ST. JOHN'S MEDICAL COLLEGE, BANGALORE
RURAL HEALTH SCHEME - NEWSLETTER
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EDITORIAL:

My dear friends,

For some of you the time is up to say good-bye to the people whom you served these two years in the rural areas. Looking back on these years must certainly mean achievement, in a certain sense. One thing is sure, a growth as a doctor and a person. All your rich experience has not only been recorded in the pages of memory but also is engraven in the hearts of simple people to whom you were someone.

There are others who are just venturing upon their new taste; yet others are questioning the stand they have taken in choosing to serve in rural India. Will it mean frustration? Is there any future to the career as doctors ? "There are always right answers to all our questions if one is prepared to ask the right question", says little Anna, in "Mister God this is Anna".

This newsletter, a simple one in fact, includes an article on breast feeding and a few hints on making good use of library facilities. The directives of the C.B.C.I. on P.G. Courses at S.J.M.C., to keep you informed well in advance, so that you get ready for the same when your time comes.

Whatever may be the role one is called upon to play, I hope the following prayer of St. Francis of Assisi comes to your aid some times:

Lord make me an instrument of your peace
Where there is hatred, let me sow love;
Where there is injury, pardon
Where there is doubt, faith;
Where there is despair, hope;
Where there is darkness, light
Where there is sadness, joy.

DR. SR. ADELCIA.

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The Secretary of C.B.C.I. speaks.....

RURAL SERVICE

One of the educational objectives for which St. John's Medical College was established is to ensure "dedication in the service of the country and especially the disadvantaged and the poor in the spirit of Christ" on the part of our graduates, as noted in the prospectus of the College. The C.B.C.I. Society for Medical Education has been insisting almost ad nauseam that what should distinguish St. John's graduates from others is their readiness to serve the poor in rural areas. In the thousands of villages of rural India, there live a mass of humanity that hardly has even the barest necessities of life.

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Health is a basic need for every human being. Health is not merely the absence of disease, but a feeling of euphoria or well-being that gives satisfaction and contentment to man and enables him to work hard and live happily and contribute to the improvement of the quality of life in and around him. It is common knowledge that the slums in our cities and the rural areas of our country are infested with different kinds of diseases, and health has become a casualty in such places. Malnutrition, lack of sanitation, lack of drinking water facilities etc. are the main cause for the poor condition of health of our disadvantaged brethren. They need to be educated in preventive health care apart from requiring curative treatment, and who is better suited than the doctor to provide medical care and instruction in hygiene?

A doctor, by virtue of his profession, is well accepted by our rural folk and well qualified to be a leader of the village comminity, not only in regard to health care but also where their economic and social amelioration is concerned. He can be an agent of change, a catalyst who can bring about a transformation. No other person can be in such close contact with people as the doctor in a village. He should, therefore, capitalise on this priveleged position of his and try to bring about a revolution - a real change in the outlook of people towards health care and social and economic uplift.

The excellent training imparted to the graduates of St. John's will become meaningful only when they actually act as catalytic agents in the remote parts of our vast country. It is then that they begin to face the real challenges of life and will have to decide how best they can apply the knowledge and principles they had acquired during their formative period at St. John's. The village setting is such that it affords ample opportunities for making independent judgements. The doctor can be the master and captian of the destiny of the villagers. He can be the monarch of all he surveys. Unique therefore is the role of the doctor in a village. If this is borne in mind, our alumni can understand why the C.B.C.I. Society for Medical Education is insisting on a two year rural service bond on the part of the students before their admission to the College. It is necessary for our alumni to involve themselves wholeheartedly in the life-pattern of our rural folk. They must get into the main stream of rural life and only then can they feel the pulse of the people both literally and figuratively. When a doctor is involved in this manner, the qualities of compassion, understanding and other humanitarian values will come into play and provide the doctor with the correct perspective; otherwise his mind would be on the good things of life--the amenities and social enjoyment that our cities provide. He cannot be a happy doctor in a village if he does not integrate himself into the life pattern of the the villagers.

The preventive, curative and rehabilitative role of the doctor and his involvement in the life of the rural folk is a gigantic task and calls for herculean efforts on his part. But once he identifies himself with the people, his task will become less difficult. Even so the goal will remain a distant reality. The sower of the seed may not see the fruit. But the trouble taken by him will not go unrewarded. Little by little, the economic, social and health standard of our rural folk will rise, thanks to the effective role of the doctor.

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Our alumni are aware of the sanctions attached to non-fulfilment of the rural bond. The sanctions are provided not with the view to penalizing, but securing actual rural service. There are also incentives to those who complete the two-year rural service bond. A recent incentive (which can be viewed as a sanction as well) is that post graduate seats in St.John's Medical College will not be given to those who have not done rural service for at least two years and a greater weightage will be given to those who have put in more than two years of rural service.

As noted above, service to the poor and disadvantaged must be rendered in the spirit of Christ. Christ went about doing good, his healing touch and soothing words were available to every one. The same spirit should animate and actuate our alumni.

FR? IGNATIUS PINTO.

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ADDED TO THE NUMBER.....

Dr. Paul Joseph,
Karuna Bhavan Hospital,
Koruthode P.O.
Via Mundakayam ,
Kottayam Dist.,
KERALA

Dr. Boban Joseph,
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BREAST FEEDING AND AFTER - A GUIDE TO INFANT FEEDING

Since ancient times, breast milk has been the only food for the human infant, and it was known and realised that if for any reason, /had breast milk was unavailable the infant/ no hope of surviving for very long. The same holds good in all developing countrys till today. Unscrupulous advertising by industrial films and the inexcusable indifference and lethargy of medical and paramedical personnel have contributed significantly in propagating the belief that breast feeding is in no way superior to artificial feeding. Recent work has not only re-emphasized the emotional and economic advantages of breast feeding but scientific data has proved the specific nutritional, antiallergic and contraceptive properties in human milk. Stuart Cloele States.

For the truth is that for babe or man there is no security to be found in a bottle. There is only one thing to be done with it and that is to empty it. It cannot be toyed caressed or stroked. It is not warm or soft. A bottle is stone, is sand fused and processed into a vaguely breast like shape for the holding of the goods, but to the infant it is a mockery.

On the other hand the breast-fed newborn has the close contact of the mother's skin paralleling the warm encompassing amniotic fluid, he has just left. The auditory stimulus of the mother's heart-beat continues to be heard. The intra uterine swaying is continued as rocking on the mother's lap. The continuous supply of nutrients transported to the fetus through the umbilical cord is almost as continuously supplied by unstreched breast feeding.

It is heartening to note that studies are being developed all over the world to try and determine more clearly the unique biological quality of mother's milk, its protective role and the effects of storage on its various properties.

As a result of the selective process of evolution, each species produces milk whose composition is optimal for its young so in reality we cannot 'humanise bovine milk (or bovinise human milk!) as is so frequently claimed. There is also a visual difference in the milk of different species I.e.Kangaroo's milk is pink while buffalo's milk is white. Human milk is not usually seen, but mothers making an inspection worry over its thin bluish appearance as it does not conform to their expectation based on cow's milk.

The production of milk during lactation consists of 2 phases:-

1. A stage of secretion under the control of prolactin which stimulates alveolar tissue to secrete milk. Prolactin secretion can be enhanced by stimulation of the nipple by sucking - prolactin reflex.
2. Stage of propulsion of milk or let - down reflex is under psychomotor control and is initiated by stimulation of the nipple by sucking - Impulses- posterior pituitary - releases oxytocin - acts on smooth muscle surrounding ducts - ejeetion of milk into terminal ducts of both breasts - nipple - infant.

The difference between the prolactin reflex and the let -down reflex is the difference between milk production in the alveoli and milk availabilty in the terminal lacteals i.e. between making milk and supplying milk. With a successful let-down reflex 90% of milk is availabel to the baby in seven minutes.

The unique quality of Mother's milk:

Colostrum - is the early secretion of the mammary gland which has undergone partial resorption. It has a bright lemony yellow viscous appearance. It is high in antibody rich protein especially IgA

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and lactoferrin. As compared to breast milk it has less fat and lactose but more sodium chloride and zinc. It has mainly an anti-infective function but its biochemical composition may have a laxative, even proteolytic effect which helps clear out the meconium . It also supplies a concentrated dose of certain important nutrients like zinc.

Breat milk is THE best and only food for infants as there is NO substitute which can exactly duplicate it whatever the advertisements say, it is just not possible to humanise cow's milk.

Studies of breat milk and breast feeding show that:

1. Breast milk best satisfies the infant's needs for the first 4-6- months of life.
2. Breast milk provides immunological protection for the infant.
3. Breast feeding costs much less than feeding with substitutes,
4. Because of the immunological and nutritional advantages and because preparing substitutes is difficult in the developing world, breast fed infants are less likely to develop infections and malnutrition.
5. Antiallergic property:- Foreign protein in cow's milk can produce allergic symptoms in infants.
6. Breast feeding protects against pregnancy; however the contraceptive effect is maximum when the infant suckles frequently and is solely nourished by breast milk i.e. for the first 4-6 months.
7. Closer maternal- infant bonding; the rise in senseless destructive violence in the western world today undoubtedly has its origins in many factors-social, psychological, technical and economic. Some of these are related basically to attitudes on child rearing especially the decline in breast feeding and altered patterns of somato-sensory contact.

Immunologically protective agents in human milk are:-

i) Immunoglobulins which produce anitbodies against specific bacteria and viruses.

ii) Leucocytes which destroy bacteria and other foreign substances.

iii) the bifidus factor which promotes the growth of bifid bacteria, the predominant intestinal flora in breast fed infants which in turn, prevents the growth of potentially harmful organisms.

Therefore, breast fed infants are less likely to develop gastrointerstinal disease and viral respiratory infections. Breast fed babies are also less likely to contract middle-ear infections(related to position during feeding). In addition a number of allergies including eczema, cow's milk allergy and allergic rhinitis are less common in breast fed infants.

A word of caution is necessary about drugs given to lactating mothers. Passage of a drug into milk is governed by four factors.

i) difference in pH of Plasma and milk
ii) molecular weight of the substance.
iii) its degree of ionisation.

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iv. Its solubility is fats and water.

Drugs contraindicated during Lactation are: Anticoagulants, antimetabolites, amphetamines, atropine, rye ergot alkaloids. metronodazole, sulphonamides, tetracyclines and ~~vision~~ oral contraceptives, steroids, reserpine, diazepam, diuretics, barbiturates, codeine, diphenylhydantoin nalidixic acid. The use of penicillins is devoid of risk.

Difference between Human and Cow's milk:

a) The proteins in milk are in 3 forms ~~casein~~ casein, lactalbumin and lactglobulin. Casein forms curd which is 6 times more in cow's milk, is difficult to digest for infants and is known to form lactobezoars in premature babies. Alpha-lactalbumin is necessary for growth, lactoferrin has antimicrobial properties and lactglobulin's transfer immunity in the form of immunoglobulin's. The amino acids in human milk are more fully utilised.

b) Fat is the main source of energy, fat soluble vitamins and essential fatty acids in human milk, levels of essential polyunsaturated fatty acids, especially linoleic acid and alpha-linoleic adid are higher in breast milk than in cow's milk. The fatty acid content varies with the mother's diet. Asian women tend to have a relatively higher proportion of shorter-chain acids than their European counterparts. During a feed the concentration of fat rises by upto 40 G/L and the content of lactose and protein falls slightly.

c) The concentration of the major carbohydrate, lactose, is high and plays an important role in maintaining low electrolyte concentration.

d) Minerals:- Human milk has lower concentrations of Ca & P than other milks but the supply is ample. The calcium is particularly well absorbed as compared to cow's milk for the following reason- as the pH of the gut is lower in the breat fed than in the formula-fed infant, the Ca is less liable to combine with human milk protein because of its low casin content. The concentration of iron ~~is low~~ but than cows milk it is well absorbed 60 - 70% and it provides enough iron for a full term infant throughout the first 6 months of life. The low concentration of sodium in breast milk is of importance because of the limited capacity of the newborn kidney to deal with a heavy load of solute.

e) Vitamins:- The infant's store of fat soluble vitamins is related to the mother's diet during pregnancy - the milk of a well fed mother contains enough fat soluble vitamins for maintenance. All water soluble vitamins in the mother's plasma readily reach her milk; their concentration depends largely on her diet but are generally sufficient for the infant if the mother is well nourished. When mothers are themselves deficient in some vitamins e.g. thiamine or Vit A, their milk cannot meet the infants needs and causes serious health consequences. The mother's diet needs to be supplemented.

Prolonged Lactation:- Prolonged breast feeding is initially a necessity for the growth and survival of infants in the tropics as it represents the only easily available source of protein of good quality for infants in the lower socio-economic strata. It can be continued for 1 - 2 years if no alternative protein food is available but must be supplemented with weaning foods after the infant is 6 months old.

After childbirth, lactation begins in 24-48 hours; for the first few days the breasts secrete colostrum. Milk comes in on the 2nd-5th day, and mature milk is available after 2 weeks.

For successful breast feeding:

1. Psychological preparation of the mother and preparation of the breasts. This is an important aspect of antenatal care and must be pursued with missionary zeal.
2. The infant must be put to the breast as soon after birth as possible as the sucking reflex is very strong at this stage. Sucking stimulates milk production and helps in involution of the uterus.

   Mothers must be persuaded to give colostrum to their infants as some feel, very erroneouly that it is bad for the infant, not knowing its immense value to the newborn baby. No feeds like jaggery or honey should be permitted and feeding bottles must be probibited in maternity wards and premature units.
3. From the 3rd day postnatally the quantity of milk increases- feeds given as the infant demands and not by the clock. They settle down by the end of the second to third week to 3 hrly feeds.
4. Night feeds: Usually babies allow their mothers to sleep from 10 pm - 6 am after the 1st month - but if they need a milk feed after that then they should be given milk; NOT water.
5. Feeding time:- 15 - 20 mins. The breasts must be emptied at each feed.
6. Position:- as the mother feels comfortable.
7. Burping or "bringing up wind" is essential after each feed.

A woman who is breast feeding her infant and suckling as the infant demands needs no contraceptive for 6 months postpartum. If pills have to be given then Progestin pills only (which may increase the breast milk) or very low dose oestrogen pills (0.05 mg) are to be used as the conventional pills interfere with milk secretion.

Sucking by the infant is the strongest stimulus to milk production. If the milk does not "come in" by the second day an injection of 5 units of pitocin 1.M. helps, and chlorpromazine 25 mgms TDS for 6 days being a dopamine antagonist increases the secretion of prolactin.

Bowe Pattern:- breast fed infants pass sticky, semi-solid yellowish stools sometimes 6-7 times a day after feeds; there are some infants who pass a stool every 2nd - 3rd day-both these bowel patterns are normal.

Weaning is a process by which foods other than milk are introduced into the infant's diet, first to complement breast milk and then to progressively replace it and adapt the infant to the adult diet. For nutritional reasons the introduction of other foods to a wholly breast fed infant becomes necessary between 4-6 months. The exact time that weaning should begin is determined by the lactation performance of the mother and the rate of growth and maturation of the infant; it does not therefore depend on age but for most infants, it is between the ages of 4 -6months. However, because of poor knowledge on the part of the mother regarding the nutritional requirements of the baby, the period between 6 months, and 2 years is one of one of "Perpetual hunger".

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knowledge of weaning foods and practices:

While low income is important as a cause of malnutrition, ignorance about the nutritive value of food is equally important. Two important facts are to be communicated to the mother - at what age which foods are to be given and what quantity to be given. When giving advice about infant nutrition remember the economic state of the family, any prejudices about certain foods and also the availability in the local market. As far as possible discourage mothers from buying expensive prepared baby foods sold in the market. Take time to explain to the mother and allay her fears and prejudices. Remember that the paternal grand mother has a considerable say in infant feeding and must be "converted" if weaning is to be smooth and successful.

In India, due to the warm climate, food does not keep long and, therefore, must be freshly prepared for every meal. The basics of hygiene should be patiently explained to the mother especially that food should not be brought from outside and should be protected from flies and dust.

Outline of Diet:

5 to 6 months:- Mashed banana in milk or porridge with suji, atta, ground rice, ragi, millet - a little oil or ghee to be mixed to improve the taste and increase the food value - start with ½ teaspoonfull and gradually increase so that after 3 - 4 weeks the infant is taking 50 - 60 gm (½ a cup)/or one whole banana.

Fruits in season e.g. papaya, chikoo, mango can be given. Apples and pears, to be given after stewing - start with small quantities and increase slowly.

6 - 7 months:- Vegetables to be added - potato, marrow, carrot later peas, beans, boiled and steamed, mashed and sieved. Add oil, start with small quantities and gradually increase. No food value in giving the water in which the vegetables are cooked, meat soup, contrary to popular belief also has no food value unless thickened with mashed vegetables or flour and added oil.

7 - 8 months:- Combinations of rice, legumes and vegetables, curds, egg-yolk, bread, biscuits, thick roti softened in milk, dhal or gravy. Raw egg is less nutritious than a boiled or poached egg. The infant is teething at this stage and can be given toast, crisp 'roti', carrots or biscuits to bite on.

9 - 10 months:- quantity of foods are increased and minced and ground meat and fish can be added.

1 - 1½ months:- should eat all household food without spices, bulk of calories to be supplied by food not milk. White of egg if given before the age of one year may cause allergy.

New foods should be started in small quantities and one at a time so that if it disagrees with the baby it can be immediately discontinued. Sometimes food put on the tip of the tongue is immediately spat out. This is usually a reflex and does not necessarily mean that the infant does not like the food. Of course, infants do have their likes and dislikes in regard to new foods and these should be respected. If a new food is rejected something else should be started and try made again after 2 - 3 weeks. If solids are not introduced in time i.e. before the infant is one year old it may be almost impossible to wean the child from a purely milk diet after this age and the stage is set for a feeding time struggle between adults and child in addition to poor feeding habits for many years.

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If is preferable to base the diet of an infant on what is already being cooked in the family kitchen without the spices. It is fortunate that Indian diet consists of a mixture of cereals and pulses which enhances their nutritive value. Food should be served in a separate plate or bowl so that the mother knows how much the infant is taking at each meal. It also encourages the infant to feed independently. Weaning foods should be started at times when the infant is very hungry. At one year the infant needs around 1000 calories i.e. ½ the requirement of the mother. The stomach capacity being small infants have to be fed small quantities more frequently. "Children like chickens, should be Always pecking".

Feeding problem in children can be avoided if a rational approach to feeding infants is practised. Singing, dancing and story telling are not a part of meal-times. Bad habits formed at this stage persist throughout childhood. Rewards for eating are best avoided. Feeding is as much a part of living as waking, sleeping and playing. Meal times should be pleasant for all members of the family and should not be a battle ground between parents and child. If a child over 1 year old deliberately refuses a meal then no food to stave the hunger like sweets or biscuits should be given before the next meal - it must be remembered that "hunger is the best sauce"! The giving of snacks instead of a meal serves the child's purpose of not remaining hungry but defeats the method of imparting good feeding habits.

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Extract of the minutes of the meeting of the Executive Committee of the Governing Body of the C.B.C.I. Society for Medical Education held on 17th, 18th & 24th April 1983.

"Norms for selection of Post-graduate Course"

1. Applications for admission to post-graduate courses of study will be invited by advertisement in newspapers about three months before the expected date of the commencement of the courses.

2. A candidate can apply for not more than two subjects.

3. Eligibility

   i) Candidates should have satisfactorily completed the one year compulsory rotating internship after passing M.B.B.S.

   ii) Candidates who have taken more than 2 years beyond the minimum period required to pass the M.B.B.S. course will not be eligible to apply for the post-graduate course.

   iii) Only candidates who have done two years' rural service after full registration will be eligible to apply. Preference will be given to those who have done more than the minimum two years of completed rural service. In case there are not enough suitable condidates with two years of completed rural service, other candidates may be considered for admission to the vacant seats.

4. Entrance Tests

   i) There will be two written tests:

      a) Paper One will be common for all candidates and the questions will be general in all subjects of Medical Sciences.

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b) Paper two will be in the subject applied for.

ii) The written tests will be held at St. John's Medical College.

iii) Based on the performance in the written tests candidates will be called for interview by the selection committee.

5. Weightage will be given to those who have had five years completed satisfactory service in the defence Forces, some weightage may be given for conduct and behaviour of the candidate during the entire under-graduate course."

LIBRARY AND INFORMATION SERVICES FOR THE GENERAL PRACTITIONER

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Abstract: The objective of this paper is to discuss the need for a role of information for the General Practitioner(GP). Emphasises the importance of continuing education of the GP. Enumerating their information needs, points out the need for the GPs maintaining their own personal libraries. Discusses the role of learned societies, professional associations and instructions in meeting the information needs of the GP in providing library facilities, the package library services, mobile library services and clinical and drug information services. The role of public nad hospital libraries in meeting the information needs of the GP are also discussed.

INTRODUCTION: The General Practitioner (GP) is a doctor of first contact. He may be defined as "A qualified man who exercises or undertakes to enhance the tenets of medical science in all its branches without restricting to any particular speciality".

It is estimated that in India out of a total of approximately 150,000 doctors trained in modern medicine, about 70% are General Practitioners, majority of whom are engaged in private practice, a small percentage is serving in Government Medical Institutions and the rest as specific speciality.

IMPORTANCE OF GP: The work carried out by the GP embraces the prevention, diagnosis and management of illness and diseases, not covered by other medical specialities. No more than 15% of patients are refered to hospitals and the detailed analysis of the remaining 85% of patients whose complaints are quite unknown to specialists is handled by the GP. Moreover, all the 15% passed on to hospitals are seen by the GP, often at a very early undifferentiated stage of diseases.

Specialists are for the classes while the GP is not for the masses. As the latter constitutes the majority in our country, it logically follows that the GP has an important role to play. The GP should be able to transfer new knowledge and technology into community application and meet effectively the health needs of the country in which he serves.

ISOLATION OF THE GP: Physicians will continue to reject small towns and rural areas because as a group they place a high value on the geographical attributes of the setting for medical practice. Although rents in the city have always been higher than in the surrounding countryside, people have always been willing to pay that price. In the past if one lived away from the place where, for him, the maximum lines of communication converged, he was effectively cut off from essential information, that is, information without

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which he could not live or work effectively. In the absence of social contact with colleagues and facility for continuing education, the GP prefers urban areas for his practice.

CONTINUING EDUCATION OF THE GP : The medical man's true education begins after graduation and continues throughout his life time. Sir William Osler and John Shaw Billings were most influential in establishing the important role of the library in continuing medical eduation. Osler pointed out the need to use books at the bedside for patient care. In 1901 Osler wrote:

> "For the general practitioner, a well-used library is one of the few correctives of the premature senility which is so apt to overtake him. Self-centred, self-taught, he leads a solitary life, and unless his everyday experience is c is controlled by careful reading or by attending a medical society, it soon ceases to be of the slightest value and becomes a more accretion of isolated facts, without correlation. It is astonishing with how little reading a doctor can practice medicine, but it is not astonishing how badly he may do it".

THE GP's NEEDS

The specialists who work in academic institutions and bigger hospitals and a GP in a large city may have many medical library resources available - a library of a teaching institution, a hospital library, a local or state medical society library. But a GP in a rural area is busy and far away from the libraries; it is difficult for him to have library facility.

The GP needs library service as much as those in teaching or doing research in medicine. For, he must:

1. Keep himself abreast of the current development in the subject,
2. seek clarification and confirmation on some doubtful points in medical practice,
3. Adapt himself to the changing needs of the society,
4. make his own contributions to the advancement of the subject; and through these means;
5. improve his professional competance and service to the society.

PERSONAL LIBRARY:

The GP, to meet his needs for continuing education and better patient, care may develop a personal library consisting of important medical books. He is entitled to get an official organ after becoming a member of learned societies and professional associations. He may even subscribe to one or two periodicals published exclusively for the GP such as American Practitioner, General Practitioner, Journal of Applied Medicine, Journal of Royal College of General Practitioner, Practitioner etc. GP may request the pharmaceutical companies to send their house journals and literature published regularly by them which contain useful information on physical and physiological properties of various drugs manufactured by them.

RESPONSIBILITY OF LEARNED SOCIETIES AND PROFESSIONAL ASSOCIATIONS

There are several international, national, and local level learned societies and professional associations. The duty of these associations is not over by merely organising meetings, lectures and conferences. It is a fundamental duty of these bodies to assist in the continuing education of its members. The American Medical Association, one of the oldest associations (1847),

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has been doing tremednous service to its members for their continuing education. The societies and associations can make arrangements for continuing education of their members by providing:

1. Library facility
2. The package library service, and
3. The information services

LIBRARY FACILITY

A good library is an essential wing of any professional association. It has a distinct role to play in information transfer and exchange activities among the members of association. The guide line set by American Medical Association serves as a standing example for associations in India in establsihing a good library facility for their members. It is interesting to note that quite a few medical associations such as Indian Medical Association, Calcutta; Associations of surgeons; Madras; Tuberculosis Association of India New Delhi, not only have a good library, but also have qualified librarians. Other medical associations in the country should follow the examples set by IMA and others.

Every year the cost of medical books and periodicals has been increasing by 30 to 35%. It is difficult for the GP to purchase many books and periodicals. Therefore the association should come forward in maintaining a good collection of medical textbooks, monographs, pamphlets and other reading materials. Members may be requested to donate their personal collection to the association library.

As most of the important medical research is reported first in periodicals, the library should concentrate on the building up of a good periodical collection. It may become a member of the US Medical Library Association, US Book Exchange Programme and WHO International Exchange of Duplicate Medical Literature for building up the back volumes of periodicals. Local academic institutes and hospital libraries may also be requested to spare the duplicate copies of periodicals.

Apart from the traditional activities, the library should provide other services such as reference services, compilation of bibliography and arranging the Inter-library loans. Abstracts of the important useful articles may be sent to the GP since he does not have enough time to go through the entire article.

Books may be sent by post to the outstation members. The Library should have photocopyihg facilities so that the articles can be duplicated immediately and sent to GP on nominal charges instead of loaning the entire volume of periodicals.

THE PACKAGE LIBRARY SERVICE

Dr. Johnston, Librarian of American Medical Association, established a package library service as long ago as 1924 which today is one of the most popular and important services of AMA library.

Ten to fifteen reprints or photocopies of the important articles, reports etc., on all phases of clinical medicine may be sent to the GP for two weeks or so. Packages may be returned immediately after use or may be renewed thereafter upon request. The library should try to collect the reprints on all the medical disciplines for the last ten years by writing to the various authors.

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INFORMATION SERVICES

Product Information Services

Drugs: Many newly-discovered drugs have their dangers too apart from their usefulness. The new antithyroid drugs of ~~xxxxx~~ thiouracil group occasionally have a serious toxic effect on the white cells. It is unfortunate that Streptomydin doses large enough in tuberculosis meningtis to produce a cure are often toxi toxic enough to harm the patient and cause deafness and occasional blindness. This is the case with antineoplastic drugs also.

The GP is subjected to high pressure advertising compaigns by pharmaceuticals companies who keep on introducing the drugs by giving inadequate ~~and misleading information~~ and one sided information about them. Many of the gullible GPs are mislead and treat their patients by wrong symptoms and subject them to unwanted drug hazards.

Again, the responsibility to save the GP and the patient too from such practices lies with the societies and associations. The members of the societies and associations should be informed about the new drugs with full details such as usefulness, dosage, toxicity and adverse effects as and when they are introduced in the market. The drugs which are withdrawn from the market or the adverse effects recently reported also may be informed to the members.

GPs need to keep themselves informed about the results of clinical trials of various drugs conducted in hospitals and medical research laboratories. The Indian Association of General Practitioners may collect all such clinical trial reports and establish a mechanism for disseminating the results of these reports to the GP.

Surgical apparatus and other equipments: The members of societies and association should be kept abreast of the recent surgical and other hospital equipment released in the market. The GP who has an in-patient section will be highly benefited from this.

Information of Manpower

There should be an information Bureau attached to the societies and associations, which collects and disseminates information about the facilities for general practice in a particular area and how many GPs are already practicing in that region. This will prevent unhealthy competition in general practice and help new comers.

OTHER LIBRARIES IN THE SERVICES OF THE GP

Academic Institutions

All the medical colleges, university libraries and other research libraries in Health Sciences should extend library facilities to the GP. Reading materials may be lent against some deposit. Some of the medical college libraries like Madras Medical College and St. John's Medical College, Bangalore do allow the use of the library by the GP for reference purposes.

Hospital Libraries

The importance of hospital libraries is recognised by the hospital administrators in UK and USA. The Medical Section of the Library Association and Medical Library Association, USA help the hospitals in building up better collections by preparing lists of recommended books to cater to physicians,

Cont'd../

hospital administrators and professional and technical personnel in the hospital.

In India, apart from teaching hospitals attached to academic institutions very few hospitals maintain medical libraries. Though there is a provision for acquiring books and periodicals in Civil Hospitals or District Head quarters Hospitals, very few of them are found making use of this facility.

Public Libraries

The St. Marylebone Branch of Westminister Public Libraries, London contains a medical collection as large as many hospital libraries, with the difference that it can be used by all, regardless of status.

Some of the larger public libraries in India like state Central Libraries and City Central Libraries in bigger cities have collections of medical books and periodicals, but a wider range of documents have to be procured by them to serve the GP better.

The mobile library unit of public libraries may have a separate section for medical books and periodicals. GP's needs may be fulfilled at this place by the regular visits of the mobile library.

The public libraries may seek the help of societies and associations in selecting the books and periodicals. Books and periodicals from society and association libraries may be collected by the mobile library operated by Public Library and delivered to the GP.

Contact Libraries:

The contact libraries maintained by foreign governments especially American libraries and British libraries which have collections of medical books and periodicals play an important role in helping GP. These libraries lend the books not only to the local members but also to the outstation members.

DOCUMENTATION SERVICES

The Indian National Scientific and Documentation Centre, New Delhi and its regional offices may be approached for compilation of bibliographies, photocopying and translation services. The National Medical Library, New Delhi; WHO Library, Geneva; Laslic Calcutta, can also offer photocopying services at nominal charges.

CONCLUSION

General practice is the corner stone of health service of the country and plays a pivotal role in the general health of the society. The GP should be given more importance while planning for the National Information System for Medical Sciences.

To
DR. Ravi Narayan,
Dept of Community Medicine,
S. J. M. C.
BANGALORE-34

st john's medical college, bangalore 560034

rural health services and training programs

24.11.83

AN INVITATION

Dear

The work of the GONOSHASTHYA KENDRA (People's Health Centre) of Bangladesh under the leadership of Dr Zafarullah Chowdhury is well known. Starting with the establishment of the health centre soon after independence, the Kendra went ahead step by step to establish the Women's Vocational Centre (Nari Kendra), the People's Workshop (Gono Shilpalaya), the People's Shoe Factory (Gono Paduka), the People's School (Gono Patshala), the People's Farm (Gono Krishu Khamar) and the Gonoshasthya Pharmaceuticals. During these years, the Kendra also organized training programmes for the paramedics of Savar and later cooperative health workers (IRDP & UNICEF) and field programmes for medical students and post-graduate doctors. Last year it has initiated steps towards the evolution of an alternative people's health oriented medical education experiment.

1982, has also witnessed in Bangladesh the governments bold decision to ban 1707 hazardous and irrational drugs, fix the fees for doctors, stop construction of eight new medical colleges and encorce a five year compulsory rural work before permanent registration of doctors--all these being steps towards a more people-oriented health service.

We are very glad to inform you that at the request of many groups including the Indian Academy of Paediatrics, Voluntary Health Association of India, Medico Friend Circle, Lok Vidnyan Sanghatana (Maharashtra), Kerala Sastra Sahitya Parishad, NISTADS, FMRAI and others, Dr Zafarullah Chowdhury has agreed to visit India from 24 Nov to 4 Dec 1983. He will be passing through Bangalore on 1st December 1983 and we cordially invite you to come and hear him share his experiences at the following two venues during that day:

1. THE PEOPLE'S HEALTH CENTRE (a lecture on the evolution of the GK Project and its training programs) : Room No.117 Ground Floor, St John's Medical College Bangalore 560034 Time: 9 am to 9.45 am

2. TOWARDS A PEOPLE'S HEALTH POLICY (a public lecture on the GK Pharmaceuticals and Bangladesh Drug Policy) : Materials Research Laboratories (MRL) Indian Institute of Science Bangalore Time: 3.30 pm to 4.30 pm

A special file on background information (priced Rs.5/-) will be available on the GK Project, GK Pharmaceuticals and Bangladesh Drug Policy at the Indian Social Institute, 24 Benson Road, Bangalore 560046 (telephone:51189) from 28 Nov 83 and at the venue of the meetings.

We request you and your friends to participate and make these programmes meaningful.

With best wishes,

Yours sincerely,

Ravi Narayan

Ravi Narayan
Associate Professor: Community Medicine
ON BEHALF OF
medico friend circle; Science Circle (Indian Institute of Science); Indian Institute of World Culture; Indian Social Institute and Voluntary Health Association (Karnataka)--Bangalore

st john's medical college, Bangalore 560034

notice

23 Nov 1983

DR ZAFARULLAH CHOWDHURY of the PEOPLE'S HEALTH CENTRE (Gonoshasthaya Kendra), Bangladesh, will be visiting St John's Medical College on the 1st December 1983. Dr Zafarullah is an internationally renowned figure and we are privileged indeed that he has agreed to share his experience with us during his tour of India. He will be delivering a lecture on -

'THE PEOPLE'S HEALTH CENTRE'

on 1.12.1983 in Room 117 of St John's Medical College from 9.00 a.m. to 9.50 a.m.

Dr Zafarullah has been one of the founders of the Gonoshasthaya Kendra in Bangladesh and has been actively involved with its community health programme, medical and para-medical training programmes and the GK Pharmaceuticals.

All staff and students are cordially invited to attend the lecture.

G M MASCARENHAS FRCS FACS
Dean

To

All the Heads of Departments in College and Hospital
The Medical Superintendent
The Administrative Officer/Deputy Administrative Officer
The Administrator
The Assistant Administrator

st john's medical college, bangalore 560034

rural health services and training programs

: ALTERNATIVES IN MEDICAL EDUCATION :

Dear

Further to my letter dated 24 Nov 1983, informing you about Dr Zafarullah Chowdhury's visit to Bangalore and his program of public lectures on 1st December, this is to invite you to an informal group discussion with him on the theme "Alternatives in Medical Education". This discussion will be held in the Board Room (next to Dean's office) of St John's Medical College from 10 am to 11.30 am on 1st Dec 83. It will follow a lecture which Dr Chowdhury will deliver to staff and students of the college from 9 am to 9.45 am on the same day (Room 117, Ground Floor of the college). The topic of the lecture will be "The People's Health Centre".

Since 1982, the Gonoshasthya Kendra in Bangladesh has been exploring the possibilities of evolving an alternative medical curriculum more suited to the health and socio-political and cultural realities of countries such as ours. In March 1983, there was a special conference held in Dacca entitled 'PEOPLE AND HEALTH' organised by the Kendra and the Jehangir Nagar University at which some recommendations for such a curriculum was made.

Though the meeting we have planned in St John's will be a short one (in view of Dr Chowdhury's packed programme in Bangalore), we hope it will be an opportunity for him to share his ideas with those of us in Bangalore who are keenly interested in this topic and will also initiate a contact for many of us with this innovative experiment in the future. It is also hoped that this meeting will stimulate some of us to think of possibilities of similar ventures in our own country and institutions.

Kindly let me know by return of post or telephonically (565435 Ext.265 inform Mr K Gopinathan) before 29th November '83 whether you will be able to attend this lecture and group discussion. This discussion will be for a small group of special invitees and since the number has to be necessarily limited we want to know in advance who all will participate. On hearing from you we shall post some cyclostyled material to you as background to the discussion.

Looking forward to your participation,

With best wishes,

Yours sincerely,

Ravi Narayan

Ravi Narayan
Associate Professor: Community Medicine and
Co-ordinator, Rural Health Services and Training Programmes

24.11.83

background paper: 'alternatives in medical education'

Report of the Dhaka Conference on 'PEOPLE AND HEALTH' :18-22 March 1983: DHRUV MANKAD.

(An extract from the Report of the Conference which featured in medico friend circle bulletin No.89, May, 1983).

introduction

People and Health - was the topic of the conference jointly organised by Gonoshasthya Kendra, and Jehangir Nagar University (Bangladesh) at GK campus from 16th to 22nd March 1983. Around 70 delegates from Bangladesh and 30 delegates from abroad (13 from India out of which 6 mfc members) took part in the 5 day long deliberations with a view to lay down some guidelines on how a new medical curriculum - an alternative to the present extant is to be formulated - the present medical education is hospital centered, urban biased and aimed at an individual patient. The participants also included around twenty five students and interns from various medical colleges in Bangladesh.

keynote address

Dr D Banerji in his keynote address pointed out that the introduction of Western Medicine in the Indian subcontinent was intended to serve the British Army and deprived the natives of their own indigenous system by destroying the economic base of their whole way of life. He contended that it was only the presence of concious doctors like Dr BC Roy within the mainstream of the anti-colonial movement that a national health policy was formulated after independence. He argued that though change in health status of the people is a function of the socio-economic change, a 'critical mass' of conscious doctors who could initiate such a change in the health status are necessary as a part of the broad movement for socio-economic change. He urged that it was with the aim of producing such a 'critical mass' that the new alternative curriculum be formulated. He stressed the need to orient the new doctors towards community diagnosis and action.

country papers

Delegates from Sri Lanka, Phillipines, Malaysia, Nepal, Mozambique, Bangladesh, North Korea and Thailand presented their papers. The papers generally covered the health situation, the health set up of each country and the alternatives tried out in their respective countries.

conclusions and recommendations

In the opinion of this conference the health care and medical education in the most third world countries is not satisfactory and there is a growing restlessness on this issue among the people as well as within the conscious section of medical profession. Attempts are being made to bring medical education more closely aligned to the health needs of individual country and this is reflected in the recent curriculum revision here in Bangladesh.

Though the socio-economic factors like poverty, illiteracy and politics are the major determinants of the health status of the people, the health services have an important role to play. Constraints do exist in the present situation but

health care workers will have to undertake the responsibility of trying to improve the health status of the people within the existing constraints instead of sitting silently and waiting for the ideal conditions.

To remedy the present day system of health care, it is necessary to go to the people and subordinate medical technology to the needs of the people, rather than to serve the interests of the upper class.

The conference took into account the health care systems of the various countries in Asia and noted the priority health problems. The target groups identified requiring immediate attention are - Children, Women, and under-privileged classes in urban as well as rural areas. To deal with the predominant health problems of the target groups through primary health care, a community health team approach is essential. In most cases doctors as the leaders of the team will have to carry out this task currently. Doctors are not trained to perform this role adequately.

The new role will require a different kind of preparation so that doctors can effectively perform the following functions:

1. Diagnosis of health problems and priorities of the area, using scientific epidemiological tools.

2. Planning, execution and evaluation of a community health programme in accordance with the community diagnosis.

3. Competently diagnose and treat the common as well as important clinical problems.

4. Training of the team including the village health workers.

5. Supervision and leadership of the health team.

6. Act as a change-agent in the health system.

7. Understanding the problems of the masses and actively associating with them.

To enable the new doctor to be able to perform above functions, the major areas in which medical education needs restructuring are as follows: (sentences in the bracket would give an idea about how these general recommendations can be interpreted as was done in an informal discussion amongst like-minded people after the workshop was over).

1. Selection of students - giving special attention to the social origin, sex, the rural background as well as the values and motivation of the aspirants. (Twenty committed students will be selected; half of them would be females and half would be paramedics. Paramedics would undergo a year's preparatory training in general and biological sciences)

2. The location and organisation of the training set up - Half of the training must take place in the community or in the community based health programme. (Half the time would be spent in a middle sized, district level hospital and half in a socially oriented well designed health project in rural area).

3. Clinical Training - with a commitment to excellence and emphasis on the practical methods of diagnosis and management of the priority problems (Training would not take place in big, sophisticated hospitals. Maximum emphasis would be placed on practical problems. Preclinical training (especially, anatomy, biochemistry etc) would be limited to fundamental and applied aspects and details would be avoided. These subjects be taught by clinical teachers - eg. Anatomy by surgeons. Preclinical and clinical aspects to be taught simultaneously and in an integrated manner).

4. Community Health Skills - To be developed in applied training, so that the doctor can fulfil the new role (Students be given specific practical responsibilities during training).

5. Teaching of social sciences - especially understanding economics, sociology, anthropology, psychology and ethics as they relate to the genesis and management of health problems.

6. The medical education institution should have a department devoted to clinical research, and practice of traditional and non-allopathic systems of medicine. The research should be carried out using combined diagnostic and therapeutic techniques of the traditional as well as the modern medicine. The remedies found to be effective and safe should be actively included in the teaching and be practised.

7. Personality development - ie., attitudes and values in personal life as in relation to the people, especially with underprivileged classes and women; also an ability to work with a team. (Students imbibe the attitude of their teachers. Hence the teachers must practice these values in their daily work).

It is not possible to undertake this during and innovative task in the existing system of medical education. A new experimental medical education institution needs to be set up which will need flexibility and autonomy in the fields of administration, management, curriculum development and training methods. It will also need necessary academic recognition and support. (Jehangir Nagar University may open a new medical college of 20 students with the help of Gonoshasthaya Kendra, All aspects of medical education like curriculum, selection of students, teaching methods etc., would be formulated and implemented in an autonomous manner, without regard to recognition by the Bangladesh Medical Council. The product of this medical college can very well work in voluntary projects. If he/she is superior to the existing doctor, society would recognise them in due course).

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HEALTH AND DEVELOPMENT ISSUES IN BANGLADESH

Dear

Further to the letter dated 24 Nov 83, informing you about the visit of Dr Zafarullah Chowdhury to Bangalore on 1st December 1983 and inviting you to two of his public lectures at St John's Medical College and Indian Institute of Science respectively, this is to personally invite you to an informal meeting with him at the Indian Institute of Science on the same day between 12 noon and 1 pm and later 2 pm to 3 pm in KSCST Conference Hall.

During this meeting, we will get an opportunity to discuss many health and development issues in the context of Bangladesh and the impact of the GK Project as well as the newly promulgated government drug policy. As preparation for this discussion we request you to collect a resource file on Bangladesh which will be available at the Indian Social Institute, 24 Benson Road, Bangalore 560046 (Telephone:55189) from 28th November 1983. Since the number of participants at this informal meeting will have to be necessarily limited kindly inform one of the undersigned (leave message at numbers given) latest by 29th November 1983 whether you will/will not be able to attend the meeting.

Looking forward to your participation,

Yours sincerely,

Ravi Narayan
St John's Medical College
565435 Ext. 265

Duarte Barreto
Indian Social Institute
55189

Sanjay Biswas
Indian Institute of Science
(Science Circle)
34411 Ext. 331

24.11.1983

comm:
SJMC

ST JOHN'S MEDICAL COLLEGE

BANGALORE

RURAL COMMUNITY ORIENTATION PROGRAMME

KEY : A - Completely False

B - Mostly False

C - Partly False

D - Partly True

E - Completely True

Using the above key, indicate your choice :

1. Villagers are incapable of making independent decisions. ( )
2. I enjoy the company of simple village folk ( )
3. Villagers line is a sta-te of ignorance ( )
4. It is impossible to educate the villagers about primary health matters ( )
5. If our country has to prosper it is necessary to improve our villages. ( )
6. I believe that a dedicated Doctor can do a lot to improve a village. ( )
7. I would be unhappy if I would have to live in a village most of the time. ( )
8. To understand the villagers and the village life one must live in a village. ( )
9. To be a successful doctor one should work in large Hospitals ( )
10. A talented doctor is wanted in a village ( )
11. I am sure that after ten years I would be working in a village ( )
12. I feel that villagers are a dirty lot ( )
13. I believe that the health needs of a village can never be met fully in the village alone ( )
14. I am of the opinion that villagers are foolish people ( )
15. Village life is Healthy ( )

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16. It is the duty of every educated citizen to contribute his services for the upliftment of our villages ( )

17. For pleasure and happiness every person must have basic amenities of life ( )

18. I feel that villagers indulge in malacious gossip ( )

19. In general villagers can be described as tolerant people ( )

20. I would like to do my best to solve the socio-economic problems of my country ( )

21. It is necessary to understand the villagers if we are to be of any service to them ( )

22. All villagers are unhygienic people ( )

23. I would like to work in a village because I am convinced that our country will not prosper unless the health problems of every village are looked after ( )

24. I would like to work in a village because it is acceptble to me ( )

25. I feel that villagers are highly superstitious ( )

26. Villagers are highly suspecious people ( )

27. To be a good doctor one must have knowledge of both rural and urban life ( )

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ST JOHN'S MEDICAL COLLEGE
BANGALORE

RURAL COMMUNITY ORIENTATION PROGRAMME

Most of the following questions can be answered by checking ( ) one block in the series opposite each item or writing in a single word of figure.

1. Name..... 2.Age..... 3.Sex.....

4. Home Address .....
.....

5. Educational attainment of:

	General					Profe-ssion-al
	Not literate	Can just read & write	Primary	Secondary	College	Degree or Dip-loma
5.1 Father						
5.2 Mother						

6. Father's/Guardian's Employment:
Medical ( ) ; Engineering ( ) ; Agriculture ( );
Business ( ); Others, specify .....

7. Father's/Guardian's approx.Monthly Income
Upto Rs.200 ( ); Rs.201-500 ( );
Rs.501-1000 ( ); Rs.1001-3000 ( );
Above Rs.3000 ( ).

8.1 Religion: Hindu ( ); Muslim ( ); Christian ( )
other specify .....

8.2 Caste.....

9. Previous Residence	Village	Town Less than 10,000	City
Approximate No. of years			

10. Any other relatives who are in health work ?
Yes ( ) No ( ) Specify what [illegible] ?.....

ST JOHN'S MEDICAL COLLEGE

BANGALORE

Date .....

=-=-=-=-=-=

1. We would like to know your own personal preference among the medical specialities listed below. Please check ( ) one block opposite each speciality indicating the extent of your own interest in the speciality.

=-=-=-=-=-=

Speciality	Not interested	Slightly interested	Moderately interested	Greatly interested
1. General Practice				
2. General Medicine				
3. Obstetrics and Gynaecology				
4. Opthalmology				
5. Paediatrics				
6. Preclinical				
7. Paraclinical				
8. Community Medicine (in medical college)				
9. Public Health (services)				
10. Surgery				
11. Other specialities, specify				

For office use only

Name:

...2

: :

4. Please check ( ) in appropriate column

4.1 Ten years from now, what do you expect to be -

General Practitioner ( ); Specialist ( ) ;
Research Worker ( ); Other, specify .....

4.2 Ten years from now, where do you expect to be -

India ( ) ; United Kingdom ( ); U.S.A. ( ) ;

Other, specify .....

4.3 Ten years from now, how much money do you expect to earn monthly ? Please check ( ) in appropriate column below :

Less than Rs.1000
Rs.1001-2000
Rs.2001-3000
More than Rs.3000

5. We would like to have your views of the conditions under which you would be willing to serve in a rural health center. Please check ( ) one block opposite the statements

Conditions	Disagree	Partially disagree	Partially agree	Agree
1. I do not wish to practice in rural areas				
2. I would accept a rural health center job as my family is in urgent need of financial help				
3. I would go only as I am legally required to serve in rural areas.				

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4. contd....

Conditions	Disagree	Partially disagree	Partially agree	Agree
4. I would work in a rural healthcenter only if I cannot find work elsewhere				
5. I would work in a rural health center if this will give advancement in government service				
6. I would work in a rural area if I would not be stuck in village for life				
7. I would go only if permitted to live in a nearby town				
8. I would go to a rural area if there was improvement in both professional standards and living conditions				
9. I would go if a liberal rural allowance and provision for personal comforts were provided but without significant improvement in present professional opportunities				
10. I would go if facilities for maintaining good quality professional standards were provided and without particular regard for improved living conditions				
11. I am willing to go and serve in a rural area indefinitely				

For Office use only

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2. Listed below are various types of professional activities. Please check ( ) one block opposite each indicating the extent, to which, you personally feel attracted by that type of professional activity as a career choice.

=-=-=-=-=-=-=

Activity	Not interested	Slightly interested	Moderately interested	Greatly interested
1. Administration - health and hospital service				
2. Government Hospital				
3. General private practice Urban				
4. General private practice Rural				
5. Service in Private Hospitals including mission institutions				
6. Research				
7. Service in Armed Forces				
8. Primary Health Center				
9. Speciality (Private)				
10. Teaching				

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3. How important to you are the following factors in choosing your career? Please check ( ) in appropriate columns below :

Factors	Not Important	Slightly important	Moderately important	Very important
1. National Needs				
2. Family opinion including parents, and close relations				
3. Nearness to home				
4. Prestige				
5. Intellectual satisfaction				
6. Influence of teachers				
7. Financial remuneration				
8. Job security				
9. Specified hours of work				
10. Leisure opportunities				
11. Humanitarian and religious motivation				
12. Career opportunities				

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7. Listed below are a number of factors which may influence unfavourably the way you feel about working in a rural area. Please indicate how important these matters seem to you by checking ( ) one of the blocks opposite each item.

Factors	Not important	Slightly important	Moderately important	Very important
1. Lack of opportunity for postgraduate education				
2. Problems with personal grooming and appearance				
3. Unsuitable Housing				
4. Lack of opportunities for professional advancement				
5. Inadequate equipment				
6. Objections of wife/ husband (even if not married				
7. Objections of other family members				
8. Lack of stimulating professional contacts				
9. Lack of transportation facilities and communication with urban areas				
10. Inadequate drugs and supplies				
11. Difficulty of access to libraries, reference materials and research facilities				
12. Lack of social activities and recreational facilities				
13. Not enough remuneration				
14. Poor quality professional assistants				

contd...

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6. Listed below are a number of factors which may influence favourably the way you feel about serving in a rural area. Please indicate how important these factors seem to you by checking ( ) one of the blocks opposite each item.

Factors	Not important	slightly important	moderately important	very important
1. Combining preventive and curative services for individuals and families				
2. Service to particularly needy people				
3. Opportunity for meeting unpredictable medical problems				
4. Helping to meet the national need				
5. Participation in developmental activities				
6. Chance to organize health service for a large group of people				
7. Opportunity to study a community as a whole				
8. Spiritual and humanitarian motivation				
9. Being able to make your own schedule				
10. Having independent responsibility for diagnosis and treatment				
11. High position in village society				
12. Medical Care				

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7. contd.....

Factors	Not important	Slightly important	Moderately important	Very important
15. Lack of variety in clinical work				
16. Lack of educational facilities for children				
17. Lack of consultants				
18. Health hazards for family				
19. Being supervised by non-medical person				
20. Too many patients				
21. Fear of losing clinical skill				
22. Too few patients				
23. Fear for personal safety				
24. Political interference				
25. Involvement in medico-legal work				
26. Living in a village				

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8. We would like toknow some of your impressions about village people. Listed below are some paired opposite terms that might be used to describe any group. Think of villagers as a group rather than of any one villager you may know. There are no right or wrong answers.

Please give us your general impressions of village people checking on appropriate space between each pair.

For example :

Kind A ____ B ____ C ____ D ____ Unkind

If you think villagers generally are very kind, you would check space A, if you think they are somewhat kind you would check B, if you think they are a little unkind you would check C, and if you think they are unkind then check ( ) D. We would like to have your impressions even if you are not certain.

	A	B	C	D	
1. Clean	____	____	____	____	Dirty
2. Unhealthy	____	____	____	____	Healthy
3. Friendly	____	____	____	____	Unfriendly
4. Cooperative	____	____	____	____	Uncooperative
5. Lazy	____	____	____	____	Industrious
6. Well informed	____	____	____	____	Poorly informed
7. Undependable	____	____	____	____	Dependable
8. Wise	____	____	____	____	Foolish
9. Suspicious	____	____	____	____	Trusting
10. Poorly-fed	____	____	____	____	Well-fed
11. Cheerful	____	____	____	____	Unhappy
12. Honest	____	____	____	____	Dishonest
13. Non-religious	____	____	____	____	Religious
14. Rational	____	____	____	____	Superstitious
15. Pessimistic	____	____	____	____	Optimistic
16. Maliciously gossiping	____	____	____	____	Not gossiping

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For Office use only

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ST JOHN'S MEDICAL COLLEGE
BANGALORE

RURAL COMMUNITY ORIENTATION PROGRAMME

Most of the following questions can be answered by checking ( ) one block in the series opposite each item or writing in a single word of figure.

1. Name..... 2.Age..... 3.Sex.....

4. Home Address .....
.....

5. Educational attainment of:

	General					Profe-ssion-al
	Not literate	Can just read & write	Primary	Secondary	College	Degree or Dip-loma
5.1 Father						
5.2 Mother						

6. Father's/Guardian's Employment:

Medical ( ) ; Engineering ( ) ; Agriculture ( );

Business ( ); Others, specify .....

7. Father's/Guardian's approx. Monthly Income — Upto Rs.200 ( ); Rs.201-500 ( ); Rs.501-1000 ( ); Rs.1001-3000 ( ); Above Rs.3000 ( ).

8.1 Religion: Hindu ( ); Muslim ( ); Christian ( )
other specify .....

8.2 Caste.....

9: Previous Residence	Village	Town Less than 10,000	City
Approximate No. of years			

10. Any other relatives who are in health work ?
Yes ( ) No ( ) Specify, what and work ?....

ST JOHN'S MEDICAL COLLEGE

BANGALORE

Date .....

=-=-=-=-=-=

1. We would like to know your own personal preference among the medical specialities listed below. Please check ( ) one block opposite each speciality indicating the extent of your own interest in the speciality.

=-=-=-=-=-=

Speciality	Not interested	Slightly interested	Moderately interested	Greatly interested
1. General Practice				
2. General Medicine				
3. Obstetrics and Gynaecology				
4. Opthalmology				
5. Paediatrics				
6. Preclinical				
7. Paraclinical				
8. Community Medicine (in medical college)				
9. Public Health (services)				
10. Surgery				
11. Other specialities, specify				

For office use only

Name:

...2

: :

4. Please check ( ) in appropriate column

4.1 Ten years from now, what do you expect to be -

General Practitioner ( ); Specialist ( ) ;
Research Worker ( ); Other, specify .....

4.2 Ten years from now, where do you expect to be -

India ( ) ; United Kingdom ( ); U.S.A. ( ) ;

Other, specify .....

4.3 Ten years from now, how much money do you expect to earn monthly ? Please check ( ) in appropriate column below :

Less than Rs.1000
Rs.1001-2000
Rs.2001-3000
More than Rs.3000

5. We would like to have your views of the conditions under which you would be willing to serve in a rural health center. Please check ( ) one block opposite the statements .

Conditions	Disagree	Partially disagree	Partially agree	Agree
1. I do not wish to practice in rural areas				
2. I would accept a rural health center job as my family is in urgent need of financial help				
3. I would go only as I am legally required to serve in rural areas.				

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4. contd....

Conditions	Disagree	Partially disagree	Partially agree	Agree
4. I would work in a rural health center only if I cannot find work elsewhere				
5. I would work in a rural health center if this will give advancement in government service				
6. I would work in a rural area if I would not be stuck in village for life				
7. I would go only if permitted to live in a nearby town				
8. I would go to a rural area if there was improvement in both professional standards and living conditions				
9. I would go if a liberal rural allowance and provision for personal comforts were provided but without significant improvement in present professional opportunities				
10. I would go if facilities for maintaining good quality professional standards were provided and without particular regard for improved living conditions				
11. I am willing to go and serve in a rural area indefinitely				

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2. Listed below are various types of professional activities. Please check ( ) one block opposite each indicating the extent, to which, you personally feel attracted by that type of professional activity as a career choice.

=-=-=-=-=-=-=-=

Activity	Not interested	Slightly interested	Moderately interested	Greatly interested
1. Administration - health and hospital service				
2. Government Hospital				
3. General private practice Urban				
4. General private practice Rural				
5. Service in Private Hospitals including mission institutions				
6. Research				
7. Service in Armed Forces				
8. Primary Health Center				
9. Speciality (Private)				
10. Teaching				

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3. How important to you are the following factors in choosing your career? Please check ( ) in appropriate columns below :

Factors	Not Important	Slightly important	Moderately important	Very important
1. National Needs				
2. Family opinion including parents, and close relations				
3. Nearness to home				
4. Prestige				
5. Intellectual satisfaction				
6. Influence of teachers				
7. Financial remuneration				
8. Job security				
9. Specified hours of work				
10. Leisure opportunities				
11. Humanitarian and religious motivation				
12. Career opportunities				

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7. Listed below are a number of factors which may influence unfavourably the way you feel about working in a rural area. Please indicate how important these matters seem to you by checking ( ) one of the blocks opposite each item.

Factors	Not important	Slightly important	Moderately important	Very important
1. Lack of opportunity for postgraduate education				
2. Problems with personal grooming and appearance				
3. Unsuitable Housing				
4. Lack of opportunities for professional advancement				
5. Inadequate equipment				
6. Objections of wife/ husband(even if not married				
7. Objections of other family members				
8. Lack of stimulating professional contacts				
9. Lack of transportation facilities and communication with urban areas				
10. Inadequate drugs and supplies				
11. Difficulty of access to libraries, reference materials and research facilities				
12. Lack of social activities and recreational facilities				
13. Not enough remuneration				
14. Poor quality professional assistants				

contd...

: :

6. Listed below are a number of factors which may influence favourably the way you feel about serving in a rural area. Please indicate how important these factors seem to you by checking ( ) one of the blocks opposite each item.

Factors	Not important	slightly important	moderately important	very important
1. Combining preventive and curative services for individuals and families				
2. Service to particularly needy people				
3. Opportunity for meeting unpredictable medical problems				
4. Helping to meet the national need				
5. Participation in developmental activities				
6. Chance to organize health service for a large group of people				
7. Opportunity to study a community as a whole				
8. Spiritual and humanitarian motivation				
9. Being able to make your own schedule				
10. Having independent responsibility for diagnosis and treatment				
11. High position in village society				
12. Medical Care				

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7. contd.....

Factors	Not important	Slightly important	Moderately important	Very important
15. Lack of variety in clinical work				
16. Lack of educational facilities for children				
17. Lack of consultants				
18. Health hazards for family				
19. Being supervised by non-medical person				
20. Too many patients				
21. Fear of losing clinical skill				
22. Too few patients				
23. Fear for personal safety				
24. Political interference				
25. Involvement in medico-legal work				
26. Living in a village				
For Office use only				

8. We would like toknow some of your impressions about village people. Listed below are some paired opposite terms that might be used to describe any group. Think of villagers as a group rather than of any one villager you may know. There are no right or wrong answers.

Please give us your general impressions of village people checking on appropriate space between each pair.

For example :

Kind __A__ __B__ __C__ __D__ Unkind

If you think villagers generally are very kind, you would check space A, if you think they are somewhat kind you would check B, if you think they are a little unkind you would check C, and if you think they are unkind then check ( ) D. We would like to have your impressions even if you are not certain.

	A	B	C	D	
1. Clean	____	____	____	____	Dirty
2. Unhealthy	____	____	____	____	Healthy
3. Friendly	____	____	____	____	Unfriendly
4. Cooperative	____	____	____	____	Uncooperative
5. Lazy	____	____	____	____	Industrious
6. Well informed	____	____	____	____	Poorly informed
7. Undependable	____	____	____	____	Dependable
8. Wise	____	____	____	____	Foolish
9. Suspicious	____	____	____	____	Trusting
10. Poorly-fed	____	____	____	____	Well-fed
11. Cheerful	____	____	____	____	Unhappy
12. Honest	____	____	____	____	Dishonest
13. Non-religious	____	____	____	____	Religious
14. Rational	____	____	____	____	Superstitious
15. Pessimistic	____	____	____	____	Optimistic
16. Maliciously gossiping	____	____	____	____	Not gossiping

For Office use only

prk/181281

ST JOHN'S MEDICAL COLLEGE

BANGALORE

RURAL COMMUNITY ORIENTATION PROGRAMME

KEY : A - Completely False

B - Mostly False

C - Partly False

D - Partly True

E - Completely True

Using the above key, indicate your choice :

1. Villagers are incapable of making independent decisions. ( )
2. I enjoy the company of simple village folk ( )
3. Villagers line is a sta-te of ignorance ( )
4. It is impossible to educate the villagers about primary health matters ( )
5. If our country has to prosper it is necessary to improve our villages. ( )
6. I believe that a dedicated Doctor can do a lot to improve a village. ( )
7. I would be unhappy if I would have to live in a village most of the time. ( )
8. To understand the villagers and the village life one must live in a village. ( )
9. To be a successful doctor one should work in large Hospitals ( )
10. A talented doctor is wanted in a village ( )
11. I am sure that after ten years I would be working in a village ( )
12. I feel that villagers are a dirty lot ( )
13. I believe that the health needs of a village can never be met fully in the village alone ( )
14. I am of the opinion that villagers are foolish people ( )
15. Village life is Healthy ( )

...2

16. It is the duty of every educated citizen to contribute his services for the upliftment of our villages ( )

17. For pleasure and happiness every person must have basic amenities of life ( )

18. I feel that villagers indulge in malacious gossip ( )

19. In general villagers can be described as tolerant people ( )

20. I would like to do my best to solve the socio-economic problems of my country ( )

21. It is necessary to understand the villagers if we are to be of any service to them ( )

22. All villagers are unhygienic people ( )

23. I would like to work in a village because I am convinced that our country will not prosper unless the health problems of every village are looked after ( )

24. I would like to work in a village because it is acceptble to me ( )

25. I feel that villagers are highly superstitious ( )

26. Villagers are highly suspecious people ( )

27. To be a good doctor one must have knowledge of both rural and urban life ( )

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prk/191281

DIRECTORATE OF RURAL HEALTH SERVICES
AND TRAINING PROGRAMMES

ST JOHN'S MEDICAL COLLEGE
BANGALORE 34

TRAINING PPOGRAMME FOR COMMUNITY
..... HEALTH WORKERS

PRE/POST COURSE TEST

DATE :

ANSWER AS MANY AS YOU CAN FROM THE FOLLOWING

I. 1. Write a few sentences about Community Development ?

2. Name the extension services involving any three areas of Development ?

3. Mention the names of a few Voluntary Organisations you know ?

4. If you are required to identify the local leaders what methods you adopt ?

5. Tick the correct functions of a Primary Health Centre from the following :

1) Control of communicable diseases

2) Transport and communication

3) Environmental Sanitation

4) Banking and Industry

5) MCH & Family Planning & Nutrition

6) Health Education

6. When you visit a family in a village and spend one hour, what are all the items you observe which have bearing on the health of the family.

7. During your family visit, one of the members asks you about diseases spread through water. What are they and how will you explain ?

8. What is communicable and non-communicable diseases ? Give examples.

9. How will you manage a case of diarrhoea in a child ?

10. How can you make water safe for drinking ?

....2

II. Write what you know about the following :

1. Minimum needs programme
2. Integrated Child Development Scheme
3. Balanced Diet
4. Village Birth Attendant or Dai
5. Fever Treatment Depot
6. Flannelgraph
7. Incubation Interval
8. Contamination
9. Isolation
10. Endemic
11. Crude death rate
12. Fly control measures.

...3

III. Answer YES OR NO depending on whether you agree or disagree with the following statements:

1. It is better to keep the local leaders away for effective implementation of any health programmes (Yes/No)

2. Vitamin ' A ' deficiency leads to beriberi (Yes/No)

3. Chloroquin is an antileprosy drug (Yes/No)

4. Soakage pit is ideal in porous terrain of rural areas (Yes/No)

5. Waterseal prevents fly breeding in Hand Flush Latrine (Yes/No)

6. Postnatal care includes care of mother and care of infant. (Yes/No)

IV. Fill up the blanks with the correct word given in the brackets.

1. Deficiency of iodine in food leads to _____

(Goitre/Marasmus/Scurvy)

2. Deficiency of iron in food causes _____

(Anaemia/Scabies/Anguler stomatitis)

3. _____ is richest single source of Vitamin C

(Sapota/Amla/Papaya)

4. Groundnut is rich source of _____

(Protein/Vit.A/Calcium)

5. Night blindness is caused by _____

(Deficiency of VitA/Vit.C/Vit.D)

6. Flash cards could be effectively used as an educational aid for _____ (Mass/Small group/Big group)

7. Kwashiorker is caused due to _____

(Successive pregnancies/rice eating/ protein deficiency)

8. Secondary Immunization against tetanus is to be given for antenatal mothers _____ (Once/Twice/Thrice)

9. Bleaching powder is used to disinfect _____

(Water/Milk/Meat)

10. The formula to calculate the Quantity of water in a round well is _____

.....

COM H 27.6

RURAL ORIENTATION PROGRAMME

Assessment Questionnaire

1 List out 4 consequences of the following situations, IN THEIR ORDER OF PRIORITY, that YOU think are most important for a RURAL family.

1. Minimum monthly expenditure requirement and monthly income do not meet.
2. Chronic indebtedness to the local money lender.
3. The monsoon rains have failed this year
4. Drinking water wells in the Harijan block of the village have dried up.
5. A Harijan has been elected to the Panchayat of the village
6. The nearest rural Health Centre is 25 Kms. away
7. The mother of a sick child believes that she and her child are being punished for their sins.
8. There is only one bus which passes through the village on its way to the City and its timing and regularity are unpredictable.
9. The village is at the cross-roads where several buses from different parts, pass through, on their way to the city.
10. The nearest primary school is 15 Kms. away.
11. The village has a primary school, a middle school and a high school.
12. Majority of the villagers are farmers.
13. Majority of the villagers are petty tradesmen
14. Majority of the villagers work in the factories of the nearby city.
15. There are four daughters aged 12 to 18 years, in the family.
16. 6 members of the family live in a single-roomed house.
17. All the 3 sons of the family have completed their B.Sc. and B.A. degrees in the nearby City and are currently unemployed.
18. There is a woman representative in the local panchayat body.
19. The village has a Primary Health Centre with 10 beds, 2 doctors including a lady doctor and several health workers.
20. The nearest post office and bank are 25 Kms. away.
21. The village has its own post and telegraph office as well as a small bank.
22. The birth of a male child in a rural family is more welcome than that of a female child.
23. Consumption of rice is considered as a social status symbol among the villagers.
24. Six times a year, the village is used as a Training Centre by a nearby urban medical college.
25. Any other situation which you feel relevant to the village community.

RURAL ORIENTATION PROGRAMME

Assessment Questionnaire

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COMH 27.5

extra

DEPT OF COMMUNITY MEDICINE

ST JOHN'S MEDICAL COLLEGE, BANGALORE 34

RURAL HEALTH EVALUATION REPORT

The following pages contain a number of incomplete stories. We want you to read and complete them giving your imaginative best as to what happened from the point where it was left off. There are no right or wrong conclusions to those stories.

Please do not try to read all of them first and then go back over them to write the conclusions.

You have only 5 minutes for each. In order to finish all of them in the allotted time you will have to write your spontaneo reaction immediately after reading each story.

1. Dr Singh is a young doctor who has finished a year's surgical house officership in his medical college hospital. He has to choose between two assignments each for a period of approximate 2 years.

The first is a government primary health centre only 5 miles from the medical college with good road connections so that it is easy for both patients and the doctor to go back and forth to the city. The second is a health centre in an isolated valley in the Himalayas, which is supported by his own religious organization. It is in an area of great medical need where communications with the outside world are frequently out off by weather and bad roads.

What choice did he make and why ?

2. Dr. Banerji is a successful practitioner who had never been out of Calcutta. He has just returned from his first visit to a village where he had gone with a wedding party. In talking w Dr Chatterji, a young colleague who was born and brought up in a village, he expresses in strong languages his revulsion and disgust at the lack of laterines in the village. He vows, that he will never go back to a village again because he can't bear the thought of going out to the fields morning and night. Dr Chatterji responds

3. Dr Viswanathan had been surprised to find that his 5 years in primary health centre had passed as a rapid and pleasant interlude. His wife and two children aged 4½ and 2½ enjoyed the life in the village and the children played happily with some of the village children. One spring day the doctor saw 5 cases of severe vomitting and diarrhoea in the dispensary. On going home he was called next door and found the 4 year old friend of his own child dying of cholera. Dr Viswanathan immediately

4. On graduation from the medical college Dr Gupta had three alternative choices. He could accept a job in a government Primary Health Centre where he could start earning Rs.550/- per mont His maternal uncle who was private practitioner in a big city invited him to join his clinic as a junior at 200 rupees a month. He was selected to do post-graduate work in a subject for which he had no particular preference. After careful consideration [illegible] decided to

DEPT OF COMMUNITY MEDICINE

ST JOHN'S MEDICAL COLLEGE, BANGALORE 34

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Com H 27.7

DIRECTORATE OF RURAL HEALTH SERVICES
AND TRAINING PROGRAMMES

ST JOHN'S MEDICAL COLLEGE
BANGALORE 34

TRAINING PPOGRAMME FOR COMMUNITY
HEALTH WORKERS

PRE/POST COURSE TEST

DATE :

ANSWER AS MANY AS YOU CAN FROM THE FOLLOWING

I. 1. Write a few sentences about Community Development ?

2. Name the extension services involving any three areas of Development ?

3. Mention the names of a few Voluntary Organisations you know ?

4. If you are required to identify the local leaders what methods you adopt ?

5. Tick the correct functions of a Primary Health Centre from the following :

1) Control of communicable diseases

2) Transport and communication

3) Environmental Sanitation

4) Banking and Industry

5) MCH & Family Planning & Nutrition

6) Health Education

6. When you visit a family in a village and spend one hour, what are all the items you observe which have bearing on the health of the family.

7. During your family visit, one of the members asks you about diseases spread through water. What are they and how will you explain ?

8. What is communicable and non-communicable diseases ? Give examples.

9. How will you manage a case of diarrhoea in a child ?

10. How can you make water safe for drinking ?

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II. Write what you know about the following :

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4. Village Birth Attendant or Dai
5. Fever Treatment Depot
6. Flannelgraph
7. Incubation Interval
8. Contamination
9. Isolation
10. Endemic
11. Crude death rate
12. Fly control measures.

...3

III. Answer YES OR NO depending on whether you agree or disagree with the following statements:

1. It is better to keep the local leaders away for effective implementation of any health programmes (Yes/No)
2. Vitamin 'A' deficiency leads to beriberi (Yes/No)
3. Chloroquin is an antileprosy drug (Yes/No)
4. Soakage pit is ideal in porous terrain of rural areas (Yes/No)
5. Waterseal prevents fly breeding in Hand Flush Latrine (Yes/No)
6. Postnatal care includes care of mother and care of infant. (Yes/No)

IV. Fill up the blanks with the correct word given in the brackets.

1. Deficiency of iodine in food leads to _____ (Goitre/Marasmus/Scurvy)
2. Deficiency of iron in food causes _____ (Anaemia/Scabies/Anguler stomatitis)
3. _____ is richest single source of Vitamin C (Sapota/Amla/Papaya)
4. Groundnut is rich source of _____ (Protein/Vit.A/Calcium)
5. Night blindness is caused by _____ (Deficiency of VitA/Vit.C/Vit.D)
6. Flash cards could be effectively used as an educational aid for _____ (Mass/Small group/Big group)
7. **Kwashiorker is caused due to** _____ (Successive pregnancies/rice eating/ protein deficiency)
8. Secondary Immunization against tetanus is to be given for antenatal mothers _____ (Once/Twice/Thrice)
9. Bleaching powder is used to disinfect _____ (Water/Milk/Meat)
10. The formula to calculate the Quantity of water in a round well is _____

.....

Extra

COMH27

DIRECTORATE OF RURAL HEALTH SERVICES
AND TRAINING PROGRAMMES

ST JOHN'S MEDICAL COLLEGE
BANGALORE 34

TRAINING PROGRAMME FOR COMMUNITY
HEALTH WORKERS

PRE/POST COURSE TEST

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....2

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8. Secondary Immunization against tetanus is to be given for antenatal mothers _____(Once/Twice/Thrice)

9. Bleaching powder is used to disinfect _____

(Water/Milk/Meat)

10. The formula to calculate the Quantity of water in a round well is _____

.....

Case no. 5

Alternative Methods of Health Care Delivery at the Village Level

Ranga Reddy district, Andhra Pradesh

Dr. Prakasamma*

The Partners: ANS and ICOMP

Ponnal & Kolthur, Ranga Reddy district

Community managed health centers

BACKGROUND

This case study describes an innovative field experiment in which two types of health workers were appointed to assess their effectiveness on providing access and quality of services in rural areas. This experiment was set up in two villages where government health centres were not located.

The Academy for Nursing Studies (ANS), Hyderabad with financial assistance for the research component from the International Committee on Management of Population (ICOMP), Kuala Lumpur carried out this experiment. Expenditures on services were met either by the community or by the clients.

The case study compares quality and quantity of services provided in two village health centres, both started in March 1997 in Ponnal and Kolthur villages under Shamirpet PHC of Ranga Reddy district in Andhra Pradesh. The two villages were similar in many respects. Both the villages were located at some distance from the PHC and subcentre. Kolthur was located 9 km from the subcentre and 15 km from the PHC. Ponnal was located 7 km from its subcentre and 10 km from the PHC. Both the villages were away from the main road. Though bus facility was available, buses were irregular and infrequent. The situation was worse during the rainy season. A bad stretch of road made them inaccessible during the rains. As a result, ANMs from government centres visited those villages usually once a fortnight. Both villages had strong and functional Women's Health Groups. These groups had their own bank accounts and were registered societies. Both villages were located away from subcentres. Government ANMs visited these villages once a fortnight or less. Other common features of the two villages were:

- Communities had decided to start the centres
- WHGs were responsible for monitoring both the centres
- Health workers stayed in the village and provided round-the-clock services
- Village health workers collaborated with the government health workers
- Academy of Nursing Studies ensured referral linkages and supervised at both the centres

**: Honorary Secretary, Academy for Nursing Studies (ANS)*

How the innovation was identified

In 1995, ICOMP had initiated a series of projects in three Asian countries (India, Vietnam and Sri Lanka) to improve the quality of care in health and family welfare programmes. In India, the Administrative Staff College of India (ASCI) implemented the project in Shamirpet PHC, during 1995-97.

Health scenario in project area

This project had shown that the benefits of ANMs' services were available to those villages where sub-centres were located. Villages located far away from these centres did not receive even the basic health services. Some of these villages were large enough to require health centres of their own. In most villages, demand for services had increased due to the intensive community mobilisation activities carried out during the quality of care project. WHGs in these villages were willing to participate in health care activities and wanted to establish regular health services in their villages.

Government of Andhra Pradehs's Universal Health Service Programme.

In the meantime, the Government of Andhra Pradesh was also considering the possibility of expanding health services to remote villages to increase their access to services. The government had started a massive programme for building awareness regarding government health facilities. Moreover, the Vision 2020 of the state government had envisaged a universal health services programme. In accordance with that vision the government planned to introduce *Arogya Sevikas* who would be trained for a short duration (3 months) and posted in their villages. They would operate village health centres with support from ANMs. The government had already started training *Arogya Sevikas* in some districts.

Arogya sevikas and a self employed ANM

ANS decided to try out an alternative, which was to be a self-employed ANM willing to operate village health centres. Andhra Pradesh has surplus trained ANMs who have not been absorbed in government service. The field experiments planned in Kolthur and Ponnal involved starting two village health centres, one looked after by an Arogya Sevika and one by a self-employed ANM. This experiment was to provide inputs for the state government's policy of appointing Arogya Sevikas and assess the effectiveness of the proposed alternative.

Description of the Intervention

In this experiment, two service-delivery options were tried in two large but remote villages where access to government health centres was low. One option was a married woman from the village and

another was a self-employed ANM (Box 1).

Box 1: Service delivery options

Option I: Arogya Sevika (Village health worker)

This option involved selecting, training and guiding an educated married woman of the village, to provide basic health care round the clock from a village health centre.

Option II: Self-employed ANM

This option involved appointing, training and supporting a qualified ANM not employed in the government system, to set up and manage a village health centre.

Two villages—Ponnal and Kolthur, in Shamirpet PHC were selected for this experiment. The similarity between the two villages was deliberate, so as to facilitate comparison of results at the end of the experiment.

Active WHGs

Both villages had poor access to health facilities. But the village environment in both the villages was supportive to the experiment. The panchayat members showed interest and willingness to contribute in cash and kind to the health centres. Both sarpanchs were women from backward communities. The WHGs of both villages were active and willing to support health centres in their villages. In one village, Ponnal, the Women's Health Group (WHG) nominated a young married woman from the village to run the village health centre. In another village, Kolthur, the health centre was run by a qualified ANM as a self-employed health practitioner. The WHGs held regular meetings and demonstrated team spirit and cohesiveness among themselves.

However the two villages were slightly different on three counts—their size, spread and people's willingness to support an ANM (Box 2)

Box 2: Details about the two villages

	Ponnal	Kolthur
Population	2,101	3,210
Households	400	600
Outreach	No hamletsattached to the village	Village was spread out with two hamlets.
Willingness	Villagers doubted their ability to support a qualified ANM	Villagers wanted a fully qualified ANM and were willing to take responsibility for her payment and accommodation.

Roles of WHGs, ANS and health facilities

Both the centres functioned under the administrative control of the village WHG. The Academy for Nursing Studies undertook technical monitoring, PHC and other nearby hospitals provided referral support. The WHG decided the amount and mode of payment to the health worker.

Implementation Experience

The implementation process consisted of five steps.

Identification of health workers

For selecting *Arogya Sevika*, the ground rules were that she should be educated at least up to tenth standard, must be young and married. She should have a small family and minimum financial constraints so that she could devote time for health activities. The choice of *Arogya Sevika* was left to the Women's Health Group. ANS took the responsibility for selecting an ANM. For that the ANS first conducted a seminar on self-employment for ANMs. More than 60 trained ANMs who were not employed in the government service, attended this seminar. There it became clear that many ANMs were in need of employment and that several of them were willing to set up village health centres on their own if they were given the opportunity and initial support. This is a peculiar situation in Andhra Pradesh, which has the largest number of ANM training schools in the country. Their output is too large for the government to absorb. Thousands of ANMs are working in private nursing homes and hospitals for very low salaries.

The health workers selected in the two villages were (Box 3):

Box 3: Characterisitics of the health workers

Arogya Sevika at Ponnal

- **A young married woman from the village with two grown up children**
- **Educated up to tenth standard, no prior training in health**
- **Nominated by the WHG.**
- **Willing to run the health centre for the remuneration decided by WHG**

Self-employed ANM at Kolthur health centre

- **A qualified ANM from another district**
- **Selected and trained by the ANS.**
- **Previously worked in a private nursing home.**
- **Willing to operate a health centre on a self-employment basis**

Discussions with community members

After ensuring that it was possible to recruit an ANM to operate a village health centre, members from ANS held meetings of the gram sabha (village panchayat) in both the villages. These meetings were conducted in open places where anyone in the village could participate irrespective of caste or economic status. Three such Gram Sabhas were conducted in Ponnal and four in Kolthur. Issues discussed were whether the panchayat would provide space for the health centre, who will maintain the facility, what services will be provided, role of WHG, and how the fee structure would be decided. Villagers in both the villages agreed to provide space and suggested possible sites for the health centre. They made the final decision in consultation with the ANS members.

Negotiations and Bargaining

Negotiating terms for setting up the health centres was an interesting process that took place at three levels. The first level was between the ANS and the villagers. The villagers tried to get the most from the ANS funds for drugs, repairs, maintenance, salaries, etc., while the ANS tried to insist on local resources and participation. The second level was between the WHG and the village panchayat. The women's health groups wanted panchayat contributions and official support for its activities. Panchayats wanted the WHG to generate as much funds through fees and donations as possible. The third level was between the health workers and the WHG. This included

negotiating the terms of work and payment between the *Arogya Sevika* / ANM and the WHG.

Finally the ANS bore the costs of equipment, furniture, records, and training. The panchayat gave a house to the WHG and made necessary repairs.

Recruitment and training

The voluntary Arogya Sevika in Ponnal required repeated and long duration training in basic health care. The training was provided by ANS, and an ANM from the PHC. The training included certain clinical skills such as antenatal examination and care, child care, simple health concepts, high risk assessment, checking blood pressure, giving injections, first aid and simple medication. In spite of repeated training the Arogya Sevika did not feel confident about conducting deliveries. The community did not think she was properly trained because she had not attended any formal training program. She therefore had to enrol for the 6-month Anganwadi Workers training programme provided by the Women's Development and Child Welfare Department.

In Kolthur, the ANM did not need technical training since she had been previously working in a private nursing home. ANS gave her one-month's training mainly in clinic management, accounts and record keeping. This was followed by a short refresher course every three months. She was also asked to make a commitment to work for at least two years.

Setting up of the centres

The project spent about Rs.50,000/- on setting-up the two health centres. This amount excluded payments for the workers and costs of monitoring and mid-term evaluation (Box 4). The project provided a medicine grant of up to Rs. 10,000 per centre to cover their first two years of operation. Thereafter medicines were to be purchased either by the panchayat or by the patients. However, payment to the workers was always the responsibility of the community. In Ponnal, the WHG paid the Arogya Sevika Rs. 450 per month as honorarium. In Kolthur, the ANM earned about Rs. 2000 - 3000 per month from the service charges she collected, using the fee structure decided by the WHG.

Box 4: Direct expenditures from 1996-98

	Ponnal (Rupees)	Kolthur (Rupees)
Community mobilisation	15,000	15,000
Equipment and furniture	13,500	15,000
Records and stationery	2,200	2,200
Drugs and supplies for three months	10,000	8,000
Training of health workers	3,500	-
Support of ANS	5,000	6,500
Total	49,200	46,700

Outcome of the Intervention

Evaluation of the experiment

Three years after the experiment was initiated, three independent investigators evaluated its outcome in February 1999. Data for this evaluation was gathered from 145 households of Ponnal and Kolthur villages, from village leaders, health providers, members of WHG, and government health staff. Their evaluation termed Ponnal a failure and Kolthur a success based on the following findings.

At Ponnal, the evaluating team noted that:

- The village health centre was not functioning regularly
- Villagers did not trust the abilities of the Arogya Sevika and did not utilise her services to the desired extent.
- *Arogya Sevika* did not seem confident about providing health services due to her lack of experience and formal training.
- She did not stock medicines because villagers were not willing to buy medicines from her.
- She did not make village rounds; there was a gap between her and the villagers.
- The village health centre had functioned only for about a year; villagers were mostly going to a private practitioner who had spread the word that the Arogya Sevika was not trained to provide health services.
- The WHG in the village had stopped functioning because of internal fights. As a result, the Arogya Sevika had lost interest in the village health centre and was looking for better avenues of employment.

At Kolthur, the evaluation team noted:

- The village health centre was well maintained and the ANM was

residing in the centre with her family.

- Since the ANM was well trained, villagers trusted her skills and were willing to use her services.
- The ANM seemed knowledgeable and confident about providing treatment for minor ailments and handling deliveries.
- The villagers paid for medicines. The ANM was able to maintain good stock of medicines, which she purchased from pharmaceutical salesmen.
- The ANM made frequent visits to villagers which helped her build a rapport with them. Women in turn visited her frequently.
- The centre was functioning without a break and round the clock because the ANM stayed at the centre.
- However, the ANM was running the health centre almost as a private practice with little supervision from the WHG.

The household surveys in the two villages also found substantial differences in the awareness, utilisation and satisfaction levels in the two villages (Box 5)

Box 5: Survey results

	Ponnal (n=74) (%)	Kolthur (n=71) (%)
1. Awareness about health centre	85.1	100.0
2. Knew timings of health centre	35.1	98.6
3. Households reported having used the centre in previous 6 months	32.4	84.5
4. Number of deliveries conducted in the centre in one month	Nil	1
5. Respondents expressed satisfaction with centre's functioning	22.8	97.2
6. Thought the care provider had the necessary skills	23.0	84.5
7. Respondents appreciated the attitude of care provider	36.5	98.5
8. Respondents felt the centre should continue to operate	86.5	98.6

Lessons learnt

Several lessons emerging from this experiment can guide efforts to extend primary health care to remote villages. Most large size villages that are located away from the health centre need a village health centre. But to make that centre a success requires several ingredients.

Consensus on establishing the centre

The decision to establish a village health centre was on consensus among village residents, especially among those who were involved in the centre's functioning. Starting a centre involves many decisions, some of which have potential for conflict. For example, the decision about where to locate the centre, what support to provide, how much to pay to the worker, are issues that are potentially contentious. In this experiment most of these issues were amicably settled probably because of the involvement of ANS, a helpful and competent outsider. When a NGO is not involved, a PHC can play that role.

Presence of a support group in the village

The presence of an active and motivated women's health group was very important for starting a village health centre. This group negotiated with the village panchayat and with the service providers to get the best possible terms for village residents. The group provided support to the workers, which the village panchayat could not have provided . In Ponnal village the centre functioned as long as the WHG was active. When the WHG stopped functioning due to internal conflicts, the clinic also became ineffective.

Sustaining worker's interest

The interest of the health worker in operating the centre was the key to sustaining the health centre. In both the villages, the community decided what they would pay to the worker. In Ponnal village the community decided to pay a salary to the worker. The amount was based on the community's ability to pay and not necessarily on what she deserved. Arogya Sevika was dissatisfied with what she received as honorarium and began to look for better alternatives. In Kolthur, the ANM was allowed to charge fees for her service as per the fee structure decided by the WHG. This arrangement allowed her to earn more by providing services, and retained her interest in running the centre.

Quality and accepatability of services

Community's perception of service quality was the key to acceptability of services. The community will be interested in sustaining a health centre if the service provider is perceived as competent, if the services are available at the time of need and the service provider is seen as being helpful and doing her best.

In Ponnal village, the community did not think that the *Arogya Sevika* was providing quality services. There lay the crux of the centre's failure. In Kolthur village, the ANM's services were highly acceptable. Therefore the centre continued to function well even though people had to pay for the services they could get free of cost from the government ANM.

Community ownership

The community not just participated, but also owned the initiative. Though initiative for this project came from a NGO, the village panchayat and the WHGs were aware that the NGO's involvement would be limited and its support would be for the first three months only. Though WHGs in both the villages participated fully, the ownership sense in Kolthur was stronger than that in Ponnal. WHG members in Kolthur village actively sought donations in cash and kind. They devised schemes to generate corpus funds. They organised Shramadans for cleaning and maintaining the health centre. They took pride in announcing the fact that their village was the first to start a health centre of its own. They invited leaders from the surrounding villages, PHC Medical Officers and staff, and also the press to give publicity to their centre.

Self employed ANM an effective option in remote villages

This experiment showed that a qualified ANM working as a self-employed professional is a more effective option for service delivery in remote villages than a poorly trained woman from the village. This concept needs to be promoted especially in states where unemployed ANMs are many. One should also realise that this concept will work in villages that are remote but not too poor. People must have the need and capacity to pay for services. In the country, there may be a sizeable number of such villages where this option needs to be encouraged, to improve quality and access to primary health care.

ComH-27.

nowing about rural community development in india.

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Lob

Dear friends,
Greetings
In 1988, Gopal quit his job in the hospital from the twin city of Hubli-Dharwad, and we decided to go a working in Kittur (in Belguam district, in Karnataka, in India) with the villagers in remote rural areas on issue health, but with an open mind to being flexible, depending on the people´s need. It was a great experienc several things (had to unlearn what ever we had studied in colleges!). People`s priorities turned to be sch children, transport, water and ultimately the struggle for the land and not the dozens of diseases that were medical colleges.
A friend of us, Srikar M S visited us at that time. And here is the report he presented.
But why this report now? For that we will have to take you for a little flash back. Our friends who, worked us(Gangadhar, Ashok and Mahaveer) in the villages at that time continue to work in a neighbouring cluster We will visit them this time (as we are visiting India on July 6th for a period of six weeks) and get more ne those who are interested in knowing about community development,
So do let us know what you feel about getting to know more and also getting involved in this venture.
With all best wishes.

Sharada and Gopal

TO: RRP
2/7/01

Kulavalli Gudda

A Struggle Still Unrecognised

by
Srikar M S
(National Law School of India;Bangalore)

INTRODUCTION

"The power, when it comes, will belong to the whole people of India".
M K Gandhi.

It has been 48 years since India gained independence from the clutches of British dominance, but wh "belongs" to the "people" of India is questionable. Before independence, it was quite evident that the Brit bourgeoisie were the one`s to benefit the most. Has the India Bourgeoisie taken over even after "indepe Conditions at the macro level, have no doubt changed but the direction of these developments pose seri still unanswered. There seem to exist "Two-India`s-In-One", the prosperous elite; the computerised India the poor and the neglected: the masses called `Bharat´. Unimaginable socio-economic inequalities exist two parallel societies in India. The masses seem to be powerless, the power having shifted to corrupt po influential bureaucrats, both of whom show an utter lack of concern to the myriad of problem`s faced by th

My exposure to Kulavalli Gudda (in Belguam) proved to be an excellent opportunity to comprehend th various peoples in Indian villages.The word Gudda literally means hills. The outcome of this visit was my the harsh realities of life, the socio-economic condition and the complex legal intricacies that the people i in.

A BRIEF HISTORY OF KULAVALLI GUDDA

The Kulavalli Gudda comprises of 9 villages namely Kulavalli, Sagara, Kathri Daddi, Paper Mill, Galag Gangyanatti, Machi, Ningapur and Dindalkoppa, having 30 to 40 houses each on an average. the populati Lingayats, Muslims, Dalits, and Scheduled Tribes living in different proportions in these villages. It`s histo traced back to the times of Rani Chennamma of Kittur who along with her trusted lieutenant Sangolli Raya about 12,000 acres of land to the persons who had assisted them in capturing Sangolli Rayanna. This 12 Kulavalli Gudda, which once comprised of rich and thick forests. The `Inam´or gift was given to persons w called Inamders and they came to own these lands. The once thick forests gradually vanished with the Inamdars/Landlords allowing various people from other nearby places to clear the forests and cultivate th done illegally and without records. Thus small farmers have cleared small tracts on for the past three or f

The majority consists of the marginal farmers who barely seek out an existence by cultivating unviable land. Since irrigational facilities are unheard of by the farmers, there is absolute dependence on the unpr monsoon showers.The only other source of income is daily-wage work in places as far as Goa on constr

The people of these villages face certain problems peculiar to them with certain typical problems fac whole of rural India. The most vital issue for the villagers is that of "Land".Along with the complex land iml is lack of clean water, transport, education and electricity. In some villages the situation is acute that one w whether our luxurious city life is justified. India`s independence, `equality´, `liberty´, `freedom´ and of late makes no sense to the people who are denied basic necessities.

In spite of myriad social welfare legislations enacted by the state the situation has not changed for th villagers are still uncertain about the status of `their´land.The absence of their names in the records of rig cultivators/Tenants column makes it all the more difficult for their legitimate right. The response of the Go officials was not very encouraging. They seemed to have turned a blind eye to this problem— contributing to the lack of faith of the people in the Governmental machinery. Though at the moment, the threat from th has been overcome, a new threat in the form of corrupt officials seems to be rearing it`s ugly head.

The problem on the other front is equally depressing. One of the villages had no access to drinking w all.Further there was no public transport facility connecting the villages to the nearest town. There were no roads linking the villages, the villagers having to walk through forest land to reach other villages and the ne Provision of basic medical facility by the State, not surprisingly was unthinkable. The state of affairs since to have improved to a little extent but the major problems keep recurring and the overall picture is dismal.

Free and compulsory primary education is one of the directive principles of State Policy, though it is non-justiciable principle, as it is supposed to serve as a guideline for the functioning of the Government. there is nothing like education in a couple of villages in Kulavalli Gudda. The school as a concrete structu exist. However, the Government teacher probably does not view teaching as his or her duty. Regular abs feature here.

Drinking water scarcity is yet another problem of these villages. The bore wells have stopped functic nearest well is drying up. In some places people have to content themselves with dirty water, unfit for drir small, shallow tanks. This water problem poses as a perennial handicap, which fails to draw the Governm attention.

The situation as far as electricity is concerned hasn`t changed since 1992. Villages still lurk in darkne even a single lamp post visible in it`s vicinity. Houses continue to be lit up by tiny lamps while India`s elite innovative lighting styles and improved quality lighting systems!

Compared to the earlier transport services the present seems to be far better. Yet there is a lot be public transport system has established itself as being infrequent and unreliable. With no other means of there is total reliance on the bus service operated between the villages. People have to walk miles to buy commodities. The irregularity is such a common feature that the villagers depend less on this transport sy

HISTORY OF THE STRUGGLE-ORGANISATION AND MOVEMENT

Until 1988 the Inamdars were playing havoc in these villages by collecting rents not legally entitled t by taking over a good proportion of the produce cultivated by the farmers. Inspite of the institution of Inar being abolished and the `paternalistic`- state enacting land reform legislation, the villagers fell easy prey t of the landlords because of illiteracy and lack of awareness. The exhortation by ruthless Inamders contin No government came to their assistance, no official seemed to understand their problems. It was in this s that a socially motivated doctor, Gopal Dabade, decided to plunge into this intricate web of problems. Alc wife Sharada Dabade and a couple of dedicated, socially active youth, he set out to make people aware injustice they were subject to. Initially they faced innumerable hurdles from the Inamdars (who saw an imr to their authority) but also from suspicious villagers. Gradually they gained the confidence of the people. importance of organisation and awareness Dr Gopal instilled a kind of confidence and fearlessness that l villagers a great deal in combating the myriad problems then faced at that time. Dedication and hard work of this group won the hearts of the people and they eventually became one with them. Facing immense p the influential but having the indomitable strength of `people`s power´ they were successful in drawing gc attention to their plight. The struggle paid rich dividends, and the exploitation that once seemed permane out. However, in all this activity, demands for rights over land fell on deaf ears. No amount of pressure wa tilt the scales in favour of the toiling masses.

The organisational apparatus in the form of Sangha Mahila sabha weekly meetings, which gained p the people, continue to this day but in a subdued manner. The reason for development is that the threat f exploitative Inamdars is no longer visible and thus seems to have become less relevant.

LEGAL TANGLE

In 1994 a federation of eminent and concerned persons along with some of the cultivators filed a l Litigation in the High Court of Karnataka. The battle for occupancy rights over the lands which had taken p the litigative process had borne no fruit. The whole legal tangle emanates from a notification issued by th Department of the Forest Department of the then Bombay State notifying more than 7000 acres of land i Gudda as forest land under Section 35 of the Forest act, 1927. Thus when the Vakkuta (federation) appli occupancy rights before the land tribunal. It was rejected , the justification being that the land in question controlled by forest department under the 1955 notification. This decision was probably taken on the ass the earlier notification affected the ownership of lands in question. However decisions of the Karnataka H regarding the interpretation of Section 35, state that such a notification in no way alters the ownership of l logically the land must belong to the Government of Karnataka after the land Reform Act came into force the social legislation the cultivators (tillers of the soil) are entitled to the ownership. However, another con arose - no entry of the cultivators names in the record of rights and tenant column. Hence although the vil been cultivating small pieces of land since decades, in the eyes of law they are `Rightless´. Thus, the pre is sought to be remedied by appealing to the judiciary to render justice.

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