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Special Report

HINDU, 6th September 1978.

What are the ways by which the millions of poor in developing and under-developed countries can be provided with a good health care system? An international meet is to discuss this question.

COMPREHENSIVE CARE WITH PEOPLE'S PARTICIPATION

"Health for all by the year 2000. This call, given by Dr. Halfdan Mahler, Director-General of the World Health Organisation at the World Health Assembly in May 1977, may sound to many as utopian dream or wishful thinking. But WHO and the United Nations Children's Fund are well set to make it a realistic goal. As part of the efforts these two have mounted, nearly 700 delegates from all over the world are meeting for a week from to-day at Alma Ata, the capital of Soviet Kazhakhstan.

The Conference, claimed to be the first ever to be convened on a world-scale to discuss ways and means of providing better health care for all people in the world, is a follow-up of the resolution adopted by the World Health Assembly in May 1975. The Assembly called for exchange of experience among member-countries on the development of primary health care as part of the national health services.

The unsatisfactory state of public health services was first highlighted by WHO in 1973. "There appears to be widespread dissatisfaction among populations about their health services. Such dissatisfaction occurs in the developed as well as in the thid world," the report had said.

From then on, WHO had been periodiocally driving home the need for correcting the situation. In May 1973, the World Health Assembly passed a resolution advocating special emphasis on meeting the needs of those populations which have clearly insufficient health services. A year later the WHO Director-General frankly admitted that the most signal failure of WHO and its Member-States was the inability to promote development of basic health services and to improve their coverage and utilisation.

Dr. Mahler had even advocated resort to "unorthodox ways, like increased use of auxiliary health personnel to correct the situation even though this might be disagreeable to some policy makers.

In January 1975, the WHO executive board underlined the plight of the rural population and recommended priority attention to primary health care at the community level. Closely following this, the World Bank came out for the first time with a study specifically addressed to health issues. Its significant feature was the link it sought to establish between health and economic development. It formed the basis of World Bank lending for projects to control major diseases.

According to WHO, about two-thirds of humanity does not have access to the simplest of health care systems. A joint report by Dr. Mahler and the UNICEF Executive Director, Mr, Henry R. Labouisse, which forms the basis working document for the Alma Ata conference, condemns the widening global gap between the "health haves" and the "health have-nots". The gap is evident not only as between affluent countries and the developing world, but also within individual countries, whatever may be their level of development.

Discussing the reasons for this situation, the report says: "Better health could be achieved with the technical knowledge available. Unfortunately in most countries this knowledge is not being put to the best advantage of the greatest number. Health resources are allocated mainly to sophisticated medical institu-

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tions in urban areas. Quite apart from the dubious social premise on which this is based, the concentration of complex and costly technology on limited segments of the population does not even have the advantage of improving health.

"Indeed, the improvement of health is being equated with the provision of medical care dispensed by growing numbers of specialists, using narrow medical technologies for the benefit of the privileged few. People have become cases without personalities and contact has been lost between those providing medical care and those receiving it At the same time, disadvantaged groups throughout the world have no access to any permanent form of health care".

Health systems are all too often being devised outside the mainstream of social and economic development. "These systems frequently restrict themselves to medical care, although industrialisation and deliberate alteration of the environment are creating health problems whose proper control lies far beyond the scope of medical care. Thus, most conventional health care systems are becoming increasingly complex and costly and have doubtful social relevance.

"They have been distorted by dictates of medical technology and by the misguided efforts of a medical industry providing medical consumer goods to society. Even some of the most affluent countries have come to realise the disparity between the high care costs and low health benefits of these systems. Obviously, it is out of the question for the developing countries to continue importing them". The report recommends in this context the alternative approach of "primary health care".

This approach does not envisage mere expansion of medical services to cover the hitherto neglected sections. It is something more than that and has social and developmental dimensions with goals like improvements of the quality of life and maximum health benefits to the greatest number. The basic premise is that in developing countries in particular, economic development, anti-poverty measures, food production, water, sanitation, housing, environmental protection and education-all these contribute to health. For the success of primary health care programme, there has to be co-ordinated effort in all these sectors.

According to WHO, the seven basic principles of primary health care are:

It should be shaped around the life patterns of the population it is to serve and should meet the needs of the community.

It should be an integral part of the national health system, and other echelons of service should be designed to support it.

It should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing and communications).

The local population should be actively involved in the formulation and implementation. Decisions as to the community's needs should be based on a continuing dialogue between people and the services.

Health care offered should place maximum reliance on available community resources, especially those that have remained untapped, and should remain within the strictest cost limitations.

Primary health care should use an integrated approach of preventive, promotive, curative, and rehabilitative services. The balance between these services should vary according to community needs.

The majority of health interventions should be undertaken at the most peripheral level possible by suitably trained workers.

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The joint report has not shut its eyes to the possible obstacles to such an approach. "Attempts to ensure a more equitable distribution of health resources could well meet with resistence from political and pressure groups and the use of appropriate technology may arouse the opposition of medical industries," it says and suggests methods to overcome these obstacles.

The most important single factor is a strong political will and support at both national and community levels, reinforced by a firm national strategy in favour of not only an increased health budget but also allocation of the increased resources to institutions providing direct support to primary health care. The report also calls for action to support national policies and strategies.

Apart from this strong political commitment and increased resources the report suggests specific antidotes to some of the obstacles likely to be encountered. For instance, health professions, from whom resistance can be expected, should be persuaded that they are not relinquishing medical functions but gaining health responsibilities. In the same way, resistance among the general public can be defused by discussions in communities and in mass media, which should aim to make people appreciate that primary health care is realistic, since it provides at a cost that can be afforded, essential health care for all rather than sophisticated medical care for the few.

Opposition from the medical industries, according to the report, can be met by making them interested in production of equipment for use in primary health care. Any losses from reduced sale of expensive equipment could be more than counterbalanced by the sale to large untapped markets of greater amounts of less expensive equipment and supplies.

The report cautions against the assumption that primary health care implies the cheapest form of medical care for the poor, with the bare minimum of financial and technical support.

The health care and medical care services that are set up should be made accessible-geographically, financially, culturally, and functionally. Geographical accessibility means that the distance, travel time and means of transportation are acceptable to the people Financial accessibility means that the services must be what the community can afford. Cultural accessibility refers to the technical and managerial methods used, which should be in keeping with the cultural patterns of the community. Functional accessibility ensures that the right kind of care is available on a continuing basis to those who need it, wherever they need it.

Then comes the question of appropriate technology. Dealing with this the report points out that fewer drugs than those now in the market are necessary and a list of 200 essential drugs has been prepared by WHO. The report feels that it will be an advantage if the equipment and drugs selected for primary health care are manufactures locally at low cost.

The maintenance of equipment should preferably be within the capacity of local people and local facilities. Locally available resources, including human, should be made full use of. In other words, the suggestion is that people should take active interest and participate in solving their health problems. By this involvement, individuals become full members of the health team.

According to the report, the most realistic solution for attaining total population coverage is to employ community health workers who can be

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trained to perform specific jobs, in short time. They have to be trained and retrained, based on a clear definition of the problems involved, the tasks to be performed and the methods to be used.

The organisational set-up at the community level and at the referral levels, to provide support, will involve increased responsibilities for the highly trained staff at the referral levels. They will also be required to guide, teach, and supervise community health workers and educate communities on all matters pertaining to health.

The report calls for mutual co-operation among developing countries by way of exchange of information and experience and urges affluent countries to increase substantially transfer of funds to the developing countries for primary health care.

The expectation is that the Alma Ata conference will prove to be a turning point in international efforts and provide concrete recommendations for action by U.N. agencies and Member-States.

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PRIMARY HEALTH CARE

Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the Community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.

Primary Health Care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. Since these services reflect and evolve from the economic conditions and social values of the country and its communities, they will vary by country and community, but will include at least: promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries.

In order to make Primary Health Care universally accessible in the community as quickly as possible, maximum community and individual self-reliance for heth development are essential. To attain such self-reliance requires full community participation in the planning, organization and management of Primary Health Care, Such participation is best mobilized through appropriate education which enables communities to deal with their real health problems in the most suitable ways. They will thus be in a better postion to take rational decisions concerning Primary Health Care and to make sure that the right kind of support is provided by the other levels of the national health system. These other levels have to be organized and strengthened so as to support Primary Health Care with technical knowledge, training, guidance and supervision, logistic support, supplies, information, financing and referral facilities including institutions to which unsolved problems and individual patients can be referred.

Primary Health Care is likely to be most effective if it employs means that are understood and accepted by the community and applied by community health workers at a cost the community and the country can afford. These community health workers, including traditional practitioners where applicable, will function best if they reside in the community they serve and are properly trained socially and technically to respond to its expressed Health needs.

Since Primary Health Care is an integral part both of the country's health system and of overall economic and social development, without which it is bound to fail, it has to be coordinated on a national basis with the other levels of the health system as well as with the other sectors that contribute to a country's total development strategy.

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(8) All Governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in co-ordination with other sectors.

(9) All countries should co-operate in a spirit of partnership and service to ensure primary health care for all people, since the attainment of health by people in any one country directly concerns and benefits every other country.

(10) An acceptable level of health can be attained for all the people of the world by 2000 A.D. through a fuller and better use of the world's resources, a considerable part of which are now spent on armaments and military conflicts.-PTI.

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10 - point declaration on health

NEW DELHI, Sept. 20. - The declaration of Alma Ata approved by the world conference on primary health care early this month says that an acceptable level of health can be attained for all the people by 2000 A.D. through a fuller use of the world's resources part of which are now spent on armaments.

According to a press release by the World Health Organisation, the declaration approved unanimously by delegates from 140 nations and numerous non-governmental organisations "calls for urgent and effective international and national action to develop and implement primary health care throughout the world and particularly in developing countries."

The 10 points of the Alma Ata declaration are:

(1) Health, which is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, is a fundamental human right.

(2) The existing gross inequality in the health status of the people, particularly between developed and developing countries is economically unacceptable and is. -therefore, of common concern to all countries.

(3) Economic and social development, based on a new international economic order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries.

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

(5) Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of Governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by 2000 A.D. of a level of health that will permit them to lead a socially and economically productive life.

INTEGRAL PART

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

(7) Primary health care reflects and evolves from the economic conditions and socio-cultural and politial charateristics of the country and includes at least education concerning prevailing health problems and the methods of preventing and controlling them.

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Health Care Policy and Delivery Methods*

by
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Introduction

Public Health in British India mainly concentrated on legislation and measures for the prevention of epidemics in the civil population to safeguard the health of the British Army. In 1943, a rapid stride was however made by the British India Government in the wake of the constitution of the famous Beveridge Committee in Great Britain, by the appointment of 'The Health Survey and Development Committee (Bhore Committee)' to survey the existing position in regard to health conditions and health organisations in the country and to make recommendations for the future development. The Bhore Committee Report, as it is popularly known, came out in 1946, which recommended a short term and long term programme for the attainment of reasonable health services based on the concept of modern health practice.

India became independent in 1947. A democratic regime was set up with its economy geared to a new concept, the establishment of a "Welfare State". The burden of improving the health of the people and widening the scope of health measures fell upon the National Government.

The Constitution of India came into force in 1950 and India became a Republic in the Commonwealth. Article 246 of the Constitution covers all the health subjects and these have been enumerated in the Seventh Schedule under three lists - Union List, Concurrent List and State List. Article 47 of the Constitution under the Directive Principles of State Policy states "that the State shall regard the raising of the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties'. The Planning Commission was set up in the same year by the Government of India which set to work immediately for drafting the First Five Year Plan and subsequent plans. Paradoxically, the policy frame for health services of Independent India was to be the blue print of health services drawn up by the Bhore Committee for post war British India.

The Bhore Committee formulated its recommendations on the basis of certain remarkably progressive guiding principles listed below:

1. Medical Services should be free to all without distinction
2. The Health programme must from the very beginning lay special emphasis on preventive work
3. Suitable housing, sanitary surroundings and a safe drinking water supply and adequate nutrition are pre-requisites of a health life
4. Health services should be placed as close as possible to the people
5. Health education should be provided on a wide basis
6. Doctor of the future should be a social physician

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*Paper read at the Plantation Medical Officers' Conference organized by UPASI during 21-22 December 1978 at Coonoor.

7. The training of the basic doctor should be designed to equip him for playing an effective role as a social physician

It is significant that even at such an early period when the country was still under colonial domination and the members of the Committee were British and native health administrators and public men of that period, they could develop such profound insights into the issues involved in the formulation of a national health policy.

The Bhore Committee had categorically stated that it is "fundamental that development of the future health programme should be entrusted to Ministries of Health at Centre and in the Provinces which will be responsible for the people and sensitive to public opinion. The need for developing the programme in the closest possible cooperation with the people has already been stressed". The Committee had also emphasised that in drawing up a health plan, certain primary conditions essential for healthful living must in the first place, be ensured. Suitable housing, sanitary surroundings and safe drinking water supply are pre-requisites of a healthy life. The Committee enjoined that "the provision of adequate protection to all, covering both its curative and preventive aspects, irrespective of their ability to pay for it, the improvement of nutritional standards qualitatively and quantitatively, the elimination of unemployment, the provision of a living wage for all workers and improvement in agricultural and industrial production and in means of communication, particularly in the rural areas, are all facts of a single problem and call for urgent attention. Nor can a man live by bread alone. A vigorous and healthy community life in its many aspects must be suitably catered for. Recreation, mental and physical, plays an important part in building up the conditions favourable to sound individual and community health and must receive serious consideration. Further, no lasting improvement of the public health can be achieved without arousing the living interest and enlisting the public cooperation of the people themselves.

The Prime Minister Jawaharlal Nehru in enunciating the health policy of Independent India to the first Conference of the Provincial Health Ministers held in 1946, endorsed the views expressed by the Bhore Committee and stated that in the past, little attention was paid to health which was "the foundation of all things". He asserted that economy in this sphere might mean greater expense in the long run and that "the health of the villagers required special attention as the country derived its vitality from that and hence benefits of health must be extended to the whole country side". The aim according to Shri Nehru was to develop a "National Health Scheme which would supply free treatment and advice to all those who require it".

Five Year Plans and the Health Status of the Indian People

Although policy decisions have been taken from time to time to evolve a sound National Health Policy over the last 28 'planned' years, we seem to have drifted further and further away from the goal of "total health for all" envisaged by the Bhore Committee. Every five year Plan document contains a brilliant rhetoric for expanding health programmes for more and better equipped Primary Health Centres and for better implementation of programmes. The recommendations of the Chadha Committee and Kartar Singh Committee were aimed towards this end. Even more recently in 1975, the Shrivastav Committee, brought out a blue print for major policy changes giving a social orientation to the entire system of medical education and in rural health programmes of India.

As stated by the Shrivastava Committee on development of a national programme of health services for the country based on the Bhore Committee Report-"During the last 30 years, sustained efforts have been made to implement its recommendations as well as those of other important Committees in this field. In spite of substantial investments made and the impressive results obtained particularly in the production of medical manpower, the health status of the Indian people is far from satisfactory. The sheer magnitude of the tasks that still remain is so great and the additional resources available for the purpose appear to be so limited that one almost despairs of meeting our health needs or realising our aspirations on the basis of the broad models we seem to have accepted. A time has, therefore, come when the entire programme of providing a nation wide net work of efficient and effective health services needs to be reviewed de novo with a view to evolving an alternative strategy of development more suitable for our conditions, limitations and potentialities".

There is no doubt that all the while manpower, material and economic resources drained inexorably away from the country's real needs. They flowed towards establishing a sophisticated, individualistic, expensive, illness service for the privileged, rather than towards a simple community based and inexpensive primary service for the deprived who form the bulk of the population. The W.H.O. Regional Director, Dr V T H Gunaratne has termed as "Disease Palaces" the present day hospitals. According to him, what we now have in India and other developing countries is an incredibly expensive health 'industry' not for the promotion of health but for the unlimited application of "disease technology" to the affluent section of society.

He further adds that consequence of the present high technological pitch of therapeutics is that the very treatment of one illness may produce another, either through side effects or iatrogenesis. He goes on to say that "this distortion of health work is self-perpetuating. The whole un-healthy system finds its most grandiose expression in buildings, in disease palaces, with their overgrowing need for staff and sophisticated equipment. In medical research too, the main thrust is towards pursuits of disease oriented establishment. Even in the less developed countries probably more than 90% of the research now going on concerns problems, the solution of which would benefit less than 10% of their populations".

Dr Gunaratne made these observations to highlight the need for a shift in favour of the 'Primary Health Care' concept, which envisaged integration, at the community level, of all the elements required to make an impact on peoples' health. This concept was explained by him thus 'It is an expression of what a person should do in order not to fall ill and what he should do when he falls ill'.

A Revised National Health Policy and Health Care Delivery System

The Bhore Committee had visualised that health services would percolate down from the teaching hospitals to the taluq hospitals and then to the Primary Health Centres, Sub-Centres and ultimately to the villages. But it never worked like that. The health services got clustered around the apex institutions - hospitals - instead of percolating to the peripherals. In the new national health policy of our government, this trend is sought to be reversed and a deliberate decision taken to spend 75 per cent of the planned allocation for health in the rural areas.

I find that in your plantations (a primary rural industry) too, the trend of expenditure has a similar pattern. With the introduction of the Plantation Labour Act, the Government placed the responsibility of providing medical care in the Planters while stipulating the minimum requirements. This was based on the concept of the Western model. Garden Hospitals and dispensaries with personnel were prescribed on the basis of the labour force. On some estates these hospitals developed to provide sophisticated medical care. In an analysis of the morbidity and mortality undertaken by Dr (Mrs) V Rahmathullah, Medical Adviser, UPASI, we find that only 3% of out-patient require admission into the Garden Hospital. The estate budget runs to about Rs.75/- per worker per annum and 85% of this budget is spent on the Garden Hospital which looks after only 3% of the out patients. This lopsided expenditure and inadequacy of health care system in plantations need to be given serious consideration. In conformity with the national health policy, it is desirable that 75% of budget is allocated for expenditure on peripheral health services ie., a shift in favour of the primary health concept is necessary. The change is imperative.

If the Infant Mortality Rate is accepted as a good index of the socio-economic progress of a country, then we have one of the highest rates in the world as far as rural areas are concerned, ranging from 90 to 138 per thousand. In some rural areas 80% of the children are undernourished and only 3% have normal body weight. Fifty per cent of the deaths in our country are of children under four.

Nearly 60% of our people who live below the poverty line, lack the purchasing power to secure health services. They constitute about 378 million people whose health care is being neglected. Let us consider this matter in terms of 'health economics' ie., the loss to the national economy due to the ill health of the poorer rural and urban people. If 40% is taken roughly as the number of able bodied people in our population, then the lowest 60 per cent of our population (approximately 378 millions) provide a work force of 151.2 million. If even 10 per cent of them are ill at a time, then 15.12 millions are away from work every day for the whole year. At the current per capita income rate of Rs.1400/- (I am quoting the lowest rate) we are losing at least Rs.2006 crores a year in Gross National Product alone due to ill health. If there are epidemics of any sort, we lose much more. This huge national loss occurs because we do not have a clear cut and firm national policy.

A major shift in the emphasis in the health services was necessary from a curative to a curative-preventive approach, from urban to rural population, from the privileged to the under-privileged and from vertical mass campaigns to a system of integrated health services forming a component of overall social and economic development. Health had to be given a high priority in the Government's general development programme.

Health services are only one factor contributing to the health of the people. Economic and social development activities often have a positive influence on a community's health status. Sanitation, housing, nutrition, education and communications are all important factors contributing to good health by improving the quality of life. In other absence, the gains obtainable with the disease-centred machinery of health services cannot go beyond a certain point. Two kinds of integration are, therefore, necessary. The first is the integration of various aspects of health policy into economic and social development. The second is the welding of the different parts of the health services into a national whole.

A firm national policy of providing total health care for all will involve a virtual revolution in the health care delivery system. It will bring about changes in the distribution

of power, in the pattern of political decision making, in the attitude and commitment of the health professionals and administrators and in people's awareness of what they are entitled to. To achieve such far reaching changes, political leaders will have to shoulder the responsibility of overcoming the present inertia as well as the well entrenched vested interests. Though the framing of health policy belongs to the domain of politicians, the medical profession has a responsibility that goes beyond protecting its own interests and the interest of individual patients, to protecting the health of the whole community. Plantations will no doubt have to adopt the national policy of health care delivery. In a captive population (labour force) in plantations, greater advances are possible, with an enlightened management and an effective medical service. Managements must accept this new philosophy and make greater investments towards providing comprehensive medical care to its labour force, with a sound peripheral health delivery system. Through your Comprehensive Labour Welfare and Link Workers Schemes, some advances have been made but a great deal is still to be done.

The new rural health programme launched in October last year by the present Government, has in my view provided the necessary break through. "Instead of waiting and waiting indefinitely for the health services to percolate down from the teaching hospitals and district hospitals and getting obstructed and lost somewhere on the way, it is a bold attempt to build from the bottom upwards using the village itself as the base", as stated by the Health Secretary to the Government of India.

The rural health and development programmes launched on the basis of the Bhore Committee Report and subsequent Community and Panchayati Raj Development Programmes, may not have made the impact expected of them to bring about an all round development of the rural areas, but the necessary infrastructure has been built up. There are now 5400 Primary Health Centres (with an equivalent number of Blocks) and 38,115 sub-centres with a large number of para medical staff (now Multipurpose Workers) trained in the delivery of the different components of the package of services required.

By the end of the sixth plan, there would be one sub-centre for a population of 5000 compared to one for 10,000 now. Each sub-centre would have one male and one female Multipurpose Worker. The day to day health care at the village level will be provided by the new category of Community Health Workers/Village Level Workers (CHW/VLW), similar in a way to the Link Workers introduced by your Medical Adviser. There will be one CHW for a population of 1000. According to the information given by the World Health Organization, at least six other countries in South East Asian Region (Bangladesh, Burma, Tailand, Indonesia, Nepal and the Maldives) have adopted this scheme.

More than any other part of this scheme, it is the deployment of CHWs that has met with opposition from the medical profession, on the ground it would promote quackery. Before the Government embarked upon this on a national scale, several projects were undertaken by hospitals and voluntary bodies. The ICMR and ICSSR reviewed these projects and the consensus was that in addition to the existing health infrastructure, front line health workers should be deployed at the rate of one per 1000 population. Twelve different duties were contemplated for them, including treatment of minor ailments. All States except Tamil Nadu, Karnataka, Kerala and Jammu and Kashmir opted for this scheme. An evaluation of the scheme within nine months of its launching was undertaken by the

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ICMR and important Health and Management Institutions in the country. There has been in general, massive support for the scheme from all sections of respondents - Community Leaders, Block Development Officers, Zilla Parishads etc.

The Government of Karnataka has now accepted the Community Health Workers Scheme.

Health Delivery through Auxilliary Health Personnel

Our Government hopes that in due course of time, when recommendations of the Shrivastava Committee on Health Services and Medical Education are fully implemented and internship training in rural areas is increased to two years, adequate number of doctors may be available for deployment in rural areas on the basis of one doctor per 10,000 population. There is a great reluctance on the part of doctors to serve in rural areas. For many years Governments and Health Administrators have been attempting to coerce; induce, persuade or even compel young doctors to go to the rural areas and we are astonished that they evince signs of reluctance. May be we should, instead, be astonished that we succeed in getting any physicians to go to these areas. One school of thought is that we are training a person in the science of Clinical Medicine and the academic pursuit of knowledge to attain excellence and then attempt to place him in a position where his whole education is negated. In short, we are attempting to place the physician, an elegantly trained professional in a somewhat inelegant position. The obvious end is dissatisfaction and frustration of the young doctor. To a large extent this may be due to defects in our medical education system or more correctly, lack of implementation of accepted educational policies by Medical Colleges, to produce the type of Social Physicians, envisaged by the Bhore Committee.

All countries want a physician-manned health service and this no doubt will ultimately be achieved in the under-privileged areas. Under-developed countries cannot immediately attain this objective, for they cannot afford to pay for a health service that gives satisfaction to its personnel, which means providing the buildings, equipment, operational funds, and supporting staff that comprise the physician's working environment. There is also a need to provide such as educational facilities for the physicians children, adequate remuneration and housing, and means to overcome intellectual isolation. All these are very expensive, which an under-developed country can ill afford.

But perhaps a physician is not needed to the extent that we imagine in rural areas and many of his functions can be undertaken by the lesser trained and much less costly personnel. What we need to do is to apply the concepts of big business-market research, job analysis or the breakdown of the job into components that require a lesser degree of skill than demanded for the whole, and organisation and management. It is partly the image of medicine that is wrong. The emphasis has been all along on clinical aspects and not the management, to-day medicine demands competent management and this applies particularly to Plantation Medicine.

Better health is desired, as stated by me earlier from the combination of many factors - not merely curative medicine and community health programmes, but also higher incomes, more education, agricultural reform, better animal husbandry, and improved sanitation. There is therefore a need to approach health from a broad ecological view point. Change can only be accepted at a certain rate. Further more, health services must have a total outreach to all the people and not merely to a small privileged urban minority, if they are to have a substantial impact on progress.

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Underdeveloped countries have several common factors. These are limited economic resources, a paucity of educated man power, rapidly expanding populations, conservative traditional cultures, a prevalence of communicable diseases and undernutrition. The use of auxiliary health workers offers a means of achieving a balanced programme of curative, preventive and promotional medicine.

Three essential distinctions have to be borne in mind in the delivery of health services.

First is the distinction between human medical wants and scientific health needs. Human medical wants are very simple. They are for relief when hurt, care when sick, and reassurance and help during maternity. The majority of people in the underprivileged countries have not yet reached the stage of interest in health as such, but only want an absence of sickness. The scientific health needs are equally clear. They are control of the common cummunicable diseases including those of childhood, the parasitic diseases, and the vector borne diseases; the need for planned fertility patterns, for, as Enke said, "the equivalent sum used to reduce births can be 100 times more effective in raising per capita incomes in underdeveloped countries than if invested in traditional development projects", and the relief of protein calorie malnutrition, which could be furthered by the marriage of agriculture and medicine.

The second distinction in the delivery of health services is that between the minor and major ills with the implication of minor and major solutions. I classify diseases into five categories for the purpose of distinguishing between minor and major ills. The symptomatic illnesses are the headaches, sore throats, bronchitis, flatulences, dyspepsias, colds, neuralgias, rheumatisms, aches and diarrhoeas. A second classification is the visible ailments, including wounds, snakebites, tropical ulcers, scabies, eczemas, impetigos, burns, conjunctivitis, caries, and goitres. A third group are those commonly known to the local population, the local entity diseases tapeworm, roundworm, anemia, malaria, and gonorrhea. A fourth group are the infant and toddler diseases, such as marasmus, kwashiorkor, whooping cough, measles, and chickenpox. The final group are the suspect and referral diseases--those which must be referred to more highly trained persons for diagnosis and treatment.

The third essential distinction in delivering health services is in the training and use of auxiliaries in the assistant role, when they are working directly subordinate to a more highly tained person and in the substitute role with supervision remote at best and completely absent at worst.

There are broadly speaking, two methods of delivering rural health services and achieving total outreach. One is to develop an absolute standard for medical and health personnel. As time goes by, the number of persons meeting these standards increases and their reach spreads from the center to the periphery, to cover the whole population. The other is to commence at the economic and educational level which the country can afford, train personnel on a less rigid standard, begin with total outreach, and over a period of time raise the standard of education until professional quality is reached. At a distant end point, both these methods will achieve the same result of quality care to all the people all the time. It is what happens to the people during the interim until this objective is reached that matters.

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A combination of these two methods offers much better prospects for this interim period. Experience dictates that the demand for physicians and other high level manpower always exceeds supply. The use of auxiliaries, working through a few dedicated physicians and para-medical personnel, offers a much greater prospect for improving the health of the populations in the underprivileged territories, than either of the two alternative methods.

'Primary Health Care' and 'Health by the People'

Health for all by the year 2000 A.D. This is the call, given by Dr Halfdan Mahler, Director General of the World Health Organization at the World Health Assembly in May 1977. Dr Mahler has advocated resort to 'Unorthodex way like increased use of auxiliary health personnel to correct the situation even through this might be disagreeable to some policy makers". Both the developed and developing countries have expressed dissatisfaction about their health service. This was highlighted by W.H.O. as early as 1973. The Director General had frankly admitted that the most signal failure of W.H.O. and its Member States has been the inability to promote development of basic health services and to improve their coverage and utilisation.

In January 1975, the W.H.O. Executive Board underlined the plight of rural populations and recommended priority attention to "Primary Health Care" at the community level.

Over 700 delegates from all over the world met for a week in September at Alma Ata, the capital of Soviet Kozhakhstan, to discuss ways and means of providing health care for all peoples in the world. There was an exchange of experience among member countries on the development of "Primary Health Care" as part of the National Health Services. India was one of the nine countries whose experience with community involvement in the health sector had triggered international action in favour of the 'Primary Health Care' approach. Besides India, the other countries whose experience has been drawn upon by W.H.O. in advocating "health by the people", were China, Cuba, Guatemala, Indonesia, Iran, Niger, Tanzania and Venezula. Based on the experience of these countries, W.H.O. brought out a book in April 1975, "Health by the People" and following that, the Executive Boards of UNICEF and W.H.O. adopted a new health policy which underscored the need for combined curative, preventive, educational and social approach and for simplified technology.

As India has accepted in principle the 'primary health care' approach as a national policy, it is worthwhile clearly defining this approach.

According to the WHO, the seven basic principles of 'primary health care' are:

a) it should be shaped around the life patterns of the population it is to serve and should meet the needs of the community;

b) it should be an integral part of the national health system, and other echelons of service should be designed to support it;

c) it should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing and communications)

d) the local population should be actively involved in the formulation and implementation. Decisions as to the community's needs should be based on a continuing dialogue between people and the services;

e) health care offered should place maximum reliance on available community resources, especially those that have remained untapped, and should remain within the strictest cost limitations;

f) primary health care should use an integrated approach of preventive, promotive, curative, and rehabilitative services. The balance between these services should vary according to community needs; and

g) the majority of health interventions should be undertaken at the most peripheral level possible, by suitably trained workers".

We may briefly state that Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community. In short, medicine has rediscovered the community at large. It is rather amazing and ironical that a profession which began in the community should suddenly need to rediscover it!

Since primary health care is a component of integrated rural development, participation in community development activities must remain one of the concerns of the health team in addition to other 'management' tasks such as registration, notification, health reports, or referrals, depending on local circumstances. These activities call upon many disciplines: nursing, obstetrics, health education and especially education in healthy and balanced nutrition, elementary medical diagnosis, therapeutics, environmental sanitation, dental health, mental health, community development, health management etc.

In the frequently presented diagram of the pyramid of health services, the organisation of Primary Health Care can be organised through a three tier system - Health Centre, Sub-Centre and Community Health Worker. At the base of the pyramid are the CHWs/VLWs, with their emergency kit boxes. A CHW/VLW is selected and supported by the local community and looks after a population of about 1000. They are given adequate training to carry out a limited number of specific curative, preventive and health promotional activities with the aid of the emergency kit and elementary sources. These workers, however, will not be able to solve the more complex but at the same time less frequent problems.

At the sub-centre level are the two Multipurpose Workers (male and female) looking after a Community of 5000, who are more experienced and have had sound training in maternity, child health and welfare programmes, national health programmes and other aspects of community health work. They will supervise and assist the community health workers, improve their skills and supplement their activities. The work of Multipurpose Workers will be supervised by the Multipurpose Worker Supervisors from the Primary Health Centre.

At the apex of the primary health care pyramid, will be the Primary Health Centre with 6 beds. A Primary Health Centre will, therefore, look after a population of about 80,000 through 16 sub-centres each with a population of 5,000 and 80 CHWs at the village level, each CHW looking after a population of 1000. The staffing pattern and functions of a Primary Health Centre are well known to you. Three medical officers will now be available at each Primary Health Centre for preventive, promotive and curative work. From the Primary Health Centre, referrals will go to the Taluq or District Hospitals.

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It will be observed the present concept of Primary Health Care delivery System is almost the same as advocated by the Bhore Committee in 1946. Let us hope that now with the strong backing of WHO, UNICEF and National Governments, the call of Dr Mahler, Director General, WHO, "Health for all by the year 2000 A.D." will come true and not sound to many as an utopian dream or wishful thinking.

In your own plantations with dispersal of labour, distance and terrain, the three tier system of primary health care could be organised through Garden Hospitals, Dispensaries (Mini Health Centre) and Link Workers, but adequately supervised by medical officers. I know that your Medical Adviser is already planning on the basis of one Garden Hospital for 10,000 population with four mini health centres, each looking after 2500 population and Link Workers (each Link Worker looking after 20-40 families)

10 point Declaration on Health (WHO/UNICEF)

I would like to conclude with the 10-point declaration on health taken at the Alma Ata Conference of WHO, which calls for urgent and effective international and national action to develop and implement primary health care, throughout the world and particularly in developing countries.

(1) Health, which is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, is a fundamental human right.

(2) The existing gross inequality in the health status of the people, particularly between developed and developing countries is economically unacceptable and is, therefore, of common concern to all countries.

(3) Economic and social development, based on a new international economic order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries.

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

(5) Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of Governments, international organisations and the whole world community in the coming decades, should be the attainment by all peoples of the world by 2000 A.D. of a level of health that will permit them to lead a socially and economically productive life.

INTEGRAL PART

(6) Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the over all social and economic development of the community.

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(7) Primary Health Care reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and includes at least education concerning prevailing health problems and the methods of preventing and controlling them

(8) All Governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system in coordination with other sectors

(9) All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people, since the attainment of health by people in any one country directly concerns and benefits every other country.

(10) An acceptable level of health can be attained for all the peoples of the world by 2000 AD through a fuller and better use of world's resources, a considerable part of which are spent on armaments and military conflicts.

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D R A F T

NATIONAL HEALTH POLICY

GOVERNMENT OF INDIA

MINISTRY OF HEALTH & FAMILY WELFARE

NEW DELHI

PREAMBLE

1.1. Health is a positive attribute of life. It is characterised by a state of complete physical, mental and social well-being and not merely the absence of disease. Maximally attainable and acceptable levels of health for all people is out goal. Every citizen should be enabled to attain a level of health necessary to develop his mental and physical faculties to their full genetic potential. Health cannot be viewed in isolation from the overall goals and policies of national development. Development implies progressive improvement in the living conditions and quality of li e enjoyed by the society and shared by its members and the central focus of such development is 'man'. Thus, health is both an important pathway to development as well as a desirable end-product of development.

1.2. Any re-organisation of the health services should be in response to the needs of the situation. Improvement in the health status of the population is achievable if there is a shift from the current emphasis on hospital-based, disease-oriented approach, depending heavily on sophisticated technology, to an approach where the attitudes, skills and methods of the trained personnel are in tune with the needs and aspirations of the common man and where the facilities available are equitable accessible to the population in physical, social, cultural and financial terms. The adoption of modern methods of medicine without adaptation to our cultural ethos has only brought in dependency and weakened the community's capacity to cope with its own problems. A wise use of the manifest and latent resources of the community can play a key role in supporting organised health services. A community achieves the highest level of health when it reaches a stage of least dependence on professionaly intervention and maximum reliance on its own resources and action.

1.3. Growth of medical technology has equipped man with increased ability to cure and decreased sensitivity to 'care'. This has created distortions in medical treatment and has led to ineffectiveness of the health system. If we can make the concept of 'care' a social reality, it would ensure the total health of the individuals as well as of the community.

PRIMARY HEALTH CARE

2.1. Active involvement of people in the health system is a sine qua non for at-taining the goal of 'Health For All'. At the International Conference on Primary Health Care held at Alma Ata in September 1978, the Nations of the world have given unto themselves the objective of attaining an acceptable level of health for all the people of the world by the year 2000. As a signatory to the Alma Ata Declaration and in a spirit of service to our own people, we have to take active steps through Primary Health Care to attain this objective.

2.2. Primary Health Care is a practical approach in making essential care universally accessible to individuals and families in the community in an acceptable and affordable manner and with their full participation. Decentralisation and self-reliance are the corner-stones of this approach. The goals of Primary Health Care are attained by social means such as acceptance of increasingly greater responsibility for health by communities and individuals and their active participation in attaining it. This approach involves large scale transfer of simple skills and knowledge to people slected by the comm
their confidence and willing to serve

compassion and spirit of service. The translation of much of medical and health knowledge into practical action involves use of simple and inexpensive inventions which can be readily implemented b ordinary people with iminimal training leading to the greatest benefit to the society.

2.3. Primary Health Care can only succeed if the organised health services povide full logistic and professional support to the voluntary workers residing within the community. Such a system would result in optimal utilisation of the knowledge and expertise at higher levels and in the long run, it can be expected to relieve the overburdened curative services in the urban and semi-urban areas. The development of an effective primary health care system both for rural and urban areas would ensure would ensure the following:-

i. A greater awareness among the community and population of the health problems and ways to tackle them at their own levels;

ii. Intervention at the lowest practicable levels by a worker more suitably trained;

iii. Optimal utilisation of khowledge and expertise by higher level technical experts, be they health workers, physicians or specialist.

iv. Increasingly less dependence on hospitals and thus optimal utilisation of such facilities for cases where they are actually needed.

PREVENTIVE AND PUBLIC HEALTH SERVICES

3.1. The emphasis on public health services has slowly decreased in the last 30 years, yielding its own rightful place to curative services. The trend has to be arrested to reversed. The coverage of public health services and provision of preventive services are now spatially very limited. Municipal and local authorities responsible for such services generally suffer from a lack of will and resources to implement them effectively. It is rational and economical to deal with a cluster of causes for poor health conditions on a broad front in the form of integrated package of services which are more than a mere collection of health interventions. There is, therefore, an urgent need to set up a chain of sanitary-cum-epidemiological stations throughout the length and breadth of the country, manned by suitably trained and equipped staff. Such stations can conveniently take care of environmental health problems, detection and control of epidemics, handle checks on quality of food, water, etc. Investments on such stations now will have a relatively high pay-off in the long run.

3.2. The pattern of diseases in developed countries has changed radically in the last 50 years. The range of vaccines, sera, etc., is ever increasing Our aim on the preventive front should be achieve 100% coverage of the total population by the year 2000 in terms of inoculation, vaccination, etc. The wherewithal is within our technical competence.

WATER SUPPLY AND SANITATION

3.3. Provision of safe water supply to the population and improvement in sanitation is basic for improving the health status of the people. This needs to be done at a cost and with a technology which the nation can afford. We should, therefore, aim at providing safe drinking water and improved sanitation to all population within a given time-frame.

PROMOTIVE SERVICES

4. For a meaningful involvement of the community in the health care system, education about the advantages both immediate and long-term are necessary. It is, therefore, in the interest of the health system itself to take on the responsibility for explaining, advising and providing clear information about the favourable and adverse consequences of interventions available or proposed as well as their relative cost. As part of promotional services, it would be necessary to educate people about food habits,

nutrition, breast-feeding, etc., which are themselves not costly if properly adopted and which could lead to substantial savings in terms of human misery. In view of the large-scale widely prevalent malnutrition, the question of proper nutrition assumes special importance and requires concerted action. There would also be a difficult but pressing need to overcome religious and social taboos which often-times prevent people from adopting healthy habits.

FAMILY WELFARE AND POPULATION POLICY

5. A reduction in birth rate is part of the National Family Welfare Policy, a Statement on which was adopted in June 1977. Health and family welfare are; so intimately intertwined that, without an active and vigorous implementation of the Family Welfare Policy, the National Policy on Health or, for that matter, any policy of national development, cannot even be conceived of.

MATERNAL AND CHILD HEALTH SERVICES

6.1 The future of any nation is the future of its children. If the limited reso rces in the health s ector are to be preferentially applied to a segment of population, it should logically flow to children and mothers. Infant mortality, child mortality and maternal mortality in this country are stark figures signifying our inability to achieve a break-through in this field. Bold attempts need to be made to ensure 100% health coverage in the next 10 to 15 years for all children in the age group 0-5 and by the year 2000 of all children up to the age of 15.

6.2 Maternal services are sparsely distributed. Our dependence on professional birth attendants will continue for a long time. While there may be an addition in the institutional facilities for deliveries - particularly to provide for complicated cases - we should ensure that all deliveries are handled by competently trained persons. This would reduce signficantly the maternal mortality and morbidity.

6.3 Along with vigorous steps needed to achieve reduction in the birth rate, we need to improve the facilities availabeltto mothers and children to assure the families of the safety of their progeny. This, by itself, will have a psychological impact and would over the period favour a reduction in the birth rate.

CURATIVE SERVICES AND HOSPITALS

7.1 We have inherited a system of health services and medical education from the colonial days which has a large emphasis on treatment in hospitals and cure of diseases. With increasing sophistication, we are now devoting 80% financial and manpower resources in the health sector to this segment of health services which is more or less concentrated in urban areas. With the public sector, private sector and voluntary sector operating jointely and sometimes at cross-purposes, there is avoidable disorganisation in the provision of curative services. Even the general hospitals run by Government do not provide equality of access to the poor. There is often-times duplicate and triplicate utilisation of facilities in an effort to get second and third medical opinions. A method should be developed to avoid this wastage of scarce resources. The urge of the common man to get quick and effective medical treatment, particularly when he is at the physical and psychological nadir is understandable. The pace of investment in hospitals and curative services has to be slowed down, linking it rationally to a national policy on urbanisation. One can, however, hope that extensive provision of preventive promotive, public health services would go a long way to relieve the burden curative health system to a large extent.

7.2. Even so, there would be a need to provide an increasing number of hospital beds; firstly to take care of some of the under_served, semi-urban and rural population and secondly, as part of the referral system. Construction of hospitals on traditional methods is a costly proposition, most of the money going into brick, mortar and equipment. We need to explore ideas on new type of hospitals in which modern construction is restricted only to essential areas such as theatres, wards, etc.; the rest being of simple structures using local materials with provision for members of the family to stay and provide basic nursing services.

7.3. We have, in addition to themodern system of medicine, indigenous systems like ayurveds, unani, siddha, naturopathy and homoeopathy in wide use. There has so far been no coordination among all these systems, either in terms of education or in terms of services, not to speak of integration. We should now begin an attempt on a co-ordination of the services offered by all these systems so as to obtain optimal economic utilisation.

7.4. The trend is towards increased application of sophisticated modern technology, be it auto-analysers, linear accelerators, EMI scanners or intensive care equipment and the like. Very often these provide a cultural shock [illegible] for the average Indian. In any case, they tend to increase competition amongst professionals to acquire more of these sophisticated techniques at great cost and thereby increase the distance between the patient and the doctor We must learn to use increasingly appropriate health technology replicable with scientific, technical and managerial resources available within the country.

MEDICAL EDUCATION AND HEALTH MANPOWER

8.1. Medical Education has suffered as a result of cultural dichotomy coupled with parallel development. The modern medical system has kept pace with developments in the rest of the world but the type of education imparted particularly at the under-graduate level is heavily hospital-oriented with little relevance to Indian situations. This makes a fresh graduate unsuitable to handly situations in the community and unable to appreciate the problems and dilemmas of the community. The indiegenous (traditional) systems of medicine have, after years of neglect, started coming into their own. The earlier attempts to integrate the modern medicine with the traditional systems have failed. While no attempt to forcibly integrate any system of medicine should be made, all the systems should realise, in the Indian conditions, the limits and potentials of other systems and draw inspiration from them and should support each other mutually. This can be done only by a concern for other systems and understanding of their functioning.

8.2. The training of agents of health care in sufficient numbers at appropriate levels, with right attitudes, outlooks and functioning in an orchaestrated manner, holds the key to success of any health system. The hierarchical structure of the presot day health manpower and the roles allocated to each level in the hierarchy are the outcome of a historical process. A dynamic process of change and innovation is needed. The concept of health team is important in this context. The national medical education policy aims at qualitative and quantitative development of adequately trained health personnel of all categories in a reorganised structure keeping in view the training of a composite health team. To help in innovative development of medical education al processes and ensure a continuous input of properly trained manpower, it would be necessary to set up a Medical and Health Education Commission embracing all systems of medicine and all categories of medical and para-medical personnel.

HEALTH PLANNING AND HEALTHE INFORMATION SYSTEM

9. The need for an effective information system in the Health field at all levels providing for collection, processing, storage, and retrieval as a tool actively actively aiding appropriate decision making and programme planning field of Health is well recognised. We have to gear our [illegible]

set up a dynamic information system to support the Health Planning and decision-making machinery.

MENTAL HEALTH

10. Mental well-being is an essential component of the state of good health. With increasing industrialisation and greater strains in the community, mental health problems are on the increase. Here again, a primary health care approach would enable isolation of the problem at an early stage and handling of the same in an appropriate manner. Traditional Indian practice such as yoga, sadhana, etc., need to be strengthened and made universally available to attempt non-medical methods of handling mental health problems.

REHABILITATION

11. Rehabilitation forms the fourth side of the health square, the other sides being prevention, promotion and cure. Medical rehabilitation services are not fully available to those in need of the same. Here again appropriate technology should be increasingly used. Medical rehabilitation also needs to be coupled with social rehabilitation in certain circumstances like 'burnt out leprosy cases', etc.

BIO-MEDICAL ENGINEERING

12. Developments in this field are occurring every day and at a rapid pace. However, particularly due to miniaturisation occurring in electronics it should be possible to take advantage of the electronic industry in the country to make available such advances to a multitude of istitutions. This branch of medical science has so far not been adequately attended to. The industrial capability of this country is of a high order and it should be possible, with some attention, to keep pace with developments in this field and transfer them in an appropriate manner to Indian conditions.

PHARMACEUTICALS

13.1 It would not be far wrong to say that the pharmaceuticals industry dominates the health sector and the doctors are deeply influenced by the drug industry. Instead of being able to dictate to the drug industry, the medical profession is in fact dependent on the drug industry of whatever continuing education it receives in the form of literature. Over-utilisation of drugs so as to increase the profits of the drug industry, has become the end and hospital and the medical profession are used as a means towards this end. This problem has been deliberated upon by various committees, essentially to ensure that the drug industry plays a subordinate and not a dominant role, without, however, minimising the plenitude of good that it brings to millions of people. The medical profession should have a greater say in determining the direction of growth of the drug industry.

13.2 Reliance on synthetic chemicals and antibiotics is a growing world-wide phenomenon. Greater utilisation of drugs tends to increase the cost of the health system. On the other hand, vaccines and sera which are used in preventive medicine need to be encouraged and new vaccines need to be developed.

13.3 In so far as the medicines belonging to the traditional systems are concerned, the age-old practices of local preparation of such drugs have slowly vanished leading to greater commercial preparation of such such drugs. It might be worthwhile and necessary to encourage local manufacture of such durgs in small communities wherever such treatments are in vogue. Further use of herbs and meicinal plants, particularly for common ailments wherever practicable, needs to be encouraged. It is expected that the local growing of such herbs and plants, harvesting, storing and preparation of medicines out of the,, at the community level, would go a long way towards self-reliance.

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13.4. In keeping with the concept of community participation and self-reliance it is also necessary to reduce dependence of the population on the formalised medical system for the use of medicines. While on the one hand it would be necessary to guide the population in the use of medicines particularly those which are toxic or have reactions, it is also necessary to depend on the people themselves for knowledge of their own conditions and use of appropriate remedies. Thus, consistent with our concern for overuse of drugs and professional supervision on the use of drugs having toxic or side-effects, we should liberalise the idea of self-medication. This will imply strict control on the quality of medicines available in the market.

RESEARCH

14. No nation can afford to neglect the support of fundamental and basic research, for without it there can be no proper teaching of science and no national capability for solving unresolved problems, meeting changing situations and for adopting, in certain instances, known technology to suit local conditions. And yet, highest priority should be given to applied research, in particular health services research, if the technological achievements of medicine are to be placed within the reach of those who need them most. Health services research is holistic, multi-disciplinary in character involving the the joint participation of bio-medical sciences and social sciences. Such research should be carried out within the health service system and research priorities determined as a result of joint discussion between researchers, administrative decision-makers and the public, The whole ethos of such research should be based on discovery of simple, low cost, appropriate health technology, the results of which are replicable under routinised settings. We also need to devote ourselves to basic research, particularly with a view to developing solutions to problems plaguing our country. We are yet to develop effective cures or vaccines, for such diseases as malaria, leprosy, etc. Likewise, there is immense scope for research in matters relating to Human Reproduction. Research in the field of medicine should be relevant to the needs of the community.

LEGISLATION, INSURANCE AND COORDINATION

15. Health being a State subject, the approaches to legislation in the health field would necessarily vary from State to State. A variety of legislation s already on the statute book, be it on the national level or State level. It would be necessary to review these items of legislation and work towards a single comprehensive legislation applicable to the health field. The services provided by government are generally free. This leads to a situation where there is not enough appreciation that the services do cost money to the nation and, therefore, should be utilised only where it is essential and unavoidable. A realisation of the utility of such services can be brought about by educating people as also by levying nominal charges for all services. The possibility of introducing some form of national health insurance, at least in the future, to provide for guaranteed health services to all segments of population needs to be pursued. In the present system since there is a co-existence of the private sector, voluntary sector as also the public sector, it is essential to coordinate the services by these sectors. The possibility of setting up coordination committees to regulate the services available in each of these sectors needs tobe explored. Secondly, in the private sector and to a limited extent in the voluntary sector, sometimes the fees charged are rather high. While this drawback will continue as long as the private sector exists, an attempt needs to be made to ascertain whether there can be any self-regulation. As part of this exercise bold attempts need to be made to end the system of private practice by doctors in Government service and in Medical Colleges.

INPUTS IN HEALTH-RELATED FIELDS

16. Developments in health come not merely as a result of inputs and activities in thehealth field, but also due to developments in health related fields such as agriculture, water supply and drainage, communication etc.

At the community level, all health activities must be coordinated with and in fact, form part of, total rural development. To the extent decentralisation of resources, planning and implementation can be achieved, there will be greater efforts and development in all field and thus in health also. Such decentralisation should, therefor , be actively pursued and supported. Even at State and national levels, health activities and inputs should benefit from investments in health-related fields and to that extent, coordination with other sectors of development have to be volunatrily sought for and achieved.

CONCLUSION

17. The following should, therefore, be the short-term and long-term goals of the national health policy:-

17.1. Short-term goals

i. to eradicate/control communicable diseases in the country;
ii. to provide adequate infrastructure for primary health care in the rural areas and in urban slums;
iii. to utilise all availabrlmethods for health education and spread the me-ssage of Health and Family Welfare;
iv. to utlise knoledge from different systems of medicine for profiding quick and safe relief from sickness and debility at the cheapest possible cost;
v. to reorient medical education to be in tune with the needs of the community;
vi. to provide increasing maternal and child health coverage.

17.2. Long-term goals

i. to improve public health services by setting up a chain of sanitary-cum-epidemiological stations;
ii. to ensure 100% coverage of all segments of population with preventive services;
iii. to create a self-sustaining system of health security so that earnings of the individual are not affected adversely during periods of illness;
iv. to impart medical education in a medium which is an integral part of our culture and life-style and thus remove the foreign concepts associated with foreign languages which are major factors inhibiting people from understanding the true and proper role which medicine plays in the development of a healthy community;
v. to utilise available knowledge from the ancient and modern systems of medicine in an effort to develop of composite system of medicine, thus obliterating the caste system prevailing in the field of medicine;
vi. to inculcate a sense of self-reliance and discipline in all segments of population so that all four sides of the health square, namely, prevention, promotion, cure and rehabilitation are effectively handled at the local level consistent with the developments in the field of medicine.

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WORKING WITH THE COMMUNITY

3.1 DEFINITION

A community is a social group determined by geographical boundaries and/or common values and interests.

The members of a community, particularly in a rural area, know and interact with each other and create certain norms, values, and social institutions.

> COMMUNITY HEALTH REFERS TO THE HEALTH STATUS OF THE MEMBERS OF THE COMMUNITY, TO THE PROBLEMS AFFECTING THEIR HEALTH, AND TO THE TOTALITY OF HEALTH CARE PROVIDED FOR THE COMMUNITY.

The assessment of the health status of the community requires an understanding of the general populations to be served. Refer to sections 4.3.1 and 4.3.2 for the methodology for collecting general information and conducting a base-line survey.

> HEALTH CARE PROVIDES A WIDE SPECTRUM OF SERVICES INCLUDING PRIMARY HEALTH CARE. THE INTEGRATION OF PREVENTIVE AND CURATIVE SERVICES? HEALTH EDUCATION, THE PROTECTION OF MOTHERS AND CHILDREN? FAMILY PLANNING AND THE CONTROL OF ENVIRONMENTAL HAZARDS AND COMMUNICABLE DISEASES.

The system of health care delivery, if it is to be effective and serve the needs of the community, must have the following characteristics:

i. It must be accessible to all the population.
ii. It must be available when needed.
iii. It must be free of economic barriers, i.e. it should be available to all economic groups.
iv. It must not be limited by social or cultural distinctions.
v. It must reflect certain inherent characteristics of the community.
vi. It must be flexible in its approaches.
vii. It must recognize that the primary avenues to health may be through education, economic progress, legislation or other aspects of society rather than through organised health structures.

3.2. YOUR ROLE IN COMMUNITY HEALTH ACTIVITIES

As a health worker in a rural community you are also a community worker and you must, therefore, work very closely with the community and other workers, e.g., agricultural, educational, public works, housing and communications, working within the same community.

3.3 WORKING WITH THE COMMUNITY LEADERS

If your services to the community are to achieve their objectives you must create a demand for these services within the community, This demand can be created in the following ways:

i. Involving the community in all aspects of health services delivery, i.e. in the planning, delivery, utilization and evaluation of health care.
ii. Inter-relating the services with other operating social systems within the community.
iii. Shaping the services around the life patterns of the community.
iv. Relying on the community to provide the mobilize its own resources to assist in the provision of health care.

..Cont'/2-

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ii. Informal Leaders (Natural/Status): These individuals may be any influential men or women in the community such as midwives, shopkeepers, farmers, housewives or other persons who have the respect and confidence of the people. They may hold a position of leadership on account of their age, caste, religion, wealth or education.

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...Contd/3-

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   1. Cause and control of communicable diseases
   ii. Maternal and child health
   iii. Family planning
   iv. Nutrition
   v. Environmental sanitation.
4. Identifying and utilizing the resources in the community to improve the health status of the community.
5. Methods of educating and motivating the community to improve their health status and change their health behaviour.
6. The need for coordinating the various developmental activities of the community so achieve improvement in the total well being of the community.

3.7 UTILIZING THE COMMUNITY LEADERS

When you work with the community leaders, you should remember that you are working; through them, with community you are serving. They can promote or destroy your programme, so you should ensure that your relationship with them remains cordial, friendly, cooperative and promotes team work. Utilize the community leaders as follows:

i. Enquire what the current needs of the community are.
ii. Relate these needs to the objectives of the health services and ensure that your activities will satisfy their needs. If you are unable to satisfy these needs explain to the leaders why you cannot do so, and what they could do to meet their requirements.
iii. Plan with the leaders the delivery of health services, their timing and what motivational steps are necessary to promote health programmes.
iv. Request the help of the leaders in the delivery of the health programmes.
v. Enquire from the leaders whether the community is satisfied with the services being delivered. If not, ask why and try to find ways, in consultation with the leaders, fr improving the programme.

REMEMBER THAT BECAUSE OF FINANCIAL CONSTRAINTS ONLY THE ESSENTIAL NEEDS OF THE COMMUNITY CAN BE SATISFIED. HOWEVER, YOU CAN HELP THE COMMUNITY TO SELECT HEALTH PRIORITIES AND MOBILIZE THE COMMUNITY RESOURCES IN ORDER TO OVERCOME THESE CONSTRAINTS.

vi. Stimulate the leaders to relate health programmess with other developmental programmes in the community Remember that major improvements in the health of the community can result from minor changes in the cultural behaviour and economic standards of the people or in the existing community organizations.
vii. Use the leaders to motivate members of the community who are resistant to health programmes. This can be done through the organization of health committees, which would encourage the community to take an active part in the running of the subcentre which serves them.

....Contd/4-

viii. Influence the leaders to assist you in your work through community participation in health activities.

REMEMBER THAT IF A PROGRAMME IS PLANNED AND OPERATED WITH COMMUNITY PARTICIPATION, THEIR INTEREST WILL BE MAINTAINED AND THE PROGRAMME WILL BE MORE EFFECTIVE.

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a. Information about the achievement of the health programme in the area.
b. Specific problems or doubts raised by the community members.
c. New developments in the health programme.
d. Planning for involvement of the community in the education and service programme.
e. Orientation of new leaders in the community.

3.8. WORKING WITH OTHER COMMUNITY WORKERS

Besides workers from the health department, there are workers from other departments such as teachers, agricultural workers, community development workers, Balsevikas, etc., all of whom have specific responsibilities but with the same overall goal of improving the welfare of the community. It is necessary for you to work closely with all these workers in order to benefit the community to the maximum extent possible The following are some of the ways in which you can get assistance from your colleagues, or help in their work:

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3.9. THE COMMUNITY LEVEL WORKER

The idea of utilizing community level workers to deliver health services of an elementary nature has now been accepted as part of the health delivery system in India. These workers will not be government employees but will be selected by the community and, after training, will work within the community. These community level workers will be drawn from among teachers and educated and willing housewives.

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CHW BC

WORKING WITH THE COMMUNITY

3.1 DEFINITION

A community is a social group determined by geographical boundaries and/or common values and interests.

The members of a community, particularly in a rural area, know and interact with each other and create certain norms, values, and social institutions.

> COMMUNITY HEALTH REFERS TO THE HEALTH STATUS OF THE MEMBERS OF THE COMMUNITY, TO THE PROBLEMS AFFECTING THEIR HEALTH, AND TO THE TOTALITY OF HEALTH CARE PROVIDED FOR THE COMMUNITY.

The assessment of the health status of the community requires an understanding of the general populations to be served. Refer to sections 4.3.1 and 4.3.2 for the methodology for collecting general information and conducting a base-line survey.

> HEALTH CARE PROVIDES A WIDE SPECTRUM OF SERVICES INCLUDING PRIMARY HEALTH CARE. THE INTEGRATION OF PREVENTIVE AND CURATIVE SERVICES? HEALTH EDUCATION, THE PROTECTION OF MOTHERS AND CHILDREN? FAMILY PLANNING AND THE CONTROL OF ENVIRONMENTAL HAZARDS AND COMMUNICABLE DISEASES.

The system of health care delivery, if it is to be effective and serve the needs of the community, must have the following characteristics:

i. It must be accessible to all the population.
ii. It must be available when needed.
iii. It must be free of economic barriers, i.e. it should be available to all economic groups.
iv. It must not be limited by social or cultural distinctions.
v. It must reflect certain inherent characteristics of the community.
vi. It must be flexible in its approaches.
vii. It must recognize that the primary avenues to health may be through education, economic progress, legislation or other aspects of society rather than through organised health structures.

3.2. YOUR ROLE IN COMMUNITY HEALTH ACTIVITIES

As a health worker in a rural community you are also a community worker and you must, therefore, work very closely with the community and other workers, e.g., agricultural, educational, public works, housing and communications, working within the same community.

3.3 WORKING WITH THE COMMUNITY LEADERS

If your services to the community are to achieve their objectives you must create a demand for these services within the community, This demand can be created in the following ways:

i. Involving the community in all aspects of health services delivery, i.e. in the planning, delivery, utilization and evaluation of health care.
ii. Inter-relating the services with other operating social systems within the community.
iii. Shaping the services around the life patterns of the community.
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Date :

6/11 Planning a Health Programme

COMH 24.7

(1) Role of religious & CHWs training

(2) Situations in which the Religious, work in which health can become an activity.

(3) Selection of Area/ Coverage.
- which village
- which group

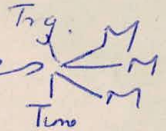
(4) Locating oneself ✓

(5) Other Health/Medical facilities/organizations

(6) Information on Village.

(7) Areas of intervention

(8) Content of Intervention — Floor mopping
Tap Runner off

(9) Resources 

(10) Educational Role.

Date :

Role of a religious in the health field as a situation CHW

1. Health centre run by congregation distributing medicine
   H.E.
2. Health as an instrument in all situations. & role to be defined when in the situation
3. Creche, unmarried girls, aged, orphanage, evangelization, parish work, administ.
4. Making people aware of their needs & helping them to find their solutions
5. Identify as religious. Identify needs of people & act in any sphere needed of which health may be one activity
6. Schools. - HE.
7. The life of the religious community may need adjustment.
8. Integrate health & catechetical work
9. Train village workers to continue work
10. " Others in the religious " "
11. Plan & Bishops/doctors etc organize seminars etc for others working in the area

3(contd) institutions

Date :

1. For women - training novices, school children
ANM's - organizing MCH work
2. Sr. ~~Bertie~~ - full time school teacher
started health centre
post students trained for HE.
3. Bihari sisters - evangelizing - home visits
Sr ~~Teres~~ Thomas - youth groups.
4. Sr Susaanto - organizer of Com. Hlth.
+ animators.
+ strong curative programme.

5. Sr. Marianne - Health Insurance
Scheme c VHAI + Govt support.
6. Sr Jonitta - team member of
Diocesan Health plan.
7. Home for aged / handicapped / Sr. Ennichette
8. Leprosy programmes. - Br Abraham
9. Infirmary - Br Nirmal.
10. Superiors - Role within congregation.
11. Further studies in health / social work
12. Sharing the life -
— x —
13. Spiritual healing, 15'.
14. conscientization.

Date : .....

Locating oneself

- which the nearest PHC.
- where are its sub-centres
- who are the other doctors + health practitioners
- where is the nearest Taluk/district hospital / Mission Hospital.
- find out about other CHW's / NGO's working in the area - UHAI etc.

Selection of area of work:

think small
reach out to people who need us most.

Date :

areas of health work.

	Service	educ^{n} -
First Aid	Burns, cuts, wounds, Drowning, Fracture, poisonous bites, Bleeding, Sprain.	Pr. req. to position, Transfer skills to children, teachers, youth
Minor Ailment Treatment.	Fever, cough, cold. Diarr, Vomit, Rehydr. Malaria. Scabies, Skin dis. Aches + pains. Worms. Stomach troubles boils / abscess constip, vomiting. urinary trouble eye, ear. ~~Headache~~.	HE for scabies, inf. GI diseases, contagious dis prevention & prob rehydr. [learn local customs, traditions + home remedies]
Nutrition.	• Identify cases of Rx + follow up. - under 5 - road to health cards. Pregn. clocks & school kids local "mix" - Propagate Kitchen gardens.	practise what you preach. Nutr. educ. - Mothers. - unmarried girls - School kids.
Sanit^{n}	- Be a good example. - dispose ale + compost pit - Soakaway pit / organize. - latrines. people. - Drain stagnant water.	HE.

Date :

Service	Educ^{n}.
MCH.	AN. IN, PN. Trainees.
	child care
	Fam. welfare
	counselling
	School health.
organizing.	Balwadi / Creche
	Mahila Mandal.
	Youth club
	Bhajan mandali
	Panchayat.
	Schools. adult educ^{n}.
	Library - info and educ^{n}.

Training village level workers

Conscientizing abt their rights.

Contact - Govt agencies.
voluntary agencies

organize seminars / camps.

Health meetings - school children.
village festivals
mahila mandal counselling.
Slide

(HHW BC8.

Chikkanahalli - learning points

1. Group work leading to better creativity - richer fruit + individual work.
2. Builds unity
3. accepting others - listening.
4. Problem solving method - ē numerous alternative solutions being discussed & a consensus is reached
5. Leads to self understanding.
6. Good method of working with a team/community
7. Gives objectivity in viewing a problem.

Objectives of a Religious with CHW training

Role: Possibilities | Limitations

Team

Actual team
+
additional
Human
Resources

How to select
field Area

Group I

Group II

Planning a Health Programme

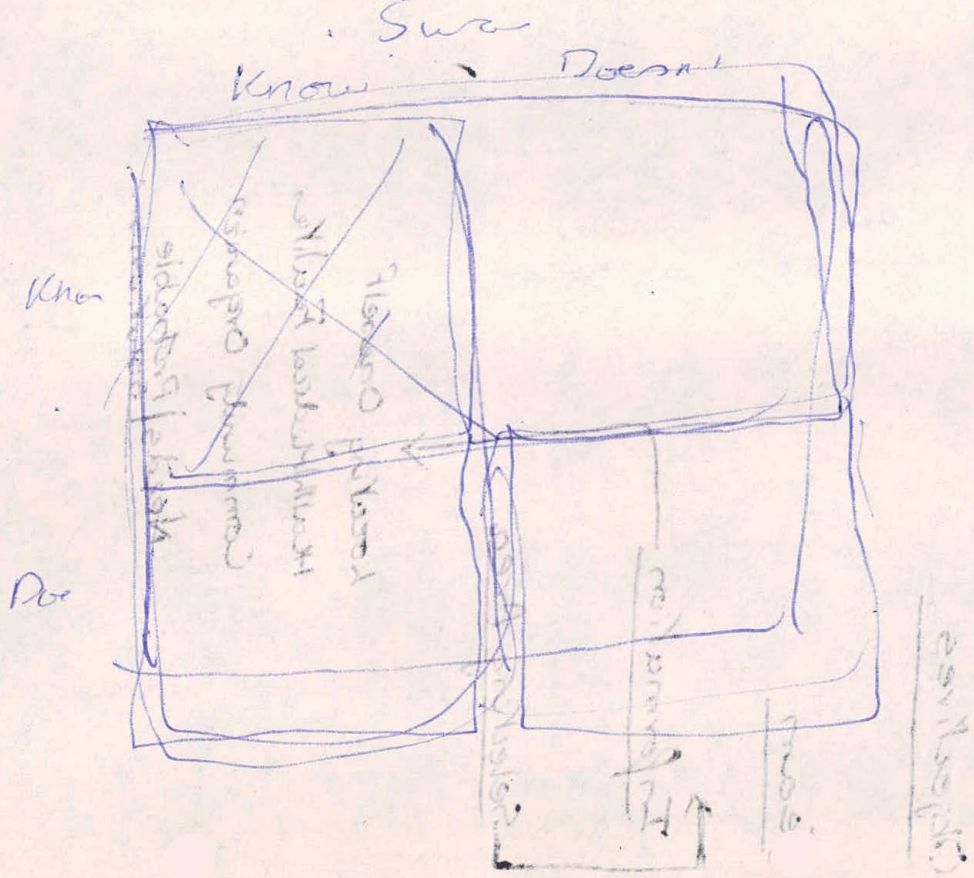
Objectives

Aim

Information

Selecting Area

Locating Oneself
Health/Medical Facilities
Community Organizn
Needs / Probable solutions.


Know
Doesn't
Know
Don't

Planning a CHW's Programme

Why - Health Needs to be Served

Human Needs

Be kind.
Share your knowledge
Respect/learn from culture

a) Know your limits but also use your head
b) Keep learning
c) Practice what you teach
d) work for the joy of it
e) Look ahead.
f) Look holistically

Look at Community

Felt Needs
Real Needs
Willingness
Resources

Evaluation
Sensible Us.
H. Educn
Evaluation

Deciding what to do / where to begin

Trying out new ideas
Balance between Prevention / Treatment

26/3

1. Sat/Monday Programme.
2. List of People to call for 4th Meeting.
3. Health Education

3. Till 9A.M – Pack up/Sort out
4. Send One Van full of Dept materials
5. Return books/Reports/Papers/Kit boxes.
6.

Finding out what progress has been made?

1. How many are you serving

2. How much Health Activities (Doing)

: Before and after statistics

Changes due to Vital Events
- Births
- Death
- Marriages

'Setting Goals often helps people work harder and get more done'

Remember
You cannot measure everything

Relating to people
learning/working/sharing together
Growth of kindness
Responsibility
Hope

Date :

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COMH 24.7

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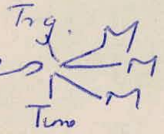
(9) Resources 

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areas of health work

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Minor Ailment Treatment.	Fever, cough, cold. Diarrhoea, Rehydr. Malaria Scabies, Skin dis. Aches & pains worms Stomach troubles boils / abscess constip, vomiting. urinary trouble eye, ear. ~~[illegible]~~	HE for scabies, inf. GI diseases, contagious dis (prevention of spread) rehydr^n - [learn local customs, traditions + home remedies]
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Contact - Govt agencies.
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organize seminars / camps.

Health meetings - school children.
village festivals
marriage counselling.
Slide

COMH 27.8

VOLUNTARY HEALTH ASSOCIATION OF INDIA

C-14, Community Centre, Safdarjung Development Area, New Delhi-110016
Phone : 652007, 652008 Telegrams : VOLHEALTH New Delhi-110016

Director of Rural Health Services
And Training Programmes

Code No. 52.

From "HEALTH CARE AND HUMAN DIGNITY"

by David B. Werner.

I would like to summarize a few of the steps that economy being taken, or might be taken, to implement a regional or country-wide approach to rural (or periurban) health care which is more genuinely community supportive.

1. Decentralization. This means relative autonomy at every level. Advice and coordination from the top. Planning and self-direction from the bottom.

2. Greater self-sufficiency at the community level. This is, of course, implicit in decentralization. The more a community itself can carry the weight of its own health activities, both in cost and personnel, the less paralyzed it will be by break-downs in supply and communications from the parent agency.

3. Open-ended planning. For all the talk about "primary-decision-making by the community," too often a program's objectives and plans have been meticulously formulated long before the recipient communities have been consulted. If the people's felt needs are truly to be taken into account, program plans must be open-ended and flexible. It is essential that field workers and representatives from the communities - not just top officials - attend and actively participate in policy planning and policy changing sessions.

4. Allowance for variation and growth. If a program is to evolve, alternatives must be tried and compared. Substantial arrangements for conceiving and testing new approaches, methods and points of view should be built into the ongoing program. Also, private or non-government projects should be observed and learned from, not forced to conform or stamped out.

5. Planned obsolescence of outside input. If self-sufficiency at the community level is indeed to be considered a goal, it is advisable that a cut-off date for external help be set from the first. All input of funds, the earliest possible date when such assistance is no longer needed. Thus the outsider's or agent-of-change's first job, whether he be a medic or an agronomist, should be to teach local persons to take his place and, in so doing, make himself dispensible. Outside funding, likewise, should not underwrite ongoing activity, but should be in the form of 'seed' money or loans to help launch undertakings which will subsequently carry their own ongoing costs.

6. Deprofessionalization and deinstitutionalization. We have got to get away from the idea that health care is something to be delivered. Primarily, it should not be delivered, but encouraged. Obviously, there are some aspects of medicine which will always require professional help - but these could be

be --

be far fewer than is usually supposed. Most of the common health problems could be handled earlier and often better by informed people in their own homes. Health care will only become truly equitable to the extent that there is less dependency on professional or institutionalized help and more mutual self-care. This means more training, involvement and responsibility for and by the people themselves. It should include continuing education opportunities for villagers which reinforce their staying in and serving their communities.

7. More curative medicine. For a long time, health care experts have been pushing for more preventive medicine at the village level — and with good reason. But too often this has been used as a convenient excuse to keep curative medicine completely — or almost completely - in professional hands. Clearly, preventive measures are basic. However, the villagers' felt needs have consistently been for curative measures (to heal the sick child, for instance). If primary health workers are to gain the respect and confidence of their people, they must be trained and permitted to diagnose and treat more of the common problems, especially those when referral without initial treatment increases the danger to the sick.

I should point out that when I say "more curative medicine," I don't mean "more use of medicines." Overmedication, by both physicians and villagers, is already flagrant. I mean more informed use, which in many cases will mean far more limited use, of medications. But this will require a major grass roots demystification of Western medicine which can only happen when the people themselves learn more about how to prevent and manage their own illnesses. To promote such a change, the village health worker must have a solid grasp of sensible medicine and, in turn, help reeducate his people.

It is, of course, doubtful whether such a metamorphic awakening to sensible medicine can ever happen outside the medical institution until there has been some radical rethinking within it.

8. More feedback between doctors and health workers. When health workers refer patients to a doctor, the doctor should always provide feedback to the health worker, explaining in full clear detail and simple language about the case. This can and should be an important part of the health worker's and the doctor's continuing education.

9. Earlier orientation of medical students. From the very beginning of their training, medical students, should be involved in community health, and be encouraged to learn from experienced village health workers and paramedics.

10. Greater appreciation and respect for villagers, their traditions, their skills, their intelligence, and their potential. Villagers, and especially village health workers, are often treated like children or ignoramuses by their more highly educated trainers and supervisors. This is a great mistake. People with very little formal education often have their own special wisdom, skills and powers of observation which academicians have never acquired and therefore fail to perceive. If this native knowledge and skill is appreciated, and integrated into the health care process, this will not only make it more truly community oriented and viable, but will help preserve the individual strnegths and dignity of the health worker and his people. I cannot emphasize enough how important it is that health program planners, instructors and supervisors be "tuned in" to the capabilities and special strengths of the people they work with.

11. That the directors and key personnel in a program be people who are human. This is the last, most subjective and perhaps most important point I want to make. Let me illustrate it with an example :

In Costa Rica there is a regional program of rural health care under the auspices of the Health Ministry which differs in important ways from the rural health system in the country as a whole. It has enthusiastic community participation and a remarkable impact on overall health. It may well have the lowest incidence of child and maternal mortality in rural Latin America. Its director is a pediatrician and a poet, as well as one of the warmest and hardest-working people I have met. The day I accompanied him on his trip to a half-dozen village health posts we didn't even stop for lunch, because he was so eager to get to the last post before night fell. He assumed I was just as eager. And I was; his enthusiasm was that contagious !

I will never forget our arrival at one of the posts. It was the day of an "under-fives" clinic. Mothers and patients were gathered on the porch of the modest building. As we approached, the doctor began to introduce me, explaining that I worked with rural health in Mexico and was the author of Donde No Hay Doctor. Frantically, I looked this way and that for the health worker or nurse to whom I was being introduced. As persons began to move forward to greet me, I suddenly realized he was introducing me to all the people, as he would to his own family. Obviously he cared for the villagers, respected them, and felt on the same level with them.

This, I must confess, was a new experience for me. I was used to being marched past the waiting lines of patients and being introduced to the health worker, who was instructed to show me around and answer my questions, while the patient, whose consultation we had interrupted, silently waited.

"This man is an exception!" I thought to myself. In our visits throughout Latin America, we found almost invariably that the truly outstanding programs have at least one or two key people who are exceptional human beings. These people attract others like themselves. And the genuine concern of people for people, of joy in doing a job well, of a sense of service, and the sharing of knowledge permeates the entire program clear down to the village worker and members of the community itself.

People are what make health care work.

RECENT TRENDS OF RURAL HEALTH CARE PROGRAMS

from this — TREND — to this

Who are served?

few most privileged → majority in accessible areas → all the people

Who provides the key services ?

professionals (a few outsiders at high cost with long inappropriate training) → sub-professionals → local persons, traditional healers (many insiders at low cost with short, practical training) → health "team"

Where are training and services provided ?

large hospitals → modest health centre → small post or dispensary → home

Primary concern:

sickness (of individuals) → health (of individuals) → health, well-being and future of the community

Focus of action:

Curative → Preventive (water sanitation hygiene, vaccination, nutrition mother/child care family planning early Dx-Rx) → Integrate Development (health education, leadership, agriculture communications) Intermediate technology (conscientizacion land reform social reform)

Geographic coverage of outreach programs:

small, arbitrarily defined areas of great need (or beauty) → entire regions or countries

Sponsoring agencies:

many small pilot projects { private, foreign, religious } → national → international, centralized, decentralized

RURAL HEALTH PROGRAMS IN LATIN AMERICA

TWO APPROACHES

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Initial objectives	Open-ended. Flexible. Consider community's felt needs. Include non-measurable (human) factors.	Closed. Pre-defined before community is consulted. Designed for hard-data evaluation only
Size of progress	Small, or if large, effectively decentralized so that sub-programs in each area have the authority to run their own affairs, make major decisions, and adjust to local needs.	Large. Often of state or national dimension. Top-heavy with bureaucracy, red tape, filling out forms. Superstructure overpowers infrastructure. Frequent breakdown in communication.
Planning, priorities, and decision-making	Strong community participation. Outside agents-of-change inspire, advise, demonstrate but do not make unilateral decisions	Theoretically, community participation is great. In fact, activities and decisions are dominated or manipulated extensively by outsiders, ofter expatriate "consultants"
Financing and supplies	Largely from the community. Self-help is encouraged. Outside input is minimal or on the basis of "seed funds", matching funds or loans. Agricultural extension and other activities which lead to financial self sufficiency are promoted. Low cost sources of medicine are arranged.	Many giveaways and handouts: free food supplements, free medicines, villagers paid for working on "community projects" Village health worker (VHW) salaried from outside. Indefinite dependency on external sources.

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Way in which community participation is achieved	With time, patience, and genuine concern. Agent-of-change lives with the people at their level, gets to know them, and establishes close relationships, mutual confidence and trust. Care is taken not to start with free services or giveaways that cannot be continued.	With money and giveaways. Agents-of-change visit briefly and intermittently, and later on discover that, in spite of their idealistic plans, they have to "buy" community participation. Many programs start with free medicines and handouts to "get off to a good start", and later begin to charge. This causes great resentment on the part of the people.
Data and evaluation	Underemphasized. Data gathering kept simple and minimal, collected by members of the community. Includes questions about the people's felt needs and concerns. Simple scheme for self-evaluation of workers and programs at all levels. Evaluation includes subjective human factors as well as "hard data".	Overemphasized. Data gathered by outsiders. Members of the community may resent the inquisition, or feel they are guinea pigs or "statistics". Evaluation based mainly on "hard data" in reference to initial objectives.
Experience and background of outside agents-of-change	Much practical field experience. Often not highly "qualified" (degrees).	Much desk and conference room experience. Often highly "qualified" (degrees).
Income, standard of living, and character of outside agents-of-change. (MD's, nurses, social workers, consultants, etc.)	Modest. Often volunteers who live and dress simply, at the level of the people. Obviously they work through dedication, and inspire village workers to do likewise.	Often high, at least in comparison with the villagers and VHW (who, observing this, often finds ways to "pad" his income, and may become corrupt). The health professionals have often been drafted into "social service" and are resentful.

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Sharing of knowledge and skills	At each level, from doctor to VHW to mother, a person's first responsibility is to teach - to share as much of his knowledge as he can with those who know less and want to learn more.	At each level of the preordained medical hierarchy (health team) a body of specific knowledge is jealously guarded and is considered dangerous for those at "lower" levels.
Regard for the people's customs and traditional folk healing, use of folk healers	Respect for local tradition. Attempt to integrate traditional and Western healing. Folk healers incorporated into the program.	Much talk of integrating traditional and Western healing, but little attempt. Lack of respect for local tradition. Folk healers not used or respected.
Scope of clinical activities (Dx. Rx) performed by VHW	Determined realistically, in response to community needs, distance from health center, etc.	Delimited by outsiders who reduce the curative role of the VHW to a bare minimum, and permit his use of only a small number of "harmless" (and often useless) medicines.
Selection of VHW and health committee	VHW is from and is chosen by community. Care is taken that the entire community is not only consulted, but is informed sufficiently so as to select wisely. Educational prerequisites are flexible.	VHW ostensibly chosen by the community. In fact, often chosen by a village power group, preacher, or outsider. Often the primary health worker is himself an outsider. Educational prerequisites fixed and often unrealistically high.
Training of VHW	Includes the scientific approach to problem solving. Initiative and thinking are encouraged.	VHW taught to mechanically follow inflexible, restrictive "norms" and instruction. Encouraged <u>not</u> to think and not to question the "system"
Does the program include "conscientization" (consciousness raising) with respect to human rights, land and social reform ?	Yes (if it dares).	Issues of social inequities, and especially land reform are often avoided or glossed over.

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Manual or guidebook for VHW	Simple and informative in language, illustrations, and content, Geared to the user's interest. Clear index and vocabulary included. All common problems covered. Folk beliefs and common use and misuse of medicines discussed. Abundant illustrations incorporated into the text. The same time and care was taken in preparing illustrations and layout as villagers take in their artwork and handicraft.	Cookbook-style, unattractive. Pure instructions. No index or vocabulary. Language either unnessarily complex or childish, or both. Illustration are few, inappropriate (cartoons), or carelessly done. Not integrated with the text. Useful information is very limited, and some of it inaccurate. Many common problems not dealt with. May use misleading and/or incomprehensible flow charts.
	Manual contains a balance of curative, preventive, and promotive information.	Manual often strong on preventive and weak on curative information; overloaded with how to fill out endless forms.
Limits defining what a VHW can do	Intrinsic. Determined by the demonstrable knowledge and skills of each VHW, and modified to allow for new knowledge and skill which is continually fostered and encouraged.	Extrinsic. Rigidly and immutably delimited by outside authorities. Often these imposed limits fall far short of the VHW's interest and potential. Little opportunity for growth.
Supervision	Supportive. Dependable. Includes further training. Supervisor stays in the background and never "takes over". Reinforces community's confidence in its local workers.	Restrictive, nitpicking, authoritarian, or paternalistic. Often undependable. If supervisor is a doctor or nurse he/she often "take over", sees patients, and lowers community's confidence in its local worker.
Encouragement of self-learning outside of norms	Yes. VHWs are provided with information and books to increase knowledge on their own.	No! VHWs are not permitted to have books providing information outside their "norms".

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Feedback on referred patients (counter-reference)	When patients are referred by the VHW or auxiliary, the M.D. or other staff at the referral center gives ample feedback to further the health worker's training.	Doctor at the referral center gives no feedback other than instructions for injecting a medicine he has prescribed.
Flow of supplies	Dependable	Undependable.
Profit from medicines (in programs that charge)	VHW sells medicines at his cost which is posted in public. (He may charge a small fee for services rendered). Use of medicines is kept at a minimum.	VHW makes a modest (or not so modest) profit on sale of medicines. This may be his only income for services, inviting gross overprescribing of medicines.
Evolution toward greater community involvement	As VHWs and community members gain experience and receive additional training, they move into roles initially filled by outsiders - training, supervision, management, conducting of under-fives clinics, etc. More and more of the skill pyramid is progressively filled by members of the community.	Little allowance is made for growth of individual members of the community to fill more and more responsible positions (unless they graduate to jobs outside the community). Outsiders perpetually perform activities that villagers could learn.
Openness to growth and change in program structure	New approaches and possible improvements are sought and encouraged. Allowance is made for trying out alternatives in a part of the program area, with the prospects of wider application if it works.	Entire program is standardized with little allowance for growth or trial of ways for possibly doing things better. Hence there is no built-in way to evolve toward better meeting the community's needs. It is static.

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
RESULTS:	Health worker continues to learn and to grow. Takes pride in his work. Has initiative. Serves the community's felt needs. Shows villagers what one of their own can learn and do, stimulating initiative and responsibility in others.	Health worker plods along obediently - or quits. He/she fulfills few of the community's felt needs. Is subservient and perhaps mercenary. Reinforces the role of dependency and unquestioning servility.
	Community becomes more self-sufficient and self-confident. Human dignity and responsibility grow.	Community becomes more dependent on paternalisatic outside charity and control. Human dignity fades. Traditions are lost. Values and responsibility degenerate.
If outside support fails or is discontinued	Health program continues because it has become the community's.	Health program flops.
TACIT OBJECTIVE	Social reform - health and equal opportunity for all.	"Don't rock the boat." Put a patch on the underlying social problems - don't resolve them !
SPONSORING AGENCIES (There are notable exceptions)	Often small private, religious, or volunteer groups. Sometimes sponsored by foreign non-government organizations.	Often large regional or national programs co-sponsored by foreign national or multi-national corporate or government organizations.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

CHW-BC4.	Class	Roll No.
8/6/79.	Semester	Subject
Gen. Mahadevan	Examination	Date

PRINCIPLES OF COMMUNITY DEVELOPMENT.

Com-Dev — a sense dev. by the people for their local common good
common good — political, social (health), religious,
economic, educational

Social welfare state provides freedom from — disease,
ignorance, squalor/poverty, by providing health services,
educ°, employment + assistance.

Politics means sharing of power — a community must assert its rights
ie there should be freedom of individuals or autonomy
In India power is conc. in the hands of a few. & the rest follow.
to leaders. Problems here are — d/o casterism — need atomization of society

Social — there shd be mutual support in the comm.

Religion — interlinked ↑ above, worship in common helps comm. life
but institutionalized religion goes against this eg Hindu caste
Probl° like social injustice etc can be tackled only on a
comm. basis

Educ° — learning from each other, teaching each other, tolerance

Economic — eg afforestation etc cooperatives but shd not leave out the Harijans
only certain leaders may dominate — only weapon against
indebtedness.

what are the probs of the caste sys. — customs, — beliefs

Summary

1. Com. developer attaches more imp to man than to institutions/ideologies.
2. Main aim is to make the indi. in the community & the community itself to grow. — stim. change.
3. Dev. critical awareness.
4. Have faith in the people & be faithful to them
5. No longer needed : comm. has taken over.

Main aim is total human dev°.

CHW - BC4.
11th June '79.
Dr. S.V. Ramarao.

Comprehensive Health Care

- Care of Health + prim health care.
- Def of health (WHO). (positive health)
  i) Approaches to all indn.
  ii) womb to tomb (all stgs of dev) (Adult - age of prod: + upd) all pervading components.
- total health care vs prim Hlth care ē is only essential hlth care it is not possible to have total care for all our 630 million people ∵ no resources ∴ PHC
- caus: of dis - Agent host envir (eg grains & plant-seed source soil)
- Natural hist of dis
- Our aim to interrupt this course - levels of prevn:

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class	Roll No.
CHW - BC 4.	
Semester	Subject
23/7/79	
Examination	Date

1. Going around Mallur Village - Chawki rearing centre, convent school, milk collection centre, Harijan colony
2. Abt gp discn + 2 reports on Mallur cooperative + Hlth centre
3. Mthd of study/classes — gp discn & max: participation
4. Papers to be read — envir: sanit", working in the community, the people, Dev. works +
5. Time table
6. Any other ques/topics to be discussed.
7. Under 5" care.

Working with the community.

1. Def: — community + its social implications
   — "working" - health + dev".
2. Prim health care / comprehensive health care + its components
3. Your role in com. health activities + coordn: & other dev. workers
4. Create a demand for your services
5. Types of leaders — formal / informal
6. Identific" of leaders
7. orient" of leaders (hlth services, needs, sp inp, resources, educ community coord: & other dev.)
8. Utilizing com. leaders
9. Working & other com: workers

- participn of community
- planning
- evaluation
- goal + your role.
- worldwide trend for C H. work
- CHW scheme.

Outline to PHC + village

1. Concept of health centres. vs. dispensary / hospital.
2. Govt prim health centres - staff, work.
3. Mallur Health Co-op Centre - origin, growth, present level
4. Economics of Mallur + Mallur health centre
5. Working of the centre
6. Socio cultural aspects: geography, pop", language, religions, castes, occup"s, marriage, festivals, environ, communication

* Health cooperatives (com + financial, manag, staff, hlth practices, services, methodology, records of work, coord: & govt)

The Indian situation (Rural)

Negative	Positive
1. Dependance consciousness	Independance consciousness
2. Indifference	participation
3. Inferiority complex	superiority complex
4. Close mindedness	open mindedness

Success of policies/projects/schemes whether economic, political, social or health depends upon the volition of the people which results from their consciousness which can be positive or negative as given above. People with plus qualities are more highly motivated & receptive to change. Changes in attitudes, habit & behaviour patterns are necessary for any positive programme of comprehensive health care. No longer is good will & heroic work the sole answer to evolving successful dev. programmes. The benefits of studies & economic principles must be applied to our programmes to make them yield the maximum gains & minimum or least expenditure.

Paradox of large urban hospitals & malnutrition, anemia, communicable diseases in their shadows. Sol: to this problem lies in several directions i) people to be made aware of their health needs

ii) after awareness comes participation

iii) Health centre must provide total care to people i.e. a prog. fitted to the needs of the community & compatible with the resources available to the community.

Community Dev: Block.

- Com. Dev Bl. progr started in 1952
- objective – integrated dev: of rural India thru' social, cultural & economic aspects : imp on: bet agri & health.
- Highest priority to agriculture, also communications, health & sanit:, housing, educ:, rural employ:, welfare of women & children & small scale industries
- a block has 2 active stg's of. organiz: both of 5 yrs
- In April '73 there were 5092 Bl's of ē 4000 had passed thru' both active stg's
- From '73 responsibility for finances were passed from the centre to the State.
- By '77 5,400 PHC's were est. in 5,245 Blocks
- Finance – a nucleus budget supplemented by the resources of substantive dev: depts like agri, health & educ:. Also mobilis: efforts by Panchayats & vol. contri by people.
- Dept. of Rural Dev: in Ministry of Agri lays down policy rel. to Comm. Dev: Progr: & formulates pattern of expenditure.
- A joint consultative council was formed in 1971 to advise the Central Govt on Comm. Dev: & Panchayati Raj.
- In a State – Dev: Commissioner is in charge of the Com. Dev. Progr.
- District level – Zila Parishad resp. for coordin: & implemen:. Parishads consist of elected representatives of the people incl. Presidents of Block Panchayat Samiti's, MP's & MLA's of concerned Dists.
- Block level – Panchayat Samiti resp. – its members incl. elected Sarpanch, Presidents of village councils & coopted persons representing women, SC's & ST's.
- Dev: Block Administ: – has the foll officers (who work under the Samiti)

Bl. Dev: & Panchayat officer (BDPO)	1
Asst. Panchayat officer	1
Panchayat Secretaries	14 - 15
Gram Sevika's	8
Agri Workers	15
Agri. Inspectors	5
Overseer	1
Mukh Sevika	1

— This staff deals with house tax, street lights, compost pits, gobar gas plants, mahila mandals, small savings, family planning targets, roads, agricultural progr. etc
— Vol. organiz's eg youth clubs, farmers forum + mahila mandals supplement the work of the Panchayat
— At village level Panchayat is in overall control.
— The Gram Sevak acts as a multipurpose extension agent with 10 villages in his charge
— Special progs. exist in certain areas viz
i) Composite Progr for Women + Pre-school children :- in areas not covered by ANP + fam + child welfare progs. Launched in '69-'70 it stresses on nutr, educ + allied fields thru existing institutions like Mahila Mandals / Balwadis
ii) Applied Nutr Progr. — centrally sponsored in collabor of UNICEF, FAO + WHO. — To educate rural people towards improved nutr — nutr supplements to under fives, expectant + nursing mothers — In March '74 progr was in operation in 1,181 Blocks, + is extended to 700 new Blocks in 5th Plan.
iii) Supplementary Nutr Programmes — Malnourished children, pregnant + nursing women in tribal villages, urban slums + drought prone areas receive nutr supplements, school children get mid-day meals — Emphasis on HE — Initially Centrally Sponsored — now implemented by State govts.
iv) Integrated child Dev Services Scheme —
Started in 1975 in 33 Blocks thru'out India. — All children under 6, preg + nursing mothers receive nutr + health care + nutr supplements if malnourished. — For 3-6 yr olds non-formal educ is provided through Anganwadis + functional literacy classes are conducted for adults — Services are provided in the Anganwadi + on the doorsteps by Anganwadi workers, one for 1000 pop
v) Drought Prone Area Progr from 1971
vi) Crash Progr for Rural Unemployment 1971
There are also village dev progs + special progs for part. regions

— Panchayati Raj - India in 1959 is a 3-tier structure of local self-govt at village, Block & district levels & are bound together. Members are elected & there are special representation for various bodies eg women & cooperative bodies.

— The Panchayat Samiti is responsible for agricultural prod^{n}, rural industries, medical relief, Maternity & child welfare, village roads, tanks & wells, maintenance of sanit^{n} & common grazing grounds. Sometimes they look after primary educ^{n}, maintenance of village records & land revenue. States are free to make changes in structure to suit local conditions & there is some variation throughout the country.

— The Panchayat, cooperative & school are the basic village institutions for carrying out democratic decentralisation. (Panchayat - Dev^{t}, Coop - economic sphere, school cum Community centre : educational, cultural & recreational activities).

— Panchayati Raj institutions have powers of taxation.

Talk by participants.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class	Roll No.
CHW - BC4.	Subject
Semester	
15/6/79.	Date
Examination	

Sr. Sarah.

- Pub. Hlth Nurse. - left Holy Fam. Hospital Delhi in 1968.
- worked 8 yrs in 12 villages around Delhi.
- 3 yrs in a mobile team in AP. c Fr. Volken (Sociologist) + Mr. Julian Gonsalves (Agricultural expert) for dryland farming)

— x —

- People in jail - socially / financially
- Unintended negative effect of our work - creates dependency.
- → realize full potential of the people.
- People had no voice / choice of services provided to them
- Dist served by a health centre — 5-10 km.
- People said they lacked - i) money - ∈ is no prob.
  ii) personnel - in our overpopulated country
  who shd be learned - administrators
  - nurses
  - villagers.
- gap bet hospital — village dais ie the top shd accept the grass root workers
  explain what you are + what you shd do
  "spirit behind flannelograph" — thru' songs + drama
  prep for del - eg buds next usual aid
  the village teachers are - talented, intelligent, close to nature, more sympathetic than we are.
- conc on the periphery of hlth centre
- ~~Dont~~ Treat local people as team members
- How to learn the people. - learn how great they are.
- "We" shd be open to how we can work better
- Train them to be masters of their own destiny
- eg planting potatoes in a greenhouse vs open field.
  current med care top vs. V. Hlth.
- in communic". - we are far from them
  eg tape recorder
- the people will accept their own much better
- let them organize themselves

- misuse more among male than women
- the most influenceable grp are ♀ + ♀ are the best to talk to + convince them
- a women is the first to detect sickness in the fam.
  women power - for attitudinal change

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

6/6/79 | Class | Roll No. | injamal
Semester | Subject | looking at the prob. together
Dr. D. Barretto. | Examination | Date

The Dev. worker & the people + working in the community

Since we are all in the field what do we understand by development.

- improving socioec. cond.
- helping a man to help himself - global
- They shd feel that they are one
- A grad process to raise the std of living
- progress of/c the community

Attitudes
- confidence in us
- we are for them

what is underdevelopment.

- ignorant
- poor.
- neglected

- absence of all above.

who told you to do this work - ie the "worker" aspect.

- hope / to help poor
- conscience
- committed
- we are free

Take it that we are underdeveloped

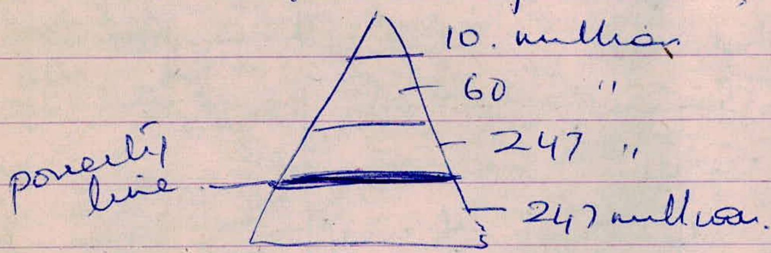
eg ignorance - what do you know of how people live
" " " about land distri: system.
(actually we go in preconceived ideas / prejudices)
" " ... "wage" - cost / life.
dev. worker / manual worker

ie the prob is not in the people but in us (esp. religious) we justify our institutions in village work
congregations may not be interested in villages tho indi may be.
- to know the prob is the beginning of the sol:.
- Society itself shapes us. we must understand the mech: of society & social process

rubelight.

- Everything in our life is related / linked tho' may not be explicitly ie our understanding of under-dev / dev / our work / rel: c people / church / religious life
- There are 4 understanding of dev.

1) - Underdev - fate, normal, will of God
45-50% below pov. line — 290 million - today.



- Dev - no. ie no need of work
- Own work - relief. - material relief / consol. / CRS.
In India we have 25 million tonnes of food rotting but we get food from America — why. < American generous. our people are selfish
ie we subconsciously consider poverty normal
& this CRS rigmarole (constraints) imposes a part rel: c the people
ie
— people become lazy / beggars
no work - unemployment - jobs only 3 mths / yr.
ie you become mother / boss* of the people : your distri of food gives you power over peoples f life c v. little religiously left. ie it doesn't let us be simply human
The term "beneficiary" reflects our attitude & we think we are helping them.
Some people live off the sickness of others
* You know the "recipe" - what they old do as they are ignorant.
- church / world / Religious - diff entities.
cut off from the struggles of life.
only concerned c life after death
Religion (Message) becomes a set of practices / doctrine / ritual
(givens)

2) - Underdev' - Backwardness ← of people — don't know modern ways of living, don't save, lazy
of country — no industry, low rate of capital formation, low rate of saving

- Dev' - modernize ← people - new ways of living, educ'
country - industry, agri, wdrs, power etc.

All this eqs capital & we don't have ∴ goes i for. aid.

- our work - we start small projects - agri / workshops / traditional industry
(at govt level by 5 yr plans & have left 80% of people to our green revol' may turn grey) we get capital from for. aid
We shd be able to set aside some of our own income for developing more people for rural work. in initial stg till we gain credibility & the villages they support us partially / wholly

- Rel & people - manager / boss
(Self reliance is the epitome of dev + not money!
Dev' - we think of "to do things (start) & goes i money
peoples participation is not possible & outside money)

- There are numerous projects of govt / Indian agencies & are unutilized

Dev' is a political process & people have to understand & cannot occur & for. aid when people expect 'miracles'
Using shortcuts in dev' may spoil people & the essence of dev' is people.
Power & the people.
Social injustice / peace
60% land is & 16% of people.
money lending
low wages

ERS food in India ⇄ Prod' crisis & USA surplus
168 million acres - under agri prod & India
30-35% " " - under green revol' prod 2/3rd of the ant
low purchasing power of people (even if we ↑ prod')

only sol' to — by hitting some vested interests ↳ but with whom Govt etc.
{ distri of land, ↑ in rural wages, Money lending } only these can improve health of people

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IV - 1) Naming the system

Capitalist — pvt ownership of land + capital
prod^n for profit. (as against prod. for needs) eg drug m
Conc^n of ec + pol power prod is
Types of

exploited < educ^n, organiz^n > political — raise the consciousness — Church — prophet role

— V. thought provoking
— esp. reg. people's particip^n.
— To be agents of social change eg: self awareness.

THE DEVELOPMENT WORKER AND THE PEOPLE

1. THE MEANING OF HELP:

One can safely assume that a voluntary organisation is primarily in the field to help the beneficiary. The word beneficiary itself speaks of a person who is helped. Therefore, the relationship between the voluntary organisation and the beneficiary will be one of helper and helped. In this relationship two different parties which often have very little in common are brought together by a magic word: "help". When this word is understood in exactly the same way at both the conscious and the unconscious level, by both the giver and the receiver the likelihood of misunderstanding between the voluntary organisations and the beneficiaries are minimal. But, unfortunately, this is not always the case.

For the beneficiary help was a very narrow meaning. In the lives of poor people, there is always one thing which needs urgent solution; to pay back a debt, to find employment, a well in the fields. This is his need. Help means to take care of that need. Any talk on something else is just words, words, words!

For the voluntary organisation on the other hand, help is very likely to be understood in a very different manner, and in different ways depending on the main aim of the organisation. Thus, if the main aim of the VO is education, then the help which the beneficiary needs will be understood to be education; but his main need will change to curative medicine, housing, agriculture, lift irrigation, control of rodents or road building depending on what is the voluntary organisation's main area of activity.

In short, help may mean one thing to the voluntary organisation and a very different one to the beneficiary, giving rise to a misunderstanding. Indeed, the very first question, that a voluntary organisation should ask itself is this: "If help has to be given in answer to a need, whose need does it answer the help which I give?" Sometimes our needs meet: the patient needs the doctor as much as the doctor needs the patient ! But sometimes the doctor may need the patient more than the patient needs him; in which case, the doctor may feel tempted to protract the illness of the patient. In other and clearer words, the need of the voluntary organisation or its personnel is made to be the need of the people. Or, in other words, the former project their needs on the latter. This projection can be of either institutional or personal needs. Let us explain each separately.

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2. PROJECTION OF PERSONAL NEEDS :

The distinction between personal and institutional needs takes cognizance of the fact that the personnel manning the voluntary organisation may have needs different from those of the institution he serves. Now these personal needs may work against the beneficiary. To clarify this point, let us take a hypothetical example where the voluntary organisation aims to help the beneficiary precisely where he wants to be helped. The example: A voluntary organisation well aware that there is lot of unemployment and eager to solve the problem sets out to help the beneficiary by setting up a milk-producers' Cooperative on the understanding that the scheme will provide additional employment and income. The organisation provides the initial loan, the managerial and animal husbandry know-how and even helps in buying the buffaloes: The result is a magnificient cooperative. The cooperative is so successful that people from all over the country come to see it; even international organisations take interest in it. The voluntary workers feel nice. The cooperative helps so many people that the local politicians begin to court its managers. The voluntary worker feels powerful. The cooperative now becomes an end in itself. It did satisfy the first need of the beneficiary. But the cooperative is subsequently made to serve the personal needs of the so-called people's helpers. The cooperative which could have helped the beneficiary first to achieve economic independence, then competence in animal husbandry and finally managerial skills to run the cooperative himself, stops short of these lofty goals. All this, of course, in the name of the people and their true welfare. Because, it is agreed, if the management is given over to beneficiary, the cooperative will soon end up in corruption and mismanagement. Those who so speak might not have been able to answer an entirely different question; "If I give power to the people where am I?"

Here the personal needs of the voluntary worker stand in the way to the true development of the beneficiary. The need for power, the need "to feel needed", the need to father or mother people are all examples of such personal needs.

From the above some may draw the conclusion that development work demands so much detachment, as to be beyond the possibility of ordinary human beings. This is not true. Development work does not ask for mahatmas or saints; All that it asks for is enlightened self-interest. Let us see how: To begin with, it is important to stress that no personal need is bad in itself; therefore, nobody should be ashamed of having such needs are motives. Secondly, it is very important that these needs be accepted by the person in question and by his organisation. Needs which are denied by us have their way of hitting back at us. Finally, the person in question

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and his organisation must find out creative ways of dealing with those needs. A creative way is that which satisfies the personal needs without harming the client. Thus, in the above mentioned example withdrawing in time will not decrease but increase the prestige of the voluntary organisation and its personnel. And, by replicating the model somewhere else, personal power, far from being lessened, is greatly enhanced.

The only difficulty in the whole exercise is that the person in question requires personal courage to accept one's own needs to oneself and to others. One requires self-confidence to believe that what has been done here can be replicated somewhere else. Personal courage, self-confidence: are not these great "developmental" needs of every individual? Here is the great paradox of life: "The more we give, the more we receive". "Acceptance of the developmental needs of our clianted leads to our own personal growth". A person need not be a great man to do development work; but he may very well end up by being one if he does it in a professional manner. For, if development work demands from us self discipline and detachment so does personal growth and emotional maturity. This may not be perceived by voluntary workers because they, like the beneficiaries at another level, are so blinded by their immediate needs that they forget their long-term interests. Development work may bring about this awareness.

3. INSTITUTIONAL NEEDS PROJECTED ON THE BENEFICIARY :

The above example has taken for granted that sometimes, the professed need of the organisation and the felt need of the beneficiary can meet. But unfortunately that is not always that case. Sometimes they differ, in which case the likelihood is that the voluntary organisation may project its needs on the beneficiary.

Here again is a hypothetical example of an organisation which specialises in slum clearance. Food, clothing and housing are understood to be three of the basic needs of man. In a city lack of decent house is seen by the affluent society as a crying need which demands urgent solution. And so an organisation has been set up to take care of this need. A number of rich and well-meaning citizens offer their money. Government and international agencies see it as their duty to help in the venture. And so the new organisation goes to a slum. What is the help the slum dwellers need? For one set of persons atleast there is no doubt - what these people needs is a good housing scheme.

Now the chances are that housing is a need which is very low in the slum dwellers' list of priorities. In which case help (the satisfaction of their needs) will be understood differently by the beneficiary and the organisation and this, of course, give rise to a misunderstanding.

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Let us now examine the possible situations which this misunderstanding may give rise to. A voluntary worker goes to a slum to meet the people. There they are: he and they, rich and poor. After the first initial misunderstandings they begin to receive a clear message: "He wants to help them". But they need money or employment and he offers them housing. Some of them say: "We don't want anything to do with him". Others cleverer say: "He is rich, he has influence. We do not want a house. But it may very well be that if we accept it we shall secure what we want". The others see reason in this and now all agree to go along with him.

This situation has all the elements of a bargain. Briefly: there is a party(a voluntary organisation) which has a need to set up a housing scheme. There is another party(the beneficiary) which needs, let us say money. In this situation how does the latter see the former and its project?

1. The beneficiary may look at the organisation as something he needs. In which case the project will be seen as something to be done in order to preserve the organisation's services.

The project then becomes the tribute the beneficiary has to pay to the voluntary organisation. A tribute is always paid reluctantly. No wonder if the project is sabotaged in more or less subtle ways. For example, the houses may be sublet or sold and the people may revert to the slums.

2. The beneficiaries may not see the voluntary organisation as indispensable; but they may see the project as means to achieve their aims In this case, the project becomes the handle which can be used to manipulate "them". "They have plenty of resources. We need money. The need a housing project. We give it to them. Let them now give us money". OR "This project must be giving plenty of money to "them". Now we also cooperate in it. Therefore, we should also share in the spoils".

In this situation, the beneficiary feels that a tough bargaining is shead; and, therefore, he is likely to adopt the usual bargaining tactics. Secrecy will be one of them "One does not show one's cards". Indeed he may even try to mislead the voluntary organisation. And, of course, in every bargain the stakes must always be kept high.

In the process the slum dwellers keep on looking at the voluntary organisation as the other bargaining party. All its moves will be interpreted in this light: "How do the voluntary workers play their cards?"

1. They may be very soft towards the beneficiary, in which case the letter is likely to interpret this attitude in three possible ways: (i) That the former are stupid, and there-fore, have no credibility, (ii) That they have a lot of money in which case the beneficiary will try to get as much as possible from them or (iii) That they need the project very badly in which case he will harden his bargaining position.

2. If the voluntary organisation is seen as a very hard bargainer he is likely to see it as an improved replica of the local money-lender Zamindar. This means that the relations between him and the voluntary organi sation will be patterned very much along the well known relationship of money-lender and the poor.

3. There is, of course, a third possibility i.e. when the voluntary workers turn the whole situation into a learning one. More will be said about this later.

This attitude of the people may trigger off similar reactions among the voluntary workers. Thus, they may brand the beneficiary as a cheater, as a lazy person or ignorant, or any other adjective to describe a situation which they see as unreasonable. If that be the case, the relationship between them and the beneficiary becomes vitiated.

4. THE NEED OF DIALOGUE:

The important thing in all the possible situation described so far is that the relationship established between the people and the voluntary organisation is not a sound one, simply because it is based on either a misunderstanding (in the case of help being understood differently) or in attitudes which are not authentic when the voluntary worker's avowed aim is one and his real motivation is another.

When such a relationship exists, it is evident that no dialogue is possible because no real communication has been established. Therefore, growth does not take place. And who can deny that growth may be required sometimes by the beneficiaries, sometimes by the voluntary organisations and sometimes by both? In development work it is first the duty of the voluntary workers to grow by making sure that they are not acting out their personal or institutional needs on the people. One way to do it may be self examination and another way is to start a dialogue with the people in order to understand them better and also to make themselves better understood by the people. Whatever may be our shortcomings the people have a way of teaching us and correcting us which is wonderful, if we only listen to them and understand them. There is also a need of dialogue when the people are so overwhelmed by immediate needs that they are ready to take steps contrary to their own long-term interests.

The beneficiary in this case must be made aware that his need is only part of a bigger reality, and that no affective means can be taken to solve their felt needs unless the totality of the situation is taken into consideration. An example will help to illustrate this point.

A Voluntary organisation working in a village, studies the situation and comes to this conclusion: the expenditure of the beneficiaries is higher than their income and consequently the people are indebted. A study of their expenditure reveals that not enough is spent on the necessaries of life, food, clothing, housing and agriculture, while too much is spent on social customs, medical bills and uneconomic borrowing. Since they are so hard for money they are forced to accept loans on adverse terms. Again, since they don't have money to buy they must take on credit paying double. The amount of money paid on interest is higher than the original amont of money borrowed.

A study of their income reveals that their income from agriculture is too low because their methods of cultivation are too primitive and because not enough is invested in their fields.

The beneficiaries are haunted by the money lenders and have an unavoidable need of cash. If the organisation gives them money, it knows too well that it is helping to perpetuate a system. If the voluntary worker, ignoring the beneficiary's needs, tries to push, say an agricultural improvement programme, than he is facing a sure failure, since the beneficiaries are not likely to give their full-hearted cooperation to something which they consider irrelevant to their present needs.

There is only one way out and that is a true dialogue where the voluntary organisation keeps on relating the beneficiaries' need to the totality of the situation. Education is anotherword for this dialogue.

On the other hand, this dialogue is not as easy as it may appear, It requires from the organisation's personnel professional skills; (i) The ability to listen to the people and understand not only their words but the real meaning behind them, (ii) knowledge of the situation. This demands deep involvement in the lives of the people and a serious study.

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(iii) Knowledge of the wider reality viz., that of the whole country (and of the world at large) of which situation is only a part.

It requires also certain inner attitude without which those skills will not be put to good use:

1. Self-confidence: to face the seduction, opposition and indifference of the beneficiaries without either being trapped or feeling personally threatened.

2. Authenticity and courage to ownup one's needs and motivation.

3. Faith in the people: If voluntary workers lack this faith no meaningful dialogue is possible with the beneficiaries and no real education will take place. Indeed the chances are that the voluntary organisation will eventually work against the long term interest of the beneficiary. If the social workers believe that the beneficiary cannot take care of himself, evidently they will never work towards an eventual stage where he becomes self-reliant. If they do not believe that he can learn they will not even try educating him, or, if they do they will unconsciously undo what they are professedly doing Let, on the other hand, the voluntary organisation have on the people and that faith will be communicated to them. If the voluntary workers fail they will attribute the failure not to the beneficiary but to their approach or methodology their imperfect understanding of the situation and the people. In other words, when there is faith, failure makes the voluntary organisation search. When there is no faith failure makes the voluntary organisation blame the beneficiary.

Faith in the people can be said, without fear or exaggerting, to be most important virtue of all those required by development workers.

Much is being said in development literature about dependence and often it is assumed that social or developmental work leads unavoidably to a state of dependence. That this happen often is evidently true. Taht this is in the nature of things is not so clear. Faith in the people and courage to live upto that faith will help the development workers to make themselves dispensable at the right moment and will

One of the objectives of this National Work-shop on Rural Development is "to evolve a more effective strategy for the mobilization of people and the resources in the struggle against poverty and injustice". The above consideration have been submitted having this objective in mind.

6. THE NEED OF PROFESSIONAL TRAINING:

One often hears complaints about the shortcomings of the people working for development. To point out defects is the first step to remedy a situation; but it is not enough. One must study the causes leading to such a situation. This paper has already suggested the first step towards better development work -- the professionalisation of its services by creating those conditions which will make it possible to recruit people who are both competent and comitted.

There remains one question to be answered: are there such people available in the country. The answer, unfortunately, is negative. Dr. Kurien of the National Dairy Development Board has been forced to plan his own training services to provide his cooperatives with competent personnel.

While much of the theory needed in development work is given at the various schools of social work, theory alone is not enough. And indeed the same theory may mean one thing when given within one value system and it may mean something quite different when the values held are different. In any case, theory alone does not bring about committment. The latter is the product of the values one upholds. And, unfortunately, the values prevalent in our universities are not likely to promote the right attitudes towards development work. To be more specific: mention can be made of those values which lead people to believe that teaching is more important than learning; that city people are better than their rural counterparts; that money and power are the standards of success of life; that a successful student is one who has made it into an executive post in industry. When our universities accept such norms they are not likely to turn out graduates who will be looking forward to work in the villages, who will think that they must learn from the poor, who will have faith in illterate people! Without these fundamental attitudes is there any chance that these graduates develop those other skills required in development work, like the, ability to

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understand others and to communicate with them which is the basis of a meaningful dialogue and true education? Therefore, development work cannot rely entirely on the training given by our universities.

May be that this work shop could explore the possibility of using the existing voluntary organisation to develop our own training facilities.

If the voluntary organisations could set a model of unity and cooperation; if the aid-giving agencies could also do the same; and if, as a result, permanance of service and professional salaries could be offered to prospective candidates, then the system could be rounded off by a number of volunatary organisations joining together to offer training services as well.

Let this paper end by stating in clear words the assumption on which the whole paper has been based: True development means, in the last analysis, personal growth the ability to cope every time more effectively with difficult situations; the ability to make history meaningfully. May be if voluntary organisations spent a little more time in "developing" their staff they would be in a better position to help in the development of others.

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TRAINING PROGRAMME FOR COMMUNITY HEALTH WORKERS

COMMUNITY DEVELOPMENT

J.M. Heredero*

Definition of Community:

A sense developed by people of their local common good.

a) Sense : To the extent to which a group of people develop a sense of their common good, to that extent, we say, there is a community.

b) Common good : It embraces various aspects:

1. Political: (Political is taken here in the sense of sharing power).

Aims:

a) to avoid a position of dependence which may lead to exploitation. The community (through united organisation) acquires sufficient power to defend the rights of its members. In other words, the community asserts its rights.

b) The individual whether in a traditional or in a modern society has very little control over his life. Most of the decisions which affect his life are taken by others. In the western consumer society this has led to non-conformist movement like the hippies. In India, the caste controls the majority of individuals through the manipulations of a few traditional leaders. In either traditional or modern society the net result is the loss of individual autonomy.

The community where each member is aware of these facts and willing to do something about them is the only means to restore the autonomy of the individual.

2. Social : Man is a social animal. There are certain things which can only be satisfied in a society. Thus, for example, the need of mutual support, of friendship, the need of celebrations, are needs which are best taken care of by the community. More in particular, man is communicative. The community provides a forum where its members can exchange their ideas. Again, man needs recreation. The Community helps each member, according to his age etc., to fulfill this need.

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3. Religion: a) Religion has always been a social phenomenon. The community helps its members to worship in common.

b) Society imposes on man values which run counter to his religious convictions. One man can individually reject these values, but it is in and through the community that man can have his religious values accepted in a manner which is relevant to him and his neighbours at a particular time in a particular place. To extent to which the true fundamental values of religion are accepted in the community to that extent religion has meaningful relevance in society. This is a living process where men discern in their own religion, the difference between fundamentals and accidentals, between inner attitudes and external rituals and, in their daily lives, men are able to see the difference between real needs and addictions or compulsions.

c) Community work should be an antidote against institutionalised religion where the institution becomes more important than the message and, especially the people.

d) The community is important to religion (and vice versa) because it is in the former that the ideas of the latter are implemented. Specifically, it is through the community that the fight against social evils and injustice can best be waged.

4. Education: The community helps its members to teach and to learn.

a) The community helps its members to learn:

i) to be more ethically sensitive in solving problems by taking cognisance not only of one's own interests but also of his neighbours;

ii) re-assess one's own attitudes and habits vis-a-vis their impact on one's own neighbours;

iii) some very specific skills which an individual learns in the community are communicationsand leadership skills;

iv) in short, the individuals learn how best to help the community to achieve the common good.

b) The community helps its members to teach:

of the socio-economic structures which influence or manipulate it;

ii) the community may organise other minor schemes where individual members will impart specific skills to others.

5. Economic: Among the weaker sections of society, the community may be the only means to solve his economic difficulties. Cooperatives of all types may be the only answer to solve problems like indebtedness, marketing difficulties and even unemployment.

II. Types of Community: Their characteristics and advantages

The Caste as Community

Caste are autonomous groups within the country, with their own legislative, executive and judiciary systems operating independently within their own sphere. Consequently, each group has a well-defined code of legislation which regulates their social life, and which confers on every caste member his own set of rights and duties.

This social structure provides for a clear sense of identity and belongingness, which is found missing in the so called "atomised society" of the West.

Another characteristic of the caste is that it is not merely an effective group, or a group organised for action but also an affective group or a group bound together by links of common fellowship.

Religion as a Community:

In India religion creates a community clearly among the Parsees. Although religion has united the Muslims as a minority in some well known political fights, still, in the day-to-day working of community the Muslims are too divided by castes and sects as to create a community. Something similar may be said about the Christians. Hinduism as a religion seldom gives rise to a community.

Territorial Group as a Community:

Government have consistently taken the view that caste and religion lead to casteism and communalism and consequently, they cannot form the basis of a community. Therefore, government and many liberal organisations claim that the territorial groups should form the basis of the community. In rural areas, it is the village, and in an urban set up it should be the neighbourhood.

While there is no doubt that certain caste evils must be rooted out it is an open question whether the whole system must be eradicated. In which case the caste would serve as an obvious basis for community development. This will become clearer if we study the characteristics of traditional and modern societies.

Characteristics of a Traditional Society:

Without attempting to define it, certain characteristics are given here below which can identify it.

i) The sense of belonging to the group is dominant in a traditional community. Belonging [illegible]

not questioned. This sense of belonging binds the members of the community together.

ii) This common membership defines their identity. Traditionally groups are characterised by a strong sense of identity.

iii) A traditional group tends to possess distinctive qualities of social life which are peculiar to itself.

iv) Like all groups it has its own culture but unlike other groups this culture is more rigid. There are three components of this culture. First, the normative system that tells people how they should behave. Secondly, the action system which includes the actual ways in which things are done -- the custom, folk ways, etc. Thirdly, the things which are produced, the symbols and material products, must also be included.

v) As for the acceptance of fundamentally perceptual and normative values, it is above all the community which largely determines the individuals' perception of possible questions and their answers.

Characteristics of Modern Societies*

"Over the last centruies, it is clear that the Western societies have moved from an emphasis upon social organisation based upon kinship, fealty and status to one based upon contract and rational co-ordination. This movement is characterized by increasing specialization of function and increasing rationality in the lives of the members of the society.

Specialization has led to the growing division of labour. There has been a powerful process of social differentiation which has operated in the separation of function of the major institutions in society and in the growth of associations aimed at furthering specific interests.

Rationality has helped the Western Society to move away from uncritical acceptance of the established order. There has been a trend towards secularism and pragmatism. Ways of doing things are measured in terms of effectiveness in achieving some material end. This has been summarised by Talcott Parsons in the notion that the dominant value theme in advanced society is mastery of the world around. This emphasis upon secularism and rationality is believed to go hand in hand with impersonality in human relations - an emphasis on heads not hearts. This society, according to Tonnes, produces the 'mass society' of rootless individuals bound together, not by unquestioned perceptions of reality and an undisputed normative order, but by personal choice. Thus, the bond is still there, but it is a much less secure one. It is dependent upon fads and fashions of individual choice and is more prone therefore to violent change and to 'sickness' or 'normlessness'.

Advantages of Traditional over Modern Societies:

1. Greater sense of belongingness
2. Greater sense of identity
3. More emphasis placed on affective links

Therefore, a traditional society lends itself better to community development.

Disadvantages:

1. It may give undue prominence to its leaders. (This may be counteracted by greater awareness of all its members).
2. It plays undue emphasis on tradition with its corresponding lack of stress on rationality. (This can be counteracted by better education of the community).
3. The caste [illegible]

III. COMMUNITY DEVELOPMENT *

1. Definition:

Community Development is a social process by which human beings can become more competent to live with, and gain some control over, local aspects of a frustrating and changing world.

2. Explanation:

i) It is a group method for expediting personality growth, which can occur when geographic neighbours work together to serve their growing concept of the good of all.

ii). It involves cooperative study, group discussions, collective action, and joint evaluation that leads to continuing action.

iii) It calls for the utilization of all helping professions and agencies (from local to international), that can assist in problem solving.

iv) But personality growth through group responsibility for the local common good is the focus.**

From the above it is clear that in recent times there has been a change of ~~emphasis from~~ improvement of facilities, and even of public opinion to improvement in people. But this personal betterment is brought about in the midst of social action that serves a growing awareness of community need.

3. Community Development is a Process:

As we shall use the word, process refers to a progression of events that is planned by the participants to serve goals they progressively choose. The events point to changes in a group and in individuals that can be termed growth in social sensitivity and competence. The essence of process does not consist in any fixed succession of events (these may vary widely from group to group and from one time to another) but in the growth that occurs within individuals, within groups, and within the communities they serve.

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*Extracts from: Biddle & Biddle: The Community Development Process.

** The Community development process is, in essence, a planned and organized effort to assist individuals to acquire the attitudes, skills and concepts required for their democratic participation in the effective solution of as w ide a range of community improvement problems as possible in an order of priority determined by their increasing levels of competence". J.D. Mezirow, "Community Development as an Educational Process", Community Development, Nati nal Training Laboratories Selected Reading Series No.4, (1961), p.16.

IV. THE COMMUNITY DEVELOPER

1. His Aim:

Community development is, essentially, human development. In the field of community development, the goal is to create an atmosphere in which men and women can express their inherent right to "Life, liberty and the pursuit of happiness", unfettered by the chains of hunger, poverty and ignorance. The attainment of that goal must start with the basic need of the human soul to express, to grow, to build a life that will fulfill its dreams. He needs only the stimulus of understanding; the knowledge that others recognize his individuality and respect it; and the guidance that evokes his latent ability to achieve his goals.*

2. His Role:

a) A nucleus level worker is the central figure in the drama of community development . He is the instigator of process. His responsibility is significant, but difficult, for he has a role of paradoxes. He is called upon to take actions that seem to be contradictory in themselves or to run counter to much conventional wisdom. He is a central figure who seeks prominance for others.

b) Is a nucleus-level encourager an innovator? Most people use the word "innovator" to describe the inventor, the introducer, or the promoter of a new idea. A community developer is none of these; he is rather an instigator of processes that call upon others to become innovators. He takes the initiative so that others will take the initiative.

c) Neither is the community developer a change agent in the sense of an advocate of (to him) favourable changes. He is rather the expediter of the favourable changes that people have chosen.

Though the process may begin and continue without him, he is central to any planned and organized utilization of it. Professionaly nucleus-level workers of some sort become indispens-able, and some institutional responsibility for employing and training them is called for, if community development is to have any impact upon the history that is lived. But if the professional workers do their job adequately, they can expect people to learn how to develop with less and less encouragements from themselves. An encourager instigates a growth of initiative that should run away from him.

3. Dilemmas of the Community Developer:

a) The Institutional Dilemma:

All helping professions face a dilemma posed by their institutionalization: Which shall come first -- service to human beings or loyalty to employing organization?

The flexibility that is required to serve the people's needs is restricted by the pressure upon the community developer to support the sponsoring institution and to follow its programme prescriptions.

The institution makes its own demands, many of which are incompatible with the processes of community development. For example, an institution may demand to be aggrandized, "played up", given credit; and, usually, there is pressure to follow traditional rituals. But the community may go off in pursuit of activities of its own choosing -- Indeed, the community developer seeks such displays of independence as evidence of the growing initiative of the citizens. But such autonomy may disturb the institution.

In working with people through the communtiy development process, it is easier for a community developer to be self-effacing than it is for him to reduce the prominence of his institution. But then, institutions, too, can change - in aspiration, and in the nature of their programmes. Sometimes they do this as a result of pressure (gently applied) from employees. There are some that are beginning to set up programmes which call for the flexibility to meet people where they are and which will free employees to follow the stumblin g yet hopeful development of ordinary people.

h) The problem of financial support:

The employed community development worker wants to keep his institution solvent, if only to preserve his salary. But if the work with community nuclei is so little heralded that the donors to the institution do not hear of it, this particular work may fall on evil days, or the institution itself be in jeopardy.

c) Identification with bourgeoise values:

Most institutions, once they have received public recognition for their work, tend to identify with the "establishment". In practice this may mean lining up with middle-class morality and values, with the ethic of "success", and so on. Indeed, most community developers must wrench themselfe away from their accepted beliefs to accept the patterns of value that may grow in the nuclei. Uncomfortable as the community developer may be, an institution is even more uncomfortable when it discovers that its employees have identified with people other than those who accept middle-class values. The community developer who does come close to people's needs and thinking may be condemned for lowering his standards of excellence or for being disloyal to middle-class ethics.

d) Personal Dilemmas:

1. Personal Relationships:

There are uniquenesses of personal relationship that seem to effect outcomes favourably or unfavourably. The success of process seems to depend upon a mutual trust between the community developer and the community developed. Unless the community developer trusts and is trusted, unless he is acceptant* of people, the process cannot be expected to work.

The relationship (rapport) is one of warmth toward people, one in which they come to trust him because he obviously believes in them. He is acceptant of them, as they are, but with the expectation that they will become better in a process that develops from friendship. He likes them as individuals and believes in their favourable potentials. His belief, expressed in manner, tone of voice, and activity, more than in words, tends to create an atmosphere of confidence -- confidence in themselves and in the growing competence of other members of the group and in the group as a whole.

The community developer contributes to this social atmosphere by being the kind of person he is. He is imperturbable, non-shockable, quietly confident, patient, nonpartisan but devoted to people.

The people thus encouraged tend to discover that they are creative in ways that they had not earlier expected. This leads them to act increasingly better. In other words, to the extent to which the community developer is successful to that extend his services will gradually become less and less necessary. This is the shoke of diminishing dependence - when he realises that he is no longer necessary to the on-going process. Will he be satisfied with such self-effacing role? This will depend on his self-concept.

*The word "acceptant" is used in this connection by psychotherapist Carl R. Rogers. See especially his On [illegible]

2. Self-concepts:

i) Expectation of Prominence:

Most trained workers-with-people feel obligated to exhibit the skills in which they are expert. The teacher must instruct; the social worker must take care of people; the religious worker must conduct worship services; the sociologist must make community surveys; and so on down a long list. The trained person's concept of his own dignity rests upon his doing the job that is associated with his own sense of importance. Merely to understand people, to share their worries, to believe in them, and to create circumstances that will chlp them to solve their problems, may not give a community developer enough of a conviction of his contribution, a sense of his importance.

The desire for personal prominence tends to interfere with sensitivity to the people who are to develop. Hopes for recognition (conscious or unconscious) reduce the probability of learning along with the participants It is better to seek the triumphs of success in the lives of those who develop. There is satisfaction in discovering such triumphs, But this is not likely to be apparent until the expectation of prominence has been cheerfully abandoned.

ii) Do-Gooder Impulses:

All community developers suffer from another dilemma, which is as old as the impulse to helf people. This might be termed "the frustration of the do-gooder". Since community developers have humanitarian motives, they have, or rapidly acquire, ideas about the "correct" improvements people "must" accept. They set out to bring the benefits they have chosen, and then they find the potential beneficiaries unwilling to acquiesce. In an extreme form, the do-gooder becomes desperate because he concludes that the people are so apathetic, stupid, or badly motivated that they will not or cannot do his bidding.

The emphasis upon predetermined imporvements and the reliance upon process represent extreme poles of a scale of operational influence. Few community developers fully escape do-gooder impulses. The seeking of acquiescence to "my" good ideas is ever a temptation. But some developers, have been attempting to make clearer a method that seeks the strengthening of problem-solving initiative among the beneficiaries of development.

iii) How much influence?

A final paradox needs to be mentioned. It has to do with a community developer's concept of his influence. He may be instrumental in bringing about the fundamental changes in people's lives that make them more ethically competent citizens. At the same time he must recognize that his voice is a feeble one among the cacophony of influences that exist in modern life.

A community developer wields one very small influence in the midst of a confusing complex of forces. The process he hopes for may never start, may be stopped after starting, or may be diverted to undesirable purposes by extraneous events and circumstances. While almost miraculous changes may occur in people (we have seen them occur time and time again), he must also be prepared for the disappointment of poor response.

Contd/ 5-

SUMMARY

1. The community developer attaches more importance to man, than to institutions/ideologies.
2. His main aim is to make the individual-in-the-community grow.
3. His method is to develop in the people critical awareness.
4. His most effective weapon is faith in the people.
5. His greatest joy is to see that he is no longer needed because the community has taken over.

28/11 GROUP DISCUSSION
Group Dynamics & Simulation Games & Health Education

Importance

a) Participatory Approach
b) Learning by Sharing
c) Encouraging Teamwork.
d) Breaking down barriers/ divisions in Communication.
e) Dialogue rather than monologue

Groups - could be of various types

a) Homogeneous / Heterogeneous
Religious/lay — Area
Language — Language
Single Team — Profession

b) Participants of course/Trg program or Health Team

(1) Group Introduction - Resource Inventory

a) Introduce one self
(Family background, Educational background, Hobbies, Interest)
Also why/how I came to the team/Dept/course

b) Introducing each other (make pairs and after some time they introduce each other)

c) Descriptions written down without disclosing patients name. (They are then read out - Group identifies and or person acknowledge

(2) Reducing Self consciousness and mixing up group

a) Seating by numbers
b) Grouping by numbers or Symbols.
c) Frequent changes of group
d) Ensuring that groups don't form on regionalism etc (ie existing divisions)

Com H 24.12

Encourage Feedback: on
- Any advantage in intermingling group → Inference →
- Value of flexibility in group affiliations at the community level.

(3) Clarifying Initial Expectations | Expectation Inventory

a) what they expect to gain from workshop/course
b) what they expect from organisers
c) what role they themselves expect to play.

Purpose

a) Sensitise planners to need and expectation of group.
b) Benchmark of initial expectation against which ~~xxxx~~ can assess changes in
- role perception
- understanding of participatory learning process etc

c) Build confidence among participants of the relevance and usefulness of their own contributions

(4) End of each day/week
Concurrent evaluation.

a) What did I like most
b) What did I like least
c) How can the workshop methodology be improved for the next day

- In slips of paper to planner
- Anonymous if felt necessary (according to group)
- 'What' not 'who' - planner to remember

(5) Exploring Self Concepts
Value/attitudes

a) Participation Assessment (form)
- each part can be taken separately
i) Behaviour in a group
ii) Why people resist change
iii) Way we adopt new practices
iv) Way we confront our problems.

b) Looking at differences in visual perception

i) Seeing faces (perception exercises)

ii) Problems & pictures

What is seen?
What is understood?
What is taboo?
What is technically correct?

iii) T.A.T.

iv) Thinking as our audience thinks (Local drawings etc)

(c) Participants share

i) Likes/dislikes/Fears/Doubts.
ii) Good/bad experiences
Moving/meaningful "

(Feelings help to understand a person better than thoughts)

(6) Games/Exercises

a) Buzz Group - Break into SG/short time/Assignment/come together in plenary session/collate SG conclusions

b) Line Experience

Inference: To look at people, team members etc with interest and openness to discover their special points and traits.

c) One way - two way communication

One person instructs others to draw giving instructions looking at the board vs looking at the people

- Look at drawing of participants (mostly incorrect in the former

d) Broken square exercise (Team work)

Help to each other in game is voluntary, unconditional and nonverbal

—

e) Scrambled word exercise (need for meaning, sequence, humour)

f) Rumour Clinic

Passing on rumours (complicated & detailed)

(7) Simulation Games

a) Monsoons

b) Chains

c) Chikkanahalli

—

(8) Group Discussion

a) what it is not?

b) what it is?

c) Members role

d) Chairmans role.

e) Types of Members

f) Types of leaders

—

Ref: Group Discussion by

—

Star Power Game

Fish Bowl Discussion.

Hollow Square Game

'Clue' or 'Ah-ha' experien

Written instructions
experience

Tower Building

Role playing

Case Study <- Story
Incident

Project Work

Field Interview

Learning by Doing

Joe Currie SJ

(AICUF Publication)

COM H 24.

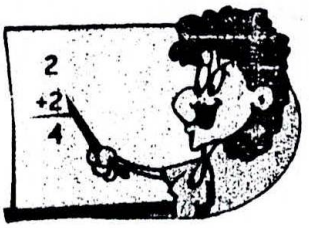
SHAPE POSITIVE HEALTH WORKBOOK

Inside this workbook:

Dedication:

This workbook is dedicated to our Pujya Gurudev Swami Chinmayananda

What is SHAPE?

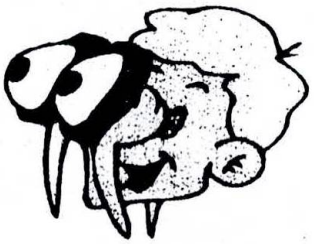


- **SHAPE** is a acronym for School **H**ealth **A**wareness **P**rogramm**E**.
- **SHAPE** is an unique student centred, activity-based learning programme .

The programme consists of six 40-minute modules that will be presented to students of classes VIII to XII.

The topics include:

1. KSHEMAM Positive health concept
2. Diet & nutrition
3. Tips for everyday fitness
4. Mind mechanics & Stress reduction strategies,
5. Study reading techniques,
6. Value-based and principle-centred living



SHAPE – VISION:

Shape aims to impart the knowledge of positive health and its maintenance to the younger generation so that they can integrate positive health practices into their everyday life.

AIMS OF THE PROGRAMME:

1. To introduce the concept of positive health in an interactive manner with the aid of games and activities.
2. To emphasize that health is made up of the physical, mental, intellectual social and spiritual components.
3. To highlight exercises in each of the above components to practice everyday
4. The reinforce overall personality development is based on values and principles and that it is a life-long process

Module: 1

POSITIVE HEALTH

You will learn

1. **View of life and widening it**
2. **Definition of positive health**
3. **Components of health**
4. **Health spectrum**
5. **Health interdependence**

Activity I

Puzzle I

Join the following 9 dots by

- Using 5 straight lines,
- Without overwriting.
- You should start and end without lifting your pencil/pen from the paper

Puzzle II

By drawing a single line change the Roman numeral 9 to 6

IX

WAY TO VIEW LIFE

Imagine a horse with a shield by the side of its eyes. The owner of the horse puts it there so that the horse can see only the road ahead of it and it is easy to steer such a horse. But as human beings we should keep our sights wide and should be able to view the world around as fully as we can. *The way we view life is called our perspective.* We learn new things by keeping an open mind and thereby widening our perspective.

We invite you to widen your perspective and learn about positive health!

Definition of Health

> WHO has defined health as "a positive state of physical, mental and social well being, not merely absence of diseases and infirmity.."

- Health is a positive state of well being.
- Being free from disease will not make you healthy

Health Spectrum

Activity II

Fill the boxes with the correct colors of the rainbow.

V	I	B	G	Y	O	R

The rainbow is an example of color spectrum.

The metamorphosis of a butterfly is another example of a spectrum

> Spectrum: Entire wide range of anything arranged by degree or quality

As you can see above each color of rainbow gradually merges with the next color. In the same way health is a spectrum with positive health on one side and disease on the other.

Positive Health ⟷ **Disease**

Dis-ease

The term dis-ease means "out-of-balance".

Many of us are in this state of health, called dis-ease. We do not suffer from any illness or disease but at the same time we are not in positive health. This lack or deficiency in positive health can be in any one of the components of health.

Components of Health

Health is a dynamic and composite entity. We call it dynamic because it changes from minute to minute. We generally think that being healthy means physical. In reality health is made up of the following 5 components:

1. Physical	2. Emotional
3. Intellectual	4. Social
5. Spiritual	

Not only should we be free from disease but also we should be strong in all four components of health to be in a positive state of health.

Health Interdependence

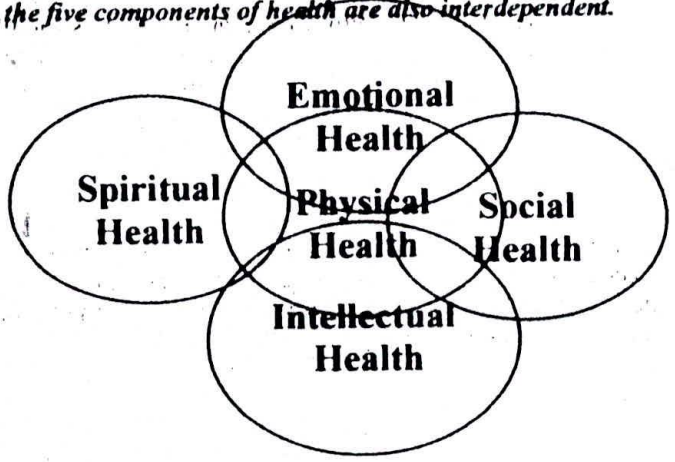
Story of Devas and Asuras

Once there was a fight between the Devas (the good) and the Asuras (the bad). One day they went to Lord Vishnu asking for justice. Vishnu decided to give a grand banquet to teach them a lesson. Though the Asuras and the Devas did not think it was going to solve their problem they agreed to it was after all a grand meal they were going to enjoy. They had dinner served in two different halls. In one hall, sumptuous vegetarian mouth watering food was served for the Devas and in another hall spicy hot non-vegetarian food was served for the Asuras.

The Asuras could not wait to enter the room as the nice aroma of the non-vegetarian food of Chinese, Mexican, Tandoori varieties made their mouth water. But to their surprise both the hands got locked at the elbow disabling them as soon as they entered the room. The hungry Asuras became even angrier when they could not get the food to the mouth. They were spilling the food all over the place but not being able to eat. They went straight to Vishnu to tell about the injustice done to them serving a grand dinner and not being able to eat it. As they talking to Him they saw the Devas coming out of their hall very happy belching away after a nice meal. This made the Asuras even angrier. Vishnu calmly told them to go and look into the room where the Devas were eating.

Can you guess what the Asuras saw? They found to their surprise that the Devas hands were also jammed at their elbows; but they were enjoying their meal by feeding each other. They returned to with their heads down ashamed of themselves that they never thought of sharing and helping each they were too selfish.

The above story highlights the fact that as individuals we need to share and we are interdependent on each other. Similarly the five components of health are also interdependent.



Module: 2

PHYSICAL HEALTH-DIET & NUTRITION

You will learn

1.Food groups and their role in our diet
2. To categorize everyday food items under these food groups
3. Importance of well balance and healthy diet
4. Healthy eating habits

Food Groups

The food that we eat everyday can be grouped under one of the following five groups:

1. Go foods- are rich in energy and provides the fuel for work and play.
   E.g.: Rice, Roti, Bread

2. Grow foods- give as protein, which are the building blocks of our body.
   (E.g.: Milk, Cheese, Curd (preferable from low fat milk), meat, fish, dal, rajma etc)

3.Glow Food- Provide vitamins, minerals and fiber, which are essential for our body. Taking adequate quantities of these foods gives a healthy skin and hence "glow". (E.g.: fruits and vegetables)

4. Junk foods- These food items give us instant energy and are tasty but not good for health and nutrition. (eg: Chips. Chocolates, soft drinks etc) Fatty food items are tasty but excessive eating of these this kind of food items are responsible for heart diseases when we grow older.

Did you know?

Fat deposits in our blood vessels, which block the arteries of our heart leading to sudden heart attacks, are found as early as 16 years of age!

Activity I

Categorize the following food items in the box under the four food groups.

Go foods	Grow foods
Glow foods	Junk goods

Fruit salad
Ice cream
Paneer
Chocolates
Mysore pak
chips
Curd
orange

Bread
Idli
Rice
Brinjal
Carrot
Meat
Spinach
Milk
Egg

Well-balanced & healthy diet

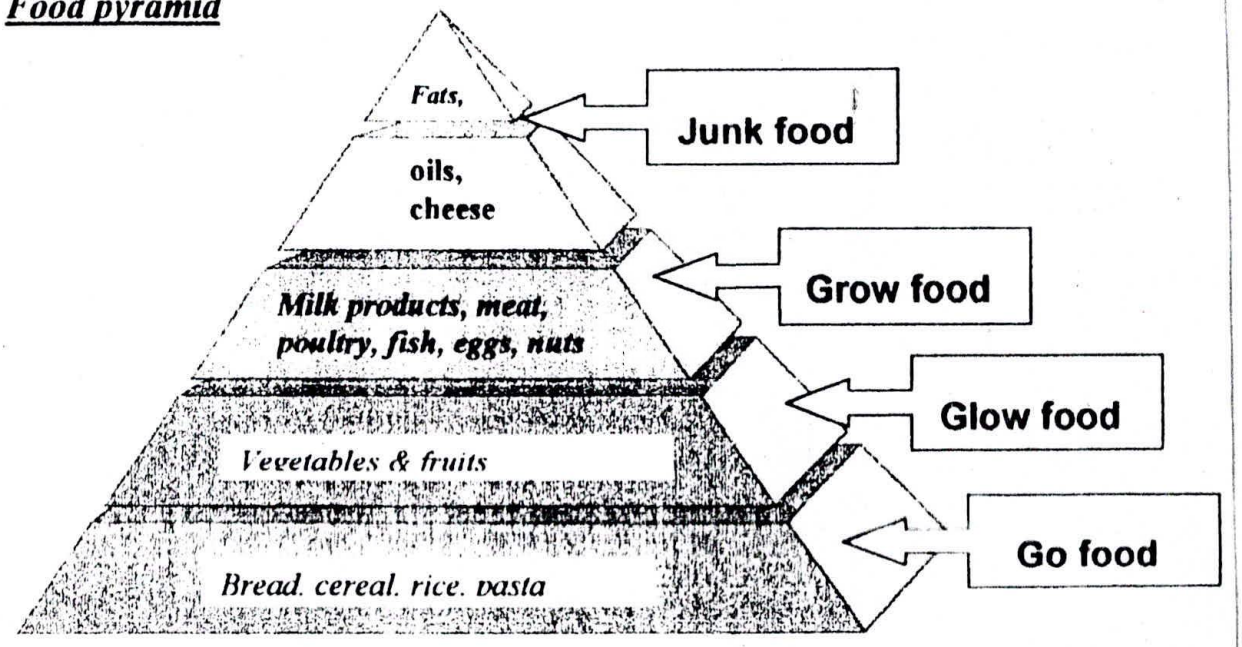
What is well-balanced diet?

Well balanced diet contains the proper proportion of the various food items. A healthy and well-balanced diet contains all the food items belonging to the four groups; but the proportion of each varies

Look at the pyramid below. If you should plan your meals like the pyramid, you are eating a well-balanced diet.

Eat plenty of grow and glow foods which forms the base of the pyramid. We should also have go foods to provide us energy for work and play. Junk food and fried food items should be kept to a minimum.

Food pyramid



Healthy eating Habits

1. Eat like a king at breakfast, like a common man at lunch and like a pauper at supper.
2. Try not to eat junk food in between meals.
3. Sit in the Dining table and enjoy your food. Do not watch TV and munch your food.
4. Keep yourself busy – boredom leads to over eating.

Module: 3

PHYSICAL HEALTH - EXERCISES

You will learn

1. **Categories of exercise**
2. **Benefits of exercise**
3. **Components of exercise**
4. **. Goals setting & practical tips**

Categories

There are 3 main categories of exercise:

1. Aerobics
2. Calisthenics
3. Weight Training

Aerobic exercises are done by moving large groups of muscles vigorously enough to increase the supply of oxygen from the lungs to the heart and other parts of the body. When done regularly it improves heart and lung fitness.

E.g. swimming, fast walking, jogging, cycling and skipping

Calisthenics are stretch exercises. It improves the flexibility. They are done by moving the large and small joints of our body. They are good as warm up and cool down routines. They do little to improve heart and lung fitness.

E.g. Touching toes, leg lifts, knee bends.

3. Weight training helps to build muscle strength. These exercises do not directly improve the heart and lung fitness.

Eg. Lifting weights.

Though all the above 3 categories of exercise are beneficial, **aerobic exercise** are very useful for overall fitness and it has be proven to prevent lifestyle related diseases like heart attacks, diabetes etc.

Activity I

Write down your previous day routines and calculate how many times you did an aerobic activity.

	Name of Activity	Place	Number of Times	No of Minutes
1.				
2.				
3.				
4.				

Benefits of Exercise

Regular physical exercise gives one a healthy body and a healthy mind.
Through regular exercise you can

- Make heart and lungs strong
- Reduce risk of heart disease, high blood pressure and high blood sugar
- Burn body fat
- Become stronger and more flexible in body movements
- Have strong bones
- Look better with good shape bright eyes and healthy skin
- Be more alert with better concentration
- Sleep better at night
- Reduce the effects of mental stress

In short you can gain
Stamina, which is the endurance to do, sustained physical activity
Strength which is the ability to have power to move or lift things
Flexibility is the ability to be agile and fit

Components of exercise

Choose an exercise that conveniently fits your daily routine.
An exercise routine should be preferably done all days of the week - at least 3 times a week
It should last for 30 -45 minutes
Always warm up - do your routine - and cool down

Goal setting & practical tips

Easy tips to be healthy

- Walk or cycle to the market instead of going by car
- Climbs stairs instead of going in lifts
- Dust and mop your rooms yourself instead of asking someone to do it
- Go for a walk with friends instead of playing video games
- Play outdoors instead of watching TV

Give no excuses like "no time", "no facilities", "too tired", "too difficult" and so on.

Like any activity in life that you need to succeed, you need to set goals for yourself and make sure you stick to your plan. The activity pyramid in the next page gives you guidelines for the goals and plan for every week


PJ's SPOTLIGHT ON the ACTIVITY PYRAMID!
FROM THE PRESIDENT'S COUNCIL ON PHYSICAL FITNESS & SPORTS
Cut down on
•Watching TV
•Playing computer games
•Sitting for more than 30 minutes at a time
2-3 times a week
Leisure activities
•Golf
•Bowling
•Softball
•Yardwork
2-3 times a week
•Stretch/strengthen
•Curl-ups; sit-ups
•Weight training
3-5 times a week
Aerobic exercise
•Swimming
•Bicycling
•Brisk walking
3-5 times a week
Recreational sports
•Basketball
•Tennis
•Hiking
•Soccer
Everyday
•Walk the dog
•Take the stairs
•Walk instead of riding
•Make extra steps in your day

Module :4

MENTAL HEALTH

You will learn

1. **What is mind**
2. **How do thoughts arise**
3. **What is stress**
4. **How to cope with stress**

Mechanics of Mind

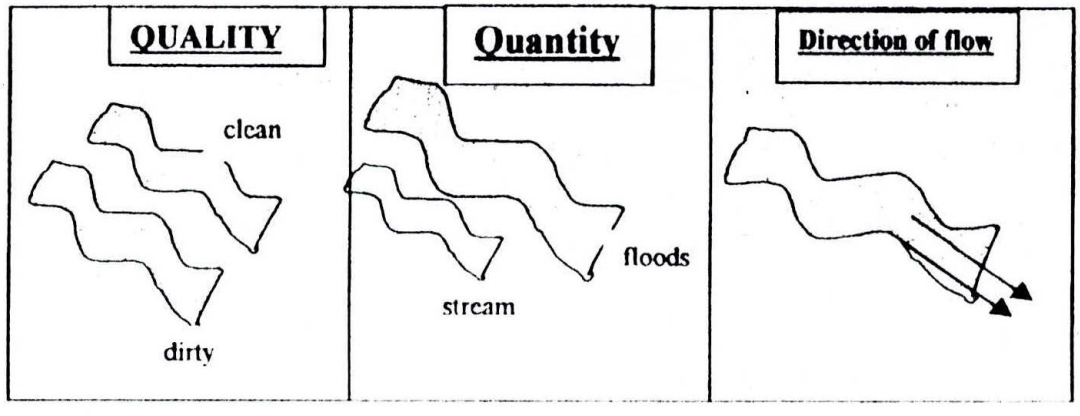
What is Mind?

Mind is flow of thoughts

Mind can be compared to a river.

Stagnant water is not a river so also when there is no thought flow (as in deep sleep) there is no mind.

The nature of a river depends on its quality and quantity of water and the direction of flow.
Quality of water in the river depends on whether it is clean or dirty. How the river flows depends on the quantity of water. When there is a flood, water overflows the banks and water gushes all over. The direction of flow depends on the banks that direct the water in the right direction so that the water will flow into the sea.
So too the nature of mind at any given time depends on quality, quantity and direction of thoughts as shown in the picture.



Our mind emotions and thoughts keep on changing every second is it natural? What is this due to?

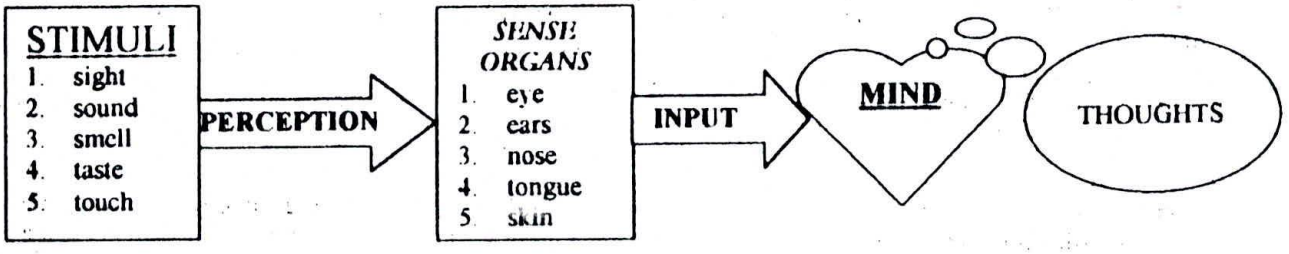
The rapidly changing character of mind is it's natural state of activity. The nature of mind at any given moment is dependent on three factors of thought flow: **quality, quantity** and **direction of flow**.

The state of our mind will depend upon:

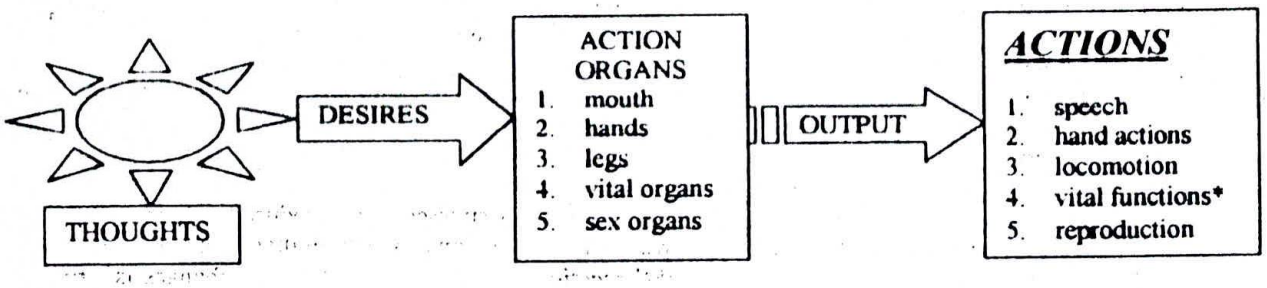
1. **Quality of thoughts** – noble and selfless thoughts make the mind pure. Low passions and criminal thoughts make it dirty
2. **Quantity of thoughts** – more the thoughts, the mind is agitated; reducing the number of thoughts make it peaceful
3. **Direction of flow**- the directions of flow of a river is determined by its banks and to the ocean into which it ultimately drains into; the direction of thought flow are guided by the values and principles that are important to us. (These are the banks) Our life time ambitions is the ocean into which our thoughts flow ultimately

How does thoughts arise?

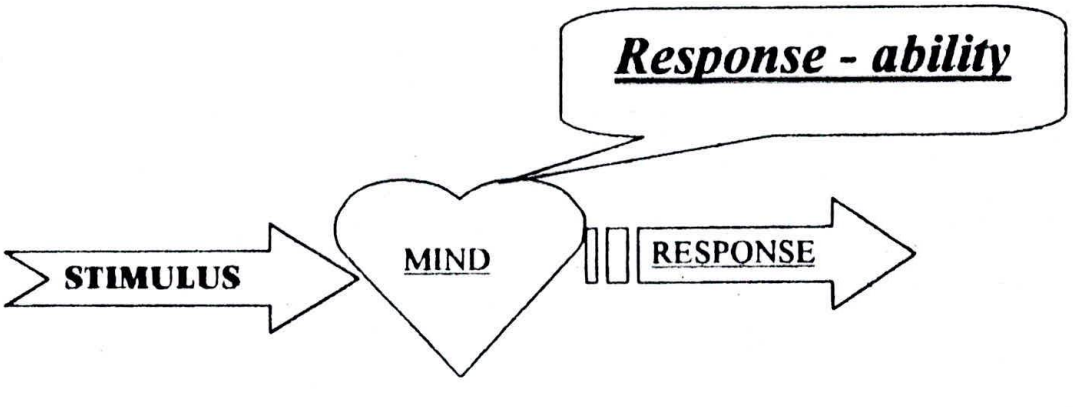
An object or action from the world outside stimulates thought. (It can be an *ice cream van* or *an unkind word*.) This is perceived by our **sense organs**. This information reaches the **mind**. Till now it is purely a physical process like any physics experiment. Once the stimulus has reached the mind, **thoughts** arise...



If we react to the stimulus then these thoughts take the form of a **desire** ("*I want strawberry ice cream*" or "*I want to bash the person who insulted me*") these desires activate the **action organs** and they carry out he appropriate actions. This last event is also purely mechanical.

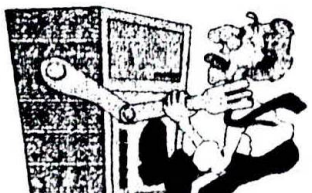


Thus we can see the only place we can intervene or make any change between the stimulus and response is in the arena of the mind. Thus the mind has the ***ability*** to choose our ***response.*** This is called responsibility ***(response –ability)***. This is a unique gift to mankind. Animals and plants are programmed by nature and do not have this *response -ability*. Hence we should take pride and use this response-ability to the maximum extent.



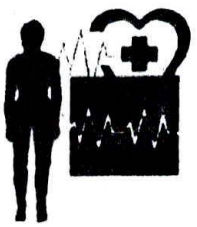
What is stress?

THE STRESS RESPONSE



Imagine the following situation.. You have rented a small cottage in a remote part of kodaikanal and one night after dinner you are standing at the sink washing the dishes. It's been raining all day, and now a strong wind is blowing the rain against the windows. Although it's pitch dark outside, the cottage itself is warm, and you are looking forward to relaxing with a book prior to going to bed. As you turn away from the sink, you suddenly see a an ugly face pressed up against the windows and grinning at you!

At the moment this happens, striking physical changes are set in motion in your body. Because you had just finished eating dinner, and relaxed, blood was being diverted to your gut to aid digestion (therefore less blood is being sent to your brain). Your breathing was relatively slow, your heart rate was quite slow and regular, and your skin was dry and warm.



Now, digestion has stopped. Blood is being shunted rapidly away from your gut to your brain, which is now highly aroused, and particularly to your muscles, which are preparing for action. Your heart rate and blood pressure have increased dramatically, and your skin (as the blood is diverted away from it feed the brain and muscles) becomes cool and clammy. The palms of your hands are becoming moist and your pupils dilate. From your nervous system a message has been sent to the adrenal glands to secrete the stress hormones, i.e. adrenaline and noradrenalin. These hormones increase the force and speed of contraction of the heart and they also enlarge the airways so that more air can reach the lungs more quickly. Blood sugar (glucose) is released from storage in the liver into that can be burned rapidly. Your blood has also become 'stickier' and more likely to clot should you be injured.

The perceived threat (the essential component in all stresses), has produced a highly complex series of biochemical and psychological reactions, which Walter Cannon of Harvard described as the ***'fight or flight' reaction'***. This sequence of bodily changes is genetically programmed into each of us and links us to our prehistoric ancestors. Of course, you don't need to go to a remote cottage in Kodai to experience all this. A near miss on the chennai roads can produce exactly the same pattern of changes.

Today, most of the stress we face are not solved physically by either fighting or fleeing, so the body's stress response has no way to dissipate. Modern man has retained his primitive hormonal and chemical defense mechanisms, but a twentieth century lifestyle does not allow a physical reaction to the stress agents we face.

Physically attacking people whom we hate, or running from what we find to be an acutely stressful event(like exams-however much we may relish the thought), are not socially acceptable reactions.

Our long evolved and ancient defense mechanisms prepare us for dramatic and rapid action, **but find little outlet.** We have to repress them. **It is the inappropriateness of the normal biological stress response in the context of modern living, which is potentially harmful.**

How can we reduce stress in our lives?

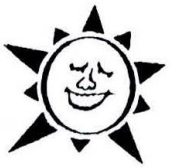
We can **reduce your stress** levels by following these **three simple strategies**

1. Live in the present.

Present is the only time we can act and do and achieve.

2. work within your area of influence

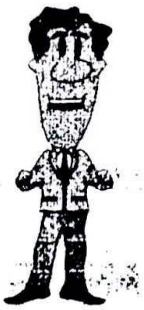
We have to be practical and do small little things which is within the area of our life that we can influence. Sitting and brooding about the state of the world over which we have no control is a sheer waste of time and mental energy.



3. Be practical - expect all eventualities

Whatever action we do, only four kinds of results are possible:

1. ***equal*** to what we expected
2. ***more*** than what we expected
3. ***less*** than what we expected
4. ***opposite*** of what we expected.



It is impossible for us to do any action without expecting results. If we expect all the above eventualities our disappointment is much less and it goes along way in reducing our stress levels.

4. Acceptance – accept that we cannot call all the shots

Our performance is usually not consistent. We have little say regarding external factors. It is impossible to predict unforeseen factors that may modify the results. So we should **learn to accept things as they are**.

Lord! Give me the courage:

- **To change things that can & ought to be changed**
- **Accept the things that cannot be changed and**
- **The wisdom to know the difference!**

Module: 5

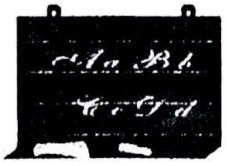
INTELLECTUAL HEALTH

You will learn

1. What is reading
2. Principles of study reading
3. Revision - the proper way

Reading for exams & enjoying it!

What is reading?



Recognition

Reading starts with recognition of written words

Physical transmission

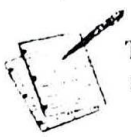
You also need a good eyesight and lighting for the transmission

Comprehension

You should next understand what you are reading. If what you are reading is ABCs, there is no problem! But if it is nuclear physics, you will not understand a thing!

Knowledge bridging

If you do not understand a certain area of what you are reading, you get a doubt. You can either ask your teacher or refer other books to bridge the gap in your knowledge



Retention & Recall

This is the most important aspect of reading for exams you want to remember what you have read and write it clearly in the examinations

Principles of study reading

Step: 1

- Read the title and think about it; how much do you know the topic

Step: 2

- Look at the Table Of Contents

Step:3
--Read introduction and summary of Chapter (or) first and last paragraph

Step:4
- Read review or discussion questions

Step:5
--Read all major headings and subheadings

Step:6
-Look at all pictures and tables

Step: 7
-Read first and last lines of the each paragraph

Step:8
--Review and write down the major points of the chapter as fast as you can (2minutes)

Step: 9
--Read the chapter in depth

Step:10
Make notes
Review & revise

Cs,

REVISION - THE PROPER WAY

First revision should be done 10 minutes after one hour of learning. This will enable you to remember what you have learnt for day only!
But if you revise the same topic the next day also. you will remember what you learnt for a week
And if you revise the same topic the next week and every week for 3 weeks, the learning is permanent and you will be able to recall at will
Another advantage of regular revision is that the time you spend in revising the same topic becomes lesser with each revision.

REVISION	TIMING	RECALL
I	10 mins. After 1 hour learning	24 hrs
II	1 day after	7 days
III	7 days after	15 -30 days
IV	Every week x 3	Long term

Module: 6

SOCIAL HEALTH

You will learn

1. What is Value

2.What is happiness

3.Living a life of values

VALUE BASED LIVING

What is value?

Value literally means worth or desirability. In our context, it stands for one's judgement of what is valuable or important in life.

What is important in life?

What is the most important thing in our lives ? Money ? Power? Home? Parents? Friends? These may look important; but when we analyze why we think any of the above is important, it boils down to a very selfish reason - our happiness! Don't kid yourself. It is a universal need. Our happiness is most important in our lives.

What has values to do with our happiness?

Remember that value is one's judgement of what is valuable in life. The most important thing in life is our happiness. Naturally we are going to pick our values for our living which will give us happiness.

How do we determine a value?

First a knowledge of standard codes of living in our society is necessary - you can call this ethics, morals, principles, it does not matter.

At birth, we have no knowledge of values. When the baby throws tantrums, it gets a strong message from the mother that it is not right. In order to please the mother, it stops the tantrums- the first step towards value based living!

All through our lives we continue making this value judgment- is this important in my life? Will this give me happiness? Will I be comfortable doing this? If we are convinced, then we internalize this value. After this internalization, our actions and interaction with the society is in line with the value set we carry.

Let us take an example - Truth. We all know Truth is a good value and telling lies is not right. But how much we adhere to this principle depends on how much we have internalized this knowledge. At one

extreme, when we have zero internalization we have absolutely no qualms about it. Mahatma Gandhi is example of 100% internalization of the value of Truth.

Free will- the human prerogative

At every turn of our lives we are faced with a choice. Man is the only being in this universe that has this free will. Though it is beneficial, this choice makes us afraid whether we will make wrong judgments. What looks like a perfectly ideal solution at one time looms as a large mistake in the future. In choose values to guide our lies this freedom of choice plays a very important role.

How to distinguish between right and wrong?

Right and wrong are relative and depend upon the society in which we live in. What we consider as wrong in India may be viewed as right in another country. In a society of cannibals, eating human flesh may not be considered wrong!

These are the two ways of finding out what is right or wrong

Step 1. Look at the collective wisdom of our society that has laid down certain codes of conduct which will lead to universal happiness. Examples of such values are honesty, charity, love, generosity, and unselfishness. We should read and acquire knowledge about these values.

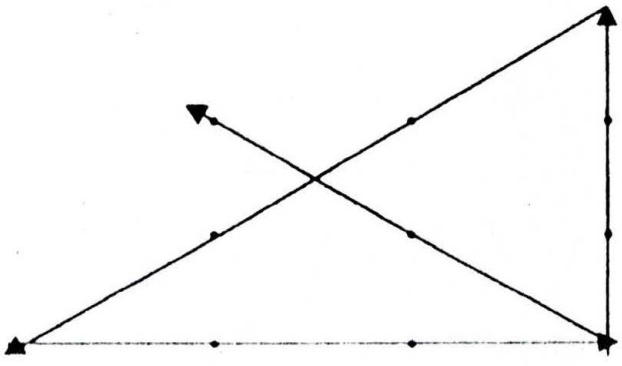
Step 2. This is a very personal one. Just watch your minds' reaction to any action you do. If the mind is agitated and keeps on thinking, "I should not have done it" then that action is wrong. You should attempt to clarify your values on that subject and avoid doing it again. Right actions on the other hand, bring happiness and your mind is at peace with itself.

Respect for elders is one value many teenagers have problems with. Especially in India this is an important value. If we are and brought up in India this value will be ingrained in us. Naturally if we act against this value it creates mental disturbances and unhappiness. It is important we accept this value and internalize it- for our happiness!

ANSWERS

Module: 1

Puzzle: 1



Module:1

Puzzle: 2

S I X

Module:2

Activity: 1

Categorize the following food items in the box under the four food groups.

Go foods	**Grow foods**
Bread	Egg
Idli	Milk
Rice	Paneer
	Curd
	Meat
Glow foods	**Junk goods**
Fruit salad	Ice cream
orange	Chocolates
Brinjal	Mysore pak
Carrot	chips
Spinach	

VALUE BASED LIVING

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Remember that value is one's judgement of what is valuable or important in life. The most important in our life is our happiness. Naturally we are going to pick values for our living which will give us happiness.

How do we determine a value?
Values start with first with the knowledge of standard codes of living in our society- you can call this ethics morals principles, it does not matter.
At birth, we have no knowledge of values. When the baby throws tantrums, it gets a strong message from mom that it is not right. In order to please the mother, the baby makes a judgement that not throwing tantrums is important or valuable-the first step towards value based living!
All through our lives we continue making this value judgement – is this important in my life? Will this give me happiness? Will I comfortable doing this? If we are convinced, then we internalise this value. After this internalisation, our actions and interaction with the society is in line with the value set we carry.
Let us take an example – Truth. We all know Truth is a good value and telling lies in not right. But how much we adhere to this principle depends on how much we have internalised this knowledge. At one extreme, when we have zero internalisation we have absolutely no qualms about it. Mahatma Gandhi is an example of 100% internalisation of the value of Truth.

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Step: 2 This is a very personal one. Just watch your mind's reaction to any action you do. If the mind agitates and keeps on remembering the action– you keep on thinking, " I should not have done it" then that action is wrong. You should attempt to clarify your values on that subject and avoid doing that action again. Right actions on the other hand, brings happiness and you mind is at peace with itself.

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Summary table of card-game for CHWs: Diagnosis of fever in adults

No.	Age/sex	Duration of fever	Periodicity	Cold?	Cough?	Any pain?	Diarrhea/ urinary complaint	Other features/Supplementary questions			Diagnosis	Treatment
1.	35, male	5 days	Fever on alternate days	No	No	Some headache, bodyache	No	Chills? Yes			Malaria	Para, Chloro
2.	6, female	2 days	Intermittent, no regularity	Yes	Yes	Some headache, bodyache	No				Common cold	Home remedies, Para
3.	14, male	1 day	Continuous	No	No	Severe headache	No	Neck rigidity? Yes	Semi-conscious, not speaking		Meningitis	Immediate referral
4.	70, male	2 days	Intermittent, no regularity	No	Yes	Pain in the chest	No	Cough since when? 2 days	Breathless-ness? Yes	Expectora-tion? No	Pneumonia	Immediate referral
5.	8, female	3 days	Intermittent, no regularity	No	No	Abdominal pain	Diarrhea	Diarrhea since when? 3 days	Blood in stools? Yes		Dysentery with fever	ORS, Para, Cotrim

Com H 24

No.	Age/sex	Duration of fever	Periodicity	Cold?	Cough?	Any pain?	Diarrhea/ urinary complaint	Other features/Supplementary questions	Diagnosis	Treatment
6.	25, female	5 days	Intermittent, no regularity	No	No	Pain in the loin, lower back	Burning urination		Urinary tract infection	Plenty of fluids, Para, Cotrim
7.	10, male	4 days	Intermittent, no regularity	No	No	Pain in the arm pit	No	Examine armpit- Boil, pus	Abscess with fever	Remove pus, Para If fever and swelling continue- Cotrim
8.	16, female	4 days	Intermittent, no regularity	No	Yes	Sore throat	No	Examine throat - purulent spots in throat, tender nodes in neck	Bacterial Pharyngitis	Gargles, Para, Cotrim
9.	45, female	3 days	Intermittent, no regularity	No	No	Aching entire body	No		Viral fever	Rest, Para
10.	12, male	8 days	Continuous	No	No	Some bodyache	No		? Typhoid	Referral

Com H 27.2.09

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

CHW - BC4 | Class | Roll No.
Semester | Subject
Examination | Date

Maternal Care

I) India's Rx to MCH.

a) Mother & child must be considered as one unit becos'
- during 280 days of preg, felus is part of the mother, & obtains all building materials + O_2 for dev't from maternal blood.
- a healthy mother produces a healthy baby
- certain diseases/conditions during pregnancy can affect the felus eg syphilis, german measles, drug intake.
- after birth the child is dependant on the mother for physical, mental & social development. The mother is the first & most imp teacher.

b) Reasons why mothers & children are important.
- They form a very large part of the total pop'n. (census)
  In India total pop'n — 670 million
  children < 15 yrs — 42% } ie 65%
  % of child bearing age (15-45 yrs) — 22% } (17-20% under 5)
- They are a vulnerable or special risk grp
  ie. risk of childbearing in women } ∴ they have special health needs
  & of growth, dev't & survival in children }
  In India a very large no. of deaths occur in infants & children. Children also get ill very frequently (Morbidity rates).
- Much of the sickness & deaths among mothers & children are preventable eg malnutr', inf's. as against sickness in older age grps & simple measures can yield life long benefits to the individuals, families & the community
- Imp. for the health of the general pop'n & the progress of the nation ie it is a profitable investment.

Inspite of efforts, mother & child health (or ill health) is still one of the most serious problems affecting the community.

c) MCH problems in India revolve around malnutrition, infection & unregulated fertility (ie pop'n prob) (uncontrolled repod'n) + poor socioeconomic conditions + non availability of health services

d) Principals of Mother & child Health care.

- Improvement of health of mother & children by.
  i) education reg. health knowledge & family spacing & planning
  ii) prev: of illness through immuniz: & better nutrition
  iii) care of those who are ill. (ie curative, preventive & hlth promotion)
- * The service is provided by a primary health care team working with & through traditional healers, dais & members of the community.
- Effective services begin by understanding & cooperating with families in their own environment
- * Mothers & children must always be considered together: they are interdependent & affect each other.
- The service must be based on the most effective use of the resources available - in the community, Dev. Block & PHC
- Services must be brought as near the home as possible
- Ultimate ideal is to reach each adult to care for their own health & for their children & to develop a sence of responsibility for his children.
  (ie not first CRS food distri:).

e) Components of MCH care.

- antenatal, intranatal & postnatal care.
- nutritional health
- immunization (prevent: of communicable/infectious dis eg
- primary health care
- family welfare & responsible parenthood (spacing & planning)

Adapt acc to local needs & circumstances & integrate with basic health services to avoid overlap.

[Prim. Hlth care is essential hlth care made available to all individuals & families by means acceptable to them, with their full participation & at a cost that the community & can afford: — eg. Sr. Manamme]

2] Maternity Cycles — stages

i) Fertiliz: — fall. tube.
ii) Ante-/Pre. natal period — 280 days
iii) Intra-natal period — labour
iv) Post-natal period — 6 wks
v) Inter conceptional period

- Stages of growth & dev^{n}.

i) Antenatal period – ovum 0-14 days, embryo 14 days - 9 wks, foetus 9th wk to birth.

ii) premature birth – 27-37 wks.

iii) full term birth – 280 days av.

iv) infant – 1yr.

v) toddler/preschool – 1-5 yrs.

vi) child – < 15 yrs.

3) ~~Antenatal care~~ MCH team

Dais + village women.
female health worker.
Vaids + Hakims.
Block extn^{n} educator + village leaders.
Doctors + nurses.
Male health workers (vacc: ten. sanit^{n})

The team can work only thro' effective communic^{n}.
Always be in contact with + refer problems to the doctor.

4) Antenatal Care (← Diagnosis/confirm^{n} of pregnancy. Period of possible labor. ANcare, at risk, danger signals)

- Def - ANcare is care of the woman during pregnancy
- The main aim is to have a healthy mother + healthy baby at the end of a pregnancy.
- Objectives - i) to protect, promote, maintain health of mother
  ii) To detect high risk cases early & refer them
  iii) To remove anxiety ass^{d} c delivery
  iv) To teach the mother elements of child care, nutrition, personal hygiene + environ. sanitation
  v) To sensitize the mothers to the need for family planning + spacing
- Antenatal visits

Ideally once a month during the 1st 6 mths, twice a month during the next 2 mths, thereafter once a week - if everything is normal.

In poor socio-economic conditions it may mean loss of daily wages
∴ at least 4-5 ex^{ns} - 1st - before 12 wks, 2nd - 20-22 wks, 3rd - 28-32 wks, 4th - 34-36 wks, 5th - 38 wk - term. of these at least one shd be c home visit + 1 after 36 wks.

- Diagnosis of pregnancy.
  Amenorrhoea
  Nausea / vomiting sometimes
  Early subjective changes
  Uterus first palpable at 12/52 if not obese.
- Registration of case on an ANC Antenatal card with registration number, identifying data., history, examination, urine Rx etc, Postnatal care etc
  Maintenance of records is essential for evaluation & improvement of your service.
- Obstetric history — number of pregnancies, any complications, duration of labour, mode & place of delivery, miscarriages, foetal deaths, still births, twin pregnancies, other at risk signs
  No. of living children
- Medical History — Rickets, high BP, urinary trouble, ~~dis~~ TB
- Socioeconomic history, occup.
- History of present pregnancy — Date of LMP — Type of calendar, previous menses, calculation of EDC (1st day LMP + Nine mths + 7 days) (Others from date of quickening / height of uterus - only a rough guide), where the mother intends to have the baby, eg. maternal immunity.
- Physical examination — Height, weight, BP & other signs
  Pallor, oedema, oral hygiene
  Breasts, varicose veins.
- Urine for sugar & Alb, Hb % est.
- Abd. palpation — size of uterus
  - presentation & pos.
  - foetal movements & F.H.
- At subsequent visits:—
  take history of health since last visit
  check regular intake of food supplements
  record weight
  palpate abdomen
  check BP.
  Test urine.
  - esp. during lactation.
  - Diff. diag.-

- Home visits - every mother should be paid at least 1 home visit. More visits are required if the delivery is planned at home. The home visit will win her confidence - she is more relaxed at home. It will provide an opportunity to observe the environmental + social conditions at home + also an opportunity to give ANC advice.
- Routine prophylaxis. Ferrous Sulfate 200mg OD after food - 60 mg
  Folic acid 0.5mg OD - 500 mcgm.
- Immunis: - Tetanus Toxoid 2 doses each separated by 8 wks - 1st 20-26 wks, 2nd 30-36 wks (16-20 booster dose in subs. preg 20-24 4 wks before 36-38 delivery)
- Danger signals - From the first visit women must be taught to note + report the following
  1) Vaginal bleeding
  2) Abdominal or pelvic pain
  3) Fever
  4) Swelling of feet or limbs.
  5) Blurring of vision
  6) Marked reduction of urinary output.
  7) Escape of watery fluid from vagina.
  8) Nausea, vomiting, epigastric pain.
- High risk patients - an imp. func: is early recog: of pts at special risk of abnormalities of delivery or damage to the infant + refer of these cases to hospital.
  9) All primigravida less than 4'10" (145 cm) in height.
  10) Elderly primis (>30 yrs) (<15 + >45)
  11) Malpresentations - breech, transverse lie (persistent after 34 wks)
  12) APH, threatened abortion,
  13) PET + eclampsia
  14) Anemia (Hb 50% + less) / Malnutrition
  15) Twins, hydramnios.
  16) Previous still birth, IUD, recd abortions
  17) Elderly grand multis.
  18) Prolonged pregnancy (>14 days after EDC)
  19) History of previous Caesarian / instrumental delivery.
  20) Preg. ass: general diseases eg CVS dis, Diabetes, TB, kidney + liver dis.

PTO

- Low risk patients (suitable for home AN care & delivery)
women with 2nd, 3rd & 4th pregnancies with good obstetric & medical history, Hb > 10g%, Vertex presentation, in normal health.
In first pregnancy labour is unpredictable & up special supervision. Primi's suitable for home deliveries. — age 18-25 yrs, deeply engaged head (Ux presen:), BP not > 130/80, Partly dilated soft cx at onset of labour, absence of gen. problems.

- Advice during pregnancy. *
Mother is most receptive at this stage & your talking points should cover not only specific problems of pregnancy & childbirth but also req. family & child health care.

i) Diet - Malnut: in preg. results in low birth weight babies with higher sickness & death rates & supplementing diets of these mothers results in a significant improvement in the birth wt of infants. On an average a normal healthy woman gains about 12 kg wt during preg. (poor Indian ♀ - 6.5 kg) : balanced & adequate diet imp.

* The health team must have consistent, prepared advice to give to individuals or groups of women. Health educ must be given both in the home and in the clinic. Many women are illiterate. Special material must be available as posters, flip charts, slides, flannelgraphs, exhibits.
Subjects of concern & interest are :-
1. Nutrition & local recipes for protein rich foods, supplements with the cost & preparation
2. Travel during pregnancy ; rest & exercise.
3. Preparations for birth.
4. Care of baby.
5. Minor complaints during pregnancy.
6. Knowledge of & attitudes towards F.P & Spacing. *

ii) Personal hygiene in pregnancy. Must know what to do & what to avoid to ensure that she does not come to harm & has a normal baby. Attention must be given to.

a) Fresh air + sunshine - some time shd be spent out of doors morning + evening, moderate exposures encourages vit D metabolism, Deprivation as in strict purdah is bad.

b) Walking, graduated acc to stg of preg. is best exercise

c) As preg. advances, she carries more weight + she should take frequent short rests during the day with feet up. Shd not lift heavy weights. 8-9 hrs of sleep desirable

d) Daily bath. improves O'. Urinal toilet

e) constip: - plenty of fluid, drink of warm water on getting up, fruit + veg. in food. gentle aperient (eg Senna leaf) may be tgd. Strong aperients to be avoided

f) care of breasts - cleanliness + encouragement of O' to keep lacteal sinuses + ducts open. Apply oil / lanoline. Colostrum escapes from 34th wk.

g) Oral hygiene - teeth + gums

h) loose clothes, flat shoes

i) Smoking bad for baby.
Medicines (drugs) only on doctor's presc.
Free from worry.
Husbands attitude imp - shd be attentive + caring.

ii) Travel by bus / bullock cart shd be avoided in first 3 mths + after 28th wk.

iii) If there have been previous abortions intercourse should be avoided in the 2nd + 3rd mths + at the time of menstrual period throughout the course of pregnancy. Intercourse does not affect the fetus but is best avoided between the 36th wk of pregnancy + 6 wks after delivery.

iv) child care - mothercraft, nutr: educ:, child rearing, hygiene, cooking demons:, fam. planning educ:, family budgeting

PTO.

- Maternal health problems that are commonly seen.

1. Malnutrition with anemia
2. Poor or no weight gain during pregnancy.
3. Poor general health due to the burden of too frequent unplanned pregnancies.
4. Toxemia of pregnancy.
5. Abortion & infection from induced abortion
6. Vaginal discharge.
7. Parasitic infestation
8. Excessive vomiting during pregnancy.

Others — Urinary tract infection. — Heart dis.
- Malaria & other fevers — TB.
- Prolonged labour etc. — Diabetes.
- A.P.H. — Abn. presentn. - Multiple.

The most common causes of death related to child bearing are
1) Infection fol. induced abortion
2) APH & PPH
3) Toxemia of preg.
4) Anemia.

Compl^ns of labour — prolonged labour
— retained placenta.
— post partum hemorr.

Compl^n. in puerperium — PPH
— puerperal inf^n.
— mastitis & breast abscess.
— Thrombophlebitis.

— x —

- Most women in the community will seek the care of the local dai when they become pregnant. Dais conduct 90% of the deliveries in India. Hence it is v. imp to contact & train the dais. We are newcomers in the field & should treat them with due respect & be willing to learn from them too.
There are numerous customs, beliefs & traditions related

to MCH. These have to be studied + only the harmful ones should be tackled. There are many useful practices which should be encouraged & the harmless ones can be allowed to continue. eg,

—x—

Common gynaecological complaints :-
leucorrhoea, infertility, prolapse, cancer of genital tract, cancer of breast, dysmenorrhoea, amenorrhoea, delayed menarche, menorrhagia + DUB, post menopausal bleeding, pruritus vulvae, etc.

—x—

Indigenous calendar.

1. Temper is a valuable possession – do not lose it
2. Teamwork is the energizing spark that creates tomorrow beyond today's imagination
3. If you can find a path with no obstacles it probably does not lead anywhere
4. Tact is the rare ability to keep silent while 2 friends are arguing & you know both of them are wrong

1. Intro: to MCH — Mother + child one unit.
— Reasons why mothers + children are imp.
— MCH probs in India.
— Principles of MCH care
— Components of MCH care.

2. Maternity cycle — Stages of pgth + dev.

3. MCH team.

4. ANcare — aim, objectives, visits, Home visits
— Δ of preg, registr.
— Obst. H, med. H, socioec. H, psycol. H.
— phy. ex: + invest.
— Subsequent checkups.
— Routine prophylaxis, immuniz.
— Danger signals / risk cases. / low risk pts.

5. Advice — Diet.
— personal hygiene / bath, vulval toilet, care of breasts, constip; oral hygiene, rest, sleep, sunshine
— travel.
— intercourse
— child care / mother engt.

6. Imp. of dais + local customs, traditions + beliefs.

Sr Meera, Celine, Nirmala, Annette, Annie Jose, Cicily, Jude

COM H 22.2.8

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class | Roll No.

Semester | Subject

Examination | Date

Domiciliary Midwifery. (conduct of labour at home)

1) Anatomy of female rpd organs

- bony pelvis contains.
- uterus (body (fundus) + cervix), fallopian tubes, ovaries.
  non gravid - 3.5-5cm, wall serous, muscular + mucous layer
  bladder in front, rectum behind.
- external genitalia - labia majora + minora, external urethral meatus, vaginal orifice., perineum, anus. — vulva.
- pattern of blood vessels

Physiology of female rpd organs

- Menarche 12-14th yr - or 10-17 yrs., menopause around 45.
- Menstrual cycles 3-6/28 days ~~appx~~ av. - great variation regular / irregular.
- Ovulation - oestrogen - oestrogen + progesterone - pituitary - gonadotrophin
  (menst - 14 days after ovul.) - proliferative + secretory follicle - gf. cell - corpus luteum
  phase of endometrium.
  cervical secretion.
  Thermogenic effect of progesterone.

2) Physiology of Rpd:

Union of sperm and ovum (gametes) at outer end of Fall. tube to form zygote. Conception occurs 10-12 hrs after intercourse. (ovum incapable of being fertilised 48 hrs after ovul: + sperm also for 48 hrs).

Changes occur in wall of uterus - hypertrophy, BV. grow. to provide nutrition.

Cell division + differentiation occurs. 2 hollow vesicles + outer layer irregular vesicle. processes for embedding.

Placenta

The chorion + amnion (double layered translucent membr) arise from the placenta at its margin to envelop the fetus. Liquor amni - a clear fluid - collects in the amniotic cavity surrounding the embryo. Sometimes there maybe too much or too little of the fluid.

chorion - chorionic villi - decidua - placenta.

umbilical cord with the umbilical vessels

Placenta connects the fetus to the uterine wall, carries out nutritive, resp & excretory functions. At term, it is a discoid organ 15-20 cm diameter, 2-3 cm thick, weighing about 500 gm, usually implanted on the posterior or anterior surface of the uterine cavity well towards the fundus. The maternal surface is divided into irregularly shaped lobes

Physiology of labour - products of conception, at or near full term, separated from uterus & expelled thro' genital passages - normal/natural when it is expelled by natural efforts unaided within 24 hrs. Premature before 37 wks Abortion or miscarriage before period of viability - 27 wks.

Stages of labour:

1st stg - onset of true labour pains & uterine contractions
- Mucous sanguinous discharge or show
- complete dilatation of cervical canal
- In normal cases fixation of head at brim of pelvis & its progressive descent.
- Rupture of membranes
- Time variable - approx 16 hrs in primi & 6-8 hrs in multi.

2nd stg. - from complete dilatation & rupture of membranes to expulsion of fetus.
- 1-2 hrs in primi & 1/2-1 hr in multi.
- characteristic uterine contractions
- action of accessory muscles of labour.
- progressive descent of fetus - presenting part.
- Dilatation of vagina & vulva & stretching of pelvic floor.
- Expulsion of foetus.

3rd stg - from complete expulsion of fetus to complete expulsion of placenta & membranes & firm contraction & retraction of the uterus subsequently.
- Time - few to 15 min.

(separation & expuls: of pl, control of haem; contr & retr:)

Conduct of normal labour

Imp. to realize that labour is a physiolog. process & that in the majority of cases nature completes the delivery without any artificial aid, we should desist from the temptation of interfering too frequently or too early. "Meddlesome midwifery" is responsible for a great deal of maternal sickness & death.

Prep: of pt. – If not having strong pains & membranes are intact give soap & water enema.
- Pubic hair & vulva shaved & cleaned & antiseptic.
- Bathe if necessary.
- General & ob. ex:- to det. presen:, pos:, station of presenting part & condition of fetus.
- Vaginal exam:- in all primi's seen for first time, if in doubt after ob. ex:- or if doubtful req. rupture of bag of waters With all aseptic precautions – see nature & dilat:° of cx, presence or absence of membranes, pos:- & station of p.p.

Manag:° of 1st stg.
(labour pains & contrs, show, prpart fixed in multi, dilating cervical canal)
- pt should be allowed to walk about.
- temp/pulse recorded 4 hrly.
- foetal heart every hour.
- bladder kept empty by 2 hrly micts
- freq & str of contrs noted
- Descent of P.P.
- Presence of vag. discharge
- small quantities of liquid nourishment at intervals (avoid solid food: if anaesthesia used it causes nausea & vomiting)
- when pains occur at short intervals, put to bed.
- Sedatives may be administered for pain.
- membranes bulge or usually rupture spontaneously when Cx is fully dilated.

Manag:° of 2nd stg
- See that bladder is not distended - encourage to pass urine
- when nearing expulsion of fetus, dorsal position
- encouraged to hold breath & bear down during pains.
- foetal heart every 15 min after rupture of membs.
- when bearing down pains commence, head presses against perineum & anus begins to dilate.

- assistant shd scrub & wash hands & put on gloves
- main task is to prevent perineal lacerations, so that puerperium will be safer, chances of sepsis less & future gynae complaints later.
- This is achieved by preventing too rapid expulsion of head promoting flexion of head, delivering head between uterine contractions.
- When the head crowns the vulval outlet place one hand over the crowning vertex & with a sterile pad in the other hand support the perineum.
- After delivery of head wipe eyelids of child c boric acid sol, wipe lips & nose, clean mouth, aspirate mucous with & rubber catheter. If cord is round the neck, slip it over the head down the shoulder or cut between clamps.
- After the head is born it is better to wait for the next pain to expel the shoulders by natural powers. Avoid tear of perineum. ~~Delivery of shoulders~~ shd be delayed till complete rotation has taken place. Head should be held in the hand & gently depressed downwards so as to get the anterior shoulder well underneath the symphysis pubis. It should then be gently & raised up so as to allow the posterior shoulder to be delivered first. Help by gentle traction of head upwards for the posterior shoulder & downwards for the anterior shoulder. Do not pull the axilla.
- After delivery of the shoulders the body is as a rule rapidly expelled. If delayed the thorax may be held by the hand & gentle traction applied.
- As soon as the child is delivered it shd be placed on its side between the legs of the mother & chest gently compressed & mucus sucked
- No hurry to ligate the cord until pulsations cease. Fetus gets 80-100 ml of maternal blood during this period
- Cord ligatured in 2 places, one 3-4 cms from umbilicus & second as close to vulval outlet as possible. Cord divided

close to umbilical ligature by taking cord in hollow of palm & cutting it with scissors passed between the 2nd & 3rd fingers to avoid injury to the actively moving extremities of the child.
- After cutting, examine stump to see that there is no bleeding, touch it antiseptic & dress it gauze.
- apply eye drops/ointment.
- Wrap it warm material.
- Examine perineum well for lacerations.

Manag. of 3rd stg. - most imp stg.
- Watch the uterus, the cond. of the patient, amount of hemorr & -
- Signs of seperation of the placenta - pain & contr, vag hemorr, cord lengthens, fundus rises above umb, soft elevation above the symphysis, if fundus is grasped & raised the cord will not recede.
- Main aim - to promote natural separation of the placenta & membs & their complete expulsion, arrest hemorr, secure good & permanent contr. & retr. of uterus.
- Where one anticipates post partum hemorr or in severe anemia, multiparity, multiple pregnancy, or hydramnios give inj Methergine 0.25 mg IM.
- Examine placenta & membrane to see if it is complete
- cleanse perineum & pr, apply pad & abdominal binder. Tr. Benzoin to small tears
- watch the pt. for at least an hour after completion of 3rd stg. expulsion cord

Care of baby.
- give a bath after smearing with oil.
- examine for any congen. abnormalities esp. genital organs & anus.
- give mother light nourishment
- baby put to breast about 6 hrs after delivery.
- Make sure that uterus is well retracted, there is no undue bleeding & pulse is below 100.
- Record birth wt on saline scale.

Domiciliary

- Where home delivery is planned antenatal care shd be as complete as possible. + carried out with the cooperation of the dais.
- at least 1 home visit shd be paid well beforehand + both mother + midwife can be prepared.
- Prep: of room is most imp - it shd be whitewashed if possible + cleaned by wet swabbing, no dump plastering to be done, no sweeping etc once labour has begun.
- Proper lighting is imp + must be considered beforehand - torch / lantern.
- Clean bed + arrange it in best pos: for light - hay covered ĩ washed + sundried sari, a plastic sheet / mackintosh may be used.
- You shd have a Kit Kept prepared + ready. (eg Mother)

ĩ	enema tubing + funnel	Torch
	Vaseline.	Plastic sheet + apron
	Safety razor	Spring balance
	Thermometer	Swabs
	Savlon lotion	Gauze
Del. pack -	2 sterilized bowls	sterile cord ties.
	2 pairs artery forceps.	pieced pads + cotton
	Scissors.	mucus sucker.
	Kidney tray for placenta	gloves.
	soft towel for baby	

- water shd be boiled / cooled / kept in a covered vessel.
- Vessel for water shd be boiled / washed ĩ soap + water

POST NATAL CARE. (6 wks)

- visits on 2nd, 6th, 14th day + 6th wk. More if possible + necessary.
- check. - mothers gen. cond., pulse, temp., BP
  - lochia. - amt, colour, smell.
  - breasts + nipples - engorgement / retracted nipples
  - size of uterus.
  - calves.
  - abdomen
  - any mid: / bowels painless + normal
  - advise abt need for food + fluids.

baby – passage of urine & meconium.
– umbilicus.
– feeding
– How to give a bath & maintain warmth.

Refer the foll: – fever >100°C on 2 consecutive days
– Breast engorgement if unrelieved, esp. if fever & chills.
– Persistent fresh bleeding.
– Raised BP 140/90
– Any unusual symptom suggestive of local/general infection.

Advise abt diet, child care, immunization, FP., under 5 card.

Importance of training of dais or Traditional Birth Attendants

Dai Kit ← blade | 2% iodine in poly bottle | cord ties 9" long No 10, gauze 4"x6", plastic envelope 3"x4" Handbag, towel, soapdish, soap.
+ supervision

aim – To improve the knowledge of practising dais by giving them regular classes every month
– Taught how to conduct a clean & safe delivery.
– To promote health thru' health educ.

They are a part of the community & have close relationship with people in the village. They help the health centre staff to communicate with the people & are a part of the team.

– x –

1. Def. / Natural process
2. Anat & physio of upd sys.
3. Physio of upd. & labour. ← 1st 2nd 3rd stg.
4. Conduct of normal labour.
prep of pr – enema, shave, Bath, Hist, phyex, obsv, vag. exn.
1st stg – walk, T,P, FHS, bladder, contn, descent, Vgl discharge, lip, later resn.
2nd " – pos, bearing down, FHS, gloves, prevent tear
3rd " –
care of baby.
5. Home del – ANC, Home visit, room, del pack
6. PNC. – mother, baby, referral, advice
7. Typ of dais

MCH - Misc points

- more than 20% of newborns are LBW ie < 5½ lbs
- some common beliefs!
  i) liver disease occurs if solid food is given too early
  ii) anna prasanna - at 10 mths to 1 yr.
  iii) curds should not be taken at night or if one has a cold

(5) At Risk Concept

Reasons for Special Care

- Low birth wt
- Twins
- Breast feeding not estd
- One parent
- working mother
- Failure to thrive - 3 months
- Loses wt "
- History of death of sibling under 2yrs
- Develops acute illness
  - gastroenteritis
  - measles
  - whs. cough
- 2nd degree of malnutrition (Below 70%)
- Birth order 5 or more
- Spacing less than 2yr
- Illness of parents esp mother

(4) Post Natal Care

Mothes

Twice/day x 3
1/day x 7

Temperature
Pulse
Respⁿ

Breasts

—

Uterus involution
Lochia

—

Urine
Bowels

—

Perineal toilet
Care of stitches

—

Complⁿ
Puerperal sepsis
Thrombophlebitis
Sec. haemorrhage

Anemia
Nutrition
Post natal exercises
— gradual return to housework

New Born

Resuscitation
Care of cord
Care of Eyes
Care of Skin

Examⁿ from head to foot

—

? cyanosis of lips / skin
difficulty in breathing
imperforate anus
persistent vomiting
~~Temperature~~ breathings
convulsions
Neck rigidity

Psych — Acceptance of Child
Confidence as mother
Help & Mother craft.

③ Risk Cases

ANC

Elderly Primi

Less than 5 ft

Malpresentation

APH

PET

Anemic- Hb 50% ↓

Twins

Hydramnios

Grand multi

Postmaturity 14+

Previous c/s or Forceps

Pregnancy c other disease

H/o Still birth / IUD ↕ Manual removal of placenta

MCH Care

NC

Sluggish pains / No pains

Good pains but no progress

prolapse cord/hand

Meconium stained liqour

FH ↕

Excessive bleeding (Show)

Collapse/Shock

PPH

Temp ↑

Placenta not separated in half hour

MCH Care

(1) Preparations for Delivery

Domiciliary

- Sun dried old saree/sheet
- Hay.
- Clean cloth for child
- Hot water
- Scissors / Blade
- (Blade / Cotton ties / Iodine solution)

- Mucus sucker
- Methergin Inj^n

(2) Home Delivery

Adv

- Familiar Surrounding
- Less cross infn
- Keep an eye on home & other children
- Less mental tension
- Support of other women (mother etc)

Dis adv

- Less supervision
- Less rest
- resumes domestic duties too soon
- Diet neglected

Date :

MCH · Culture

Com H 22.27

1. Family - Important - Monogamy
   Motherhood
   Male Child preference
   Consanguinous marriages
   Village alliances

2. Marriage
   Many ceremonies
   Child Marriages - ?
   Arranged | Horoscope
   Vows - 7 steps -
   Witness wedding

3. Attitude to children
   - God given
   - Cared for not planned

4. Pregnancy -
   Monthly Rituals.
   Mothers House
   Food taboos
   Mental Health.

   7th month Ritual

5. Dai tradition - Practices | Payment | Service

6. New born care.

7. Child Health Practice

MCH

Reasons for MCH imp.
M & C as one unit
Def of preventive & social pead.
MCH problems.
objectives of MCH.
MCH care package
AN care – visits, ex:, needs, advice, risk approach
Antenatal care – aims, domiciliary care
postnatal care – mother, breast feeding, F.P., newborn, LBW, SFD
under 5 care –
School health
Behavior problems – child guidance clinic
Children Act.
Social welfare progs. ICDS

— X —

Health status of mothers & children – present situ: & recent trends
Social & cultural. changes – urbanis: / rural areas
Content of MCH care & priorities
MCH care at various stgs of dev:
Manag: of commandis,
care during preg & labour
perinatal care
infant & child health care.
Day care of children outside the home
Health of the school age child.
care of adolescents
Handicapped children.
– H.E. in the delivery of MCH care
– An integrated approach in the delivery of the MCH care package
– Priority content of MCH care
Nutr: protection & promotion
Imf's – prev: & manag:
F.P.
breast feeding.

Delivery of MCH care within the health care sys (service aspects)
Prim. level – utilis: of comm. resources.
Referred "
Central "

Indicators of MCH health
mortality, morbidity, gth + dev + rpd. health
probs of collecting + analysing those data.

Objectives (WHO) of MCH services begin with the immediate health probs of mothers + children + extend to health throughout life + to comm. health. Through concern with child development + the HE of parents + children the ultimate objective of MCH services is lifelong health. The effect of careful + informed mothering on the health of the entire family + the relation of fam. health to comm. hlth are imp factors in indi, comm + national dev."

The specific objectives – reduction of maternal, perinatal, infant + childhood mortality + morbidity + the promotion of reproductive hlth + the physical + psychosocial dev of the child + adolescent within the family.

Hlth of mothers + children is closely related to the gen. hlth of the community + is directly influenced by the prevailing socio-economic conditions. Improvement of hlth ∴ gets impulse from hlth + other sectors. (They are biologically more vulnerable to environmental influences + in need of special care.)

Recent knowledge of hlth probs – better understanding of the multifactorial origins of the main hlth probs of mothers + children, constant interaction bet the biolog. needs of the growing indi + the influence of the physical + psychosocial environ.; the imp of nutr to overall health, fetal + childhood gth + dev; increasing knowledge of the prevalence + consequences of LBW, impact of fertility regul on improved fam. hlth services M + C

New approaches in the delivery of care – dev of local strategies for the delivery of an MCH package adapted to the needs of the pop – special attention being given to nutrition, inf + fertility regul. the flexible + rational utiliz. of existing resources for improved MCH coverage within prim. hlth care; active community participation, the importance of an intersectoral approach linking health activities for mothers + children with the health related activities of other sectors from the fam. unit to the planning level. Integrated care at the primary level ē emphasis on the special needs of mothers + children
— × — (AN, NPN, infant, under 5, school 5–15)

– MCH – clinical aspects in OB + Paed. – the care – but how to get the services across – marketing
– MCH – the problems, the needs + their priorities + organiz. – in India – The local context
– In total health care of a pop. MCH is 1st on the list – why
+ reasons for MCH
– M + C as one unit .. – history.
– Def. of prev + social paed. – health status of mothers + children – present + in other
– MCH problems – health status of mothers + children – present + in other
social + environ. changes
– Objectives of MCH
– content of MCH + priorities
MCH care package
– Delivery of MCH within the health care syst.
– Indicators of MCH care

INSTRUCTIONS
FOR
COMMUNITY HEALTH WORKERS

CHAPTER 7

Maternal and Child Care

The care of mothers and children is an important part of family welfare services. Some of your tasks which relate to the health care of mothers and children have been described elsewhere in this Course e.g. in the chapters on Nutrition, Immunization and Family Planning.

7.1 Advise pregnant women to consult the Health Worker(Female) or the trained dai for prenatal, natal and postnatal care

It is important that a mother maintains good health during her pregnancy in order that she may deliver a healthy baby. It is also important that she should receive competent care during her labour and that after delivery she and her baby should be followed up to ensure that they progress normally.

Therefore, during your home visits whenever you find a pregnant woman, you should emphasize the following points about the need for prenatal, natal and postnatal care:

1. Regular prenatal care given by the Health Worker(Female) or trained dai is important for the health of both the mother and her unborn baby.
2. Prenatal care ensures the following:
   (a) The health problems of the woman are treated or she is referred as early as possible
   (b) Tetanus toxoid is given well before the expected date of delivery
   (c) Iron and folic acid tablets are given to those who are anaemic
   (d) The woman receives the necessary information about how to look after herself during pregnancy and how to prepare for delivery
3. Proper care during labour ensures the following:
   (a) Prevention of infection
   (b) Prevention of complications caused by improper handling during delivery
   (c) Early referral when complications arise
4. During the first week after delivery the mother and baby should be seen by the Health Worker(Female) or the trained dai, and subsequently, both mother and child should attend regularly the MCH clinic at the Subcentre
5. Regular postnatal care ensures the following:
   (a) Health problems in the mother can be identified and treated early
   (b) Health problems in the baby can be identified and treated early
   (c) If necessary the mother or baby can be referred in good time
   (d) Iron and folic acid can be given if necessary
   (e) The baby can be given the necessary immunization
   (f) The mother can be given family planning advice
   (g) The mother can be advised about infant care and proper feeding

7.2 Advise pregnant women to get immunized against tetanus

Tetanus germs are commonly found in rural areas because of the close association between animal manure and human habitation. The use of unclean instruments during home delivery and the improper care of the cord stump after it has been cut can cause tetanus in the newborn. This is usually fatal.

The disease can be avoided by the following measures:

(a) Immunization of the pregnant woman with tetanus toxoid is given between the 5th and 8th months of pregnancy in two doses at an interval of 2 to 3 weeks

(b) If, for some reason, tetanus toxoid has not been given during pregnancy, it is very important that special precautions should be taken to use sterile instruments and dressings in cutting and medicating the baby's cord.

7.3 Educate the community about the availability of maternal and child care services and encourage them to utilize the facilities

You should inform the people in the community about the various services which are available for mothers and children in the village, at the Sub centre, and at the Primary Health Centre. Take every opportunity to encourage the community members to make use of these facilities so as to promote maternal and child health.

These facilities are as follows:

1. In the village:

(a) The trained dai is always available for giving prenatal, natal and postnatal care. She will accompany the mother to the Subcentre for MCH care.

(b) The Health Worker(Female) will be available on the specified days when she is scheduled to visit the village in her intensive area. During these visits she will do the following:

(i) Examine pregnant and nursing women
(ii) Conduct home deliveries
(iii) Immunize mothers and children below one year
(iv) Distribute iron and folic acid tablets topregnant and nursing women.
(v) Distribute vitamin A to children 1 to 5 years of age
(vi) Treat mothers and children for minor ailments and refer them to the PHC if necessary
(vii) Give health teaching about the care of mothers and children

(c) The Health Worker(Male) will be available on the specified days when he is scheduled to visit the villages in his intensive area and those in his twilight area. He will carry out the following activities:

(i) Immunize children over one year in the intensive area and all mothers and children in the twilight area
(ii) Distribute iron and folic acid and vitamin A in coordination with the Health Worker(Female)
(iii) Treat minor ailments in mothers and children and refer them to the PHC if necessary

(d) The Health Assistant (Male) will be available on specified days each month for carrying out the immunization of school-going children

2. At the Subcentre: (a) The daily general clinic will be attended either by the Health Worker (Female) or the Health Worker (Male) The services for mothers and children will be as follows:

(i) Prenatal and postnatal care
(ii) Child health care
(iii) Immunization
(iv) Distribution of iron and folic acid and vitamin A
(v) Treatment of minor ailments
(vi) Health teaching

(b) The weekly MCH clinic will be attended by the Medical Officer, Primary Health Centre, and/or the Health Assistant (Female)

3. At the PHC : The following services will be available:

(a) Daily general clinics attended by one of the Medical Officers
(b) Weekly out-patient MCH clinics, attended by one of the Medical Officers
(c) In-patient care
(d) Referral to the District Hospital

7.4 Educate the community about how to keep mothers and children healthy

Some of the topics about which you should talk to people in the community are as follows:

1. The value of pregnant women attending MCH clinics regularly and the need for postnatal examination of the mother and her baby
2. The need for delivery to be conducted by the Health Worker (Female) or a trained dai and for precautions to be taken to prevent infection
3. The importance of having children examined and weighed at regular intervals to check that they are developing and growing normally
4. The importance of good nutrition for the mother and baby
5. The need to protect pregnant women and children against communicable diseases by immunization
6. The importance of personal hygiene and of hand-washing before handling the baby and especially before preparing food for the baby
7. The need to make the environment in and around the home clean and safe so as to prevent children from getting diarrhoeal diseases, worms and sore eyes
8. The need for every child to be a wanted child and to receive love and affection
9. The need to seek early treatment if either the mother or the child is ill

If any of the following signs and symptoms are present the mother or child should be taken immediately to the Health Worker or to the Subcentre:

(a) In pregnant women

(i) Headache
(ii) Swelling of feet, fingers, face or vulva
(iii) Blurring of vision

(iv) Pallor
(v) General feeling of weakness
(vi) Yellow eyes and highly coloured urine
(vii) Swelling and pain in legs
(viii) Vaginal bleeding
(ix) Vaginal discharge
(x) Fever
(xi) Cough

(b) In newborn infants (within one week of birth)

(i) Inability to suck
(ii) Difficulty in passing urine
(iii) Stools not passed
(iv) Jaundice
(v) Diarrhoea
(vi) Fever
(vii) Discharge from cord stump

(c) In infants (up to one year)

(i) Inability to suck or refusal of feeds
(ii) High fever
(iii) Severe or persistent diarrhoea
(iv) Vomiting
(v) Excessive crying or irritability and drawing up legs on abdomen
(vi) Convulsions
(vii) Listlessness or drowsiness
(viii) Difficulty in breathing
(ix) Skin rash
(x) White patches on tongue
(xi) Discharge from eyes
(xii) Discharge from ears

(d) In children (one to five years)

(i) High fever
(ii) Severe or persistent diarrhoea
(iii) Vomiting
(iv) Passing worms in stools
(v) Skin rash
(vi) Convulsions
(vii) Paralysis or weakness of muscles
(viii) Stiffness of neck
(ix) Pallor
(x) Dryness of eyes
(xi) Shiny, dry and scaly skin or wrinkled skin
(xii) Not gaining weight and not developing for his/her age
(xiii) Poor appetite
(xiv) Bowing of legs
(xv) Rubbing eyes or discharge from eyes
(xvi) Pulling ear or discharge from ear

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CHAPTER 9

MATERNAL AND CHILD HEALTH

Health services for mothers and children, more commonly known as maternal and child health, are a 'package of services' that has been developed to meet the needs of pregnant women before, during, and after delivery, and of infants from birth to five years.

The package of maternal and child health services is concerned with the following:

i. Ensuring the birth of a healthy infant to every expectant mother.

ii. Providing services to promote the healthy growth and development of children up to the age of five years.

iii. Identifying health problems in mothers and children at an early stage and initiating prompt treatment.

iv. Preventing malnutrition in mothers and children.

v. Preventing communicable diseases in mothers and children.

vi. Improving the health of mothers and children by providing family planning services.

vii. Educating mothers on how to improve or maintain their own health and that of their children.

9.1 THE NEED FOR MCH SERVICES

1. Human Resources : If children are to be born strong and healthy, their mothers will need to receive good prenatal and natal care. After they are born, they need specially designed health services so that their survival and healthy growth are ensured through proper nutrition and protection against communicable diseases and poor environmental conditions.

SERVICES FOR IMPROVING THE HEALTH OF MOTHERS AND CHILDREN IN THE VILLAGES ARE IMPORTANT FOR THE CONTINUED PROGRESS OF THE NATION.

2. Numbers Affected: Sixty per cent of the total population in the country consists of women of child bearing age and children under 15 years. Twenty per cent of this group are children under five years of age. This means that maternal and child health services would reach almost two thirds of the population.

3. Special Health Needs: Women and children have the highest risks in terms of number of illness and deaths. They also have special health needs which are not met by other services.

4. Investment in Health: The early identification of health problems and prompt treatment of disease among mothers and children can yield life-long benefits for the individuals, their families and communities in which they live.

DELIVERING CURATIVE AND PREVENTIVE HEALTH SERVICES AT THE SAME TIME TO MOTHERS AND CHILDREN IN THE VILLAGES IS A PROFITABLE INVESTMENT IN THEIR HEALTH.

contd./..... 2

lkr:

MOST WOMEN IN THE COMMUNITY WILL SEEK THE CARE OF THE LOCAL DAI WHEN THEY BECOME PREGNANT AND ARE READY TO DELIVER. YOU WILL HAVE TO CONVINCE THE WOMEN ABOUT THE VALUE OF ALSO ATTENDING THE MCH CLINIC FOR THE HEALTH OF THE UNBORN CHILD.

The advantages of attending the MCH clinic are as follows:

i. General health assessment can reveal abnormalities which can be corrected or treated early.

ii. Further evaluation and treatment can be carried out when there are irregularities related to the pregnancy.

iii. Health education can be given regarding care during pregnancy, preparation for home delivery or hospital delivery, and care of the infant.

Emphasize these advantages while motivating women to attend the MCH clinic.

MANY OF THE HEALTH PROBLEMS RELATED TO PREGNANCY AND CHILD-BEARING CAN BE PREVENTED OR REDUCED BY REGULAR EXAMINATION DURING PREGNANCY AND PROMPT TREATMENT.

9.2 WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF PREGNANT WOMEN.

In the twilight area, among pregnant women, you will have to concentrate on those who are more likely to develop complications and assist them to obtain the necessary health care. At present, in the twilight area, in the absence of the Health Worker (Female), pregnant women without complications will be cared for by the local dais.

Maternal health problems that are commonly seen are as follows:

1. Malnutrition with anaemia.
2. Poor or no weight gain during pregnancy.
3. Poor general health due to the burden of too frequent, unplanned pregnancies.
4. Infection from induced abortion.
5. Toxaemia of pregnancy.
6. Vaginal discharge.
7. Parasitic infestation.

THE MOST COMMON CAUSES OF DEATH RELATED TO CHILDBEARING ARE:

i. INFECTION FOLLOWING INDUCED ABORTION.
ii. ANTEPARTUM AND POSTPARTUM HAEMORRHAGE.
iii. TOXAEMIA OF PREGNANCY.
iv. ANAEMIA.

Women who are likely to develop complications during pregnancy and child-birth include the following:

i. Those under 15 or above 45 years of age.

ii. Those who have had four or more pregnancies.

iii. A woman 35 years or older who is pregnant for the first time.

iv. Those who have had previous abortions, either induced [illegible]

v. Those whose last child is under one year.

vi. Those who have had previous premature births.

vii. Those who have had complications during previous pregnancies or deliveries.

viii. A woman of small build.

ix. A woman with twin pregnancy.

x. Those who are malnourished.

xi. Those who have a chronic disease such as tuberculosis or malaria.

After identifying a woman who is likely to develop complications during pregnancy or childbirth, proceed as follows: -

i. Do a Tallquist haemoglobin estimation and administer iron and folic acid tablets if indicated.

ii. Advise her to attend the MCH clinic at the subcentre for examination and treatment.

iii. Find out what she is eating daily and advise her as to how to improve her diet.

iv. Persuade her and her husband to allow you to immunize her against tetanus in order to protect her unborn child.

IF YOU COME ACROSS A WOMAN WHO IS LIKELY TO DEVELOP COMPLICATIONS DURING PREGNANCY OR CHILDBIRTH, INFORM THE HEALTH WORKER (FEMALE).

Prenatal complications that are commonly found include the following:

i. Threatened abortion.

ii. Incomplete abortion or expulsion of the contents of the pregnant uterus early in pregnancy usually beofore 20 weeks.

iii. Septic abortion or infection of the uterus. This develops after abortion when unsterile methods or equipment have been used to induce expulsion of the foetus.

iv. Haemorrhage after the seventh month of pregnancy.

v. Toxaemia of pregnancy is characterized by two sets of signs and symptoms. Pre-eclampsia is the earlier stage of the condition and is characterized by swelling of the legs and fingers which may be accompanied by headache. Eclampsia is the more severe form of the condition in which the woman has generalised swelling of the body, severe headache and convulsions. Abortion or premature delivery often occur when a pregnant woman develops eclampsia.

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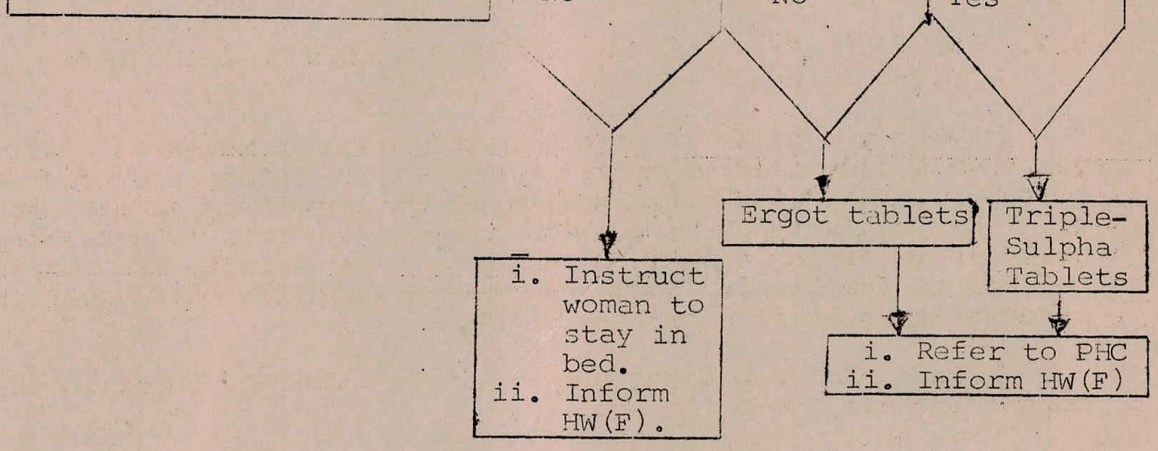
If a pregnant woman has any of the following conditions, proceed as follows:

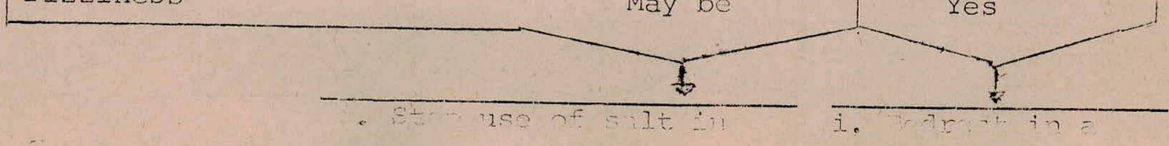
	Threatened Abortion	Incomplete Abortion	Septic Abortion
History of vaginal bleeding	Yes	Yes	Yes
Amount of bleeding	Slight	Heavy	Variable
Products of conception passed	No	Yes	May be
Purulent, foul discharge	No	No	Yes
Abdominal pain or tenderness	Yes	Yes	Yes
Fever	No	No	Yes



IF YOU COME ACROSS A WOMAN WHO HAS VAGINAL BLEEDING AFTER THE SEVENTH MONTH OF PREGNANCY, ARRANGE FOR HER IMMEDIATE TRANSGER TO THE PRIMARY HEALTH CENTRE. HER HUSBAND SHOULD ACCOMPANY HER IN CASE HIS PERMISSION IS REQUIRED FOR SURGERY. INFORM THE HEALTH WORKER (FEMALE) AND THE DAI CONCERNED.

If a pregnant woman has any of the following conditions proceed as follows:

	Pre-Eclampsia	Eclampsia
Swelling:		
Feet and legs	Yes	Yes
Hands and fingers	Yes	Yes
Face	No	Yes
Puffiness of eyes	Yes	Yes
Convulsions	No	Yes
Headche	Occasional, severe	Frequent or continuous, severe
Blurring of vision	No	Yes
Dizziness	May be	Yes



in the diet. ii. Refer to PHC iii. Inform HW (F)	quiet, darkened room ii. Attendant constantly with patient. iii. During convulsions: (a) Turn head to one side. (b) Place padded piece of wood between the teeth to prevent biting of tongue. iv. Inform PHC or arrange to transfer patient to PHC. v. Inform HW(F).

9.3. WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF WOMEN AFTER DELIVERY

When you visit the home shortly after a woman has delivered, you should ascertain whether the mother and infant are progressing normally. The dai who has delivered the woman may or may not refer her patient for medical care even when this is necessary. Delay in referring either the mother or the infant with complications to the Primary Health Centre or hospital may result in unnecessary suffering or even death.

Postnatal complications which may commonly occur in the mother include the following:

i. Puerperal sepsis (infection of the genital tract).
ii. Mastitis (infection of the breasts).
iii. Severe or prolonged bleeding following delivery or abortion.
iv. Thrombophlebitis (infection of the veins of the legs).

Signs and Symptoms:

If a woman who has recently had a baby has any of the following conditions, proceed as follows:

	Puerperal Sepsis	Mastitis	Severe or prolonged bleeding	Thrombo-phlebitis
History of:				
Excessive vaginal bleeding	May be	No	Yes	May be
Purulent discharge	Yes	No	No	No
Pain and tenderness:				
Lower abdomen	Yes	No	May be	No
Breasts	No	Yes	No	No

	Puerperal Sepsis	Mastitis	Severe or prolonged bleeding	Thrombo-phlebitis
History of: Swelling of legs	No	No	No	Yes
Headache	Yes	Yes	No	May be
Fever	Yes	Yes	No	Yes
Rigors (shivering)	Yes	Yes	No	May be
	i. Triple-sulpha tablets ii. Refer iii. Inform HW(F)		i. Refer ii. Inform HW(F)	i. Triple-sulpha tablets ii. Bed rest iii. Refer iv. Inform HW(F)

9.4 WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF NEWBORN INFANTS

Whenever you encounter a newborn infant (within a week after birth), you should make sure that the baby:

i. is able to suck.
ii. is urinating freely.
iii. is passing stools within 24 hours after birth.
iv. does not have fever.
v. does not have jaundice.
vi. does not have diarrhoea.
vii. does not have any birth injury or malformation which can be observed.

MOST NEWBORN INFANTS WHO ARE LESS THAN 1 WEEK OLD HAVE YELLOW COLOURING OF THE SKIN AND EYES. IF THIS PERSISTS BEYOND TEN DAYS, THE INFANT SHOULD BE REFERRED TO THE PRIMARY HEALTH CENTRE

REMEMBER THAT INFANTS ARE SOMETIMES BORN WITH SERIOUS PHYSICAL DEFECTS WHICH NEED PROMPT MEDICAL CARE. DELAY IN REFERRAL MAY RESULT IN DEATH.

YOU WILL HAVE TO WORK CLOSELY WITH THE LOCAL DAIS SO THAT THEY UNDERSTAND THE NEED FOR REFERRAL TO THE PRIMARY HEALTH CENTRE OF EITHER THE WOMEN THEY DELIVER OR THE INFANTS WHO DEVELOP COMPLICATIONS FOLLOWING DELIVERY.

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Complications which may commonly occur in the infant include the following:

i. Prematurity (birth weight of 2,500 grams or less)

ii. Eye infections are characterized by inflammation and discharge from the eye varying from sticky, watery discharge to thick, purulent material. The infant's eyes can become infected during the passage through the birth canal or later by the dirty hands of the birth attendant or mother or by flies. With the control of sexually transmitted diseases and the use of silver nitrate drops at birth, the incidence of opthalmia neonatorum has become minimal in the country

iii. Umbilical infections are characterized by inflammation and discharge from the umbilicus. Unclean hands and utensils used by the birth attendant in handling the cord, or the application of cow dung, dirty coverings or other substances to the cord or umbilicus are sources of infection. Tetanus infection is the most serious type of infection of the umbilicus. It continues to occur in rural areas because most women have not been immunized against the disease during pregnancy. The disease is characterized by muscular spasms, stiffness of the jaw and foul, purulent discharge from the umbilicus. The disease is usually fatal in infants.

iv. Thrush is a disease which is characterized by the appearance of white curd-like patches in the mouth and on the tongue. A woman who has the same fungal infection of the vagina can pass it on to her baby if she is careless about washing here hands or breasts before feeding her baby. The condition should be suspected when the baby who seems to be hungry is put to breast for feeding and pulls away and screams. In order to cure the infant, simultaneous treatment of mother and baby is necessary.

v. Gastroenteritis in newborn infants is characterized by sudden onset of water, yellow stools. At times there is vomiting, and the infant looks ill. Because infants have little physical reserve for resisting infections and can become critically ill within a short time, prompt medical care is needed.

If a newborn infant has any of the conditions already mentioned, proceed as follows:

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	Pre-matu-rity	Eye Infec-tion	Umbili-cal In-fection	Thrush	Gastro-enteri-tis
Unable to suck	Yes	No	No	May be	May be
Body temperature	Unstable	Raised	Raised	Normal	Raised
Weight under 2,500gms.	Yes	No	No	No	No
Vomiting	No	No	No	May be	May be
Refusing feeds	May be	No	No	Yes	May be
Crying and Irritable	No	No	May be	Yes	Yes
White patches on tongue	No	No	No	Yes	No
Purulent discharge:					
from the eye	No	Yes	No	No	No
from the umbilicus	No	No	Yes	No	No
Watery stool	No	No	No	No	Yes

- i. Handle as little as possible
- ii. Keep baby warm

- i. Clean eyes.
- ii. Apply tetra-cycline ointment

- i. Clean mouth
- ii. Apply gentian violet to mouth
- iii. Teach parent to apply gentian violet
- iv. Revisit next day

with spasms

Without spa-sms

No Vomit-ing

Vomit

- i. Clean umbili-cus.
- ii. Apply warm compress
- iii. Triple-sulpha tablets.

- i. Continue breast feeding.
- ii. Rehydration mixture

In-form

9.5 WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF INFANTS AND PRE-SCHOOL CHILDREN

Almost one out of every six infants born dies before reaching five years of age because of improper child care, poor environmental conditions and malnutrition. Therefore, this group needs to be given high priority in health care.

YOUR ACTIVITIES IN THE COMMUNITY FOR PREVENTING DISEASE ARE VERY IMPORTANT FOR ENSURING THE SURVIVAL OF MANY CHILDREN.

These activities include the following:

i. Health teaching (educating the parents and relatives).

ii. Improving the environment around the homes.

iii. Administering immunizations.

iv. Early detection of illness.

v. Giving simple medical treatment and early, prompt referral for more specialized care when indicated.

vi. Promoting child spacing (family planning) and preventing unwanted pregnancies.

You must, therefore, be very observant as you go about in the villages and use every opportunity to examine young children who are not growing like other children or who have signs of illness. Administering treatment for minor ailments, referring those who need special care to the Primary Health Centre, and teaching parents about child care are all important ways of promoting and maintaining the health of young children.

HEALTH EDUCATION IS ESPECIALLY IMPORTANT FOR PREVENTING MALNUTRITION, ACCIDENTS AND DISEASE AMONG YOUNG CHILDREN AND SHOULD BE GIVEN AS A PART OF EACH CONTACT WITH PARENTS.

Health problems that are commonly seen among infants and young children are as follows:

1. Low birth weight.
2. Malnutrition.
3. Infectious diseases.
4. Accidents.

THE YOUNGER THE CHILD, THE HIGHER ARE THE RISKS OF DEATH OR DISEASE WHEN PROPER DIET, CHILD CARE AND IMMUNIZATIONS ARE NOT GIVEN.

9.51 HEALTH NEEDS OF CHILDREN

It is necessary that you should know the health needs of children and how their needs can be met by their parents and others who care for them. The following points should be kept in mind:

1. Careful observation and health assessment of infants and young children is necessary because the younger the child, the higher the risk of his dying for lack of proper child care.
2. It is very important that infants and young children are seen regularly at the clinics in order to check their growth and development and to keep them well and healthy. The child should be seen once every month for the first year, every three months during

the second year, and once a year thereafter.

3. Due to their very rapid growth, children have special food requirements.

4. The weaning period, i.e., from six months to about three years, when the transition is made from diet of only breast milk to the full family diet, is a very important time for young children because improper feeding results in severe malnutrition with grave consequences.

5. Young children are susceptible to communicable diseases and should be protected by timely immunization.

6. Health education of the parents, grandparents and other relatives is necessary so as to ensure proper child care. Particularly useful topics for discussion are as follows:

   i. The early signs and symptoms of illness.

   ii. The selection and preparation of weaning foods.

   iii. How to recognize malnutrition and how to prevent it.

   iv. The need for a safe and hugienic environment.

   v. The dangers of using water from unprotected ponds and rivers for drinking and washing utensils.

   vi. How to look after a child with symptoms such as fever, disrrhoea, constipation, vomiting or cough.

   vii. The need for immunizations.

7. There is a need to assist older children who care for their younger brothers and sisters while their mothers work outside the home, to learn about proper child care.

REMEMBER, HEALTHY CHILDREN ARE THE RESULT OF TEAM WORK BETWEEN PARENTS, GRANDPARENTS, THE DOCTOR, THE INDIGENOUS PRACTITIONERS AND DAIS, THE COMMUNITY MEMBERS, THE HEALTH WORKER (FEMALE) AND YOURSELF.

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8. The smaller the family and the longer the birth interval (at least three years) between children, the more likely is the child to receive the care he needs.

9. Children need love and affection in order to become healthy adults who are capable of giving and receiving love.

10. Efforts to help parents and the community to make the environment around homes safe and hygienic will pay high divends in terms of reduction of illness in children (see Chapter 6, 'Environmental Sanitation', for details)

INCREASING THE HEALTH AWARENESS OF PARENTS THROUGH HEALTH EDUCATION CARRIED OUT INDIVIDUALLY AND IN GROUPS IS THE MOST EFFECTIVE METHOD OF BRINGING ABOUT IMPROVEMENT IN CHILD CARE PRACTICES.

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A healthy child (see fig.9.1):

i. is happy and alert to the people and things in his environment.

ii. has an abundance of energy and is active almost constantly.

iii. develops at a normal rate.

iv. grows in height and gains weight at a regular pace.

v. has a good appetite.

vi. has moist and clear eyes.

vii. has abundant, shiny hair which is springy in texture.

viii. has a firm abdomen which is not enlarged.

ix. has a clear skin, and pink nails and conjunctivae.

x. is able to run and jump as well as other normal children of the same age.

xi. enjoys receiving and giving affection.

xii. recovers from illness rapidly.

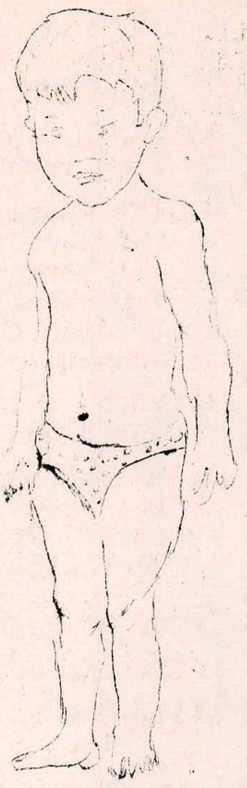

Fig. 9.1: A healthy child

9.5.2. ILLNESS IN CHILDREN

Illness of any kind in an infant or young child can quickly become very serious. Therefore, parents and others who care for children must be familiar with the early signs and symptoms of illness and take prompt measured to avoid deterioration of the condition.

Some of these signs and symptoms are as follows:

i. Fever with or without other symptoms.

ii. Twitching of the muscles or convulsions.

iii. Excessive crying and irritability.

iv. Poor appetite or refusal to eat as usual.

v. Loss of weight or stationary weight over a period of time.

vi. Change in colour or consistency of stools.

vii. Vomiting or passing worms in stools.

viii. Drawing up the legs on to the abdomen.

ix. Dry, wrinkled skin that keeps a fold when pinched (see fig. 22.2)

x. Dry mouth and dry red tongue .

xi. Less urine than usual.

xii. Running of the nose and breathing that is more rapid than usual, is noisy, or becoming difficult. (Nostrils [illegible] clearly visible).

xiii. Pallor and lack of interest in play.

xiv. Dryness of eyes and inability to see well in the dark.

xv. Rubbing the eyes or discharge from the eyes.

xvi. Pulling on the ears or discharge from the ears.

9.6 HEALTH EDUCATION

Some of the topics about which you should talk to individuals or to groups in the community are as follows:

1. The value of pregnant women attending MCH clinics regularly and the need for postpartum examination of the mother and her baby. The importance of having children examined regularly in order to keep them healthy and well.
2. The importance of good nutrition for mother and baby. What and when to feed young children (see Chapter 11, 'Nutrition').
3. Personal hygiene of both mother and child. The importance of hand washing before handling the baby and especially before preparing food or eating.
4. The need to protect pregnant women and children against common communicable diseases by immunization (See Chapter 12, 'Immunization').
5. The value of spacing children for the improved health of both mother and child (See Chapter 10, 'Family Planning').
6. The need to make the environment clean and safe to protect children from contracting gastrointestinal infections and from accidents (See chapter 6, 'Environmental Sanitation').
7. The early recognition of signs and symptoms of illness. The reasons for seeking prompt medical care or advice when either the mother or the infant is ill (see Part IV, 'Primary Medical Care in Accidents and Diseases' for specific ailments).
8. Simple measure which parents can take in caring for the sick child at home until it is seen by the doctor or health worker, e.g.,
   i. Applying cold compresses to bring down fever (see section 27.1).
   ii. Keeping the child warm.
   iii. Giving it plenty of fluids including rehydration fluid (see section 30.10).
   iv. Giving it a light non-spicy diet.
9. The importance of love and affection for the healthy growth and development of children, the need for constant mothering and the need for the provision of a substitute where the mother is away at work.

9.7 SERVICES PROVIDED FOR MOTHERS AND CHILDREN

At the Primary Health Centre:

i. Out-patient MCH clinics (usually held once a week)	Health services, curative and preventive, are provided by a team of doctor, nurse and other health workers.

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Clinics for sick and well children are often held on the same day as those for women who are pregnant or delivered. Health education is provided by all the members of the health team as part of their work. This may include demonstrations of preparing weaning foods, snacks for young children, etc.

ii. In-patients care (available for 24 hrs. a day) — Medical nursing and obstetric care is provided in the wards of the PHC for those who need it. Patients requiring more specialized care are referred to the district hospitals.

iii. Domiciliary visits (made periodically) — Periodic visits are made to homes for follow-up of pregnant women or those who have recently delivered to conduct a home delivery or to supervise the care of children who have health problems. Visits are usually made by members of the health team.

iv. School Health — Health services for children in schools are limited to what can be done on periodic visits to the school by the MO, PHC and other members of the health team. Health education of both teachers and children is done mostly in groups. Immunizations are given to children by the health team. Teachers are helped to learn to identify children who require referral.

At the Subcentre:

i. Clinics — These are conducted daily by the Health Worker (Female) and Health Worker (Male). In these Clinics:

i. Immunizations are administered on scheduled days.

ii. Minor ailments are treated and those who require further treatment are referred.

iii. Dietary supplements, e.g., calcium lactate tablets, vitamin B-complex tablets, Liver extract for pregnant and nursing mothers and vitamin A and D capsules for mothers and children.

iv. Distribution of vitamin A solution (2 lakh dose) to children aged one to five years every six months as a special programme.

v. Health education is included in all these activities.

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	Mothers and children who require special examination or treatment are seen by the doctor on a regularly scheduled day each week.
ii. Domiciliary Visits	The services provided are similar to those described above for the PHC. However, in the twilight area, the Health Worker (Female) along with the dai will visit on request the homes of women who are pregnant or who have recently delivered. Following a maternal death or infant death the Health Worker (Female) will visit the home to investigate the cause of death.
iii. School Health	Immunizations are given to susceptible children by the Health Assistant(Male) assisted by the Health Worker (Male).
iv. Health Education (May also be held in places other than sub-centre)	Both the Health Worker (Female) and the Health Worker (Male) are expected to utilise the various groups which exist in the villages or organize fresh groups and conduct health education on topics that pertain to preserving and improving the health of mothers and children.
v. Referral	Referral of patients for more specific treatment can be done either by the Health Worker(Female) or the Health Worker (Male). Depending on the situation and circumstances, such referrals may be made to their respective health assistants or directly to the PHC.
vi. Health Records	Several kinds of registers and records of services delivered to mothers and children are kept by the Health Worker (Female) at the subcentre. These are supplemented by those that are maintained by the Health Worker (Male) so that together they reflect the health status of the family. These records are used by the health workers to give continuity of care based on needs and enable them to evaluate their work or have their work evaluated by their respective superiors.

REMEMBER, THE AIM OF MCH SERVICES IS TO HELP MOTHERS TO LEARN WHAT THEY SHOULD DO TO MAINTAIN THEIR HEALTH AND THAT OF THEIR CHILDREN.

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CHAPTER 9

MATERNAL AND CHILD HEALTH

Health services for mothers and children, more commonly known as maternal and child health, are a 'package of services' that has been developed to meet the needs of pregnant women before, during, and after delivery, and of infants from birth to five years.

The package of maternal and child health services is concerned with the following:

i. Ensuring the birth of a healthy infant to every expectant mother.

ii. Providing services to promote the healthy growth and development of children up to the age of five years.

iii. Identifying health problems in mothers and children at an early stage and initiating prompt treatment.

iv. Preventing malnutrition in mothers and children.

v. Preventing communicable diseases in mothers and children.

vi. Improving the health of mothers and children by providing family planning services.

vii. Educating mothers on how to improve or maintain their own health and that of their children.

9.1 THE NEED FOR MCH SERVICES

1. Human Resources : If children are to be born strong and healthy, their mothers will need to receive good prenatal and natal care. After they are born, they need specially designed health services so that their survival and healthy growth are ensured through proper nutrition and protection against communicable diseases and poor environmental conditions.

SERVICES FOR IMPROVING THE HEALTH OF MOTHERS AND CHILDREN IN THE VILLAGES ARE IMPORTANT FOR THE CONTINUED PROGRESS OF THE NATION.

2. Numbers Affected: Sixty per cent of the total population in the country consists of women of child bearing age and children under 15 years. Twenty per cent of this group are children under five years of age. This means that maternal and child health services would reach almost two thirds of the population.

3. Special Health Needs: Women and children have the highest risks in terms of number of illness and deaths. They also have special health needs which are not met by other services.

4. Investment in Health: The early identification of health problems and prompt treatment of disease among mothers and children can yield life-long benefits for the individuals, their families and communities in which they live.

DELIVERING CURATIVE AND PREVENTIVE HEALTH SERVICES AT THE SAME TIME TO MOTHERS AND CHILDREN IN THE VILLAGES IS A PROFITABLE INVESTMENT IN THEIR HEALTH.

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MOST WOMEN IN THE COMMUNITY WILL SEEK THE CARE OF THE LOCAL DAI WHEN THEY BECOME PREGNANT AND ARE READY TO DELIVER. YOU WILL HAVE TO CONVINCE THE WOMEN ABOUT THE VALUE OF ALSO ATTENDING THE MCH CLINIC FOR THE HEALTH OF THE UNBORN CHILD.

The advantages of attending the MCH clinic are as follows:

i. General health assessment can reveal abnormalities which can be corrected or treated early.

ii. Further evaluation and treatment can be carried out when there are irregularities related to the pregnancy.

iii. Health education can be given regarding care during pregnancy, preparation for home delivery or hospital delivery, and care of the infant.

Emphasize these advantages while motivating women to attend the MCH clinic.

MANY OF THE HEALTH PROBLEMS RELATED TO PREGNANCY AND CHILD-BEARING CAN BE PREVENTED OR REDUCED BY REGULAR EXAMINATION DURING PREGNANCY AND PROMPT TREATMENT.

9.2 WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF PREGNANT WOMEN.

In the twilight area, among pregnant women, you will have to concentrate on those who are more likely to develop complications and assist them to obtain the necessary health care. At present, in the twilight area, in the absence of the Health Worker (Female), pregnant women without complications will be cared for by the local dais.

Maternal health problems that are commonly seen are as follows:

1. Malnutrition with anaemia.
2. Poor or no weight gain during pregnancy.
3. Poor general health due to the burden of too frequent, unplanned pregnancies.
4. Infection from induced abortion.
5. Toxaemia of pregnancy.
6. Vaginal discharge.
7. Parasitic infestation.

THE MOST COMMON CAUSES OF DEATH RELATED TO CHILDBEARING ARE:

i. INFECTION FOLLOWING INDUCED ABORTION.
ii. ANTEPARTUM AND POSTPARTUM HAEMORRHAGE.
iii. TOXAEMIA OF PREGNANCY.
iv. ANAEMIA.

Women who are likely to develop complications during pregnancy and child-birth include the following:

i. Those under 15 or above 45 years of age.

ii. Those who have had four or more pregnancies.

iii. A woman 35 years or older who is pregnant for the first time.

iv. Those who have had previous abortions, either induced

v. Those whose last child is under one year.

vi. Those who have had previous premature births.

vii. Those who have had complications during previous pregnancies or deliveries.

viii. A woman of small build.

ix. A woman with twin pregnancy.

x. Those who are malnourished.

xi. Those who have a chronic disease such as tuberculosis or malaria.

After identifying a woman who is likely to develop complications during pregnancy or childbirth, proceed as follows:

i. Do a Tallquist haemoglobin estimation and administer iron and folic acid tablets if indicated.

ii. Advise her to attend the MCH clinic at the subcentre for examination and treatment.

iii. Find out what she is eating daily and advise her as to how to improve her diet.

iv. Persuade her and her husband to allow you to immunize her against tetanus in order to protect her unborn child.

IF YOU COME ACROSS A WOMAN WHO IS LIKELY TO DEVELOP COMPLICATIONS DURING PREGNANCY OR CHILDBIRTH, INFORM THE HEALTH WORKER (FEMALE).

Prenatal complications that are commonly found include the following:

i. Threatened abortion.

ii. Incomplete abortion or expulsion of the contents of the pregnant uterus early in pregnancy usually beofore 20 weeks.

iii. Septic abortion or infection of the uterus. This develops after abortion when unsterile methods or equipment have been used to induce expulsion of the foetus.

iv. Haemorrhage after the seventh month of pregnancy.

v. Toxaemia of pregnancy is characterized by two sets of signs and symptoms. Pre-eclampsia is the earlier stage of the condition and is characterized by swelling of the legs and fingers which may be accompanied by headache. Eclampsia is the more severe form of the condition in which the woman has generalised swelling of the body, severe headache and convulsions. Abortion or premature delivery often occur when a pregnant woman develops eclampsia.

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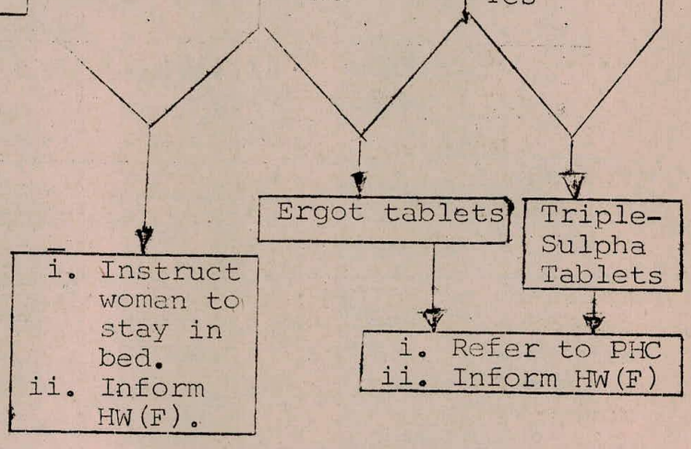
If a pregnant woman has any of the following conditions, proceed as follows:

	Threatened Abortion	Incomplete Abortion	Septic Abortion
History of vaginal bleeding	Yes	Yes	Yes
Amount of bleeding	Slight	Heavy	Variable
Products of conception passed	No	Yes	May be
Purulent, foul discharge	No	No	Yes
Abdominal pain or tenderness	Yes	Yes	Yes
Fever	No	No	Yes



IF YOU COME ACROSS A WOMAN WHO HAS VAGINAL BLEEDING AFTER THE SEVENTH MONTH OF PREGNANCY, ARRANGE FOR HER IMMEDIATE TRANSGER TO THE PRIMARY HEALTH CENTRE. HER HUSBAND SHOULD ACCOMPANY HER IN CASE HIS PERMISSION IS REQUIRED FOR SURGERY. INFORM THE HEALTH WORKER (FEMALE) AND THE DAI CONCERNED.

If a pregnant woman has any of the following conditions proceed as follows.

	Pre-Eclampsia	Eclampsia
Swelling:		
Feet and legs	Yes	Yes
Hands and fingers	Yes	Yes
Face	No	Yes
Puffiness of eyes	Yes	Yes
Convulsions	No	Yes
Headche	Occasional, severe	Frequent or continuous, severe
Blurring of vision	No	Yes
Dizziness	May be	Yes

i. Stop use of salt [illegible]

i. Admit in

in the diet. ii. Refer to PHC iii. Inform HW (F)	quiet, darkened room ii. Attendant constantly with patient. iii. During convulsions: (a) Turn head to one side. (b) Place padded piece of wood between the teeth to prevent biting of tongue. iv. Inform PHC or arrange to transfer patient to PHC. v. Inform HW(F).

9.3. WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF WOMEN AFTER DELIVERY

When you visit the home shortly after a woman has delivered, you should ascertain whether the mother and infant are progressing normally. The dai who has delivered the woman may or may not refer her patient for medical care even when this is necessary. Delay in referring either the mother or the infant with complications to the Primary Health Centre or hospital may result in unnecessary suffering or even death.

Postnatal complications which may commonly occur in the mother include the following:

i. Puerperal sepsis (infection of the genital tract).
ii. Mastitis (infection of the breasts).
iii. Severe or prolonged bleeding following delivery or abortion.
iv. Thrombophlebitis (infection of the veins of the legs).

Signs and Symptoms:

If a woman who has recently had a baby has any of the following conditions, proceed as follows:

	Puerperal Sepsis	Mastitis	Severe or prolonged bleeding	Thrombophlebitis
History of:				
Excessive vaginal bleeding	May be	No	Yes	May be
Purulent discharge	Yes	No	No	No
Pain and tenderness:				
Lower abdomen	Yes	No	May be	No
Breasts	No	Yes	No	No

	Puerperal Sepsis	Mastitis	Severe or prolonged bleeding	Thrombo-phlebitis
History of: Swelling of legs	No	No	No	Yes
Headache	Yes	Yes	No	May be
Fever	Yes	Yes	No	Yes
Rigors (shivering)	Yes	Yes	No	May be
	i. Triple-sulpha tablets ii. Refer iii. Inform HW(F)		i. Refer ii. Inform HW(F)	i. Triple-sulpha tablets ii. Bed rest iii. Refer iv. Inform HW(F)

9.4 WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF NEWBORN INFANTS

Whenever you encounter a newborn infant (within a week after birth), you should make sure that the baby:

i. is able to suck.
ii. is urinating freely.
iii. is passing stools within 24 hours after birth.
iv. does not have fever.
v. does not have jaundice.
vi. does not have diarrhoea.
vii. does not have any birth injury or malformation which can be observed.

MOST NEWBORN INFANTS WHO ARE LESS THAN A WEEK OLD HAVE YELLOW COLOURING OF THE SKIN AND EYES. IF THIS PERSISTS BEYOND TEN DAYS, THE INFANT SHOULD BE REFERRED TO THE PRIMARY HEALTH CENTRE

REMEMBER THAT INFANTS ARE SOMETIMES BORN WITH SERIOUS PHYSICAL DEFECTS WHICH NEED PROMPT MEDICAL CARE. DELAY IN REFERRAL MAY RESULT IN DEATH.

YOU WILL HAVE TO WORK CLOSELY WITH THE LOCAL DAIS SO THAT THEY UNDERSTAND THE NEED FOR REFERRAL TO THE PRIMARY HEALTH CENTRE OF EITHER THE WOMEN THEY DELIVER OR THE INFANTS WHO DEVELOP COMPLICATIONS FOLLOWING DELIVERY.

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in the diet. ii. Refer to PHC iii. Inform HW (F)	quiet, darkened room ii. Attendant constantly with patient. iii. During convulsions: (a) Turn head to one side. (b) Place padded piece of wood between the teeth to prevent biting of tongue. iv. Inform PHC or arrange to transfer patient to PHC. v. Inform HW(F).

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Postnatal complications which may commonly occur in the mother include the following:

i. Puerperal sepsis (infection of the genital tract).
ii. Mastitis (infection of the breasts).
iii. Severe or prolonged bleeding following delivery or abortion.
iv. Thrombophlebitis (infection of the veins of the legs).

Signs and Symptoms:

If a woman who has recently had a baby has any of the following conditions, proceed as follows:

	Puerperal Sepsis	Mastitis	Severe or prolonged bleeding	Thrombo-phlebitis
History of:				
Excessive vaginal bleeding	May be	No	Yes	May be
Purulent discharge	Yes	No	No	No
Pain and tenderness:				
Lower abdomen	Yes	No	May be	No
Breasts	No	Yes	No	No
			No	

	Puerperal Sepsis	Mastitis	Severe or prolonged bleeding	Thrombo-phlebitis
History of: Swelling of legs	No	No	No	Yes
Headache	Yes	Yes	No	May be
Fever	Yes	Yes	No	Yes
Rigors (shivering)	Yes	Yes	No	May be
	i. Triple-sulpha tablets ii. Refer iii. Inform HW(F)		i. Refer ii. Inform HW(F)	i. Triple-sulpha tablets ii. Bed rest iii. Refer iv. Inform HW(F)

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vi. does not have diarrhoea.
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YOU WILL HAVE TO WORK CLOSELY WITH THE LOCAL DAIS SO THAT THEY UNDERSTAND THE NEED FOR REFERRAL TO THE PRIMARY HEALTH CENTRE OF EITHER THE WOMEN THEY DELIVER OR THE INFANTS WHO DEVELOP COMPLICATIONS FOLLOWING DELIVERY.

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Complications which may commonly occur in the infant include the following:

i. Prematurity (birth weight of 2,500 grams or less)

ii. Eye infections are characterized by inflammation and discharge from the eye varying from sticky, watery discharge to thick, purulent material. The infant's eyes can become infected during the passage through the birth canal or later by the dirty hands of the birth attendant or mother or by flies. With the control of sexually transmitted diseases and the use of silver nitrate drops at birth, the incidence of opthalmia neonatorum has become minimal in the country.

iii. Umbilical infections are characterized by inflammation and discharge from the umbilicus. Unclean hands and utensils used by the birth attendant in handling the cord, or the application of cow dung, dirty coverings or other substances to the cord or umbilicus are sources of infection. Tetanus infection is the most serious type of infection of the umbilicus. It continues to occur in rural areas because most women have not been immunized against the disease during pregnancy. The disease is characterized by muscular spasms, stiffness of the jaw and foul, purulent discharge from the umbilicus. The disease is usually fatal in infants.

iv. Thrush is a disease which is characterized by the appearance of white curd-like patches in the mouth and on the tongue. A woman who has the same fungal infection of the vagina can pass it on to her baby if she is careless about washing here hands or breasts before feeding her baby. The condition should be suspected when the baby who seems to be hungry is put to breast for feeding and pulls away and screams. In order to cure the infant, simultaneous treatment of mother and baby is necessary.

v. Gastroenteritis in newborn infants is characterized by sudden onset of water, yellow stools. At times there is vomiting, and the infant looks ill. Because infants have little physical reserve for resisting infections and can become critically ill within a short time, prompt medical care is needed.

If a newborn infant has any of the conditions already mentioned, proceed as follows:

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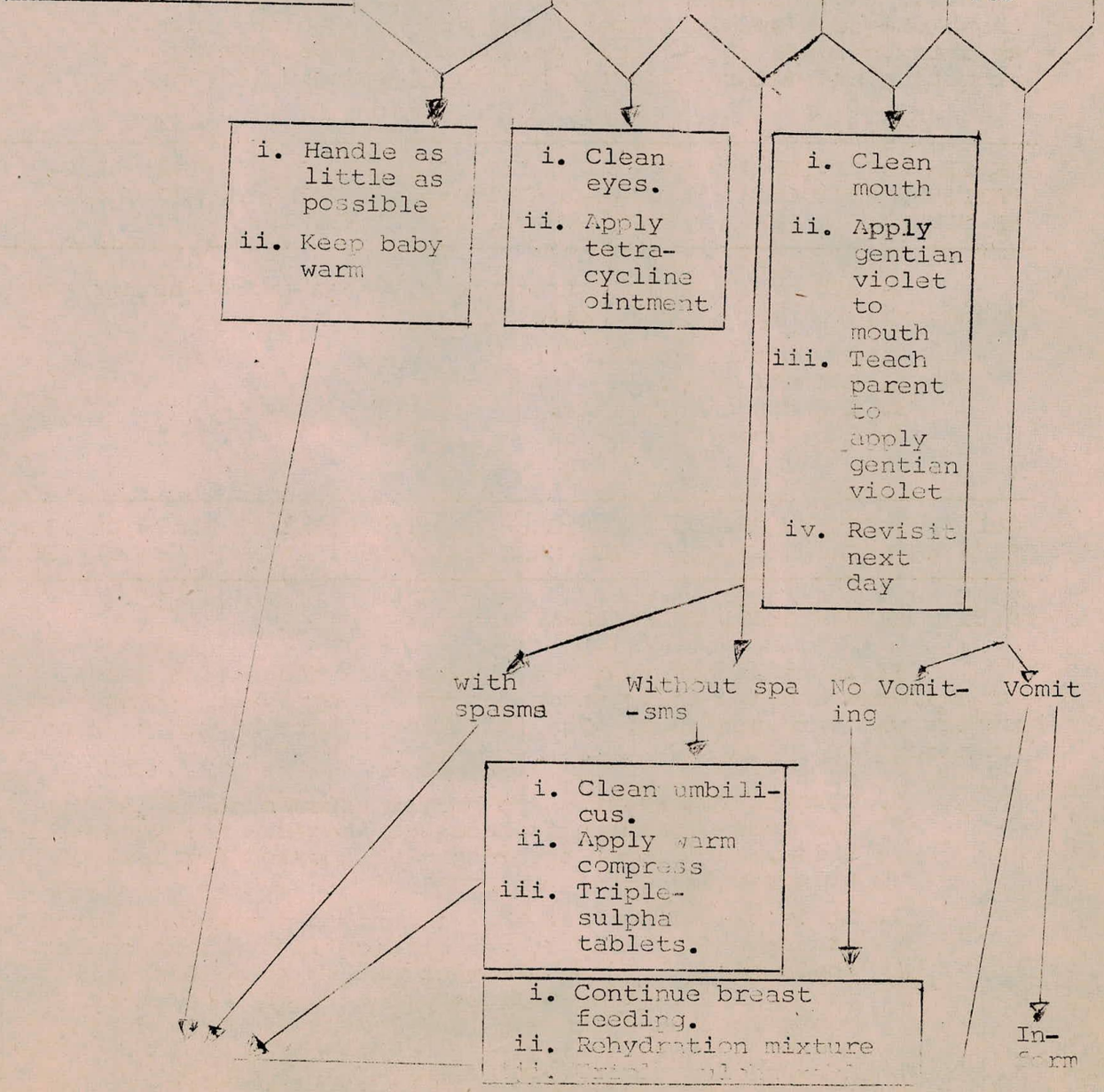
	Pre-matu-rity	Eye Infec-tion	Umbili-cal In-fection	Thrush	Gastro-enteri-tis
Unable to suck	Yes	No	No	May be	May be
Body temperature	Unstable	Raised	Raised	Normal	Raised
Weight under 2,500gms.	Yes	No	No	No	No
Vomiting	No	No	No	May be	May be
Refusing feeds	May be	No	No	Yes	May be
Crying and Irritable	No	No	May be	Yes	Yes
White patches on tongue	No	No	No	Yes	No
Purulent discharge:					
from the eye	No	Yes	No	No	No
from the umbilicus	No	No	Yes	No	No
Watery stool	No	No	No	No	Yes



9.5 WHAT YOU SHOULD KNOW ABOUT THE HEALTH CARE OF INFANTS AND PRE-SCHOOL CHILDREN

Almost one out of every six infants born dies before reaching five years of age because of improper child care, poor environmental conditions and malnutrition. Therefore, this group needs to be given high priority in health care.

YOUR ACTIVITIES IN THE COMMUNITY FOR PREVENTING DISEASE ARE VERY IMPORTANT FOR ENSURING THE SURVIVAL OF MANY CHILDREN.

These activities include the following:

i. Health teaching (educating the parents and relatives).

ii. Improving the environment around the homes.

iii. Administering immunizations.

iv. Early detection of illness.

v. Giving simple medical treatment and early, prompt referral for more specialized care when indicated.

vi. Promoting child spacing (family planning) and preventing unwanted pregnancies.

You must, therefore, be very observant as you go about in the villages and use every opportunity to examine young children who are not growing like other children or who have signs of illness. Administering treatment for minor ailments, referring those who need special care to the Primary Health Centre, and teaching parents about child care are all important ways of promoting and maintaining the health of young children.

HEALTH EDUCATION IS ESPECIALLY IMPORTANT FOR PREVENTING MALNUTRITION, ACCIDENTS AND DISEASE AMONG YOUNG CHILDREN AND SHOULD BE GIVEN AS A PART OF EACH CONTACT WITH PARENTS.

Health problems that are commonly seen among infants and young children are as follows:

1. Low birth weight.
2. Malnutrition.
3. Infectious diseases.
4. Accidents.

THE YOUNGER THE CHILD, THE HIGHER ARE THE RISKS OF DEATH OR DISEASE WHEN PROPER DIET, CHILD CARE AND IMMUNIZATIONS ARE NOT GIVEN.

9.51 HEALTH NEEDS OF CHILDREN

It is necessary that you should know the health needs of children and how their needs can be met by their parents and others who care for them. The following points should be kept in mind:

1. Careful observation and health assessment of infants and young children is necessary because the younger the child, the higher the risk of his dying for lack of proper child care.
2. It is very important that infants and young children are seen regularly at the clinics in order to check their growth and development and to keep them well and healthy. The child should be seen once every month for the first year, every three months during

the second year, and once a year thereafter.

3. Due to their very rapid growth, children have special food requirements.

4. The weaning period, i.e., from six months to about three years, when the transition is made from diet of only breast milk to the full family diet, is a very important time for young children because improper feeding results in severe malnutrition with grave consequences.

5. Young children are susceptible to communicable diseases and should be protected by timely immunization.

6. Health education of the parents, grandparents and other relatives is necessary so as to ensure proper child care. Particularly useful topics for discussion are as follows

   i. The early signs and symptoms of illness.

   ii. The selection and preparation of weaning foods.

   iii. How to recognize malnutrition and how to prevent it.

   iv. The need for a safe and hugienic environment.

   v. The dangers of using water from unprotected ponds and rivers for drinking and washing utensils.

   vi. How to look after a child with symptoms such as fever, disrrhoea, constipation, vomiting or cough.

   vii. The need for immunizations.

7. There is a need to assist older children who care for their younger brothers and sisters while their mothers work outside the home, to learn about proper child care.

REMEMBER, HEALTHY CHILDREN ARE THE RESULT OF TEAM WORK BETWEEN PARENTS, GRANDPARENTS, THE DOCTOR, THE INDIGENOUS PRACTITIONERS AND DAIS, THE COMMUNITY MEMBERS, THE HEALTH WORKER (FEMALE) AND YOURSELF.

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8. The smaller the family and the longer the birth interval (at least three years) between children, the more likely is the child to receive the care he needs.

9. Children need love and affection in order to become healthy adults who are capable of giving and receiving love.

10. Efforts to help parents and the community to make the environment around homes safe and hygienic will pay high divends in terms of reduction of illness in children (see Chapter 6, 'Environmental Sanitation', for details)

INCREASING THE HEALTH AWARENESS OF PARENTS THROUGH HEALTH EDUCATION CARRIED OUT INDIVIDUALLY AND IN GROUPS IS THE MOST EFFECTIVE METHOD OF BRINGING ABOUT IMPROVEMENT IN CHILD CARE PRACTICES.

A healthy child (see fig.9.1):

i. is happy and alert to the people and things in his environment.

ii. has an abundance of energy and is active almost constantly.

iii. develops at a normal rate.

iv. grows in height and gains weight at a regular pace.

v. has a good appetite.

vi. has moist and clear eyes.

vii. has abundant, shiny hair which is springy in texture.

viii. has a firm abdomen which is not enlarged.

ix. has a clear skin, and pink nails and conjunctivae.

x. is able to run and jump as well as other normal children of the same age.

xi. enjoys receiving and giving affection.

xii. recovers from illness rapidly.

Fig. 9.1: A healthy child

9.5.2. ILLNESS IN CHILDREN

Illness of any kind in an infant or young child can quickly become very serious. Therefore, parents and others who care for children must be familiar with the early signs and symptoms of illness and take prompt measured to avoid deterioration of the condition.

Some of these signs and symptoms are as follows:

i. Fever with or without other symptoms.

ii. Twitching of the muscles or convulsions.

iii. Excessive crying and irritability.

iv. Poor appetite or refusal to eat as usual.

v. Loss of weight or stationary weight over a period of time.

vi. Change in colour or consistency of stools.

vii. Vomiting or passing worms in stools.

viii. Drawing up the legs on to the abdomen.

ix. Dry, wrinkled skin that keeps a fold when pinched (see fig. 22.2)

x. Dry mouth and dry red tongue .

xi. Less urine than usual.

xii. Running of the nose and breathing that is more rapid than usual, is noisy, or becoming difficult. (Nostrils [illegible] are clearly visible).

xiii. Pallor and lack of interest in play.

xiv. Dryness of eyes and inability to see well in the dark.

xv. Rubbing the eyes or discharge from the eyes.

xvi. Pulling on the ears or discharge from the ears.

9.6 HEALTH EDUCATION

Some of the topics about which you should talk to individuals or to groups in the community are as follows:

1. The value of pregnant women attending MCH clinics regularly and the need for postpartum examination of the mother and her baby. The importance of having children examined regularly in order to keep them healthy and well.

2. The importance of good nutrition for mother and baby. What and when to feed young children (see Chapter 11, 'Nutrition').

3. Personal hygiene of both mother and child. The importance of hand washing before handling the baby and especially before preparing food or eating.

4. The need to protect pregnant women and children against common communicable diseases by immunization (See Chapter 12, 'Immunization').

5. The value of spacing children for the improved health of both mother and child (See Chapter 10, 'Family Planning').

6. The need to make the environment clean and safe to protect children from contracting gastrointestinal infections and from accidents (See chapter 6, 'Environmental Sanitation').

7. The early recognition of signs and symptoms of illness. The reasons for seeking prompt medical care or advice when either the mother or the infant is ill (see Part IV, 'Primary Medical Care in Accidents and Diseases' for specific ailments).

8. Simple measure which parents can take in caring for the sick child at home until it is seen by the doctor or health worker, e.g.,

   i. Applying cold compresses to bring down fever (see section 27.1).
   ii. Keeping the child warm.
   iii. Giving it plenty of fluids including rehydration fluid (see section 30.10).
   iv. Giving it a light non-spicy diet.

9. The importance of love and affection for the healthy growth and development of children, the need for constant mothering and the need for the provision of a substitute where the mother is away at work.

9.7 SERVICES PROVIDED FOR MOTHERS AND CHILDREN

At the Primary Health Centre:

i. Out-patient MCH clinics (usually held once a week)	Health services, curative and preventive, are provided by a team of doctor, nurse and other health workers.

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Clinics for sick and well children are often held on the same day as those for women who are pregnant or delivered. Health education is provided by all the members of the health team as part of their work. This may include demonstrations of preparing weaning foods, snacks for young children, etc.

ii. In-patients care (available for 24 hrs. a day)

Medical, nursing and obstetric care is provided in the wards of the PHC for those who need it. Patients requiring more specialized care are referred to the district hospitals.

iii. Domiciliary Visits (made periodically)

Periodic visits are made to homes for follow-up of pregnant women or those who have recently delivered to conduct a home delivery or to supervise the care of children who have health problems. Visits are usually made by members of the health team.

iv. School Health

Health services for children in schools are limited to what can be done on periodic visits to the school by the MO, PHC and other members of the health team. Health education of both teachers and children is done mostly in groups. Immunizations are given to children by the health team. Teachers are helped to learn to identify children who require referral.

At the Subcentre:

i. Clinics

These are conducted daily by the Health Worker (Female) and Health Worker (Male). In these Clinics:

i. Immunizations are administered on scheduled days.

ii. Minor ailments are treated and those who require further treatment are referred.

iii. Dietary supplements, e.g., calcium lactate tablets, vitamin B-complex tablets, Liver extract for pregnant and nursing mothers and vitamin A and D capsules for mothers and children.

iv. Distribution of vitamin A solution (2 lakh dose) to children aged one to five years every six months as a special programme.

v. Health education is included in all these activities.

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	Mothers and children who require special examination or treatment are seen by the doctor on a regularly scheduled day each week.
ii. Domiciliary Visits	The services provided are similar to those described above for the PHC. However, in the twilight area, the Health Worker (Female) along with the dai will visit on request the homes of women who are pregnant or who have recently delivered. Following a maternal death or infant death the Health Worker (Female) will visit the home to investigate the cause of death.
iii. School Health	Immunizations are given to susceptible children by the Health Assistant(Male) assisted by the Health Worker (Male).
iv. Health Education (May also be held in places other than sub-centre)	Both the Health Worker (Female) and the Health Worker (Male) are expected to utilise the various groups which exist in the villages or organize fresh groups and conduct health education on topics that pertain to preserving and improving the health of mothers and children.
v. Referral	Referral of patients for more specific treatment can be done either by the Health Worker(Female) or the Health Worker (Male). Depending on the situation and circumstances, such referrals may be made to their respective health assistants or directly to the PHC.
vi. Health Records	Several kinds of registers and records of services delivered to mothers and children are kept by the Health Worker (Female) at the subcentre. These are supplemented by those that are maintained by the Health Worker (Male) so that together they reflect the health status of the family. These records are used by the health workers to give continuity of care based on needs and enable them to evaluate their work or have their work evaluated by their respective superiors.

REMEMBER, THE AIM OF MCH SERVICES IS TO HELP MOTHERS TO LEARN WHAT THEY SHOULD DO TO MAINTAIN THEIR HEALTH AND THAT OF THEIR CHILDREN.

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DELIVERY OF INTEGRATED SERVICES FOR MATERNAL AND CHILD HEALTH, FAMILY PLANNING, NUTRITION AND IMMUNIZATION

The health of the mother and child are intertwined so that the services of maternal and child health, family planning, nutrition, and immunization are closely inter-related and require to be delivered as an integrated package of family health care. This is indicated in gi fig. 8.1.

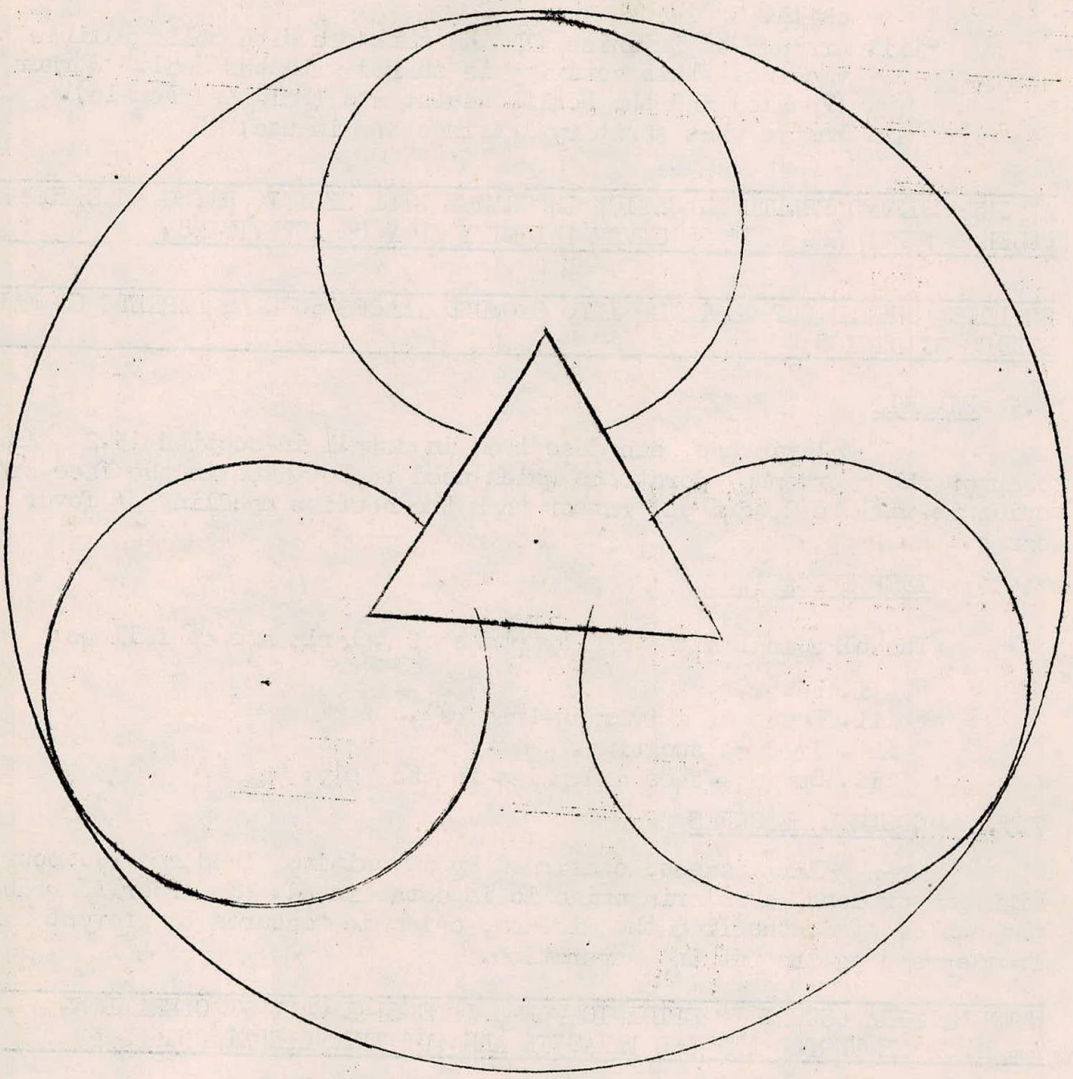

Fig. 8.1: Integrated family health care

DELIVERING INTEGRATED MATERNAL AND CHILD HEALTH, FAMILY PLANNING AND OTHER HEALTH SERVICES IN THE VILLAGES CAN HELP TO IMPROVE THE HEALTH OF THE WHOLE FAMILY.

In order to extend integrated maternal and child health services using the presently available health workers, the area and population covered by the subcentre has been divided temporarily into intensive and twilight areas.

i. The intensive area includes an area of approximately 5 kilometres radius surrounding the subcentre with a population of about 4,000.

v. Investigate any child who is away from school or in the same household who is sick.
vi. Carry out a health education programme to inform the community about the protective measures against the disease and to and to advise them to seek early treatment in case their children get sick. The Health Worker (Female) must also participate in this activity.

If the case is confirmed as a case of poliomyelitis, proceed as follows:

vii. Disinfect the house and all the articles belonging to the child.
viii. Arrange to immunize all the children with poliomyelitis vaccine. This activity is shared with the Health Worker (Female) and the Health Assistants (Male and Female).
ix. Ensure that sanitary latrines are in use.

AN INTENSIFIED HEALTH EDUCATION PROGRAMME WILL HELP TO BRING AN EPIDEMIC UNDER CONTROL AND MUST BE GIVEN PRIORITY IN YOUR ACTIVITIES.

CHILDREN SHOULD NOT BE TAKEN INTO CROWDED PLACES SUCH AS MARKETS OR FAIRS DURING EPIDEMICS.

7.5 MALARIA

Malaria has been described in detail in section 15.2. In this chapter the emergency operations which need to be taken in the face of an epidemic will be described, rather than the routine handling of fever cases.

7.5.1 IDENTIFICATION

The classical signs and symptoms of malaria are as follows:

i. Fever.
ii. Bouts of shivering (rigors).
iii. Profuse sweating.
iv. Severe aches and pains in the body.

7.5.2 CONTROL MEASURES

When malaria cases, confirmed by a positive blood smear, occur in high proportions, a malaria epidemic is established. In order to reduce the number of deaths from the disease, epidemic measures to prevent malaria from spreading are put into operation.

WHEN MALARIA OCCURS IN EPIDEMIC FORM, INTENSIVE CONTROL OPERATIONS AGAINST THE VECTOR AND THE PARASITE ARE PUT INTO OPERATION.

The containment measures include the following:

i. The distribution of radical treatment to all positive malaria cases.
ii. The distribution of prophylactic chloroquine to all fever cases in the area.
iii. Spraying of houses with insecticide to reduce the adult mosquito population.
iv. Larviciding operations to reduce the mosquito larval population in urban areas, and in rural areas only if feasible.
v. Destruction of mosquito breeding places in urban areas, and in rural areas only if feasible.
vi. Intensive health education programme.

AS A HEALTH WORKER AT THE PERIPHERY YOU HAVE TO PREPARE THE COMMUNITY [illegible] TO OBTAIN THE DISEASE, AND ASSIST YOUR SUPERVISOR

ii. The twilight area is the periphery beyond the 5 kilometres radius surrounding the subcentre and has a population of about 6,000/(see fig. 8.2).

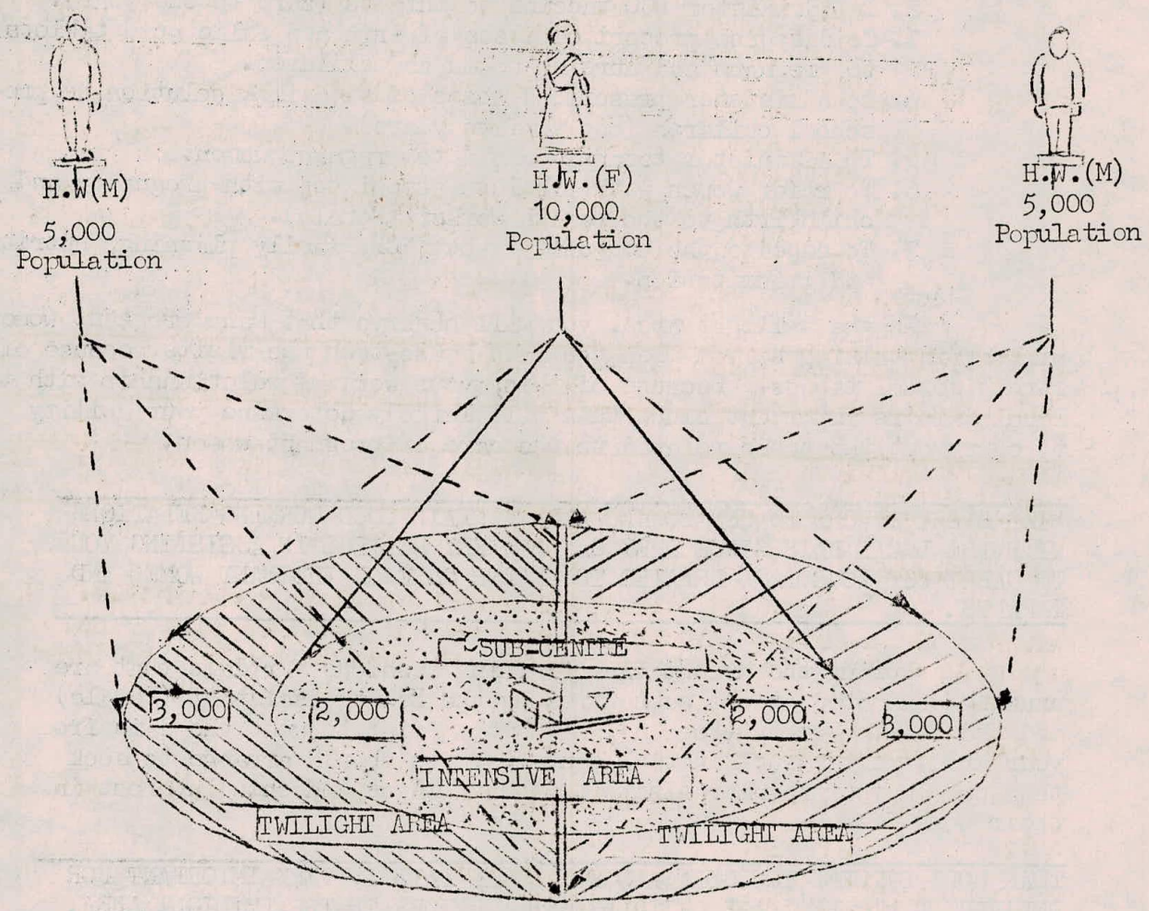

Fig. 8.2:Intensive and twilight areas
Distribution of area between health workers (Male and Female)

Total population covered by subcentre: 10,000
Population covered by one Health Worker (Female): 4,000 Intensive
6,000 Twilight
Population covered by each Health Worker (Male) : 2,000 Intensive
3,000 Twilight

As more health personnel become available at the subcentres, the worker-population ratio will be increased so that this division of areas will be eliminated.

The Health Worker (Female) has the major responsibility for the delivery of MCH services in the intensive area, but you also have certain tasks to perform. These are as follows:

1. To immunize pre-school children (one to five years) against smallpox diphtheria, pertussis and tetanus and, where available, poliomyelitis.
2. To administer BCG Vaccine to pre-school children (one to five years).
3. To identify and refer malnourished pre-school children
4. To assist the Health Assistant (Male) in the immunization of school children.
5. To participate in health education activities pertaining to MCH, family planning, nutrition and immunization.

In the twilight area, besides the tasks listed for the intensive area, you will also have the following additional tasks:

1. To immunize infants (zero to one year) against smallpox, diphtheria, pertussis and tetanus and, where available, poliomyelitis.
2. To administer BCG vaccine to infants (zero to one year).
3. To dispense prescribed doses of iron and folic acid tablets to pregnant and nursing women and children.
4. To administer prescribed doses of vitamin A solution to pre-school children (one to five years).
5. To administer tetanus toxoid to pregnant women.
6. To refer women with problems associated with pregnancy and childbirth to the Health Worker (Female).
7. To educate the community about MCH, family planning, nutrition and immunization.

In the twilight area, you will observe that many pregnant women will avoid talking to you when you make house-to-house visits because of strong social taboos. Because of this, your working relationship with the local dais is important since this will largely determine your ability to carry out the tasks related to the care of pregnant women.

MAKE EVERY EFFORT TO GET TO KNOW AND MAINTAIN GOOD WORKING RELATIONS WITH THE LOCAL DAIS SINCE THEY CAN BE VERY HELPFUL IN ASSISTING YOU TO CARRY OUT YOUR TASK RELATED TO HEALTH CARE OF PREGNANT WOMEN AND INFANTS.

During the orientation training sessions for dais that are usually conducted at the subcentres by the Health Assistant (Female) and the Health Worker (Female), make it a point to meet the dais from your area. After such initial contacts, you should arrange to seek them out on your regular visits to the villages and show interest in their work.

TEAM WORK BETWEEN YOURSELF AND THE LOCAL DAIS IS VERY IMPORTANT FOR DELIVERING MATERNAL AND CHILD HEALTH SERVICES IN THE TWILIGHT AREA.

You will be delivering selected health services to mothers and children in the intensive area along with the Health Worker (Female) who has the major responsibility for providing maternal and child health services in this area. In order to avoid duplication of activities within the same family, time should be set aside for planning your activities with the Health Worker (Female). During these meetings the following may be discussed:

i. Women and children who require to be seen by the Health Worker (Female) should be referred to her.
ii. The Health Worker (Female) should refer to you husbands who are reluctant to permit their wives to accept a family planning method, or families who want their wells chlorinated, or pre-school children or school-aged children who have not been immunized.
iii. The Births and Deaths Register and Eligible Couple Register should be brought up to date.
iv. If any special programmes are to be carried out, e.g., group meetings, you and the Health Worker (Female) should plan these together.

IT IS IMPORTANT TO HAVE A BRIEF DAILY CONFERENCE WITH THE HEALTH WORKER (FEMALE) TO EXCHANGE INFORMATION REGARDING SPECIFIC FAMILIES AND TO ENSURE THE DELIVERY OF INTEGRATED HEALTH SERVICES.

You will be working alone in the twilight are at least until sufficient numbers of Health Workers (Female) are available. Therefore, in addition to your tasks in the intensive area, you will be responsible for referring pregnant women with health problems which cannot be handled by the dais to the Health Worker (Female) or Primary Health Centre, or for requesting the Health Worker (Female) to attend deliveries in the twilight area.

In order to be able to do this effectively you must know what are the most common problems relating to pregnancy and childbirth. In addition to care of pregnant women in the twilight area, you will be responsible for advising mothers about the care of children from zero to five years of age and for referral of those children who require medical care.

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FAMILY PLANNING

10.1 What is Family Planning

Family planning services include the following:

1. Educating the community as to:
   - i. the advantages of a planned family;
   - ii. the selection and use of contraceptive methods;
   - iii. medical termination of unwanted pregnancy;
   - iv. the causes and treatment of infertility (inability to have children).
2. Providing facilities for:
   - i. sterilization;
   - ii. IUD insertion;
   - iii. prescription of oral contraceptives;
   - iv. distribution of conventional contraceptives through clinics, home visits and depot holders;
   - v. medical termination of pregnancy;
   - vi. treatment of infertility.

The operational goals of the family planning programmes are, therefore, as follows:

1. To create the concept of a small family as a norm among all married couples and to ensure its acceptance by the different groups in every community.
2. To disseminate information to all eligible couples as to the family planning methods available.
3. To assure an adequate supply of contraceptives within easy reach of all eligible couples.
4. To arrange for clinical and surgical services.

10.2 FAMILY PLANNING AID FAMILY WELFARE

Frequent pregnancies in malnourished women result in mothers who are:

- i. weak and who lack energy to care for their children;
- ii. often sick because of poor resistance to infections;
- iii. anaemic and subject to complications during pregnancy and childbirth, e.g., premature delivery or haemorrhage.

Babies born to such women tend:

- i. to be born early, and to be small and weak;
- ii. to develop nutritional deficiency diseases early;

Serious malnutrition usually develops in infants who are displaced from breast feeding early due to the birth of a new baby within a period of about two years.

SPACING A PREGNANCY CAN PROTECT THE HEALTH OF THE MOTHER AND HER CHILD BECAUSE:

i. SHE IS LESS LIKELY TO HAVE SERIOUS COMPLICATIONS OF PREGNANCY.
ii. SHE IS LESS LIKELY TO PRODUCE A WEAK, LOW BIRTH-WEIGHT INFANT.
iii. SHE WILL HAVE MORE TIME AND ENERGY TO CARE FOR THE INFANT AND FOR OTHER CHILDREN.
iv. THE TIME INTERVAL BETWEEN PREGNANCIES WILL HELP HER BODY TO RECOVER FROM THE BURDEN OF CHILDBEARING.

Limiting population growth in the country can make it possible for more people to have.

i. better job opportunities;
ii. higher family income;
iii. better facilities for schooling;
iv. better health care;
v. better housing;
vi. more adequate food supply.

10.3 TARGET GROUPS FOR FAMILY PLANNING

All couples where the woman is in the reproductive age group, i.e. she is between 15 to 44 years old, are eligible for family planning services.

GIVE PRIORITY TO COUPLES HAVING TWO OR MORE LIVING CHILDREN AND TO NEWLY MARRIED COUPLES. ENCOURAGE THESE COUPLES TO ADOPT EITHER A PERMANENT OR TEMPORARY METHOD OF CONTROLLING FERTILITY.

10.4 RESPONSIBILITIES OF THE HEALTH WORKER (MALE) IN THE DELIVERY OF FAMILY PLANNING SERVICES:

In the intensive area:

1. To develop, maintain and use the Eligible Couple Register for planning and carrying out family planning activities.
2. To confer regularly with the Health Worker (Female) and refer to her women who require her assistance.
3. To inform men about the advantages of a planned family.
4. To motivate men to adopt a contraceptive method.
5. To distribute condoms to acceptors.
6. To provide follow-up services to male family planning acceptors.
7. To recruit, train, supervise and supply male depot holders.
8. To identify, train and involve male leaders in each village in family planning activities.
9. To utilize satisfied family planning acceptors and other interested individuals in promotional activities for family planning.
10. To identify and refer any woman with an unwanted pregnancy, for medical termination of pregnancy to the Health Worker (Female).
11. To inform couples about medical termination of pregnancy and infertility services.
12. To maintain and submit the required records and reports.
13. To confer regularly with the Health Assistant (Male) regarding specific aspects of his work.

In the twilight area:

(In addition to the tasks listed above)

14. To inform women about the advantages of a planned family and to motivate them to adopt a contraceptive method.

10.6 WORKING WITH THE HEALTH WORKER (FEMALE) IN FAMILY PLANNING

In order to achieve the family planning targets that have been set for the subcentre, it will be necessary for you and the Health Worker (Female) to plan your promotional activities and follow-up of family planning acceptors together as a team.

When there is joint planning and implementation of common activities groups of eligible couples and influential men and women in each village can be systematically reached and informed according to a planned schedule. Duplication of efforts can be avoided or minmized and the information that is conveyed can be designed to reinforce rather than merely repeat what has already been said about family planning.

Points to consider in Coordinating your work with the Health Worker (Female):

1. Share information regarding approaches that have been found useful in motivating male acceptors.
2. Request her assistance in motivating the wife when the husband is resistant to adopting a contraceptive method.
3. Discuss with her some of the doubts and misconceptions raised by the women in the twilight area and seek her assistance in clarifying these doubts.
4. Give her a copy of the Eligible Couple list and keep it up to date with her assistance.
5. Together with her, plan the educational activities for health and family planning so that groups in the community can be combined when feasible, e.g., male and female school teachers, or male and female depot holders.

10.7 CONTRACEPTIVE METHODS

In this section of the Manual, the various contraceptive methods that can be used by men or by women are described and their advantages and disadvantages listed. The illustrations have been selected for your own clarification as well as for their value as teaching aids for you to use in your educational programmes in the community.

In some instances a man may wholly reject the use of any contraceptive method for himself and insist that his wife should use a method. You will be able to assit such a family by informing the man about female methods in general so that he can encourage and support his wife in adopting a method either for spacing pregnancies or for limiting the size of their family.

There are two types of contraceptive methods:

1. Temporary Methods: These can be discontinued easily at any time by the user when a pregnancy is desired. The methods differ for men and women.

   Temporary Methods for Women
   i. Intra-uterine devices (IUD)
   ii. Oral contraceptives (the pill)
   iii. Diaphragm (cap)
   iv. Foam tablets and jellies
   v. Rhythm method (safe period).

   Temporary Methods for men
   i. Condon (Nirodh)
   ii. Withdrawal.

2. Permanent Methods: These consist of surgical procedures performed on either the man or woman which will make either individual permanently sterile.

Permanent Method for Women

i. Tubectomy i.e. tubal ligation (severing and tying off the fallopian tube).

Permanent Method for Men

i. Vasectomy (severing and tying off the vas deferens).

REMEMBER, CONCEPTION CAN BE PREVENTED IF:
i. THE MAN'S SPERM CANNOT REACH THE OVUM.
ii. THE OVUM IS NOT RELEASED EACH MONTH BY THE WOMAN.
iii. THE OVUM CANNOT ATTACH ITSELF TO THE WALL OF THE UTERUS.

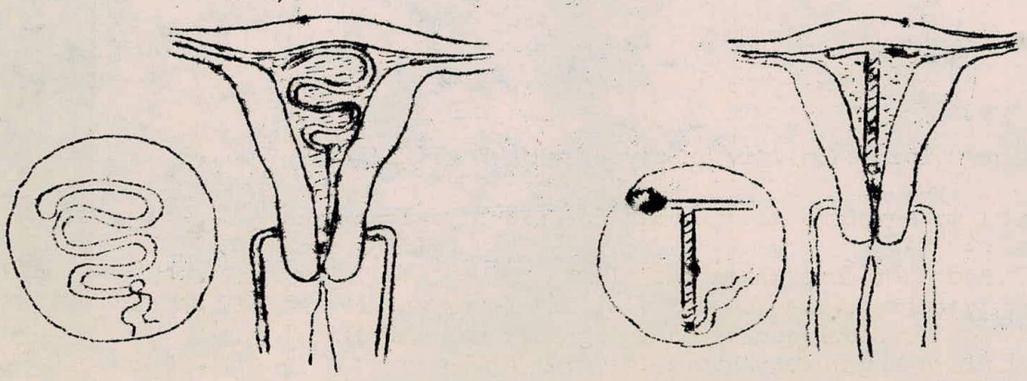
10.7.1 SELECTION OF COUPLES FOR CONTRACEPTIVE METHODS

In advising a couple as to the most suitable method of contreeption to be used by them, the following factors should be taken into consideration:

1. The age of the couple.
2. The health of the couple.
3. The number of pregnancies the woman has had.
4. The number of living children.
5. The health of the children.
6. The sex of the children.
7. The age of the youngest child.
8. The availability of the services, viz. personnel, supplies and follow-up.
9. Whether the couple wish to space their children or limit the size of their family.
10. The preference of the couple for a particular method.
11. The facilities available in the home, e.g., privacy, water supply and facilities for storage of contraceptives.
12. The cost involved in purchasing contraceptives or in travel to the place of free supply.
13. Specific family situations, e.g., either partner refuses to use any method, irresponsibility of either partner, long absence or chronic illness of either partner.
14. The presence of medical contraindications to the use of a particular method. This could be determined after history taking and medical examination at the clinic.

10.7.2 CONTRACEPTIVE METHODS FOR WOMEN:

1. Intra-uterine Device (IUD): The intra-uterine devices currently used in India include the Lipres loop which is made of polyethylene and the Copper T device which is made of polyethylene and copper. The IUD is inserted into the uterus to prevent coception (see fig.10.1a & b).



Advantages:

i. The wearer has little responsibility for preventing conception once the device is inserted.
ii. The device can be removed when a preghancy is desired.
iii. The procedure does not require hospitalization.
iv. It does not interfere with intercourse.
v. It is a reliable method for spacing children especially for women who are unable to use other methods.

Limitations:

i. There may be some bleeding or pain, which is usually temprorary.
ii. The device may come out spontaneously so the wearer must check the threads attached to the IUD each month usually after the menstrual period.
iii. An examination by the doctor, at least once a year, is necessary.
iv. The device must be changed at least once every three years.
v. The IUD cannot be used in the presence of certain gynaecological conditions.

If this method is preferred by the couple, refer the woman to the Primary Health Centre and inform the Health Worker (Female).

2. Oral Contraceptives (Pill): The oral contraceptives are pills that are taken daily by a women to prevent her ovaries from releasing any eggs so that she cannot become pregnant. The pills must be taken on a prescribed monthly schedule to be effective since seven of the pills in each 28-day supply package are black pills, i.e. they do not contain the contraceptive drug but contain only iron. These pills are usually packed as shown in fig. 10.2.

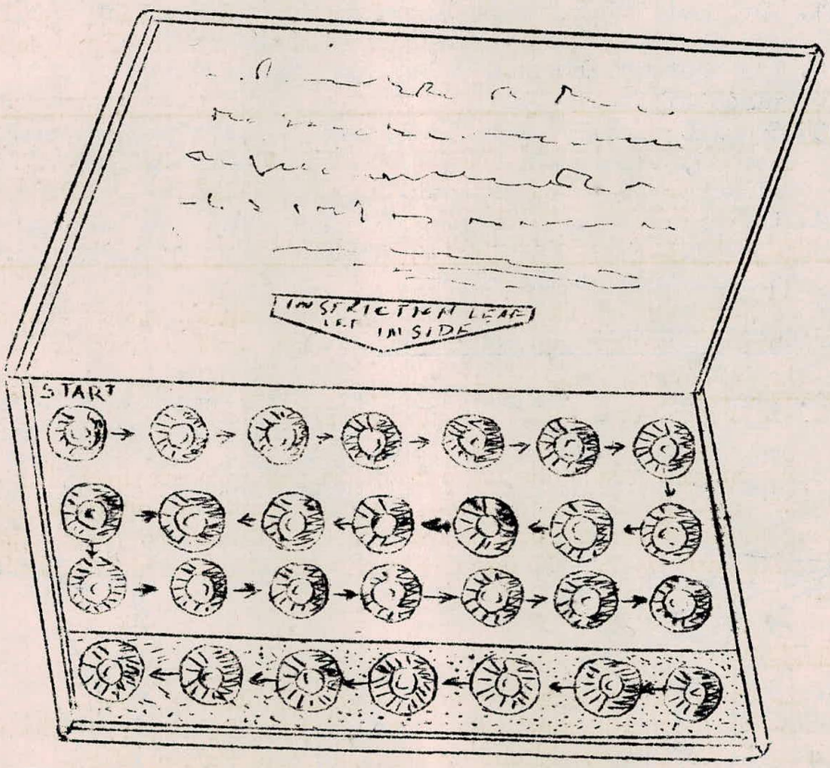


Fig. 10.2: Contraceptive tablets - 28 tablets pack (IDPL)

Advantages:

i. It is an effective method.
ii. There is no interference with the sex act.

iv. It is useful for a newly married woman who wishes to postpone having her first child.

LIMITATIONS:

i. A careful history and medical examination by a doctor are required before the pill is prescribed.
ii. Side-effects may occur, i.e. nausea, headache, bleeding between menstrual periods or increase in weight.
iii. It requires self-discipline, and is likely to be stopped or forgotten by women who are not strongly motivated to control conception.
iv. There are certain contraindications to the use of oral contraceptives so that all women cannot be given the pill.

Instructions for Use of Contraceptive Tablets - 28 tablets pack (one tablet a day without interruption).

NOTE: These instructions are for the use of Contraceptive tablets manufactured by the Indian Drugs and Pharmaceuticals Limited for the Ministry of Health and Family Planning. The instructions are issued with each packet of Contraceptive tablets.

The first course of tablets should be started on the fifth day of the menstrual cycle (counting the first day of bl bleeding as day No.1) by taking the talbet from the pocket marked as 'start' (white tablet). For subsequent days one tablet a day should be taken from the pockets in the other indicated by arrows on the pack, till all the tablets are consumed. The new pack should be started the very next day by taking the first tablet from the pocket marked as 'start'. The tablet should be taken every day at a fixed time, preferably before going to bed at night.

CAUTION:

i. THE FIRST COURSE SHOULD BE STARTED STRICTLY ON THE FIFTH DAY OF THE MENSTRUAL PERIOD, AS ANY DEVIATION IN THIS RESPECT MAY NOT PREVENT PREGNANCY.
ii. KEEP ALL TABLETS AWAY FROM CHILDREN.

If this method is preferred by the couple, refer the woman to the Primary Health Centre and inform the Health Worker (Female).

3. Diaphragm (Cap): The diaphragm is a soft, rubber, doneshaped device, the rim of which contains a metal spring.

Diaphragms are made in various sizes and are used for covering the lower opening of the uterus. They prevent the spermatozoa from entering the uterus during intercourse and should be used together with spermicidal creams or jellies for more effective contraception (see fig. 10.3).

Advantages:

i. It does not interfere with sexual intercourse.
ii. It does not hurt or affect either the woman or the man.
iii. It is a very effective method of contraception.
iv. It can be placed in the vagina at any time by the woman herself once she learns how to use it.

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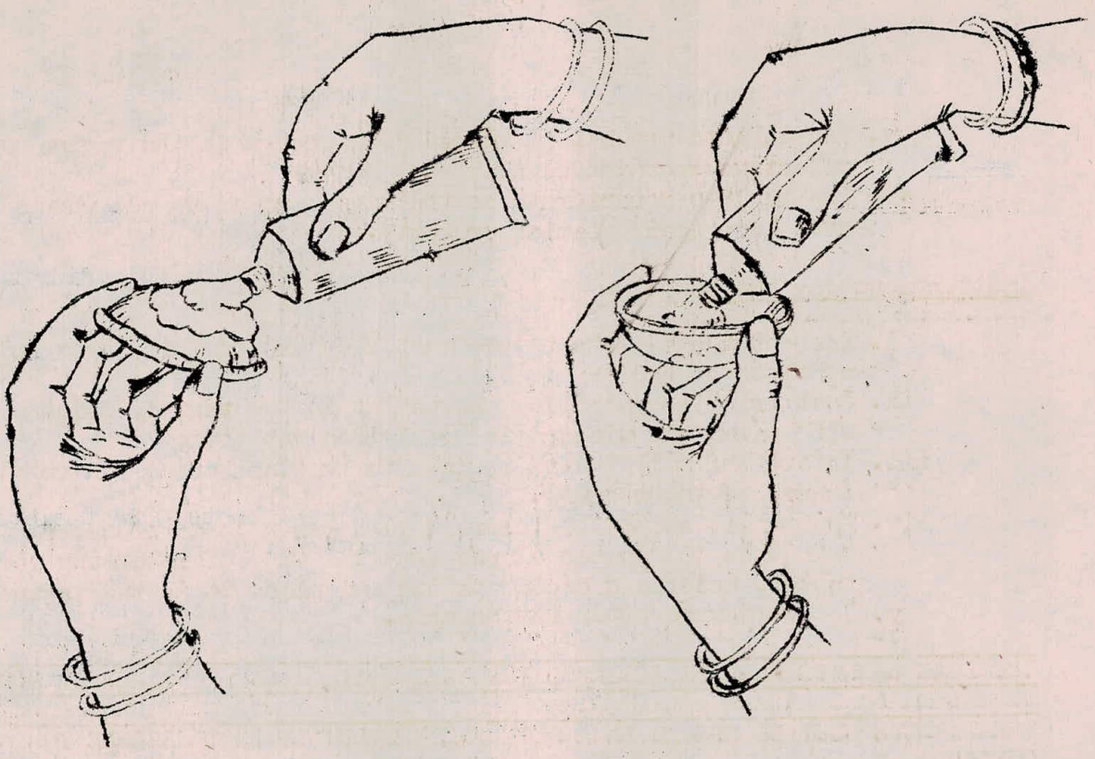

Fig.10.3: Diaphragm and Jelly

Limitations:

i. One size does not fit all women.
ii. Vaginal examination by a doctor is required for determining the proper size needed and for excluding conditions where the diaphragm cannot be used.
iii. It must be left in place for at least 6 hours after intercourse
iv. It must be washed, dried and stored carefully in between use.
v. It must be checked each time before use to exclude defects.
vi. It should preferably be used with a spermicidal cream or jelly which requires regular replenishment.
vii. Once a year examination is needed to see if the prescribed diaphragm is still of the correct size.

If this method is preferred by a couple, refer them to the Primary Health Centre and inform the Health Worker (Female).

4. Foam Tablets: These are vaginal tablets which dissolve on contact with moisture by developing a thick foam which is spermicidal, i.e. it is able to kill the spermatozoa in the vagina during intercourse.

Advantages:

i. Insertion of the tablet in the vagina is simple.
ii. It does not interfere with sexual intercourse.
iii. No prior medical examination is necessary.

Limitations:

i. It is no an effective contraceptive method.
ii. There is a time limit for inserting the tablet (5 to 10 minutes) prior to intercourse.
iii. A new tablet is required for each sexual act.
iv. Occasional side effects include irritation or a burning sensa-

v. The tablets may not be placed deep enough in the vagina for effective spermicidal action.
vi. The tablets deteriorate so that they are of no use when they have lost their foaming property.

Instructions for the User:

i. Inspect the tablets to see that they are of the proper colour, consistency and form.
ii. Just prior to inserting the tablet in the vagina, moisten it with water and discard it if it does not foam,
iii. Insert the tablet high up into the vagina behind the cervix (mouth of the uterus).
iv. The tablet should be inserted just prior to intercourse. If more than 10 minutes elapse from the time of inserting the tablet, moisten a second tablet and place it in the vagina.
v. Do not douche after intercourse.

THE FOAM TABLETS MUST BE INSERTED INTO THE VAGINA AND NOT TAKEN BY MOUTH.

THE TABLETS MUST BE STORED IN A SAFE PLACE WHICH IS INACCESSIBLE TO CHILDREN.

5. Creams and Jellies: There are various kinds of spermicidal creams and jellies which are used for contraception by the woman. They may be used alone or with a diaphragm or condom. When used alone, the jelly or cream is inserted in a measured amount into the vagina with a special applicator.

Advantages:

i. It is easy to use.
ii. No prior medical examination is necessary.
iii. It can be used by a newly married woman who wishes to postpone having her first child.

Limitations:

i. When used alone it is not a very effective contraceptive method.
ii. Side-effects may include local irritation or soreness in either the man or the woman, or vaginal discharge in the woman.
iii. Errors in the amount of jelly or cream used or in the depth of its application may occur.

Instructions for the User:

i. Screw the applicator on to the nozzle of the tube containing the jelly or cream.
ii. Press the tube so that the applicator is filled with jelly or cream.
iii. Unscrew the applicator.
iv. Just prior to intercourse the woman should lie on her back and insert the applicator into the vagina behind the cervix.
v. Inject the jelly by pressing the plunger while gradually withdrawing the applicator.
vi. Do not douche after use.
vii. Wash and dry the applicator. Store the jelly or cream out of the reach of children.

6. Rhythm Method (Safe Period): For those who will not adopt any other method of family planning because of religious or other reasons, the rhythm method (safe period) may be advised. The method is based on the fact that ovulation occurs from 12 to 16 days before the onset of menstruation (see fig. 10.4). The days on which conception is likely to occur are calculated as follows:

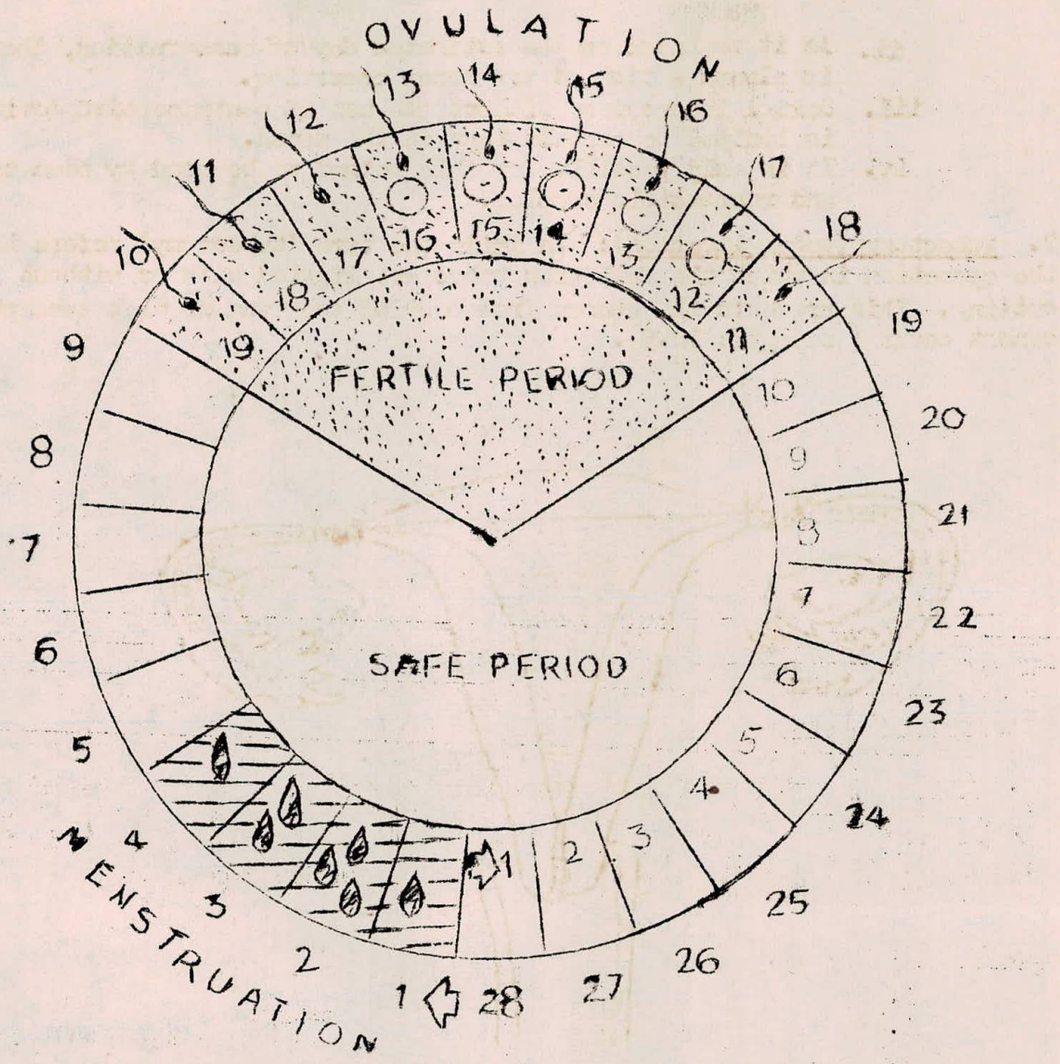

Fig. 10.4 Safe period in a 28-day cycle

The shortest cycle minus 18 days gives the first day of the fertile period. The longest cycle minus 10 days gives the last day of the fertile period. For example, if a woman's menstrual cycle varies from 26 to 31 days, the fertile period during which she should not have intercourse would be from the 8th day to the 21st day of the menstrual cycle, counting day one as the first day of the menstrual period.

Fig. 10.4 indicates the fertile period and the safe period in a 28-day cycle.

NOTE: For more exact calculation the temperature method is used, i.e. the rise in temperature is taken as the time of ovulation. However, this requires careful daily observation of temperature and is of little practical use among illiterate groups.

Advantages:

i. No prior medical examination is necessary.
ii. No devices are required to be used.

Limitations:

. It cannot be used in those woman who have irregular cycles.

ii. As it is based on the estimated day of menstruation, there is always a risk of pregnancy occurring.
iii. Sexual intercourse without the use of contraceptive devices is limited to certain days in the month.
iv. It is only possible for this method to be used by educated and responsible couples.

7. Tubectomy (tubal ligation): In India the term 'tubectomy' refers to the operation in which the fallopian tubes are ligated with or without cutting. This prevents the sperms from meeting the ovum so that conception cannot occur (see gif: 10.5).

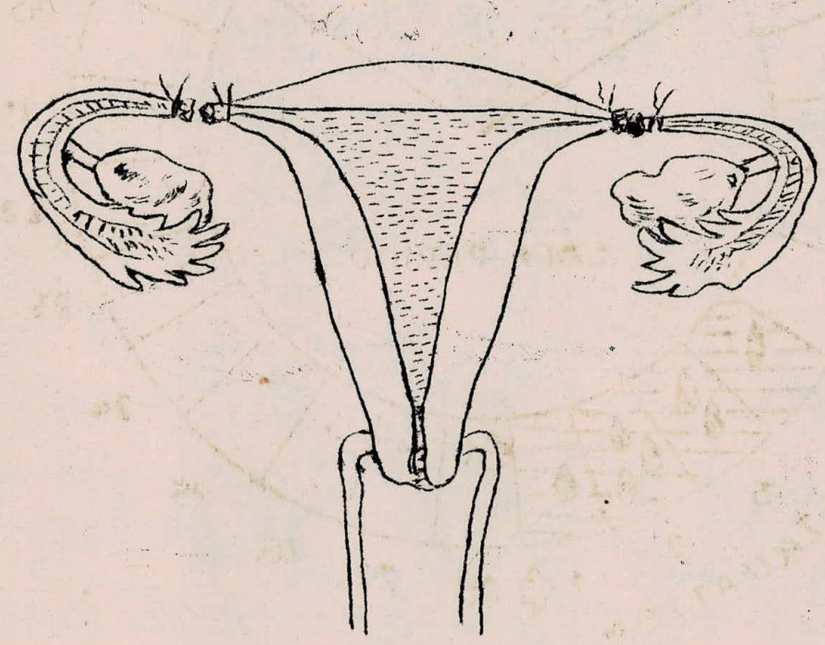

Fig: 10.5: Tubectomy (tubal ligation)

Advantages:

i. After the operation has been performed, no further action is necessary by either the man or the woman for preventing conception.
ii. The operation can be done immediately after delivery in a hospital or it can be carried out at the time of some other lower abdominal or vaginal operation, or at any other time convenient for the woman.
iii. The operation is done free of charge in a government hospital or Primary Health Centre.

Limitations:

i. The women has to stay in hospital for about a week.
ii. The results of the operation can be reversed by recanalization, but this is not always successful.

If this method is preferred by the couple, refer them to the Primary Health Centre and inform the Health Worker (Female).

10.7.3 CONTRACEPTIVE METHODS FOR MEN

1. Condom (Nirodh): This is a think rubber sheath which is used to cover the penis just before intercourse so that spermatozoa are prevented from entering the vagina (see gif.10.6).

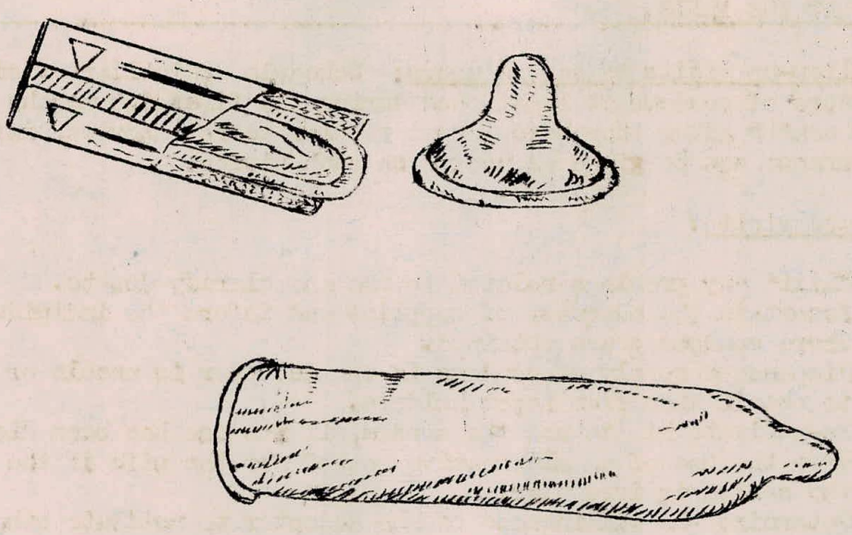

Fig: 10.6: Condom (Nirodh) - rolled and unrolled

Advantages:

i. It is available free at the subcentre or from the male or female health workers, or at little cost from local depot holders (3 pieces for 5 paise).

ii. No examination by a doctor is required before using the condom.

iii. It is relatively simple to use.

iv. It is a reliable method of contraception.

v. There are usually no complications after use.

vi. It protects against the spread of sexually transmitted dieases.

Limitations:

i. It may tear or slip off if not used properly.

ii. Without self-discipline, it may not be used every time.

iii. The supply may be inadequate or irregular.

iv. It may interrupt intercourse because it has to be put on after erection.

v. Occasionally a man or a woman may be allergic to the dusting powder used for packing condoms.

Instructions for the user:

i. It must be fitted on the erect penis before intercourse.

ii. The condom must be held carefully as the penis is taken out of the vagina in order to avoid spilling seminal fluid into the vagina.

after intercourse.

iii. A new condom should be used for each sex act.

iv. The used condom should not be thrown about indiscriminately but it should be wrapped in paper and thrown in the dustbin.

DEMONSTRATE THE APPLICATION OF THE CONDOM BY USING A CHART OR A MODEL OF THE MALE GENITAL ORGANS RATHER THAN USING THE FINGER OR SOME OTHER OBJECT TO REPRESENT THE PENIS.

Making follow-up visits to condon users: Schedule domiciliary visits to new acceptors of condoms at least once during the first two months and every six months after they have become regular users. Advice, information and reassurance can be given as needed on such visits.

During these visits:

i. Elicit any problems related to use and clarify doubts.

ii. Ascertain the adequacy of supplies and inform the individual where condoms can be obtained.

iii. Dispense a supply of condoms if the acceptor is unable or unwilling to obtain them from depot holders.

iv. Re-motivate him to use the condom, if its use has been dicontinued.

v. Urge the use of an alternative method for the wife if the use of the condom is irregular.

vi. Determine the willingness of the acceptor to motivate other or to be a depot holder.

2. Withdrawl (Coitus interruptus): In this method the penis is withdrawn from the vagina just before ejaculation.

Advantages:

i. No devices are necessary.

ii. No cost is involved.

iii. No prior medical examination is required.

Limitations:

i. It is unreliable as a contraceptive method.

ii. It can cause psychological disturbances in either the man or the woman.

iii. The sexual act is interrupted.

3. Vasectomy: This is an operation done on men and consists in cutting and tying the two tubes (vas deferens) that carry spermatozoa from the testes. When the operation has been done, fertilization of the woman's ova is no longer possible since no spermatozoa can reach the vagina (see fig.10.7a & b).

Advantages:

i. It does not require hospitalization.

ii. It does not in any way interfere with sexual desire or intercourse.

iii. It does not reduce the capacity for physical or mental work.

iv. After the initial three months following the operation, no further action is needed to prevent conception.

Limitations:

i. The results of the operation can usually be reversed by recanalization, but this is not always successful. Hence, careful selection of men for this operation is necessary.

ii. Condons will have to be used during the first three months after [illegible] until the laboratory test confirms that [illegible]

VASECTOMY IS A SIMPLE, SAFE AND PERMANENT METHOD OF FAMILY PLANNING FOR THE MAN.

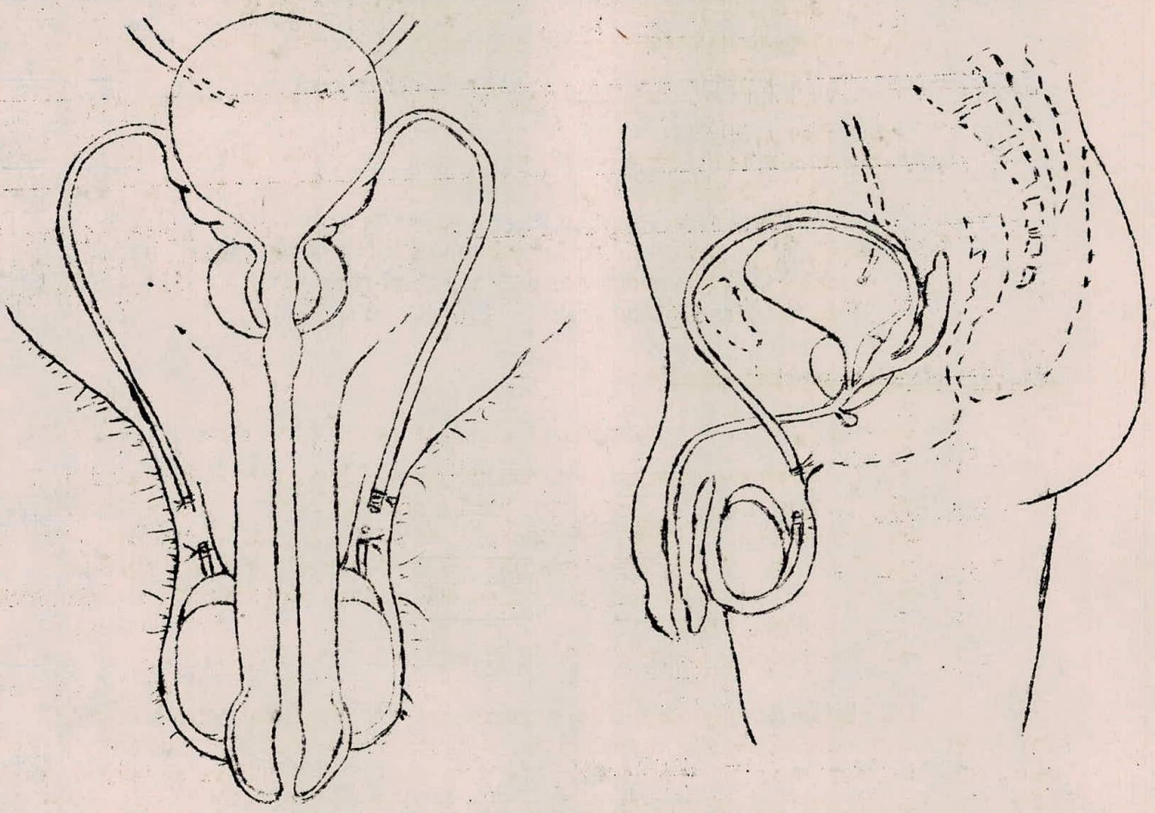

Fig. 10.7a:Vasectomy (front view) Fig.7b: Vasectomy (Side view)

Common fears and doubts about vasectomy: Although vasectomy has been proven to be a safe and simple procedure, many men have certain fears and doubts about the operation. Their main fears are usually related to the following:

i. The harmful effects that they think it will have on their sexual function.
ii. The pain and discomfort connected with the procedure.
iii. The effect it will have on their ability to work.
iv. The physical risk of the operation.

Your major task is to reduce such fears and doubts by using every available occasion and creating opportunities to encourage men in the villages to discuss what they have heard about vasectomy and to ask questions.

Points for emphasis regarding vasectomy:

i. It is a simple procedure that can be done by the doctor in 10 to 15 minutes. The man can go home within a short while after the operation.
ii. The procedure consists in cutting and tying the tubes that carry the spermatozoa to the penis so that the sperms cannot be released during intercourse.
3. Vasectomy is not the same as castration which is done to animals The testes are not touched or removed so that a man who has had a vasectomy done will not become obese, and will not have any change in his sexual desire or in his ability to carry out sexual intercourse.

4. It is the method of choice for men who do not want any more children since it is a permanent method of contraception.
5. It is always done free of charge by specially trained doctors at the Primary Health Centre or in a central place or camp which is temprorarily set up for this purpose.
6. Follow-up services are provided for acceptors. You will visit the man in his home after vasectomy and medical care from the doctor at the Primary Health Centre will be available if needed.
7. Incentrives for acceptors as well as for motivators are available. These incentives vary from State to State. Find out what incentives and compensation payments are available in your State for persons undergoing vasectomy and what incentives are available for motivators, so that you can give the community this information.

Selecting men for vasectomy:

The criteria for selecting men for vasectomy are as follows:

1. The couple should have two or more living children.
2. The age of the youngest child should be two years or more.
3. The couple should preferably have at least one son.
4. The age of the wife should be between 20 and 45 years.
5. The man should not be below 25 years, nor should be be over 50 years old.
6. The couple should not want any more children.

In order to prevent the occurrence of serious psychological problems that occasionally develop in some men who undergo vasectomy, you will need to use care in selecting the men to be motivated to adopt vasectomy. If a man is found not to be suitable for vasectomy, his wife may have to be approached by the Health Worker (Female) to undergo ster-ilization.

In any of the following conditions exact, the men should not be motivated for vasectomy because they are the ones who are most likely to develop psychological problems related to the operation.

1. If the marriage is an unstable one and is in the process of breaking up.
2. If theman has doubts about this masculinity or he has borderline impotence.
3. If he is unduly concerned with his health and fears that he may have a serious disease.
4. If his wife is forcing him to undergo the operation.
5. If the couple has the mistaken belief that sterilization is a temporary measure and that it can easily be reversed.

If you have any douts as to the suitability of the man for undergoing vasectomy, you can discuss the problems with your supervisor. The doctors at the Primary Health Centre or those who conduct camps are also expected to do the final screening of men who will undergo vasectomy.

Information to be given to acceptors of vasectomy:

1. Inform the man of the place and time of the operation and plan where and when he will meet you so that you can accompany him to the place where the operation will be carried out.
2. Ask him to bring his wife along, if possible.
3. Explain what he should expect, i.e. that the site will be cleaned with antiseptic, that a local injection will be given to deaden pain, that the operation will be done on both sides,

and that he will be completely conscious during the operation.

4. Tell him to shave the part, bathe, and wear clean clothes before coming for the operation.

Instructions for men who have undergone vasectomy:

In order to ensure a minimum of discomfort and to ensure normal healing of the operation site, you will have to make certain that men who have had a vasectomy follow these instructions:

1. Avoid taking a bath for at least 24 hours after the operation.
2. Keep the dressing in place, keep the site clean, and wear a T-bandage or scrotal support (langot) for 3 to 4 weeks.
3. Avoid heavy physical work and cycling for a week.
4. Return to the Primary Health Centre or subcentre to have the stitches removed on the 5th day after the operation.
5. Intercourse can be resumed after 7 days but condoms (Nirodh) must be used for at least 3 months after the operation, because some spermatozoa are present in the part of the vas beyond the operation site and are passed during that time.
6. Return to the Primary Health Centre after 6 weeks and after 3 months to have the semen examined, and deepending on the result, the use of condoms can then be stopped.

Follow-up Activities: Visits should be made to the man's home to make sure that he is making normal progress, to treat minor problems and refer serious ones to the doctor at the Primary Health Centre.

You will have to plan your work so that you can schedule time to do regular follow-up of the cases from your area who have undergone vasectomy.

All vasectomy cases should be visited according to the following schedule:

1. Twice during the first week in order to:

   i. identify any side-effects;
   ii. give the necessary reassurance;
   iii. treat minor symptoms;
   iv. refer those cases with complications to the PHC;
   v. remind them about having the stitches removed on the 5th day;
   vi. supply condoms and instruct about their use for three months.

It is important to find out how the man is feeling and whether he has fever, pain, or other discomfort.

DO NOT ASSUME THAT EVERYTHING IS PROGRESSING NORMALLY BECAUSE THE MAN TELLS YOU SO. EXAMINE THE OPERATION SITE TO MAKE SURE THAT HEALING IS PROGRESSING AS EXPECTED.

REMEMBER, FREQUENT VISITS AND PROMPT REFERRAL ARE NECESSARY FOR ANY MAN WHO HAS COMPLICATIONS.

2. Once in the next month in order to:

   i. ascertain the condition of the wound;
   ii. give the necessary reassurance;
   iii. distribute condoms and reinforce the need to continue their use;
   iv. refer the man to the Primary Health Centre for semen examination at six weeks.

IMPRESS ON THE MAN THAT THE USE OF CONDOMS FOLLOWING VASECTOMY IS ESSENTIAL UNTIL THE SEME IS FREE FROM SPERMATOZOA.

3. Once after three months in order to:
   i. ascertain that he has had a semen examination before discontinuing the use of condoms;
   ii. encourage him to motivate his friends for vasectomy.

Refer to chart on pages 104-105.

10.8 APPROACHES FOR ASSISTING ELIGIBLE COUPLES TO CONTROL THEIR FERTILITY

You will need tact and understanding in order to motivate people to accept family planning methods.

During your home visits, proceeds as follows:

1. Enquire about the health of the members of the household. Handling their health priorities is important for developing rapport.
2. Identify health problems and give the necessary treatment or assistance in order to establish your credibility as a health worker.
3. Find out if any family planning method is being used.
4. Find out what they already know so that new, additional, or correct information can be supplied.
5. Emphasize the health benefits of family planning to gain the confidence of eligible couples, especially the men.
6. Keep explanations as simple as possible. Use words and examples that are familiar in the local area.
7. Supplement verbal explanations with pictures, diagrams or the actural devices, e.g., Nirodh or IUD.
8. Be tactful when attempting to correct misinformation or rumours. Strong condemnation may lead to negative results.
9. Avoid exaggerating the effectiveness of any contraceptive method. Inaccurate information may lead to disappointment and create resentment.
10. Listen sympathetically to what people have to say about family planning. Discuss with them and try to remove any antagonism towards the programme.
11. Respect people's religious beliefs when giving advice about family planning.
12. Several visits may be necessary before a family planning method is accepted.
13. Persistent rejection of family planning by an eligible couple may be handled in the following ways:
    i. Ask a satisfied acceptor or respected elder to speak to the husband.
    ii. Request the Health Worker (Female) to contact the wife.
    iii. Discuss the problem with the Health Assistant (Male).

KEEP THE HEALTH ASSISTANT (MALE) AND MEDICAL OFFICER OF THE PRIMARY HEALTH CENTRE INFORMED OF ANY ADVERSE COMMENT OR RUMOURS IN THE COMMUNITY WHICH MAY AFFECT THE SMOOTH RUNNING OF THE FAMILY PLANNING PROGRAMME.

10.9 SELECTION, RECRUITMENT AND SUPERVISION OF DEPOT HOLDERS:

A depot holder is a man or woman who agrees to store and dispense condoms (Nirodh) regularly to anyone requesting a supply, keeps records of supplies held, and influences couples to become users.

You are responsible for the selection, recruitment and supervision of community members to serve as depot holders so that any couple who wants to use.

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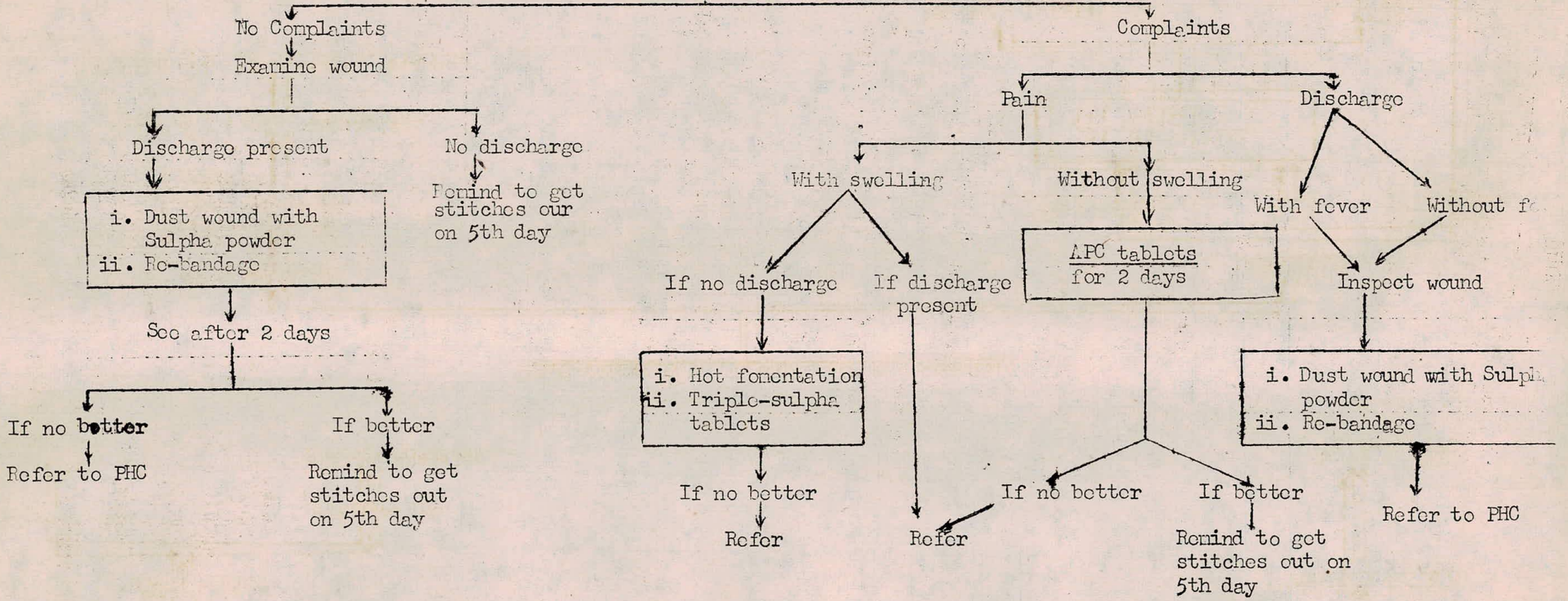
FOLLOW-UP OF MEN WHO HAVE UNDERGONE VASECTOMY

First visit (3rd day after operation)



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Second visit (7th day after operation)

- Wound healed
  - Stitches cut → Advise use of condom for 3 months
  - Stitches in → Remove stitches
- Wound not healed → Refer to PHC

Third visit (6 to 10 weeks after operation)

- No complaints → Continue use of condom for up to 3 months → Refer for semen examination → Encourage him to motivate friends
- Complaints
  - Scar tenderness / pain → i. APC tablets ii. Reassure
    - Symptons persist → Refer
    - No symptons → Cured
  - Impotence → Refer

YOU CAN PROMOTE FAMILY PLANNING IN THE COMMUNITY BY ENLISTING THE ASSISTANCE OF MEN WHO ARE SATISFIED VASECTOMY ACCEPTORS.

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condons can procure the supplies within the village from individuals who are known to them without having to go to a distant place or centre for supplies.

Depot holders should preferably be selected from among community members who:

i. practise family planning and have a small family;
ii. are at least 30 years old;
iii. are able to teach individuals about the proper use of condons, explain about other methods, and answer questions pertaining to contraception;
iv. are active in community affairs;
v. have sufficient time to carry out the necessary activities;
vi. can carry out this work without objections from their spouses;
vii. are willing to assist in family planning educational activities in the local area;
viii. can maintain simple records and reports.

Orientation of depot holders should consist of the following:

1. An explanation of how family planning can contribute to improving the welfare of families.
2. The various tasks to be carried out by a depot holder, namely:
   i. obtaining supplies and storing condons;
   ii. dispensing condons to anyone requesting a supply;
   iii. explaining how condons are used;
   iv. encouraging acceptors to be regular users;
   v. maintaining simple records and submitting reports regularly;
   vi. referring cases to the Primary Health Centre for sterilization and IUD, and for problems following surgical procedures;
   vii. reporting problems related to condon distribution, acceptance, and use, to the male or female health worker for necessary action.
3. The procurement and use of visual aids to supplement verbal explanations.
4. An explanation of the value of distributing condons to the users and to the depot holders in their respective villages.

Supervision (support and guidance0 of depot holders should include the following:

i. Regular, planned contacts with depot holders to acknowledge the work being done by them and to maintain their interest.
ii. Discussion and assistance in problems faced by the depot holders with regard to family planning activities.
iii. Giving information about the achievements of the family planning programmes in the area.
iv. Scheduling monthly delivery of supplies to depot holders slightly in excess of needs.
v. Assisting depot holders, especially those who may be illiterate, in making entries and preparing reports.
vi. Informing neighbourhood groups about the existence of local depot holders and their activities.
vii. Contacting on a sample basis those men who have been motivated by depot holders to become users, in order to ascertain whether they are using the condons properly and are satisfied with the method.
viii. Arranging for official recognition of the depot holder's work from the Medical Officer at the Primary Health Centre and from others.

REGULAR CONTACTS, BOTH FORMAL AND INFORMAL, BETWEEN THE HEALTH WORKERS, VILLAGE LEADERS AND DEPOT HOLDERS ARE NECESSARY FOR KEEPING INTEREST AT A HIGH LEVEL AND PROMOTING THE ACCEPTANCE OF FAMILY PLANNING.

10.10 RECORDS AND REPORTS

Generally, there will be several kinds of information relating to family planning that you and the Health Worker (Female) will be responsible for tabulating, maintaining and using at the subcentre. These include the following:

1. Registers
2. Health cards
3. Programme promotion activities
4. Reports.

1. Registers: These are usually of two types, one for eligible couples and the other which shows how various supplies have been dispensed, e.g., pills or condoms.

2. Health Cards: Services delivered to individuals who become family planning acceptors are recorded in their respective health cards including:

i. regularity of use;
ii. reasons for discontinuing a method;
iii. side-effects or complications;
iv. treatment for problems related to various methods.

3. Programme promotion activities: Records are kept showing the kind, number and frequency of activities for promoting the programme with various groups in the villages, e.g., depot holders, teachers, and community leaders.

4. Reports: A tabulated report of various activities is usually required to be sumitted monthly, quarterly or annually to the Primary Health Centre (see Chapter 4, 'Record Keeping', for details).

10.11 MEDICAL TERMINATION OF PREGNANCY (MTP Or Abortion)

Many women living in rural ar as still die needlessly from the results of illegal abortions performed on them by untrained persons and often under insanitary conditions. This method of getting rid of an unwanted pregnancy is no longer necessary because in India the Medical Termination of Pregnancy Act (1971) has made abortions done by doctors, under certain conditions, legal. Information pertaining to this Act needs to be widely disseminated in the villages so that women need no longer resort to unsafe, illegal means in order to terminate an unwanted pregnancy.

10.11.1 THE MEDICAL TERMINATION OF PREGNANCY ACT (1971)

Before the law was passed, several million women, the majority of them married, had induced abortions done and most of them had to go to local quacks in desperation. Because such women were desperate, they usually paim exorbitant fees, which they could ill afford, to unscrupulous quacks. The unskilled efforts of these quacks and diity equipment used have been the cause of a high rate of serious complications and even death among women undergoing illegal abortions. The Medical Termination of Pregnancy Act is expected to create conditions that would make it difficult for quacks to victimize pregnant women and ruin their health.

10.11.2 THE CONDITIONS UNDER WHICH A PREGNANCY CAN BE TERMINATED UNDER THE MTP ACT

There are five conditions that have been identified in the Act:

1. Medical: Where the continuance of the pregnancy might endanger the mother's life or cause grave injury to her physical or mental health.
2. Eugenic: Where there is substantial risk of the child being born with serious handicaps due to physical or mental abnormalities.
3. Humanitarian: Where pregnancy is the result of rape.
4. Socio-economic: Where actual or reasonably foreseeable environments (whether soical or econmic) could lead to risk of injury to the health of the mother.
5. Failure of contraceptive devices: The anguish caused by an unwanted pregnancy resulting from a failure of any contraceptive device or method can be presumed to constitute a grave mental injury to the health of the mother.

10.11.3 OTHER PROVISIONS OF THE ACT

Where abortions can be done: They can be done at all hospitals owned or maintained by government and at such other places (not being government institutions) which have the necessary equipment and facilities for termination under safe and hygienic conditions and which have been appro approved for the purpose by the government.

Who can perform the abortions: Not all doctors are authorised to perform the operation. Those who can do so are doctors who have necessary qualifications or experience provided under the Rules. Under the Act, others are not allowed to perform abortions.

10.11.4 RESPONSIBILITIES OF HEALTH WORKER (MALE) RELATED TO MEDICAL TERMINATION OF PREGNANCY

1. Informing men and women about the provisions of the MTP Act.
2. Early identification of pregnant women who want abortions.
3. Referring women who have an unwanted pregnancy for MTP to an institution or person approved for carrying out termination.
4. Informing the Health Worker (Female) of the names of MTP acceptors so that she can follow up these cases.
5. Maintaining the records in a confidential manner and submitting the necessary reports.

10.11.5 WHAT YOU SHOULD KNOW ABOUT MEDICAL TERMINATION OF PREGNANCY

1. Medical termination of pregnancy or abortion refers to the various medical procedures that can be done to empty the pregnant uterus of the products of conception.
2. The operation for terminating a pregnancy is simple and without much risk if it is done within the first 12 weeks of pregnancy.
3. Hospitalization is not always necessary and the women can usually go home after the procedure when it is performed within the first 12 weeks of pregnancy.
4. Serious complications from the operation are rare, but sometimes there may be bleeding, pain, fever or menstrual irregularity. Such problems can easily be treated by the doctor at the PHC.

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5. Women who want a pregnancy terminated after the 12th week may need an abdominal operation which will require hospitalization.
6. A woman desiring MTP and whose pregnancy is beyond 12 weeks but not beyond 20 weeks will have to be examined and the operation approved by two qualified doctors.

REMEMBER, THE EARLIER THE ABORTION IS DONE, THE SIMPLER IT IS AND THE LESS THE RISKS FOR THE WOMAN.

7. To avoid the need for repeated MTP, it is essential that in each case undergoing MTP the woman or her husband should be encouraged to use any one of the contraceptive methods or undergo sterilization if eligible.

10.11.6 INFORMING MEN AND WOMEN ABOUT MTP

Although you will ordinarily have rather limited opportunities for directly informing women about the availability of services for the medical termination of pregnancy, you are expected to use your usual contacts with the men in the community for this purpose so that they can inform their wives, female relatives, and other men who could benefit from such information.

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EVERY EFFORT SHOULD BE MADE BY YOU TO INFORM MEN AND WOMEN ABOUT THE SERVICES AVAILABLE FOR MTP SO THAT NEEDLESS DEATHS OR DISABILITY FROM ILLEGAL ABORTIONS CAN BE REDUCED.

You can carry out this task while you are:

i. orienting or training family planning depot holders or village leaders;
ii. meeting with individuals and groups of men;
iii. talking to parents accompanying children for health care.

You may also have opportunities to reach women and older children with the information when you encounter them while:

i. administering various immunizations in house-to-house visits in both the intensive and twilight areas;
ii. systematically looking for malnourished pre-school children in homes with four or more children.
iii. administering immunizations to children in the upper grades in schools.

Other activities would include the following:

i. Developing simple posters and displaying them in public places.
ii. Distributing literature on MTP in the villages to those who can read.

In order to reach women with information on MTP you can seek the assistance and guidance of other members of the health team such as the Health Worker (Female), Health Assistant (Male), Health Assistant (Female) and Block Health Assistant. Indigenous health practitioners, dais, as well as other village level workers and their supervisors can also assist you in disseminating information about MTP.

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10.11.7 HEALTH EDUCATION

Topics that you should talk about include the following:

1. Any woman with an unwanted pregnancy can have MTP on request on medical, eugenic, humanitarian, or socio-economic grounds or because of failure of family planning methods.
2. There is no charge for having an MTP performed in the general ward of a government hospital.
3. MTP is a simple, safe procedure when it is done by qualified doctors in government-approved health institutions.
4. Women need to inform each other about MTP so that they can refer themselves for the procedures as early as possible, e.g., during the first 12 weeks of pregnancy.
5. The earlier the stage of pregnancy in which the MTP is done, the lower the risk.
6. There are provisions for prompt care and treatment if any complications should arise following MTP.
7. Preferably insertion of an IUD or sterilization should be done at the time of the MTP.

10.11.8 EARLY IDENTIFICATION OF PREGNANT WOMEN WHO WANT MTP

The earlier any woman with an unwanted pregnancy is referred for MTP, the fewer are the medical risks for her, In order for you to be able to do this, you will have to be familiar with the early signs and symptoms of pregnancy.

EARLY SIGNS AND SYMPTOMS OF PREGNANCY ARE:

i. A MISSED MENSTRUAL PERIOD
II. TINGLING AND ENLARGEMENT OF THE BREATS
iii. VOMITING IN THE MORNING
iv. FREQUENT URINATION WITHOUT PAIN OR BURNING.

The above symptoms occur separately, but when they occur together it usually means that the woman is pregnant. If she is concerned about this, refer her to the Primary Health Centre for confirmation of the pregnancy and medical termination.

In your house-to-house visits to deliver health care, you should encourage early self-referral by women desiring MTP.

REMEMBER, WOMEN MUST KNOW THE FACTS BEFORE THEY CAN BENEFIT FROM GOVERNMENT-APPROVED SERVICES FOR MTP

You should be familiar with the usual kinds of family circumstances that influence the desire for MTP by pregnant women. Such knowledge will alert you to the households where information about MTP would be welcomed and used by the women.

A woman is more likely to seek abortion when

1. her last child is less than 12 months old;
2. she has four or more living children;
3. she is unmarried or has been deserted by her husband;
4. her husband is unemployed or drinks heavily;
5. she has been raped;
6. the family planning method used has failed to prevent conception;
7. there has been a natural disaster, e.g., drought or floods.

10.11.9 REFERRING WOMEN FOR MTP

Since this is a relatively new programme, there is considerable variation in the pattern of locally available MTP services. In addition, various strategies are being developed in the districts to make such services more easily available and acces sible. Therefore, you will have to keep yourself well-informed of the developments in your block through your supervisor so that you can make prompt effective referrals that are not hampered by needless delays due to misinformation.

IN ORDER TO MAKE EFFECTIVE MTP REFERRALS AND AVOID UNNECESSARY DELAYS, YOU MUST KEEP YOURSELF CONSTANTLY INFORMED ABOUT THE LOCATION AND HOURS OF OPERATION OF SUCH FACILITIES.

For each MTP referral, you should make sure that the woman:

1. knows where to go and how to get there;
2. knows when to go, e.g., the specific hours and days of the week when the MTP centre is functioning;
3. knows how long she will have to stay at the MTP centre;
4. has a referral chit which lists her name, age, address, estimated duration of pregnancy, date of referral, your name and designation, and name of subcentre.

In the intensive area, you will assist the Health Worker (Female) in the identification and referral of women for MTP. However, since she will not normally be given prenatal care in the twilight area, you will be responsible for referral of women for MTP in this area. Since village women may often be reluctant to discuss their desire for MTP with a male worker, you will need to seek the assistance of the local dais, the members of the mahila mandale, women leaders, and elderly women in the community.

10.11.10 FOLLOW-UP ACTIVITIES

Because there is a kind of social stigma attached to abortions, women usually shun or reject any official follow-up after MTP for fear that their mothers-in-law or other relatives will come to know about it and criticize them. Therefore, it is necessary for you to be very discreet i in making such contacts. These visits should, preferably, be made by the Health Worker (Female) or the dai as part of her MCH services.

During your regular house-to-house visits, you can:

i. reinforce the need for prompt self-referral for any symptoms, such as fever, chills, pain or excessive bleeding;
ii. inform women where they should go for relief of symptons.

REMEMBER, IF THE WOMEN FEEL THAT THE FACT OF THEIR UNDERGOING MTP IS NOT KEPT CONFIDENTIAL THEY WILL RESORT TO OTHER MEANS TO GET RID OF AN UNWANTED PREGNANCY.

10.11.11 RECORDS AND REPORTS

In the family folder, information related to MTP should be recorded in:

1. Prenatal record: Date of referral, institution or person to person to whom referred, estimated lenght of pregnancy, and problems following the procedure should be noted.
2. Family planning record: Information related to contraceptive method accepted or sterilization in conjunction with MTP should

Each State will develop its own MTP registers and monthly reporting forms which you will be expected to keep and submit as required.

10.12 INFERTILITY

An infertile couple is one where the woman has not been able to become pregnant despite intercourse without any contraceptive methods for at least two years.

Although the bulk of family planning efforts and activities are aimed at reducing unplanned population growth by regulating fertility, your tasks also include assisting those couples who are infertile so that they are able to produce a wanted child. Childlessness can be the cause of social ridicule and much distress to a couple who desire children. In India, it is considered a very serious problem since such couples will not have anyone to care for them when they are old or no longer able to work.

Your tasks related to infertility are as follows:

1. Identifying childless couples who desire children.
2. Informing them about what can be done and where services can be sought.
3. Referring them for services.
4. Making follow-up visits.
5. Maintaining records.

10.12.1 CAUSES OF INFERTILITY

Infertility can be either a temporary or permanent condition affecting either the man or the woman. The most common causes of infertility are as follows:

1. The semen may contain no spermatozoa or insufficient numbers of spermatozoa.
2. The woman may have a chronic disease affecting her sex organs.
3. The technique of intercourse may be incorrect.
4. Intercourse may not be carried out during the part of the month when the woman is most fertile.

IT IS IMPORTANT TO REMEMBER THAT EITHER THE MAN OR THE WOMAN MAY BE RESPONSIBLE FOR INFERTILITY.

10.12.2 IDENTIFICATION OF INFERTILE COUPLES

If you keep yourself alert to the existence of this condition, you may be able to detect infertile couples in the course of your regular ho se-to-house visits in the villages. You may also find others when you discuss the problem with local leaders since they are often consulted by childless couples who desire children.

Those who have had positive past experiences with your health activities may approach you directly to report infertility as a personal problem or as a problem of a relative or a close friend who is reluctant to discuss it with someone outside the family.

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