost.

Cont'd.../6.

Antidiarrheal Preparations

NAME	CONTENT	COSTIM Rs.
1. Kaltin c Neomycin (Abbott)	Each 30 ml contains Kaolin 6 gm, Pectin-130mg Neomycin -300 mg, Sodium lactate-500 mg, Tinct. Belladona -0.3 ml, Pot Chloride -330 mg. Sodium chloride -470 mg.	60 ml cost 5-20
2. Pekolin (Cadila)	Each 15 ml contains 0.225 grams of Pectin Kaolin-3 gms.	150 ml. cost 11-68.
3. Kaopectin c Vellafon (Pharma Lab)	Each 5 ml contains Kaolin 1.25 gm. Pectin - 0.0625 gm, Belladona - 0.125 ml.	450 ml. cost 11.00
4. Pectocin (Pharma Lab)	Each 30 ml contains Kaolin - 6 gm. Pot Chloride- 0.32 gm. Pectin -0.13 gm Neomycin -0.3gm, Sodium acetate-0.1 gm.	60 ml cost 6.00
5. Bismopep (Anakem)	Each 5 ml contains. Sodium Bismuth tartarate -100 mg Pepsin-2.5 mg, Nux Vomica 0.05 ml. Glycerin 0.05 ml Alcohol -13%	110 ml cost 5 [illegible] = 0
6. Eukopect (Eupharma)	Each 5 ml. contains 1 gm - Kaolin 0.05 gm-Pectin	100 ml cost 4.00
7. Pectilin SG (Wockhardt)	Each 30 ml contains Sulfa guanidine -1.380gm Pectin -150 mg Homatropine Kaolin -6 gm.	450 ml cost 14-76
8. Streptomagma (John wyeth)	Each 15 ml contains streptomagma -0.15 gm Kaolin -1.5 gm Pectin - 0.135 gm Aluminium gel -70mg	90 ml cost 6-10

If one sees the contents of the different proprietory preperations carefully. It is evident that most of them are shot gun preparations. Most of them contain Kaolin alone or in combination with pectin. The role of Kaolin in diarrhea is

Cont'd...7.

highly controversial. Some workers have found it to be of some help whereas others observed no significant benefit from its administration. In the symptomatic treatment of diarrhea, it has been recommended by Martindale (1972) to be given in the dose of 15-75 gram per day. The 2 gram dose generally used in the antidiarrheal mixture has little effect. Adecuately controlled clinical studies that demonstrate the efficacy of these popular preparations are lacking. They may have minimal effective antidiarrheal action. The general opinion is that even if it does not reduce the number of stools their consistancy changes for the better. Some of the proprietory preparations contain Neomycin. Neomycin can act as an intestinal antiseptic in the dose of 2 - 8 gm per day. It is poorly absorbed from GIT and helps in suppression of bacterial growth in intestinal tract. In infantile diarrhea it has to be given in the dose of 30-50mg/kg body weight. When given by mouth, Neomycin sometines can produce laxation and may interfere with intestinal absorption of food. Prolonged oral therapy may result in overgrowth of non-susceptible organisonal such as Candida in intestines. To avoid this it has been advocated that Neomycin should not be given for more than 3 days.

Reports regarding the use of codeine, Bismuth Salts and opiates are conflicting. Generally they should be avoided in infective diarrhea. Their use, it is feared, may prolong damaging effect on the bowel mucosa and absorption of toxing preparations containing Atropine are definitely Contra indicated in cases showing Pyrexia a sign of toxemia.

The cost of treatment with most of the ineffective proprietory antidiarrheal mixtures is exorbitant and certainly so in a country like ours. So while prescribing the above mixtures one should think twice regarding their efficacy, their usefulness and their cost.

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DR. P.S. PATKI, Pune.
M.D.(Pharmacology).

(MFC Annual Meet-1982)

Lomotil in young children:
Is it useful?
or
It is dangerous?

The latest WHO pronouncement on the treatment of diarrhea says "Lomotil is one of nine treatments not recommended" (1)

Lomotil is being used widely by majority of physicians. Let us analyse scientifically its effectiveness & dangers.

Is it useful?

a. Against dehydration:

The cause of death in diarrhea is dehydration. Lomotil may appear to help by reducing the frequency of motions but it does not reduce the loss of fluid into the intestinal lumen. This internal loss of fluid is difficult to assess clinically. Therefore, Lomotil is in fact dangerous, as it can mask dehydration. (2)

b. Against infections :

Acute diarrhea in children is usually infective , but antibiotics and antidiarrheal drugs rarely help. (3)

Lomotil prevents the children from getting rid of the infective agent and may prolong the period of infection. (4)

Febrile volunteers receiving lomotil alone experienced over a day more fever than those in other treatment groups suggesting that drugs that retard gut motility facilitate intestinal infection (5).

Is Lomotil dangerous?

Lomotil ingestion is a cause of serious poisoning in young children, especially those aged under five. (6)

Lomotil poisoning in children can include atropinism, respiratory depression, & coma even with therapeutic dosage. There is no correlation between the severity of symptoms and the dose ingested.

Manufacturer's warning:

In the U.S., Lomotil is contraindicated for children under two years.

This warning by the manufacturer is not because there has been inadequate pediatric testing of the drug but rather because severe life threatening reactions (which are not rare) occurs in this age group (7) P.R., Sureka, Bombay-64.

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(Based on the leaflet on lomotil - published by Social Audit Limited, 9 Poland street. London WIV 3 DG.)

Correspondence:- In the last newsletter we published a long article by Dr. G.D. Ravindran. Here are some replies. First comments by Dr. A.R.A. Fernandez from Chickmagalur.

- Dr. G.D. Ravindran's view that only success stories are published in this newsletter are totally incorrect.

- I agree with Dr. G.D. Ravindran in doubting whether the S.J.M.C. M.B.B.S. course has any relevance to rural health care.

- All I could say is rural service is not too easy for anybody. There are various reasons for them. This could be discussed at a later date.

Dr. Dara Amar was asked for his comments as the Community Medicine Department plays a large role in rural orientation. He has given a detailed reply:-

Orientation of Medical Graduates of St. John's, to serve in rural areas - An Introspective View. by Dr. Dara S. Amar.

I write this with special reference to the letter written by Dr. G.D. Ravindran. It was a nice experience to read this letter and know that some of us are truly perturbed about the situation of Rural Orientation among our graduates. His letter shows a lot of insight into the real problem and I appreciate him for having brought it to light. However, there are a few points which I would like to clarify and also to bring upto date the fresh efforts made in this orientation endeavour.

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At the outset I may confidently state that orienting a medical graduate, or anybody for that matter, to accept a changed manner of thinking is not as simple as is often made out to be nor is it the sole responsibility of any individual, department or for that matter the the institution itself. Orienting a medical graduate to serve in the rural areas must be viewed in the context of how this graduate's mind and thinking as been influended by his social and family background, his parental aspirations for his future, the economic returns and the most important of all is the peer group pressure brought on the fresh medical graduate.

A lot of water has flowed under the bridge since Ravindran's posting posting at our institution and I shall attempt to bring uptodate some of of our new programmes. The credit for the new changes brought in, especially by the Department of Community Medicine in their field programmes, goes largely to the recommendations made by innumerable interns like Dr. Ravindran. But it has taken time for implementation due to several administrative, financial and other constraints.

Nevertheless each of their recommendations are and will be implemented over the course of time. One of the major recommendations which repeatedly was voiced by several earlier interns was the fact that when they were posted to a rural centre where a Medical Officer was stationed, they had very little to gain in terms of independent patient management and confidence in handling cases. It was with this view and partly due to the successful grant of finances from the State Bank of India that we were able to launch into a new scheme of rural centres deep in the interiors of Dammasandra Block. Four such centres are functioning and two more are envisaged. The uniqueness of these four Sub-centres is that the interns themselves (two boys) have to manage the entire centre which includes not only patient-care but financial management and organisation etc., under the realistic constraints of administration and monitary factors. Thus the emphasis is on the interns being able to manage a General Practitioners Clinic in the rural area with limited fundsm limited medicine, limited diagnostic facilities and the usual constraint of rural life. Thus the emphasis has broadened out from mere preventive and promotive methods to curative services as well, as we have realised that the entry to any health care system is through curative services. The old system of compulsory projects, programme components etc., have been done away with inorder to give the interns a lot more time to devote their skills as a General Practitioner in a rural area. This is not to say that the other programmes of training in preventive and promotive care have come to a halt but under the new circumstances, curative services have been given greater importance than in the past. One could say that at the the end of the three months posting as independent doctors in the rural centres, the graduates will now be armed with sufficient experience to manage a general practitioners clincc even if it is in a rural village. So far this newer system of independent posting of intern has been extended to the male interns only. However, we propose to very soon broaden it out to include lady interns as well, the only constraint being one of security. The old centres like Mallur are now not being used for internship posting unless there is an excessive number of interns coming in to the department. But this problem seldom arises as the interns postings have been streamlined for the entire year and an advance planning can now be undertaken. Incidentally Dr. Ravindran's suggestion for short term 15 days postings in small specialities has now become a reality. I do agree that even under this new system of independent interns posting there are a number of lacunae.

But any change is bound to throw up newer challenges and it is only a matter of time before these are streamlined.

Apart from the above, attempts at orientation are being made also at the undergraduate level. Dr. Ravi Narayan, in an earlier newsletter has already written about the rural orientation programme for the 1st MBBS students and therefore I shall not go into its details. However, again certain points need clarification. In the first instance, the Rural Orientation Camp is not merely meant to increase the knowledge in terms of health care or medical problems of a village. The main intention is to impart an EXPERIENCE to the students, of village life. To this end the camp emphasizes that the students find out for themselves about other social factors like transport, communications, trade, religion, politics etc., of the village. The idea being that without a knowledge of these factors of rural life, there is no point in giving a tubular vision of only health, to the students. In fact the response of the last three camps has been one of overwhelming enthusiasm on the part of the students. During these camps it is the senior faculty of the department who reside with the students and this I believe is very important. This camp is meant to be repeated in the third and final years. I hasten to add at this juncture, that having learnt a lot of lessons from the old (and now given up) Mallur posting of interns, we have realised what it means to overstay our training programmes in one village only. Therefore, the Rural Orientation Programmes are conducted in different sets of villages each year, thus not exhausting the patience of the villagers either. As these camps are conducted mostly in the drainage areas (in terms of patients) of the College Hospital, these students are in a much better position to understand the village milleau of the patients coming to the hospital. This indeed is a great step forward considering the fact that these student graduates will now think in practical terms before advising or recommending any followup measures to their patients in the hospital.

The third major facet of rural orientation attempts by the department is directed towards the staff of other departments. Even in this sphere I can confidently say that a lot of progress has been made considering the fact that originally it was believed that clinical staff would never go to rural areas. There could be no greater falsehood that saying the clinical people are not interested in going to the rural areas. What is necessary is to create an opportunity for them to go to the village and this is being done by the department in terms of organising monthly Multi-disciplinary Camps in each of these village centres (using theomnipresent white elephant, officially termed the Mobile Clinic). The interns posted at the subcentres carry out an intensive publicity campaigns. This has resulted in an attendance of over 300 to 400 patients at each camp. Being a multi-disciplinary camp the disciplines involved are at present the socalled minor specialities like dental, ENT, Ophthalmology, Skin and one major department, the Surgery Department. I assure Dr. Ravindran that these Multi-disciplinary Camps (based on a regular programme schedule and not "ipsofacto") are no more the old types of "picnic" trips to the village and this

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could be corroborated by the actual clinical staff. Infact at the last such camp the patient turnover crossed 500. This amply disproves the fact that these camps are mere picnics jaunts! Most importantly, the followup of the patients at these camps are carried out by the residential interns and the departmental social worker and behavioural scientist.

I do not say that following all the above new changes at orientation, I expect the entire lot of graduates of St. John's to rush to the villages and it would indeed be absurd to dream of such a proposition at this juncture, at least. However, we must remember that the interns of St. John's Medical College are the only interns who continue to reside in the new sub-centres without any supervision, unlike the scenes witnessed at other Medical Colleges. It is unfair to pat our own backs for this comparitive analogy and I do understand that we must try for the absolute ideal. However it is at least a step in the right direction. Indidentally other medical college staff and Govt. officials have visited the institution, after having heard of the newer projects to orient our students and their verdict is that we are ahead of others on this path, but I do agree with Dr. Ravindran that we have a very long way to go! It is only a matter of time before the changes become evident.

I assure Dr. Ravindran that we shall continue to try and improve methods of orienting the graduates to rural health and I hope that he shall continue to favour us with his recommendations and suggestions which are most welcome.

Com H 10.11

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Directorate of Rural Health Services
and Training Programmes

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Roa
BANGALORE - 560 001

St John's Medical College, Bangalore

DRHSTP-ACC-81

2[illegible] Nov 1981

Dear

Seasons Greetings for Chirstmas and the New Year from all of us in the Department of Community Medicine at St John's!

1982 is going to be a special year for us since a long standing plan to meet all of you in the field has finally materialised. Thelma and I are on special leave for a year starting December 1981 and during this year we plan to visit as many of you as possible in your own areas of work to re-establish contact, share experiences, reflect together and grow in our understanding of our people and our work. We have already been in touch with many of you and we shall be writing to others as the weeks go by. We thank all those who have so promptly and enthusiastically received this news and welcomed us to their villages in 1982. We hope to hear from many others amongst you soon.

In order to get some common information from all of you in the field we have drawn up a simple questionnaire taking ideas from many of your own letters. Please fill these up and add any other comments, information, suggestions you would like to send us. Those of you, who have already sent us some details of your work recently fill in only those sections which you did not cover in your personal letters. We would like very much to hear from each of the 150 Community Health Workers we have trained. Even a blank questionnaire with only your latest address and information on how to meet you next year would be most welcome.

Meeting you and seeing your programme will be a good experience for us but in case you feel there are any other ways in which our visit could be mutually beneficial please suggest this in Section C (b).

In preparation for this visit many other materials are being organized which we hope to send you soon - a list of Community Health Workers addresses, news bulletins, list of new handouts and educational materials and so on. So please keep in touch.

Hoping to hear from you soon and also meeting you next year.

With best wishes and regards,

To

Yours sincerely,

Ravi

PS: Please post this to Drs. Ravi & Thelma Narayan, D-10 Staff Quarters, St John's Medical College, Bangalore 560 034 before Christmas 1981)

Directorate of Rural Health Services &
Training Programmes

FOLLOW-UP EVALUATION OF COMMUNITY HEALTH WORKERS TRAINED IN ST JOHN'S MEDICAL COLLEGE

PROFORMA

Instructions : Section A and C to be filled in by all Community Health Workers
Section B to be filled in by those who are doing health work at present.

(Please keep us informed regarding change of Address)

SECTION - A - GENERAL INFORMATION

a) Name :

b) Age:

c) CHW Course No.:

d) Name of Congregation:

e) Diocese:

f) Permanent Address
(Mother House/Superior) :

g) Present Address
(For future correspondence) :

h) What have you been doing after the course ?
(If you have changed from place to place give us some details of your work in each place).

i) Give us a short description of the present team you are working with and what each member does (not only health activities)

j) Have you attended any course/meetings/workshops since you completed the Course ?

...2

k) Are you in touch with any of the other Community Health Workers? If so give us their recent address.

l) Give in a few sentences a description of the poeple you are working with (rural, urban, tribal, non-tribal, main occupation, other characteristics etc). How many villages? Total population, what distances apart ?

SECTION B

a) Give a short description of the health activities you are involved in.

b) How many hours are allotted for this daily/weekly ?

c) Are you functioning independently or with a team of workers? If so, how is the health work shared amongst you ?

d) Do you get any assistance from the local Primary Health Centre? If so, specify ?

e) Do you get any assistance from a Taluk/Mission Hospital? If so, specify?

f) Do you work with any special groups in the village (young farmers, youth, mothers, harijans etc.)?

...3

g) Do you participate in training of local people ? Grihinis, village level worker, mothers etc.

h) Do you have any of the following programmes?
Food for work, Health Insurance, CRS- MCH Programme, any others

i) Are you part of any Diocesan Society or Health Team ? If so, specify.

SECTION C (Regarding 1982 project)

a) Give us detailed information on how to reach your village/project/centre? (By bus and train, also from station and bus stop)

b) Are there any forms of support which a visiting team can give you next year ?

Date: Signature:

Please use the remaining blank space to give any further details for which there was not adequate space in the questionnaire.

From: Thesis: "Evaluation of a decade of Community Health Workers' Training at St. Johns Medical College — its relevance to local health needs." COMH 10128

VII. SUMMARY AND CONCLUSIONS

VII.1 SUMMARY

Community health worker training began in India on October 2nd 1977. The community health worker was to be a person of the community, who would live with the community and serve them. They would undergo a short training course for a period of 200 hours spread over 3 months. They were to be voluntary workers and not government servants. The concept was therefore to promote the extension of health services to rural areas by involving or increasing community participation.

St. John's Medical College in its effort to promote rural services especially to under served areas, following the biddings of the Srivastava committee report, the guidelines of the CBCI commission and on the basis of its own experience in the use of village health workers in some of its micro projects, began a community health workers basic course in April 1978. The trainees were mostly "religious" sisters who came from all over India, especially rural areas.

The community health workers basic course has been going on for more than 13 years now. Though informal and formal evaluation of each course was conducted, no formal evaluation of the training was conducted even a decade after the institution of this course. An evaluation was thus felt necessary.

A literature review of studies on community health workers provided guidelines on formulating the evaluation but these were felt insufficient. It was therefore decided to adopt an innovative approach to the evaluation.

As a first step in evaluation it was decided to evaluate only "the relevance" of the training programme - the relevance to the local health needs of the community. It was decided to evaluate a decade of training and decade chosen was 1981 - 1990. A multi faceted approach was used for the study.

The objective of the study was to determine the content and methodology of training of the community health worker, to study the work of the community health worker and to study the local health needs of the community. From an analysis of the above mentioned components the study was to identify areas that required strengthening and to offer appropriate recommendations for training. As a background to the study a general profile of the community health workers providing not only general characteristic such as age and sex but also other information regarding their work status and the feed back on training, was also elicited.

The community health workers trained during the decade were first traced through reply paid post cards sent to their superiors. The community health workers traced through post card replyies were stratified on the basis of states or regions within the country and arranged in serial order of the year in which they had attended the course and the number on the nominal role. All of these were sent a structured closed postal questionnaire to elicit the general profile. A response rate of 67.94% was received.

10% of the sampling frame was considered feasible given the constraints of time and finance and this was chosen by systematic stratified sampling. The work of the community health workers and the local health need

of the community served by the community health worker was studied using interview schedule and personal observations.

Trainers of community health workers were chosen by purposive sampling, a trained being defined as one who have been involved in training of community health workers for 3 or more years and the years falling within the decade. 23 trainers were thus identified and of whom 21 (91.30%) were presonally interviewed on the opinion on specific aspects on training in specified fields of interest to determine whether the training was knowledge, attitude or skill oriented.

Training was also studied for its course contents and methodology from a records review of files in the department.

The data collected by the above method was compiled and is presented using descriptive statistics in the form of percentages or proportions in four chapters namely,

i) General profile of the CHW
ii) The training of the CHW
iii) The work of the CHW
iv) The local health need of the community.

Analysis was then made by simple comparison of the three angles of the study namely the training, work and local health need of the community and this was viewed in the background of the general profile.

Areas in training that required strengthening were thus identified in 10 specified fields of interest and one additional aspect namely

i) Communicable disease control

ii) Maternal and child health

iii) Nutrition

iv) Immunization

v) First Aid and Care in Minor ailments

vi) Environmental sanitation

vii) Health Education

viii) Community development activity

ix) Health planning and management

x) Other systems of medicine

* Continuing education

In conclusion certain strengths and weaknesses of the training programme as whole as it existed for a decade are highlighted. The recommendations are then proposed for the training programme as a whole and specifically through the modified schedule for community health workers basic course.

VII.2. CONCLUSIONS

In conclusion, the evaluation of the decade of community health worker training at St. John's Medical College brings to light certain strengths and weaknesses of the programme.

These strengths and weaknesses of the program are categorized under the following headings:

i. Content of Training.

ii. Methodology of Training.

iii. Flexibility in Training Program.

iv. Field-based Training.

v. Approach in Training.

vi. Training Resources.

vii. Trainers characteristics.

viii. Selection criteria.

ix. Student characteristics.

x. Evaluation of Training.

xi. Follow-up of Trainees.

xii. Continuing education.

VII.2.1.STRENGTHS OF THE PROGRAMME

VII.2.1.i. Content of Training.

A wide coverage of topics and a firm foundation on basic concepts which contributes to the trainees developing a conceptual approach.

On an average about 12.52% of the total training time is spent on basic concepts in Health and Development.The total duration of the course has remained the same as that recommended by the Government of India, though the total number of teaching hours is much more.

VII.2.1.ii. Methodology of Training.

There are a wide variety of methods used in training. These include :

classroom based lectures, group discussions, demonstrations , practicals, learning by doing, simulation games, role plays, field visits and studies, project work and visits to various institutions.

VII.2.1.iii. Flexibility in Training Program.

The course schedule has not been rigid, but, flexible and changes have been made from time to time even during the course as is obvious from the ink correction on the printed schedules on different dates.

VII.2.1.iv. Field-based Training.

There is a proportion of training which is totally field based in all courses and this usually about 33.33% of the total duration of the course.

VII.2.1.v. Approach in Training.

There is a multi faceted approach in training and type of trainers. Training has included visits to various institutions and projects especially for development aspects, rehabilitation care of special groups and to intensify training in these specific "health" issues.

VII.2.1.vi. Training Resources.

Training resources in the form of material resource - reading material, library facility, class room facility, availability of audio visual aids, facilities for residence, food and transport have all been provided and seem adequate from feed back reports. Wherever pointed out by trainees, necessary changes have been immediately implemented.

VII.2.1.vii. Trainers characteristics.

Trainers characteristics and number have also contributed to the training. All the faculty directly involved in the training are teachers of community health/Medicine. There is a 2 : 1 proportion of medical: Non medical faculty for most years of the training. The staff student ratio in any given course during the decade has not exceeded 1 : 3.

VII.2.1.viii. Selection criteria.

Basic "Selection criteria" have been laid down and this has resulted in more or less homogenous group of students.

VII.2.1.ix. Student characteristics.

Students are mainly "religious" and this has also contributed to the homogeneity among students.

VII.2.1.x. Evaluation of Training.

Formal evaluations; before, during and after the course and informal evaluations conducted through group discussions with faculty and through project presentations regularly, during the course, have contributed to a continuous evolution of the course.

VII.2.2. WEAKNESSES OF THE PROGRAM

VII.2.2.i. Content of Training.

There are too many topics and list of topics have been growing with evolution of the course, whereas the course duration as a whole, or time spent on training has not altered much. This could only result in lesser time for experiential learning and practice of skills necessary. "Content too much" and "Duration too short" were among the most common problem encountered by trainees during the training.

VII.2.2.ii. Methodology of Training.

While a variety of methods have been used in training, class room based lectures is still the most commonly used and in the recent year has even exceeded all other methods combined together. This not only compromises on skill based learning but also is not suitable for adult learners (VHAI 1978).

VII.2.2.iii. Flexibility in Training Program.

The over flexibility in course schedule has been a constraint in learning. "Frequent changes in time table" was the third most common problem in learning for the trainees.

VII.2.2.iv. Field-based Training.

The proportion of field training in the various courses has been dependent on the availability of dormitory facilities in the primary health centre and this has resulted in compromising the duration of field based training in certain courses.

VII.2.2.v. Approach in Training.

While the multi faceted approach to training may be unique, this was found useful to less than 25% of the trainees. This especially included visits to various physically or mentally handicapped rehabilitation centres.

VII.2.2.vi. Trainers characteristics.

Most of the Trainers were Medical personnel.English was the medium of instruction for all courses.The most common difficulty experienced by trainees was "language". The use of medicall jargon and technical terminology is probable.

VII.2.2.vii. Selection criteria.

Selection criteria have not been strictly applied. While the fact that an under qualification may be over looked, many health professionals, including nurses, have also joined the community health workers course and this has to be paid attention to.

VII.2.2.viii. Follow-up of Trainees.

There is no formal system of follow up of trainees after training. Only about 65% of trainees could be traced in the decade on the basis of addresses that were available. Apart from the present study there is no data available on what trainees are presently engaged in, in the field of community health or other wise.

VII.2.2.ix. Continuing education.

Continuing education programmes are strikingly deficient. Though about 68% community health workers had had some form of continuing education

mainly through informal processes (Diagram), 88.73% felt the need for a refresher course. Only 4.23% did not feel this need.

VII.2.2.x. Evaluation of Training.

There is no system by which impact of the community health worker on the community can be studied. No conditions have been laid down regarding the community health workers continuing in community health activities after the course. 10.42% of those traced in the courses of the last year in the decade (1990) are not yet involved in community health activities and have never been involved in activities before the course either. 7.65% of those traced in the decade have never been involved in community health activities either before nor after the course. (diagrams).

VIII. RECOMMENDATIONS

VIII.1.GENERAL RECOMMENDATIONS

VIII.1.i. Content of Training.

Community health workers need to be taught only what is necessary for them in the field. Topics may be excluded where they have no relevance and are not necessary even for a conceptual background. Thus many topics especially on the human biology dealing with the endocrine system and so on may be deleted. The number of topics "taught" must thus be reduced.

VIII.1.ii. Methodology of Training.

Training must be strengthened in the development of skill by the use of more participatory methods of learning. Thus use of practice sessions, learning by doing, project work, simulation games, role plays, supervised field work, group discussions must be used more often. Participatory methods of situation analysis of a community through use of methods such as social or community mapping and body mapping must be included.(Chambers R.,1990 & Rifkin S. et al,1988) Participatory methods of training and use of audio-visual aids were preferred by many community health workers.

VIII.1.iii. Flexibility in Training Program.

While a certain degree of flexibility in schedule is recommended it must be emphasized that frequent changes in time table must not be resorted to.

VIII.1.iv. Field-based Training.

WHO recommended that a proportion of training must be conducted in the field.(WHO, 1979:Technical Report Series, 633). It did not specified the

proportion. However it was elicited from trainees and trainers and it thus recommended that an ideal training programme must be totally field based. In the absence of facilities for field based training for Field-based workers, such endeavours should not be undertaken.

VIII.1.v. Trainers characteristics.

Trainers of community health workers have been mostly doctors, social scientist, social workers. It is recommended that experienced community health workers be used as trainers too.(WHO 1989;Technical Report Series, 780)

"Language" was the most common difficulty experienced in learning, by the community health workers.It is recommended that Trainers use simple language and avoid the use of complex, scientific, technical, medical,jargon during training.

"Personalised attention of the trainer" was the most common activity that enabled learners to overcome their difficulty.It is recommended that this be continued.

VIII.1.vi. Approach in Training.

Visits to various institutions especially in the field of rehabilitation must be reduced to a bare minimum and even here the visit may be left as an "elective" for the trainee.

VIII.1.vii. Selection criteria.

Selection criteria must include attitudinal characteristics such as willingness to hard work, ability to communicate, ability to work with others in a health team, since these are some of the attributes most difficult

to develop during training. (see appendix xi.7).

Under selection criteria itself a stipulation must be laid down that the community health worker must be involved in community health activity for a minimum specified period of time (Say 3 years) after completion of training.

One of the commonly expressed reasons for non-work was the furtherance of education or religious formation. It may therefore be laid down that only those who have completed their religious formation may apply.

Another common reason for non involvement in community health work was the holding of other responsibilities for example superior. This category may also be selectively excluded in certain situations where it is sure that the added responsibilities would prevent active involvement in community health activities.

VIII.1.viii. Student characteristics.

The advantage of homogeneity and diversity within the group of learners must be capitalised on during the training programme by use of group sessions and group dynamics including healthy competition. This makes learning experience more satisfying.

VIII.1.ix. Follow-up of Trainees.

A system of follow up must be built up. A regularly updated directory of the community health workers is a necessity. The directory must contain not only the address of the community health worker but also give brief details of the type of activity he/she is involved in. This would not only keep the organisers aware of the whereabouts and activities of their trainees but would also enable the organisation of regional workshops for

continuing education. Personnel Resources for technical guidance on the field could also be identified and intimated to the community health workers as necessary if the directory was maintained.

VIII.1.x. Continuing education.

A system of continuing education must be built up. This could be achieved by -

a) Periodic refresher courses on specific relevant topics as requested by the participants.

The refresher course must be of a short duration so that the work of the community health worker in the field is not interfered with.

The refresher course could be organised at a regional level if a directory of community health workers is developed and maintained.

b) Circulation of a regular bulletin of health and related issues would also be a means of continuing education.

c) Distance education modules for learning on specific topics can also be developed and these would perhaps be the most cost effective means of education. Moreover the community health would not have to leave her place of work.

Recommendations (ix. and x.) would necessitate the mobilization of adequate resources for the same.

VIII.2. SPECIFIC RECOMMENDATIONS

As a recommendation to the training programme details itself, "A Modified Schedule" of the community health workers course has been drawn up and is presented. (See appendix)

The modified scheduled envisages a total duration of 12 weeks. All the 12 weeks are residential in the field.

All topics to be taught have been converted into problems that are commonly expressed by community health workers. Thus a problem solving approach must be adopted in these sessions.

A systems approach has been adopted and thus human biology has been integrated with first aid and care in minor ailments, communicable disease control with lab diagnosis for the same.

Within the systems approach a life-cycle approach has been adopted. Thus one begins with conception and a pregnant mother then deals with infant, growing child, an adolescent, an adult and finally the aged. This enables a health oriented approach rather than a diseases or problem based approach.

Duration of each sessions has not been specified. However, it departs from the routine of hourly sessions and is restricted to a minimum of only 3 sessions or less per day. It is proposed that these three sessions be of Three, two, and one hour duration respectively on each day. Thus there will be an average of about six hours of training each day except on Saturdays where

only one session will be conducted and Sunday where there will be no session.

This enables more participatory learning through exercises or group discussions, which are not feasible in hourly sessions of previous years.

In addition it decreases the frequency of rotation of faculty and this has a dual benefit for both trainers and trainees. Trainees are not rapidly changed over from one topic to another and total number of trainers required for a days teaching sessions is also reduced - only one or two trainers are necessary for the entire days session.

This would not be burdensome to the trainer as the trainer is expected to facilitate a process of learning and not "to teach" .

Flexibility has been allowed not only by granting open sessions but also by permitting inter change of sessions on any given specified day. It has been the experience that rural folk are usually unavailable during the mid morning hours. Field visits may thus be shifted to afternoon or dusk sessions and the number of hours modified accordingly.

Modular forms of training have been introduced especially for topics related to maternal and child health , including diarrhoea and ARI.

With regard to the content of training itself:

- Other systems of medicine have been restricted to formal and informal systems where skill development is feasible.

- More emphasis has been given on health planning and management and especially the use of participatory methods in the same.
lack of community participation was a commonly expressed (22.53%) problem in work.Participatory methods in Planning and Management especially through use of techniques such as "community mapping" may enable community health workers to overcome this difficulty.

- Formulation of an action plan proposal by mid course, to be implemented in the later weeks in the field has also been included in order to develop the skills of the community health worker in planning and management.35.21% of the community health workers expressed "lack of support" in the form of finance and materials.This training component would perhaps enable them to mobilise resources that are necessary.

- The need of urban areas and especially the urban slums has been included.

- More time has been devoted to Health education and Communication.

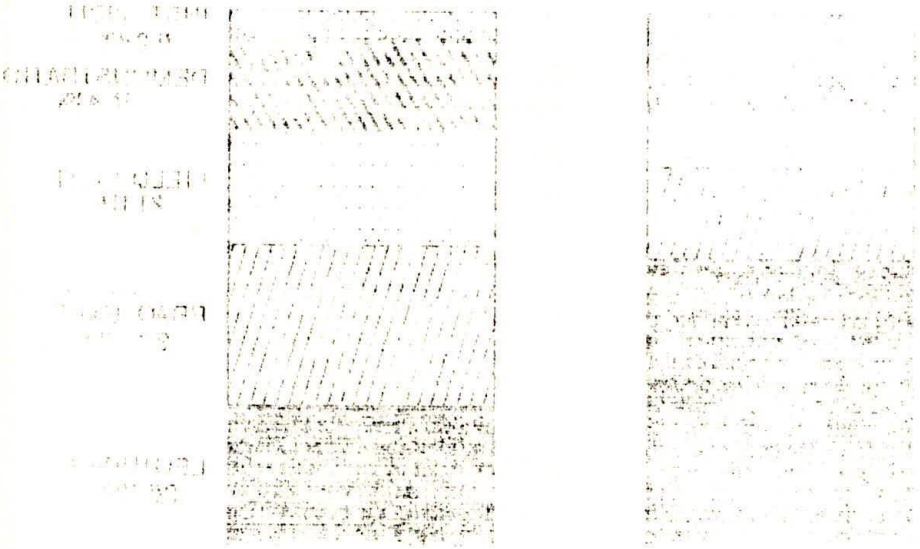
- Training in Communicable Disease Control has not only been integrated with lab diagnosis of the same but time has also been given for practice sessions.

- Training in epidemiology in health care has been included. This increases the value and credibility of the community health worker within the community by enabling the community health worker to explain the "how" and "why" of any given situation.(See appendix).

- The care of the aged has also been included into the curriculum.

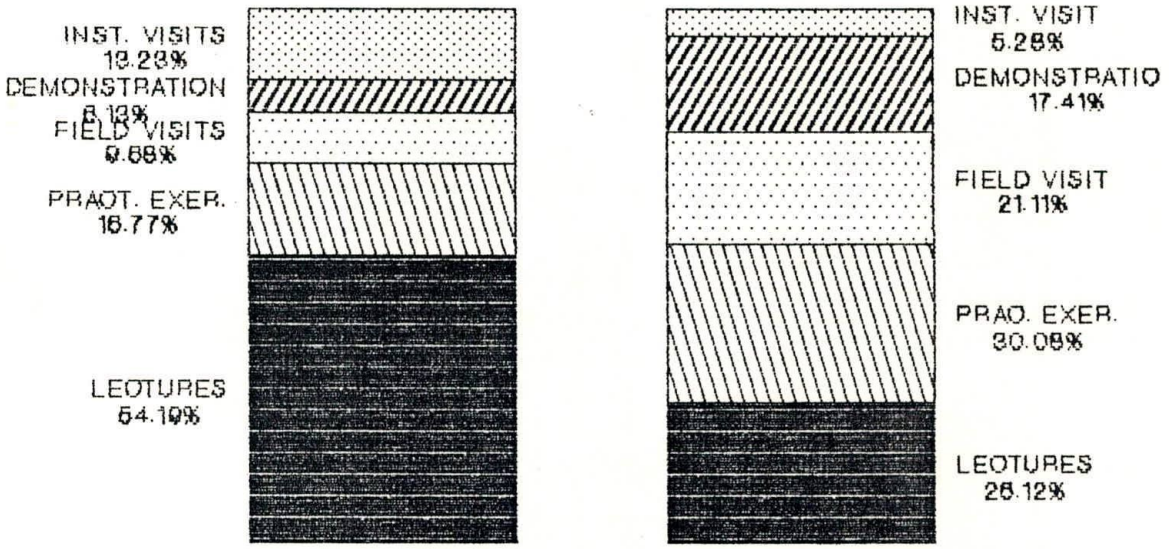
- Occupational health hazards of a rural community have been included instead of topics irrelevant in rural areas (example;ESI Act).

- Evaluation especially informal evaluation almost every week has been given a substantial proportion of time.



The proportion of time spent on the various teaching methods used in the year 1990 and in the modified schedule is represented in the diagram below.

VIII.a. METHOLOGY IN TRAINING
1990-COURSE Vs MODIFIED SCHEDULE



1990 COURSE MODIFIED SCHEDULE

PERCENTAGE DURATION CALCULATED IN HOURS

The modified schedule envisages only 26.12% of time to be spent on lectures.Other participatory methods of learning such as Practical exercises (30.88%), Demonstrations(21.11%), Supervised Field visits(17.41%), and Institutional visits(5.28%), are given emphasis.

Practical Exercises include; practice sessions, group dynamics/exercises,simulation games,individual or group assignments,role-plays,and use of modules for learning.

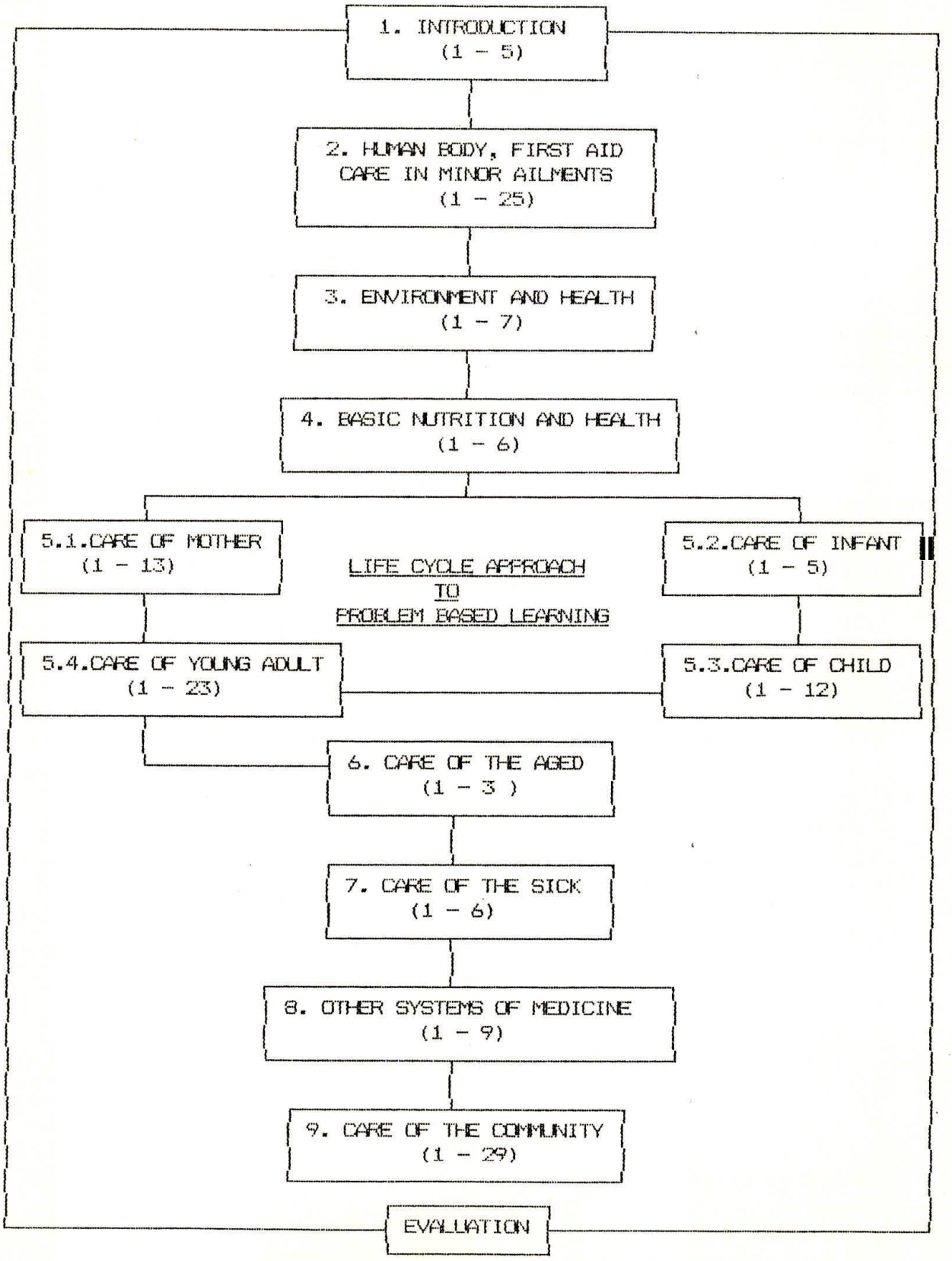
Demonstrations include; demonstration of procedures,laboratory and clinical demonstrations,and demonstration of training programs(TBA training).

Field visits include; Family studies, Mobile clinics, Field surveys, School health and Balawadi visits and activity,Field-based education programs and visits to Field based projects.

Institution visits include; visits to various Rehabilitation centres.

The Format of the Training is presented in the diagrams and the table.The details of the modified schedule are given in the appendix.

MODIFIED SCHEDULE FOR COMMUNITY HEALTH WORKER BASIC COURSE
SYSTEMS APPROACH TO PROBLEM BASED LEARNING



( ) : Indicates No. of sessions
"Child": Refers to pre school and school going.

MODIFIED SCHEDULE FOR COMMUNITY HEALTH WORKER BASIC COURSE

A SYSTEMS APPROACH TO PROBLEM BASED LEARNING

1. INTRODUCTION (1 - 5)

- Self introductions
- Experience sharing
- Role of CHWs
- Basic concepts in Health/Development

2. HUMAN BODY, FIRST AID CARE IN MINOR AILMENTS (1 - 25)

- Human biology
- First Aid
- Care in minor ailments

3. ENVIRONMENT & HEALTH (1 - 7)

- Housing
- Safe water
- Sanitation
- Role of vectors

4. BASIC NUTRITION AND HEALTH (1-69)

- Digestive system
- Basic foods
- Malnutrition
- Food safety
- Food toxins
- Food adulteration
- Anemia

7. CARE OF THE SICK (1 - 6)

7.1. Home Nursing
7.2. Essential drugs

6. CARE OF THE AGED (1 - 3)

- Social problems
- Medical problems

5.4. CARE OF YOUNG ADULT (1 - 23)

- Family Welfare
- Fertility awareness
- STD/AIDS
- Occupational Health
- Rheumatic fever
- Social problems
- COMMUNICABLE DISEASES

5.1. CARE OF MOTHER (1 - 13)

- Care in pregnancy
- Care in delivery
- Care of newly delivered
- TBA training

LIFE-CYCLE APPROACH

8. OTHER SYSTEMS OF MEDICINE (1 - 9)

- Acupressure (2)
- Herbal Medicine(4)
- Home remedies (3)

9. CARE OF THE COMMUNITY (1 - 29)

9.1. Health Education & Communication (6)
9.2. Health care delivery (5)
9.3. Rehabilitation(6)
9.4. Health Planning & management (12)

5.3. CARE OF CHILD (1 - 12)

- Diarrhoea
- A R I
- Worm infestation
- Immun. coverage
- Nutrition assessment
- School health
- Health education

5.2. CARE OF INFANT (1 - 5)

- Neonatal care
- Infant feeding
- Growth monitoring
- Immunisation

E V A L U A T I O N

MODIFIED COURSE SCHEDULE FOR COMMUNITY HEALTH WORKERS

SL. NO.	T O P I C	%AGE COV.	LECT URES (c)	PRACT. EXER. (p)	FIELD VISIT (F)	INST. VISIT (I)	DEMON. (D)
1.	Introduction	3.17	5	7	—	—	—
2.	Human body, First aid care in minor ailments	14.78	24	7	9	—	16
3.	Environment & Health	3.69	5	—	3	2	4
4.	Nutrition & Health	3.69	5	—	3	—	6
5.1.	Care of mother	7.39	7	5	3	—	13
5.2	Care of Infant	4.22	8	5	—	—	3
5.3.	Care of child	8.97	3	17	10	2	2
5.4	Care of young adult	13.72	23	5	11	—	13
6.	Care of Aged	1.58	2	1	3	—	—
7.	Care of Sick	2.90	—	3	—	—	8
8.	Other systems of Medicine	6.33	2	11	—	—	11
9.	Care of community						
9.1.	Health education	3.96	3	9	3	—	—
9.2.	Health care delivery	5.28	2	6	12	—	—
9.3.	Rehabilitation	4.75	2	—	—	16	—
9.4.	Health planning & management	8.18	3	12	12	—	4
10.	Evaluation	7.39	5	23	—	—	—
	TOTAL	100.00	99	111	69	20	80
	%age	100.00	26.12	29.29	18.21	5.28	21.10

Foot note: The percentage is calculated on the basis of number of teaching hours versus the total number of hours for supervised training.

Total No. of teaching hours = 379, which is about 31.58 hours per week or 5.26 hours per day for six days a week.

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COURSE SCHEDULE FOR COMMUNITY HEALTH WORKERS

WEEK - I

DAY	SESSION - I	SESSION - II	SESSION - III
Monday	1.1(p) Prayer - Inauguration From known to unknown (self introduction/ group introduction) Experience sharing Expectation from course	1.2 (c) How much do we know (Pre test) What will we learn (Plan of the course) What must we do as CHWs (Role of the CHWs)	Settling in
Tuesday	1.3(c) Why health & develop- ment together? Why do we fall ill? Can we prevent illness?	1.4(p) — MONSOONS — — (Simulation Game)	1.5(p) Assignment (Preparation of charts on the days teaching)
Wed.	9.1.1.(p) How must we communicate with one another (Communication exercises)	9.1.2.(c) Communication skills How can we interview families	9.1.3.(p) Role play
Thurs.	2.1(c) What is First Aid History taking? What is a symptom/sign	2.2(D) Our skeletal framework Muscles we work with Fractures: Why & What do we do?	2.3(p) How do we apply slings and splints (Individual exercise)
Friday	2.4(c) How and why does the heart beat How and why we breathe (structure and function of circulatory and Respiratory system)	2.5(D) Can our breathing stop if the heart fails to beat. (Demonstration of cardio pulmonary resuscitation)	2.6(D) How do we transport an injured person?
Saturday	WEEKLY EVALUATION [10.1(c)]		

WEEK - II

DAY	SESSION - I	SESSION - II	SESSION - III
Mon.	2.7(D) Why and how does bleeding occur Cuts, Bruises,wounds what do we do.	2.8(D) What is blood transfusion (Demonstration of blood grouping and typing)	2.9(p) Dressings and Bandages (Individual supervised exercise)
Tues.	2.10(c) How does our skin protect us? Common skin diseases	2.11(c) Burn/scald what will we do?	2.12(c) Poisoning What do we do?
Wed.	2.13(c) A person: Unconscious With stroke With fits Why & What do we do	2.14(D) Headaches, if the head is injured Why and What do we do?	2.15(p) Head bandages (Individual supervised exercise)
Thurs.	2.16(c) How do we see (structure and function of the eye) What are sore eyes If eye gets injured	2.17(D) Why do we wear spectacles? How do we test for vision?	2.18(c) Foreign body in the ear An infected ear If the nose bleeds Sore throat Why and what do we do?
Fri.	9.3.1(I) What is blindness? Can it be prevented? (visit to blind school)	9.3.2(I) Can we prevent deafness Visit to Institute of speech and hearing.	2.19(c) What does our Kidney do? Common urinary problems
Sat.	2.20(c) Diseases we get from Animals. Dog bite, snake bite What do we do? WEEKLY EVALUATION [10.2.(c)]		

WEEK - III

DAY	SESSION - I	SESSION - II	SESSION - III
Mon.	3.1(F) Field study / Mobile/ MCH CLINIC	3.2(c) Housing: What role does it play on Health	3.3(c) Do insects transmit disease - How can we prevent and control?
Tues.	3.4(D) How can we dispose of solid/liquid wastes? (Soakage pit / compost pit)	3.5(I) Visit to station health organisation or demonstration of environmental models.	
Wed.	Field study / Mobile/ Dispensary {2.22(p)}	3.6(c) What diseases can we get from drinking impure water - How can we prevent them?	3.7(D) How do we purify water? Demonstration of chlorination of well
Thurs.	4.1(F) Field study on nutrition (Food habits, infant feeding practices, foods grown and consumed.....)		4.2(c) Fate of the food we eat (Digestive system) What foods should we eat & why?
* Fri.	4.3(D) Consequences of eating less.....	4.4(D) How do we keep food safe? (Food hygiene, food preservation).	4.5(D) Can certain foods be harmful? (Food toxins) What is food adulteration?
Sat.	4.6(c) What is anemia - How can we prevent it?		

WEEKLY EVALUATION [10.3.(c)]

(Field study/ mobile clinic/ dispensary/ MCH clinic small batches in rotation.

WEEK - IV

DAY	SESSION - I	SESSION - II	SESSION - III
Mon.	5.2.3.(p) Nutrition Demonstration (How should an infant be fed)	5.2.4.(c) How do we know if one is eating well.	5.2.5.(D) Road to health card
Tues.	- - - - - - - - - - - - -	5.3.3.(p) Module on diarrhoea	- - - - - - - - -
Wed.	- - - - - - - - - - - - -	5.3.4.(p) Module on ARI - - - - — — - —	- - - -
Thurs.	5.2.6.(P) Preventing specific disease by immunisation (Domm. PHC)	5.2.7.(c) Six killer diseases in children	5.2.8.(D) Video film
Fri.	5.3.1.(F) Immunization coverage - Field study		5.3.2.(p) Evaluation of Immunization programme
Sat.	10.5.(p) PROJECT PRESENTATION		

WEEK V

DAY	SESSION - I	SESSION - II	SESSION - III
Tues.	5.1.1.(p) Care during pregnancy	5.1.2.(D) Lab. tests in pregnancy	5.1.3.(p) Practice of tests
Wed.	5.1.4.(D) MCH clinic/Dispensary (Mallur)	5.1.5.(c) How a child is born? Care during delivery	5.1.6.(D) Video film
Thurs.	2.24(p) MCH clinic/Mobile (Dommasandra) clinic.	5.1.7.(c)& 5.2.1.(c) Care of newly delivered mother Care of the newborn baby	5.1.8.(D) Video film
Fri.	MCH clinic/Mobile (Kalkunta agrahara)	5.1.10.(D) TBA contact training program	5.1.11(c) Discussion
Sat.	10.4.(p) Weekly evaluation PROJECT PRESENTATION		

WEEK – VI

DAY	SESSION – I	SESSION – II	SESSION – III
Mon.		MCH CLINIC (MUGALUR)	
Tues.	5.3.5.(p) Nutrition demonstration II	5.3.6.(D) Child passing worms Common stool tests	
Wed.	5.3.8.(F) Nutrition assessment: How & Why? (Balwadi)	5.3.7.(p) Practice of stool tests	5.3.9.(C) Caring for school children
Thurs.	5.3.10 (F) School health program	5.3.11(c) Common diseases among children? What do we do?	9.1.4.(p) Child to child program (preparation)
Fri.	9.1.4.(p) Child to Child programme (Conduct)	9.1.5.(c) Child to Child programme (Evaluation)	5.1.12(c) Registers for MCH Preparation of MCH
SAT.	9.4.1.(p) Action plan format		

WEEK - VII

DAY	SESSION - I	SESSION - II	SESSION - III
Mon.	5.4.1.(F) Family Welfare - Field study	5.4.2.(c) Discussion	5.4.3.(c) Population explosion What does it signify?
Tues.	5.4.4.(c)	5.4.5.(D) - - - - - - - - - - Fertility awareness - - - - - - - - - - Sr. Augostina Thomas	
Wed.	5.4.6.(c)	5.4.7.(D) - - - - - - - - - - Fertility awareness - - - - - - - - - - Sr. Augostina Thomas	
Thurs.	5.4.8.(p) Health Education in Family Welfare-Field	5.4.9.(c) If one is indisciplined in sex.(STD/AIDS)	5.4.10.(D) Other methods of contraception
Fri.	5.4.11.(F) Occupational hazards of a rural community	5.4.12.(c) Discussion	Project preparation
Sat.	10.6.(p) PROJECT PRESENTATION		

WEEK - VIII

DAY	SESSION - I	SESSION - II	SESSION - III
Mon.	5.4.14.(F) Social problems in young adults	5.4.13.(c) Rheumatic fever Who does it effect? How can we prevent?	5.4.15.(C) What is leprosy How can we prevent and control
Tues.	5.4.16.(F) Leprosy survey -field	5.4.17(c) What is Tuberculosis? How can we prevent & control?	
Wed.	5.4.18.(D) Lab Tests (skin smear for Leprosy)	5.4.19.(D) Lab tests (Sputum for AFB)	5.4.20.(p) Practice
Thurs.	5.4.21.(D) Lab Tests (Smear for MP/MF)	5.4.22.(c) Fevers, what to do? Malaria, Filaria: What to do?	5.4.23.(p) Practice of Tests & continue theory session.
Fri.	6.1.(F) Care of the aged. (field study)	6.2.(c) Diseases of lifestyle	6.3.(p) Discussion
Sat.	10.7.(p) PROJECT PRESENTATION		

WEEK - IX

DAY	SESSION - I	SESSION - II	SESSION - III
Mon.	8.1.(D)	8.2.(p) Acupressure and Health Dr. Shirdi Prasad	
Tues.	8.3.(c)	8.4.(D) Home remedies Dr. Shirdi Prasad	8.5.(p)
Wed.	9.3.3.(I) Rehabilitation of physically handicapped (visit to APH and visit to Spastic society)		9.3.4.(c) Discussion
Thurs.	9.2.1.(F) Visit to Community development centre (ASTRA)	Role of the Church in delivery of Health care Fr. Sebastian	
Fri.	9.3.5.(I) Rehabilitation of mentally handicapped (visit to NIMHANS/Child guidance clinic/Sakalawara)		9.3.5.(c) Mental health & primary health care.
27/11/93 Sat.	10.8.(c) WEEKLY EVALUATION		

WEEK - X

DAY	SESSION - I	SESSION - II	SESSION - III
Mon	7.1.1.(D) Home nursing: Measurement of temperature, pulse, respiratory rate, blood pressure Administration of medicines: Oral tablets/syrup/drops	7.1.2.(p) Injections IM/ID/SC/IV	
Tues	Cold compress, steam inhalation, hot formentation, Mouth wash, gargling, application of eye and ear drops cleaning and dressing of wounds and ulcers (Demonstration and individual supervised exercise)		
	7.1.3.(D)	7.1.4.(p)	
Wed.	8.6.(D)	8.7.(p) Herbal Medicine and Health	
Thurs.	8.8.(D)	8.9.(p) Herbal Medicine and Health	
Fri.	7.2.1.(D) Village Kit box (Demonstration)	7.2.2.(D) Allopathy common drugs used	
4/12/93 Sat.	10.9.(p) Role of indigenous systems of medicines (DEBATE)		

WEEK - XI

DAY	SESSION - I	SESSION - II	SESSION - III
Mon.	9.4.1.(F) - - - - - - - - -	9.4.2.(D) Community study problems/need/resources - - - - - - (Social mapping)	
Tues.	9.4.3.(F) Identification of leaders	9.4.4.(p) - - - - - " CHICKANAHALLI" - - - - - - - (Simulation game)	
Wed.	9.4.5.(D) Body mapping	9.4.6.(p) ——Role of Women in Health & Development- - - - (Mahila vikas)	
Thurs.	9.4.7.(P) ——— " CHAINS " - - (Simulation game)	9.4.8.(F) Urban slum need assessment	
Fri.	9.4.9.(F) Measurement of health status of a community	9.4.10.(c) Epidemiology in Health care (Maintenance of records and registers)	
Sat.	10.10.(p) PROJECT PRESENTATION		

WEEK - XII

DAY	SESSION - I	SESSION - II	SESSION - III
Mon.	9.2.1.(c) Health care delivery in India.	9.2.2.(p) Study of PHC : Structure, function, organisation staffing	
Tues.	9.2.3.(F) Working with field staff of PHC		9.2.4.(p) National Health programme at PHC
Wed.	9.2.5.(I) Working through cooperatives (Visit to Mallur Health Cooperative)		Community participation in Health care and planning.
Thurs.	- - - Planning, Management and	9.4.11.(c) 9.4.10.(c) Evaluation of a health programme	- - - -
Fri.	10.11.(c) & 10.12.(p) How much do we know? Final evaluation	Evaluation of the Course	Action plan for the year
Sat.	- - - - - VALEDICTORY FUNCTION - - - - - - -		

RGW **Dr Dara S. Amar**

Com M 10.15

REFRESHER COURSE FOR COMMUNITY HEALTH WORKERS - REPORT (16th TO 28th AUGUST 1993)

- Dr REYNOLD WASHINGTON

After almost a decade, a **REFRESHER COURSE** for **COMMUNITY HEALTH WORKERS** trained between **1981 and 1991**, was conducted in our **COMMUNITY HEALTH TRAINING CENTRE, at MUGALUR**, from the 16th to the 28th of August 1993. This is envisaged to be the first step towards a **CONTINUING EDUCATION PROGRAM** for the community health workers , a glaring lacuna in the Training program thus far, as evident from the Evaluation study done on training during the decade 1981-1990.

A total number of 17 community health workers attended the course. The response of the "religious sisters" was however unexpectedly poor, and "religious" made up less than 25% of the total number of participants for the course.

The participants had come from different regions in the country, including Madhya Pradesh, Delhi, Karnataka, Kerala and Tamil Nadu , representing alumni from 1982, 1985, 1989, 1990 and 91. All of them were actively involved in different forms of community health and development activity in their respective areas of work.

The **course content included:** Control of communicable diseases, including ~~the dreaded~~ AIDS, Health planning and Management including techniques of Participatory Rural Appraisal, Health Education Materials and Methods, Herbal Medicines and an update on the use of common drugs, an integrated approach to the problems of Mother and Child through an overview of the Child Survival and Safe Motherhood Program, Nutrition Intervention and

Nutrition Education, Community development and Project Planning. Much time was devoted specifically and concurrently during sessions to "experience sharing" among the participants.

The whole course was conducted by the faculty of the department of Community health, to the exclusion of Fr. Joseph Chitoor for Herbal Medicines. All topics were taught by a team of resource personnel; Doctor : Social Scientist/worker, Doctor : Lab. technician, or Doctor : Doctor combinations as relevant.

The methods adopted during training included, use of Modules, Role-plays, Case- studies, Demonstrations both classroom and field-based, Field studies at Family and community level, Group discussions and Group exercises, in addition to classroom based lecture-discussions. The course was **totally residential** in the Training centre.

A feedback evaluation from the 17 participants, both in the form of a **formal semi-structured questionnaire** and through an **informal classroom discussion** which specifically dealt with each session with regard to the content, methodology adopted, time spent, place of training and the clarity of the staff, was conducted. The former gave a broad overview of the total course; its content, relevance, duration and organisation, and the latter was useful for individual topic and staff development. The course concluded with a short and entertaining Valedictory session.

A brief report of the Formal feedback is presented graphically. The Informal Feedback has been communicated individually to each staff.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE 560 034

TENTATIVE SCHEDULE FOR REFRESHER COURSE

Community Health Workers (16 - 28 August, 1993)

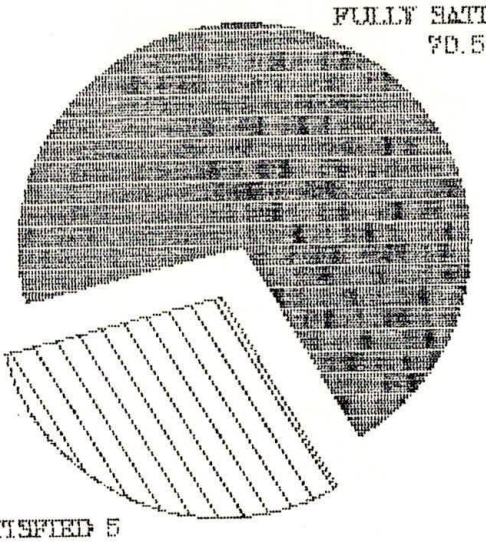
Date/Day	I	II & III
16.8.93 Monday	Settling in and Course expectations -RGW/RMC	Control of Diarrhoeal diseases Modular Training -RGW/RMC
17.8.93 Tuesday	Communicable Disease Control How do we prevent & control AIDS? - RGW/RMC	How do we prevent & control? TB/Leprosy/Malaria - (includes lab. demonstration) - PM/JM
18.8.93 Wednesday	Control of ARI Modular Training -PM/JM	How do we prevent & control? TB/Leprosy/Malaria - (includes lab. demonstration) - PM/JM
.9.8.93 Thursday	Health Planning & Management Evaluation of Health status of a community - PM/MIQ/MG	PRA Techniques: -Social Mapping/Focussed interviews/Body mapping/ demonstration -MG/MIQ
20.8.93	Conduct of Child-to-Child programme at school/ community -MG/MIQ	Nutrition Demonstration in the Community - practicals - MIQ/MG
21.8.93 Saturday	Experience sharing -DSA/MG/MIQ/AK	Herbal Medicine -AK/Fr. J. Chitoor
22.8.93 Sunday	Herbal Medicine - Fr. Joseph Chitoor/AK	
23.8.93 Monday	Health Education Materials & Media -BJ/DM/RMC (exercise)	Update on Common Drugs - BJ/DM
24.8.93 Tuesday	CSSM Programme Modular Training Interventions for the Child	- BJ/DM
25.8.93 Wednesday	Participation in Maternal & Child Health clinic activities - KRMT/CS (Mallur MCH clinic)	Common problems among women (Medical) - KRMT/CS
26.8.93 Thursday	CSSM Programme Modular Training Interventions for the Mother - KRMT/CS	Nutrition assessment of a community - KRMT/CS
27.8.93 Friday	Community Development Interventions- LB/RMC/RGW	Project planning for individual participants - LB/RGW
28.8.93 Saturday	Evaluation & Valedictory - All Faculty	

28.7.93

DR. DARA S AMAR
Professor & Head

RGW/as

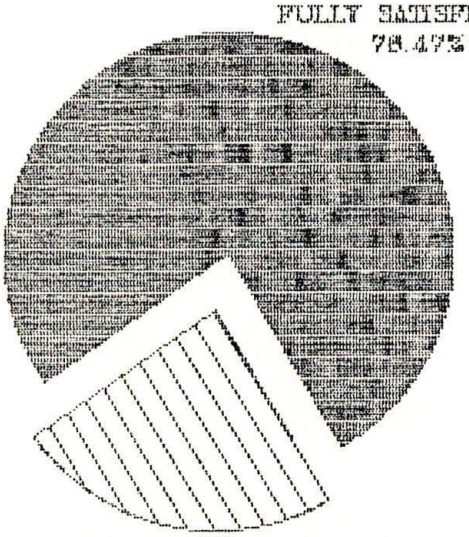
SATISFACTION OF CHWs (CONTENT OF COURSE)



DISSATISFACTION: CONTENT INADEQUATE, LACK OF PRACTICALS, MATERIALS, EXAMPLES

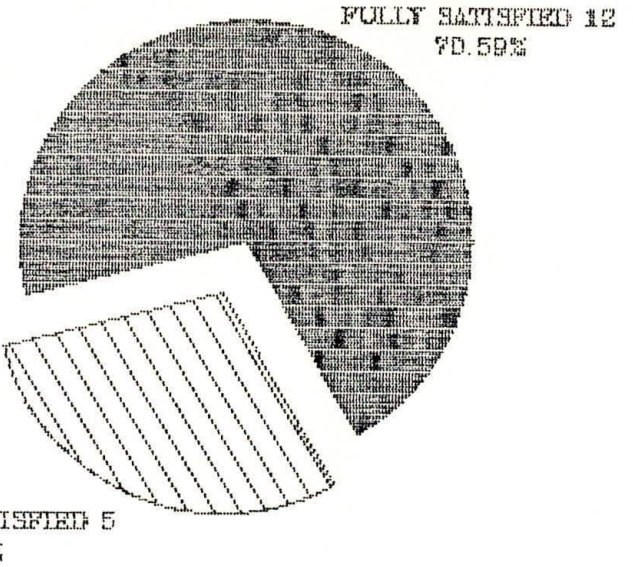
TOTAL=17

SATISFACTION OF CHWs (RELEVANCE TO WORK)



TOTAL=17

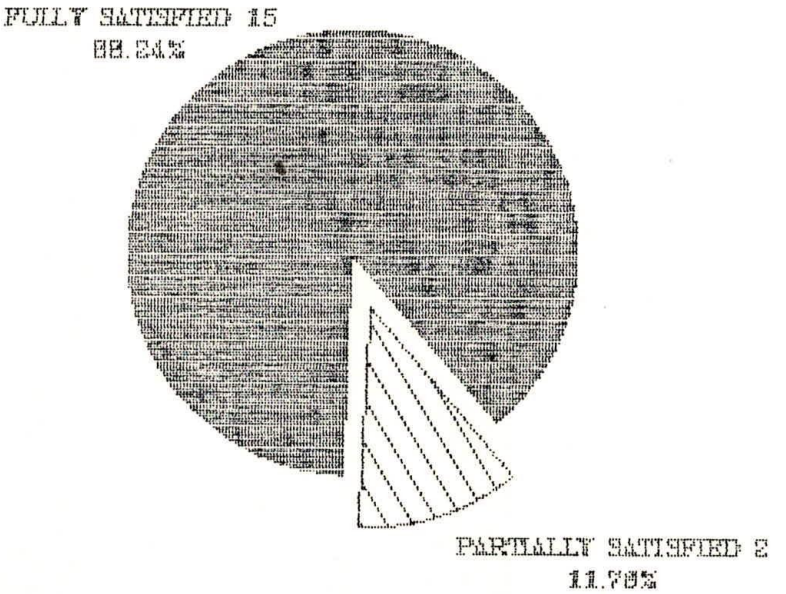
SATISFACTION OF CHWs
(ORGANISATION OF COURSE)



DISSATISFACTION: FIELD VISITS TOO FAR
GROUP DYNAMICS NOT USED APPROPRIATELY

TOTAL=17

SATISFACTION OF CHWs
(LODGING FACILITIES)



DISSATISFACTION:
FOOD, WATER & ELECTRICITY SUPPLY.

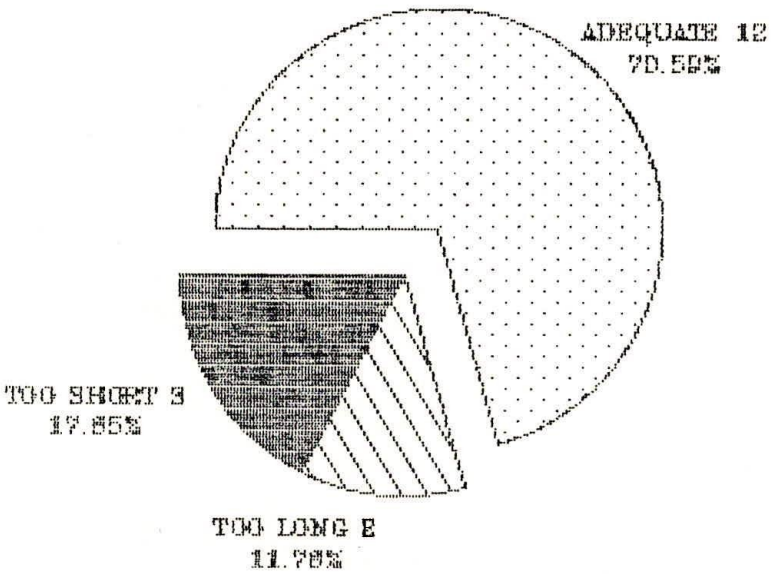
TOTAL=17

TOPICS OF IMPORTANCE COVERED DURING COMMUNITY HEALTH WORKER-REFRESHER COURSE

GREATEST IMPORTANCE	LEAST IMPORTANT
1) Maternal and Child Health	1) P.R.A. Techniques
2) Child to Child	2) Herbal medicines
3) Communicable Disease control	3) (Malaria)
4) CSSM Program	4) Health status eval/
5) Nutrition	Update on drugs/
6) Health Education	Project proposal

TOTAL=17 (IN ORDER OF COMMONALITY OF RESPONSE)

OPINION OF CHWs (DURATION OF COURSE)



TOTAL=17

TOPICS INADEQUATELY COVERED DURING REFRESHER COURSE FOR CHWs

NOT AT ALL COVERED

1) Women and Development

INADEQUATELY COVERED

1) Project proposal
2) Community development
3) Maternal & Child Health
4) Child to Child/ PRA
5) ARI/ CSSM/Herbal Medicine

TOTAL=17 (IN ORDER OF COMMONALITY OF RESPONSE)

CHANGES IN REFRESHER COURSE RECOMMENDED BY TRAINEES TO MAKE IT MORE USEFUL

1) Training to include more practical exercises and to allow more practical experience.
2) More demonstrations to be included.
3) Field visits to be more practical oriented and not to be too distant from centre.
4) Games to be organised during free time.
5) More songs to liven up sessions.
6) Group activities/responsibilities to be alloted. (classroom cleaning/ washing/ etc.)
7) Participants to arrive one day before the course.
8) Group discussions using homogenous groups and heterogenous groups depending on the issue discussed. (homogeinity with regard to type of work involved in)
9) More time to be given for experience sharing and this to be done at the beginning of the course.
10) Hand-outs in simple language to be given for all topics.

TOTAL = 17

Com H 10.14

REPORT OF COMMUNITY HEALTH WORKERS BASIC COURSE -28

RECOMMENDATIONS BASED ON FEEDBACK FROM CHW TRAINEES FOR FUTURE COURSES

STRUCTURE AND ORGANISATION

1) Course to begin on a Tuesday to prevent confusion as to how to transport the CHWs to the Training Centre.

2) Course must be more structured. A lot of time wasted waiting for staff to arrive, between sessions, and during the evenings.

3) A Library is an essential pre-requisite to enable more self-learning. In the absence of relevant reading material, assignments that could have been given are impossible to complete satisfactorily.

4) There must be more facility for recreation and relaxing. Provision of more facilities for indoor games and light informative reading material would be suitable for the CHW age group.

5) Adequate sitting arrangements must be provided for in the classroom. While sitting on the floor on mats may be culturally appropriate, it is uncomfortable when the duration extends to three months, especially for the more elderly.

6) Vehicle movements must be co-ordinated better. There were so many vehicles moving up and down everyday, yet no vehicle available when actually needed.

7) Staff movements (change from one to another) have been too frequent and often unpredictable.

8) A single co-ordinator for the entire course is necessary to ensure that the course is proceeding according to plan. A faculty resident for at least a week or a learning block would alternately suit the purpose.

9) The RMO was very approachable and helpful at any given moment. However the same could not be said of the interns who were not only unapproachable but also very condescending in their attitude.

TEACHING LEARNING PROCESS:

1) Language has been a barrier to learning. Staff must be urged to use more simple language. Besides since the group itself was heterogenous as far as language is concerned,communication through "sharing sessions" did not really make headway.

2) During the field sessions:
- supervision was grossly inadequate. Very often briefing itself was not adequate and CHWs were at a loss as to what exactly they were expected to learn from the field situation.
- language was a barrier , since only three were very conversant with Kannada.
- the visits to far off places may be reconsidered as the benefit derived from these visits were not as much as the effort and time expended, leave alone the cost.

3) It is necessary that individual and group written assignments be given throughout the course. A Library is a necessary pre-requisite.

4) Practical exercises especially with regard to individual care for minor ailments were inadequate. Though the Mugalur centre was dealing with such cases, unless the CHWs are formally posted to the various sections in the centre (Lab., Injections, Dressing) they are unlikely to utilise the opportunity provided.

5) There must be more sessions using "modules" as teaching aids. The module on diarrhoea was well appreciated but the module on ARI requires that more copies be produced for distribution. Appropriate modules may be developed, or acquired if already available, for other important topics.

6) Use of Audio visual aids was restricted to the use of the blackboard and occasional use of the slide projector. The use of other aids as video films could be useful. Preparation and use of simple audio-visual aids that will be available and useful within the community that the CHW works in must be taught.

7) Lectures must be made shorter and more assignments may be given.

8) Simulation games must be conducted more slowly to enable every individual to participate more fully.

9) There were contradictory opinions from different teachers on the same topic in a few instances. This resulted in confusion. This could be avoided if the staff themselves clarify these issues.

10) It would be preferable if one entire learning block is conducted by a single staff or a single team of staff. This would reduce frequency of change, vehicle movement and would prevent contradictory messages on topics.

11) Reduce the actual number of faculty directly responsible for teaching to ensure continuity with a given **block.**

12) Topics must be done sequentially as planned irrespective of change in staff to suit individual convenience. Staff wanting to make changes with regard to their residential posting must ensure that there is no ~~drastic~~ change in the schedule of teaching.

13) The total duration of the course could be reduced to about 10 weeks to cover everything that is being taught at the moment.

EVALUATION PROCESS:

1) Concurrent Evaluation during the course must be through both written and oral questioning. It must be done at the end of every "subject block".

2) Weekly evaluations on Saturdays were conducted only twice. These must be conducted with more ~~diligence~~ REGULARITY and must also be better structured.

3) During the "Project presentations" it would be more useful and encouraging if more faculty attended. The presence of the faculty responsible for teaching

1 appreciated but the module on ARI requires that more copies
be produced for distribution. Appropriate modules may be deve
or
acquired if a

the concerned topic is mandatory.

SPECIFIC SESSIONS:

1) The exposure to MCH clinics and the PHC were very comprehensive and useful. Only the visit to Mallur was a little too distant and tiring.

2) Laboratory tests require more demonstration and practice. It is advisable that they be conducted by a team of Doctor and Lab. technician to ensure greater applicability of the tests.

3) The time alloted to the "Other systems of Medicine" must be increased to allow more time for practice. The session on "Preparation of Mixtures and Ointments" may be either conducted by dept. staff themselves or totally left out.

4) The visit to NIMHANS was not useful. The session was too theoretical, and at a level too high for comprehension of the CHWs.

5) The visit to the "Station Health Organisation" was not relevant to the rural situation at all.

6) The session on "Poultry Training" was a waste of time as only a few could understand Kannada. To make matters worse the session was repeated. The training could be conducted by the dept. staff itself in a language understood by all.

7) The Session on "TBA Training " was very useful both in its content and in reinforcing appropriate methods of training.

8) More time to be alloted to the "Update on Common Drugs".

9) More time to be spent in explaining anatomy. While very beautiful charts were used it was difficult to visualise reality. The visit to the Anatomy Museum may therefore be reintroduced. Appropriate models may also be used.

10) The session on "Natural Family Planning" was very useful but requires more time.

11) "Role of the Church" was totally irrevelant in the mixed group of CHWs.

12) "Population Explosion" was ~~not only~~ not understood, ~~but also irrevelent~~ in ~~the given session~~. A social analysis of the country would be more appropriate.

13) There must be more time for practice of "Home Nursing". This could be accomadated during the night sessions.

14) "Health Education - Materials and Media" was not conducted at all.

*15) A session on "Drug-abuse" to be included in the next schedule.

Com H 10.17

Paper on CHW & other training courses at the Dept. prepared for a CMAI workshop. R.S. Vaidyan

(Pl. ignore page numbers)

Condense for a box - half page printed. CM 18/7/94

COMMUNITY HEALTH WORKERS COURSE

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

HISTORICAL BACKGROUND AND EVOLUTION OF THE COURSE

In the years 1973 to 1976, the Dept. of Community Medicine had gained some experience in training and utilization of village workers in health care in two of their micro-level health care projects in the villages of Mallur and Silvepura.

1975: Srivastav report on medical education and support manpower recommended training of Community Based, Semi-professional, part time workers to provide a whole range of Basic Health Services.

1977: A perspective report to the Catholic Bishops Conference of India on St. John's Medical College in its subsection Looking to the future (31.4) an idea was mooted that the college should undertake the training of the seminarians as village health workers, in response to the Government of India proposal.

1977: World Health Organization brought out an experimental edition of a book called Primary Health Worker, which outlined various guidelines for training of personnel to intervene in health care at the most peripheral practicable level after simple training.

1977: Prof. S.V. Rama Rao of the Dept. of Community Medicine, outlined the broad and specific objectives of the course for primary level health workers.

1978: A cor in anum publication from Vatican on The new orientation of health services with respect to primary health care work helped in clarifing the Christian approach.

1978: Major Gen. Mahadevan, the newly appointed Director of Rural Health Services and Training Programmes, further outlined the Learning objectives of the course.

1978: St. John's Medical College involvement in Primary Health care work was given certain policy guidelines by the Dean and the Director of Rural Health Services. Dr. C.M. Francis, Dean, outlined further ten areas of expertise of participants of these courses to be organised in St. John's.

April 1978: The first pilot course for Community Health workers was held at St. John's Medical College and Hospital and Rural Centres for a duration of three months.

The course subsequently evolved both in content and training methodology.

In 1988 an attempt was made to integrate related topics. Thus a system was dealt with as a whole beginning with the Anatomy and Physiology, continuing with common ailments and minor injuries and their management or first aid respectively, and followed by pathology and preventive and promotive and curative measures for the same.

1991: All topics were converted into problems. The teaching schedule was now altered to include two three hour session per day in college and three sessions in the field. This did away with the hourly changes of staff and topic which was not conducive to student learning. This problem based teaching was also more practical since they raised issues that had been brought to light by CHWs in the past. The scientific approach problem based teaching also required a re-orientation of the staff in training methodology.

TO DATE

Total No. of courses conducted = 27
Total No. trained = 526
Usual intake per course - 18 to 25

SELECTION CRITERIA

Basic Qualification : S.S.L.C. or Equivalent

Those already engaged in Social Developmental and Health fields in peripheral areas.

Priest , Seminarians, Religious Sisters, sponsored by the congregation or Bishop.

Lay people sponsored by voluntary agencies engaged in developmental work.

Lay people in health team sponsored by congregation, Bishop or institution

Working Knowledge of English

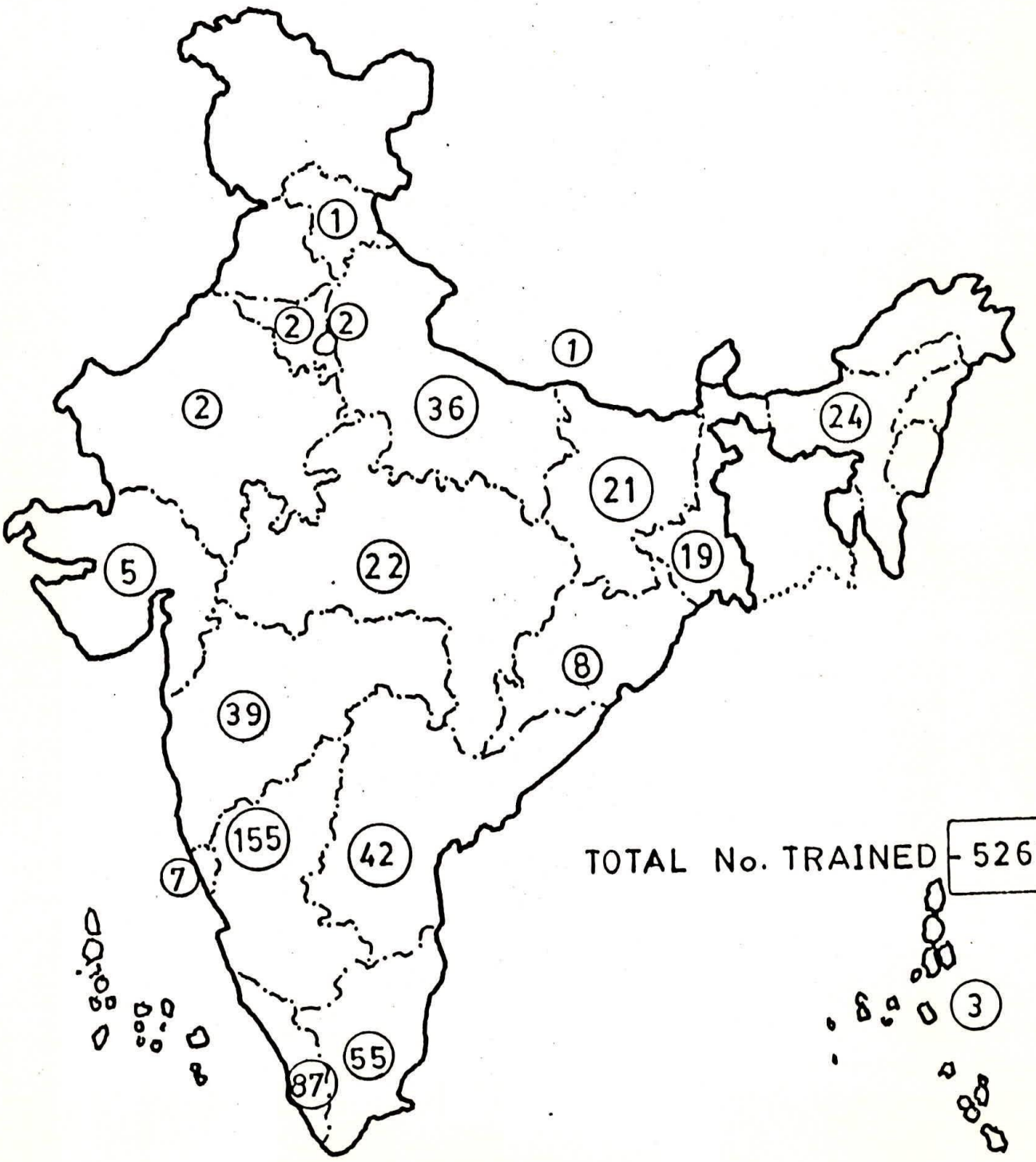
Exclusion criteria

Previous medical or nursing training

Inclusion criteria

Person from the same congregration or diocese
Person recommended by previous CHW trainee.

ADDRESS OF ORIGIN OF 27-BATCHES OF COMMUNITY HEALTH WORKERS (1978-1992)



TOTAL No. TRAINED - 526

GOAL

The Community Health Worker must:-

a) Determine the needs, problems and potentials in the community in the field of health.

b) Accord priority to community participation in Health services.

c) Provide primary health care when and where it is most needed.

OBJECTIVES

To enable the Community Health Workers to help their community in:

a) **Control of communicable diseases** by:
- preventing the spread of epidemics and notifying such diseases
- undertaking vaccinations as approved
- identifying, treating, advising and when necessary referring patients with communicable diseases.

b) **Provision of Maternal Care** by:
- identifying the pregnant women in the community, advising them and referring high-risk cases to the health centre or hospital.
- preparing for delivery, assistance at child birth, giving first care to the mother and the baby, calling for assistance or referring cases when necessary
- giving post-natal care, advice and family planning information

c) **Providing child care** for both well and badly fed children and promoting nutrition education.

d) **Giving first aid** in cases of burns, wounds, fractures, bites, and accidents and referring them when necessary.

e) Concerning himself with **environmental sanitation, health problems** by advising the community on water supply, excreta and waste disposal and food protection.

f) **Identifying community health problems** with a view to solve some of them.

g) **Measurement of health status** of a community using standard indicators of health

h) **Care in minor ailments** and referral for cases such as pains, intestinal worms, skin diseases, eye diseases, diseases of mouth and teeth, mental diseases, venereal diseases and head-aches.

i) Promoting health education trying to make each person and family, an agent for change for better health and health practices.

j) Community Development activities of various types including animal husbandry, agriculture, horticulture, poultry, piggery and so on, by discussing community problems with local leaders and working out solutions for improving the quality of life of the population.

k) Referring to appropriate centres all cases and problems outside or above his competence.

l) Maintaining basic medical records of vital events (Births and deaths in the Community.

COURSE CONTENT

1. Human Biology
2. First Aid and care in minor ailments
3. Nutrition
4. Immunization
5. Maternal and Child health
6. Natural Family Planning
7. Environmental Health
8. Control of Communicable and Non-communicable diseases
9. Health Education methods
10. Medical Records
11. Health planning and management
12. Statistics
13. Home Nursing
14. Simple laboratory procedures
15. Mental health
16. Occupational health
17. Traditional systems of medicine
18. Essential drugs
19. Role of the Church in health care
20. Conversational Kannada

Field level:

1. Primary Health Centre: Organisation, structure, functions staffing pattern and functions of staff.

2. Village family life, Community diagnosis, Community organisation, environmental sanitation,

3. Maternal and child health care services, school health, nutrition assessment.

4. Health education methods, organisational matters, Mobile clinic

METHODOLOGY

1. Didactic sessions
2. Lectures with audio-visual aids
3. Group discussions
4. Demonstrations and practicals
5. Simulation games
6. Role play
7. Learning by doing
8. Supervised field visits/field work
9. Visits to institutions
10 Visits to hospital and college departments
11. Work on the Mobile clinic.
12. Use of modules

(Audio-visual aids used commonly include, slides, chalk black board, over head projector, models and video films)

FACULTY AND INSTITUTIONS INVOLVED IN TRAINING

1. Faculty of Dept. of Community Health
2. Faculty of Dept. of Fertility and Family Welfare
3. Faculty of Clinical Departments (Dermatology, Eye, ENT)

(Visit to Anatomy Museum, and Blood Bank, SJMC)

Rehabilitation centres

1. Association for the physically handicapped
2. Spastic Society
3. Institute of Speech and Hearing
4. Sheil Kotwala school for deaf and dumb
5. Community mental health rehabilitation centre (Sakalawara, NIMHANS)
6. Child Guidance clinic (NIMHANS)

Development

1. Visit to Astra
2. Visit to Mallur Health Cooperative

Individual faculty

1. Dr. Shirdi Prasad: Accupressure and Homeopathy
2. Fr. Joseph Chittoor: Herbal Medicine
3. Dr. Ida : Ayurvedic Medicine
4. Mr. AK Roy: Health Care Administration

DURATION OF COURSE

The course is of twelve weeks duration. This is conducted twice a year commencing every July and October. Of the twelve weeks 8 weeks are institution based and four weeks rural based.

Note: From 1993 onwards the course is of twelve weeks duration totally rural based in our training centre in Mugalur. Only one course will be held every year in the month of October.

A two week Refresher course will be held for those who have completed the basic course and are actively involved in Community Health and Development work in peripheral areas. This course will also be rural based and will be conducted in the month of July.

EVALUATION

Evaluation is conducted both concurrently and terminally

Concurrent: Weekly/Fortnightly evaluation through feedback sessions and group discussion or project presentation.

Terminal: Written, oral and practical examination in First aid, written examination at the end of the course.

The trainees who have difficulty in writing their exam in English are allowed to use their own vernacular. Evaluation is conducted also through self and participant evaluation after giving them the expected answers.

STRENGTHS OF THE PROGRAMME

1. Wide coverage of topics with a firm foundation on basic concepts, thus strengthening conceptual thinking.

2. Problem based approach both during teaching and in evaluation.

3. Flexibility in schedule.

4. Balance between field based and institutional based learning.

5. Cordiality between staff and students very good.

6. Trainers are teachers of community health. Most of them have had experience in working in rural and backward areas.

7. Involvement of outside faculty and other institutions - especially for developmental processes and Other systems of Medicine, provides for wider coverage.

8. Firm selection criteria.

9. Relatively homogenous group of students, mostly religious.

10. Evaluations during and after the course have been conducted and necessary changes are made after each course.

WEAKNESSES OF THE PROGRAMME

1. Too many topics and hence skill based training giving way to more knowledge oriented training.

2. Not all trainers have been trained or exposed to problem based teaching

3. Frequent changes in the time table has been an expressed difficulty of learners.

4. Field training has been dependent on availability of the primary health centre.

5. Selection criteria has been relaxed in certain instances.

6. Institutional visits have not been found useful to many.

7. A chasm tends to divide the religious from the lay leading to unhealthy groupism within the class

8. No system of follow up after training.

9. No organised system of continuing education has been built up

10. No system of evaluation or indicators specified to assess impact of the community health workers services on the health status of the community - No conditions have been laid down as to the status after training.
    (The community health worker is often unsure where she will go to or what type of work she will be involved in after training.)

WAYS IN WHICH ATTITUDES ARE FOSTERED

1. Providing information
2. Providing role models
3. Providing experience
4. Providing discussions following an event
5. Role playing exercises.

Training of Auxiliary Health Workers

COURSE	FOR WHOM	DURATION	FREQUENCY	PLACE
a) Community Health Workers	X std Pass (basic qualification)	12 weeks	twice a year	8 weeks Institution 4 weeks field
b) Anganwadi Workers Training Program (Karnataka State Council for Child Welfare)	Anganwadi workers pre-placement & in-service	-	twice a month	Field based
c) Traditional Birth Attendants (TBAs)	TBAs of our field practice areas & of NGO(s)	-	ongoing	-
i) Contact Training Programme	-	One day		field based
ii) Regular Training	-	5 days		-"-
d) Health Animators Trg. Programme	Voluntary Workers from Community (NGOs)	-	ongoing	Field based
e) Health cum development workers training	Mahila vikas	-	on going	Field and Institution
f) Training of Change Agents	Mahila Vikas	-	ongoing	Field

Health Related Training Programs

COURSE	FOR WHOM	DURATION	FREQUENCY	PLACE
1) Health Management Trg. Workshop	Managers in the Plantations under UPASI	-	-	Field based (Plantations)
2) Food Hygiene Course	1) Hotel Managers & & Supervisors	10 days	on request	Institution based
	ii) Cooks & Servers	5 days	on request	Field based (hotels)
3) Teacher's Trg. Program	Rural School Teachers	One day	Once a month	Field based
4) Trg. Program on First Aid, Personal Hygiene, Home Nursing, Management of Common ailments	1) Deacons, Seminarians 2) (NGOs) 3) Plantation Staff	one week	On request	Institution based
5) Trg. in Occupational Health (detection of occupational hazards their prevention & control)	1) Small Scale Industries	1 day	twice a	Field based (factory)
6) Natural Family Planning Courses	- Medical & Nursing students - Community Health Workers - Health Animators	5 days	ongoing	Institution/ field based
7) Child-to-child ealth Education Programs	students/school teachers/ NGO	--	ongoing	field based
8) Group Motivation Programme for Parents of Spastic children	Parents of Spastics children	-	ongoing	Field based
9) Training in Public Health Laboratory Techniques	Plantation Nurses/ Compounders	--	ongoing	Plantations

Com H 10-18

DEPT. OF PREVENTIVE & SOCIAL MEDICINE
ST.JOHN'S MEDICAL COLLEGE, BANGALORE-34

Instructions to interns

1. Consumption of alcoholic beverages while the interns are posted for training to field health centres, is strictly prohibited.

2. The interns should not leave the health centre before 4.00 P.M. on Friday to attend Interns' Meeting on Saturdays, and they will be back at their post (Rural Health Centre) On Sunday night latest.

3. It is reported by the medical officer that the ante-natal cards, under-five clinic cards which are supplied at considerable cost and difficulty are being misused and wasted. The interns are requested not to indulge in such wasteful activities.

COMPULSORY ROTATING INTERNSHIP IN PREV & SOC MED: OBJECTIVES :

1. To give practical training to medical graduates in the administrative, preventive, promotive and clinical aspects of integrated health service in rural/urban areas.

2. To orient an intern to the social effects of illness on an individual and family, and the role of socio-economic factors in the causation of health and disease.

3. To orient an intern in the social dynamics of a community including dynamics of leadership, the motivation of a community and the various important factors of influencing leaders in the promotion/acceptance of health programmes.

4. To orient an intern in the organisation and management of a comprehensive health service for a community including environmental sanitation, immunization, health education and specific care of vulnerable groups.

5. To orient an intern to the concept of team work with para medical health workers.

6. To orient an intern to the working of the national health programmes at the primary health centre/village levels.

7. To expose the students to the role of voluntary agencies and other Government agencies in the promotion of health and welfare of the people.

PROGRAMME COMPONENTS

1. Participation in the preventive, promotive and curative services of a rural/urban health centre.

2. Participation in the activities of all categories of field staff in a primary health centre

3. Planning and undertaking of a community survey or an epidemiological project in the community

4. Planning and participation in an immunization and health education programme.

ALLOCATION

Urban posting – 4 weeks – National Tuberculosis Institute – 1 week
– City Family Planning Bureau – 2 weeks
– Action Group/Student Health Service – 1 week

Optional – Plantation Health Service – 4-6 weeks

REPORTS

A – from medical officer of health centre

i. attendance report

ii. Confidential report on conduct, attitude, motivation special aptitudes and quality of work done.

B – from intern

i. report of service responsibilities

ii. report of community survey/epidemiological project

iii. diary of weeks posting in primary health centre

DEPARTMENT OF PREVENTIVE AND SOCIAL MEDICINE

St. John's Medical College

Internship objectives expressed as specific knowledge, skills and attitudes to be learnt by each intern during 3 months posting in Rural Urban areas.

Knowledge

1. Knowledge about community, environment and diseases with health problems, Role of individual members in the community.

2. Knowledge about political structure and community health set ups at local, block, district, state, national and international levels. Orientation of administrative set up for all National Health Programmes.

3. Knowledge about community development and welfare agencies and their respective roles in relation to agriculture and health programmes.

4. Knowledge about functions of Primary Health Centres and national health programmes, keeping adequate statistical records and interpretations of Health Indices.

5. Knowledge about Social dynamics of the community, socio economic, literacy, cultura l, geographical and communication aspects of rural areas especially in his region of work - Dynamics of leadership, motivation of community in health activities.

6. Knowledge about diagnosis and management of communicable, nutritional and other common diseases.

7. Concept of team work and knowledge of roles of various paramedical workers.

8. Basic knowledge of health administration including management techniques like cost/effectiveness, personnel management, etc.

9. Administrative aspects of running the Primary Health Centre - Purcahse of drugs, basic equipments, cost of diet - utilisation of allotted budget to the best advantage.

10. Meet villagers, participate in village committee meetings (atleast health committee) and participation. Role of village teacher and village level workers and getting familiar with other village development activities.

i) Case detection
ii) Notification
iii) Surveillance
iv) Contact tracing
v) Immunization
vi) Concurrent and terminal disinfection.

2. Practical measures for environmental sanitation

i) Chlorination of drinking well water
ii) Construction of sanitary latrines
iii) Soakage pits
iv) Other simple methods of wastes and sullage disposal.

3. Participation in the implementation of National Programmes at the Village Level.

i) Small pox eradication programme
ii) Malaria eradication programme
iii) Applied Nutrition programme
iv) T.B. Control
v) Family Planning
vi) Other programmes.

4. Participation and organisation of health education programme.

i) Health talks to groups of villages with aid of flash cards, flip charts, flannel graph, slides, films.

5. Participation in Maternal Child Health and school health services.

i) Antenatal check ups
ii) Domiciliary midwifery
iii) Post natal
iv) Under 5 clinics
v) School Health Examinations.

6. Participation in organisation and implementation of mass campaigns.

i) Mass immunization programme
ii) Sterilization camps
iii) Eye camps
iv) Specialist camps

7. Compilation, analysis and interpretation of health and disease data.

8. Participation in administrative activities of a health centre.

i) Planning of work
ii) Analysis of Records
iii) Meetings of health team (Weekly and monthly meetings of Staff at Primary Health Centres and at College)
iv) Assessment and evaluation of health services

Programme Components:- (action oriented)

A. Participation in community health programmes of centre

1. Immunization:- administration and follow up of

a) Small pox - at least 5 vaccinations

b) Triple antigen - at least 15 immunizations

c) Tetanus toxoid - 10 doses

d) BCG, TAB, Cholera, as many as possible during mass programmes.

2. Maternal Child Health:-

a) Antenatal check up (at least 10 cases

b) Domiciliary deliveries (at least 3)

c) post natal check up of (b)

d) Under 5 clinic - (at least 100 children with complete follow up of 11nd and 111rd degree malnutrition cases)

e) Health examination of school children.

3. Environmental Sanitation:-

a) Chlorination of wells (at least 5)

b) Supervision of construction of sanitary latrines and soakage pits (at least one each).

4. Curative work

a) Attending out patient clinic

b) Stool examination of at least 5 cases

c) Urine examination of at least 5 cases

d) Blood/sputum investigations whenever indicated.

5. Social case history taking

At least 2 Medico Social case histories may be obtained

6. Health Education

a) At least one health talk with Audio Visual Aids.

b) Organisation of 1 film show/mass media programme.

7. Family Planning Work:-

a) Motivation and follow up of atleast 2 couples in the use of contraceptives.

B. Participation in the activities of the following categories of health workers (at least 1 day each).

a) Medical officers of health centre

b) Public Health Nurse/Health Visitor

c) Auxiliary Nurse Midwife

d) Extension educator

e) Basic Health Workers

C. Planning Organisation, Execution and reporting of at least one community survey/epidemiological investigation/knowledge, attitude & Practice study and reporting of the same in the accepted scientific paper format. (Summary, Introduction, objectives, materials and methods, observations and results, conclusions discussions suggestions or recommendations acknowledgements, ~~references~~)

PROGRAM COMPONENTS

[A] Community Health Programs

1. Immunization.
2. MCH
3. Environ. sanitation.
4. Curative work.
5. Social case history.
6. Health Educn.
7. Family Planning

4. COMPULSORY ROTATING INTERNSHIP-RURAL TRAINING

It is essential to outline the objectives that are to be achieved during the 3 months rural stay during internship period. An outline of the objectives to be achieved is suggested.

a) Administrative aspects
b) Preventive aspects
c) Clinical aspects

a) ADMINISTRATIVE ASPECTS:

1) Under administrative aspects, rural internship should serve to orient the student in the political structure and administration of a rural areas, and in the actual working of those organisations concerned with local self government namely, zila parishads, the panchayat samities and other facts of community development work.

2) It should serve to orient the intern with the concept of team work with para medical health workers namely, the health visitor, the vaccinator, the sanitary inspector, the social scientist and the health educator, especially in connection with national health programmes.

3) It should orient the intern in the social dynamics of a community. This has an important bearing in health work. This should include the dynamics of leadership, the motivation of a community and the various important factors of influencing leaders in the promotion of health programmes. This is an integral part of the application of health education principles in the promotion of development work.

4) It should serve to orient the doctors on the administrative aspects of various national health programmes which are an integral part of work at primary health centres. These should primarily be such programmes as:

a) the malaria eradication programme
b) small pox eradication programme
c) tuberculosis control
d) family planning
e) certain specific communicable diseases, such as filaria, leprosy, trachoma, V.D. etc.

5) It would serve to put the health programmes in the perspective of the overall national development programmes, namely, agriculture, education, social welfare etc.

B) PREVENTIVE ASPECTS:

1) It should serve to orient the intern in the organisation and management of a comprehensive health service for a community. This programme should invariably include the environment of the community.

2) It should serve to orient the intern in the role of individual members of the health team and of important leaders in a community.

4) It would serve to orient the doctor towards the effective utilisation of all resources in the community for promotion of health programmes.

5) It would serve to indicate that illness is an episode in total frame work of an individual's health. The need for adequate contact tracing and follow up of sick patients after therapeutic treatment should be demonstrated to the maximum in a rural community.

6) It should give an indication of the priority needed of various facts of health programmes, such as the importance of immunization of nutritional education, care of the pre-school child etc.

7) The social effects of illness on an individual and family, and the result of socio-economic factors in causing illness should be demonstrated.

8) The planning and evaluation of a community health service.

C) CLINICAL ASPECTS

1) It should sharpen an individual's diagnostic capacity, so that he may be able to make use of his individual senses without dependence on expensive aids, such as laboratory, X-ray etc.

2) It should permit of an individual taking responsibility for minor illnesses and surgical complications

3) It should serve to indicate his limitations and realization of when to call for consultative services or a referral.

The methods by which this could be achieved:-

1) A planned programme in order that all students should have an opportunity to meet with village representatives and to participate in village meetings, especially those of the health committee. In order to effectively demonstrate the role of community leaders in a health programme, it should be the duty and responsibility of the staff of the rural field centre to form a health committee in every rural field training area.

2) The role of other officials in the village, namely the teacher, the village level worker etc, should also be demonstrated and the students should be given an opportunity to meet with the block development officers and his staff, and to become familiar with the other development programmes in the village.

3) Every effort be made to ensure that the hostels and the houses of the staff of the health centre, as well as well as the surroundings of the centre itself should be such that minimum facilities, such as protected and safe water latrine etc, are provided. Wherever possible the students should be made to live in the village, but under hygienic conditions which are capable of reproduction by the villager.

5) It should be ensured that the primary-health centre is supplied with adequate vaccines and sera and modern drugs.

6) The administrative aspects of running a primary health centre should be demonstrated to the students, and they may be allowed to make suggestions in such matters, as the purchase of drugs, the type of basic equipment, the cost of the diet etc, and how the Centre funds could best be utilised.

7) The students should have every opportunity of working with the health centre staff and visiting the homes. The principles of health education and the approach to a community, and of an individual should also be effectively demonstrated to them and the students be required to practise this under skilled supervision.

8) To effectively implement the above requirements the staff of the field training area be adequate in number, be properly trained, and have the facilities to undertake the teaching andtraining that are required.

(A true extract from the Medical Council of India letter No MCI-9(5)/70-Med/583 dated 1.4.71)

Com H 10.19

CURRICULUM ON SOCIAL & PREVENTIVE MEDICINE FOR UNDERGRADUATE TRAINING

SUMMARY

a) The teaching of Social & Preventive Medicine should take place throughout the teaching period.

b) During the pre-clinical period, a minimum of 50 hours be devoted to the teaching of social & Preventive Medicine.

c) In the clinical period, about 250 hours be devoted to the teaching of the subject. The detailes are included in the report.

d) During the students attendance at various departments, which is now required under medicine and surgery, such as infectious diseases, T.B.? Leprosy, V.D. etc., emphasis should be laid as much on the preventive as on the clinical and therapeutic aspects of these diseases.

e) In addition to the teaching undertaken by the departments of Social & Preventive Medicine, a joint programme with other departments is essential in order to give the students a comprehensive picture of man, his health and illness.

f) Stress be laid on national programmes, including those of control of communicable diseases and family planning and health education.

g) A separate examination in Social & Preventive Medicine may be undertaken in the 2nd professional examination. Questions on the preventive and social aspects of diseases should also be included in the examination in clinical subjects at the final M.B.B.S.

h) An epidemiological unit as an integral part of every hospital in order to achieve a comprehensive study of disease by the students shouldbe established.

i) The objectives of the internship should be clearly defined and that a proper training programme be oriented for this p period. Objectives, and the methods by which the internship could be made into a much more satisfying and fruitful experience than at present have been laid down. This is one of the weakest links of the teaching programme and there is an urgent need for sharpening and for planning in this phase of education.

j) As regards the qualifications of the teachers, it is highly important that all teachers in Social & Preventive Medicine should have as far as possible had adequate administrative experience in addition to the teaching experience.

The following are the recommendations of the Council:

UNDERGRADUATE OR M.B.B.S. COURSE

CURRICULUM

1. PRE-CLINICAL

a. The present educational system requires those students intending to undertake medical studies to chose the science group of subjects. In order to prepare the student for

b) A minimum of 50 hours be devoted for Social & Preventive Medicine in the pre-clinical period. The following subjects should form a part of the teaching in this discipline:

i) Personal Hygiene
ii) Bio-statistics and vital statistics
iii) Human Ecology
iv) Elementary psychology
v) Elementary social science
vi) Normal growth and development
vii) Nutrition and dietetics.

A number of these items could be undertaken in collaboration with the departments of physiology and bio-chemistry, and should form integral part of their teaching.

c) The teading of Social & Preventive Medicine should be undertaken by the department of Social & Preventive Medicine in coordination with other departments.

2. CLINICAL

a) A course of systematic instructions in the principles and practices of social & preventive medicine which should extend throughout the whole period of study.

b) There should be aminimum of 250 hours in total for attendance of lectures, demonstrations, seminars, conferences, field visits and practicals during the clinical period.

The following subjects should be included in the teaching programme

i) Medical statistics, including collection, tabulation, presentation and the interpretation of data, and the use of statisticsl methods

ii) Environmental Hygiene, including man and his environment, occupational and industrial hygiene, village and town sanitation, bacteriology of water, milk, food and food hygiene.

iii) Parasitology, helminthology and entomology in relation to communicable diseases, their prevention and control.

iv) Principles of epidemiology

v) Communicable diseases, their prevention and control

vi) Public Health Administration, including the requirements of international health, social security, public health law, and the role international and other health, organisations.

vii) Advanced courses on nutritional deficiencies.

viii) Community Medicine Teaching should include clinico socio-pathological conferences with other departments, maternal and child health the care of mothers and infants including family planning and school health, supervised field study and visits.

c) In order that the discipline of Social & Preventive

d) To study disease in a comprehensive manner, it is essential that an epidemiological unit be set up in the out-patient department of the teaching hospital. Such an epidemiological unit will enable the students to understand the social, economic and environmental factors in relation to illness during his training period.

e) During the students attendance at the specialist departments, instruction in the preventive aspects should be emphasised during the study.

i) Acute infectious diseases and other local endemic diseases, for example, trachoma goitre, filariasis etc.

ii) Tuberculosis

iii) Preventive aspects of psychological medicine and psychiatry

iv) Preventive aspects of leprosy

v) V.D. Control

vi) Preventive aspects of dietetics and Nutrition information on all national health programmes and the role of international health organization should be given in order that the medical graduate may participate in the successful implementation of these schemes during his career after graduation.

f) In order to make the students practise what is being taught, it is absolutely necessary that the hospital where he works and the hostel he resides should be a model of sanitation. To this extent, he should be involved along with the professors of the various diciplines of the hospital, and other authorities concerned, to take a keen interest in the environmental sanitation.

g) Principles of health education including the education of hospital and health staff, patients and their relatives within the hospitals.

h) The medical students should be given demo stration of family planning at a family planning centre attach to the medical college or at a recognised health centre during the regular course for undergraduate training either under the department of obstetrics and gynaecology or Social & Preventive Medicine. The concept of family planning and population control should be emphasised by all disciplines.

i) Every student should be required to submit one satisfactory writeen history of a community health survey undertaken under the guidance of staff of the Social & Preventive Medicine in a rural are , and o e written case history of a patient followed up with the assistance of the epidemiological unit, in coordination with the department of social and preventive medicine.

3. EXAMINATIONS:

a) There should be a separate university examination in social and preventive medicine which may be held

4. COMPULSORY ROTATING INTERNSHIP-RURAL TRAINING

It is essential to outline the objectives that are to be achieved during the 3 months rural stay during internship period. An outline of the objectives to be achieved is suggested.

a) Administrative aspects
b) Preventive aspects
c) Clinical aspects

a) ADMINISTRATIVE ASPECTS:

1) Under administrative aspects, rural internship should serve to orient the student in the political structure and administration of a rural areas, and in the actual working of those organisations concerned with local self government namely, zila parishads, the panchayat samities and other facts of community development work.

2) It should serve to orient the intern with the concept of team work with para medical health workers namely, the health visitor, the vaccinator, the sanitary inspector, the social scientist and the health educator, especially in connection with national health programmes.

3) It should orient the intern in the social dynamics of a community. This has an important bearing in health work. This should include the dynamics of leadership, the motivation of a community and the various important factors of influencing leaders in the promotion of health programmes. This is an integral part of the application of health education principles in the promotion of development work.

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8) The planning and evaluation of a community health service.

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2) The role of other officials in the village, namely the teacher, the village level worker etc, should also be demonstrated and the students should be given an opportunity to meet with the block development officers and his staff, and to become familiar with the other development programmes in the village.

3) Every effort be made to ensure that the hostels and the houses of the staff of the health centre, as well as well as the surroundings of the centre itself should be such that minimum facilities, such as protected and safe water latrine etc, are provided. Wherever possible the students should be made to live in the village, but under hygienic conditions which are capable of reproduction by the villager.

4) The students should have an opportunity of visiting and

5) It should be ensured that the primary health centre is supplied with adequate vaccines and sera and modern drugs.

6) The administrative aspects of running a primary health centre should be demonstrated to the students, and they may be allowed to make suggestions in such matters, as the purchase of drugs, the type of basic equipment, the cost of the diet etc, and how the Centre funds could best be utilised.

7) The students should have every opportunity of working with the health centre staff and visiting the homes. The principles of health education and the approach to a community, and of an individual should also be effectively demonstrated to them and the students be required to practise this under skilled supervision.

8) To effectively implement the above requirements the staff of the field training area be adequate in number, be properly trained, and have the facilities to undertake the teaching andtraining that are required.

(A true extract from the Medical Council of India letter No MCI-9(5)/70-Med/583 dated 1.4.71)

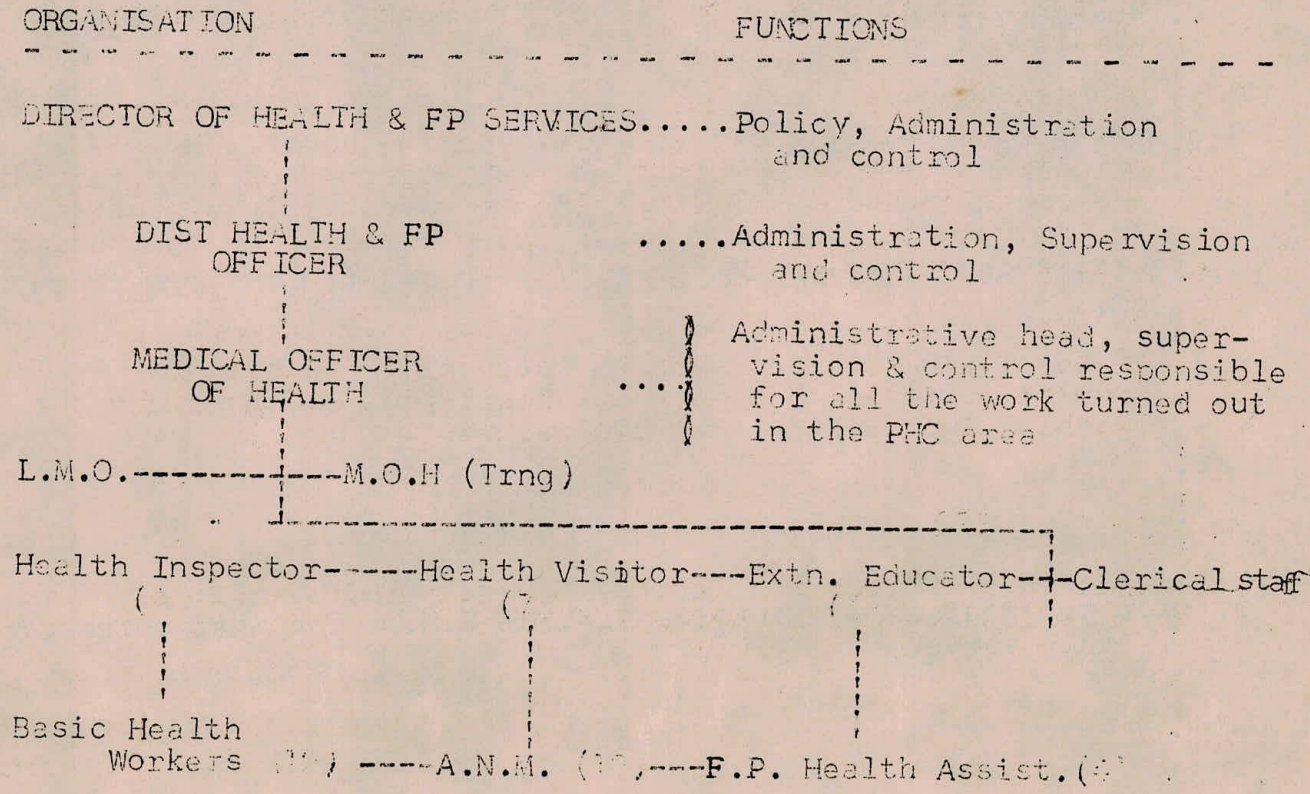
Com H 10.2

rural internship

Posting in a Primary Health Centre

Note: In order to help you understand the working of a Government Primary Health Centre, a work-sheet has been designed to be used during your posting. The questions and comments are to be used as guidelines.

1. ORGANISATION OF PRIMARY HEALTH CENTRE



2. Basic Health Service rendered in the Primary Health Centre

1. Medical Care 2. MCH and FP 3. Control of Communicable Disease 4. Vital Statistics, 5. Environmental sanitation, 6. Health Education, 7. School Health Service, 8. National Health Programmes

3. Duties and Responsibilities:

Write down the responsibilities and activities of each staff by talking to them:

1. Medical Officer of Health

2. Medical Officer of Health (Training)

3. Lady Medical Officer

4. Health Visitor

6. Extention Educator

7. Family Planning Health Assistant

8. Aux. Nurse Mid-wife

9. Basic Health Worker

4. LIST THE REPORTS THAT ARE SENT EVERY MONTH FROM THE PHC TO THE DHO.

1.
2.
3.
4.

5. List the Registers maintained in the P.H.C. and what purpose they serve.

6. NATIONAL HEALTH PROGRAMME: (outline the work done in the PHC in each of the following)

1. N M E P:

2. N S E P:

3. Applied Nutritional Programme

4. Tuberculosis Control Programme

5. Leprosy: Control Programme

6. Family Planning Programme

7. Give suggestions to improve the quantity and quality of health work taking into account the difficulties and problems encountered in the villages.

DEPT. OF PREVENTIVE & SOCIAL MEDICINE
ST. JOHN'S MEDICAL COLLEGE, BANGALORE

PSM/IPR/76 Date:

To:

At the end of your rural posting at Mallur/Sil.Pura/Uttarahally you are required to submit a report on the work/survey done during your posting. The report should be prepared on the following lines:

1. Short Summary of Project. 2. Introduction; 3. Material (subjects, patients) and methods; 4. Results/Observation
5. Discussion; 6. Conclusion; 7; Acknowledgement; &
8. Reference.

The report should, at first, be submitted to the Medical Officer concerned and after perusal by him/her, with his/her signature on the report, the report should reach the Dept. of Preventive and Social Medicine, within one week after the date of relief at the Centre, failing which the confidential report of the concerned intern, will not only be withheld but is likely to be forwarded with remarks that the intern's work was not up to the mark.

S.V.Ramarao 16/8/71
(DR.S.V.RAMA RAO, MBBS., DPH., MPH.,)
for Prof. & Head of the Dept. of
Preventive & Social Medicine

DEPARTMENT OF PREVENTIVE & SOCIAL MEDICINE

ST. JOHN'S MEDICAL COLLEGE, BANGALORE - 34

Intern's Attendance Form

Name of Centre posted:

Name of Sister-in-charge/Medical Officer:

1. Name of intern:

Day Month Year

2. Date of commencement of posting:

3. Last date of posting:

1	_____		
2	_____	17	_____
3	_____	18	_____
4	_____	19	_____
5	_____	20	_____
6	_____	21	_____
7	_____	22	_____
8	_____	23	_____
9	_____	24	_____
10	_____	25	_____
11	_____	26	_____
12	_____	27	_____
13	_____	28	_____
14	_____	29	_____
15	_____	30	_____
16	_____	31	_____

Signature
Medical Officer/Sister-in-charge

(Please return in a sealed cover on completion of posting addressed to the Professor, Dept. of Preventive & Social Medicine, St. John's Medical College, Bangalore.560034)

APPLICATION FOR CASUAL/SPECIAL LEAVE FOR INTERNS

(To be submitted at least TWO WEEKS in advance for special leave)

PART I:

Name of Intern: Date:
Department: Unit:

Period of leave: From.....To.....Reasons.....
(Total no. of days:)

Sundays & Holidays, if any, proposed to be prefixed/suffixed to leave (with dates) — Prefixed.....
Suffixed.....

Remarks from:-

1. Head of Unit/Department.....
2. Internship Coordinator.....
3. Dean for sanction.....

Signature_____
INTERN

PART II

MEMO

Date:

Shri/Smt.....is hereby informed that special casual leave requested for from.....to.....(inclusive) is sanctioned subject to the following:-

a) no stipend will be paid during this period of leave
b) this period of leave will be made up for through additional postings at the end of the internship
c) clearance should be obtained from the Dean before rejoining duty.

INTERNSHIP CO-ORDINATOR

PART III

(Applicant may please detach this joining report for completion and return to the office on the expiry of leave).

To: The Dean,
Through the Head of the Department of_____

Dear Sir,

After the expiry of my leave from.....to.....
I have rejoined duty this day the.....

Yours faithfully,

Signature

To

The Internship Coordinator,

The above mentioned intern may rejoin his duties.

Com H 10.21

Title: COMMUNITY HEALTH AND ST. JOHN'S.

The Department of Community Medicine at St. John's has always played the pivotal role in fulfilling the most important objectives of the college. Serving the under privileged and more importantly training others to serve the underprivileged has been the main focus of the Department. The enabling process of identifying and attempting to meet the felt needs of the community, is done by the Department. The training and service components are provided to all members of the health team (from the grass-root level workers to terfiary care specialists).

TRAINING FOR COMMUNITY HEALTH CARE:

Being a Medical College, St. John's is in a unique position to provide all the training components in the formation of a Health team. This creates a better understanding of each member's role in Community Health Care rather than a isolated form of training to separate Health Team Members in separate institutions. The various Training programmes in Community Health are as follows:-

1. For Medical Students:-

a) Rural Orientation Programme:- Conducted every year, during the months of January - February, the main objective of the camp is to expose the medical students to the various facets of rural life through a residential programme at Dommasandra Primary Health Centre. The students visit all the rural subcentres and are guided in determining the various factors which govern rural life such as - Agriculture, Animal Husbandary, Small Scale Industries, Fairs, Festivals, Customs and traditions, Commerce and trade, Transport, Traditional systems of Health, Housing and environment, Role of women in society, Maternal care practices, Child Care practices and Food practices. These are presented in the form of field projects by groups of students. In addition, the students also organise many

b) Clinico Social Case work for MBBS Students:- This is conducted every month, by posting them in batches to the health centres. Their training involves case work in the field, working up the social aspects of a number of communicable diseases as well as antenatal cases. The objective is to train the students to consider a case as a holistic health care problem rather than a mere clinical entity. The socio economic causes, contributing factors and consequences of major diseases are highlighted in this training programme in addition to the usual clinical features of the disease.

c) National Social Services in rural villages:- Under this scheme, the medical students carry out community health and developmental projects at various villages in batches once a week. In contrast to the generally known NSS activities, the NSS programme of this institution aims at highlighting community health and community development, as the main features of this service . Education for school children, adult education, school health education, improving environmental health etc., are some of the main components of this programme.

d) Child to Child health education programme:- Evolved as a novel approach to health education, this programme has proved to be an immense success at Dammasandra, Anekal and Bidadi health centres. The basic objectives is to teach groups of children, various aspects of health, using innovative teaching materials, live demonstrations and "health songs". Later the children are allowed to share their knowledge with each other and each child is encouraged to tell the other what he or she saw in her/his group teaching. This way the factor of curiosity and natural thirst for knowledge and sharing the same, are invoked in each of the children. This greatly contributes to strengthening the health education in a natural cumulative manner from child to child. At each rural centre, the major middle and high school are covered under this programme. The positive aspect of this programme is the school teacher's involvement and their willingness to

e) Mothers' Motivation Programme: Groups of rural mothers are invited to the rural subcentres and they are made aware of various facets of nutrition, maternal care, child care, immunization etc. The Programme is conducted in the form of practical nutrition demonstration, immunization procedures, infant feeding techniques, preparation of weaning diets etc. Emphasis is laid on the fact that all the components of this programme must be done through practical demonstrations, using locally available resources only, with the mothers themselves actually executing the work. Emphasis is also stressed on the cost factor during these demonstrations.

f) Field work in urban slums:- Senior clinical students visit families and maintain family health records, enumerate eligibles for immunisation, do immunization coverage, refer to the St. John's Hospital those in need of medical services and also carry out field surveys in Nutrition, child health etc.

g) Seminars, discussions and Lectures:- Over 400 hours are spent in teaching Community Health to medical students during their entire MBBS training period. All the subjects from concepts in Health care, to Nutrition, Maternal and Child Health, Occupational diseases, statistics, sociology, Behavioural sciences, Health Management and Planning, control of communicable and non-communicable diseases etc. are taught to the medical students.

h) Study tours to other Health related Institutions:- In an effort to expose our students to real life situations, they are taken to various health institutes, field projects and institutions of public health importance. Here they get a chance to interact with other Health agencies and their staff and actual field problems in health care.

2. For Nursing Students:

a) Rural Orientation Programme for Nursing Students:- Conducted every year during the month of May, the main objective of this camp remains the same as that for medical students. The camp is conducted at Bidadi Primary Health Centre and the rural Mobile Clinic stationed therein is used extensively during the programme. In addition to theactivities refered to in the medical students camp, the Nursing students are given extra assignments in the field of Maternal and child care, Domiciliary deliveries etc.

3. For Community Health Workers:-

Rural Training programme for Community Health Workers:- This course is a three months programme, conducted twice a year, during which one month is spent as a rural residential camp. The emphasis during this course is on various field, clinical, Lab and institutional training in the various aspects of community health. Additional training in first aid, home nursing, natural family planning, Herbal medicine, counselling, community development and human biology are also conducted. The rural posting comprises mainly of various field projects on the dynamics of rural life, rural Mobile clinic work, domiciliary deliveries, maternal and child health, school health etc. Rural projects planning and management of health centres is also taught to the community health workers. As of the current 20th basic course for Community Health Workers, a total of 355 community health workers from every state in India and also from Nepal have been successfully trained.

4. Interns:

Rural Internship training programme:- All Interns in batches, are posted to the six rural subcentres for a period of three months duration each. Apart from managing the rural clinic, these interns are also involved in epidemiological surveys, domiciliary visits, domiciliary deliveries, immunization and school health. Besides, they parti-

They have successfully participated in field evaluation surveys for immunization coverage, in remote villages in a number of districts in Karnataka.

5. Training programmes for Deacons, Seminarians and others:- Being basically a training institute, a large number of small organisations are constantly availing the facilities for training their own health workers. This programme is arranged on individual request basis with the theme of the training being highly specific to the need of that organisation. Many of these programmes are in the form of work experience in our ongoing rural programmes. Some of the programmes, however, are formal month long structured training programmes. The Deacons and Seminarians from St. Peter's Seminary, Suvidya College, Deena Seva Ashram, Workers from Association of Physically handicapped and several other Government and Non-governmental agencies, undergo these courses in Community Health conducted by the Department.

6. Food Hygiene Training Programme:- Keeping in view the importance of Food Hygiene in Public Eating Places, this training programme aims at providing appropriate knowledge and methodology of safe food keeping to Hotel Managers, cooks and Servers. This is a monthly programme conducted at the Hotel premises itself in the local language so that the programme is highly effective. The topics of food hygiene are especially selected to reflect Indian foods and indigenous techniques of food preparations.

7. Plantation Health Services:- Under the aegis of the United Planters Association of South India and the Department of Community Medicine, a series of training programmes, collaboration research and service Programmes are undertaken throughout the year for the plantation workers, Doctors, Managers and Lab Technicians of the Tea, Rubber, Coffee plantation of South India. Elective clinical training for

training of plantation creche attandants are some of the major areas of involvement of our institution. The main objective is to provide adequate community Health care to the workers of the plantation community in South India.

8. Rural School Health Programme:- Under this programme all the rural middle and high school teachers of Anekal Taluk are trained in the various facets of school health. The main objectives of this training is to train rural school teachers in basic health care, early detection of illness in children, immunization and health education. Follow up of this programme has revealed that the school teachers have successfully organised regular teaching programmes in health for their school children. In addition, some of the senior school children have been trained to supervise healthy practices, environmental cleanliness etc. Thus the responsibility for health is transferred to the school child. Periodical school health surveys and health camps in the specialised areas of ENT, Ophthalmology, Dentistry and Surgery are carried out by the clinical faculty of the concerned departments of the Hospital. These clinical faculty participate in these rural programme regularly.

9. For the students of Diploma in Hospital Administration:- Apart from severals hours of didactic teaching in Community Health, these students are posted to our rural health training centres and other field health programmes of the department. They also carry out Health Management projects with the guidance of the departmental faculty.

10. Colloquim for doctors and Community Health Workers working in rural areas:- In addition to basic training in health care to various categories of health workers, it is important that a follow up is done on the utilisation of the knowledge gained. For this purpose, several methods are followed. At the professional level, doctors can seek elective posting in selected specialities for skill development. Regional colloquim are organised for sharing professional experiences among

Alumni doctors, permanently working in rural areas, attended this two-day colloquim wherein they shared their experiences in management of clinical emergencies with limited resources, motivation of villagers on health awareness, communicable disease control, use of herbal medicine, management of social problem, cultural taboos, etc. The following recommendations were forthcoming as a result of this charing experiences:-

- To arrange a one year training programme in family medicine covering all major clinical subjects including behavioural sciences, counselling, community development etc. This could enhance the knowledge and skill level of the rural-based doctors. Several of the participating rural doctors have offered to participate in this course by offering their own centres for specific training sessions under rural conditions.

- A short in-service, skill oriented training for all interns, before they take up their rural postings. This training should essentially cover maternal and child health.

- To coordinate a national network of our rural graduate doctors' with our college newsletter acting as the mode of communication between the members of the rural doctors network.

- Conducting regional colloquia of a similar nature in various parts of our country on a regular basis. The present teachers of our college should participate in these regional colloquia in order to discover the actual needs of our rural graduate doctors, so that their teaching methodologies and syllabi can be restructured to suit rural realities.

11. Integrated child Development Scheme Anganwadi Training Programme:- Under this programme, the Anganwadi workers in the Anekal and Attibele circles are trained in various health programmes with greater emphasis

12. Extension training in agriculture, water resources and Veterniary care for village youth:- This programme has been organised in the Dommasandra, Anekal areas. The programme consists of imparting field training and guidance on improvisation of existing methods and provision of expert assistance to extension workers. The stress is laid on youth motivation and training in these areas since it has been found this scheme provides useful outlet for youthful energies and enthusiasm especially among these who are unemployed and sufficiently educated. This scheme is seen as a method of providing entry into the field of agriculture and veterinary care for fresh workers rather than merely intensify and promote already established rich farmers etc.

13. Integrated Health Care Training:- Villagers in India often resor to indigenous systems of medicine. The training at St. John's for the various categories of health workers including its own medical students comp-rise training in Herbal Medicine, Herbo-mineral Medicine, Accupressure, Homeopathy and Yoga. Many of its graduate doctors working in remote rural areas have substantiated the fact that there is this need to integrate allopathic Medicine with the other systems of Medicine.

14. Training of Govt. Medical Officers:- At the request of the State Government, our departmental staff conduct training programmes in Universal Immunization Programme methodologies for Govt. Medical-Officers in various parts of the State.

15. Training of foreign Elective Posting Medical Students: Under this scheme, on an average, 10 - 15 Medical students per year from U.K., U.S.A., France, Italy are given experiential learning in Community Medicine for 4 - 6 weeks each at our rural health centres.

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12) Participatory process:- The main objective of the various health programmes of St. John's aims at a participatory process, wherein the the villagers themselves participate in financing health care, supply of materials and manpower, etc. This is particularly exemplified by the Mallur Health Cooperative Centre, which now has its own hospital building and other facilities provided through a cooperative movement which the college initiated in 1973. Village Health Committees have been formed at each of the Rural Health Centres, and all decisions are participatory in nature. A largepart of the organization of surgical and other speciality Rural Camps is also under taken by village youth groups and Mahila Mandals. Even the training of the various categories

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The fact that a large number interns are posted to our rural health centres each year, has enabled the formulation and execution of several research studies, by the staff of the Department. Some of the important research projects covered over the years are detection of goitre in the Mundar region, health hazards of sreiculture workers, house dust mites and allergy in rural areas, Prevalence surveys of Leprosy, TB and other Major diseases, Polio lameness surveys Leprosy health education methodologies, helminthic surveys, Knowledge attitude practice surveys, school health surveys, environmental health factors surveys, anaemia and productivity among tea pluckers in the plantation etc. Papers have been published by the staff in various national and international health journals.

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All the programmes outlined, so far, are dynamic in nature since they are updated constantly depending on the feedback received of their effectiveness and efficiency. The emphasis is thus on training and health education rather than merely the provision of multiple services. This ensures that whatever may have been the programme inputs, the results will be long lasting, self perpetuating and effective.

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Title: COMMUNITY HEALTH AND ST. JOHN'S.

The Department of Community Medicine at St. John's has always played the pivotal role in fulfilling the most important objectives of the college. Serving the under privileged and more importantly training others to serve the underprivileged has been the main focus of the Department. The enabling process of identifying and attempting to meet the felt needs of the community, is done by the Department. The training and service components are provided to all members of the health team (from the grass-root level workers to terfiary care specialists).

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Being a Medical College, St. John's is in a unique position to provide all the training components in the formation of a Health team. This creates a better understanding of each member's role in Community Health Care rather than a isolated form of training to separate Health Team Members in separate institutions. The various Training programmes in Community Health are as follows:-

1. For Medical Students:-

a) Rural Orientation Programme:- Conducted every year, during the months of January - February, the main objective of the camp is to expose the medical students to the various facets of rural life through a residential programme at Dommasandra Primary Health Centre. The students visit all the rural subcentres and are guided in determining the various factors which govern rural life such as - Agriculture, Animal Husbandary, Small Scale Industries, Fairs, Festivals, Customs and traditions, Commerce and trade, Transport, Traditional systems of Health, Housing and environment, Role of women in society, Maternal care practices, Child Care practices and Food practices. These are presented in the form of field projects by groups of students. In addition, the students also organise many

b) Clinico Social Case work for MBBS Students:- This is conducted every month, by posting them in batches to the health centres. Their training involves case work in the field, working up the social aspects of a number of communicable diseases as well as antenatal cases. The objective is to train the students to consider a case as a holistic health care problem rather than a mere clinical entity. The socio economic causes, contributing factors and consequences of major diseases are highlighted in this training programme in addition to the usual clinical features of the disease.

c) National Social Services in rural villages:- Under this scheme, the medical students carry out community health and developmental projects at various villages in batches once a week. In contrast to the generally known NSS activities, the NSS programme of this institution aims at highlighting community health and community development, as the main features of this service. Education for school children, adult education, school health education, improving environmental health etc., are some of the main components of this programme.

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h) Study tours to other Health related Institutions:- In an effort to expose our students to real life situations, they are taken to various health institutes, field projects and institutions of public health importance. Here they get a chance to interact with other Health agencies and their staff and actual field problems in health care.

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a) Rural Orientation Programme for Nursing Students:- Conducted every year during the month of May, the main objective of this camp remains the same as that for medical students. The camp is conducted at Bidadi Primary Health Centre and the rural Mobile Clinic stationed therein is used extensively during the programme. In addition to theactivities refered to in the medical students camp, the Nursing students are given extra assignments in the field of Maternal and child care, Domiciliary deliveries etc.

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Rural Training programme for Community Health Workers:- This course is a three months programme, conducted twice a year, during which one month is spent as a rural residential camp. The emphasis during this cource is on various field, clinical, Lab and institutional training in the various aspects of community health. Additional training in first aid, home nursing, natural family planning, Herbal medicine, counselling, community development and human biology are also conducted. The rural posting comprises mainly of various field projects on the dynamics of rural life, rural Mobile clinic work, domiciliary deliveries, maternal and child health, school health etc. Rural projects planning and management of health centres is also taught to the community health workers. As of the current 20th basic course for Community Health Workers, a total of 355 community health workers from every state in India and also from Nepal have been successfully trained.

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training of plantation creche attandants are some of the major areas of involvement of our institution. The main objective is to provide adequate community Health care to the workers of the plantation community in South India.

8. Rural School Health Programme:- Under this programme all the rural middle and high school teachers of Anekal Taluk are trained in the various facets of school health. The main objectives of this training is to train rural school teachers in basic health care, early detection of illness in children, immunization and health education. Follow up of this programme has revealed that the school teachers have successfully organised regular teaching programmes in health for their school children. In addition, some of the senior school children have been trained to supervise healthy practices, environmental cleanliness etc. Thus the responsibility for health is transferred to the school child. Periodical school health surveys and health camps in the specialised areas of ENT, Ophthalmology, Dentistry and Surgery are carried out by the clinical faculty of the concerned departments of the Hospital. These clinical faculty participate in these rural programme regularly.

9. For the students of Diploma in Hospital Administration:- Apart from severals hours of didactic teaching in Community Health, these students are posted to our rural health training centres and other field health programmes of the department. They also carry out Health Management projects with the guidance of the departmental faculty.

10. Colloquim for doctors and Community Health Workers working in rural areas:- In addition to basic training in health care to various categories of health workers, it is important that a follow up is done on the utilisation of the knowledge gained. For this purpose, several methods are followed. At the professional level, doctors can seek elective posting in selected specialities for skill development. Regional colloquim are organised for sharing professional experiences among

Alumni doctors, permanently working in rural areas, attended this two-day colloquim wherein they shared their experiences in management of clinical emergencies with limited resources, motivation of villagers on health awareness, communicable disease control, use of herbal medicine, management of social problem, cultural taboos, etc. The following recommendations were forthcoming as a result of this charing experiences:-

- To arrange a one year training programme in family medicine covering all major clinical subjects including behavioural sciences, counselling, community development etc. This could enhance the knowledge and skill level of the rural-based doctors. Several of the participating rural doctors have offered to participate in this course by offering their own centres for specific training sessions under rural conditions.

- A short in-service, skill oriented training for all interns, before they take up their rural postings. This training should essentially cover maternal and child health.

- To coordinate a national network of our rural graduate doctors' with our college newsletter acting as the mode of communication between the members of the rural doctors network.

- Conducting regional colloquia of a similar nature in various parts of our country on a regular basis. The present teachers of our college should participate in these regional colloquia in order to discover the actual needs of our rural graduate doctors, so that their teaching methodologies and syllabi can be restructured to suit rural realities.

11. Integrated child Development Scheme Anganwadi Training Programme:- Under this programme, the Anganwadi workers in the Anekal and Attibele circles are trained in various health programmes with greater emphasis

12. Extension training in agriculture, water resources and Veterniary care for village youth:- This programme has been organised in the Dommasandra, Anekal areas. The programme consists of imparting field training and guidance on improvisation of existing methods and provision of expert assistance to extension workers. The stress is laid on youth motivation and training in these areas since it has been found this scheme provides useful outlet for youthful energies and enthusiasm especially among these who are unemployed and sufficiently educated. This scheme is seen as a method of providing entry into the field of agriculture and Veterinary care for fresh workers rather than merely intensify and promote already established rich farmers etc.

13. Integrated Health Care Training:- Villagers in India often resort to indigenous systems of medicine. The training at St. John's for the various categories of health workers including its own medical students comprise training in Herbal Medicine, Herbo-mineral Medicine, Accupressure, Homeopathy and Yoga. Many of its graduate doctors working in remote rural areas have substantiated the fact that there is this need to integrate allopathic Medicine with the other systems of Medicine.

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The fact that a large number interns are posted to our rural health centres each year, has enabled the formulation and execution of several research studies, by the staff of the Department. Some of the important research projects covered over the years are detection of goitre in the Mundar region, health hazards of sreiculture workers, house dust mites and allergy in rural areas, Prevalence surveys of Leprosy, TB and other Major diseases, Polio lameness surveys Leprosy health education methodologies, helminthic surveys, Knowledge attitude practice surveys, school health surveys, environmental health factors surveys, anaemia and productivity among tea pluckers in the plantation etc. Papers have been published by the staff in various national and international health journals.

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LOOKING BEYOND:

All the programmes outlined, so far, are dynamic in nature since they are updated constantly depending on the feedback received of their effectiveness and efficiency. The emphasis is thus on training and health education rather than merely the provision of multiple services. This ensures that whatever may have been the programme inputs, the results will be long lasting, self perpetuating and effective.

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The Department of Community Medicine at St. John's has always played the pivotal role in fulfilling the most important objectives of the college. Serving the under privileged and more importantly training others to serve the underprivileged has been the main focus of the Department. The enabling process of identifying and attempting to meet the felt needs of the community, is done by the Department. The training and service components are provided to all members of the health team (from the grass-root level workers to tertiary care specialists).

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Being a Medical College, St. John's is in a unique position to provide all the training components in the formation of a Health team. This creates a better understanding of each member's role in Community Health Care rather than a isolated form of training to separate Health Team Members in separate institutions. The various Training programmes in Community Health are as follows:-

1. For Medical Students:-

a) Rural Orientation Programme:- Conducted every year, during the months of January - February, the main objective of the camp is to expose the medical students to the various facets of rural life through a residential programme at Dommasandra Primary Health Centre. The students visit all the rural subcentres and are guided in determining the various factors which govern rural life such as - Agriculture, Animal Husbandary, Small Scale Industries, Fairs, Festivals, Customs and traditions, Commerce and trade, Transport, Traditional systems of Health, Housing and environment, Role of women in society, Maternal care practices, Child Care practices and Food practices. These are presented in the form of field projects by groups of students. In addition, the students also organise many "Child to Child" health education programmes, Mother's motivation

b) Clinico Social Case work for MBBS Students:- This is conducted every month, by posting them in batches to the health centres. Their training involves case work in the field, working up the social aspects of a number of communicable diseases as well as antenatal cases. The objective is to train the students to consider a case as a holistic health care problem rather than a mere clinical entity. The socio economic causes, contributing factors and consequences of major diseases are highlighted in this training programme in addition to the usual clinical features of the disease.

c) National Social Services in rural villages:- Under this scheme, the medical students carry out community health and developmental projects at various villages in batches once a week. In contrast to the generally known NSS activities, the NSS programme of this institution aims at highlighting community health and community development, as the main features of this service . Education for school children, adult education, school health education, improving environmental health etc., are some of the main components of this programme.

d) Child to Child health education programme:- Evolved as a novel approach to health education, this programme has proved to be an immense success at Dommasandra, Anekal and Bidadi health centres. The basic objectives is to teach groups of children, various aspects of health, using innovative teaching materials, live demonstrations and "health songs". Later the children are allowed to share their knowledge with each other and each child is encouraged to tell the other what he or she saw in her/his group teaching. This way the factor of curiosity and natural thirst for knowledge and sharing the same, are invoked in each of the children. This greatly contributes to strengthening the health education in a natural cumulative manner from child to child. At each rural centre, the major middle and high school are covered under this programme. The positive aspect of this programme is the school teacher's involvement and their willingness to

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h) Study tours to other Health related Institutions:- In an effort to expose our students to real life situations, they are taken to various health institutes, field projects and institutions of public health importance. Here they get a chance to interact with other Health agencies and their staff and actual field problems in health care.

2. For Nursing Students:

a) Rural Orientation Programme for Nursing Students:- Conducted every year during the month of May, the main objective of this camp remains the same as that for medical students. The camp is conducted at Bidadi Primary Health Centre and the rural Mobile Clinic stationed therein is used extensively during the programme. In addition to theactivities refered to in the medical students camp, the Nursing students are given extra assignments in the field of Maternal and child care, Domiciliary deliveries etc.

3. For Community Health Workers:-

Rural Training programme for Community Health Workers:- This course is a three months programme, conducted twice a year, during which one month is spent as a rural residential camp. The emphasis during this course is on various field, clinical, Lab and institutional training in the various aspects of community health. Additional training in first aid, home nursing, natural family planning, Herbal medicine, counselling, community development and human biology are also conducted. The rural posting comprises mainly of various field projects on the dynamics of rural life, rural Mobile clinic work, domiciliary deliveries, maternal and child health, school health etc. Rural projects planning and management of health centres is also taught to the community health workers. As of the current 20th basic course for Community Health Workers, a total of 355 community health workers from every state in India and also from Nepal have been successfully trained.

4. Interns:

Rural Internship training programme:- All Interns in batches, are posted to the six rural subcentres for a period of three months duration each. Apart from managing the rural clinic, these interns are also involved in epidemiological surveys, domiciliary visits, domiciliary deliveries, immunization and school health. Besides, they participate in all the other rural service programmes conducted by the

They have successfully participated in field evaluation surveys for immunization coverage, in remote villages in a number of districts in Karnataka.

5. Training programmes for Deacons, Seminarians and others:- Being basically a training institute, a large number of small organisations are constantly availing the facilities for training their own health workers. This programme is arranged on individual request basis with the theme of the training being highly specific to the need of that organisation. Many of these programmes are in the form of work experience in our ongoing rural programmes. Some of the programmes, however, are formal month long structured training programmes. The Deacons and Seminarians from St. Peter's Seminary, Suvidya College, Deena Seva Ashram, Workers from Association of Physically handicapped and several other Government and Non-governmental agencies, undergo these courses in Community Health conducted by the Department.

6. Food Hygiene Training Programme:- Keeping in view the importance of Food Hygiene in Public Eating Places, this training programme aims at providing appropriate knowledge and methodology of safe food keeping to Hotel Managers, cooks and Servers. This is a monthly programme conducted at the Hotel premises itself in the local language so that the programme is highly effective. The topics of food hygiene are especially selected to reflect Indian foods and indigenous techniques of food preparations.

7. Plantation Health Services:- Under the aegis of the United Planters Association of South India and the Department of Community Medicine, a series of training programmes, collaboration research and service Programmes are undertaken throughout the year for the plantation workers, Doctors, Managers and Lab Technicians of the Tea, Rubber, Coffee plantation of South India. Elective clinical training for Plantation Medical Officers, training in Public Health Laboratory

training of plantation creche attandants are some of the major areas of involvement of our institution. The main objective is to provide adequate community Health care to the workers of the plantation community in South India.

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a) Rural Orientation Programme for Nursing Students:- Conducted every year during the month of May, the main objective of this camp remains the same as that for medical students. The camp is conducted at Bidadi Primary Health Centre and the rural Mobile Clinic stationed therein is used extensively during the programme. In addition to theactivities refered to in the medical students camp, the Nursing students are given extra assignments in the field of Maternal and child care, Domiciliary deliveries etc.

3. For Community Health Workers:-

Rural Training programme for Community Health Workers:- This course is a three months programme, conducted twice a year, during which one month is spent as a rural residential camp. The emphasis during this course is on various field, clinical, Lab and institutional training in the various aspects of community health. Additional training in first aid, home nursing, natural family planning, Herbal medicine, counselling, community development and human biology are also conducted. The rural posting comprises mainly of various field projects on the dynamics of rural life, rural Mobile clinic work, domiciliary deliveries, maternal and child health, school health etc. Rural projects planning and management of health centres is also taught to the community health workers. As of the current 20th basic course for Community Health Workers, a total of 355 community health workers from every state in India and also from Nepal have been successfully trained.

4. Interns:

Rural Internship training programme:- All Interns in batches, are posted to the six rural subcentres for a period of three months duration each. Apart from managing the rural clinic, these interns are also involved in epidemiological surveys, domiciliary visits, domiciliary deliveries, immunization and school health. Besides, they parti-

They have successfully participated in field evaluation surveys for immunization coverage, in remote villages in a number of districts in Karnataka.

5. Training programmes for Deacons, Seminarians and others:- Being basically a training institute, a large number of small organisations are constantly availing the facilities for training their own health workers. This programme is arranged on individual request basis with the theme of the training being highly specific to the need of that organisation. Many of these programmes are in the form of work experience in our ongoing rural programmes. Some of the programmes, however, are formal month long structured training programmes. The Deacons and Seminarians from St. Peter's Seminary, Suvidya College, Deena Seva Ashram, Workers from Association of Physically handicapped and several other Government and Non-governmental agencies, undergo these courses in Community Health conducted by the Department.

6. Food Hygiene Training Programme:- Keeping in view the importance of Food Hygiene in Public Eating Places, this training programme aims at providing appropriate knowledge and methodology of safe food keeping to Hotel Managers, cooks and Servers. This is a monthly programme conducted at the Hotel premises itself in the local language so that the programme is highly effective. The topics of food hygiene are especially selected to reflect Indian foods and indigenous techniques of food preparations.

7. Plantation Health Services:- Under the aegis of the United Planters Association of South India and the Department of Community Medicine, a series of training programmes, collaboration research and service Programmes are undertaken throughout the year for the plantation workers, Doctors, Managers and Lab Technicians of the Tea, Rubber, Coffee plantation of South India. Elective clinical training for

training of plantation creche attandants are some of the major areas of involvement of our institution. The main objective is to provide adequate community Health care to the workers of the plantation community in South India.

8. Rural School Health Programme:- Under this programme all the rural middle and high school teachers of Anekal Taluk are trained in the various facets of school health. The main objectives of this training is to train rural school teachers in basic health care, early detection of illness in children, immunization and health education. Follow up of this programme has revealed that the school teachers have successfully organised regular teaching programmes in health for their school children. In addition, some of the senior school children have been trained to supervise healthy practices, environmental cleanliness etc. Thus the responsibility for health is transferred to the school child. Periodical school health surveys and health camps in the specialised areas of ENT, Ophthalmology, Dentistry and Surgery are carried out by the clinical faculty of the concerned departments of the Hospital. These clinical faculty participate in these rural programme regularly.

9. For the students of Diploma in Hospital Administration:- Apart from severals hours of didactic teaching in Community Health, these students are posted to our rural health training centres and other field health programmes of the department. They also carry out Health Management projects with the guidance of the departmental faculty.

10. Colloquim for doctors and Community Health Workers working in rural areas:- In addition to basic training in health care to various categories of health workers, it is important that a follow up is done on the utilisation of the knowledge gained. For this purpose, several methods are followed. At the professional level, doctors can seek elective posting in selected specialities for skill development. Regional colloquim are organised for sharing professional experiences among

Alumni doctors, permanently working in rural areas, attended this two-day colloquim wherein they shared their experiences in management of clinical emergencies with limited resources, motivation of villagers on health awareness, communicable disease control, use of herbal medicine, management of social problem, cultural taboos, etc. The following recommendations were forthcoming as a result of this sharing experiences:-

- To arrange a one year training programme in family medicine covering all major clinical subjects including behavioural sciences, counselling, community development etc. This could enhance the knowledge and skill level of the rural-based doctors. Several of the participating rural doctors have offered to participate in this course by offering their own centres for specific training sessions under rural conditions.

- A short in-service, skill oriented training for all interns, before they take up their rural postings. This training should essentially cover maternal and child health.

- To coordinate a national network of our rural graduate doctors' with our college newsletter acting as the mode of communication between the members of the rural doctors network.

- Conducting regional colloquia of a similar nature in various parts of our country on a regular basis. The present teachers of our college should participate in these regional colloquia in order to discover the actual needs of our rural graduate doctors, so that their teaching methodologies and syllabi can be restructured to suit rural realities.

11. Integrated child Development Scheme Anganwadi Training Programme:- Under this programme, the Anganwadi workers in the Anekal and Attibele circles are trained in various health programmes with greater emphasis

12. Extension training in agriculture, water resources and Veterniary care for village youth:- This programme has been organised in the Dommasandra, Anekal areas. The programme consists of imparting field training and guidance on improvisation of existing methods and provision of expert assistance to extension workers. The stress is laid on youth motivation and training in these areas since it has been found this scheme provides useful outlet for youthful energies and enthusiasm especially among these who are unemployed and sufficiently educated. This scheme is seen as a method of providing entry into the field of agriculture and veterinary care for fresh workers rather than merely intensify and promote already established rich farmers etc.

13. Integrated Health Care Training:- Villagers in India often resort to indigenous systems of medicine. The training at St. John's for the various categories of health workers including its own medical students comprise training in Herbal Medicine, Herbo-mineral Medicine, Accupressure, Homeopathy and Yoga. Many of its graduate doctors working in remote rural areas have substantiated the fact that there is this need to integrate allopathic Medicine with the other systems of Medicine.

14. Training of Govt. Medical Officers:- At the request of the State Government, our departmental staff conduct training programmes in Universal Immunization Programme methodologies for Govt. Medical Officers in various parts of the State.

15. Training of foreign Elective Posting Medical Students: Under this scheme, on an average, 10 - 15 Medical students per year from U.K., U.S.A., France, Italy are given experiential learning in Community Medicine for 4 - 6 weeks each at our rural health centres.

SERVICE PROGRAMMES IN COMMUNITY HEALTH CARE:

1. Meternal and Child Health Clinics:- Conducted fortnightly at all the six subcentres by the faculty of the Department these clinics provide an apportunity for the women and children to avail themselves of medical care by senior doctors. The faculty concerned, carryout

5. Universal Immunization Programme: Organised in collaboration with the UNICEF, this programme is a major service programme whose main objective is to achieve nearly 100 percent of coverage with immunization against Diphtheria, Pertusis, Tetanus, Polio, TB & Measles for children below 1 year of age in Anekal, Dommasandra and Bidadi Primary Health Centres plus a five lakh population in the urban areas as well.

6. Rural Mobile Clinics:- As part of the Re-Orientation of Medical Education Programme, three rural Mobile Clinics operate in 18 remote villages of the Anekal, Dommasandra and Bidadi Primary Health Centres. On an average, 80 to 100 patients attend these clinics per day. The Mobile Clinics provide an ideal opportunity to conduct not only routine clinical care at the remote villages, but they also provide an opportunity to carry out specialists care such as ENT, Ophthalmology, Dentistry, surgery and Dermatology. Basic clinical features of common diseases can be taught especially to para-medical workers at these Mobile Clinics since the rural patients are not constrained by the awe inspiring presincts of a large hospital. This aids in better ineraction between the patients and health worker which is not possible in the sophisticated hospitals.

7. Serving the Urban under-privileged:- Urban slums in and around Bangalore, are also served by St. John's. Health programmes such as immunisation coverage against the major killer diseases for children, maternal and child health clinics for expectant mothers, school health programmes are some of the urban-based health activities of St. John's. In addition, the medico-social unit provides councelling in alcoholism drug addiction, juvenile delinquency etc. The trainees learn to serve the under privileged in all aspects of health care.

8. Referal Services:- Village patients are refered to the Hospital for tertiary care. The referal is done by the resident intern at the rural health centres and followed up by the social workers of the department.

This particular service is all the more important since large number of females patients often hesitate to be attended by our male residential interns. During these clinics, the opportunity to educate the mothers on ante-natal, natal, post-natal and child care services are also availed of.

2. Rural Specialists camps:- As mentioned earlier, the rural Mobile clinics are amply provided with facilities which are made use of to organise rural surgical camps in the field of Ophthalmology, ENT, and Dental surgery. This has been a novel programme. Thraugh these rural specialists camps, it has been proved that it is possible to conduct surgical procedures such as Tonsillectomies, Antral wash, Cataract extraction, Dental extraction, Dental fillings, and other surgical procedures, even under General Anaesthesia. It has been heartening to note that there has been no post operative complications or infections reported so far although each camp has on an average of 30 to 40 operative cases. The local Youth Clubs are involved in the management of the organisation and publicity etc., of these camps. Follow up care is provided by the residential interns.

3. Natural Family Planning Services:- The family Welfare Services section of the Department of Ob & Gynae of the Hospital accampany the Maternal and child health service teams and conduct awareness programme in Natural Family Planning among the villagers of the Six rural subcentres, An average of 4 to 6 couples accept the Natural Family Planning each week.

4. Factory Workers Health Services:- Under the occupational Health Services provided for small factory workers, the department is involved actively in the provision of pre-placement, periodic examination, factory safety education, Occupational hazards survey and executive

The ENT, Skin, Dental and Ophthalmology departments participate in these specialist camps.

9. Food Hygiene Inspection:- The Hospital Canteen and other Messes in the institution, are subject to regular food hygiene inspections carried out by the Department faculty. This is done in collaboration with the concerned administrative chiefs for effective and prompt implementation of the recommended control measures.

10. Immunization Coverage Evaluation Surveys:- In collaboration with the State Government Directorate of Health Services, teams of staff from the department conduct specialized immunization coverage evaluation surveys in various districts of the state such as Kolar District, Mysore District, Coorg District etc.

11. Preperation of Health Education Materials:- With a regular artist as part of the Department staff, several posters, charts, etc., on Health Education has been prepared and used in health exhibitions. These materials are also borrowed for use by various other institutions The same is true of audio cassettes prepared in local languages to depict songs and drama about important issues in Health of the Community.

12) Participatory process:- The main objective of the various health programmes of St. John's aims at a participatory process, wherein the the villagers themselves participate in financing health care, supply of materials and manpower, etc. This is particularly exemplified by the Mallur Health Cooperative Centre, which now has its own hospital building and other facilities provided through a cooperative movement which the college initiated in 1973. Village Health Committees have been formed at each of the Rural Health Centres, and all decisions are participatory in nature. A largepart of the organization of surgical and other speciality Rural Camps is also under taken by village youth

RESEARCH PROGRAMME IN COMMUNITY HEALTH

The fact that a large number interns are posted to our rural health centres each year, has enabled the formulation and execution of several research studies, by the staff of the Department. Some of the important research projects covered over the years are detection of goitre in the Mudhar region, health hazards of sericulture workers, house dust mites and allergy in rural areas, Prevalence surveys of Leprosy, TB and other Major diseases, Polio lameness surveys Leprosy health education methodologies, helminthic surveys, Knowledge attitude practice surveys, school health surveys, environmental health factors surveys, anaemia and productivity among tea pluckers in the plantation etc. Papers have been published by the staff in various national and international health journals.

Publications in food hygiene and immunization methodologies have been written by the staff in English and the local language of Kannada as well.

Using appropriate technology, practical methods of solar cooking vegetable storage devices, smokeless chullas, kitchen nutrition gardens etc., have also been evolved by the staff of the Department.

LOOKING BEYOND:

All the programmes outlined, so far, are dynamic in nature since they are updated constantly depending on the feedback received of their effectiveness and efficiency. The emphasis is thus on training and health education rather than merely the provision of multiple services. This ensures that whatever may have been the programme inputs, the results will be long lasting, self perpetuating and effective.

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- WHO manual on H.E or Evaluation
- Evaluation methods. 198 (Health for All Series)

EVALUATION - THE NEED, ITS VALUE AND METHOD

By Dr. Dara S Amar.

1. What is Evaluation?

Evaluation, in lay language, would mean the separation of the most valuable from the less valuable and the value-less.

Evaluation measures:-

1.1 The degree to which objectives and targets are fulfilled
1.2 The quality of the results obtained
1.3 The productivity of available resources in achieving objectives
1.4 The cost effectiveness achieved.

Evaluation makes possible the reallocation of priorities and resources on the basis of changing health needs.

2. Types of Evaluation:

2.1. Pre-evaluation: It is necessary to establish a baseline at the beginning of a programme against which to measure the results.

2.2 Concurrent evaluation: Evaluation should not be left to the end but should be made from time to time, so that if the programme is not progressing successfully, modifications can be made. The programme moves thus:-

2.3 Terminal evaluation: The evaluation of the ultimate achievement of the programme in terms of objectives and sub-objectives fulfilled and the extent of planned activities carried out.

Evaluation may be approached from the following angle too:-

2.4 Evaluation of structure and organization.
2.5. Evaluation of the Process
2.6. Evaluation of the results.

Cost Benefit — Cost of project / (Cost of no. of cases if not prevented)

Ex WHO paper on Public Health - Health Economics.
BR - Mathematics in Biology or Med.

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3. Tools used for Evaluation:

3.1 Observation schedules
3.2 Records and registers
3.3. Work diaries
3.4 Personal interviews
3.5 Health Examination
3.6 Discussions
3.7 Questionnaires.

4. Provision for Evaluation in your programme:

The following provisions must be made at the stage of planning itself.

4.1 Person responsible for evaluation should be specified.
4.2 Amount of time, the personnel can give for evaluation work.
4.3 The funds available for evaluation
4.4. Stages of the programme at which evaluation will be done
4.5 Is there a provision in the planning, for making either major or minor modifications in the programme, depending on the "feed-back" from the evaluation.

5. The process of Evaluation:

A systematic procedure should be followed in evaluating any programme. The theoretical concept of evaluation is relatively simple but its practical application can be very difficult, too often, these difficulties have been used as excuses for not starting, but the right approach is to begin; for once begun, experience, techniques, and data grow rapidly. It is better to start even if only with the evaluation of a few aspects of some activities of a programme, than never to have started at all.

The basic steps in evaluation are as follows:

i) Statement of objectives
ii) Establishment of Baseline Data
iii) Measuring coverage and Utilization of services
iv) Evaluating utilization of Resources
v) Evaluating Activities and Attitudes of the programme staff and public
vi) Measuring effectiveness of programme + benefit.
vii) Measuring efficiency of programme.
viii) Collection of Data
ix) Analysis of Data
x) Presentation of Results and Recommendation.

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5.1 Statement of objectives:

Since evaluation is related to and dependant on objectives, the statement of objectives must be sufficiently specific to be measured. In fact, the more specific the objectives, the better the evaluation. Two levels of objectives are distinguished.

a) General objective (or aims) which may or may not be measurable.

b) Specific objective which are measurable.

General objectives only set out the main intentions but not the details.

eg: To provide preventive, promotive and curative health services to the community.

Specific objectives set out measurable details. The following are the criteria for making specific objectives.

5.1.1 A clear definition os what is to be attained; for example, /*"primary vaccination" of all children before they are six months of age.

5.1.2. A clear statement of the amount or degree of intended attainment; for example, 100% of the children must have primary vaccination before each child is six months old.

5.1.3 A clear statement of the time in which this degree of attainment; is expected; for example, "between I July and I September 1968".

5.1.4 A clear specification of the geographic location of the programme; for example, Bata Village.

5.1.5 A clear specification of the particular people, or the portion of the environment, in which the objective is to be attained; for example, the parents of all children under six months of age should have these children vaccinated.

The objective might read, "To persuade parents of children under six months of age in Bata village to have all these children (100%) vaccinated between I July and I September 1968". Sub-objectives might include the following:

I) "To carry out a house-to-house survey of the village in order to list the names of all the infants under six months."

2) "To identify leaders especially among the women who can assist with this survey."

The programme's success depends on accomplishment of the sub-objectives. Sometimes a sub-objective may not be directly related to health. If the objective were "To get 50% of the restaurants in a given locality to reach a specified level of cleanliness in one year", one sub-objective might be "To have restaurant owners buy new uniforms for the

5.2 Establishment of Baseline Data:

Often termed as "pre-evaluation", it measures the current Health Status and needs of the community so that these may be compared again at the end of the programme in order to measure the changes in health status and fulfillment of the needs of the community.

The Health Status of the community is usually studied by collecting data on:-

i) Age/Sex distribution of population
ii) Mobility of population
iii) Socio-economic levels and factors prevalent
iv) Birth Rate
V) Death Rate
vi) Morbidity Rates
vii) K.A.P. Surveys.

The needs of the community may be PERCEIVED needs (i.e. the people themselves perceive the need for the programme) and PROFESSIONAL needs (i.e. what the medical professionals believe are the needs of the community). Most often both the needs are beyond the capacity of the resources available for the programme. Whereas the change in the Health Status of the Community at the end of the programme, can be measured quantitatively, the measurement of the "fulfillment" of the needs is often qualitative and therefore subjective. Nevertheless, an effort must be made, since without the Baseline data, evaluation cannot begin.

5.3 Measuring Coverage and Utilization of Services:

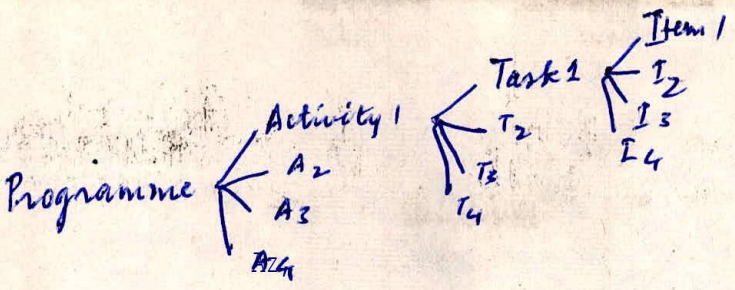
This is often referred as measurement of the "adequacy" of the programme. The three components measured here are:

i) Geographical coverage
ii) Population coverage
iii) Utilization rate of the programme services.

5.3.1 Geographical coverage: This refers to the geographical distribution of the people who make use of the programme services e.g. Catchment (drainage) area of a hospital. If the geographical area of coverage is large, it could mean

Need / Demand / Use
1) May need not demand. (1.a) → even though aware) b) → not aware)
2) May demand not need.

...5



i) Your programme is popular

ii) Your programme is more of a specialized nature which is generally not available.

5.3.2 Population coverage: This refers to proportion of the whole population, who are eligible for your programme services. If your programme is specialized, the coverage is low (eg. only maternity services) but if your programme is of a general nature (e.g. Community development projects) the coverage is often 100%.

5.3.3 Utilization Rate: Not everyone eligible for your programme service, will necessarily use your services, therefore it is necessary to measure the proportion of the eligible population who make use of your services.

5.4 Evaluating utilization of Resources:

Resources are men, material, money and time. These form the inputs that is consumed or utilized to produce the output of the programme. Merely because resources are consumed rapidly, does not signifiy that your programmes is progressing equally rapidly. What needs to be evaluated or measured, are the following criteria.

5.4.1 Quantity of Resources available/used.

5.4.2 Quality of Resources available/used.

5.4.3 Rate of utilization of resources in relation to programme phases/duration.

5.4.4 Distribution of Resources

(The use of resources in measuring the EFFECIENCY of a programme is denoted later)

Evaluation of resource utilization and its optimization can be carried out using techniques in the realm of operations Research, cost effectiveness studies etc, which are beyond the scope of this present paper.

5.5 Evaluating Activities and Attitudes of staff and Public:

5.5.1. Activities: These are the number of items of work (eg. vaccinating children, making home-visits, registering births etc)

that may be used is the O and M technique or the organization and methods evaluation which measures such matters as division of work, delegation of authority, co-ordination, etc. Another type of activity analysis which is increasing/used is the P.E.R.T./C.P.M. or programme evaluation Review Technique/ Critical path method in Operations Research. Detailed reviews of the above techniques are available in specialized texts.

5.5.2 Attitudes: This is most often ignored in any evaluation, mainly because of its difficult and subjective nature. The techhiques employed are usually in the form of questionnaires that are framed to provide unambiguous replies and the method of filling the questionaires is through direct personal interviews and discussions. However, unless the people are well informed and sufficiently knowledgable on the matter, most of the responses are guarded, generalized and do not reflect true attitudes of the people. Though very difficult and subjective, the technique of direct observation combined with the above technique, aids in arriving at a fair diagnoses of the changes or otherwise of the attitudes of the people towards the progress of your programme:

5.6 Measuring Effectiveness of the programme:

Very often, due to constraints on resources and often due to faulty management, many of the objectives planned ** are not fully accomplished at all or only partially so. Measurement of the EFFECTIVENESS, using the following proportion formula, often serves as a rough guide to your achievement.

** at the beginning of the programme, are often not accomplished

$$\text{Effectiveness} = \frac{\text{No. of objectives actually achieved}}{\text{No. of objectives originally planned.}}$$

To have an idea of the extent of individual objectives achieved, the percentage coverage of each objective may also be calculated.

5.7 Measuring efficiency of the Programme:

This constitutes the most important factor for evaluation of your programme, as far as your funding agency is concerned. It relates your programme output to the money spent forthe programme. However, since money is not the only important consumable resource, the following proportion formula must be

+ Shadow pricing (opportunity costing)

Efficiency ∝ $\frac{\text{No. of objectives actually achieved.}}{\text{Total cost (direct \& indirect) actually expended.}}$

5.8 Collection of Data: So far, we discussed WHAT data to collect for evaluation of a programme. The following points constitute the main criteria in the actual methodology of collecting the data:-

i) How should the data be collecte?
ii) When should the data be collected?
iii) From whom should the data be collected?
iv) By whom should the data be collected?

5.8.1. How-------?: This is usually in the form of a health survey for which there are 4 approaches:

i) Using exhisting records/registers for gathering data.
ii) Using Questionaires containing unambiguous and well structured questions.
iii) Personal interviews and discussions
iv) Health examination of individuals.

5.8.2. When--------?: Two points to be remembered are

i) Season of the year: eg. If the baseline data ia collected during an epidemic of cholera, the morbidity rate will be unusually high.

ii) Evaluation procedure: Is the data gathering a continuous procedure throughout the year or is it episodic?
It is preferable to collect basic data continuously (to overcome problem(i)) but a more detailed data collection must be carried out at predetermined intervals. Thus the workload of the data collecter is not continuously overburdened.

5.8.3 From whom.-----?: Obviously, larger the number of sources and people from whom data is collected, better would be the evaluation. However, practical constraints in resources may necessiate the employment of SAMPLING TECHNIQUES. Thus "populations at risk" may be measured first due to the economy achieved. If, however, your programme is a unique and innovative type, then a group of matched CONTROL population must be simultaneously studied in order to claim the unique benefits of your programme.

5.8.4: By whom-----?: This is entirely dependant on the resources available for your programme. A lot of project leaders feel that an independant group of staff, not involved with the programme, must do the evaluation in order to avoid any biassed opinions. Though this method may be theoritically sound, its practical implication can be often futile and useless. The reason being that many of the project workers "feel" that an "outsider" knows little about the actual conditions of work and so his evaluation and recommendations are not always right. In order to avoid such "discontent" in the organization, a PART of the evaluation team must consist of the project workers (actual field- workers and NOT project leaders/consultants!) so that a balanced opinion and analysis is made.

5.9: Analysis of Data: Before analysis, the data must be "collated" ie: checking of completeness of data and sequencing and tabulation of the data collected. The work of collation can go on simultaneously with data collection and not be left to the end.

The amount and type of analysis required will depend on the problem and complexity of the programme and can vary from simple tabulation to complex analysis of multiple variants. The services of a statistician is often required.

6. Presentation of Results and Recommendations:

The presentation of the evaluation report depends upon for whom it is sent. If it is to the project agency, then it must contain all details but if it is for publication then a lot of summarization is required. The report should, however, generally follow the criteria stated below:

6.1 Be brief as possible

6.2 Results must be tabulated simply

6.3 Emphasize practical implications rather than theoritical discussions

6.4 Emphasize improvisations especially for field workers. | not criticisms!

6.5 Make clear, practical recommendations.

6.6 Illustrations in the form of graphs etc. should be used.

6.7 Figures in tables must not be repeated in the text.

6.8 The FORMAT of the report should be as follows:

- Summary of Report
- Aim of Evaluation
- Methods used for Evaluation
- Results in the form of tables/graphs etc.
- Discussion of results of evaluation
- Recommendations.

7. Common difficulties in Evaluation:

7.1 Demands and needs often exceed resources and so evaluation results are often discouraging.

7.2 Inadequate planning, especially for evaluation, before start of programme.

7.3 Lack of expertise. Evaluation requires expertise in such fields as social medicine, statistics, sociology, social psychology, economics, administration, computer science etc. Qualified people are thus scarce.

7.4 Techniques and terminologies in evaluation procedures are strange to programme/project staff and so they are often distrusting and uncooperative. Some terminologies have forbidding names but are basically simple eg. cost-benefit analysis, network analysis, simulation, management audit, resource allocation model etc.

7.5 Methodological difficulties. For example, many health programmes cannot be measured in quantifiable terms and their benefit to the people are often subjective, general rather than specific and have subtle effects that cannot be measured.

7.6 Due to the pressure of day-to-day work of the programme, the "demands" to analyse, record, compile, measure activities etc. "seem" to be an additional burden.

HOWEVER IT MUST BE REMEMBERED THAT THE OBJECTIVE OF EVALUATION IS NOT TO CONDEMN OR PRAISE, BUT TO SIMPLY STATE FACTS SO THAT THE PROGRAMME MAY BE SUITABLY MODIFIED TO GIVE ITS BEST TO THE PEOPLE FOR WHOM IT SERVES.

6.8.1. Recommendations : 1) Good / Bad / etc. - Taboo - % figures (Objective evaluation).

5). Discuss this.

A.

What are these stds.?

1) Effectivity ← Objectives. → Actual obj achieved ÷ planned obj.
Activities. → — do —.
Resources. → R. used ÷ planned Res.

2) Efficiency ← O → Achieved O ÷ Actual Resources spent.
A → A. A. ÷ — do —.
R

To improve efficiency — 1:1 ratio in AA/AR.
— AO/AA.

∴ ↑ Activity per resource ⇒ ↑ obj per activity (eg: DPT vaccⁿ)

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RURAL HEALTH EVALUATION REPORT

ComH 10

The following pages contain a number of incomplete stories. We want you to read and complete them giving your imaginative best as to what happened from the point where it was left off. There are no right or wrong conclusions to those stories.

Please do not try to read all of them first and then go back over them to write the conclusions.

You have only 5 minutes for each. In order to finish all of them in the allotted time you will have to write your spontaneou reaction immediately after reading each story.

1. Dr Singh is a young doctor who has finished a year's surgical house officership in his medical college hospital. He has to choose between two assignments each for a period of approximate 2 years.

The first is a government primary health centre only 5 miles from the medical college with good road connections so that it is easy for both patients and the doctor to go back and forth to the city. The second is a health centre in an isolated valley in the Himalayas, which is supported by his own religious organization. It is in an area of great medical need where communications with the outside world are frequently out off by weather and bad roads.

What choice did he make and why ?

2. Dr. Banerji is a successful practitioner who had never been out of Calcutta. He has just returned from his first visit to a village where he had gone with a wedding party. In talking wi Dr Chatterji, a young colleague who was born and brought up in a village, he expresses in strong languages his revulsion and disgust at the lack of laterines in the village. He vows, that he will never go back to a village again because he can't bear the thought of going out to the fields morning and night. Dr Chatterji responds

3. Dr Viswanathan had been surprised to find that his 5 years in primary health centre had passed as a rapid and pleasant interlude. His wife and two children aged $4\frac{1}{2}$ and $2\frac{1}{2}$ enjoyed the life in the village and the children played happily with some of the village children. One spring day the doctor saw 5 cases of severe vomitting and diarrhoea in the dispensary. On going home he was called next door and found the 4 year old friend of his own child dying of cholera. Dr Viswanathan immediately

4. On graduation from the medical college Dr Gupta had three alternative choices. He could accept a job in a government Primary Health Centre where he could start earning Rs.550/- per mont His maternal uncle who was private practitioner in a big city invited him to join his clinic as a junior at 200 rupees a month. He was selected to do post-graduate work in a subject for which he had no particular preference. After careful consideration Dr Gupta decided to

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1. Dr Singh is a young doctor who has finished a year's surgical house officership in his medical college hospital. He has to choose between two assignments each for a period of approximately 2 years.

The first is a government primary health centre only 5 miles from the medical college with good road connections so that it is easy for both patients and the doctor to go back and forth to the city. The second is a health centre in an isolated valley in the Himalayas, which is supported by his own religious organization. It is in an area of great medical need where communications with the outside world are frequently out off by weather and bad roads.

What choice did he make and why ?

2. Dr. Banerji is a successful practitioner who had never been out of Calcutta. He has just returned from his first visit to a village where he had gone with a wedding party. In talking with Dr Chatterji, a young colleague who was born and brought up in a village, he expresses in strong languages his revulsion and disgust at the lack of laterines in the village. He vows, that he will never go back to a village again because he can't bear the thought of going out to the fields morning and night. Dr Chatterji responds

3. Dr Viswanathan had been surprised to find that his 5 years in primary health centre had passed as a rapid and pleasant interlude. His wife and two children aged $4\frac{1}{2}$ and $2\frac{1}{2}$ enjoyed the life in the village and the children played happily with some of the village children. One spring day the doctor saw 5 cases of severe vomitting and diarrhoea in the dispensary. On going home he was called next door and found the 4 year old friend of his own child dying of cholera. Dr Viswanathan immediately

4. On graduation from the medical college Dr Gupta had three alternative choices. He could accept a job in a government Primary Health Centre where he could start earning Rs.550/- per month His maternal uncle who was private practitioner in a big city invited him to join his clinic as a junior at 200 rupees a month. He was selected to do post-graduate work in a subject for which he had no particular preference. After careful consideration

The following pages contain a number of incomplete stories. We want you to read and complete them giving your imaginative best as to what happened from the point where it was left off. There are no right or wrong conclusions to those stories.

Please do not try to read all of them first and then go back over them to write the conclusions.

You have only 5 minutes for each. In order to finish all of them in the allotted time you will have to write your spontaneous reaction immediately after reading each story.

1. Dr Singh is a young doctor who has finished a year's surgical house officership in his medical college hospital. He has to choose between two assignments each for a period of approximately 2 years.

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THE RAJHARA HEALTH PROGRAMME .
A YEAR'S EXPERIENCE

Since June'1981, Kishor Bharati has sponsored me to work in a programme, initiated and organised by the Chattisgarh Mukti Morcha, to build up a health movement in and around Dalli-Rajhara. This sponsorship was an outcome of the belief, held at that time by many in Kishor Bharati, that reform programmes, such as health programmes, could not have any significant and lasting social impact, unless they were linked to, and formed part of, ongoing people's movements. My own academic and field experience of Public Health work, and my interaction with experience with the Medico friend circle, led me to broadly share this view. I was also at that time, looking for a socially significant and useful role for myself, as a health professional. It was therefore considered that my being sponsored by Kishor Bharati for this work would be to our mutual advantage.

The objects of this sponsorship were two-fold viz:

Health-programme,

(1) To enable me to explore the feasibility and scope of CMSS, and of my own participation in it,

(2) By sharing and discussing my experiences at Rajhara with others at Kishore Bharati, to enable the people at Kishor Bharati to enlarge their general understanding about the role of, and process of implementing a health programme within the context of a people's movement.

Soon after arriving at Rajhara, I made myself at home in the Union Office, where I also used to stay. I was quickly absorbed, although to a limited extent only, in the day to day life and work of the Union. Personally for me this was a very stimulating experience, as I had never been involved with any political work before. However, the lack of any concrete task to perform was very trying to my patience, particularly as I had to overcome a lifetime's conditioning of adherence to the work ethic, and of feeling an obligation to employ myself "Usefully". Nevertheless, I was determined not to rush precipitately into any particular course of action. I therefore bided my time.

On investigating what ideas the Union leadership had about the future shape of the health programme, I found that a decision had already been taken to build a "PRASUTI GRIHA" (Maternity Hospital) near the Union Office. The plans were already at an advanced stage, and the money had been set aside, architectural blueprints drawn up etc. I also discovered that the Union Leaders very clearly expected me to devote a large part of my energies to clinical curative work. Their ideas on the actual content of a health programme consisted largely of what seemed to me to be fairly conventional ideas, such as performing Health Surveys, organising clean-up compaigns, etc. These discoveries dismayed me greatly. I was extremely cynical about the effectiveness of curative clinical work; I certainly had no ideas of working in a hospital, and a maternity hospital as that. I had also plenty of experiences of how activities such as health Surveys could degenerate into time-filling

This was difficult for me to digest, - accustomed as I was to a political "sanctity' of health work. However, at this time I took a very crucial decision that determined in a very large measure, the nature and extent of my future involvement in the health programme and the Union. This was; that, while maintaining and constantly developing my own theoretical understanding, I would give first priority to the existing perceptions and priorities of the people, as articulated in the direction of the Union Leadership. This may seem like a very conventional decision to a Government Bueaucrat; however, none of the numerous friends I had, working in health programmes all over the country, had ever voluntarily put themselves in such a position. The top-level health professional is almost always in a position to determine his own programme priorities and to set his own goals. I also did not have any well worked out theoretical arguement for making such a decision, it was made mainly because I found the CMSS atmosphere very exhilerating, and had made up my mind to work with them at any cost. As it was turned out to be a fateful decision; and ultimately led to a totally new theoretical understanding of the role of health and other reform programmes in a people's movement. This understanding is outlined later on in this paper.

The inaguration of the programme: The programme was inaugurated on 15th August '1981, during the Independence Day-Celebrations. We had by then articulated an Eight Point Programme, which was outlined in a pamphlet distributed at the inauguration. In the pamphlet, the basic philosphy of the programme-that it was an attempt to direct the energies of Union to goals larger than economic one's and designed to set the foundation for a new society-was outlined. The Eight Point were drawn up on more or less theoretical considerations; they were:-

1. A Tuberculosis Programme,
2. Sanitation and Water Supply,
3. Building a Hospital,
4. Running a Dispensary,
5. Carrying out health surveys,
6. Training health cadres,
7. Maternal and child health programmes,
8. Health education.

The programme was called-STRUGGLE FOR HEALTH COMPAIGN' ("SWASHTHYA KE LIYE SANGHASHA KARO ANDOLAN).

"SAFAI-ANDOLAN"

The first major campaign we carried out was designed to force the BSP to take its Public Health, and in particular its scavanging duties seriously. The whole of Dalli-Rajhara township is under the administrative control of the BS P Management. The sanitary arrangements throughout the area where the Contract Labourers lived were woefully inadequate, and large piles of rubbish could be seen at frequent intervals. The Union organised a massive clean-up campaign. About 2000 workers together with students and small businessmen from the town spent an entire morning loading trucks with rubbish. A number of these trucks were BSP Trucks commandeered off the road. The sting of the compaign was in its tail. At the end of the morning, all the trucks loaded with rubbish were parked in front of the Mines Office, and a huge procession shouting health

and told that if we had to repeat this Clean-up campaign, the rubbish would be dumped on his lawn. The result was that the BSP has deployed special trucks in Rajhara specifically designed for cleaning away rubbish, and all rubbish piles are cleaned every day.

Health Committee: In November'1981, a Health Committee was chosen to oversee the Health programme. Representatives were chosen from each mohalla, by the people living in the mohalla. At a very big meeting at which all these representatives and the Union Executive were present together, people were asked to volunteer their names for the Health Committee. 107 out of all those who had been chosen volunteered. From among these 107 people, the Union Executive and these 107 people together selected an Executive Committee of 27 men and women.

The participation of the Health committee members and the executive, in the day to day running of the health programme, and in the hospital construction effort has been extremely disappointing. Right from the first meeting more than half the members simply failed to attend. We arranged weekly meetings; attendance at these meetings quickly dwindled, and less than 10 people attended regularly. However, a few people have takem a very active and responsible role both in running the Health Programme and in building the hospital.

Hospital Constructiion: The hospital is a large cement and Steel building which will house an outpatient department together with minor surgery and labour rooms, and wards to accommodate twenty beds. Of two floors, one has been constructed. The task of constructing the building has been a truly Herculean one, carried out in the face of constant Government non-cooperation and interference. Here again, while a few of the workers have contributed a great deal of their time and energy in managing the construction, reqisitioning materials, etc, the majority of the health committee as well as the ordinary mazdoors have shown little active interest in the work. However, whenever the Union has requested volunteers for specific tasks (loading trucks with bricks, or getting sand from the river bed, or the magnificiant occasion on which relays of 200 workers worked all day to pour the roof of the ground level) such volunteers have always been available.

Dispensary: Dr. Ashish Kundu, and I had been attending to patients in the Union Office on an adhoc basis for a very long time. It was decided in January'82 to improve the physical arrangements for seeing patients and to regularise the working hours for the dispensary. A temporary shed was built to house the dispensary in the garage adjoining the Union Office. Initially we had both men and women colunteers working with us in the dispensary helping to keep accounts, dispensing medicines and generally helping us to attend to the patients. Two men, Takshlal, and Eval Singh developed into very good, skilful and committed workers. It is a great tribute to their tenecity that they are present in the dispensary every day, after working a full day in the mines. The women workers were also very sincere. This dispensary was inaugurated on 26th January'82.

dispensary

(Women-workers) But because family responsibilities weighed more heavily upon them, they were unable to attend the clinic as regularly. However, here as elsewhere, the familiar pattern presented itself. Thus, while there were a few genuinly excellent workers, most of the people took little interest in the actual running of the dispensary, although from the point of view of the patient load, we were quite successful.

Working in the Mohallas: Along with our work in the clinic, we had decided that, instead of trying to implement our programme diffusely throughout the organisation, that we would initially concentrate on small areas and work intensively. Accordingly I started living and working in an area called Pandridalli, and Asshish Kundu concentrated in an area called Kachhe Dafai.

My work at Pandridalli was not successful. I held numerous meetings and spent a lot of time trying to explain our programme to the people there. We had a large number of Mohalla meetings, and finally we were able to agree on a programme to establish a clinic where I would give part of my time. This seemed logical as this Mohalla was a considerable distance from the Union Clinic. However, this clinic never actually started work, as there was no concerted support for it in the Mohalla.

Dr. Ashish Kundu was much more successful in the Kachhe-Dafai. He was able to organise the people of the Kachhe Dafai to set up a small creche for pre-school children of working mothers. This doubled as a library for the Schoolgoing boys in the evening. The schoolgoing boys of the area organised themselves into an enthusiastic group; they frequently initiated and carried out new ideas. One of the reasons for the success of this Mohalla was that almost all the people in this mohalla also worked together in one co-operative mining society. The discipline and organisation of the work place reflected on their work in the mohalla as well.

Conclusion: Looking back at the end of one year's exciting and exhilerating experience, what general lesson can we learn from our work?

One of the featuers that puzzled us a great deal, was the tremendous contrast between the enthusaistic, committed and immesely creative contributions of a few people and one or two small groups, and the overall apathy towards the health movement of the general mass of the people. This was particularly puzzling because we were able to see, every day fresh evidence of the fact that the people were genuinly organised into a militant trade union movement, for which (even in non-economic issues) people were willing to work and sacrifice. Our puzzlement led us to question one of the basic assumptions with which we started the programme; that people organised for one issue (Trade Union) will be easy to organise for a different issue (Health Movement).

Then what is the advantage of working is a set up like the CMSS/Chattisgarh Mukti Morcha, instead of any

correctly directed process of social change, and not simply tinkering around with a few social institutions of peripheral importance. The second difference is that one has ready access to a large number of highly committed political and health cadres- a much larger number than one could find in any ordinary community. The third difference is that one possesses an indigenous resource base that can sustain the programme.

What can a politically conscious health professional contribute to such a programme? Apart from the obvious answer-technical skill-these are a number of other possibilties. No revolutionary programme is born out of a vacuum, but out of the womb of bourgeois traditions. The revolutionary health professional needs to possess a critical awareness of the entire health service tradition, which he can bring to the work at hand.

The other contribution is a more general one-the ability to abstract from the life experience of the people in the working class, and on the basis of these abstrations, to concretise their aspirations. This process is known aphoristically as "from the people, to the people" and forms an important part of the work of any intellectual, working in a Peoples Movement.

In Rajhara , an organised people's movement has taken a conscious decision to build and run a hospital anddevelope a health programme. While other similar organisations have in the past, built hospitals or have attempted to develop decentralised primary health care services, it is probably the first time that this programme of social reform, along with other reform programmes such as the 'anti-liquor campaign', have been incorporated into the Central Political programme of the organisation.

What is the object of this programme, and why is it given so much prominence? In order to understand this, it is necessary to articulate our objedtives in terms of the general differences between bourgeois reformism and revolutionary social reform programmes. The first difference, is that burgeois reformism is directed primarily at suppressing the emerging class antagomisms and contradictions between State Power and people's Power. Revolutionary social reform, on the other hand, by the very fact that it is based on a militant recognition of class antagonisms and of the oppressive nature of the State Power, is directed towards precisely the opposite goal. Consequently, the most important goal of a revolutionary reform programme is not the ach-

The second difference is that revolutionary reform does not derive its strength from any exogenous group of "Reformers" standing outside the mainstream of the people's movement. Instead, its primary resources are a the political consciousness, organised strength and creative power of the working class and peasantry. Consequently, we cannot take a single step in this programme without considering the direction in which the people want it to proceed. Any attempt to work out new ideas has to be preceded by an effort to explain these to the people, and to establish them in the popular consciousness.

This also means that at any given moment, the direction of the programme cannot be governed by "a priori" considerations of the appropriateness of the measures taken. The existing direction is always limited by the existing perception of the people, of the issues around which the programme is formed, based on their collective past experience. Nevertheless, it is necessary for those leading programmes to have a deep and concrete historical knowledge of similar programmes, and of the issues as they exist concretely in the community. (In the case of health, this would mean that we should possess a knowledge of epidemiology and a knowledge of the history of technology and health service programmes.). This knowledge is necessary so that it may be posed ina constant dynamic tension to existing perceptions, so that the two may come close to each other in a dialectical process of successive approximation.

The third difference is that revolutionary reform is vitally conscious of the inevitability of its own failure. That is, we believe that the ills which owe their existence to an oppressive social order cannot, except marginally, be cured except by a radical restructuring of that order - that is - revolution. Consequently, we do not hope nor expect that our programme will succeed in effecting more than marginal improvements in the health of the people or even in the availability of curative care. However, our attempt is to direct the energies of the people into the establishment of an institution and a programme which reflects their aspirations, and in this process presents to them a redically new vision of an alternative social order.

We also hope to create within the internal organisation of the programme, an image of what the social organisation of such a programme in a socialistic society might be. Through the working of the programme and through its internal organisation, we also hope to raise questions in the minds of the people about the way in which the existing social and political structure and the existing health services expropriate rather than add to the health of the people, and thereby articulate a living critique of one part of the existing social order.

Com H 9A.

Subject: Re: [mfriendcircle] INTERNET AND HEALTH: is there a doctor?
Date: Wed, 23 May 2001 10:04:36 +0530
From: "tapasvi73" <tapasvi73@yahoo.com>
Reply-To: mfriendcircle@yahoogroups.com
To: <mfriendcircle@yahoogroups.com>

hello sir,
telemedicine seems to be doing well in Mozambique. but certain issues are there which must be answered.
if some one refer to a doctor via telemedicine. now suppose that perticular doctor is not practising ethically & only interested in moneymaking then how to rely upon the advice.As for example one doctor at village refers a ECG to cardiologist via telemedicine. now if that doctor is not a rationlist may advice for angiography for it. which might be not required at all. many doctors will find it suitable to increase their practice via telemedicine with finding a base in rural/remote area too.MAny big private hospitals may take advantage & may find telemedicine for their profit making by unneccesary advices for referal via telemedicine.
Some one has also raised the medicolegal issues relating to the telemedicine. So before we may go for it in our country we must think on these issues. ISRO has started its pilot project for telemedicine in gujarat for three months. Let's hope for the best.

----- Original Message -----
From: DOLKE
To: MFC eForum
Sent: Tuesday, May 22, 2001 9:56 AM
Subject: [mfriendcircle] INTERNET AND HEALTH: is there a doctor?

http://www.itu.int/newsroom/wtd/2001/FeatureHealth.html

INTERNET AND HEALTH: is there a doctor?

Picture this. A young child in a poor, rural town, playing football by the
side of a busy road, runs out on the street to chase the ball and is hit by
a car. The frightened parents take the unconscious child to the nearest
medical centre for emergency aid. The doctor, a young, eager but
inexperienced practitioner fresh out of medical school, takes an X-ray of
the child's skull to determine the extent of the injuries. Although the
child is stable, the doctor faces the difficult dilemma of either providing
treatment locally, based on his or her own diagnosis or sending the child on
a long, arduous and perhaps dangerous journey to the capital for treatment
at the country's better-equipped hospital. It is a choice which could have
life or death consequences..

Now picture the same scenario, but with a different ending. The injured
child is brought to the rural doctor. The doctor takes an X-ray of the
skull, but instead of making the diagnosis, he or she sends the image via
the Internet to the hospital in the capital so that more experienced doctors
can make the call. The image is sent via low-cost teleradiology equipment,
which not only allows X-rays to be sent in a digital format clear enough for
experts to identify the extent of injury, but also allows the experts to
send advice back to the doctor for treatment. The doctor successfully treats

TO: RRP
23/5

the child, who soon returns home and continues to play football with friends, well away from the busy road.

A vision of the future? No! A snapshot of reality in countries such as Mozambique shows that "telemedicine" is making a real impact on the availability of health care and health care information in the developing world. Telemedicine is a term which has emerged to describe the provision of medical services and health care via telecommunications-based systems such as the Internet, either by terrestrial, wireless or satellite links. Mozambique is being viewed as perhaps one of the most successful examples of telemedicine in action. In cooperation with the International Telecommunication Union, through its Telecommunication Development Bureau (BDT), the government of Mozambique has established a telemedicine link between the central hospitals of Maputo, the capital, and Beira, the country 's second largest city some 1000 km away from the capital. The link allows the hospitals to exchange messages regarding laboratory results and treatments as well as radiographs.

As a result, doctors in Beira can refer cases to the central hospital in Maputo for primary or secondary opinions and to send medical records to the capital so that experts there can determine whether patients facing more serious problems can be treated locally or transferred to Maputo. The project was especially important for the hospital in Beira since it had no radiologist when the telemedicine link was established. "They were handling roughly ten thousand X-ray films per year," noted Leonid Androuchko, a Geneva-based professor of telecommunications who formerly headed an ITU telemedicine programme. "On simpler cases it was easy to interpret the image locally, but for more complex cases they had to refer to the capital. That was not only frustrating but very costly."

For developing countries, such telemedicine projects tend to be relatively inexpensive to implement. Mr Androuchko said the approximate cost in hooking up Maputo and Beira was around USD 50 000, with the main cost being the digitalization of the X-ray images. Mozambique's Government is so satisfied with the results that its Prime Minister has written to the ITU to ask for its help in establishing additional telemedicine links with a hospital in Nampula, the country's third-largest city, with part of the cost to be covered by the government.

A similar project is being implemented in Senegal, where a telemedicine link will be established between the country's main hospital in Dakar Fann and regional hospitals in the towns of St Louis, Djourbel and beyond. The link will not only allow for the transmission of medical images and medical information, but will also allow doctors to discuss cases in detail via videoconferencing. As in Mozambique, the telemedicine connection is especially important for the regional hospitals in interpreting X-ray images

since neither hospital has a staff radiologist.

Additional telemedicine projects have been set up with ITU assistance in countries such as Bhutan, Georgia, Malta, Uganda and Ukraine. In Georgia, the project is relatively simple and involves trans-telephonic electro-cardiogram (ECG) monitoring systems. With this simple system, a cardiovascular patient holds a small, box-shaped ECG device that transmits information to a hospital-based cardiologist. The remote monitoring allows cardiologists to monitor their patients' progress after they are discharged from the hospital without the time and expense of frequent return visits.

Petko Kantchev, the coordinator of ITU's telemedicine projects, says the benefits of telemedicine are not only the ability to bring rural areas into the net of the national health care service at relatively low cost, but also the ability to better utilize the intellectual resources within a country.
"The typical rule in a developing country is the concentration of the most-able intellectuals and professionals in the capital," he noted. "These people, who tend to be very few in number, have extremely important know-how and experience which is pertinent to the local environment. They are more familiar with the diseases and illnesses which can be handled locally rather than consulting with doctors in Canada, Russia, Germany or the United States."

Dermatological diseases are an example, of a type of illness which is prevalent in developing countries and where telemedicine can facilitate treatment. A telemedicine project, now being considered in Ethiopia, would allow digital and video images of patients in rural areas suffering from skin disorders to be sent, via the Internet, to doctors in the capital. These doctors would then consult among themselves and forward advice on treatment. The project has become more feasible thanks to the widespread availability of digital cameras. "There are a lot of skin disorders in these countries which rural medical staff don't know how to deal with," Kantchev noted.

An area in which the Internet can instead make a difference is in the support of medical research and the training of health professionals. After all, the Internet was until recently a purely academic/research network - a function which still holds a strong and solid presence among academics and researchers in developing countries.

The possibility of accessing a vast source of medical information and professionals on a global scale provides unique learning opportunities for medical students and other health professionals. Distance-education opportunities are not new, but the Internet and its unique communication features provide a new and unprecedented medium for accessing education

services worldwide. Distance education in the health sciences was hampered - as in other disciplines - by some of the traditional problems which all non face-to-face education suffered: poor interaction with tutors and no interaction with other students, a slow response rate, a sense of isolation and lack of incentives to continue, therefore, a high drop out rate. Furthermore, in the medical sciences there were considerable problems in sharing images and explaining hands-on procedures.

With the Internet, most of these problems are gone. Even with a slow Internet connection, the educational experience can be dramatically different.

Another way in which the Internet is making a difference is in the easy, fast, and almost free distribution of high-quality educational material to support the activities of health workers working on the ground at the community level. An example of this is the launch of the Tools for Life Kit, a versatile health communication kit that includes Activity Cards and Information Cards designed to enhance community health workers' education and counselling skills. The Tools for Life Activity Cards can assist in engaging communities in relevant health issues, such as safe motherhood, nutrition and infant health, diarrhoea, prevention of common illnesses and reproductive health. The Tool Kit has been posted on the Web for comments and improvement. The open and collaborative nature of the Internet has, in the first three months of the pre-test, attracted more than 5000 visitors from 29 countries to the 'Tools for Life' website, many of whom haveprovided valuable comments and contributions to the design of the material.

Advocates of telemedicine are quick to note that it is not a panacea for a nation's health care woes. In fact, a number of telemedicine projects introduced in the late 1960s and early 1970s failed for reasons such as inadequate medical regulations in force, the high cost of equipment, lack of suitably trained staff and administration and, in the case of teleradiology, poor image quality. "To make it work, you need a good telephone line, a good ISDN connection or a VSAT (very small aperture terminal) link," noted Kantchev. "You also need good local leadership to ensure proper implementation and follow-up." Many developing countries are setting up national committees or task forces comprising representatives from both the telecommunication and health care sectors. These groups play a very important role in enlisting support from all stakeholders in the country and in formulating viable telemedicine projects.

Most telemedicine projects call upon a mix of delivery paths. High-precision remote surgical interventions, for example, or remote access to very complex imagery such as brain scans, dictate the use of high-speed broadband telecommunication links. However, in many cases, the public Internet offers huge possibilities. It provides fast access to medical data and

expertise
nationally, regionally or globally, thus bringing medical care to patients,
who would have been otherwise unattended. Whether for seeking advice on standardized symptoms or real physiological data, including a patient's vital signs from on-line doctors that can be anywhere on the planet, the
Internet is increasingly being exploited. The increasing quality of videoconferencing and audio tools on the Internet are also providing a valuable resource for live, remote consultation and diagnosis.

The continuing decline in the cost of telecommunications and information
technology, as well as great leaps in digital imaging and compression techniques have spurred a new wave of enthusiasm for telemedicine, particularly in developing countries. It is in these countries where telemedicine's greatest asset - allowing specialist medical expertise to be
delivered to regions and locations where doctors are few on the ground -
shows the best prospects for success. For governments struggling with limited health care budgets, a shortage of doctors and other health care
professionals, dispersed rural hospitals and poor transportation infrastructure, telemedicine may help them overcome some of these difficult
challenges in meeting the health care needs of their citizens.

When opinions count

The Research Institute of Radiology and Interventional Diagnostics in Tbilisi, Georgia, provides a number of sophisticated medical services using
modern technology. From time to time, however, doctors at the Institute seek
to verify some difficult cases with colleagues from other medical centres
within Georgia and abroad. The telecommunications link connecting the Institute with other medical centres allows them to obtain a second opinion
quickly and efficiently but it also provides enhanced access to medical information within the nation and abroad.

In September 1998 the first medical file including the X-ray film was sent
over the Internet to Switzerland for a second opinion. Specialists from the
Centre of Imaging Diagnostic in Lausanne studied the case, and within 48
hours the Institute of Radiology in Georgia received an opinion with recommendations for the treatment. During September and October of 1998,
more than 10 cases coming from Georgia were analyzed by high-level medical
professionals in Switzerland-several of the cases under consideration were
of professional interest to doctors at both ends of the line.

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