THE ECUMENICAL CHRISTIAN CENTRE, WHITEFIELD, B'LORE-16

Seminar on Community Health - 29 January - 1 Feb 1981

REPORT AND RECOMMENDATIONS

The seminar on Community Health, sponsored by the Ecumenical Christian Centre in January - February was attended by 40 men and women -- doctors, nurses, para-medical workers, representatives from medical colleges, hospitals and community health workers involved in tribal, slum and rural areas from all over India. The seminar affirmed that community health work should be 'self destructive' and that it should not be institutionalised. The community health workers should be prepared to move to fresh areas at a stage when their services are not required for the people.

PERSPECTIVES:

The ultimate aim of the community health work should be structural changes where in each person's dignity is honoured and his/her physical, mental, social and spiritual well being is taken care of. It should function as a catalyst creating awareness for structural change at the grass root level as well as conscientising or even pressurising the power structures. The poor people should be made aware of the extent of the exploitation and oppression and should be motivated to fight for their rights.

APPROACH:

Health work should not be done in isolation from other development activities. Otherwise it will turn out to be a hap hazard patch work which postpones the radical change required. Genuine participation of the people in the health programmes should ensure decision making by the people at all levels, in planning and implementation. Community health programme should be preventive rather than curative. Periodical evaluation of the work will ensufe effectiveness.

COST:

It is high time that community health workers should resort to cheaper medicines which the community can afford. Indegenous medicines should be encouraged as far as possible. Awareness should be created among the medical personnel not to be biased by the propoganda of pharmaceutical companies. Young doctors should be more cost benefit oriented in their therapy. Raising resistance by correcting the nutritional deficiency by making use of the locally available food stuffs will go a long way in preventing disease. Foreign tree drugs should be discouraged.

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PERSONNEL AND TRAINING ,

The content of the training of the community health worker should be the simple medical knowledge. Apart from the medical education they should be trained how to educate the community about their rights and about the exploitative nature of the society at the micro level. The trainee should be a person who accept the basic perspectives of the programmes. He/she should have leadership qualities. The community health worker who undergoes training should be acceptable to the community. They should be paid a fair wage.

There is dire need to change the present system of education of the doctors and other medical personnel to make it relevant to the realities of the country.

GOVERNMENT AND OTHER AGENCIES:

The community health workers should help people to obtain the maximum benefit from the government. In the actual health services their work should complement rather than compete with the government or other agencies. It is highly essential that duplication should be avoided at all levels. Co-operation and common programmes should be encouraged with groups having the same perspectives.

RECOMMENDATIONS:

I) Bring down the cost of health care and drugs.

II) Indegenous medicine especially the use of herbal medicine shcuild be encouraged.

III) The Christian Medical Association, the Catholic Hospital Association and the Voluntary Hospital Association should work together in dealing with the problem of community health especially in--

1. manufacturing low cost medicines in bulk for the use of non-profit making service organisations.
2. Central purchasing and distribution of drugs.
3. Research and publications.

IV) A forum should be formed to educate people about the false propoganda, promotion and use of unnessary drugs and tonics.

First : Loss of Initiative : Although it is alleged the human donkey probably needs, in this state of modern barbarism, some sort of vegetable dangled in front of his nose, these need not be golden carrots; a posy of prestige will do as well.

Second: Bureaucracy : This can be checked by democratic control of organization from bottom to top.

Third : The Importance of the Patient's Own Selection of a Doctor:

This is a myth; its only proponents are the doctors themselves- not the patients. Give a limited choice-say two or three doctors, then if the patient is not satisfied, send him to a psychiatrist! Sauce for the goose is sauce for the gander - the doctor must also be given some measure of selection of patients! Ninety-nine percent of patients want results, realizing the inseparability of health from economic security.

Let us abandon our isolation and grasp the realities of the present economic crisis. The world is changing beneath our very eyes and already the barque of Aesculapius is beginning to feel beneath its keel the great surge and movement of the rising world tide which is sweeping on, obliterating old landscapes and old scenes. We must go with the tide or be wrecked.

The people are ready for socialized medicine. The obstructionists to the people's health security lie within the profession itself as well as outside it. Recognize this fact. It is the all-important fact of the situation. These men with the mocking face of the reactionary or the listlessness of the futilitarian proclaim their principles under the guise of "maintenance of the sacred relationship between doctor and patient," "inefficiency of other non-profit nationalized enterprises," "the danger of socialism," "the freedom of individualism." These are the enemies of the people, and make no mistake - they are the enemies of medicine too.

The situation which is confronting medicine today is a contest of two forces in medicine itself. One holds that the important thing is the maintenance of our vested historical interest, our private property, our monopoly of health distribution. The other contends that the function of medicine is greater than the maintenance of the doctor's position, that the security of the peoples' health is our primary duty, that we are above professional privileges. So the old challenge of Shakespeare's character in Henry IV still rings out across the centuries: "Under which King , Bezonian, stand or die"

Duplicate

CASE OF THE PEOPLE VERSUS THE DOCTORS

BY

DR. NORMAN BETHUNE

"Tonight there has been brough before you the most interesting'case' ever presented to this Society. It is- the Case of the People versus the Doctors. In the problem now under discussion it is necessary to emphasize that medical men themselves are being weighed in the balance. Yet we are acting both as defendant and judge. That behooves us to apply our minds with the utmost objectivity to this question."

That makes it necessary to bring the problem back to its proper setting. For the health of the nation involves more than the personal fate of the private doctor. What we have here is an ethical and moral problem in the field of social and political economics, and not medical economics alone. Medicine must be seen as part of the social structure. It is the product of any given social environment. Every social structure has an economic base, and in Canada that economic base is called capitalism, avowedly founded on individualism, competition and private profit. But this system of capitalism is undergoing an economic crisis - a deadly disease requiring systemic treatment. And here a problem presents itself with special urgency. There are those who are trying to treat the systemic disease as if it is only a temporary illness. They are doomed to failure.

The palliative measures suggested by most of our political quacks are like aspirin tablets given for a syphilitic headache. They may relieve; they never will cure.

Medicine is a typical, loosely organized, basically individualistic industry in this "catch as catch can" capitalistic system operating as a monopoly on a private profit basis. Now, it is inevitable that medicine should undergo much the same crisis as the rest of the capitalistic world and should present much the same interesting and uncomfortable phenomena. This may be epitomized as "poverty of health in the midst of scientific abundance in a country of disease." Just as thousands of people are hungry in a country which produces more food than the people can consume (we even burn coffee, kill hogs and pay farmers not to plant wheat and cotton), just as thousands are wretchedly clothed though the manufacturers can make more clothing than they can sell, so millions are sick, hundreds of thousands suffer pain, and tens of thousands die prematurely through lack of adequate medical care, which is available but for which they cannot pay. Inability to purchase is combined with poor distribution. The pro[illegible]cal economics is a part of the problem of world economics [illegible]e and indivisible from it. Medicine, as we are practising it,

is a luxury trade. We are selling bread at the price of jewels. The poor, who comprise fifty per cent of our population, cannot pay, and starve; we, the doctors, cannot sell and suffer. The people have no health protection and we have no economic security. This brings us to the point of the two aspects of this problem.

There are in this country three great economic groups; first, the comfortable; second, the uncomfortable; third, the miserable. In the upper bracket are those who are moderately uncomfortable and insecure; and in the lower, those vast masses, not in brackets but in chains, who are living on the edge of the subsistence level. These people in the in the lower income class are receiving only one-third of the home, office and clinic services from physicians that a fundamental standard of health requires.only fifty-five per cent of as many cases are being hospitalized as an adequate standard would prescribe, and only fifty-four per cent of as many days are being spent in hospitals as are desirable.

In short, one has to suffer a major surgical catastrophe to have even approximate adequate care. The report of the Committee on the Cost of Medical Care (American Medical Association) showed that 46.6% of people whose income is less than $1200 a year received no medical, dental or eye care whatsoever in a year. If this combined with those whose income is $10,000 or more (13.8% of such persons received no similar care) we are faced with the appalling fact that 38.2% of all people, irrespective of income, received no medical, dental or eye care whatsoever. What is the cause of this alarming state of affairs ? First, financial inability to pay is the major cause; second, ignorance; third, apathy; fourth, lack of medical service.

Enormous accumulation of scientific knowledge has made it practically impossible for any one man to have an entire grasp of even the facts- much less their application - of the sum total of medical knowledge. This has brought specilization in concentrated centers of population. The general practitioner, unsupported by specialists, knows that he cannot give the people their money's worth, yet the financial cost of specialization bars many from proceeding to such fields. The necessity to make money after a a difficult financial struggle to pay for medical education drives the young doctor too often into any form of remunerative work, however uncongenial it may be. There he is, caught up in the coils of economics, from which not one in a thousand can ever escape. The fee for service is very disturbint

morally to practitioners. The patient is frequently unable to appraise correctly the value of the doctors' service or disservice. Perrot and Collins in 1933, in an investigation of 9130 families in America, found the depression poor had a larger incidence of illness than any other group, Also that 61% of all physicians' calls to such a class were free, that 33% of calls to the moderately comfortable were free, and that 26% of calls to even those comfortably well off were not paid for.

Permit me a few categorical statements, for dogmatism has a certain role in the realm of vacillation :

The best form of providing health protection would be to change the eco -mic system which produces ill health, and to liquidate ignorance, poverty and unemployment. The practice of each individual purchasing his own medical care does not work. It is unjust, inefficient, wasteful and completely outmoded. Doctors, private charity and philanthropic institutions have kept it alive as long as possible. It should have died a natural death a hundred years ago, with the coming of the industrial revolution in the opening years of the 19th century. In our highly geared, modern industrial society there is no such thing as private health - all health is public. The illness and maladjustments of one unit of the mass effectsall other members. The protection of the people's health should be recognized by the Government as its primary obligation and duty to its citizens.

Socialized medicine and the abolition or restriction of private practice would appear to be the realistic solution of the problem. Let us take the profit, the private economic profit, ot of medicine, and purify our profession of rapacious individualism. Let us make it disgraceful to enrich ourselves at the expense of the miseries of our fellow men. Let us organize ourselves so that we can no longer be exploited as we are being exploited by our politicians.

Let us redefine medical ethics - not as a code of professional etiquette between doctors, but as a code of fundamental morality and justice between medicine and the people.

In our medical societies, let us discuss more often the great problems of our age and not merely interesting cases; the relationship of medicine to the State; the duties of the profession to the people; the matrix of economics and sociology in which we exist. Let us recognize that our most important contemporaneous problems are economic and social

and not merely technical and scientific in the narrow sense that we employ the words.

Medicine, like any other organization today, whether it be the Church or the Bar, is judging its leaders by their attitude to the fundamental social and economic issues of the day. We need fewer leading physicians and famous surgeons in modern medicine and more farsighted, socially-imaginative statesmen.

The medical profession must - as the traditional, historical and altruistic guardians of the people's health - present to the Government a complete, comprehensive program of planned medical service for all the people. Then, in whatever position the profession finds itself after such a plan has been evolved, that position it must accept. This apparent immolation as a burnt offering on the altar of ideal public health will result in the profession rising like a glorious Phoenix from the dead ashes of its former self.

Medicine must be entirely reorganized and unified, welded into a great army of doctors, dentists, nurses, technicians and social service workers, to make a collectivized attack on disease and utilizing all the present scientific knowledge of its members to that end. Let us say to the people - not "How much have you got?" - but, "How best can we serve you?" - not

Socialized medicine means:

First, that health protectionbecomes public property, like the post office, the army, the navy, the judiciary and the school.

Second, that it is supported by public funds.

Third, that service is available to all, not according to income but according to need. Charity must be abolished and justice substituted. Charity debases the donor and debauches the recipient.

Fourth, its workers are to be paid by the State, with assured salaries and pensions.

Fifth, there should be democratic self-government by the health workers themselves.

Twenty-five years ago it was though contemptible to be called a socialist. Today it is ridiculous not to be one.

Medical reforms, such as limited health insurance schemes, are not socialized medicine. They are bastard forms of socialism produced by belated humanitarianism out of necessity.

The three major objections which the opponents of socialized medicine emphasize are :

First : Loss of Initiative : Although it is alleged the human donkey probably needs, in this state of modern barbarism, some sort of vegetable dangled in front of his nose, these need not be golden carrots; a posy of prestige will do as well.

Second: Bureaucracy : This can be checked by democratic control of organization from bottom to top.

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Shelf I:

1. Ross Unit (SJMC) - link up (Background)
2. Ross Unit Archives - I (1974-83)
3. Ross Unit Archives - II (1974-83)
4. LLoyd Jones Report - 1947 (Plantation Health)
5. R.I. Bulletins - Rabies, Malaria (1940s) Sanitation
6. Ross Unit Reports - 1945-51
7. " 1956-60
8. " 1961-70
9. London School ~~IIM~~ Reports - 1966-71
10. " 1974-81
11. " UPASI ~~Reports~~ & ~~IIM~~ - Prospectus & Courses
12. TUC - OH Institute Reports
13. UPASI CLWS Reports 1971-74
14. UPASI CLWS (Munnar) Reports
15. Planters Chronicle - Health Issues
16. Ross Unit-SJMC Handouts
17. R-I - Hyderabad Archives
18. Plantation Medical Records
19. PMO Course Information Sheet
20. Comm Health Seminar (Nilgiris) 1974
21. PMO's Refresher Course (I) Handouts (1977)
22. " Management Workshop (1977)
23. " Pathology Handouts (1977)
24. " Management Seminar IIM (1977)
25. " Course Report 1977
26. Water Epidemiology Seminar (Munnar) 1977
27. PMO's Conference (1978) - Primary Health Care
28. PMO's Conference (1979) Child Care
29. PMOs Refresher Course III - 1979
PMOs Seminar on Health Management (1980)
30. /
31. OH + Mental Health in Industry Course (1977) - IIM
32. Water Seminar 1981 (Proceedings)
33. Water Seminar 1981 (Technical Notes)
34. Water Seminar 1981 (Technology Information)
35. Shuni Feeder (Chlorinators)
36. BEL Handouts/Reports
37. ITI Handouts/Reports
38. HMT Handouts/Reports
39. HAL Handouts/Reports
40. Internation Instruments "
41. Leslico Safety Equipment Diary
42. Hygiene Equipment Catalogues
43. Takas " Industrial Health Semi Report
44. /
45. Safety Equipment Catalogues
46. Indian Industry - Reports Review - 1978
47. - IIM Courses/Handouts

Shelf II

48. - Industrial House Journals/Handouts (Foreign)
49. " (Indian)
50. Agro Chemicals - Product information
51. - Agro Technology " (Tea Factory)
52. Rubber Cultivation Reports
53. Cardomom Cultivation Report
54. Tea Reports.
55. Plantation Labour (Note)
56. Link Worker Scheme - Handouts
57. UPASI Handouts for PMO's
58. Dr Mackays Papers.
59. UPASI Medical Advisers Papers.
60. UPASI-CLWS Handouts
61. OH Medical Records
62. OH Legislation (India)
63. OH Legislation (U.K)
64. Occup Lung Disease
65. Occupational Cancers
66. Occupational Dermatitis
67. Skin Protection - Product information
68. Occupational
69. Environmental Pollution
69. Monitoring Environment - ROHE Seminar, 1983
70. Noise Hazard

71 Lead Poisoning

72 Occup Lung Disease - Bibliography

73. OH. Health Education Materials

74 OH Teaching Aids/Books Catalogue

75 OH Rehabilitation/Trg - U.K.

76 Industrial Accidents ([illegible])

77 Road Safety Handouts/Studies

78 OH General Principles (RN Personal)

79 Toxicology & Hazards A-L (RN Personal)

80 Toxicology & Hazards M-Z (RN Personal)

81 Toxicology - Medical Data A-Z

82 Toxicology Hazard Data A-Z

83 Occupational Eye disease

84 OH Service in Hospitals

85 OH in Chemical Industries - Thesis

86 OH Training - Symposium 1970

87 Sickness Absenteeism

88 OH Practicals: Demonstration Materials.

89 IAOH Conference - 1976 / 1977.

90 KSCST Reports

91 KSCST Seminar & Project Guidelines

92 Bio-Medical Engineering - Reports

93 Royal Society of PH & H - Year Books

SHELF III

94. Central Labour Institute Reports

95 Central Mining Research Station Report

96 NIOH - Ahmedabad Reports

97 Work Physiology Studies

98 Pesticide Studies

99 Pneumoconiosis Studies

100 Trade Unions

101 Food hygiene course & papers

102 " " " - programmes

103 " " papers SJMC hostel (Dr Daraman.

104. Food Handlers project reports

Filing Index

DRHSTP (P Series) Shelf I

P1 What we Believe in

P2 CHW Information Sheet

3 CHW Brochures

4. List of Superiors / Bishops

5 SJMCH Brochure

6. College prospectus

7. – 24 CHW handouts

25 Biodata's

26 Mallu paper - gen M.

27. Chains – SEARCH game

28. SEARCH – Harijan story

29. " – Chikkanahalli exercises

30. " – Monsoon game, scenario, worksheet cards.

~~31 Health paper material~~

31 " – " scenario, worksheets

32 ROP material

33. Participation assessment forms

34 Communication exercise

35 - 47 ——— To

48 Search Quest

49

TEACHING FILES - T SERIES

T - 1	-	Teaching Programme Planning
T - 2	-	Teaching Programme Until 1976
T - 3	-	Teaching Programme since July 1978
T - 4	-	Internship Handouts
T - 5	-	Internship Programme
T - 6	-	Student Conferences/Seminars
T - 7	-	Field Visits
T - 8	-	Practicals/Records
T - 9	-	Examinations/Evaluations
T -10	-	Extension Programmes
T - 11	-	Health Centre Project Reports
T - 12	-	Overseas Student Programme
T - 13	-	Chains - Simulation Game
T - 14	-	Harijan Stories (SEARCH)
T - 15	-	Chikkanahalli - Simulation Game
T - 16	-	Monsoon Game (SEARCH)
T - 17	-	Occupational Health Survey Forms
T - 18	-	Research Protocols
T - 19	-	Karnataka State Council for Science & Technology Report
T - 20	-	Audio-visual aids - Catalogues
T - 21	-	Book catalogues
T - 22	-	Louis Baretto's Papers
T - 23	-	Bibliographies
T - 24	-	Bio-Datas
T - 25	-	Chikkanahalli Work Sheets (filled)
T - 26	-	R.O.P. Organisation
T - 27	-	R.O.P. Student Evaluations
T - 28	-	R.O.P. Projects 1980
T - 29	-	R.O.P. Projects 1981
T - 30	-	R.O.P. Projects 1981

....2.

T - 31	-	R.O.P. Notice Board
T - 32	-	Pallur Papers (Gen/SVR)
T - 33	-	Medical Education (RN)
T - 34	-	Papers by Dr.David Mackay
T - 35	-	Goa Workshop Papers (CHN)
T - 36	-	FICCI Workshop Papers (Rural Development)
T - 37	-	IIM Workshop Papers (Alternatives in Development)
T - 38	-	IAUH Conference Papers
T - 39	-	Student Vacation Projects
T - 40	-	Pathology Handouts
T - 40A	-	Brain Drain Papers
T - 41	-	Study Tour (Occupational Health)
T - 42	-	Miscellaneous Papers (Study Tour)
T - 43	-	Epilepsy Seminar Papers
T - 44	-	Conference (Economic Planning)
T - 45	-	DTPH Programme
T - 46	-	DIH Programme

ROSS INSTITUTE FILES - R SERIES

R - 1	-	Ross Institute Link up
R - 2	-	Ross Unit Handouts ~~Plantation Health (world)~~ + UPASI Papers
R - 3	-	Community Health on Plantation (UPASI)
R - 4	-	Community Health Seminar (Nilgiris)
R - 5	-	Plantation Medical Records
R - 6	-	Health Management Workshop
R - 7	-	Pesticide Toxicity Papers
R - 8	-	Epidemiology Seminar (Munnar)
R - 9	-	P.M.O. 1st Refresher Course Report
R - 10	-	Primary Health Care in Plantations (Conference 1978)
R - 11	-	Handouts of Medical Advisor
R - 12	-	Handouts of Medical Advisor
R - 13	-	Handouts of Medical Advisor
R - 14	-	Link Workers Scheme Handouts
R - 15	-	Medical Advisor (Papers)
R - 16	-	UPASI Programmes Evaluation
R - 17	-	Child Care in Plantations (Conference 1979)
R - 18	-	CLWS Reports
R - 19	-	P.M.O. Course Pathology Handouts
R - 20	-	Health Management Seminar 1980
R - 21	-	Occupational Health Institutions (INDIA) Reports
R - 22	-	Occupational Mental Health (IIM Seminar)
R - 23	-	Management Seminars (P.M.O. Course)
R - 24	-	Plantation Labour - Reports
R - 25	-	Plantation Health - District Reports
R - 26	-	Economics of Tea - Report
R - 27	-	UPASI Proformas
R - 28	-	Pesticides in Plantations
R - 29	-	P.M.O.'s Course - Information Sheet
R - 30	-	Ross Institute Handouts

.....2.

R - 31	-	Ross Institute Hyderabad (Archives)
R - 32	-	Neurological Emergencies (P.M.O. Course Papers)
R - 33	-	Shunt Feed Chlorinators
R - 34	-	Water Seminar Report
R - 35	-	Water Seminar Report
R - 36	-	Water Seminar Handouts
R - 37	-	Water Seminar Handouts
R - 38	-	Food Hygiene Course Programmes
R - 39	-	Food Hygiene Course Question Papers
R - 40	-	Plantation Chronicle Health Issues
R - 41	-	Plantation Labour Act
R - 42	-	Handouts on Bangalore Industries (Public Sector)
R - 43	-	Bibliography on Occupational Lung Disease.
R - 44	-	Interns T.A.T. Based on Hopkins Project
R - 45	-	Interns attitude Survey (Case studies)
R - 46	-	Conference on Social Aspects of Medical Education in India (Nov. 1977)

FILING INDEX

ROSS UNIT (R- Series)

(S. J. M. C.)

Shelf I

1. Rosse Unit - link up (Background)
2. Ross Unit Archives - I (1974-83)
3. Ross Unit Archives - II (1974-83)
4. LLoyd Jones Report - 194 (Plantation Health)
5. R.I. Bulletin - Rabies/Malaric (1940) Sanitation
6. Ross Unit Reports - 1948-54
7. Ross Unit Reports - 1955-60
8. Ross Unit Reports - 1961-70
9. London School Reports - 1966-71
10. London School Reports - 1974-81
11. London - Prospectus of Courses
12. TUC - Occupational Health Institute Reports
13. UPASI CLWS Reports 1971-74
14. UPASI CLWS (Munnar) Reports
15. Planters Chronical - Health Issues
16. Ross Unit - SJMC Handouts
17. R.I. Hyderabad Archives
18. Plantation Medical Records
19. PMO course Information sheet
20. Community Health Seminar (Nilgiris) 1974.
21. PMO's Refresher Course (I) Handouts (1977)
22. PMO's Management Workshop (1977)
23. PMO's Pathology Handouts (1977)
24. PMO's Management Seminar IIM (1977)
25. PMO's Course Report 1977
26. Water & Epidemiology Seminar (Munnar) 1977
27. PMO's Conference (1978) Primary Health Care
28. PMO's ~~Refresher~~ Conference (1979) Child Care
29. PMO's Refresher course II - 1979
30. PMO's Seminar on Health Management (1980)
31. Occupational Health and Mental Health in Industry Course (1977)- IIM
32. Water Seminar 1981 (Proceedings)
33. Water Seminar 1981 (Technical Notes)
34. Water Seminar 1981 (Technology Information)
35. Shunt Feed Chlorinators
36. B E L Handouts Reports
37. I T I Handouts / Reports
38. H.M.T Handouts / Reports
39. H A L Handouts / Reports
40. Internation Instrument Reports
41. Leslico Safety Equipment Diary
42. Hygine Equipment Catalogues
43. Hygine Equipment Catalogues
44. Tatas Industrial Health Service Report
45. Safety Equipment Catalogues
46. Indian Industry Review - 1978
47. I I M Courses / Handouts

.....2

SHELF II

48. Industrial House Journals / Handouts (Foreign)
49. Industrial House Journals / Handouts (Indian)
50. Agro chemicols - product information
51. Agro Technology - product information (Tea factory)
52. Rubber Reports
53. Cardamom Reports
54. Tea Reports
55. Plantation Labour (Note)
56. Link Worker Scheme - Handouts
57. UPASI Handouts for PMO's
58. Dr. Mackaya Papers
59. UPASI Medical Advisers papers
60. UPASI- CLWS Handouts
61. Occupational Health Medical Records
62. Occupational Health Legislation (India)
63. Occupational Health Legislation (U.K.)
64. Occup Lung Disease
65. Occupational Cancers
66. Occupational Dermatits
67. Skin Protection - Product information
68. Environmental Pollution
69. Monitoring Environment - ROHE Seminar 1983
70. Noise Hazard
71. Lead Poisoning
72. Occup. Lung Disease - Bibliography
73. Occupational Health Education Materials
74. Occupational Health Teaching Aids/Books Catalogue
75. Occupational Health Rehabilitation / Training - U.K.
76. Industrial Accidents
77. Road Safety Handouts / studies
78. Occupational Health General Principles (RN Personal)
79. Toxicology and Hazards A-Z (RN Personal)
80. Toxicology and Hazards M-Z (RN personal)
81. Toxicology - Medical Data A-Z
82. Toxicology Hazard data A-Z
83. Occupational Eye disease
84. Occupational Health Service in Hospitals
85. Occupational Health in chemical Industries - Thesis
86. Occupational Health Training - Sumposium 1970
87. Sickness Absenteeism
88. Occupational Health Practicals: Demonstration Materials
89. IAOH Conferences - 1976 / 1977
90. KSCST Seminar and Project Guidelines
91. KSCST Reports
92. Bio-Medical Engineering - Reports
93. Royal Society - Year Books
94.

RN = Ravi Narayan

SHELF III

94. Central Labour Institute Reports
95. Central mining Research Station Reports
96. NIOH - Ahmedabad Reports
97. Work Physiology Studies
98. Pesticide Studies
99. Pneunoconiosis Studies
100. Trade Unions
101. Food hygiene Course Papers
102. Food Hygiene Course Programmes
103. Food Hygiene Papers SJMC hostel (Dr. Dara Amar)

..3

104. Food Handlers project reports.

DRHSTP (P Series)

SHELF IV

P1 What we Believe in
P2 CHW Information Sheet
P3 CHW Brochures
4 List of Superios / Bishops
5 SJMCH Brochure
6 College Prospectus
7- 24 CHW Handouts
25 Biodatas
26. Mallur Paper - (General Mahadevan)
27. Chains - SEARCH game
28 SEARCH - Harijan Story
29. SEARCH - Chikkanahalli exercises
30 SEARCH - Monsoon game - Car
31 SEARCH - Monsoon scenauio worksheets
32 Rop material
33 participation assessment farms
34 Communication exercise
35- 47 Group dynamics - exercises/handouts
48 Search Quest

CHW = Community Health workes
ROP = Rural orientation Programme

GOVERNMENT OF KARNATAKA

DEPARTMENT OF HEALTH & FAMILY WELFARE SERVICES

SHORT COMINGS & SHORT FALLS IN THE IMPLEMENTATION OF PRIMARY HEALTH CARE SERVICES.

1. HEALTH & FW GOALS:

The Health &FW goals as spelled out under National Health policy is of much helpful to the States to devise their own goals and judge the progress made. However these goals have concentrated almost entirely on 'Health status' indicators. As against these indicators many of the States may not be in a position to indicate their level of achievement to all the indicators. Further there are certain indicators against which the level of achievement cannot be indicated in the usual situations but require special studies or survey. Such indicators needs thorough examination to include them or not.

There may be some other areas where a particular state might have progressed very well. Hence, there is a need to include some of the socio-economic indicators like provision and quality of health care including institution & Health Manpower status, consolidation of the infra-structure, safe water supply, adult literacy rate etc.,

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2. HEALTH INFRASTRUCTURE:

During the previous three, 5 year plan period, population norms has been the criteria for establishing the rural health infra-structure. This is most convenient and reasonable.

There may be certain regions in plain areas where the prescribed population might have spread over wide areas where in people have to travel long distances for availing the health care facilities from the institutions. In such instances there is a need to consider 'distance factor' also while establishing the health institutions especially Primary Health Centres.

3. CONSTRUCTION OF HEALTH INSTITUTIONS:

Compared to the cost of the construction of building recommended by Planning Commission and the actual cost being incurred by the State, it can be said that, there is a difference which can be observed from the following:

(Rs. in lakhs)

Type	Plg.Commn. recommendation (unit cost)	Actual cost being incurred by State (unit cost)
Sub Centres	1.00	1.25
PHCs	3.00	6.90 (including qrts)
CHCs	10.00	25-30

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unless an alternative to bring down the cost is devised, it is likely that the completion of the building will be a long drawn process. Because of the poor progress in respect of building works in the State the Planning Commission has recommended nearly 87% of the budget under MNP for construction of buildings in the 1990-91 Annual Plan Budget.

The State will have to decide the future course of action whether to bring down the cost of construction of buildings, or continue as usual. This is to be considered as a future policy matter.

4. FUNCTIONING OF PRIMARY HEALTH CENTRES:

PHCs play a vital role in the delivery of primary health care services. There are various factors involved in the effective functioning of Primary Health Centres.

(i) Residential quarters: The Medical Officers of Primary Health Centres staying always in the headquarters and available for long hours to the people for providing services determine the quality of services given by these institutions.

The State so far could only provide residential quarters at mere a quarter no. of PHC locations & the remaining are without provision of quarters requiring huge funds, the position is likely to continue in future also.

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(ii) Mobility: Due to expansion of health infrastructure all these years, sufficient funds are not allocated to provide vehicles to all the health institutions either for early arrival of the Medical Officers & the staff or for better field work & supervision.

The position is likely to continue unless some efforts are made by the State.

(iii) Professional equipments & reading materials:

It is observed that when once the doctor report to work in rural areas there will be meagre chances to utilise the professional equipments either due to lack of opportunities or equipments themselves. Further, there will be no opportunities to update their knowledge because of non-availability of reading materials like periodicals, magazines, reports etc., There is a need to look into these aspects and improve in future.

(iv) Management Training: The holding of continuing education training programmes has definitely provided opportunities to update the knowledge of inservice doctors to some extent. But those who are fresh from College after graduation will not be in a position to manage health institutions in rural areas unless they are given

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atleast 2-3 months training in 'Health Management' immediately after recruitment before actually posting them at rural hospitals.

5. MOBILE TRAINING UNITS:

The ' Health Sector ' consists of huge manpower both technical & non-technical. Although there are few training centres to impart continuing education programmes, it has not become possible to bring a fast turn over of all the candidates, atleast once in 3-5 years for updating the knowledge in health field. It is an important short coming in the State. The State has also recognised the need of such Mobile Training Units at District Level to train the Medical and para-medical on 'As is where is basis'. This is to be considered for future policy.

6. SPECIALIST AT COMMUNITY HEALTH CENTRES:

The concept of a Community Health Centre is to provide better referral services in the rural areas. To meet this objective the staff pattern includes four specialists of physician, surgeon, obstetrics & Gynaecologist and a Peadiatrician, one among them trained or qualified in Public Health. This type of staff pattern calls for posting of candidates with prescribed qualification

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to provide the desired services. As many of these CHCs are located at Taluk headquarts(urban) which will be having basic facilities, the doctors of Assistant Surgeon or Deputy Surgeon rank will manage to get postings at these institutions irrespective of qualification and thus it is observed that there is a gross " mal-distribution" of specialists because of non creation of posts with specialist designation. Unless such designated posts are guaranteed and the qualified candidates work against such posts, the qualitative referal services cannot exist in the Community Health Centres. Realising this important problem, the department has formulated the proposals and it is under active consideration of the Government.

It is feared that there will be problems also in future regarding the promotions of the specialist cadres. Hence, this needs to be examined carefully.

7. HEALTH WORKER (MALE) AT SUB CENTRES:

As per the National Guidelines of the State should achieve 100% requirement of sub centres at the end of 7th five year plan. Each Sub Centre should have one Health Worker(Female) and one Health Worker(Male) to provide basic health care services. Karnataka State required 7025 Sub Centres based on projected rural population by 1990. As against this the State has, on

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today 7793 Health Worker (Female) almost working in the designated Sub Centres with itinerary work and the remaining few working in taluk level and other institutions without itinerary work.

With regard to Health Worker(Male) we have as on today 5556 sanctioned posts requiring nearly additional 1500 posts to be created. At the present rate of pay scales it is estimated that nearly Rs.300/- lakhs is required per annum towards salaries, if these posts are newly created. When the funds are meagre to meet the basic requirement to the already established institutions, Should we still go on creating the posts or should we enhance the allocation of population for the Health Worker(Male) from present 5000 to 7500-8000.

This is well justified as far as Karnataka State is concerned, in view of 'Leprosy Eradication' having made as a virtical programme and 'Malaria Eradication' has been satisfactory.

There will be no set back if Karnataka State adapts this as a policy to enhance the allocation of population to the Health Worker(Male).

The present five Health & Family Welfare Training Centres will be able to turnover 300 candidates every year to fill up vacancies falling due to retirement etc.

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Health Engineering, but still the education, guidance, utility monitoring, feed back, availability of services etc., should be looked after by the ' health sector ' through the locally placed district health system. This is possible only by way of establishing a sanitary wing with most essential staff under District Health System to take stock of the availability of water, quantity, quality and quality control, utility, improvement of sanitary facilities including availability of sanitary latrines, construction, maintainence and education in basic sanitation etc., in rural areas.

10. POOR EMPHASIS ON SUPPORTIVE ACTIVITIES:

The World Health Organisation has recommended various supportive activities which on one side for strengthening the eight elements of Primary Health Care & on the other side to strengthen the Health Care System.

Although there has been good progress in the implementation of the schemes and establishment of Health System, some areas like health service research, appropriate technology, referral support, leadership for Health for all, have not received due individual attention so far.

This is due to lack of nodal cell exclusively for Primary Health Care System development at the State level.

Further, unless these areas are accepted and politically committed as a policy, there will not be success stories in Primary Health Care System Development.

* * *

Drugs in Small Rural Hospital
: A repliminary study

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1. State in which hospital located:

2. Bed strength: <25 >25 >50

3. Staff position (specify number and grades):

   a. Medical Officer

   b. Nurses

   c. Others

4. Facilities available

   a. Laboratory b. X-ray

   c. Pharmacy d. O.T.

5. Patient load - numbers seen in last year.

   a. Out-patients:_____ b. In-patients:_____

6. Commonest disorders seen (top 5 only)

	Medical	Obst & Gynae	Paediatric	Surgical
OPD				
IPD				

B. Drug Availability (range and type)

7. How many drugs are available in your pharmacy?

   a. tablets/capsules:

   b. Injections:

   c. Syrups/liquids:

   d. Skin/eye/ear: _____

   e. Total _____

p.t.o....2

8. What are the brands you stock in the following categories? (Mention brand names (company names in brackets) eg., Baralgan (Hoechst))

   a. Antibiotics

   b. Analgesic/antipyretic

   c. Anti-inflammatory

   d. Antidiarrhoeals

   e. Steroids

   f. Hormonal preparations

   g. Psychotropic drugs

   h. Anti-histaminics

   i. Cough syrups

   j. Tonics/Vitamins

   k. Skin preparations

   l. Non-allopathic drugs (or combinations)

   m. Food substitutes

   n. Eye/ear preparations

9. What fixed-drug combination drugs do you stock in the following categories?

   a. Antibiotics

   b. Vitamins with other drugs

   c. Steroids with other drugs

   d. Antihistaminics with others

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C. Drug selection/Purchase/Pricing

10. Who selects drugs in your hospital?

11. What are all the criteria for selection?

12. Do you purchase -

a. whole sale; retail; through medical representative

b. by generic names or brand names?

13. Do you purchase any drugs in bulk? Specify.

14. Do you prepare any medicines/mixtures/ointments in the hospital? Specify.

15. Do you get drugs donated from abroad? (Mention names and sources).

16. How do you price your medicines? (What percentage formula over wholesale-retail price)

a. Injections:

b. Tablets/capsules:

c. Vaccines:

d. Samples:

e. Foreign drugs:

D. Dispensing/Prescribing

17. What categories of staff in your hospital -

a. prescribe? b. dispense?

18. Do you have a trained pharmacist?

19. Does your hospital dispense drugs in any of the following situation? If so, in each one (a) who prescribes? (b) who dispenses? (c) is there a standardised list for each level?

a. Mobile clinics

(a)

(b)

(c)

b. Village Health Centre/Sub-Centre

(a)

(b)

(c)

c. School/Hostel/infirmary

(a)

(b)

(c)

d. Rehabilitation Centre

(a)

(b)

(c)

20. What is the regime you follow in your hospital for the treatment of (specify brand names of drugs) -

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b. Tuberculosis

c. Diarrhoea in children

21.a Do you have any policy about use of expired drugs?

b. If you use some beyond the expiry date, which are these?

c. For how long beyond expiry date do you use them?

22. Do you use any drugs as Placebos? Yes/No

    If yes, which are the commonest and for what situation?

23. Are you aware of the drugs banned by the Government in July 1983?

    Do you have a banned brand list?

    Have you weeded those drugs out of your hospital?

E. Drug information

24. How do you/your staff get information on drug indications/ doses/side effects.

    a. Product literature - Yes/No

    b. Drug company handouts - Yes/No

    c. Any other sources

25. Do you have in your hospital -

    a. formulary;

    b. list of minimum/essential drugs; and

    c. standardised drug regimes?

F. Adverse Reactions

26. Have you had any adverse reactions with drugs in your practice in the last one year? YES/NO
    If yes, specify:

G. Drug Budget

26.1 What is the annual expenditure on drugs in the last financial year?

26.2 Did the pharmacy run at a loss or a profit? LOSS/PROFIT
    If so, how much during that year?

H. Additional Information

27. Have you taken any initiatives in recent times to rationalise the prescribing/dispensing practices in your institution?

    What are they? How successful have you been?

28. If there are any other problems/issues that you have come across with your hospital, please mention them here.

29. Have you identified any forms of irrational prescribing, over-prescribing, under-prescribing or wrong prescribing of the medical practitioners in your area through prescriptions your patients may have brought with them? Give details.

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(c)

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a. formulary;

b. list of minimum/essential drugs; and

c. standardised drug regimes?

F. Adverse Reactions

26. Have you had any adverse reactions with drugs in your practice in the last one year? YES/NO
If yes, specify:

G. Drug Budget

26.1 What is the annual expenditure on drugs in the last financial year?

26.2 Did the pharmacy run at a loss or a profit? LOSS/PROFIT
If so, how much during that year?

H. Additional Information

27. Have you taken any initiatives in recent times to rationalise the prescribing/dispensing practices in your institution?

What are they? How successful have you been?

28. If there are any other problems/issues that you have come across with your hospital, please mention them here.

29. Have you identified any forms of irrational prescribing, over-prescribing, under-prescribing or wrong prescribing of the medical practitioners in your area through prescriptions your patients may have brought with them? Give details.

.....7

30. Are there any pressing drugs issues on which you would like reliable information?

31. Do you have any suggestions for issues/problems that should be discussed/considered at the workshop? Mention.

.....

13 PAISE FOR YOUR HEALTH

How much money does the government spend on your health? Given below in repees are the per capita expenditure incurred by each state on health.

State/U.T.s	1974-75	1975-76
Nagaland	80.84	75.84
Pondicherry	38.84	50.04
Goa, Daman & Diu	35.20	47.59
Arunachal Pradesh	-	43.12
Meghalaya	18.52	24.81
Sikikm	-	23.06
Himachal Pradesh	17.10	19.36
Punjab	12.34	17.88
Jammu & Kashmir	15.77	17.02
Manipur	16.20	16.98
Kerala	12.37	14.12
Maharashtra	13.52	13.41
Rajasthan	12.11	13.27
Tripura	11.09	13.22
West Bengal	9.78	12.31
Haryana	9.99	11.19
Karnataka	8.81	11.26
Tamil Nadu	9.81	10.94
Gujarat	8.57	10.68
ALL INDIA	9.44	10.63
Assam (including Mizoram)	9.56	10.27
Orissa	6.93	9.13
Andhra Pradesh	7.35	8.86
Madhya Pradesh	8.38	6.98
Uttar Pradesh	5.08	5.36
Bihar	4.09	4.46

But if you are in the villages your share dwindles further. As Dr.M.P.Mangudkar, Chairman of the committee appointed by the Government of Maharashtra to study the state of health services in Maharashtra reported, out of the total health expenditure of Rs.156 million by the Government in the state, 80% was spent on 3 cities - Bombay, Pune and Nagpur; 6.2% was spent on the district towns; 4.5% on the villages and 0.9% on the tribal areas. Per capita per year health expenditure in the village was 13 paise.

SOURCE — HEALTH FOR THE MILLIONS

No. Age Sex Cause of death

Health Team concept - There are so many minor complaints that you cannot deal with them all yourself, you must attend to pts more seriously ill + have time for leadership + management & make the health team effective. 50% of children's ejections are responsible, & this trouble, most of these can be seen initially by trained health worker.

Team - Dr. nurse, ANM, FHW, vaccinator dai, traditional healer, village women, village leaders. Block. extn. educator. panchayat member.

Who is the leader. - have to learn the responsibilities & relationships You must find yourself working = staff who are older & have practical & clinical experience in rural surroundings — such experience

∴ your role as the physician will be
1) clinical
2) Teaching
3) Manager - administrative } those also have to be learnt.
(coordinator)

Team - a group of people who work together to achieve a common objective. - ē in the case delivery of health care to mother & children

The leader is responsible for the operation of a team as a group, each category of ē has his or her part to the diff from that of the other members, each contributing to the work of a whole, but together the team is more effective than if the same no. of health workers worked independently. Leader - plan, coordinate, supervise, manage - so that it works as a unit. Being the leader demands that you command have tech. knowledge & skills upd of all the health workers, that you understand the imp & managerial personal relationships & the art of getting people to work together.

Teacher + learner You: every action sets an example of experience staff + pts — only consistency brings regard, people observe + remember.

Clinical — curative, preventive, promotive
Imp of referral even by dr.'s: everyone has limitations

No. of Sex Cause of death

MCH - II

① Revision of MCH I viz.
- MCH care is del. of services to mother & children in the community
- Reasons why MCH is imp.
- Mother & child as a unit in the delivery of care.
- Profile of MCH in India.
- Content of MCH - integrated package of multifactorial problems — to ensure max. coverage of target pop.
  Risk approach.
- H.E.

② Health team concept.

③ Your role as a physician — clinician, teacher, manager.

④ Antenatal care — aims, objectives

⑤ Risk approach.

⑥ A.N. progr — Registr, Records, AN visits (content, home visits), specific hlth pctr, H.E incl psychol prep, F.P. paediatric component.

⑦ Intranatal care.

— x —.

AN card
Dai tip slides / filmstrip.

★ Primary Health Care ★

I Components

5- Part of the total sys (social + country's health sys.
6- Self reliance + self determination

II Alma Ata — 10 pts.

III What is essential health care. —

Do we have the resources to render it - men, material, money

IV Experiences of V.L.W's.

- Referrals.
- Continuing educ. for VLW's.
- Respect their beliefs.
- Be v. clear abt guidelines for VLW's
- Support from (esp. of govt. workers : they work in such an impersonal set'up).
- Link.
- Skills transferable + not.

V Functions of a VLW

VI Other aspects of S.E. dev. - part played by VLW,

- Visits to projects near their home. & reports on SSK visits.
- 2 yrs compulsory rural service.
- Encourage attendance to AICUF, NSS work camps

Thelma Rodriguez.
6/10/78.

25:28

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 health 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 position 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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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 political characteristics of the country and includes at least education concerning prevailing health problems and the methods of preventing and controlling them.

,,, 2

(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.

@/@/@

MS/28978/

Vital Events

Vital events refer to events which affect life such as birth and death. The reporting of births and deaths in villages is done by the village chowkidar, dais, and other leaders of the community including yourself.

9.1 Report all births and deaths in his/her area to the Health Worker(Male)

In the course of your visits to the homes, enquire whether any births or deaths have occurred since your last visit. Make a note of these births and deaths in your diary and inform the Health Worker(Male) about them on his next visit to your village. Give the Health Worker(Male) the exact address so that he can visit the house and collect the necessary data about births and deaths.

9.2 Educate the community about the importance of registering all births and deaths

You should impress upon the community that it is essential to register every birth and every death in the village for the following reasons :

1. Information about the births occurring in a village helps the Health Workers to plan for the provision of services to the newborn babies and their mothers both at home as well as at the Subcentre
2. Death registration is necessary because it can help to find out whether any deaths have been due to communicable diseases so that the necessary measures can be taken to prevent further deaths
3. The registration of deaths will help to identify and investigate those deaths occurring during pregnancy and within 40 days of delivery as well as deaths occurring in the newborn, i.e. within 28 days after birth. This information can be used to plan improvements in maternal and child health services.
4. Registration of births and deaths is also necessary in order to assess the birth rate, the death rate, the growth of population and the age distribution of the population. This information helps in planning for the needs of the population in terms of education, health care, food, housing, employment and social welfare.

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LAL BAHADUR HEALTH INSURANCE SCHEME

AIM'S AND OBJECTIVES

1. To make health care possible by the people.
2. To provide low cost medical care.
3. To foster unity and self help.
4. To make each one responsible for their own health, and thus build up a healthy community.

POLICY

1. A policy should be drawn up by the Committee and it should be made clear to every member before starting the Scheme.
2. This policy can be revised as and when needed with the consent of the general body.

Membership Fee (M.F)

3. The present membership fee is Rs.2/- per family per month. This can be revised as and when needed with the consent of the General body.
4. The M.F. should be paid between the 5th and 10th of every month. It can also be paid once a year as Rs.24/- or Rs.6/- every three months. But the date should be same.

   The fees can be paid by cash or kind (market rate) or by both.

5. Pass-Book should be maintained for each family.
6. The pass book should contain the following details.
   (a) The name of the family members (Husband, Wife and Children who are not married) should be entered.

   If it is a joint family with unmarried brothers, sisters and parents of the head of the family, it should be registered as a separate family.

   (b) The fees should be entered clearly and correctly in the pass book.
   (c) In the same way the date of the visit, name of the medicine given by the health workers or in the dispensary and the total cost should be entered.
7. Maximum benefit for a family per year will be upto a value of Rs.100/- of medicines. Once they exceed this amount they should pay the full cost.
8. Selection of members:

   Before registering the family, all the members of the family should have a physical examination and the children below 5 years should have small pox, BCG, DPT, Polio Cholera and Typhoid Vaccination. All the members should have small pox, Cholera, Typhoid Vaccination every year. If they fail to have the vaccination and get any of these disease all the expenses should be met by the family.

.....2.

9. Any one who gets sick should come for treatment immediately to avoid unnecessary expense.

10. During the physical examination if any one is found to have a serious disease, such as, heart disease, paralysis, deformity, fracture, diabetes, serious TB cases, the family can become a member, but that particular patient should be treated by a specialist and the expenses should be met by the family. (As a health Insurance member a recommendation letter can be obtained from the President of the Lal Bahadur Co-operative Society or Sister-in-charge, St. Philomena's Hospital).

11. The following diseases can be treated under the Scheme:
    1) Common Diarrhoia
    2) Cold, Cough, Fever
    3) Ordinary aches and pains.
    4) Anaemia and malnutrition
    5) Common Stomach problem
    6) Early stages of TB and chronic cases if it is not too severe (provided they continue the treatment for two years regularly).

    If they don't taken the treatment regularly then they will be out from the Insurance benefit (i.e) should pay for the treatment.

    7) Ordinary cuts, wounds and sores.
    8) Sore eye & ear infections.
    9) Scabies.
    10) Asthma or Pneumonia if not too advanced. If any of these above diseases by chance becomes serious and needs to go to hospital a letter of recommendation will be given but the expenses will not be met under the Scheme.
    11) Normal deliveries will be conducted.
    12) Complicated cases should be taken to the hospital.
    13) Treatment during pregnancy will be given under the Scheme.

DEFAULTERS

The membership will expire 30 days after the due date. (All the benefits also will be closed). After the date of expiry they will cease to be a member. Whatever amount has been deposited will not be refunded. If they want to be members again they have to join as a new member. But if they have received their total benefit of Rs.100 for that year no benefit will be give till the next year. If they had partial partial benefit, the rest will be given to them for the total year.

11. To those families who had never benefited from any medical care during the year a health shield will be presented by the Officials at the annual meeting.

12. The treatment will be given by the health workers as far as possible.

13. Most of the deliveries will be conducted by the trained midwife.

14. Financial report will be prepared and presented every 3 months to members.

Application to OXFAM for the training of Basic Health Workers and for Health Insurance Scheme of Dhamara Bhimanapally

Background information

LOCATION: It is a Village in Devarakonda Taluk of Nalgonda District in Andhra Pradesh. It also belongs to Nalgonda Diocese.

POPULATION: Dhamara Bhimanapally has 3 villages with a population of 3,500. The names of the villages are Dhamara Bhimanapally, Karmaguda, and Lambadi Tanda.

SOCIO ECONOMIC CONDITION: In Karmaguda is agriculture, and in the other two villages agriculture and other types of Labourers. For about 6 to 7 months a year the people are occupied, the rest of the year the work depends upon the cultivation and rains. The Average income of a labourer family is Rs. 90 - 100 if both husband and wife get a job, and the average size of a family is about 6 members.

The main crops are Jawar and Cash Crops like Tobacco, Chillies and Caster seeds. The crops depend upon the rains. There is no possibility of digging wells due to the rocky land, also (PH) and fluride content of the water is very high. Hence it is not good for cultivation. The people are very poor. The average land holding is about 5-10 acres but due to draught cultivation is not possible, hence most of the people are in debt even if they have land.

HEALTH CONDITION: The High content of fluoride in the water is a big public health problem. Most of the children suffer from Calcium deficiency and deformity of bones. Women after 2 - 3 pregnancies suffer from Osteomalacia, which is a big public health problem, Men also suffer from the same. Other diseases are nutritional deficiency diseases such as :-

Anaemia,

Protein Malnutrition,

Vitamin 'A' Deficiency

Vitamin 'B' Deficiency

Diarrhoea,

Fever,

Typhoid,

Gastric Ulcers,

T.B. (almost one in every family),

Seabies, eye infection and other common and seasonal diseases.

There are no medical facilities in these villages except a small dispensary run by the Sisters. The nearest health centre is 16 k.M. away in Marriguda. The nearest Hospital is in Nalgonda which is 50 K.M. also Devarakonda which is 50 K.M. away. These villages are 4 - 5 K.M. away from the main road. There is no bus service from the villages to the main road. The patient has to be carried or taken in a bullock cart to reach the main road. There are no regular bus services, except three or four times a day.

....2/-

PROJECT PROPOSAL :

Though the sisters run a dispensary, so far only curative services have been given to the people.

The Parish has started a youth club and this association has been registered as "Lal Bahadur Labour Cooperative Society". The main aim of this association is to up lift their economic condition by improving their agricultural and health condition.

I.S.I. mobile training team has offered to help in different aspects of training. In the month of January, we are planning to have a training programme for basic health workers and agriculture extention work by the I.S.I. team. The reason for training, the Basic Health Workers is to provide better health care since there is only one sister in the dispensary. In order to reduce the cost of medical care and to have better health. We are planning to have a health insurance programme. The youth of the association are very much interested and have taken the lead to start this scheme. The insurance fees is Rs.2/- per month per family (the aims and policy are enclosed). At present about 300 families have been enrolled and more will be encouraged to join.

In order to start the health insurance scheme an initial expense is needed for one year as a subsidy.

Hence we request a grant of Rs.15,000/- Rs.10,000/- for the medicines and Rs.5,000/- for training and salary of basic health workers. The peoples' contribution will be almost Rs.6,000/- to Rs.7,000/-.

This first year will be on an experimental basis. In the second year we are planning to reduce the cost and if any help is needed we will request later. We are also planning to get some help from the Government by the second year.

JOB RESPONSIBILITIES OF HEALTH WORKER (MALE)

NOTE: Under the multipurpose workers scheme, a Health Worker (Male) is expected to cover a population of 5,000 wherein he will carry out the responsibilities assigned to him. He will have different sets of responsibilities for MCH, Family Planning, Immunization, and Nutrition in the intensive and twilight areas of the Health Worker (Female). (The functions to be carried out only in the twilight area are printed in italics).

He will make a visit to each family once a month.

He will carry out the following functions:

1.1 MALARIA

1.1.1 Identify fever cases

1.1.2 Make thick and thin blood films of all fever cases

1.1.3 Send the slides for laboratory examination

1.1.4 Administer presumptive treatment to all fever cases

1.1.5 Record the results of examination of blood films.

1.1.6 Refer all cases of positive blood films to the Health Assistant (Male)for radical treatment.

1.1.7 Educate the community on the importance of blood film examination for fever cases, treatment of fever cases, insecticidal spraying of houses, larviciding measures, and other measures to control the spread of malaria.

1.2 SMALLPOX

1.2.1 Identify cases of fever with rash and report them to the Health Assistant (Male).

1.2.2 Take containment measures until the arrival of the Health Assistant (Male), i.e. isolation of the suspected case.

1.2.3 Conduct a scar survey to identify the unprotected children and adults.

1.2.4 In the intensive area conduct primary vaccination of all the unprotected above the age of one year and periodic revaccination of all children and adults.

1.2.5 In the twilight area, conduct primary vaccination of all the unprotected from birth onwards and periodic revaccination of all children and adults.

1.2.6 Educate the community on the importance of smallpox vaccination, care to be taken in case of an outbreak of smallpox the reporting of all cases of fever with rash, and the reward available for reporting a case of smallpox.

1.3 COMMUNICABLE DISEASES

1.3.1 Identify cases of notifiable diseases, i.e. cholera, smallpox, plague, poliomyelitis, and persons with continued fever, or prolonged cough, or spitting of blood, which he comes across during his home visits and notify the Health Assistant (Male) and Primary Health Centre about them.

1.3.2 Carry out control measures until the arrival of the Health Assistant (Male).

1.3.3 Educate the community about the importance of control and preventive measures against such communicable diseases including tuberculosis.

1.3.4 Report the presence of stray dogs to the Health Assistant (Male).

1.4.5 ENVIRONMENTAL SANITATION

1.4.1 Chlorinate public water sources at regular intervals.

1.4.2 Educate the community on (a) the method of disposal of liquid wastes; (b) the method of disposal of solid wastes; (c) home sanitation; (d) advantages and use of sanitary type of latrines (e) construction and use of smokeless chulas.

1.4.3 Help the community in the construction of (a) soakage pits; (b) kitchen gardens (c) manure pits; (d) compost pits; (e) sanitary latrines.

1.5. Immunization:

1.5.1 In the intensive area, administer DPT vaccination, BCG vaccination and, wherever available, oral poliomyelitis vaccine to all children aged one to five years (Also refer to 1.2.4 for smallpox vaccination).

1.5.2 In the twilight area, administer DPT vaccination, BCG vaccination and, wherever available, oral poliomyelitis vaccine to all children aged zero to five years (Also refer to 1.2.5 for smallpox vaccination and to 1.8.3 for tetanus toxoid).

1.5.3 Assist the Health Assistant (Male) in the school immunization programmes.

1.5.4 Educate the people in the community about the importance of immunization against the various communicable diseases.

1.6 FAMILY PLANNING

1.6.1 Utilize the information from the Eligible Couple Register for the family planning programme.

1.6.2 Spread the message of family planning to the couples in his area and motivate them for family planning individually and in groups.

1.6.3 Distribute conventional contraceptives to the couples.

1.6.4 Provide facilities and help to prospective acceptors of vasectomy in obtaining the services.

1.6.5 Provide follow-up services to male family planning-acceptors in the intensive area and all family planning acceptors in the twilight area, identify side-effects, give treatment on the spot for side-effects and minor complaints, and refer those cases that need attention by the physician to the PHC/Hospital.

1.6.6. Build rapport with satisfied acceptors, village teachers and others and utilize them for promoting family welfare programmes.

1.6.7 Establish male depot holders in the intensive area and male and female depot holders in the twilight area. Help the Health Assistant (Male) and Health Assistant (Female) in training them, and provide a continuous supply of conventional contraceptives to the depot holders.

1.6.8 Identify the male leaders in each village in the intensive areas and the male and female leaders in the twilight area.

1.6.9 Assist the Health Assistant (Male) in training the leaders in the community, and in educating and involving the community in family welfare programme.

1.7 MEDICAL TERMINATION OF PREGNANCY

1.7.1 Identify the women in the twilight area requiring help for medical termination of pregnancy and refer them to the nearest

1.7.2 Educate the community on the availability of services for medical termination of pregnancy.

1.8. MATERNAL AND CHILD HEALTH (In the twilight area)

1.8.1 Identify and refer women with abnormal pregnancy to the Health Worker (Female).

1.8.2 Identifyand refer women with medical and gynaecological problems to the Health Worker (Female).

1.8.3 Immunize pregnant women with tetanus toxoid.

1.8.4 Refer cases of difficult labour and newborns with abnormalities to the Health Worker (Female).

1.8.5 Educate the community about the availability of maternal and child health services and encourage them to utilize the facilities.

1.9. NUTRITION

1.9.1 Identify cases of malnutrition among pre-school children one to five years in the intensive area and refer them to Balwadis/Primary Health Centre for nutrition supplements.

1.9.2 Identify cases of malnutrition among pre-school children (zero to five years), in the twilight area and refer them to Balwadis/Primary Health Centre for nutrition supplements.

1.9.3 Distribute iron and folic acid as prescribed to children from one to five years in the intesive area and to pregnant and nursing mothers, children from zero to five years, and family planning acceptors in the twilight area.

1.9.4 Administer vitamin 'A' solution as prescribed to children from one to five years in both the intensive and the twilight areas.

1.9.5 Educate the community about nutritious diet for mothers and children.

1.10 VITAL EVENTS

1.10.1 Enquire about births and deaths occurring in the intensive and twilight areas, record them in the births and deaths register and report them to the Health Assistant (Male).

1.10.2 Educate the community on the importance of registration of births and deaths and the method of registration.

1.11 RECORD KEEPING

1.11.1 Survey all the families in his area and collect general information about each village/locality in his area.

1.11.2 Prepare, maintain and utilize family record and village registers.

1.11.3 With the assistance of the Health Worker (Female) prepare the Eligible Couple Register from the family records and maintain it up to date.

1.11.4 Prepare and submit periodical reports in time to the Health Assistant (Male).

1.11.5 Prepare and maintain maps and charts for his area and utilize them for planning his work.

1.12 PRIMARY MEDICAL CARE

1.12.1 Provide treatment for minor ailments, provide first aid for accidents and emergencies, and refer cases beyond his competence to the Primary Health Centre or nearest hospital.

1.13 TEAM ACTIVITIES

1.13.1 Attend and participate in the staff meetings at Primary Health Centre/Community Development Block or both.

1.13.2 Coordinate his activities with the Health Worker (Female) and other health workers, including the dais in the twilight area.

1.13.3 Meet with the Health Assistant (Male) each week and seek his advice and guidance whenever necessary.

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TEAM WORK

2.1 DEFINITION

A TEAM IS A GROUP OF PERSONS WITH DIFFERENT LEVELS OF KNOWLEDGE, ABILITIES, AND PERSONALITIES SHO MUST COMPLEMENT EACH OTHER AND WHO SHARE A COMMON, UNIFYING GOAL.

(J. Bryant) - Health & The Developing world)

As a health worker at the periphery you are a member of the health team at the block. Moreover, you are the member of the team closest to the community and, therefore, the first line of health activities is to be delivered by you and your team mate, the Health Worker (Female).

REMEMBER THAT SHARED PARTICIPATION IS THE HIGHEST ELEMENT OF TEAM WORK. IF YOU FORGET THIS PRINCIPLE AND TRY TO ORGANIZE YOUR ACTIVI - TIES IN ISOLATION YOU ARE BOUND TO FAIL.

Team work has to be planned so that each member of the team develops his or her activities to achieve the common goal.

2.2 HOW TO ORGANIZE YOUR ACTIVITIES IN THE TEAM

Your activities have to be coordinated with:

1. the Health Worker (Female) and
2. the Health Assistant (Male)

However, you must also remember that the community is the consumer of your services so that you must coordinate your work with the community leaders to make sure that the needs of the community are satisfied. Also, although your team leader is the Medical Officer (PHC), you are not likely to be in very close contact with him, except when he visits your area, because of the location of the subcentre. The responsibilities of team coordination will be delegated to the Health Assistant (Male) with whom close collaboration is necessary for success.

2.3 COORDINATING ACTIVITIES WITH THE HEALTH WORKER (FEMALE)

The job responsibilities of the Health Worker (Female) complement your job responsibilities and the two of you will provide comprehensive health services to the whole community. This can only be achieved if both of you coordinate your activities in the following ways:

i. Organizing your daily activities through consultation
This will avoid duplicating activities and will, in the long run, save time and unnecessary travel and expenses.

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YOU SHOULD ENSURE THAT AT LEAST FIFTEEN MINUTES EVERY DAY ARE SPENT IN MUTUAL CONSULTATION WITH THE HEALTH WORKER (FEMALE) TO ASSESS THE DAY'S WORK AND PLAN THE WORK FOR THE NEXT DAY.

ii. Exchanging information on activities of mutual interest, e.g., family planning, nutrition, and health education activities. Although the Eligible Couple Register is maintained by you, yet the Health Worker (Female) must feed information into it so that the records are kept up to date. This information is used by both of you in implementing the programme.

iii. Organising combined activities. Health education activities should be organised together with the Health Worker (Female) involving other concerned workers and interested persons if necessary.

iv. Planning your activities so that one of you is always available at the subcentre to deliver medical care, both routine or in an emergency.

v. Combining your activities in time of crisis, e.g., an epidemic outbreak when vaccination is one of the activities which is organised to stop the spread of disease.

vi. Following up cases during home visits. This can be organised to avoid duplication and is a sequel to exchange of information.

vii. Cooperating in the compilation of reports, records, charts and the preparation of maps.

In the Twilight Area: In the initial stages of implementation of the programme, the Health Worker (Female) will be concentrating her activities in the intensive area around the subcentre. It will not be possible for her to look after the needs of the community living away from the subcentre (usually beyond 5 kilometres). In this twilight area you will have to extend your services to cover some of the responsibilities of the Health Worker (Female), and work closely with the dais.

IN THE TWILIGHT AREA YOU WILL HAVE TO PROVIDE THE HEALTH WORKER (FEMALE) WITH INFORMATIONWHICH SHE CANNOT COLLECT HERSELF BECAUSE OF HER WORKLOAD IN THE INTENSIVE AREA. HER SERVICES IN THE TWILIGHT AREA WILL BE AVAILABLE ON DEMAND ONLY AND YOU SHOULD CALL ON HER SERVICES WHEN REQUIRED WHILE UNDERTAKING SOME OF HER ROUTINE ACTIVITIES.

2.4 COORDINATING ACTIVITIES WITH THE HEALTH ASSISTANT (MALE)

Your supervisor will visit you at least on one day a week and he will spend the whole day with you. He will guide you in your work and will help you to improve your knowledge and skills. He is also, in many ways, deputizing for the Medical Officer of the PHC and you should avail yourself of his leadership during these visits. Besides, the Health Assistant (Male) has other specific activities assigned to him such as giving radical treatment to malaria cases and immunization of school children, and you are expected to help him in these tasks.

Success can be achieved only if your activities are coordinated in the following ways:

i. Planning your activites in consultation with your supervisor. This is necessary as he may need your help in delivering some of the programmes where your participation is required and the workload has to be distributed. Also, in planning your programme together he will know where to contact and locate you in case of emergency and vice versa.

identified. This is an essential feature of the supervisory visit and both of your should utilize the opportunity to the best advantage.

iii. Utilizing your supervisor to establish where your efforts have not achieved the desired degree of success.

iv. Visiting with your supervisor problem areas which you were unable to tackle on your own.

v. Utilising your supervisor's visit to improve your knowledge knowledge and skills.

DO NOT BE ASHAMED TO ASK FOR GUIDANCE FROM YOUR SUPERVISOR. HE IS THERE TO GUIDE AND LEAD YOU IN YOUR WORK.

vi. Taking the necessary action on your supervisor's suggestions to improve the delivery of the services.

vii. Coordinating your activities with those of your supervisor. This is an essential feature of team work.

viii. Preparing the community or the schools for mass programme which your supervisor will be implementing. Your contribution in motivating and brining the community together to accept the programme will help in achieving success.

ix. Physically assisting your supervisor in performing immunizations in schools and the promotion of sanitation programmes.

x. Keeping your supervisor informed of positive malaria cases who will require radical treatment.

xi. Alerting your supervisor and seeking his advice and assistance in the face of outbreaks of epidemics, such as cholera, smallpox or malaria.

ALWAYS USE THE SUPERVISOR'S VISIT TO SOLVE DIFFICULTIES AND DISCUSS POINTS OF MUTUAL INTEREST. REMEMBER THAT YOUR WORK IS COMPLEMENTARY TO THAT OF THE SUPERVISOR AND YOUR JOB DESCRIPTION DEMANDS THAT BOTH OF YOU WORK TOGETHER.

2.5 COORDINATING ACTIVITIES WITH OTHER MEMBERS OF THE TEAM AT BLOCK LEVEL:

You are expected to attend staff meetingssat the Primary Health Centre/community development block or both. These meetings will help you in getting to know what health activities are going on or are being planned in the block. Other activites which lead to team coordination at the periphery include the following:

i. A monthly meeting of the Health Assistants (Male and Female) with the Health Workers (Male and Female) to review the overall activities developed in the sub-centre during the month and plan forthcoming activities to be delivered by the team.

THESE MEETINGS ARE NOT ONLY SUPERVISORY BUT ALSO EDUCATIVE IN CHARACTER AND CAN GO A LONG WAY IN FOSTERING TEAM SPIRIT AND A COLLECTIVE APPROACH TO PROBLEM SOLVING.

ii. Periodic meetings between the community leaders, health assistants and health workers help to foster mutual understanding and acceptance of the health programme. Involvement of the community leaders in planning activities will also help in getting full community participation.

INVOLVING THE COMMUNITY IN PLANNING ITS HEALTH SERVICES HELPS TO ATTAIN FULL ACCEPTANCE AND COOPERATION IN THE DELIVERY OF THESE SERVICES.

2.6 VISITS BY THE MEDICAL OFFICER FROM THE PRIMARY HEALTH CENTRE

Under the Multipurpose Workers Scheme, each Medical Officer in the PHC will be the supervisor of half the area in the block, while the Medical Officer-in-Charge of the PHC is the overall team leader. You must, therefore, expect at least a monthly visit by the doctor from the PHC, and you should try to get the maximum benefit from this visit.

IDEALLY THE VISIT BY THE DOCTOR SHOULD COINCIDE WITH THE VISIT BY THE HEALTH ASSISTANT (MALE) SO THESE TWO OFFICERS MUCH PLAN THEIR WORK IN ADVANCE. IF BOTH VISIT TOGETHER MORE PROFITIABLE DISCUSSIONS ARE LIKELY TO RESULT AND UNIFORMITY IN THE HEALTH SERVICES OF THE AREA IS ESTABLISHED.

You should:

i. plan this visit in advance with your supervisor so that he is fully aware of what your difficulties are;

ii. prepare a listof any points which need clarification by the doctor;

iii. arrange for the doctor and your supervisor to visit the community leaders;

iv. arrange for the doctor and your supervisor to visit areas with health related problems;

v. inform patients who need to be seen by the doctor about his visit and request them to be present at the subcentre at the right time.

The doctor's visit is a supervisory visit to assess the type of services delivered and to advise on how things can be improved. It is your duty, therefore, to ask for advice and to be frank and honest in your discussions with your team leader. You will also be able to learn many things by assisting the doctor during the doctor during the clinical sessions.

THE DOCTOR'S VISIT, AS WELL AS THE VISIT OF YOUR SUPERVISOR, MUST ALWAYS BE PLANNED IN ADVANCE AND YOU SHOULD KNOW THE EXACT DATE AND TIME OF THE VISITS. THIS WILL HELP YOU TO ARRANGE YOUR PROGRAMME AND ARRANGE FOR THE COMMUNITY LEADERS TO MEET THE DOCTOR AND THE HEALTH ASSISTANT (MALE).

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RECORD KEEPING

Information on the village where you are working and its people, as well as information on the work you carry out is made available through the recor s which are kept at the subcentre and which you will be required to compile. The number and types of records which need to be kept are decided by the health authorities of the state in which you are working and it is your duty to know how, when and where to fill them as well as what to include in the prescribed forms supplied to you. A set of stnadard forms which you will be required to complete is included for your guidance in the supplement to the Manual (see Annexures 4.1, 4.2 and 4.3).

REMEMBER THAT ONLY THOSE RECORDS WHICH ARE ACCURATED MAINTAINEDARE USEFUL. RECORDS WHICH ARE HAPHAZARDLY COMPLETED ARE NOT ONLY USELESS BUT MISLEADING AND WILL INEVITABLY LEAD TO FALSE DECISIONS AND CONCLUSIONS.

4.1 THE NECESSITY FOR RECORD KEEPING

Records are necessary for three main purposes:

1. To collect base-line information which could be used to:

   i. plan programmes for development;
   ii. plan training programmes;
   iii. plan field activities including supervision;
   iv. evaluate progress.

2. To keep a record of activities. These records could be used to:

   i. get information on the amount of work done each day, each week, etc.;
   ii. find out what types of ailments are seen by the health worker;
   iii. assess the workload of the health worker;
   iv. Compile administrative information, e.g., the amount of drugs used in relation to the number and types of patients treated, the amount of fuel used in relation to distances covered, etc.

3. For research purposes.

Although you will not be required to collect data and records for research purposes, your base-line records and your records of daily actitivites may, if necessary, be used for research purposes.

4.2 RECORDS TO BE MAINTAINED BY THE HEALTH WORKER (MALE) AT THE SUBCENTRE

Your duties in relation to record keeping start from the time you assume duties at the subcentre and continue throughout with periodic reports and other records which are required to be kept according to your job description.

The types of records you must maintain include:

1. General information collected through an initial base-line survey of the villages to compile an inventory of the health, environmental and family activities, as well as related information which will help you in your work (Village Record).

2. The maintenance of family folders which include the Household and Family Record and the Individual Health Cards.

3. The maintenance ofrecords relating to malaria and other communicable diseases.

4. The maintenance of records relating to eligible couples, depot holders and other activities in the field of family planning.

5. The recording of vital events, i.e. births and deaths.

7. The maintenance of records relating to the administration of iron and folicacid tablets and vitamin A solution.

8. Records of medical care provided and drugs utilized.

9. Records of activities carried out in the fields of education and environmental health.

10. The compilation of monthly reports and other periodic reports as and when requested.

11. Records of liaison activities between yourself and your supervisor and the Health Worker (Female).

BESIDES KEEPING THE RECORDS YOU MUST ENSURE THAT THEY ARE DESPATCHED TO THE RIGHT PERSON AT THE RIGHT TIME USING THE RECOGNIZED CHANNELS.

REMEMBER THAT MANY OF YOUR RECORDS CONTAIN INFORMATION WHICH IS COLLECTED IN CONFIDENCE. THESE RECORDS MUST, THEREFORE, BE CAREFULLY PRESERVED AND NOT MADE AVAILABLE TO PERSONS UNAUTHORISED TO HAVE THEM.

4.3 PLANNING YOUR ACTIVITIES WITH REGARD TO RECORD KEEPING

Record keeping can be a time-consuring job if you do not develop a system which is feasible and easy to maintain. Therefore, do not let records collect at the subcentre to be sorted out periodically but record your day's activities when you finish your day's work. Not only will this make your record keeping easier, but it will also ensure that all information is included and there is less chance of forgetting things.

ALWAYS RESERVE THE LAST HALF HOUR OF THE DAY FOR COMPLETING THE RECORDS.

4.3.1 COLLECTING GENERAL INFORMATION

As a newcomer to your area, your first job is to get to know the area, the people and the environment. You can only achieve this by carrying out a survey to include all the relevant information which will help you in developing your activities.

The base-line survey in a public health programme is an operation which by means of census, mapping and sampling prododures will determine the quantity, nature, distribution, accessibility and other characteristics of the houses, population, environmental conditions, health units, schools etc.

The objectives for conducting the base-line survey are as follows:

1. General

   i. To permit the adequate planning of your activities
   ii. To ensure that the desired population coverage is achieved.

2. Specific

   i. To find out the exact location of the houses, schools, wells and other water points.
   ii. To collect demographic data, i.e.

      a. To find out the total population in the area (population census)
      b. to find out the age-group distribution
      c. to find out the sex distribution
      d. to find out the family size distribution.

   iii. To collect social data, i.e.

      a. to find out the educational levels of the population
      b. to find out the religious groups
      c. to find out population movements
      d. to find out the social structure of the community

iv. To collect economic data, i.e.

a. to find out the sources of income (agriculture, animal husbandry, cottage industries, etc)

b. to find out the living conditions (type of house, accommodation for livestock and poultry, etc).

v. To list the communications available, i.e.

a. the type and number of roads and pathways

b. water communications such as rivers, or lakes

c. public transport availability such as buses, trains, etc.

vi. To list the channels of communication, i.e.

a. indigenous, such as drumbeating, kirtans, carrier pigeons, etc.

b. modern, such as radio, telephone, newspapers, etc.

vii. Toccollect health data, etc.

a. immunization status of the population

b. nutritional status of mothers and children

c. number of couples eligible for family planning advice

d. Use of family planning methods

e. environmental sanitation, viz. water supply, excreta disposal, sullage disposal and refuse disposal.

f. incidence of communicable diseases.

4.3.2 CONDUCTING A BASE-LINE SURVEY:

A door-to-door survey may take a coupe of weeks to complete but it will be very useful and will help you to plan your activities on a realistic basic with factual information to build on. Forms for collecting the information required for the base-line survey are included in the supplement (see Household and Family Record annexure 4.1, and Village Record annexure 4.2).

If information is already available with the Health Assistant (Male) use it for your base-line survey. If it is not available, with the help of your supervisor and the collaboration of the Health Worker (Female) proceed as follows:

1. Acquire the forms in sufficient numbers.
2. Conduct the survey and fill up the forms with the marks relevant to the survey.
3. On completing the survey, chart the information on a map of the area, This will give you the information you require at a glance.
4. Keep your chart up-dated whenever any changes occur.

FACTUAL INFORMATION MUST BE AVAILABLE IF WORK IS TO BE PROPERLY PLANNED, AND TIME SPENT IN COLLECTION OF BASE-LINE INFORMATION IS TIME WELL SPENT.

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The items included in the charts or maps of the area under your care will be as follows:

1. The numbered houses.
2. The roads and pathways as well as any waterways.
3. The location of the subcentre, school, market, police station, panchayat ghar, post office, etc.
4. The location of the water points and the type of supply.
5. The type of latrine used by each household.
6. The method of refuse disposal in use.
7. The method of sullage disposal.
8. The house with eligible couples.
9. The houses with children aged 0 to 1 year and 1 to 5 years.
10. The location of depot holders (Nirodh)
11. The location of practising dais.
12. Any other information which will be of help to you in your work.

IT WOULD BE A BIG ADVANTAGE TO NUMBER THE HOUSES IN YOUR AREA, IF THEY ARE NOT NUMBERED ALREADY. THIS WILL EHLP YOU TO INDEX YOUR FAMILY RECORDS AND THE HOUSE WILL BE EASY TO LOCATE FOR EMERGENCY AND OTHER SERVICES.

4.3.3 MAINTAINING FAMILY FOLDERS

Family records are important as the unit to which the services are directed is the family rather than the individual. The family records should be kept up to date by entering the information on the day when the it is obtained. For this purpose a good filing system has to be worked out and the records must be kept in the proper order for easy retrieval.

WHENEVER A FAMILY FOLDER IS USED IT MUST BE REPLACED IN ITS PROPER PLACE AFTER USE. THIS WILL MAKE RETRIEVAL AT ANY LATER DATE EASY.

The family folder should contain the following:

1. The Household and Family Record which includes information about the socio-economic status of the family, the number of family members, the immunization status of the family members the nutritional status of the mother and children, the use of family planning methods by the couple, the environmental sanitation of the household and the presence of communicable diseases in any family member.
2. The individual Health Cards which are prepared for each family member and which record the health of each individual, his or her ailments and the treatment received.

4.3.4 REPORTING COMMUNICABLE DISEASES:

Under the multi-purpose workers scheme, a number of records have been combined in order to reduce the volume of work. The information to be collected is included in annexures 4.1, 4.2 and 4.3. However, you must still send special reports on those diseases which require reporting by current standing orders. For instance, refer to section 15.2.7 for reporting of blood smears.

MAKE SURE THAT YOU KEEP YOURSELF INFORMED AS TO THE DISEASES WHICH MUST BE REPORTED IN ACCORDANCE WITH CURRENT STANDING ORDERS.

4.3.5 MAINTAINING RECORDS ON VITAL EVENTS (BIRTHS AND DEATHS)

The reporting of births and deaths in villages is done by the village chowkidar, dais and other leaders of the community. As a health

worker who visits people in their homes you are in an advantageous position to know what events have taken place since your last visit. When you visit a home you must ask about births and deaths and keep a record if any have occurred since your last visit.

BIRTHS AND DEATHS MUST BE REPORTED TO THE HEALTH ASSISTANT (MALE) WHO WILL IN TURN REPORT THEM TO THE MEDICAL OFFICER (PRIMARY HEALTH CENTRE).

With regard to the registration of these vital events, it is your duty and responsibility to educate the community on the importance of registration. You must tell them that:

i. Birth registration is necessary so that the health workers can provide services to the newborn and at the same time look after the mother and advise her about her own health and how to look after her new baby.

ii. Death registration is necessary as part of the communicable diseases surveillance operationsand to find out other causes of death, particularly in infants and during pregnancy and childbirth. If the patient has not been seen by a doctor, the signs and symptoms preceding death must be recorded to give some idea of the possible cause of death.

AS PART OF YOUR EDUCATIONAL PROGRAMME, YOU MUST INFORM THE COMMUNITY WHERE BIRTHS AND DEATHS CAN BE REGISTERED.

4.3.6 MAINTAINING THE ELIGIBLE COUPLE REGISTER

The maintenance of the Eligible Couple Register is the most important information on which family planning services can be delivered The initial records are collected during the base-line survey and all consequent information is entered both in the Eligible Couple Register which is kept under the family planning programme, and the family folder, in which all information on the family is recorded.

YOU MUST COLLABORATE CLOSELY WITH THE HEALTH WORKER (FEMALE) IN COMPILING THE ELIGIBLE COUPLE REGISTER AND MAINTAINING IT UP TO DATE.

4.3.7 MAINTAINING IMMUNIZATION RECORDS:

Immunization of children is a very useful and efficient weapon for the control of communicable diseases. It is, therefore, important that all children should be protected with the necessary vaccinations. Wherever a special immunization card is available, this should be kept up to date, so that primary vaccination and booster doses are given in accordance with the schedules in use. The immunization status of each family member should also be recorded in the Household and Family Record (Annexure 4.1) and the Individual Health Cards in the family folder.

YOU MUST REFER TO THE IMMUNIZATION RECORDS PERIODICALLY TO KEEP YOURSELF INFORMED ABOUT THE DATES WHEN BOOSTER IMMUNIZATION IS DUE AND TO ENSURE THAT THE MOTHERS BRING THEIR CHILDREN TO BE IMMUNIZED IN TIME. IT IS YOUR DUTY TO INFORM THE MOTHERS OF THESE DATES ON YOUR HOME VISITS OR ON THE VISITS CARRIED OUT BY YOUR COLLEAGUE, THE HEALTH WORKER (FEMALE).

You will include information on immunizations given in your monthly report (see annexure 4.3).

4.3.8 MAINTAINING RECORDS OF THE DISTRIBUTION OF IRON AND FOLIC ACID AND VITAMIN A SOLUTION

Under the MCH programme you are required to maintain a record [illegible]

issued and in balance. You are also required to submit a monthly report which includes:

i. A statement of the beneficiaries of iron and folic acid;

ii. A statement of the beneficiaries of vitamin A solution;

iii. The position regarding the receipt, issue, and stock held of iron and folic acid;

iv. The position regarding the receipt, issue, and stock held of vitamine A solution.

Refer to sections 11.8.4 and 11.8.5 for details on these records and reports.

You will also include this information in your monthly report (see annexure 4.3).

4.3.9 MAINTAINING RECORDS OF OTHER ACTIVITIES:

The health authorities will want to know how much work you have done during the month, the number of blood slides you have taken, the type of ailments you have treated, the number of wells you have chlorinated, the educational activities you have organized, the number of home visits you have carried out, etc. Daily records of all your activities must, therefore, be kept in your diary and all this information will be compiled in your monthly report (see Monthly Report Form for Male and Female Health Workers, annexure 4.3).

YOU SHOULD PREPARE CHARTS AND GRAPHS SHOWING THE WORK BEING DONE IN THE VARIOUS FIELDS OF HEALTH SERVICES DELIVERY IN YOUR AREA. THESE CHARTS SHOULD BE DISPLAYED IN THE SUBCENTRE. THEY WILL SHOW AT A GLANCE HOW YOUR WORK HAS BEEN PROGRESSING AND WILL HELP IN SELF-EVALUATION OF YOUR ACTIVITIES.

You may display your maps and charts on the walls of the subcentre or you may prepare an album about 22 cm x 17 cm in which the maps and charts can be maintained. The important maps and charts which you should maintain are listed below:

A. Maps of each village in the area showing:

i. Numbered houses.
ii. Roads.
iii. Location of subcentre, panchayat ghar, police station, etc.
iv. Water points
v. Types of latrines.
vi. Houses with eligible couples
vii. Houses with children zero to five years.
viii. Location of depot holders of Nirodh.
ix. Location of dais (trained/untrained).

B. Bar diagram charts (yearwise and monthwise) indicating the following:

1. Immunization: Number of persons given

i. Smallpox vaccination (Primary/revaccination)
ii. BCG vaccination (2 doses)
iii. DPT vaccination (2 doses)
iv. Poliomyelitis vaccination (2 doses)
v. Tetanus toxoid (2 doses)

2. Malaria

i. Number of blood films taken
ii. Number of positive cases of malaria

HEALTH CO-OPERATIVE - A NEW STRATEGY IN THE DELIVERY OF COMPREHENSIVE HEALTH CARE - AN EXPERIMENT AT MALLUR

INTRODUCTION

Health facilities in rural areas in the country were provided through Primary Health Centres started as part of a national rural development scheme called 'Community Programmes' in 1952, with a very modest staff in each centre to form the nucleus of integrated health services and cater to the need of about 60,000 population in a Block. There are now over 5,200 Primary Health Centres, each Centre serving a population of 80,000 to 120,000.

For establishing an effective and viable Primary Health Care system, the co-operation of the local community must be ensured. In fact, the people should be adequately motivated, involved in decision making and actively participate in health programmes, so that ultimately it becomes their own "peoples programme". Local resources such as co-operatives, agriculture, manpower, buildings and most important of all local leadership, should be used to solve and finance the local health programmes. It is desirable that the Primary Health Care system should be a self-sufficient fiscal entity. Community priorities are more likely to be met if the people themselves raise and spend the resources required. A "Total health" approach is essential. Promotional, Preventive and Curative care need to be completely integrated.

THE MALLUR MILK CO-OPERATIVE (MMC)

Mallur is a village in Kolar District of Karnataka, situated 35 miles from the city of Bangalore. The Mallur Milk Cooperative (MMC) was an established concern with a sound and progressive leadership and had been functioning for many years. In addition to production and sale of milk, it provided other benefits like provision of fodder and cattle foods, tractor facilities and looms at low rates of interest.

Besides the people of Mallur, two other villages, Muthur and Kachahalli were members of the Co-operative and the total population covered was about 3,000. These villages had a silk farm co-operative besides cooperative dairying. The economic position was satisfactory, and, therefore, all conditions were favourable for the introduction of other self-supporting schemes.

The inspiration for establishment of a Comprehensive Health Care Programme for the Cooperative Members and their families of these villages, came from Sr Anne Cummins of Coordinating Agency for Health Planning (CAHP) and Fr Jonas of the Catholic Bishops Conference of India (CBCI). With these pioneers, the Dean and the Department of Preventive and Social Medicine of St John's Medical College, representatives of the Karnataka Government and Bangalore Government Dairy with leaders of the Mallur Milk Cooperative, worked out a scheme for tagging on a health service to the existing MMC.

The main objectives of the Mallur Health Project were:

(a) to study and devise methods by which the financial base needed for effective health services could emerge from the people themselves in a self-sustaining manner;

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(b) to help in the establishment of rural health centres with the staff and rendering of effective health services to a wide circle of needy people without distinction of race, caste or creed;

(c) to study the required strategy and methodology for the effective rendering of primary health care in rural areas by trying to determine the priority areas in health care and devising the structure found suitable to village conditions;

(d) to help in those developmental activities which are very necessary to ensure effective rendering of health services in rural areas; and

(e) to train intern doctors, nurses and other medical and para-medical staff for the purpose of rendering assistance in rural areas.

The St John's Medical College and its Department of Preventive and Social Medicine were to be mainly concerned in acting as a catalytic agency, in the formation of a self-sustaining rural community health scheme, fulfilling the above objectives.

It was estimated that a monthly budget of Rs.2,500-3,000/- would be required for running the Health Cooperative and financial support was forthcoming by a joint contribution of 3 paise per litre from the MMC and Bangalore Dairy, in a phased formula as shown in Table I below. Ultimately the MMC was to completely finance the scheme.

Table I (Contributions to the Health Co-operative)

Year	Contributions/litre	
	Milk Co-operative	Bangalore Dairy
1st	1 p.	2 p.
2nd	2 p.	1 p.
3rd	3 p.	nil

This budget was adequate to support a health programme, organised by a Medical Officer, Nurse, Compounder and an Ayah. The staff were appointed by the Health Co-operative Committee.

The Health Co-operative Committee included the following members:

Chairman, MMC
Secretary, MMC
Dean, St John's Medical College, Bangalore
Head of the Dept of Preventive and Social Medicine, St John's Medical College, Bangalore
Director/General Manager, Bangalore Dairy
Representative of State Health Service
Medical Officer, Mallur Health Cooperative (Secretary)

The composition ensured integrated planning between the MMC and Health Co-operative.

The Health Cooperative got off to a good start by being inaugurated on 19 March 1973 by the Minister of Animal Husbandry. Dr VK Rajkumar, a Senior House Officer in St Martha's Hospital, joined as Resident Medical Officer in charge of the Co-operative.

The Health Cooperative, in November 1973, was joined by another dedicated worker, Maria, an Italian Public Health Nurse. She with her companion Cathy, a Volunteer from Canada, looked after the Maternal and Child Health Work.

Within five months of starting the project (August 1973), the cost of fodder went up and milk production of the Milk Cooperative fell as some members began to sell out on higher rates. The MMC took a decision, much to the discomfiture of the Government Dairy Authorities, to sell directly to private parties in Bangalore, who offered better prices. The Government Dairy, therefore, stopped its contribution of 2 paise per litre as health subsidy, and the Health Co-operative was in a critical situation. It is at this stage, a momentous decision was taken by the responsible village leaders who were more than convinced of the positive role of the Health Centre and its staff in improving the health status of the people in Mallur and other villages. The Milk Cooperative was doing well and decided to contribute 5 paise per litre for health and took over financial responsibility for running the Health Centre. This financial strategy on the part of village leaders resulted in the Project becoming a viable unit. The Milk Cooperative has borne the entire recurring costs of the health project ever since. Receipts/Payments position for the period 1975-76 is appended (Table II).

Although the Mallur Health Project is mainly financed by the Mallur Milk Cooperative, it also receives help and technical direction from St John's Medical College and the Government Health Service. These inputs are shown in Table III.

Table III

Source	Capital	Recurring
1. Mallur Milk Cooperative	Buildings, Furniture, Refrigerator, Health Education Materials	Salaries, Rents/Electricity, Drugs, General Stores, Petrol
2. St. John's Medical College	Physicians and Midwifery Kit, Minor Surgical Equipment, Lab Equipment Motor Cycle (on loan through UNICEF)	Interns services Specialist Services Rent and electrical charges for interns quarters
3. Government Health Service	Nil	Vaccines, Vit. A., Iron, Folic acid supplementary FP Devices, Surveillance of Communicable Diseases (through PHC Sidlaghatta) Health Education Films (through Health Education Departmentof DHS)

SERVICES RENDERED THROUGH COMMUNITY PARTICIPATION

The St John's Medical College adopted this Health Cooperative as a rural training centre for interns. Visits by specialists of other departments including specialist camps were organized. At present, 4 interns are attached at any one time for whom residential accommodation has been provided by the MMC on a rental basis. The interns conduct base line demographic surveys, immunization and school health programmes, special health projects and mass health education programmes.

The Health Cooperative Committee meets at Mallur periodically to discuss progress and plan for the future.

Dr Rajkumar after a dedicated service of nearly 4 years resigned from his post and Dr Kiriti Keshavan has taken over from 15 June 1977.

The Health Team comprising of Dr Kiriti, his staff and interns under the technical supervision of Department of Preventive and Social Medicine, St John's Medical College, has made good contact with the villagers and a comprehensive health care programme has been introduced. The community of Mallur and other member villages actively participate in all programme. They have no unreasonable expectations or demands, as the health project is their own programme brought about through their own contributions. This is a basic difference between Health Centre organised through Cooperatives and Governmental Agencies. The leaders are actively involved in the planning and organization as the Chairman, MMC is the Chairman of the Health Cooperative Committee and the Secretary, MMC its member. Paramedical workers are drawn from the village community and trained for Community Health work. The Young Farmers Association actively assists in any of the health programmes. They help interns in their survey programmes of immunizations and environmental sanitation including chlorination of wells and construction of sanitary latrines. They also organise the physical arrangements for the Mass Health Education Programmes. The Mahila Mandal runs a nursery school and acts as a forum where health education, applied nutrition programmes are undertaken.

The Health Team and interns organise the following services with community participation.

PERSONAL SERVICES

1. Curative Clinic (daily out-patients)
2. Maternity and Child Health Services:

   i. antental care; ii. midwifery (domiciliary)
   iii. postnatal care; iv. under five clinics (domiciliary)

3. School health services for village schools
4. Immunization programmes for smallpox, triple antigen, tetanus toxoid, BCG, typhoid and oral polio
5. TB and Leprosy case detection, treatment and follow up.
6. Motivation for family planning
7. Specialist Camps at Mallur (monthly visits by Specialists from St Martha's Hospital, Bangalore)
8. Hospital Referrals
9. Family record maintenance

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COMMUNITY SERVICES

1. Protection of well water by chlorination
2. Popularisation and construction of sanitary latrines and soakage pits and other advise on environmental sanitation
3. Collection of health data through periodical surveys
4. Coordination and cooperation with government health personnel in National Health Programme activities
5. Health education at personal, group and village levels
6. Nutrition education and nutrition supplementation programmes

Members of the Milk Cooperative and their families are entitled to all the above mentioned services free of cost. Non-members coming from other surrounding villages pay for drugs/dressings and minor surgery. All preventive and promotive work are given free to all categories. Table IV below shows the percentage of member and non-member families in each village.

Table IV (Percentage of member and non-member families in each village)

Village	Families		
	Member	Non-member	Total
Mallur	188	202	390
Muthur	63	124	187
Kachahalli	30	21	51
Bhatrenahalli	17	14	31
Harlurnaganahalli	6	18	24
	304	379	683
	45%	55.5%	

CONCLUSION

Our experience over the last two and half years have shown that

i) A health function can be grafted on to an economic cooperative

ii) A sound cooperative such as MMC can support substantially the recurring costs of a health programme

iii) Tagging on of a health function to a cooperative, benefits not only the members and their families but also the non-members who get indirect benefits of professional services, preventive and promotive programmes.

The Department of Preventive and Social Medicine and its staff, was mainly concerned in acting as a catalytic agent, in the formation of a self sustaining rural community health scheme. An experiment was embarked upon and the Mallur Project is this experiment. A Total Health Care Programme can be effectively delivered through

.....6

a Cooperative in rural areas.

The Mallur Milk Cooperative is even contemplating construction of a 15 bedded hospital at Mallur, with the help of Government and its own funds. We are convinced of the responsible role of Village Leaders in such a programme.

Further, the Health Centre with its working philosophy has indirectly helped the Department of Preventive and Social Medicine to conceptualise a primary health care system for training of future physicians, so that they play their rightful role in a contemporary society.

The Health Team and interns have played an important role in the development of the village in general and health aspects in particular. We are fully aware that in the planning of such self-supporting programmes, the Health Team has to be actively supported by other members who will attend to the social and economic development problems of the community. Success or failure would depend on tackling the financial side efficiently.

A drive to improve the education of the people including health education, is to be attempted through use of Village Level Workers. Their training programme is being organised. Whether there has been an improvement in the morbidity and mortality statistics at Mallur, subsequent to the introduction of these cooperatives in comparison with other areas in the vicinity, needs study and this has been taken up as a health project.

The question of introducing such self-sustaining Cooperative Schemes to other areas should receive active consideration. Challenges have to be met in rural India and we hope that with the cooperation and participation that is readily forthcoming from the simple rural folk, our economic and health projects will meet with success.

//////////

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1. What is Rational Drug Therapy
2. Drug Colonialism.
3. Why are Essential drugs essential
4. De branding society.
5. Hard sell and the Bad buy
6. Drinking to whose Health
7. An enhancing Vitamin
8. Tonics
9. Common cold war.
10. Bulk purchasing.
11. Healing without drugs
12. Traditional Medicines: Where are they
13. Case for Compounders Course
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15. Homeopathic medicines
16. VHAI's role in the Drugs issue.

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a) Govt - Drug policy

b) Voluntary organisat.

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a) GK Project - Bangladesh

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d) Bangarpet Mission Tablet Industry

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"THE GREATEST DANGER TO HEALTH IN INDIA IS THE OVER MEDICALISING OF OUR HEALTH CARE SYSTEM. ETERNAL VIGILANCE IS REQUIRED THAT THE DOCTOR-DRUG PRODUCER AXIS DOES NOT EXPLOIT THE PEOPLE AND THAT THE 'ABUNDANCE' OF DRUGS DOES NOT BECOME A VESTED INTEREST IN ILL HEALTH"

MULTIPLE DRUGS COMBINATIONS OFTEN CONTAINING DRUGS, PARTICULARLY VITAMINS, IN AMOUNTS FAR IN EXCESS OF WHAT IS REQUIRED ARE PRESENTLY MARKETED IN INDIA. THERE IS A COLOSSAL NATIONAL WASTAGE OF DRUGS BECAUSE OF SUCH COMBINATIONS.

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Date : .....

Alternative Drug Policy

Resource

1. Philosophy & Spiritual Testament of VHAI
2. Alternative Drug Policy - (ICMR/ICSSR)
3. Drug Policy (1978)
4. Pattern of Drug production in India
5. Price Control
6. Essential drug list
7. Prerequisites for Health for all by 2000
8. Drugs in India
9. Research
10. Primary Health Care Priorities
11. Alternate drug policy - Components
12. " for Hospital
13. " for Medical practitioner
14. While prescribing what to ask oneself

The Philosophy of VHAI

"We begin with the community. Our goal is a healthy community. Our aim is to maintain the health of the community".....

We promote Social Justice in the provision and distribution of Health Care.....

We know enough already to provide all citizens with simple health care.....

If the poor do not have health, it is not because we do not have sufficient knowledge. It is because we as the organised people of India lack the will.

Our old Health Services have been built to favour the educated, the privileged and the powerful.

We wish all goods and Services to be more equally shared with the whole community.

The world community joins us to proclaim:

Health Care for all by the Year 2000 A.D

The Spiritual Testament of VHAI

"From the beginning our principle has been to Emphasize areas of agreement and de-emphasise areas of controversy. People are not merely individuals. All of us are also social, political economic and religious ....."

Alternate Drug Policy ?

- There is need For a clear cut drug policy and a National Drug Agency to implement it.
- The pattern of drug production should be oriented to the disease pattern, with an emphasis on the production of essential and basic drugs (especially those needed by the poor and underprivileged groups) which should be produced in adequate quantities and sold at cheapest possible prices
- The domination of the foriegn section in drug production should

be reduced further and price control made more effective by reducing overheads and packaging costs and adoption of generic names.

- There should be strict quality control, supply of adequate drugs to the rural sector and a move in the direction to make the clients pay for the cost of drugs.

Recommendations of
Study Group of ICSSR/ICMR
on
Health for All - an Alternative
Strategy

Date : 5

In 1978

Drug Policy of Govt of India (1978) was clearly laid out finally

Broad Objectives:

a) To develop self reliance in drug technology;

b) To provide a leadership role to the public sector;

c) To aim at quick self sufficiency in the output of drugs and to reduce the quantum of imports;

d) To foster and encourage the growth of the Indian sector;

e) To ensure that drugs are available in abundance in the country to meet the health needs of our people;

f) To keep a careful watch on

the quality of production and prevent adulteration and malpractices

—

Date : 6

Pattern of Drug Production (India)

What drugs are produced and for whom ?

- There is now an overproduction of drugs (often very costly) meant for the rich and well to do while the drugs needed by the poor people (and these must be cheap) are not adequately available. This skewed pattern of drug production is in keeping with our inequitous social structure which skews the production of luxury goods for the rich at the cost of the basic needs of the poor.

• Drug industry in India is an offshoot of development of the industry in the western world . . . .

Drug Industry in India is in private hands which produces mainly for profit . . . .

These two factors result in a situation where the drugs required by the poor are not produced on the main ground that there is no profitable market and adequate demand for them, while the country continues to be flooded by a plethora of costly and wasteful drugs meant for the minor illnesses of the rich and well to do?

For instance

Production of INH for Tuberculosis and of Dapsone for leprosy is only one third and one fifth respectively of minimal requirement.

On the hand, Tonics and vitamins, most of which are alcoholic preparations and "spirit" money are produced in wasteful abundance . . .

ICMR/ICSSR Study

National Committee on Science and Technology

Task Force (Planning Commission)

Total Production of Rs 700 Crores (1976

25% Vitamins, tonics, health restoratives and enzyme digestants

20% Antibiotics

1·3% Sulphonamides

1·4% anti tuberculosis drugs

One of the most distressing aspects of the present health situation in India is the habit of doctors to over prescribe or to prescribe glamorous and costly drugs with limited medical potential. It is also unfortunate that the drug producers always try to push doctors into using their products by all means fair or foul. .....

If the medical profession could be made to be more discriminating in its prescribing habits, there would be no market for irrational and unnecessary medicines."

4

Drug Production

ICMR/ICSSR Recommendations

- The small scale sector needs to be encouraged, subject to strict quality control.
- It would be desirable to introduce the cooperative sector.
- Drug production by village communities for their own use (e.g through cultivation of herbs) should be encouraged

—

Date : 10

Price control

ICMR/ICSSR Recommendations

- Packaging increases the cost of drugs very greatly because the trend is to make it attractive and highly elegant and to add cosmetic embellishments to promote sales. This should be discouraged.
- Packaging should ensure undamaged transit, freedom from impurity or adulteration, and prevention of deterioration by exposure to ambient temperature and moisture. All these conditions can be fulfilled with excessively increasing the cost. It should also be possible to supply drugs to hospitals etc in bulk packages to reduce cost.

- Drugs banned in other countries should not be allowed in India.
- It is important to ensure that the prices of essential drugs are kept down to the extent possible.
- A list of essential drugs should therefore be drawn up.
- All essential drugs should go generic.
- The proliferation of drugs by minor variations in composition should be totally discouraged.

—

Date : 11

"In an urban hospital, for instance, the drug cost is Rs 6 per patient per year while in a PHC, it is about 40 paise per patient per year"

If all essential drugs are made available at reasonable prices, health care costs will fall further.

It may therefore be an advantage to move in the direction of a partial support system under which all patients bear at least the cost of drugs, which they are generally willing to do.

"

While the supply of drugs should be adequate, eternal vigilance is required to ensure that the health care system does not get medicalised, that the doctor-drug producer axis does not exploit the people, and that the 'abundance' of drugs does not become a vested interest in ill health"

KMR/ICSSR Study

Date : 13

Essential drugs Needed at the Community Level

- Aspirin
- Chloroquin
- Sulphonamides
- Streptomycin
- Penicillin
- Isoniazid
- Thiacetazone
- Dapsone
- Piperazine
- Mebendazole
- Diiodohydroxy-quinoline
- Mekronidazole
- Ferrous Sulphate
- Vitamin A
- Vitamin B Complex
- Thiocarbamazine
- Sulphur Ointment
- Oral Rehydration salt

– ICMR/ICSSR study

The attainment of this goal depends, above all on three things: (1) the extent to which it is possible to reduce poverty and inequality and to spread education;

(2) the extent to which it will be possible to organise the poor and underprivileged groups so that they are able to fight for their basic rights; and

(3) the extent to which we are able to move away from the counter productive, consumerist western model of Health care and to replace it by the alternative model based in the community

These are our tasks and it needs millions of young men and women, both within and without the health sector, to work for them. If a mass movement for this purpose can be organised and the people rededicate themselves to the realisation of their national goals, the country will be able to keep its tryst with destiny at least by AD 2000.

Date : 15

Drugs in India

- 15000 branded drugs are on sale in India. But a government committee believes health needs would be met by only 116 drugs.

- In India, 60 firms with foreign shares accounted for 70% of the country's total drug sales in 1973-74. The remaining 30% was shared by 116 large and 2500 small manufacturing companies.

- In India the consumption of modern drugs in 1973 was only 6 rupees per person, and only 20% of the population used them. This is despite the fact that India has the most sophisticated drug industry in the Third World.

- The prices of many drugs sold by western drug companies to developing countries like India are often higher than the prices at which they are sold at home. e.g Britain paid US firms $2.40 per kg of Vitamin C in 1973, India had to pay nearly $10.

Tetracycline antibiotics which cost $24-30- in Europe, were being sold to India for $100-270.

- In India foreign drug companies have usually shown the highest profits of any foreign manufacturers.

Finally

Date : 19

or VHAI

A National drug policy should first and foremost be linked to a health strategy which meets the real health needs of the people -

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

Any attempt to move towards a rational drug policy is likely to be opposed by the local medical establishment and the international drug & medical equipment industry

But this is an eventuality that has to be met by an organised effort because of our commitment to a "Health for All goal.

From the points that I have covered the various possible components of an Alternative Drug policy being put up to you for consideration today are.

Date : 20

Alternative drug Policy

Basic drugs list

—

● Generic prescribing

—

Bulk purchasing

—

Local formulation and Manufacture.

—

Alternative Technology

—

● Indigenous Drugs

Taken separately each policy is a powerful weapon for change. Taken together they build into integrated strategy which could alter the world Pharmaceuticals scene

Date :

Alternative drug Prescribing Policy for the Medical Profession

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

1. Accepting an essential and basic drug list for our practice.
2. Accepting generic prescribing.

3. Accepting cost as an important criteria for selection of remedy in addition to safety, efficacy and quality

4. Discouraging prescription of drugs - whose only additional advertised value are
   - cosmetic embellishments
   - attractive / highly elegant packing.
   - inadequate evidence of greater value
   - irrational combinations
   - unitative drug

5. Promoting barefoot pharmacy - preparation in clinic

6. Not accepting Physicians samples and other monetary or material

Date :

inducement which corrupts us and make us promote a company products.

We must prescribe because we think a product is the best suited for a condition not because the company gave us the maximum material advantage. We are leaders not drug pushers.

7. Issues in selection

Indian instead of foreign

Govt instead of Pvt

Small scale instead of large scale

Cooperative rather than corporate

Bulk purchase rather than branded

(8) Promote Priorities of Primary Health Care

Mothers milk before powdered baby foods mixed with dirty waters

Food before vitamin pills

clean water before antibiotics

Vaccination before vitamin pills

Local herbal remedies before latest branded drugs from international pharmaceutical company

9. Check out all new products for - prover

(8) Promoting use of locally tested and researched indigenous medicines

(9) Promoting use of well researched Non drug therapies

DIED :- of Inf. Hepatitis.

Z-9

CASE RECORD

Analysed by : Technical Guidance Cell of the German Leprosy Relief Association

1. Patient's Name (In Block L tters) : PARVATHAMMA

2. Father's Name :

3. Permanent Native Addrsss : Hubli, Karnataka

4. Case Summary : 40 year old lady with loss of fingers, contracture of legs, ~~and~~ foot drop and ulcers in the sole of the foot - 10 years duration. - Tuberculoid.

5. Physical Assessment :

Classification -Bacteriology

Deformity	R	L
E	–	–
H	+	+
F	+	+

Ulcers	R	L
F	+	+
H	–	–

6. Educational History :

NIL.

Dubizade

7. Vocational History : Beggar

8. Family & Contacts :

Male	Mc	Female	Fc	Total
1	1	1	1	2

Particulars of Children

Nil.

Total No. of Dependants

9. The Problem :

10. Whether new type of work preferred? If so, details of work :

COMPREHENSIVE RURAL HEALTH PROJECT, JAMKHED

STANDING ORDERS

Jan. 1972

UNDER-FIVES

I. A. DIARRHOEA

Signs and Symptoms: Loose bowel movements, more than three times, with or without fever. May be present with cold, ear infection, etc.

Treatment:
1. Advise plenty of fluids, sugar water with a pinch of salt.
2. Pectokab, 1 tsp. with every stool.
3. Sulphamezathine
4. Baby aspirin for fever p.r.n.

B. DEHYDRATION

Causes: Diarrhoea , vomiting or fever

Signs and Symptoms:

ASSESSMENT OF DEHYDRATION BY FIVE CLINICAL SIGNS

	Appearance	Skin	Anterior	Eyes	Mouth
MILD	Fretful	Elasticity Normal or slightly reduced	Fontanelle Normal or slightly depressed	Normal or slightly sunken	Dry, red
MODER--ATE	Restless	Moderately Impaired	Moderately sunken	Sunken	Very dry, slight cyanosis
SEVERE	Semi-coma	Severely Impaired	Deeply sunken	Deeply sunken 'staring'	Very dry cyanosed

Note: Do not rely on skin elasticity in the presence of malnutrition

Treatment: Fluid replacement

1. Fluid requirement first 24 hours
   Mild dehydration - 90 cc/lb body weight
   Moderate dehydration - 110 cc/lb body weight

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Severe dehydration: refer immediately to Jamkhed clinic after giving initial 100 cc. subcutaneous saline.

2. Treat cause of dehydration

II. FEVER

Causes

A. UPPER RESPIRATORY INFECTION

Signs and Symptoms: Fever, running nose, cough and sometimes vomiting.

Treatment:
1. Baby aspirin
2. Sulphamezathine
3. Cough sedative
4. Plenty of fluids and normal diet.

B. EAR INFECTION

Signs and Symptoms: May be as above with ear ache, ear discharge, eardrums red and tender.

Treatment:
1. As above
2. Local treatment: a) Antibiotic eardrops
   b) Hydrogen Peroxide (H_2O_2)

III. PNEUMONIA

Signs and Symptoms: Patient looks sick, rapid respiration with alaenasi working, chest pain, high fever, cough. May be restless. Rales heard and poor air entry.

Treatment:
1. Plenty of fluids
2. Normal diet
3. Aspirin
4. Antibiotics-Procaine Pencillin, 4 lakhs
5. Refer to hospital

IV. MEASLES

Signs and Symptoms: Cough, fever, redness of eyes, running nose rash appears (4th day), on face, trunk, extre--mities, irregular, maculo-popular.

Treatment:
1. Plenty of fluids and food, normal diet.
2. Aspirin
3. Antibiotics to prevent complications, such as otitis, pneumonia, diarrhoea- Sulphamezthine.

V. PERTUSSIS

Signs and Symptoms: Persistent cough, often with whoop, fever, running nose, and red eyes.

Treatment:
1. Chloromycetin
2. Phenobarb
3. Cough sedative,
4. Aspirin
5. Adequate fluids and frequent small feeds.

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VI. FEBRILE CONVULSIONS

Signs and Symptoms: Fever due to any cause and convulsions involving one or more extremities.

Treatment:

1. Give paraldehyde, 1 cc per year of age, I.M.
2. Cold sponging and aspirin
3. Phenobarbitone
4. Treat cause of fever
5. Refer to hospital

VII. ROUND WORMS

Treatment:

1. For children up to 5 years, piperazine liquid , 1 tsp. t.i.d. x 2 days

   For children 5 years to 12 years, Piperazine ii t.i.d. x 2 days.

VIII. IMPETIGO

Signs and Symptoms: Repeated boils

Treatment:

1. Inject pecaine penicillin , 4 lakhs, I.M.
2. Sulph.ozathine
3. G.V. Ointment
4. Advise to wash and scrub with soap and water.

IX. SCABIES

Treatment:

1. Benzyl benzoate for external use
2. Wash and boil clothes and dry in sun.

X. SORE EYES

Treatment:

1. Apply penicillin eye ointment

XI. TRACHOMA

Signs and Symptoms: Small granules in eye lids (patient complains of sand in eyes.)

Treatment:

Sulphacetamide drops to eyes

ADULTS

I. FLU, UPPER RESPIRATORY INFECTION

Signs and Symptoms: Headache, feeling weak, cough and fever, 1-4 days

Treatment:

1. Plenty of fluids
2. Normal diet
3. Aspirin
4. Inject Novalgin, 2 cc I.M., if necessary.

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II. PNEUMONIA

Signs and Symptoms: Fever, cough, chest pain, shortness of breath rapid breathing, alaenasi working. Rales heard over one or both sides of chest.

Treatment:

1. Inject Terramycin, 250 mgm. I.M.
2. LAS i.q.o.d. x 1 day
3. Aspirin ii t.i.d. x 1 day
4. Cough sedative i.t.i.d. x 1 day
5. Advise hospitalisation or consultation with doctors
6. Plenty of fluids and normal diet.

III. TYPHOID

Signs and Symptoms: Fever, body ache, coated tongue, patient looks sick, Cough, diarrhoea or comstipation, abdominal distension.

Treatment:

1. Chloromycetin ii tablets q.i.d.
2. B.Complex
3. High protein diet with plenty of fluids
4. Advise hospitalisation

IV. PEPTIC ULCER DISEASE

Signs and Symptoms: Apigastric pain, acid eructations, pain increased after hot food or on empty stomach

Treatment:

1. Magnesium trisilicate t.i.d.
2. Belladonna tab i t.i.d.
3. Advise small, frequent food
4. B1 and diet.

V. DIARRHOEA AND VOMITING

Signs and Symptoms: Loose bowel movements and abdominal pain. Abdomen soft, generalised tenderness but no gourding.

Treatment:

1. Diarrhoea tab ii t.i.d. x 1 day
2. Sulphamezathine ii t.i.d. x 2 days
3. Plenty of fluids
4. Diligan i p.r.n. for vomiting
5. If severe, start I.V. fluids.

VI. ARTHRITIS

Signs and Symptoms: Joint pains in one or more joints

Treatment:

1. Aspirin ii t.i.d. 3 days
2. Methyl salicylate for external use
3. If having extreme pain, inject Butazolidine 3 cc, deep I.M.
4. Advise consultation with doctor.

.....5/

VII. RHEUMATIC FEVER

Signs and Symptoms: Fever, fleeting joint pains, pains mainly of large joints. Very tender and swollen. Rapid pulse. History of previous attack often present. Ask for history of suggest--ive of heart disease, such as chest pain, shortness of breath, cough.

Treatment:

1. Aspirin ii t.i.d.
2. Bedrest
3. Las i.q.o.d.
4. Inject Butazolidine, 1 amp I.M., if necessary
5. Advise consultation with doctor.

VIII. BRONCHIAL ASTHMA

Signs and Symptoms: Repeated attacks of difficulty in breathing wheezing, cough and mucoid sputum, prolonged expiration with generalised rhonchi.

Acute attack treatment:

1. Inject Adrenaline ½ cc subcutaneously
2. Aminophylline 1 t.i.d.
3. PET i h.s. q.o.d.

Chronic treatment:

1. Aminopgylline i t.i.d.
2. PET i h.s. q.o.d.

ANTENATAL CARE

Complete obstetrical history

Danger signs needing hospital referral.

1. Anaemia, hemoglobin below 9 grams.
2. Bleeding after previous delivery or during this delivery
3. Any baby born dead or after difficult delivery forcepts or caesarian
4. Swelling of hands or face
5. Diastolic blood pressure over 90 mm Hg
6. Breathlessness with heart murum or cough or sputum for 1 month.

I. REGULAR ANTENATAL CARE

1. Two doses of Tetanus Toxoid during pregnancy
2. Fersolate i daily
3. Calcium gluconate i daily
4. B Complex i daily
5. Family Planning advice should be given at each ANC visit

.....6/

II. TOXAEMIA OF PREGNANCY

Signs and Symptoms: Any two of the following present:

1. Albuminuria
2. High blood pressure, diastolic above 90 mm Hg.
3. Swelling of face or extremities

Treatment:

1. Advise low salt diet
2. Diuril iron alternate days
3. Rest
4. Advise consultation with doctor. Warn patient about dangers of eclampsia.

III. VOMITING OF PREGNANCY

Treatment:

1. Diligan i p.r.n.
2. Vitamin B_2 i daily
3. ANC pack

If persistent and uncontrollable, consult with doctor.

IV. ANEMIA OF PREGNANCY

Treatment:

1. Folic acid i b.i.d.

If hemoglobin below 9 grams, refer to hospital

TUBERCULOSIS

Signs and Symptoms: Fever, especially in the evening, loss of appetite, loss of weight, cough of more than two weeks duration, hemoptysis. Two confirm diagnosis:

1. collect sputum for AFB x 3
2. advise chest X-Ray and screening.

Treatment:

1. Streptomicin
2. Isozone Forte
3. Multivitamin
4. Cough sedative
5. Good nutrition, no diet restriction
6. Advise patient to cover mouth while coughing.

Contacts:

(a) Treat all contacts with INH
(1) Adults - 300 mgm. daily
(2) 5-12 years - 200 mgm. daily
(3) 2-5 years - 100 mgm. daily
(4) below 2 years - 50 mgm. daily.

(b) Advise chest screening of all contacts.

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LEPROSY

Signs and Symptoms: Anaesthetic patches, thickened, greater auricular, ulna and lateral popliteal nerves, Loss of sensation in hands and feet and motor weakness of fingers. Loss of eye brows, thickening of skin, especially ear lobes. Trophic ulcers. Take skin clip for AFB.

Treatment:

1. D.D.S. dosage schedule:

   (1) 5 mgm. twice a week x 4 weeks
   (2) 10 mgm. twice a week x 4 weeks
   (3) 20 mgm. a week x 4 weeks
   (4) 25 mgm. a week x 4 weeks
   (5) 25 mgm. a 4 times a week x 4 weeks
   (6) 25 mgm. 6 times x 4 weeks
   (7) 50 mgm. times a week x 8 weeks
   (8) 100 mgm. 6 times a week

2. Examine eyes for corneal ulceration and give sulphacetamide drops

3. Trophic ulcers should be taken care of with acriflavine dressing, penicillin ointment, magnesium sulphate soaks.

4. Glycerin for dry nadal mucous membranes.

Treatment for D.D.S. reactions (in order):

1. Rest, Aspirin
2. Chloroquine i t.i.d. x 3 days
3. Lamprene i on alternate days, increasing to i daily, if necessary.
4. Precin.

Contacts: Treat all contacts of lepromatous and indeterminate cases with D.D.S.

DRUG REACTION

Drug reaction may be mild, moderate, or severe.

I. Mild reaction: Such as urticaria and drug rash may occur immediately to one week after drug has been started.

Treatment:

1. Stop the drug causing reaction.
2. Benadryl, 50 mgm. t.i.d. or q.i.d.

II. Moderate reaction: Occuring within few hours of intake of drug, urticaria, vomiting, diarrhoea, dizziness, fall in blood pressure.

Treatment:

1. Inject Synopen 1 amp I.M.
2. Inject Adrenaline 1cc, if necessary
3. Benadryl 50 mgm. t.i.d. or q.i.d.
4. If hypotensive, intravenous fluids be started.

.....8/

III. Severe reaction : (anaphylactic shock), immediate shock like and frequently fatal reactions which occur within minutes of administration of drugs. Three syndromes of anaphlyaxis may be recognised:

1. Laryngeal edema
2. Bronchospasm and
3. Vascular collapse

Signs and Symptoms: Apprehension, paraesthesia, generalised urticaria, choking, sensation, cyanosis, wheezing cough, incontinence, shock, fever, dilatation of pupils, loss of consciousness and convulsions, death may occur within 5-10 minutes. Therefore, treatment must be available wherever injections are given.

Treatment:

1. Adrenaline 1 cc I.M. immediately
2. Place patient in shock position.
3. Maintain adequate airway
4. Inject Synopen 1 amp I.M.
5. If patient has not responded to adrenaline, give Betnesol I.V. 2 amp.
6. For hypotension, start intraennous fluids with noradrenaline 4 mgm. in 1 litre of saline
7. 02 (Oxygen)
8. For bronchospasm (wheezing), give aminophylline I.V. slowly.

REFERENCE TABLE

DRUG DOSAGE IN CHILDREN

	0-6 mos	over 6 mos - 1 year	1-4 years	4-10 years
Baby Aspirin	½ tab t.i.d.	1 tab t.i.d.	2 tabs t.i.d.	Adult ASA t.i.d.
Sulphamezathine	½ tab t.i.d.	1 tab t.i.d.	1 tab t.i.d.	1 tab q.i.d.
Phenobarbitone	5 Mgm. t.i.d.	7½ mgm. t.i.d.	10 mgm. t.i.d.	15 mgm. t.i.d.
Chloromycetin	100 mgm. t.i.d.	200 mgm. t.i.d.	250 mgm. t.i.d.	250 mgm. q.i.d.
Paraldehyde	1 cc per year of age			
Streptomycin	200 mgm. per day	400 mgm. per day	½ gram per day	½ gram per day
INH	50 mgm per day	50 mgm. per day	100 mgm. per day	200 mgm. per day.

COMPREHENSIVE RURAL HEALTH PROJECT, JAMKHED.

COMMUNITY PARTICIPATION IN A COMMUNITY HEALTH PROGRAMME.

R. S. AROLE, M.B.B.S., M.P.H.

A medical programme aimed at the community must have community support for its success. We therefore need to realize we are not only working for the community, but also must work with the community. We must convince ourselves of this reality and find ways and means of getting the community involved in the health programmes. Since about 80 per cent of our population lives in the rural areas and since only about 20 per cent of the nation's resources and efforts reach these villages, I am mainly concerned with the practice of community medicine in rural areas.

For a whole-hearted participation of the community in the health programme, it is essential that the community is involved not only in the implementation of the programme, but also in decision making. The community must be convinced that a certain programme we want to introduce is really necessary. The community must first decide and we should make ourselves available to help in its implementation. Our role as health workers then is to be activators and to be their guide in decision making.

It is possible that the community is unaware of its health needs. It may be necessary for us to draw their attention to these needs; but, we must resist the temptation to force anything on them. We often discharge a child cured from diphtheria or tetanus from the health centre. The health team accompanies the child and the parents to their village. The parents or relatives gather the villagers and tell the story of the child's recovery. Here is an opportunity to explain to the villagers that the family need not have suffered financially and the child need not have undergone the ordeal of illness and hospitalization had he been immunized against the disease. We then offer our services to the villagers to get all children immunized to avert a similar problem. The result might be that the community makes a decision to invite us to give immunizations. This way and by other methods, we generate a need. However, we do not take action until the community takes the decision and participates in collecting children (80 per cent of the total under five population must be immunized) and helping our team in their work. It has been possible for us to immunize 12,000 children in 30 surrounding villages in the past 2 years by this type of co-operation.

Apart from generating need, we can also begin with a felt need of the community. In this context we must understand that their priorities may be different from ours. Continued exposure to sick people in the hospital distorts our outlook to the community. We get so disease-oriented that we forget that large numbers of people are healthy and only a few are not well. The priorities of the community may not even be related to their health. Their felt need may not be related to health. Considerable time should be spent with the community to find out their felt needs and we should use our ingenuity in translating their needs into health programmes. When we began our work in Jamkhed2 years ago, the area was facing famine. The felt needs were food and water supply. Through these felt needs, we were able to focus the attention of the community on the problem of nutrition of children under five years. We were able to organize under-five clinics in 15 different villages. One of the components of the under-five clinics is supplementary feeding. We find raw materials from various agencies and the community takes responsibility for supplying fuel, sweeteners, and the personnel to cook and distribute the food,

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and to keep records. Three thousand children are caredfor in these villages with the help of volunteers. Similarly, the felt need for water supply was translated into getting an agency to dig community wells for 5 villages. As a result the community set apart 2-3 acres of land in each village to grow appropriate crops for mothers and children of the village.

A reasonable felt need of a community is to have someone to take care of emergencies and of day to day minor illnesses. Since health personnel are not always available to meet their needs, the community participates in solving this problem. One or two interested people are chosen by the community. We give them training in treating minor illnesses and in following up children with fever and diarrhoea and pregnant mothers. They also get training in health education. In one village, our nurse after regular visits to it for one month could register 5 women for antenatal care and could get 5 women for tubectomy. An illiterate village worker after training convinced over 30 women for regular antenatal care and brought 25 women for tubectomy in a period of only two weeks. Out of 55 villages in our area only four villages have a qualified physician leaving 51 villages without a doctor. In the absence of a qualified physician, someone in the village usually practises medicine. From the villagers point of view, he fulfils the important function of giving cheap symptomatic relief from minor illness and gives moral support during illness. Since these indigenous practitioners enjoy respect and confidence of the community, we need to get this segment of the community involved in our programmes. If not, they can effectively obstruct a good programme. If we understand the services they can give to the community and refrain from belittling them or from being snobbish, they can be useful. By giving them advice, by enhancing their skills, by supplying them with simple, cheap drugs, we can improve the quality of care in addition to gaining partial control over their practice. Most important, we can get involved in the community health programmes.

Young people from the villages who study in schools and colleges in the towns, understand us. They are eager to improve village health conditions. Formation of youth clubs in the villages has often helped in health education, improved sanitation, and in family planning work.

The community must have a stake in the health programme. The receivers of the health services must have some way of reciprocating the gift. We therefore need to give opportunities for the community to solve some of the problems related to community health. The community in Jamkhed with its poverty, lack of good housing facilities, lack of electricity and running water, made available simple accomodation for our work and staff of 20 workers. The people emptied a veterinary dispensary to house our out-patient clinics. A village store room was converted into wards and a private house was given to house the operation theatre and laboratory. The community in the surrounding area donated lands and building for our work in their own villages. This kept us obliged to the community. There is mutual co-operation in health work.

It is necessary to know the structure of a village well enough to be able to work effectively. The caste system is still dominant in rural areas and Jamkhed is no exception. The higher caste people are used to making decisions for the whole village. They often perpetuate injustice to weaker communities, predominantly the harijan community, which is the most deprived as far as health is concerned. In our anxiety to reach these poor masses, we should remember not to by-pass the existing community structure. If we do we might antagonize the establishment and

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accomplish nothing. In spite of the unjust system, we have to work through them; often beginning our programmes with them as they are undoubtedly looked upon as leaders. Similarly, political leaders both elected and self-appointed should be recognized.

Community involvement in decision making, actual participation in programmes, and genuine mutual dependence between us and the community are necessary for the success of a community health programme.

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VOLUNTARY HEALTH ASSOCIATION OF INDIA
C-45, SOUTH EXTENSION PART-II, NEW DELHI-110049
Phone : 616308, 78433 Telegrams : 'VOLHEALTH New Delhi-49'

VHAI - 251

VILLAGE HEALTH WORKERS (VHWs) SCHEME

Ingredients for Success.

DEFINITION

* A village health worker is any health worker who works for the people of his or her own neighbourhood to improve their health.

* A village health worker is one of the people chosen by the people, to work for the people, of that neighbourhood.

* A village health worker is regularly guided and supervised to work with the people of the neighbourhood, and regularly trained by health professionals.

THE INGREDIENTS OF SUCCESS IN VHW SCHEMES

1. Involvement of the community. Many people now believe that community participation is a "must", if the goal is not just health but total development . Total development cannot happen without involvement of the people in planning and determining their own destiny. When the people are fully consulted and involved, only then are their full energies released.

   The projects now using village health workers have all involved some degree of community participation. But the degree of this community participation should now be carefully evaluated for each project and compared with the project outcomes such as extent of change in birth and death rates.

   My own impression is that success is greater where community involvement has been greater.

2. Respect for the VHW's as persons. Widows, Harijans and women without issue have found fulfilment and work. This has awakened hidden talents.

   Comments from VHW's (at Jamkhed)

   > "They (the project leaders) believed in us. That was what got us started. Before I did not have any ideas. Now I have so many ideas about improving my village that I cannot go to sleep at night".

   These VHW's like new flowers must not be crushed but allowed to flower fully.

Psychologically crushing the village volunteers, destroys the scheme. The Tumkur project near Bangalore used hundreds of volunteer workers to control T.B. a few years ago. According to a leading person in National T.B. Programme, this volunteer involvement failed mainly because the doctors and other professionals were unable to accord proper respect and unable to listen to any ideas from the volunteers. There was an authoritarian relationship resented by the volunteers.

3. Financial plan of support.

" There is no need to form them into a cadre and pay them a remuneration from public funds. It would be desirable to leave them to work on a self employment and part time basis"

--Report of the Group on Medical Education & Support Manpower, Ministry of Health & Family Planning, New Delhi April 1975.

Unfortunately, very few villages have been found willing to support such workers and Panchayats in some States cannot legally use their funds for such purposes. Thus the project or PHC must pay the VHW, with all the dangers that the chance for local participation in the scheme and necessary for consulting the village will disappear.

In another area last year a small scheme using VHWs failed to control TB and other diseases as hoped by the doctor in charge. He had excellent rapport with the village people but supervision was not effective due to lack of community support (Panch was weak) and project did not pay the health worker . So there was no control from either village or project over the VHW.

GOOD LEADERSHIP AND ADMINISTRATION - HEALTH PROJECT MANAGEMENT

There is an old saying that if one wants a new and difficult job done, one should find an experienced and trained hand for the job.

Frequently a young doctor at age 25 with no previous experience of administration is placed in charge of 40 staff in a Primary Health Centre or health project.

If an inexperienced young manager is also expected to start village health worker schemes, which could add on up to 100 workers per PHC to supervise, the results will not be good.

Already serious project failures have occurred, traceable to inexperienced doctors without suitable training.

One project had a doctor who had not learnt to share his medical knowledge with lay people, and so when a village health worker brought a patient with TB, he did not tell the patient or the village health worker about the diagnosis. Consequently they could not cooperate with him in keeping the patient on treatment.

Another project had a doctor, who was not familiar with high risk, under-fives, third degree malnutrition, tetanus toxoid in pregnancy, and other community health concepts. He also had difficulties relating to the nurse, in accepting that a nurse had useful ideas. Such difficulties are bad enough in a clinic, but in village health worker schemes, they make for certain failure.

Those projects which have succeeded so far, have succeeded because top management has been sound, and has personally taken part in training of the nurses and village health workers.

TRAINING IN HEALTH PROJECT MANAGEMENT.

For expansion of programmes it will be necessary to give wider and broader training to PHC or health project doctor, or special administrators from management or social science backgrounds may be recruited .

All project managers will need training in several areas beside public health, so that the necessary knowledge attitudes and skills are acquired. Some suggested topics -

Management.	Decision making, problem solving, use of time, management by objectives, project formulation, costing, cost and benefit, personnel management, budgeting, management of physical plant, vehicles and materials, control, evaluation, organisation structure, leadership styles, participatory management.
Sociology	Economic causes of ill health, socio economic analysis of a village, village expectations of outside agencies, village profiles of land, water, literacy, power, health, caste, crops and markets, food taboos. Local leaders of various caste or community groups could be asked to tell about their own villages.
Communication	Art of listening, known village perceptions of health programmes, exact local meanings of certain words used for disease, making visual aids locally, transactional analysis as an aid to better inter personal communication in the health team, how to conduct a meeting and elicit all points of view .
Training.	Writing learning objectives, writing lesson plans, designing curriculum to suit local conditions and priorities, teaching methods for training village health workers.
Public Health	Community diagnosis, survey, selection of priorities, community participation, census and population projections for the local area , writing objectives, writing detailed plans for control of local diseases and pests, organisation of mass campaigns, health records, information system and built in evaluation.

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This was a paper presented to the Nov 76 Seminar on "Community Leadership - Education of Agents for Health Care" by Dr. Murray Laugesen, Community Health Consultant at VHAI. The Seminar was sponsored by the Indian Association for Advancement of Medical Education, ICMR, AIIMS & NI[illegible]E