WHO Day 1981

Health care for all by 2000 AD

Material for exhibition

(1) "Health for all" means the attainment by all people of the world of a level of health that will permit them to lead a socially and economically productive life.

(2) Primary health care is an emotional response to a growing international health conscience about the gap between the health "haves" and health "have-nots."

(3) I was hungry
and you set up commissions
I was without work
and you said God help those - - - - - -
I was homeless
and you strutted around in cars
I was naked and cold
and you discussed my modesty
I was thirsty
and you downed a couple of chilled beers.
I was without love
and you caressed your dog
I was without a sense of direction
and you looked away
I was poor
and you said the poor are always with us
I was without care and attention
and you had higher priorities
Lord, will anyone ever
give us a hearing.

— Christian Children Fund Inc
Newsletter - April : June 1979.

(4) Can we look forward to a better quality of life of which health is an essential ingredient?

P.T.O.

(5) go to the people
live among the People
~~learn from them~~
learn from People
Plan with the People
Work with the People
Start with what the people know and
Build on what the people have.
Teach by showing, learn by doing,
NOT a showcase, but a pattern
NOT odds and ends, but a system
NOT piecemeal, but with an integrated approach
NOT conforming, but transforming
Not relief, but release.
— Credo of IIRR, Philippines

(6) Health for all does not mean that in the year 2000 A.D. doctors and nurses will provide medical repairs for everybody in the world for all their ailments;
nor does it mean that in the year 2000, nobody will be sick or disabled.

(7) It is here where people live and work that health is made or broken.
It means that health begins at home, in schools + factories

(8) It means that people will use better approaches than they do now for preventing disease and alleviating unavoidable illness and disability and better ways of growing up, growing old and dying gracefully

PTO

(9) It means that there will be an even distribution among the population of whatever health resources are available.

(10) It does mean that essential health care will be accessible to all individuals and families in an acceptable and affordable way and with their full involvement.

(11) It does mean that people will realise that they themselves have the power to shape their lives and the lives of their families free from the avoidable burden of disease. aware that ill-health is not inevitable.

(12) Only a privileged minority mainly from the cities is treated in hospitals. The rest of the population that receives health care of any kind is attended to in small health centres.

(13) This woman is in need of help but, can she feel confident about the advice she is given in the strange surroundings of a "model" health centre.

(1) In remote areas sick people turn to the community health worker in his/her hut or room. CHW's play an essential role in health care because nearly 75% of the world's people live in the countryside. Moreover, hospitals are expensive. A hospital bed costs ten times as much as a rural health unit.

(15) Primary Health Care - Helping people help themselves

(16) Illness and death may be the result of infection but, simple curative actions alone cannot solve the problem.

PTO.

(17) Very simple changes in our way of life can do much to fight disease.

(18) Primary health care includes at least:
1) Proper nutrition
2) Adequate supply of safe water
3) Basic sanitation
4) Maternal and child care including family planning.
5) Immunization against the major infectious diseases.
6) Prevention + control of endemic diseases.
7) Education regarding prevailing health problems + methods of preventing + controlling them.
8) Treatment for common diseases + injuries.

(19) Only when they have an acceptable level of health can individuals, families and communities enjoy the other benefits of life.
Health development is therefore essential for social + economic development and the means for attaining them are intimately linked.

(20) Development implies progressive improvement in the living conditions + quality of life enjoyed by society and shared by its members.
It is a continuing process that takes place in all societies; few would claim that their development is complete.
The purpose of development is to permit people to lead economically productive + socially satisfying lives.

(21) The drudgery of water carrying — a major occupation of women.
Providing safe, sufficient + accessible water is a priority, but is difficult without a community organization.

(17) Most conventional health care systems are becoming increasingly complex and costly and have doubtful social relevance. They have been distorted by the dictates of medical technology and by the misguided efforts of a medical industry providing medical consumer goods to society.

Other approaches have to be sought.

(18) Health for all is a moving target to be reached by a continuing process.

As a certain health status is reached, people will try to reach a higher level & so on.

The road does not end at the year 2000.

(1.) Health care is not only everyone's right, but also everyone's responsibility.

(20.) Bottle feeding is dangerous — it can kill your child.

(21) Basic Health care should not be delivered, it should be encouraged.

(2~)

Half the World is Starving
Half the world is over fed.
Half take sleeping pills
at night
Half don't have a bed
Half struggling to live.
Half is sitting right
Which side are you on brothers
Think before the night

— Maitland + Scott

Basic health care should not be denied but encouraged

—

Many problems can be resolved when people work together & give each other help + support.

—

Bottle feeding is dangerous, it can kill your baby

SHOCKING STATISTICS

KNOW YOUR INDIA. HERE ARE SOME SHOCKING STATISTICS TO JOLT YOU

* MORE THAN 6 OUT OF EVERY 10 YOUTH IN INDIA ARE BELOW THE POVERTY LINE.
* TWO OUT OF EVERY THREE OF THEM GO TO BED HUNGRY.
* SEVEN OUT OF EVERY TEN YOUTHS ARE ILLITERATE.
* 60 MILLION OF OUR YOUTH SUFFER FROM MALNUTRITION AND OF THEM 400,000 MAY DIE IN THE NEXT 3 MONTHS.
* THERE ARE 19 MILLION UNEMPLOYED REGISTERED YOUTH IN THE COUNTRY. THIS, OF COURSE DOES NOT INCLUDE THE GREATER PART WHO ARE UNQUALIFIED.

—FROM FRIENDS MAGAZINE

— X —

THE WRETCHED OF THE EARTH

— X —

THIS YEAR 15.5 MILLION CHILDREN UNDER FIVE WILL DIE AND OF THESE 15 MILLION WILL BE IN DEVELOPING COUNTRIES LIKE INDIA

— UNICEF.

PHC
(2)

IT MEANS THAT PEOPLE
WILL USE BETTER APPROACHES
THAN THEY DO NOW
FOR PREVENTING DISEASE AND
ALLEVIATING UNAVOIDABLE
ILLNESS AND DISABILITY
AND
BETTER WAYS OF GROWING UP,
GROWING OLD AND DYING
GRACEFULLY.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class	Roll No.
Semester	Subject
Examination	Date

I was hungry
And you set up commissions
I was without work
And you said God help those ----
I was homeless
And you strutted around in cars
I was naked + cold
And you discussed my modesty
I was thirsty
And you downed a couple of chilled beers
I was without love
And you caressed your dog
I was without a sense of direction
And you looked away
I was poor
And you said the poor are always with us.
~~I was sick~~
I was without care + attention
And you had higher priorities
Lord, will anyone ever
give us a hearing.

Christian Children's Fund Inc.
Newsletter — April : June 1973

ST JOHN'S MEDICAL COLLEGE BANGALORE 34

(Dept of Community Medicine)

C O N J U N C T I V I T I S

Conjunctivitis is a highly infectious eye disease. It is caused by bacteria, fungus or virus. It is the inflammation of the thin transparent sheet that covers the white of the eye (sclera) and innerside of the lids. Though the disease is normally not dangerous delay in proper treatment may affect the eye-sight.

Conjunctivitis starts quite suddenly and may become severe within four to six hours sincethe onset of its early symptoms.

All age group is equally affected by Conjunctivitis.

SYMPTOMS : The disease begins with irritation in one or both the eyes. The eyes look red and more painful and the eye-lids are swollen. There is watery or thin mucus discharge from the eyes in the beginning, followed by thick white or yellowish-white discharge that may collect in the eye.

There is inability to open the eye and the patient shuns bright light. If untreated, it can lead on to ulceration of the cornea and permanent corneal opacity (Safedi, Madha, Phoola) and permanent impairment of vision.

HOW IT SPREADS : The disease spreads through the contaminated fingers, clothings such as towels, handkerchief, etc., and other articles of the patient suffering from this disease. Flies and other eye-gnats also spread the disease from a sick person to others. It also occurs due to dust, dirt, smoke, use of dirty water for bathing, or using the common Surma Salai from the patient of this diseaseor by use of the same finger for application of Kajal to more than one person.

If treated properly the disease can be cured within four to seven days. Patients do not require hospitalisation.

PREVENTION : - Personal cleanliness, hygienic care and keeping the surroundings clean are the best prevention against the disease. Towels, handkerchiefs and other clothes of daily use of the patients should not be mixed with the clothes of others until they are washed. Over-crowding should be avoided.

Wash the clothes including the towels and handkerchiefs of the patient preferably in hot water, before use again.

Children suffering from the disease should not go to the school till they are cured.

Use sun-glasses to protect the eyes from too much light or protect the eyes from the flare by use of umbrella or by covering the head with a clean piece of cloth which also protects the eyes. Sun-glasses of a patient should not be used by others.

Avoid bathing in ponds or swimming pools when there are large number of cases.

Wash the eyes with clean luke warm water three to four times a day.

Take rest for three to four days in the house. Consult the doctor immediately This will help in speedy recovery on the one hand and reduce the chances of spreading the diseasein the community on the other hand.

Do not use common Surma Salai (applicator) meant for all members of the family.

Avoid use of Kajal.

REMEMBER :

Conjunctivitis is a highly infectious eye disease.

The disease is not dangerous except where the treatment is delayed.

Irritation, watering of eyes, selling of eye-lids, redness of eyes and discharge from the eyes, are the symptoms of the disease.

The disease spreads through contaminated fingers, clothing and other articles of the patient.

Systematic treatment will cure the disease within four to seven days.

Personal cleanliness and hygienic care will help prevent the disease. Keep your surroundings clean to avoid flies.

YOU TAKE CARE OF EYES - THEY TAKE CARE OF YOU

--

Primary Health Care

Earthscan Press briefing document No 9

(1) Primary health care is not just medicine, or means ditches, water pipes, nutrition, latrines, contraceptives. Health is development.

(2) 80% of the worlds disease is linked to water. "Clean water for all by 1990" would cost only one sixtieth of the global arms bill each year.

(3) In the rich world, diarrhoea is a nuisance. In the Third World, it kills.

(4) Primary health care is about priorities.
- Many paramedical personnel rather than a few doctors.
- Many rural community health centres before a few hospitals.
- Traditional medicine before western-trained specialists.
- Local herbal remedies before the latest branded drug from an international pharmaceutical company.
- Mothers milk before powdered baby foods mixed with dirty water.
- Clean water before antibiotics
- Food before vitamin pills.
- Vaccination before kidney machines.
- Prevention before cure.
- Less tobacco advertising before more cancer wards.
- Health for villages + slums before more health for the affluent suburbs of capital cities.

(5) Primary health care puts the patient first: not the smooth running of the hospital, or the needs of the medical industry, or the professional pride of doctors.

(6) Primary Health care says that health is not something created in hospitals by doctors. It is created in the human environment by the community.

(7) Primary Health care is about appropriate technology: health care using local materials, indigenous skills, drugs which can be manufactured regionally, medicines available in the community.

(8) Primary Health Care is about self-reliance: personal self-reliance, family self-reliance, community self-reliance, national self-reliance.

(9) Primary Health care is the key to achieving an acceptable level of health throughout the world in the foreseeable future as part of social development and in the spirit of social justice. It is equally valid for all countries, from the most to the least developed. Though the form it takes will vary according to political, economic, social & cultural patterns. For developing countries in particular, it is a burning necessity.

(10) Health is about more than health services — curing the ailing from clinics and hospitals is something like trying to empty the Atlantic ocean with a teaspoon.

(11) Health cannot be attained by the health sector alone — in developing countries in particular, economic development, anti-poverty measures, food production, water, sanitation, housing, environmental protection + education all contribute to health + have the same goal of human development. — Mahler / Labouisse

(12) WHO suggests that minimal indicators of achievement of "Health for All" would be an infant mortality rate of 50 per 1000 live births, & a life expectancy at birth of more than 60 years.

(13) Disadvantaged groups throughout the world have no access to any permanent form of health care. These groups probably total 4/5th of the world's population, living mainly in rural areas & urban slums.
- Mahler-Labouisse

(14) Medical graduates in developing countries are usually trained in institutions which have been modelled on those in the developed world. They use developed country textbooks, and take developed country exams. The doctors that emerge are fitted to practise urban medicine with immediate access to a large hospital. Such medicine is largely irrelevant to the health problems of the rural population — and to those living in urban slums.

(15) ✓ Should Third World countries invest in a few good hospitals and a totally inadequate Primary Health care service? Or should they work towards a reasonably comprehensive Primary Health care system and relatively meagre hospitals.

(16) ✓ The diseases of developing countries are typically those of poverty. The solution lies in improving living conditions, and teaching the elements of preventive medicine. Hospitals are largely irrelevant to priorities like those.

(17) Developing country teaching hospitals, dubbed "disease palaces" by some critics, do not obtain the type of health personnel required; they do not act as referral centres; nor do they undertake the type of research that the community which supports them requires.

PTO

(18) An analysis of patients from 8 hospitals in India showed that nearly half of them would not have needed hospital treatment if they had been treated earlier by a primary health worker. Where hospitals are in short supply, they should be used sparingly.

(19) Primary Health care involves a major rethinking of ways of delivering health care. To make the community the focal point of the whole health system, to look for the relevant technology that countries & communities can accept & afford, and to aim at the universal accessibility of health care: are in many ways revolutionary — Mahler - Labouisse.

(1) Peoples Health in Peoples Hands. (College)

Most people today see the idea of self reliance in health as basically possible, and realise the value of giving back to people confidence in their own knowledge, skills and experience in order to help themselves. People are not satisfied with health care which has become impersonal, technologically oriented & highly specialized.

— Ilona Kickbusch.

—x—

(2) New health goals require new technologies

(3) How the new health systems work - pg 5.

(4) The new community health worker is not a passive provider of care who waits for patients to present themselves, but a dynamic promoter of self-help programmes leading to community self-reliance & thus to better community health

(5) The advocates of the primary (— Gill Walt) health care approach are under no illusion that the goal of "Health for All" is easy to achieve. The new health movement will draw sustenance from four principal strategies :- political commitment, community participation, concerted action not only inside the health sector but among various sectors of development. & appropriate choices of technology.

— Dr E Taviño.

(6) The health officers realized that if the people were to be rid of diseases like tuberculosis & diarrhoea, more than medicine was needed. People had to have adequate food, water, shelter. Health measures alone would not do.

(7) More than the medical system, the concept of "Health for All" challenges the prevailing concept of development the idea that human communities are passive receptacles of a "future" that has been outlined for them by someone else. It is their future & they must decide it & make it.

Anil Agarwal.

Extract from the TECHNICAL SERIES issued
by the Director of Health & Family Welfare
Services, Bangalore.(Ref.HEE/35/80-81 dt.5/1/81)

No.3/160/81 DIARRHOEAL DISEASES - THEIR SIGNIFICANCE 12th Jan.,81

DIARRHOEAL DISEASES - THEIR SIGNIFICANCE

1. Diarrhoea is the most common cause of sickness and death among children below three years of age.

2. Repeated attacks of diarrhoea during early childhood precipitate malnutrition which makes the children susceptible to diarrhoea thus setting in a vicious cycle.

3. It is a popular practice to withhold milk and other food from a child suffering from diarrhoea. This is wrong, as a child with diarrhoea requires more fluid and nourishment.

4. Diarrhoeal diseases are caused by annumber of pathogenic germs including cholera vibrio and these harmful germs thrive in places where sanitary conditions are poor.

WHAT HAPPENS IN DIARRHOEA?

There is an enormous loss of water (dehydration) and salts from the body due to vomiting and diarrhoea in these conditions. This loss of water & salts from the body causes various symptoms like intense thirst, restlessness, cold hands & feet, weak pulse, lowering of blood pressure and stoppage of urine; when severe, this condition may lead to death of the patient.

TREATMENT OF DIARRHOEA PRIMARILY MEANS THE TREATMENT OF DEHYDRATION

Replacement of water and salts, which have been lost from the body forms the basis of treatment of all diarrhoeal diseases. This can be done with :

1) ORAL GLUCOSE-SALINE :

It has been shown that oral glucose solution increases the absorption of water & salts in the body. Based on this, a glucose-salt solution has been developed by the Cholera Research Centre, Calcutta. This preparation named as 'CHOROSOL' contains the following ingredients per litre of water :

Sodium chloride (common salt)	- 3.5 grams
Sodium bicarbonate (baking soda)	- 2.5 "
Potassium chloride	- 1.5 "
Glucose	- 20.0 "

The above salts and glucose can be dissolved in one litre of drinking water & then given to patients liberally.

2) INTRAVENOUS SALINE :

A small number of patients with severe dehydration who do not respond to oral glucose-saline or who cannot be given oral fluids because of unconsciousness may require intravenous saline. Treatment with intravenous saline can only be given in hospitals and dispensaries under the supervision of an experienced doctor.

.....2

ANTIBIOTICS :

Cases of severe diarrhoea and those passing blood and mucus in the stools may be treated with tetracycline, 2 capsules (500 mg.) 6 hourly in adults and one capsule (or 2 teaspoonfuls of syrup) every 12 hours in children for 2 days. Furazolidone or chloramphenicol can also be used in place of tetracycline.

ASSESSMENT OF DEGREE OF DEHYDRATION :

Patients with watery diarrhoea and vomiting may present with various degrees of dehydration. When mildly dehydrated, a patient may appear almost normal whereas those with severe dehydration may be in comatose (almost unconscious) condition. Therefore, the degree of dehydration must be assessed before initiation of treatment. Certain symptoms and signs help in this assessment.

HOW DEHYDRATED IS THE PATIENT?

Mild	Severe
1. Thirsty	1. Too weak to drink
2. Alert	2. Drowsy or unconscious
3. Radial pulse normal	3. Radial pulse weak or absent
4. Urine flow normal	4. Urine flow reduced or absent
5. Skin elasticity may be reduced	5. Skin elasticity poor

ORAL FLUID THERAPY :

How to make the fluid :

Fixed quantities of salts and glucose as indicated earlier are to be dissolved in one litre of drinking water and should be used within 24 hours. The solution should not be boiled.

How to administer the Fluid : Infants & younger children :

A small quantity of Glucose-salt solution (2-3 teaspoonfuls) should be given by mouth every five minutes to infants and young children. Large quantity of fluid given at a time may result in vomiting. Therefore, fluid should not be given in too large a quantity. But as much as a patient is willing to drink may be given.

Older Children and Adults :

Patients may be instructed to drink as much fluid as they like from a clean glass or cup. A large container with glucose-salt solution may be kept at the bed side.

HOW MUCH FLUID TO BE GIVEN?

In a mild state of dehydration, a child may require about a litre and an adult may require 2-3 litres of oral fluid per day.

In severe cases, however, the requirement may be much more. The fluid should be continued until the diarrhoea stops and dehydration is compensated and the patients look normal.

WHAT HAPPENS WHEN THE PATIENT IS VOMITING?

A patient may sometimes vomit out a part of the oral fluid; however, the rest of the fluid gets rapidly absorbed and once the dehydration is corrected the patient stops vomiting.

ADVANTAGES OF ORAL FLUID THERAPY :

1. The patient need not be hospitalized and can be treated at home by para-medical staff or by the relatives.

2. Oral fluid therapy is cheap and the ingredients are available locally. A packet of CHOROSOL costs about a rupee.

3. The solution can be made with ordinary drinking water. No sterilization is required.

4. Storage and transportation cost is minimum. A packet of CHOROSOL can be stored at room temperature for long.

INTRAVENOUS FLUID THERAPY :

Experience at the Infectious Diseases Hospital, Calcutta, has shown that as many as 95% of all cases of gastro-enteritis including cholera can be treated with oral fluid alone. Less than 5% of cases who come with severe dehydration may require intravenous saline to start with, followed by oral glucose-salt solution. However, the number of such severely dehydrated cases can be reduced if oral fluid therapy is given during the early stage of dehydration.

The severely dehydrated cases should be transported to the nearest hospital or dispensary for intravenous rehydration. Oral glucose-saline must be started, however, even before this, and should be continued till the patient reaches the hospital and till such time intravenous therapy could be started.

WHAT INTRAVENOUS FLUIDS ARE TO BE USED?

1) RINGER'S LACTATE SOLUTION is the best commercially available solution which can be used for children and adults. However, it is not readily available in most places.

2) NORMAL SALINE has been in use at the Infectious Diseases Hospital, Calcutta, for the last few years. Intravenous normal saline alongwith oral glucose-salt solution can be successfully used for the treatment of all degrees of dehydration.

HOW MUCH TO BE GIVEN?

Ringer's lactate or normal saline may be given at a dose of 100 ml./kg. body weight initially during the first 6 hours. Oral glucose-salt solution may also be given liberally.

It is absolutely of no use to given subcutaneous saline and this practice must be stopped.

EDUCATING THE MOTHERS IN HOME-CARE

Treatment of a child with diarrhoea should begin at home and therefore, mothers should be educated on the basic principles of home-care. A mother should know that :

1) A child who has diarrhoea, should be given as much fluid as he/she will drink. For this purpose, the glucose-salt solution can be prepared by dis-solving a packet of 'CHOROSOL' in one litre (2 pints) of drinking water. In case of infants, a teaspoonful of fluid may be given every five minutes until the diarrhoea stops. Large quantity of fluid, if given at a time, may cause vomiting.

2) A child with diarrhoea should get his normal food to maintain his nutrition. With-holding milk and other food will make the child weak. If the infant is being breastfed, breastfeeding should be continued.

3) A child gets infection through contaminated food or drink and diarrhoea can be prevented by following hygienic practices in child care, particularly in feeding. A child should be given freshly prepared food in clean utensils.

4) A child with poor health suffers more often from diarrhoeal diseases. Therefore, the general health of the child should be improved to prevent diarrhoea. The following basic facts should be remembered :

   a) A child's body is just like a running machine and it needs food (fuel) to keep the machine in running condition. Therefore, a child should not be allowed to starve at any time - in health or in disease.

   b) A child's body is growing all the time. The child needs food containing the building materials such as proteins (egg, fish, meat, milk, dal, etc.,) as well as energy-giving food (rice, wheat, potato, sugar, etc.,) to build the body.

   c) It is a common practice to keep a child on barley-water for days when he is sick. This is wrong since barley water is the most inferior food and contains no protein. Enough quantities of simple food stuffs like rice, chapati, and dal can support the normal growth of a child if meat, fish or eggs are not available.

- - - - - -

Copy to
1. Interns
2. Staff, Department of Paediatrics
3. Staff, Community Medicine.

DEAN

ROSS INSTITUTE UNIT OF
OCCUPATIONAL HEALTH
St. John's Medical College.
BANGALORE-560034.

The choice:-

Essential health care for all in a spirit of social justice rather than ~~sophisticated~~ medical care for the few in a counter spirit of social inequality

- Transfer of a greater share of health resources to the under-served majority of the population.

Prim. Hlth care contributes to development by improving health status + by stimulating action + organization in support of the development process.
of control of cable communicable diseases promotion of gen. dev:, proper nutrition + reduction of sickness increase work productivity. Breaking the vicious cycle / cycle of malnut: + inf = improves the physical & mental dev: of the child & reduction in both child + adult mobility can induce the feeling that the future is worth planning for. By drawing on untapped human + financial community resources, prim. hlth care can contribute to the awakening of the social interest that is so important for mobilizing people's efforts for development

P.T.O

Social improvements that increased purchasing power can bring — better food, housing, educ^{n}., leisure opportunities & last but not least, better health.

Only when they have an acceptable level of health can individuals, families & communities enjoy the other benefits of life. Health dev^{t} is therefore essential for social & economic dev^{t} & the means for attaining them are ultimately linked. For this reason, actions to improve the health & socio-economic situation should be regarded as mutually supportive rather than competitive.

Development
- implies progressive improvements in the living conditions + quality of life enjoyed by society + shared by its members.
It is a continuing process that takes place in all societies; few would claim that their development is complete.
The purpose of development is to permit people to lead economically productive + socially satisfying lives.

Prim. Health care

The national programme may begin in selected parts of the country provided that all are covered as soon as possible. It may also start with only a limited number of the components of PHC, provided that the others are added in the course of time. Essential feature is that it shd be extended progressively in both geographical coverage + content until it covers all the pop- with all essential components. The national strategy will include the referral systems already mentioned, + support from relevant components of other sectors such as educ', transport agriculture + sectors dealing with the environment.

PHC means much more than the mere extension of basic health services.. PHC has social + developmental dimensions + if properly applied will influence the way in which the rest of the health system functions.

ROSS INSTITUTE UNIT OF
OCCUPATIONAL HEALTH
St. John's Medical College
BANGALORE-560034

Most conventional health care systems are becoming increasingly complex & costly & have doubtful social relevance. They have been distorted by the dictates of medical technology & by the misguided efforts of medical industry providing medical consumer-goods to society.

Alternative approaches have to be sought.

Primary health care is the Key to achieving an acceptable level of health throughout the world in the foreseeable future as part of social development & in the spirit of social justice.

For developing countries in particular it is a burning necessity.

Primary Health care includes at least.

1. proper nutrition
2. adequate supply of safe water
3. basic sanitation
4. maternal + child care including family planning
5. immunization against the major infectious diseases
6. prevention + control of locally endemic diseases
7. educ. reg prevailing health problems + methods of preventing + controlling them
8. Treatment for common diseases + injuries.

It would be useful to know more about

- community participation + behavior
- joint action with other sectors
- appropriate technology.
- training + supervision of com Hlth workers + questions relating to their careers, means of support + referral
- + methods of communication between primary health care + other levels of the health system

Much can be learnt by doing but there is need for organized research that is closely linked to the provision of service.

Health Education in St.John's Medical College Hospital

One of the important functions to be served by any hospital and particularly a teaching hospital is HEALTH EDUCATION.

Health Education attempts to close the gap between what is known about optimum health practices and that which is actually practised.

Goal : The ultimate goal is improvement of Health of the people, reduction of preventable illness, disability and death, and assistance to people to achieve optimal stage of health by their own activities and efforts.

Activities : (1) Inform people about health, illness and disability and ways in which they can improve their health or protect their health

(2) Motivate people to want to change to more healthful practices.

(3) Help people to learn the necessary skills for healthful practices

(4) Foster communication skills and knowledge in all those engaged in health.

(5) Advocate changes in environment to facilitate healthful living.

For Whom : Patients/relatives/attendants

Who : Medical Officers/medico-social workers/Nurses/Dieticians/ Pharmacists/Radiographers/Laboratory Technicians/Helpers/ aides/voluntary workers/Everyone working in Hospital.

What : (1) Educate people coming to the Hospital as patients or attendants regarding treatment, maintenance and improvement of health

(2) Guide the patients and relatives about the services and facilities available in the hospital

(3) Dispel wrong beliefs and fears about diseases

(4) Educate people about prevention of diseases

(5) Inform people of ways of achieving and maintaining health.

Where : O.P.D., Inpatient wards, X-ray department, Dispensary, clinical laboratory, kitchen, anywhere in the hospital.

How ? Let us P L A N it.

::*:*:*:*:*:*:*

Class | Roll No.

Semester | Subject

Examination | Date

Appendix II

Sources of Health Education Material - Addresses

1. Voluntary Health Ass'n of India, (VHAI)
   C-14 Community Centre,
   Safdarjung Development Area,
   N. Delhi — 110016.
   (A catalogue of all available H.E. material is available)

2.

2. Directorate of Advertising & Visual Publicity (D.A.V.P.)
   Ministry of I & B, Govt of India
   Kuldip Press, N. Delhi 10028.

3. Central Health Education Bureau (CHEB),
   Directorate general of Health Services,
   Kotla Road, N. Delhi 110002.

4. State Health Education Bureau.
   Directorate of Health Services
   Anand Rao Circle
   B'lore

5. National Institute of Nutrition — for material on nutrition

6. "Gandhigram" Madurai.

7. CMC — Vellore.

PTO

Films in B'lore available from

1. Films Division.

2. Directorate of Health Services.

3. Field Publicity office.

appendix I

The services available at St. John's Medical College Hospital are as follows — (1) The OPD functions from 8:00 am to 12:30 pm with the following departments — General medicine, paediatrics, obstetrics + gynaecology, general surgery, dermatology + venereology, ophthalmology, ENT, dentistry, orthopaedics, thoracic surgery, genito-urinary surgery, plastic surgery, physiotherapy

(2) The following special clinics are also run.

i) Well baby clinic — Thursday morning.
ii) Antenatal + postnatal clinic — Wednesday + Saturday morning
iii) Infertility clinic — Tuesday afternoon.
iv) Diabetic clinic — Thursday afternoon.
v) Leprosy clinic — Thursday + Saturday. 2:30 - 4:30 pm.
vi) Psychiatry — everyday 2 — 4 pm.

EXHIBITION ON CHILD HEALTH.

1. A year for the child — UNICEF symbol
2. WHO day poster — A healthy child a sure future
3 a. IYC 1979 — Indian Symbol
3 b " " — " " — explanation
3 c. " " — Indian slogan & theme.
4. Child health in the plantations — 2nd Annual P.I.M.O. conference
5. Rights of the child.
6. Infant mortality rate - explanation
(The average world wide infant mortality - - - - -)
7. How many children die — pictorial diagram.
8. Deaths of children as a percentage of total deaths.
9. Deaths due to malnutrition
10. Leading causes of child deaths
11. a Cause specific deaths
11 b. Deaths 1-4 yrs.
12. Malnutrition prob — PCM
13. Poor birth weights
14. Poor intake of nutrients
15 a. Problem of child education
15 b. Primary / Middle school children
15 c. Secondary schools.
16. Other needs — deprived children.
16 b. Pictorial chart on deprived children
17. World population trends
18. Population in India
19. Poem — "I want to do it"
20 a MCH linkage
20 b. MCH principles.
21. MCH components
22. Antenatal services.
23 a. Intranatal & postnatal care
23 b Diet for nursing women.
23 c. The breast fed are healthy
23 d. Breast feeding — contd.
24. Under-5 care
25. Under Fives Clinic
26. The Road to Health Card

P.T.O.

27 Immunization

? 28
? 29
? 30
? ~~31~~ 28 Diarrhoea.
~~32~~. 29 Child care education
33. Pictorial chart - Misery go round
34. Pictorial chart - Merry go round
35 A healthy child a sure future
37. Poem - 1979 is a gift - - - Paul Gaudo.

+
5 pictorial charts on MCH.
? Plantation figures.

Symbol

1

1981 WAS PROCLAIMED AS THE INTERNATIONAL YEAR OF DISABLED PERSONS (IYDP) BY THE U.N. GENERAL ASSEMBLY.

THE THEME IS "FULL PARTICIPATION AND EQUALITY." THIS MEANS INTEGRATION SHOULD REPLACE THE PRESENT TREND TOWARDS SEPERATING THE DISABLED FROM THE ABLE AT SCHOOL, AT WORK, AT HOME, AND IN SOCIETY IN GENERAL.

THE SYMBOL ~~BEAR~~ REPRESENTS TWO ~~A~~ PEOPLE HOLDING HANDS IN SOLIDARITY AND SUPPORT OF EACH OTHER. IN A POSITION OF EQUALITY.

DECLARATION ON THE RIGHTS OF DISABLED PERSONS

1. DISABLED PERSONS HAVE THE INHERENT RIGHT TO RESPECT FOR THEIR HUMAN DIGNITY. DISABLED PERSONS, WHATEVER THE ORIGIN, NATURE AND SERIOUSNESS OF THEIR HANDICAPS AND DISABILITIES, HAVE THE SAME FUNDAMENTAL RIGHTS AS THEIR FELLOW-CITIZENS OF THE SAME AGE, WHICH IMPLIES FIRST AND FOREMOST THE RIGHT TO ENJOY A DECENT LIFE, AS NORMAL AND FULL AS POSSIBLE.

2. DISABLED PERSONS HAVE THE SAME CIVIL AND POLITICAL RIGHTS AS OTHER HUMAN BEINGS; PARAGRAPH 7 OF THE DECLARATION ON THE RIGHTS OF MENTALLY RETARDED PERSONS APPLIES TO ANY POSSIBLE LIMITATION OR SUPPRESSION OF THOSE RIGHTS FOR MENTALLY DISABLED PERSONS.

3. DISABLED PERSONS ARE ENTITLED TO HAVE THEIR SPECIAL NEEDS TAKEN INTO CONSIDERATION AT ALL STAGES OF ECONOMIC AND SOCIAL PLANNING.

4. DISABLED PERSONS HAVE THE RIGHT TO LIVE WITH THEIR FAMILIES OR WITH FOSTER PARENTS AND TO PARTICIPATE IN ALL SOCIAL, CREATIVE OR RECREATIONAL ACTIVITIES. NO DISABLED PERSON SHALL BE SUBJECTED, AS FAR AS HIS OR HER RESIDENCE IS CONCERNED, TO DIFFERENTIAL TREATMENT OTHER THAN THAT REQUIRED BY HIS OR HER CONDITION OR BY THE IMPROVEMENT WHICH HE OR SHE MAY DERIVE THEREFROM. IF THE STAY OF A DISABLED PERSON IN A SPECIALIZED ESTABLISHMENT IS INDISPENSABLE, THE ENVIRONMENT AND LIVING CONDITIONS THEREIN SHALL BE AS CLOSE AS POSSIBLE TO THOSE OF THE NORMAL LIFE OF A PERSON OF HIS OR HER AGE.

5. DISABLED PERSONS SHALL BE PROTECTED AGAINST ALL EXPLOITATION, ALL REGULATIONS AND ALL TREATMENT OF A DISCRIMINATORY, ABUSIVE OR DEGRADING NATURE.

6. DISABLED PERSONS, THEIR FAMILIES AND COMMUNITIES SHALL BE FULLY INFORMED, BY ALL APPROPRIATE MEANS, OF THE RIGHTS CONTAINED IN THIS DECLARATION.

Excerpts of 2433rd plenary meeting
9 December 1975
U N General Assembly

IYDP: THE FIVE PRINCIPAL OBJECTIVES FOR THE YEAR ARE

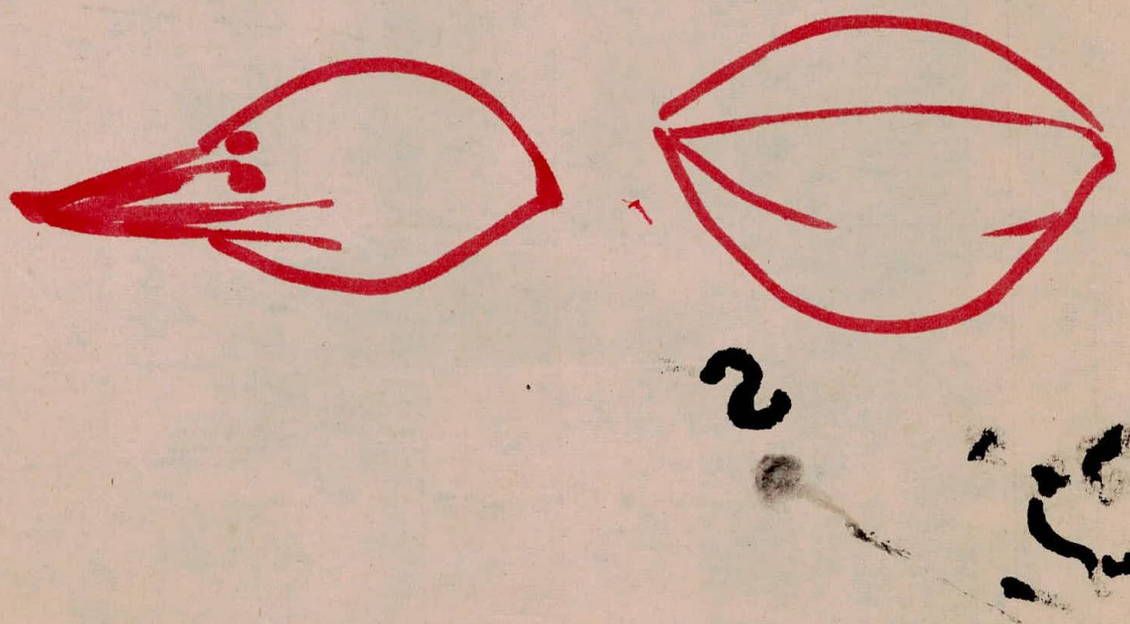
a) HELPING DISABLED PERSONS IN THEIR PHYSICAL AND PSYCHOLOGICAL ADJUSTMENT TO SOCIETY.

b) PROMOTING ALL NATIONAL AND INTERNATIONAL EFFORTS TO PROVIDE DISABLED PERSONS WITH PROPER ASSISTANCE, TRAINING, CARE AND GUIDANCE, TO MAKE AVAILABLE OPPORTUNITIES FOR SUITABLE WORK AND TO ENSURE THEIR FULL INTEGRATION IN SOCIETY.

c) ENCOURAGING STUDY AND RESEARCH PROJECTS DESIGNED TO FACILITATE THE PRACTICAL PARTICIPATION OF DISABLED PERSONS IN DAILY LIFE, FOR EXAMPLE, BY IMPROVING THEIR ACCESS TO PUBLIC BUILDINGS AND TRANSPORTATION SYSTEMS;

d) EDUCATING AND INFORMING THE PUBLIC OF THE RIGHTS OF DISABLED PERSONS TO PARTICIPATE IN AND CONTRIBUTE TO VARIOUS ASPECTS OF SOCIAL, ECONOMIC AND POLITICAL LIFE.

e) PROMOTING EFFECTIVE MEASURES FOR THE PREVENTION OF DISABILITY AND FOR THE REHABILITATION OF DISABLED PERSONS



I.Y.D.P.

SPECIFIC OBJECTIVES FOR INDIA SET BY THE GOVERNMENT INCLUDE :-

1. EVOLVING A NATIONAL POLICY ON THE DISABLED
2. DEVELOPING A STRONG NATIONAL DISABILITY PREVENTION PROGRAMME
3. GIVING A POSITIVE RURAL BIAS TO SERVICES FOR THE HANDICAPPED.
4. ENCOURAGING THE FORMATION OF COOPERATIVES BY THE HANDICAPPED BY PROVIDING CONCESSIONS.
5. CONDUCTING A SAMPLE SURVEY ON THE HANDICAPPED IN INDIA.
6. PROVIDING LEGISLATIONS FOR THE HANDICAPPED.

— x —

THE AIM OF THE YEAR IS TO ENCOURAGE THE REHABILITATION OF THE ESTIMATED 450 MILLION PEOPLE ON EARTH WHO SUFFER FROM SOME FORM OF PHYSICAL OR MENTAL IMPAIRMENT

— X —

HANDICAPPED CHILDREN

IN INDIA, OVER THIRTY LAKHS CHILDREN SUFFER FROM SOME KIND OF HANDICAP OR THE OTHER. THE BREAKDOWN IS:

MENTALLY RETARDED — 20 LAKHS
BLIND — 8 LAKHS
ORTHOPAEDICALLY (PHYSICALLY) HANDICAPPED — 5 LAKHS
DEAF — 2 LAKHS

TRAINING AND REHABILITATION OF THESE CHILDREN ARE SO INADEQUATE THAT THEY CATER TO THE NEEDS OF ONLY

4% OF THE PHYSICALLY HANDICAPPED
2% OF THE BLIND
2% OF THE DEAF
AND 0.2% OF THE MENTALLY RETARDED

— "A SMALL VOICE"
UNICEF, March '79.

73.80.
738
147.60
738.30
885.90

738.30. Eight hundred.
73.85
8121 5
8.000.50.

THE UNITY OF ALL PEOPLE REQUIRES ~~THE FULL PARTICIPA~~ EQUALITY AND FULL PARTICIPATION OF DISABLED PEOPLE IN COMMUNITY LIFE.

FULL PARTICIPATION IN LIFE REQUIRES ACCESS, A REMOVAL OF STRUCTURAL AND ARCHITECTURAL BARRIERS.

DISABLED PEOPLE
MUST HAVE THE
OPPORTUNITY FOR
PARTICIPATION IN LIFE;
THIS DEMANDS A
FAIR CHANCE AT
MAXIMUM MOBILITY
AND INDEPENDANCE

— x —

finished

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class	Roll No.
Semester	Subject
Examination	Date

BLESSED ARE THOSE . . . .

. . . WHO UNDERSTAND MY AWKWARD
STEP AND CLUMSY HAND.

. . . WHO KNOW THAT MY EARS TODAY
MUST STRAIN TO UNDERSTAND THE
THINGS THEY SAY.

. . . WHO SEEM TO KNOW THAT MY EYES
ARE BRIGHT BUT MY MIND IS SLOW.

. . . WITH A CHEERY SMILE WHO
ENCOURAGE ME TO TRY ONCE MORE.

. . . WHO KNOW THE WAYS OF MY HEART,
AND LOVE ME AS I AM.

. . . WHO MAKE ME KNOW THAT I AM
LOVED, RESPECTED AND NOT ALONE.

. . . WHO KNOW I'M AT A LOSS,
TO PUT INTO WORDS MY THOUGHTS.

. . WHO LISTEN, FOR I TOO, HAVE
SOMETHING TO SAY.

F.W.M.R. NEWSLETTER.
NOV. 1976.

GIVE US A CHANCE

—x—

TO LEARN

—x—

TO WORK

—x—

TO ACHIEVE

... IN THE SEARCH

FOR THEIR LIBERATION

FROM ISOLATION.

Dr. Rekha Nair

INDEX OF SLIDES/FILM STRIPS/16 MM. MOVIES AVAILABLE IN THE DEPARTMENT OF COMMUNITY MEDICINE.

As on 1st July '81.

There are 3 Kodak slide cabinets with 8 trays in each. There are 3 rows of slides (each row having a capacity of 50 slides) in each of these tray. The rows of each of these trays numbered a, b and c from left to right.

I Kodak slide cabinet No.1:-

Projection slides on Health Administration, Mallur Health Co-operative, Ross Institute Unit, Occupational Hazards, Occupational Health and First Aid Slides etc. are kept in this cabinet.

II. Kodak Slide Cabinet No.2:-

Entomology, Communicable Diseases, Food Hygine etc are kept in the second cabinet.

III. Kodak Slide Cabinet No.3:-

Family Planning, MCH, Nutrition etc., are in this cabinet.

IV. List of 35 mm. film strips available in this department.

V. List of movies (16 mm. sound) available.

**Description pamphlets are available for these sets of slides from their original sources namely, W.H.O., Institute of Child Health, London, VHAI etc.

Arranged by Joseph

Joseph Panackel,
Senior Laboratory Technician.

1.07.1981.

VN
10/7/81

35 mm. PROJECTION SLIDES/TRANSPERMICES:

/KODAK SLIDE CARBINET NO.1/

HEALTH ADMINISTRATION/MALLUR/ROSS INSTITUTION/
OCCUPATIONAL HEALTH/FIRST AID SLIDES ETC..

TRAY NO.	1A-1-9:	Planning and Health Servicess(PHS)
"	1A-10-16:	Hospital wards-Doors etc. (HD) 6 BW
"	1A-25-39:	Care of Community Health (CCH) 14 B & W slides
"	1A 40-50:	Hospital Linen and Laundry (HLL) 9 B & W slides
"	1 B I-16:	Concept of Health (CH) 16 B&W slides
"	1 B 20-25	10-point declaration on Health (3 bludeshade slides)
"	B 32 - 31:	Hospital Laundary (HL)
"	1 C I-40 :	Public Health Administration (PHA) (B & W slides)
"	1 B 35-50:	Health education in Hospital Practice (HEHP) 16 B & W slides
"	1 C 40-47	Public Health Administration (PHA) (S.V.R.)- 7 B & W Slides.
"	2 A 1 -24:	Communication in Health (CM) 24 Colour Slides*
"	2 A 27-39:	Thermatic Aperseption Test (TAT)/Internship Rural Health Evaluation-Tes t (IRHET)
"	2 A 40-46:	Draft National Health Policy.
"	2 B I	Water seerminar (plantations) slides.
"	2 b -	
"	2 C I -50	Environmental Sanitation (ES) 46 B & W Slides.
"	2 C	
"	3 A I -37	Water analysis/water supply (W) B&W Slides
"	3 B I -	Mallur Health Co-operative (MHCC) B&W Slides
"	3 B -	
"	3 C I -	Mallur Sericulture (MS) B&W and Blue colour shade.
"	4 A I -	Mallur Weaving (MW) B & W Slides
"	4 A-25-50	Dommasandra Project (DP) 26 B&W Slides.
"	4 B:	
"	4 B:	
"	C I -15	Organization and Function of Ross Institute (RI) B & W Colour Slides.
"	4 C :	
"	5 A I-50	Occupational Health Slides
"	5 C I -	
"	5 C	
"	5 C :	
"	5 C :	
"	6 A I -25	Drug Dependence and Alcoholism (DDA) B&W Slides.
"	6 A 24 - 34:	Ecology.

.....2

TRAY NO. 6C I-9 : Injuries to Hand (IH) B & W Slidds
" 6C :
" 7 A I-24: Goitre Survey (GS) B & W Slides
" 7 A I -47:Health Planning (HP) S.V.R. 47 B & W sli des
" 7 B I - 12: Health Statistics (HS)
" 7 B :
" 7 C :
" 7 C :

Comprehensive Rural Health Project - 24 colour slides.
By VHAI (Jamb - Available with Dr.Ravi Narayan (personal)

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35 mm PROJECTION SLIDES/TRANSPERENCIES

/KODAK SLIDE CABINET NO.2/

ENTOMOLOGY/COMMUNICABLE DISEASES,FOOD HYGEINE:-

TRAY NO. IAI - 50 } Staining of Blood films (BFS) WHO
" I B I -30 } 80 Colour slides*
" I B 3 1
" I B
" I C I -33 Preparation of thick and thin films (BF) WHO 33colour slides*
" 2 C 34-50
" 2 A - 24 Mounting of Mosquita Larva (ML) W.H.O. 24 Colour*
" 2 A 26-50 Anthropodes of Medical Imp ortance (AMI) 25 colour slides*
" 2 C I-26
" 2 C I-26: Entomology 76 B & W Slides
" 2 C 27 :
" 2 C -
" 3 A I - 31 M.P.Life Cycle (MLC) W.H.O. 31 Colour slides *
" 3 A 32 :
" 3 A
" 3 B I -33 Rodents and their control, disease of the Dogs-(R) 33 B & W Slides .
" 3 B 34 - 46 Food Hygine Cours e - Parasitology 12 B & W slides (P1-12)
" 3 C I -38 Food Hygine Course(SF) Safe Food 38 B & W slides.
" 3 C 39-47 Food Hygine CourseeGerms-their life (G-1-G4) 4 B & W Slides)
" 4 A I - 36 Plasmodium Vivax stages (PV) W.H.O. 36 colour slides*

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TRAY NO.	4 A 37-50:	
"	4 B - 42	Pl. Falciparam stages (PF) W.H.O. 42 sikix colour slides *
"	4 B 43-50:	
"	4 C I -25	P.Malaria stages (PM) 25 W.H.O. Colour slides
"	4 C 26-36	Monkey pox (MP)
"	4 C	
"	5 A I -50)	Diagnosis of smallpox (SMP) W.H.O. Colour slides*
"	5 B -1)	
"	5 B 3 -37	Smallpox in children (SPC) 24 colour slides *
"	5 B 27-50	Severe Meas eles (MS) 24 colour slides *
"	5 C I -24	Leprosy in Childhood (LP) 24 colour sslides*
"	5 C 27 -50	Common skin Diseases (SK) 24 colour slides *
"	6 A I -24	Natural History of untreated TB (TbNH) 24 colour slides *
"	6 A 30 - 42	T.B.Control, B.C.G. Vaccination, Chemotherapy 12 B & W slides
"	6 A 43 :	
"	6 B I - 6	Trachoma - 6 B & W Slides
"	6 B 15 -	Immunization
"	6 B :	
"	6 C I -24	Cancrum Oris (CCO) 24 colour slides *
"	6 C	
"	7 A	
"	7 A	
"	7 A 49-50	Food Hygine Course - Food Handler (FHI-2-2 B&W slides
"	7 B I - 23	Food Hygine Course - Food Poisoning-FP 1 -23 B & W Slides.
"	7 B -25-43	Food Hygine Course - Natural history of food (NHF 1-18)
"	7 B 44 - 50	Food Hygine Cours e - "Hygine" (H)
"	7 CI - 19:	Food Hygine Course - Bateriology (B)
"	7 C 20 - 30 :	Acute Nephritis B & W Slides.
"	7 C 31 -35-	Chronic Bronchities B & W Slides.

35 mm. PROJECTION SLIDES/TRANSPENCIES

/KODAK SLIDE CABINET NO.3/

FAMILY PLANNING/MCH/NUTRITION:

TRAY NO.	I A I -24	Contraceptive Devices (CD) 24 colour slides *
"	I A 28 -50	Vasectomy operation (VD) 23 Agfa colour slides*
"	IBI -12	Tubectomy operation (T.O.) 12 Agfa colour slides *

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TRAY NO.	I B 13 -	Population explosion (PE)
"	I B-14-38	Clinical Genetics (Cl.G) 24 colour slides*
"	I C I -48	Mental Retardation (MR) 48 colour slides*
"	I C	
"	I C	
"	2 A I -50)	Natural Family planning methods (NFP)
	)	Ovaluation method (OM) Mucus system
"	2 B I -)	Method, Basal body temperature (T.M.) etc.,
"	2 C I -	Population Growth causes and its effects (PGCE) -B & W Slides.
"	3 A I -24	Physiology of women-(PHW)-24 colour slides*
"	3 A 27-50	Breast Feeding (BF) 24 colour slides*
"	3 B I -31	Feeding your Baby (ch-54) 30 B & W Slides *
"	3 B 1 2	
"	3 B-	
"	3 C I-24	Managent of child Health Health (MnCH) 24 colour slides*
"	4 A I-50	More about child care (part I, II, III, &IV
"	[illegible]	
"	4 B I-22	(MCC) 72 colour and B&W slides*
"	4 B 27-50	the Ilesha weight chart (CH) 24 colour slides* The Road to Health Chart)
"	4 C I-24	Growth (GR) 24 colour slides *
"	4 C 27-50	Xerophthalmia (Xma) 24 colour slides *
"	5 A I-50)	Milestones in Development (MD)*
"	5 B I-5)	55 B & W slides*
"	5 B 6 -22	Mal nutrition slides (Mallur)-16 B&W slides
"	5 B	
"	5 C I -24	Peadiatric Haematology (PH) 24 colour slides *
"	5 C 27-50	X-rays in childhood (xrc) 24 colour slides*
"	6 A I-24	Malnutrition in India (MI) 24 colour slides*
"	6 A 27-50	Management of Severe Kwashiokar (KWM) 24 colour slides*
"	6 B I -24	Protien calorie Deficiency (Pcd) 24 colour slides *
"	6 B 27-50	Fibre in Human diet (F B R) 24 colour slides*
"	6 C I-44	Vitamin Deficiency (VD) B & W and colour slides
"	7 A I -24	Training of Traditional Brith Attendents (Dais)* (M-8) 31 B & W slides*
"	7 A 32-30	
"	7 B I	
"	7 B -	
"	7 C I-24	
"	7 C	

1. Nutrition Rehabilitation (NTR) 24 colour slides
VHAI Available with Dr.Ravi Narayan (Personal)

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LIST OF FILM STRIPS

1. Before the Baby comes
2. Organising a DPT immunization programme.
3. Balanced Diet for adults in India
4. Better Diet at low cost
5. Key to health
6. Diarrhoea.
7. Human reproduction
8. Family Planning Service Camps
9. Integration of MCH & F.P.
10. Family Planning made easier.
11. Campaign for family planning
12. Family planning worker.

FOOD HYGIENE COURSE

13. Introduction to Bacteriology*
14. Preventing Contamination*
15. Clean as you go*
16. Make itt easy
17. Rat - A deadly Enemy*
18. Village life lines*
19. Rural Housing*
20. Poor housing and poor roads*
21. Poor family living*
22. In farm and field*
23. How to prevent Cholera in the village*
24. Village Well*
25. Organization of clubs*
26. Water seal Latrine*
27. Continueous Gastro-Intestinal Drainage*
28. Fly. Your worst Enemy*
29. Care of the Eyes*
30. Filariasis*
31. Visit to Rural Balwadi*
32. Education for life*
33. An Adequate Teaching Environment*
34. Low cost Educational Toys.
35. Young Farmers Clubs*

SVE FILM STRIPS

36. Alcohol and your Health*
37. Tobaco and your Health*
38. Venereal Disease and your Health
39. Human Body Frame work*
40. Human Digestive System*

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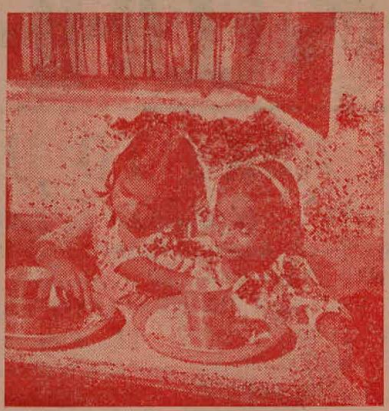
List of 16 mm. movies

1. Human Fertility - 25 minutes - Black and white.
2. To be a doctor - 25 minutes - colour- (UNIEF)



Children Learn What They Live

IF A CHILD LIVES WITH CRITICISM.
HE LEARNS TO CONDEMN.

IF A CHILD LIVES WITH HOSTILITY.
HE LEARNS TO FIGHT.

IF A CHILD LIVES WITH RIDICULE.
HE LEARNS TO BE SHY.

IF A CHILD LIVES WITH SHAME
HE LEARNS TO FEEL GUILTY.

IF A CHILD LIVES WITH TOLERANCE
HE LEARNS TO BE PATIENT.

IF A CHILD LIVES WITH ENCOURAGEMENT.
HE LEARNS CONFIDENCE.

IF A CHILD LIVES WITH PRAISE.
HE LEARNS TO APPRECIATE.

IF A CHILD LIVES WITH FAIRNESS.
HE LEARNS JUSTICE.

IF A CHILD LIVES WITH SECURITY.
HE LEARNS TO HAVE FAITH.

IF A CHILD LIVES WITH APPROVAL.
HE LEARNS TO LIKE HIMSELF.

IF A CHILD LIVES WITH ACCEPTANCE AND FRIENDSHIP
HE LEARNS TO FIND LOVE IN THE WORLD.

IYC exhibition

1. Deprived child / Handicapped
2. Immunization
3. Fam. welfare / fam.
4. DHS posters on MCH, - Mrs B.
5. ? Miss P. Asemi.
6. WHO posters
7. WHO literature.
8. Breast feeding - Reading + more

9 Headings causes of death under five care

11. child at play / psy / mental dev.
12. Nutr
13. Radio - MCH
14. 2 english posters from Mr. NG.

Exhibition for
World Health Day 1979
The Year of the Child

WORLD ENVIRONMENT DAYJUNE 5TH 1980

EXHIBITION ON ENVIRONMENTAL POLLUTION (ROSS INSTITUTE):

CATALOGUE OF POSTERS:

(1) "Space slip earth" is an encapsulated planet within whose confines man and his fellow lodgers- the beasts and even the bugs have to live together. If we foul up that living space, vitiat the atmosphere , person the water, restrict out food rations, tamper with the heating system a wallow in the excrement, domestic and industrial, and out tenancy will be limited, we can irreversibly damage the biosphere on which all life depends. (Ref- World Health August September 1971).

(2) POLLUTANTS IN AIR AND EFFECTS ON HUMAN HEALTH:

i) Oxides of sulfur:- Aggravation of existing respiratory diseases; impairment of lung function; sensory irritation.

ii) Airborne particles:- Increase in the effects of gascans pollutants such as sulfur dioxide, possible toxic effects depending on chemical composition (eg. particles containing lead or asbestos)

iii) Oxidants including ozone:- Eye irritation, possible association with association with asthmatic attacks, impairment of lung function in diseased persons.

iv) Carbon Monoxide:- By combining with haemoglobin deprives tissues of oxygen, individuals suffering from cardio-respiratory disease more sensitive; psychophysiological effects.

(3) Air pollution - Contd.

v) Intake through food and water and air enhances the total body burden of this element; in excessive amount it may develop poisoning.

vi) Asbestos: A possible factor in the incidence of lung disease along with other air pollutants and smoking; pleural calcification observed also in non-occipational exposure.

viii) Beryllium: "neighbourhood" cases of chronic berylium poisoning observed neat beryllium production plants.

4) Car Exhaust gases:-

1) 150 different chemicals have been identified in car exhaust.

2) Carbon monoxide is the most abundant of these.

3) In heavy city traffic concentrations of 500 ppm are common. 100 ppm is is the accepted maximum concentration for working conditions.

4) Lead retracthyl added to petrol is absorbed by the body and accumulates especially in brain tissue.

5) Children are particularly sensitive to lead poisoning.
6) Two British research workers have recently stated that average lead levels in urban dwellers are very close to the levels which cause enzyme inhibition in human metabolism.
7) The lead industry in this country takes 80 mg per cent in the blood as the level at which to show concern.
8) In Russia after extensive research the industrial limit has been reduced to 10 mg per cent.
9) Polycyclic hydrocarbons are more abundant in diesel engine exhaust. They are amongst the most potent cancer causing chemicals known.

(5) INDUSTRIAL:

1) Coal oil are still major sources of power. Electrical generating plants using these produce colourless sulfur dioxide in large amounts. It is claimed that there is not an economical way of removing it . Brick works and metals melting also produce SO_2.
2) Dissolved in water sulfur dioxide produces on acidic solution.
3) Areas of Northern England are uncultivatable due to acidic rainfall. The sulfur dioxide comes from the Manchester industrial complex.
4) Sulfur dioxide also blackens and "cats"away stone buildings.
5) Combustion of one ton of coal releases 150 lbs of "Soot", 80 lbs of sulphut dioxide, 8lbs nitrogen dioxide, 30 lbs of acids, 20 lbs miscellabeous substances.
6) New Yark city burns the equivalent of 32 million tons of coal each year.

(6) Pollutants in hand and effects on human health:-

i) Human excreta:- Schistosomiasis, taeniasis, hookwarm and other infections.
ii) Sewage:- Urban filariasis, flies and other disease vectors.
iii) Garbage and Vectors inhabiting it:- Rodent borne diseases; pollution of water and air from disposal practices.
iv) Industrial and radioactive waste:- Efects from stored toxic metals and other substances through food chains.
v) Pesticiales: - Contamination of vegetation and secondary foodstuffs and and entry into food chain.

(7) Pollutants in food and water and effects on human health Micoorganisms:

i) Bocteria:- Epidemic and endemic gastro-intestinal infections (typhoid, Cholera, Shigellosis, Salmonellosis, leptospirosis etc).
ii) Viruses:- Viral infections eg. epidemic hepatitis, possible eye and skin inflammation from swimming.

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iii) Protozoa and Metazoa:- Amoebiasis, schistosomiasis hydatidosis and other parasitic infections.

(8) Pollutants in food and water - contd.

Chemicals:

i) Metals:- Lead poisoning, methyl mercury poisoning (through food chains); cadmium poisoning (through food chains) arsenic poisoning ("Blackfoot" disease).

ii) Nitrates:- Infant methoemoglobinaemia (a condition caused by changes in the haemoglobin molceule)

iii) Fluorides:- Mattling of reeth when in excess, fluarosis.

iv) Oil, Petroleum, phenals, dissolved solids:-
Impaired potability.

(9) Pollutions child:- In 1953 the world saw to its horror, the accumulative effects of dumping mercury polluted water into the sea at Minamata, Japan. Minamata disease was born - The first sign of the horror was when the local cats began to go beserk. Some even killed themselves by plunging into the sea. Soon after the people began appearing in the streets turtching with paralysed hands and grotesquely dilated pupils, many children were affected since their mothers had eaten polluted fish and mercury had affected the child in the womb. Although its symptoms were final and absolute - there is no known antidote its long term implications are not fully understood. After a major trial chisso chemical company lost the case and the victims got compensation after 20 years.

(10) Oil:- (i) Man puts at least 3 million tons of crude oil into the ocean each year-

ii) There is an estimated 1 million tons at present floating on the surface of oceans.

iii) The "do-it-yourself" motorist uses over 20 million gallons of oil each year, 40% of which goes down drains and into river systems.

II. Sewage;-

i) The biggest polluter of fresh water is sewage.

ii) It makes enormous demands on the Oxygen capacity of the water.

iii) Nitrates from sewage and fertilizers and phosphates from sewage and detergents over stimulate plant growth. This causes deoxygenation of the water which bills most of the life forms present.

iv) In Switzerland bathing has been banned in lakes Lugarno, Constance, Geneva, Bienne, Luzern, Wechatel, Thun, Zurich, and Zug because of pollution.

.....4

12) Toxic chemicals and heavy metals:-

i) In the U.S. 12,000 toxic compounds enter the natural water system via Sewage discharge and only a portion is removed by normal sewage treatment.

ii) 14 states in the U.S. have reported cases of mercury poisoning in recent years.

iii) Minamata Bay, Japan - 112 cases of Mercury poisoning (44 deaths) as a result of eating fish caught in the bay.

iv) Bristal University school of Chemistry recently reported "exceedingly high levels of cadonuion" in the Bristol channel (550 ppm in limpets).

v) Symptoms of mercury poisoning - low levels - headaches, fatigue, insomnia, anxiety, lethargy, loss of appetite. High levels-blindness, deafness, conoulsions, coma, mental retardation.

vi) 6,000 poisonous products flow down the Rhine, including 16,150 tons of sulfates everyday. The river deposits 70 tons of mercury in Holland each year.

vii) In the North Sea recently a layer of dead fish was discovered stretching 80 miles and packed several.

viii) In 1970, the world catch of fish was lower than in 1969.

(13) ANTI-POLLUTION MEASURES:

Environment education
Anti-pollution checks/surveillance
Exhaust emission control devices in vehicles.
Clean air/water/land legislation
Environmental sanitation measures.
Reduction of use of pesticides, fertilisers, detergents.

(14) ECONOMICS OF POLLUTION:

Higher medical costs
Reduced or destroyed crops.
Loss of livestock
Higher food bills
Higher cleaning costs
Greater absenteeism
Costlier equipment
Increased maintenance costs

ENVIRONMENTAL DETERIORATION has continued and accelerated until it has reached the point of crisis. We must understand the problems we face if we are to solve them. It isn't too late to learn. The more we know about our world, the more effectively we can work to save it. It's the only one we have.

National Geographic.

GOVERNMENT ACTION:- for conservation of natural resources, and protection of air, water and land from pollution. - In order to evolue and promote national policies relating to environmental preservation, the Government of India has constituted the national Committe on Environmental

.....5

Planning and coordination (NCEPC). Some of its terms of referance are - identification and proposing solutions for problems of the human environment; reviewing policies and programmes having bearing on the quality of the environment, advising government departments, public authorities and industries on environmental matters, promoting environmental reaearch, public awareness and cooperating with the UN and other international agencies on action to safeguard the human environment. Quite a few research projects in environmental preservation and biosphere studies have been identified and funded by this National Committe.

WHO is developing an international environmental surveillance and monitaring network. The incoming information received from organizations, institutions, laborataries or national health services is treated by WHO. It is analysed and interpreted so that any change of importance should be noticed and instantly signalled. The network is still in its initial stages. When the components play their full part it will be a sensitive alert system for detecting adverse changes in the environment.

(15) Is pollution the partner of economic progress?

Must man pay for his economic well-being with foul water, naxious fumes and nerve-jarring noise? Can we achieve the material benefits of industrialization for all the peopleof the world without jeopardising out health and despoiling out environmental heritage?

(16) For centuries we have treated land, sea and sky as though they were limitless. They are not. We have pumped millions of tons of particulate matter and noxious gases into the atmosphere .....polluted most of our rivers and lakes ..... prodeuced so much trash that were running out of places to put it ---- allowed pesticides to travel all through the food chain----- occumulated mercury, lead, DDT and strontium go in our bodies.

We have disrupted natures systems - The self renewing cycles that have automatically rejuvented out land, water and air. When we temper with these systems we threaten the basis of life itself.

WHO Definition of Normal Blood Pressure.

	SYSTOLIC	DIASTOLIC
UPPER LIMIT	160 mm Hg.	95 mm Hg.
LOWER LIMIT	90 mm Hg.	60 mm Hg.

(These upper limits are revised downwards for younger individuals)

When SYSTOLIC BLOOD PRESSURE is MORE THAN 160 mm Hg and/or ~~it~~ DIASTOLIC 95 mm Hg, then it is termed as High Blood Pressure.

④ PREVENTION OF HIGH BLOOD PRESSURE

Primary Prevention is hindered by lack of knowledge of the etiology.

However, preventive steps can be taken concerning the risk factors. viz.

① STRESS - by leading a calm, peaceful life with good utilization of leisure time

② SMOKING - should be out for any person interested in avoiding heart disease

③ PHYSICAL EXERCISE - suited to the age and condition of the person.

④ DIET - Avoiding a high fat content especially saturated fats which raise blood cholesterol They are mainly of animal origin eg whole milk, cream, butter, cheese, meat fat etc.

Unsaturated fats [of vegetable origin] tend to lower blood cholesterol eg sunflower, cotton-seed, maize and fat of fish

⑤ OBESITY - should be cut down by diet, exercise etc

~~Height Weight Table~~

⑥ PREVENTION & TREATMENT OF DIABETES

⑦ YOGA and MEDITATION for prevention and treatment of early cases when stress and environmental factors are the main causes.

Kidney

Specimen of the kidney mg 9cms x 6cms x 5 cm. The external surface is smooth & the capsule strips easily. The cortical surface appears greyish white with occasional areas of irregular brownish discoloration. On section it is observed that the normal cortico-medullary demarcation is lost in areas. These sites being replaced by dark brown granular foci of necrosis. The calyces appear normal

Path { Enlarged Heart
Chr. G Pyelonephritis
Atheroma (aorta).

Anatomy   Heart

Ly 4

History of Medicine — SVR room.

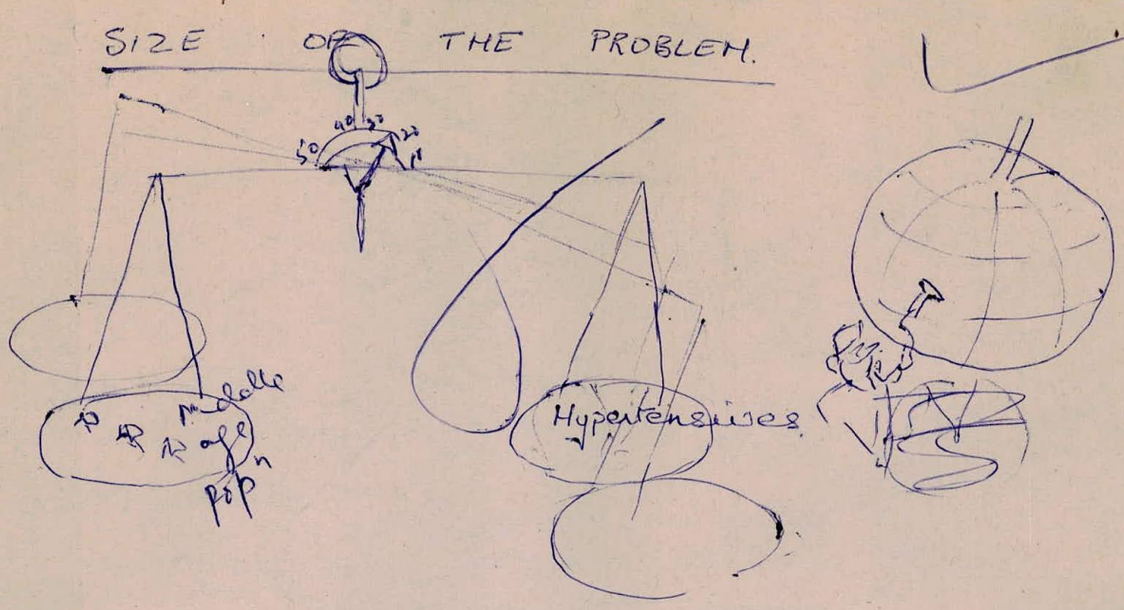
Atheroma Aorta with thrombus formation

Specimen of aorta showed extensive aortic ulceration and calcification were seen. A large thrombus was noted occupying part of the lumen of aorta below the origin of the renal arteries. It is [illegible] attached to one of the atheromatous ulcer.

Hypertrophied Heart:

Heart weighed 250 gm. All chambers of the heart were enlarged. [illegible] can [illegible] the left ventricular wall hypertrophied ~~[illegible]~~ thickened. [illegible] in due to the effect of high blood pressure.

(2) SIZE OF THE PROBLEM.



High blood pressure is found in most parts of the world.

10-20% of the middle-aged population have high-blood pressure.

About 22 MILLION are affected in ~~the~~ America!

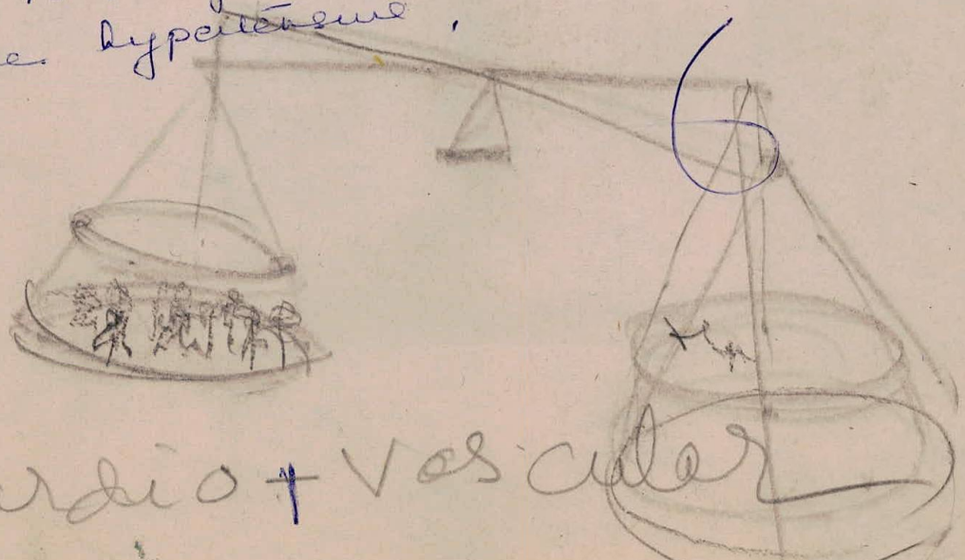
In INDIA, infectious diseases and malnutrition still remain major health problems.

But, cardiovascular disease has become an important cause of ill-health.

Prevalence of high blood pressure in ~~rural~~ India is 3-15%, ~~and in urban, urbanised areas 6-16%~~

Recent studies from A.I.I.M.S. show that 15% of 40,000 patients in Delhi were hypertensive.

(15)



India

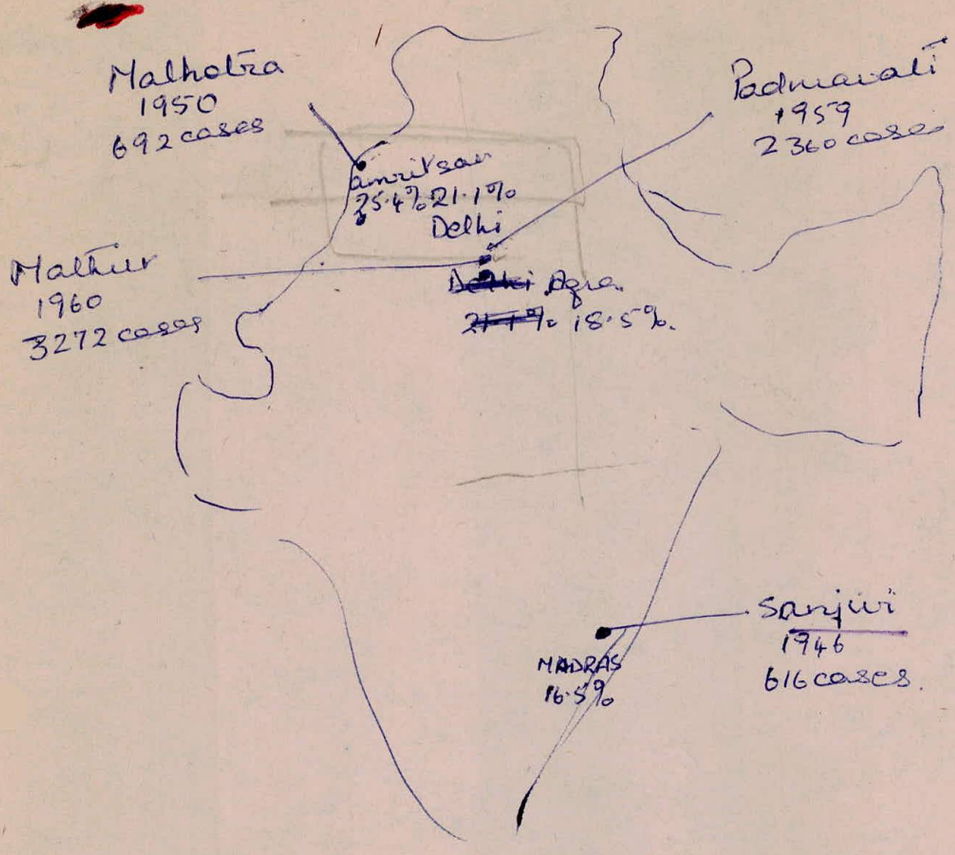
Amritsar (1950)	= 25%
Delhi (1958)	21%
Agra (1960)	18.5%
Madras (1946)	16.5%

Delhi: Studies showing of 30 yrs. peaks at 40-50 & comes down very sharply after 60 yrs.

Age: σ^2 = 65.6%

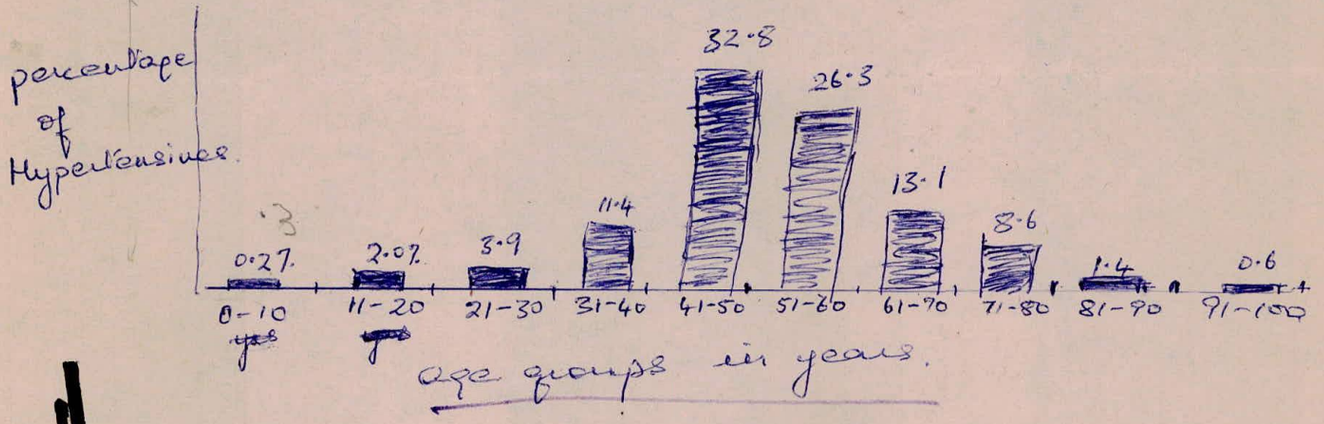
Sex: ρ = 34%

(3) SOME INDIAN STUDIES ON THE INCIDENCE OF HYPERTENSION.
(in percentages)



a.
Sanjur
1946.
616 cases

i) AGE DISTRIBUTION (5,560 cases)



ii) SEX DISTRIBUTION (5,560 cases).

Male figure

65.6%

female figure

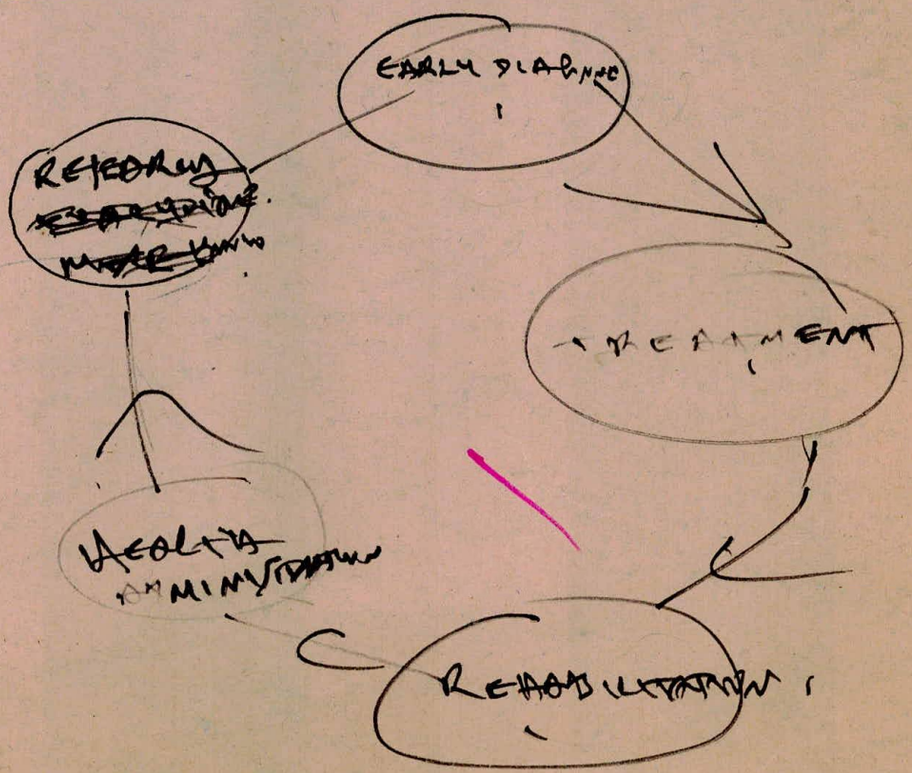
34.4%.

Hypertensive patients comprise 10-20% of the adult population and their management requires a community approach.

W.H.O. has initiated single and multiple factor prevention trials for ischaemic heart diseases, cardio-vascular disease registers and a study of the early signs and symptoms of acute myocardial infarction in a number of national centres.

CONTROL OF A DISEASE IMPLIES :-

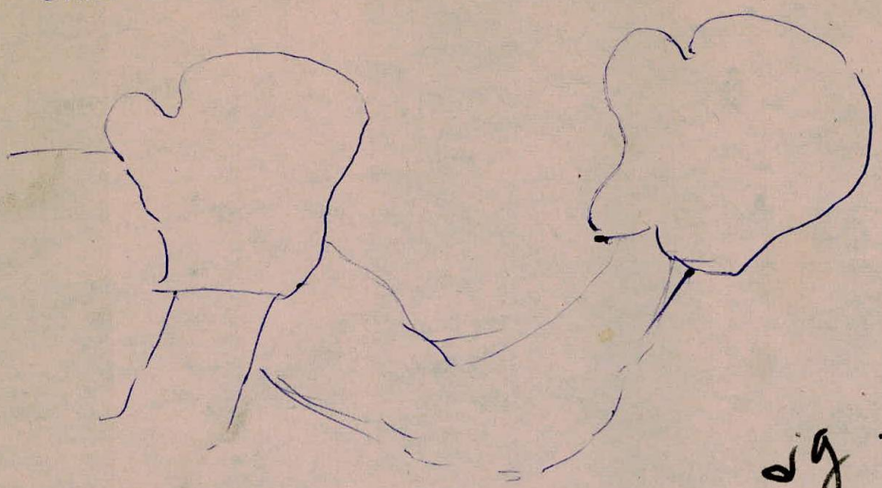
- Prevention of disease or complications!
- Early diagnosis.
- Treatment
- Rehabilitation
- Health Education
- Research to acquire more knowledge of the disease.



(5)

Clear evidence that hypertension is not an inevitable part of the ageing process

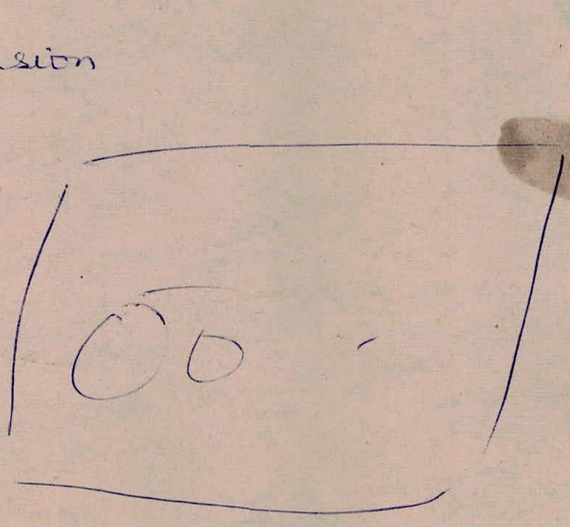
CHALLENGES US TO DO SOMETHING ABOUT IT.



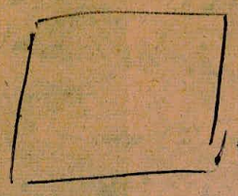
eg.

Low risk populations eg in the Pacific are characterized by their isolation from the Modern World of Industry, Rush and Affluence

~~Enviro~~ Enviorenmental changes play a key role in determining the occurence of hypertension



(9) STROKE



After a stroke there is —

1. Severe damage to all vital functions
2. Musculoskeletal impairment
3. Threat of a new attack.
4. Emotional unstability
5. changed social outlook and sometimes a breakup in family life
6. Sometimes speech is affected
7. Maybe intellectual deficits + behavioral sequelae
8. Maybe spastically later on.

(10)

Stroke demands long term rehabilitation which starts 2-4 days after the attack, when the life threatening stage is over.

Even in the acute stage some breathing exercises can be done

Rehabilitation includes nursing, physiotherapy, occupational therapy, speech therapy and psychotherapy.

When rehabilitation is neglected at the early stages, a higher degree of dependance develops.

REHABILITATION OF STROKE PATIENTS.

DOZI-S

DO'S AND

PEOPLE SHOULD KNOW ~~THEIR~~ NOT ONLY THEIR OWN BODY WEIGHT BUT ALSO THEIR BLOOD PRESSURE

(11) Initial Phase of Rehabilitation

1) Passive movements of all joints.
2) Exercise of intact limbs against resistance.
3) Breathing exercises.
4) Prevention of contractures by physiological positioning of limbs.
5) Prevention of bed-sores.
6) encouraging self-feeding - self-hygiene.
7) Developing bowel and urine control.
8) Bioelectrical stimulation.

The family should also be involved.

⑤ DIAGNOSIS.

An organized approach is needed to reach the majority of the community.
Possible ways of doing this are :-

① Mass screening of the entire population
② Measurement of B.P. at every medical consultation
③ Search only in certain occupational groups.
④ In cooperation with occupational health services.

Special attention is paid to the high risk group - over the age of 35 years.

For mass-screening, blood-pressure is measured only once. If high values are obtained more detailed examination is done

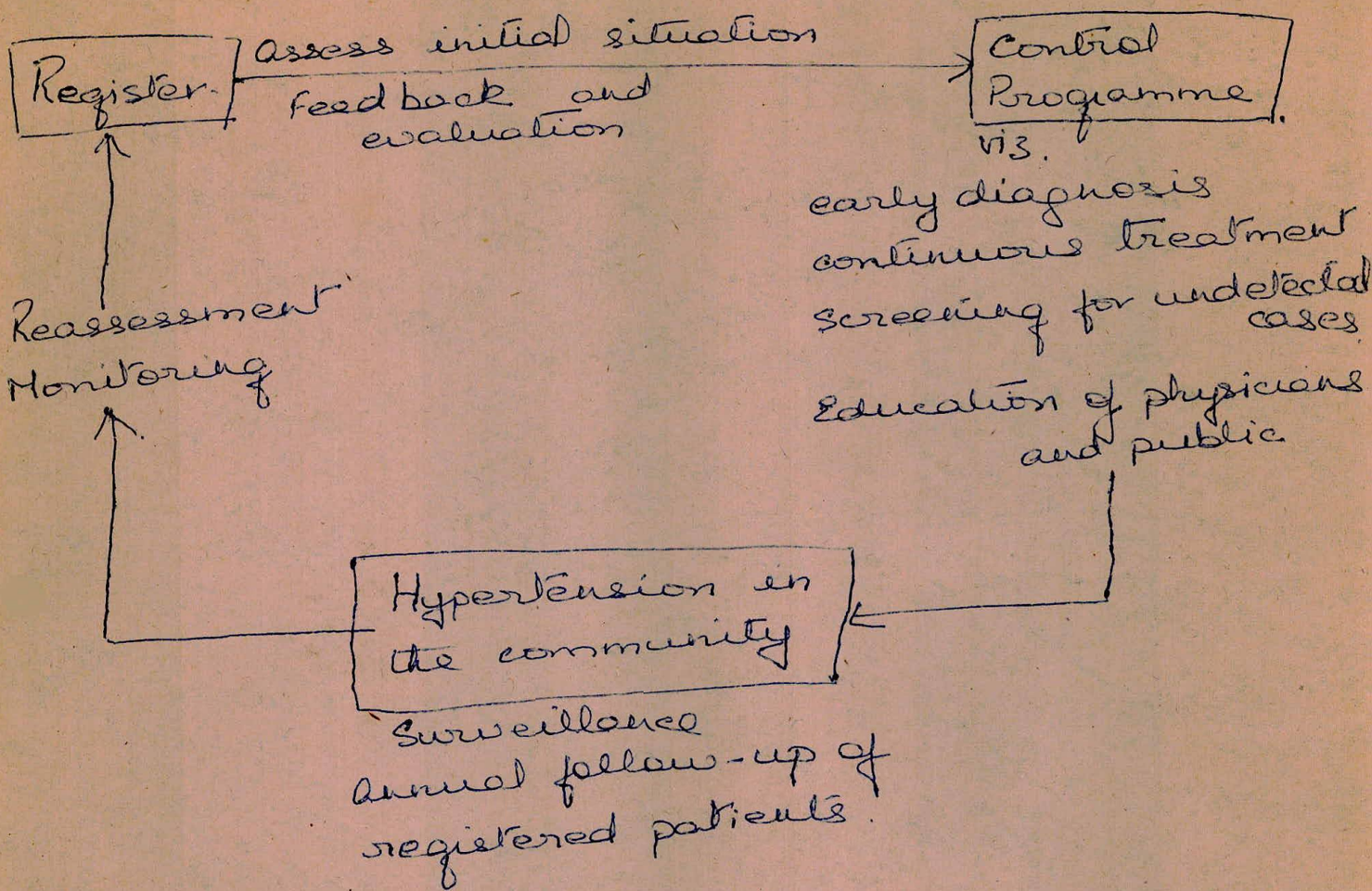
W.H.O. criteria -

(6) STAGES IN MASS EXAMINATION

1. Interview by physician / public health nurse.
   - Demographic information
   - Medical history
   - Family history
   - Symptoms.
2. Height and bodyweight.
3. Blood Pressure - sitting, after 15 min. rest.
4. Physical examination
5. Urine examination for albumin / sugar.
6. Electrocardiogram.
7. Fundus examination.
8. Cholesterol / serum lipids

(8) Disease Registers are usually the backbone of many community control programmes.

Function of Registers -



(17) Allied Health Personnel can also play a role in detection and follow-up - viz
- Doctors other than internists.
- Nurses
- Volunteers under a physicians supervision.

Automatic Sphygmomanometers provide the possibility of :-
- economizing on time.
- non-medical personnel can do the measurement.
- self-measurement.
- standardization of measurement.

Cooperation of the people can be obtained by involving local lay voluntary associations, educating local leaders, organizing "Health Promotion clubs" etc.

③ MILD HYPERTENSION

Proofs of the benefits of life-long treatment are not yet available.

Therefore in these cases

- Have yearly check-ups.
- If the patient has other risk factors eg family history, hyperlipidemia consider medical treatment.
- give health education regarding risk factors ie no smoking, adequate exercise, low fat diet, cutting ~~on~~ down on obesity etc.

① When break-down of speach occurs they must receive some means of communication as soon as they become conscious. eg picture cards, written instructions

② Spasticity a physical + psychological handicap is approached by - local nerve (Nerve) blocks or surgery.

③ Many behavioral sequelae may regress completely. Most improvement is seen in the first 3-6 months. It needs patience + understanding from all members of the family and coworkers

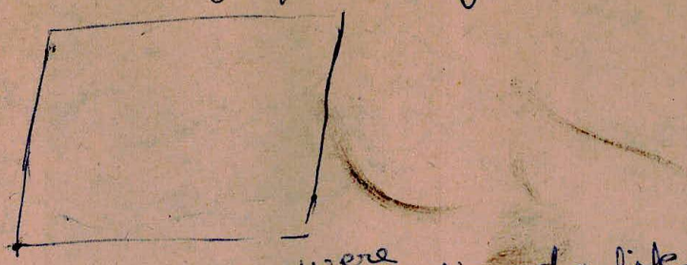
Some motivation for returning to an independant life is one of the most important elements in the rehabilitation programme.

(12) OUTLINE OF DRUG THERAPY OF THE AMBULATORY HYPERTENSIVE PATIENT

Degree of Hypertension	First drug to be given	If not effective in reducing M.B.P. more than 20 mmHg add the following
Mild, labile	Chlorothiazide 500 mg BD	Rauwolfia
Mild, stable	Chlorothiazide + Rauwolfia 2 mg QID X 1/week then BD	Hydrallazine 25 mg QID, ↑ at weekly intervals
Moderate	Chlorothiazide + Rauwolfia	Hydrallazine and/or ganglion blockers
Severe	Chlorothiazide + Rauwolfia	Ganglion blockers 1.25 mg mecamylamine or 20 mg pentolinium tds, ↑ dose progressively till control achieved.

TREATMENT

Modern Anti-hypertensive drugs can reduce high blood pressure, and also reduce the associated risks significantly.



WITH TREATMENT: – symptoms were relieved + life prolonged in severe hypertension
– incidence of stroke + heart failure was reduced.
– advance of Kidney failure was halted.
– in many, lesions of retina healed.
– malignant hypertension, an emergency, can be cured if therapy begins soon enough.
However the incidence of myocardial infarction is little affected by treatment.

ANTIHYPERTENSIVE TREATMENT IS SYMPTOMATIC.

NECESSITATING CONTINUED THERAPY.

(1)

1979

[redacted] IS A GIFT,

TO GIVE A CHANCE, TO LET A CHILD SING,

TO LET HIM SPREAD HIS WINGS.

WITH YOUR HELP. THE CLOUDS WILL

AWAIT HIM. LIKE OPEN DOORS

TO THE BLUE SKY ABOVE

AND THE FLIGHT WILL LAST FOREVER.

— PAUL. R. GARRIDO.

I.Y.C. SECRETARIAT.

IYC 1979 — INDIA.

(2)

INDIA HAS SELECTED A SPECIAL SYMBOL FOR THE INTERNATIONAL YEAR OF THE CHILD. THE SYMBOL DEPICTS A MALE AND FEMALE CHILD, WITH THE SUN AND A SLATE. THE SUN SIGNIFIES HEALTH AND STRENGTH. THE SLATE STANDS FOR THE IMPORTANCE OF EDUCATION FOR THE FUTURE OF CHILDREN.

THE INDIAN SYMBOL IS DISTINCT FROM THAT ADOPTED BY UNICEF AS IT WAS FELT THAT THE INDIAN SYMBOL SHOULD BE RELATED TO THE COUNTRY'S SOCIO-ECONOMIC LIFE.

(3)

A SLOGAN HAS BEEN SELECTED BY INDIA FOR IYC; 1979

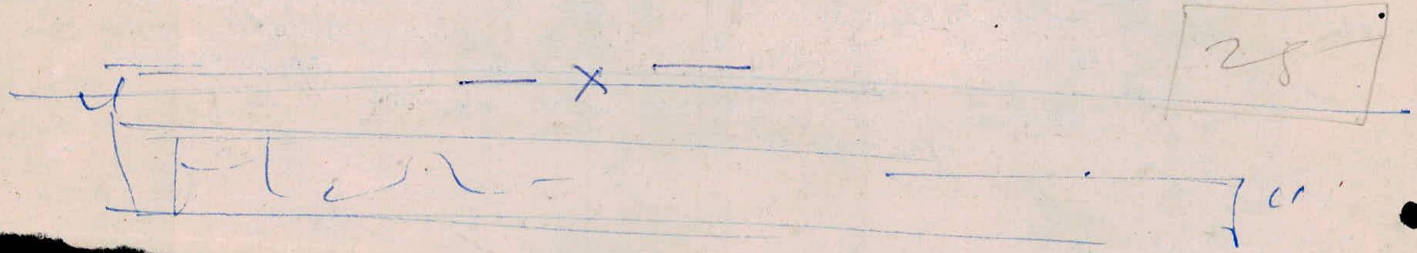
WHICH IS

"HAPPY CHILD NATIONS PRIDE".

THE GENERAL THEME IN INDIA FOR IYC-1979

is

"REACHING THE DEPRIVED CHILD".



11

World Health Day – 7th April 1982

Theme – Smoking or Health – the choice is yours.

(1)

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Dept. of Community Medicine
St. John's Medical College
Bangalore-560 034.

Exhibition put up at SJMCH by the Dept. of Community Medicine

Class | Roll No.

Semester | Subject

Examination | Date

(1) You can break free if you want to.
Cigarettes are only a habit.

(2) Danger -
~~Smoking area~~

You have been warned.

(3) Smoking or Health – the choice is yours

(4) Smoking is
" a custom loathesome to the eye,
hateful to the nose,
harmful to the brain
dangerous to the lungs
and in the black stinking fumes thereof,
nearest resembling the horrible stigian smoke
of the pit that is bottomless. "
King James of England.
(3 centuries, 76 yrs ago)

(5) Objectives

The objectives of WHO day 1980 are:

i) To educate people on the harmful effects of smoking on health – how cigarette smoking accelerates the disease process and produces irreversible damage (1)

ii) To create positive attitudes among non-smokers that they do not acquire the smoking habit

iii) To motivate smokers to discontinue the habit.

(6) The smoking habit poses a challenge to all who are concerned about the health of people and of the future GENERATION.

(7) Give yourself some breathing space (lungs full of cigarette butts)
Stop smoking. Now!
(Source - Indian Cancer Society)

(8) Know these hazards & stop smoking. } Headings.
The problem }

(9) (The problem I) smoking & health ☆
Studies have shown that smoking is dangerous to health.
Smoking is related to :-
(2) lung cancer & other cancers
Heart ~~disease~~ (cardio-vascular) disease
lung (& respiratory) disease
gastroduodenal ulcers
Risks to the unborn child
Lowered life span etc
Read on for more details.

10. Tobacco is a source of revenue ☆
at the expense of ~~individuals~~ the health of individuals

11. In the developed countries smoking rates are coming down while the opposite is happening in developing countries, where few efforts are ~~done~~ made to ~~at~~ ~~controlling~~ the consumption of cigarettes.

12 The estimated world production of cigarettes rose from 3180 thousand million pieces in 1970 to 3850 thousand million pieces in 1976.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class | Roll No.

Semester | Subject

Examination | Date

13. The proportion of teenage smokers is increasing significantly. This is a matter of particular concern. Those who start smoking when young have considerably higher death rates & are more likely to be heavy smokers & deep inhalers.

(14) Smoking + lung cancer:-

- Excessive smoking is a major cause of lung cancer. Heavy smokers are over 20 times more likely to develop lung cancer than non smokers. (3)
- The risk is 10 times more for average smokers than non smokers.

(15) Smoking & lung cancer

The risk of developing lung cancer increases with (4)

- longer duration of smoking and,
- number of cigarettes smoked per day

and ~~is diminished~~ decreases by

- discontinuation of smoking.

(16) Smoking + lung cancer.

(17) Smoking & respiratory diseases: ★

- Smoking is the most important of the causes of chronic bronchitis
- Bronchitis is an inflammation of the bronchial tubes that slows down the flow of air to & from the lungs
- The lining membranes of the air passages of smokers are thickened & become abnormal
- The hair like cilia on these membranes are damaged & less effective in removing the toxic & irritating chemicals introduced by the inhalation of smoke.

(18) Smoking & respiratory diseases ★

- Smoking affects the membranes lining the larynx or voice box
- The changes are similar to those that occur in the air passages & the lungs.
- The irritation causes swelling & increased secretion & result in "smokers cough."

(19) Smoking & respiratory diseases ★

- "Emphysema" is a disease that kills mostly smokers.
- The lungs lose their elasticity & hold in too much of air
- Victims have a daily struggle to keep their lungs working.
- Each breath requires a major effort.
- Potentially harmful particles are deposited in the air sacs, the point where emphysema develops.

(20) Smoking & other cancers ★

- Pipe smoking appears to be related to cancer of the lip
- Cigarette smoking is a significant factor in the causation of cancer of the larynx
- Evidence supports the belief that an association exists between tobacco use & cancer of the oesophagus (gullet)
- and between cigarette smoking & cancer of the urinary bladder in men.

Class | Roll No.

Semester | Subject

Examination | Date

(21). SMOKING and the Digestive System. ★

(19) A few puffs of a cigarette inhibit gastric hunger contractions for 15-60 mins.

(20) The organs of taste become less sensitive.

- The ~~above~~ following 2 factors decrease the smokers interest in food.

(22) While smoking, saliva absorbs tars + nicotine which may be swallowed. These irritate the gastric mucosa (lining) and cause an outpouring of hydrochloric acid. Continued irritation can cause congestion of the membranes. + produce / aggravate peptic ulcers.

(23). Risks to the unborn child:- ★

Smoking during pregnancy is associated with :-

i) lower birth weights.

ii) Shortened gestation

(13) iii) Higher rates of spontaneous abortion, especially during the last months of pregnancy.

iv) More frequent complications of pregnancy + labour.

v) Higher rates of perinatal mortality.

The risk increases with the number of cigarettes smoked per day.

(24). Chewing tobacco leads to cancer ★

- The habit of chewing tobacco is significantly associated with cancer of the mouth (cheek, tongue etc)

(9) The combined habit of chewing + smoking is linked with cancer of the back of the tongue + upper part of the pharynx.

- Bidi smoking is associated with cancer of the upper part of the gullet + adjoining portion of the pharynx.

(25) Smoking is distasteful ★

- Cigarette smoking leaves a bad taste in the mouth.
- Smoking makes the clothes smell bad.
- Smoking gives a sluggish feeling
- Smoking makes the breath foul
- Smoking discolours fingers & teeth and it damages health.

(26) Smoking a hazard to non-smokers ★

Smoking hazards of cigarettes & bidis are as pressing on the neighbourship persons as on the smoker itself.

Non smokers exposed to the side-stream & mainstream of smoke ~~of smoke~~ in enclosed ill-ventilated spaces like cars, buses and small offices may be exposed to harmful concentration of smoke.

*

(27) Stopping cigarette smoking, even after long exposures, is beneficial & is possible.

(28) ~~Once the habit is adopted~~, also the incidence of smoking among teenagers is high & in children whose parents smoke.

(29) Smoking & the circulatory system ★

Smoking affects the heart & blood vessels. Nicotine stimulates that part of the nervous system that controls the heart, blood vessels & other internal organs that function almost automatically normally.

- The pulse rate increases upto 20 beats/min
- The blood pressure increases
- Blood flow through the coronary arteries may be significantly reduced - producing cardiac pain in some subjects with electrocardiographic changes
- Peripheral blood vessels are constricted decreasing blood flow. A marked reduction of oxygen carrying power of the blood occurs.

Class	Roll No.
Semester	Subject
Examination	Date

(30) Cigarette smoking is now as important a cause of death as were the great epidemic diseases such as small pox, cholera & tuberculosis

Once the causes of these had been established they were gradually brought under control.

We must take widespread measures to control the present epidemic of smoking.

(31) Holocaust is a reasonable word to describe an annual death roll of some 27,500 in men & women aged 35 – 64 from the burning of Tobacco.

(32) Some tips to smokers ★

- Smoke fewer cigarettes
- Inhale less
- Smoke less of each cigarette
- Take fewer puffs from each cigarette
- Take the cigarette out of the mouth between puffs.
- Smoke brands with low nicotine & tar content.

(33) Air pollution is a much less serious hazard to life & health than cigarette smoking

(34) The smoking habit is so costly to so many people in health & life & to the country in financial loss that remedial action is urgently needed. Only a change in smoking habits can prevent this national wastage.

(35) A smokers cough or evidence of abnormal lung function maybe a warning of lung cancer, bronchitis or emphysema Cigarette smoking is particularly hazardous to those with such symptoms or with characteristics indicating an increased risk of coronary heart disease. ★

(36) A survey confirmed that while almost everyone knows of the risks they underestimated their magnitude & relevance to themselves.

Most smokers who admitted any danger to health considered that it applied only to those who smoked more than they did.

(37) Even so called moderate cigarette smoking does cause disease.

(38) Doctors have a unique opportunity for preventing common dangerous & disabling diseases by persuading their patients to give up cigarette smoking

(39) Employers please note!-

In view of the fire risk of smoking & the greater sickness absence rate of smokers compared with non-smokers, employers might improve your ~~their~~ own productivity, the safety of your ~~their~~ premises & your ~~their~~ employees health by banning smoking

(40) Anatomy & Physiology of cigarette:-

Nicotine — maybe responsible for the increase of cardio vascular disease in smokers

— Maybe the basis for many smokers dependance on the habit

The tar fraction contains cancer producing substances.

(41) The example & attitudes of parents towards smoking can have an important influence on the child

(42) There is evidence of psychological needs that outweigh the usually unpleasant effects of the first few smokes. Boys who smoke regularly tend to be less successful at work & games than those who do not & may wish to compensate by smoking as a symbol of toughness & precocity

Class	Roll No.
Semester	Subject
Examination	Date

(43) Pharmacological dependance.
The smoking habit certainly conforms to the definition of drug dependance given by Paton - "
Nearly all drug addicts are cigarette smokers.

(44) Acceptance of the facts about the harmful effects of cigarette smoking provides a powerful motive for giving it up.

(45) Smoking & other conditions
- Diseases of teeth & gums
- Loss of body weight.
- Decrease in physical fitness
- Blindness - Tobacco amblyopia.
- TB lungs.
- Accidents
- Cirrhosis of liver.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class	Roll No.
Semester	Subject
Examination	Date

Exhibition on "Safe water for All"
Catalogue of posters

(1) "one hospital bed out of four in the world is occupied by a patient who is ill because of polluted water..... Provision of a safe & convenient water supply is the single most important activity that could be undertaken to improve the health of people living in rural areas of the developing world" — WHO.

Rural population without access to safe water (in millions)

i) Africa — 135
ii) Latin America & Caribbean — 89
iii) Eastern Mediterranean — 138
iv) South East Asia — 632.
v) Western Pacific — 59

Children, water & UNICEF.

(2) "Surely a world which has enough technological skill to send men into outer space can manage to deliver the simple technology required to bring clean water to villages. And surely a world which can afford to spend many billions of dollars on luxuries & destructive weapons can also afford to spend a few billion dollars on necessities, such as wells, pumps & pipes that will give people a healthier, happier life."

(3) Water can cause disease & death
Children are particularly vulnerable

(4) Water is invaluable, it gives life
Safe water for all : the goal.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class	Roll No.
Semester	Subject
Examination	Date

TUBERCULOSIS

1. IT IS A DANGEROUS DISEASE IF IT IS NOT TREATED PROPERLY
2. PROPER TREATMENT MEANS TREATMENT FOR AT LEAST A YEAR
3. IF THE PATIENT STOPS TREATMENT AS SOON AS HE FEELS BETTER, THE DISEASE WILL SURELY RETURN. THIS TIME CURE WILL BE DIFFICULT AND VERY EXPENSIVE.
4. TAKE TREATMENT ONLY FROM TRAINED HEALTH WORKERS.
5. SPECIAL FOODS ARE NOT NECESSARY, BUT REGULAR TREATMENT IS ESSENTIAL
6. REGULAR TREATMENT SOON MAKES THE PERSON NON-INFECTIOUS
7. TUBERCULOSIS IS A DISEASE WHICH IS SPREAD BY SPUTUM AND COUGH
8. STOP THE DISEASE FROM SPREADING-
   COVER THE MOUTH WHEN COUGHING.
   DO NOT SPIT ON THE FLOOR
   KEEP A SPECIAL CONTAINER FOR SPUTUM, AND BURN IT IN THE FIRE.
9. IF THERE IS COUGH WITH SPUTUM LASTING MORE THAN 2 WEEKS IT MIGHT BE TUBERCULOSIS. GET THE SPUTUM TESTED AT THE NEAREST HEALTH CENTRE. SHOW ANY THIN CHILD WITH COUGH TO THE HEALTH WORKER; IT MIGHT BE TUBERCULOSIS
10. PROTECT ALL CHILDREN FROM TUBERCULOSIS BY BCG INJECTION.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class | Roll No.

Semester | Subject

Examination | Date

Q1 A mother c̄ an infant 6 mths old wants to start her child c̄ artificial feeding c̄ buffalo's milk. What is the qty of the buffalo's milk + the no. of feeds per day that you would advise? What other advice would you like to give to the mother abt the feeding c̄ buffalo's milk? Considering the deficiencies in the milk, what supplements would you advise

S - Buffalo's milk supplies 115 cal/100g. A child of 6 mths weighing 6 kg (normal) will rq 600 cals.

115 cal — 100 g
600 — ~~100~~ 20 x 600 / ~~115~~ 56 = ~~7500~~ ~~15000~~ 30,000 / 56 ~~28~~ ~~14~~ 7 = 3750 / 7 = 534 gm/day

or 16 - 17 oz = ~~18~~ ~~19~~ oz. 1 oz = 28.3495 g.

(1 std cup = oz.

This milk must be diluted with water to reduce the fat content + sugar must be added to ↑ the carbo. content

Comp^n - Buffalo milk Fat ~~8.8~~ 7.0 g% Sugar 5.5 g%
Human " " 3.4 g% Sugar 7.2 "

ie the milk must be humanized

Thus 16-17 oz of diluted milk must be given in 4 feeds (6 hly).

- Milk is def. in iron + vit C ∴ fruit juices + GLV soup.
- Supplementary food shd also be given
(soft cooked rice, ragi porridge)

- artificial feeding.

28 g = 1 oz
1 — 1/~~28~~ 14 x 534 = 267/14
534

14 | 267 | 18
14
127
126

② A fam. consists of an adult ♂ (55 kg) + adult ♀ (45 kg) + a child of 5 yrs weighing 15 kg. On a diet survey of this fam, it was observed that the consumption/day in terms of the proximate principles + nutrients was as follows.

Prot-	— 150 g.	Vit A	— 1000 IU
Carbo	— 2000 g.	Vit B	— 10 mg. (B_1 B_6 B_{12})
Fats	— 100 g	Vit C	— 150 mg

a) Comment on the qty & quality of the diet
b) Suggest improvements confining your attention to the above nutrients only.

Ans ① calorie (energy) reqmts (acc'g the coeff's are)

1 + 0.9 + 0.5 = 2.4 coef.

ie 2.4 × 2,400 = 5,760 cals

240
24
960
480
5760

The above diet provides

1) prot- 150 × 4 = 600 cal
2) carbo 2000 × 4 = 8000 "
3) fats 100 × 9 = 900 "

ie 9500 cal

~~15~~ 9
× 1.66
15
24.90

ie cals more than ample

② Prot- reqmt male female child (1.66/kg)
55 g 45 g. 25 g = 125 g

③ Carbo = 864 gm.
④ Fats. =
⑤ Vit B 2 2 1 = 14.9%,
⑥ Vit C. 50 50 40 = 140 mg
⑦ Vit. A (Retinol) 750 µg 750 µg 300 µg = 1800 µg.

1 IV = 0.3 µg

∴ 1000 = 0.3 × 1000 = 300 µg. — V. insuff.

CHO Requirement = 60% of total Cal.

ie: 60% of 5760 ie: $\frac{60}{100} \times 5760$

∴ In terms of Grams = $\frac{\frac{60}{100} \times 5760}{4}$ = 864 Grms of CHO.

Fat Requirement 30% of total Cal

ie: $\frac{30}{100} \times 5760$

In Grams = $\frac{\frac{30}{100} \times 5760}{9}$ = Grms of fat

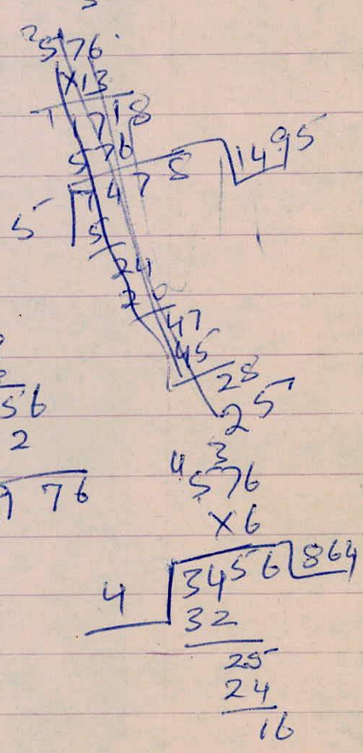
Thiamine Riboff. Niacin

B — 0.40 + 0.6 + 1.6 — 2.6 mg. / 1000 Cal

For 1000 cal —— 2.6 mg of B

∴ " 5760 —— $\frac{5760 \times 2.6}{1000}$

$= \frac{5764 \times 2.6}{1000}$



$\frac{576}{3}$ $\frac{192}{9}$ 2

1) What type of daily diet would you recommend for a
a) labourer weighing 65 Kg.
b) a pregnant mother

2) An analysis of daily diet taken by a fam. consisting of
1 adult male (sedentary) 55 kg.
1 " female (") 45 kg.
2 children of 3 yrs — 12 kg.
8 yrs — 20 kg.

It was found to contain the foll nutrients. * Comment on the qty & quality of the diet.

Prot. — 100 g.
Carbo — 1000 g.
Fats — 55 g

Vit A — 900 µg retinol
Vit B — 5 mg.
Vit C — 1000 mg
Vit D — 2000 IU.
Iron — 35 mg
Ca — 2.5 g.

How will you improve the diet.

Milk composition

	Buffalo	Cow	Human
Fat	7	3.8	3.1
Prot	3.6	3.5	1.25
Lactose	5.5	4.8	7.2
Ca	210	120	28
Fe	0.2	0.2	-
Vit C	1	2	3
Water	83	87	88
Energy	117	67	65

Recommended Nutrient Allowances

	Indian rel of (sdd)	preg	lact
Cal	1900	+300	+700
pro	45	55	65
Ca	500	1000	1000
Fe	20	40	30
Vit A	750	750	400
Vit D	2.5	10	10
Vit C	30	50	50
Folic acid	200	400	300
Vit B_{12}	2.0	3.0	2.5

		Energy req.	Coeff	Man value / consumption unit
♂ 55 kg	Sed.	— 2400	1	1-3 — 0.4
	mod	— 2800	1.2	3-5 — 0.5
	Heavy	— 3500	1.6	5-7 — 0.6
♀ 45 kg	Sed	— 1900	0.8	7-9 — 0.7
	Mod	— 2200	0.9	9-12 — 0.8
	Heavy	— 3000	1.2	12-21 — 1.0
preg		+ 300		
lact		+ 700		
Infants	0-6	120/kg		
	6-12	100/kg		
1-3		1,200		
4-6		1500		
7-9		1800		
10-12		2100		
~~13-15~~				

13-15 — ♂ 2500, ♀ 2200

15-18 — ♂ 3000, ♀ 2200

Community Health Volunteers (CHV's)

Govt of India scheme to provide 1 CHV / 1000 pop: by 1985.
145, 139 CHV's are now working.

Hasanpur 30 miles from N. Delhi close to the Haryana State Border. 110 houses + 900 residents. CHV named Charan Singh. Refer pts to PHC at Ujwa + Rural Health Training Centre, Najafgarh - Dr B.N Mittal - MO.

Jitendra Tuli - World Health Feb/Mar '81.

— x —

Ref

(1) Health for all by the year 2000 : the role of health education
by V.T.H. Gunaratne - International Journal of HE

"The greatest potential for improving health lies in what we do + don't do for + to ourselves" Victor Fuchs

- The report of the organization "New directions in education for changing health care systems" examined the cost of health care in its member countries in response to advances in treatment repertories, higher salaries + increasing consumer demands as well as in response to the corresponding pressures for cost control, a critical concern of governments. The report saw primary health care as an alternative to existing health care systems + as a solution to rising health care costs. The report, which sees health as an integral part of socio-economic development, strongly advocates health promotion by "providing citizens with the knowledge + the means to achieve greater level of physical, mental + social effectiveness, helping them to modify their life styles - habits, exercise, patterns, diets + handling of alcohol, tobacco + drugs - in ways conducive to improve health". The role assigned to health education again is unmistakable.

- In developing countries PHC is the only means of providing the least health care to more than 80% of the underserved & unserved population living in the rural areas + urban ghettos
- In these parts of the world, the major health problems which are responsible for high morbidity + mortality are nutritional deficiencies, vector borne diseases, childhood infections, respiratory infections + TB, diarrhoeal diseases, worm infestations, leprosy, blindness + so on. In India there are 9 million blind + 3.2 million cases of leprosy.

Here the problem is not one of the rising cost of health care but the very unavailability of health care

itself. The costs of providing the minimum health care to these people are staggering, as seen from the estimated cost of providing safe water + excreta disposal facilities to take only a single component of primary health care - as an example.

When the costs of providing PHC to more than 80% of the people who have no access to such facilities - ie education concerning prevailing health problems + the methods of identifying, preventing + controlling them, promotion of food supply + proper nutrition, MCH including FP, immunization against the major infectious diseases, prevention + control of locally endemic diseases, appropriate treatment of common diseases + injuries, promotion of mental health + provision of essential drugs - are added, the problems + constraints imposed by the scarcity of resources would become compounded.

- full participation of the individual, family + community at every stage
- underlying philosophy is self-reliance + self-determination.
- individual, family + community must "do" certain things to prevent communicable diseases or PCM, such as sanitary latrines + provide safe water or seek care when they are ill + so on.
- Participation required in the planning, implementation + evaluation of PHC services, in the support of the services established + the acceptance + use of such services.

It can only be brought about by active + appropriate educational means which are designed to inform, motivate + enable the individual, the family + community to perform their varied + vital roles.

- Health administrators sought to "teach" the "backward superstitious, uneducated villagers" about the virtues of "modern health services" by employing a corps of "well trained" health educators. The results have been unproductive to say the least, both in the

developed + developing world.

- the consumer or learner is central to HE just as he is central to programme or technology design. The emphasis must now shift from "education" to "learning" + from educator to learner.

— Where HE is done, health workers have not always taken into account, in addition to "consumer" characteristics, determinants of health behaviour, the motivation of the individual, family + the community to bring about a change; the communication patterns that hinder or foster learning + the appropriateness of the technology or the procedures recommended. Health professionals armed with predetermined innovations + procedures inherent in our technical orientation, have gone to the people with a set of "do's" + "don'ts". They have done little to provide an environment in which people could examine the innovations + procedures, whether or not they fit with their culture, are feasible in terms of cost + lifestyle + have the social + psychological support where all criteria are met education efforts have not been sustained long enough to make the technology permanent or the procedures a part of their behavioral pattern. This applies particularly to developing countries where resistance to change is greater

The danger of over-reliance on mass-media —

One wonders whether these aids, especially those that are mass produced centrally, are tailor made to fit the varying perceptual patterns of different population groups + whether they are selected with reference to the relevance + appropriateness of the educational objectives

- A situation comparable to having blackboards without teachers — H.E. must come to grips with the priorities between ends + means.

Unexamined reliance on mass media — punked projected + broadcast — to bring about health change this is to adopt a very simplistic approach to HE

PHC – World Health April '75

- Helping people help themselves
- There is no single world solution to the problems of rural health. People must be asked what they need rather than having solutions imposed on them
- Poverty with its implications of undernutrition, crowding + ill health, narrows the opportunities of human development. It is essential to involve the underprivileged pop.n in improving their own standard of living + their health.
- The drudgery of water carrying - a major occupation of women - providing safe, sufficient + accessible water is a priority in many developing countries but is difficult without a community organization.
- Most people in the developing world live from farming. Better agricultural methods + land use mean a better standard of living + better health
- Illness + death may be the result of infection but simple curative actions alone cannot solve the problem.

- Maintaining a viable village organization often means playing due respect to the experience of the elders
- This woman is in need of help but can she feel confident about the advice she is given in the strange surroundings of a "modern" health centre.
- Village medical helpers are selected by their fellow villagers
- Self reliance is considered essential for self supporting health services. It implies thinking in terms of what is available, or can be made available, at a comparatively small cost.
- Revolution in health - cure will to implement decisions good organization of services excellent programming feeling of participation among all health staff human scale decision to be taken at higher political level that health + education are the primary objectives in general social + economic development.

struggle for world peace + most in need of progressive strengthening of international detente + cooperation among peoples.

"Health for all" is interpreted to mean the attainment by all people of the world of a level of health that will permit them to lead a socially + economically productive life

---

Health is wealth

The future of our country depends on young mothers + children.
They need our special attention.

Translate child care + nutritional principles into Romanche.

~~– N. Hostel – 2/8/7.~~
~~– Clerk~~
–

— x — (WHO Chronicle. July 1980)

PHC

If health doesn't start with the individual, the home, the family, the working place, and the schools, we will never get to the goal of health for all – Dr H. Mahler March 80

—

Health + world peace

Health as a universal human value, as an inalienable right of man and as a basic necessity for a fulfilled and happy life, is evolving into a banner + symbol of rapprochement among peoples, irrespective of their economic + social systems + of their desire to strive for common objectives. The struggle for health is a standing repudiation of the arms race + an appeal for that indivisible peace to which all peoples + nations have a right, no matter what their level of social + economic development, their geographical extent, their population or their natural wealth. Health is undoubtedly one of the human values most intimately bound up with the

- community participation
  organise into groups / committees
- Evaluation of curative + preventive services
- Is the health of the people your responsibility - the story of Cuba.
- Health as a right of people
- Use of traditional practitioners
- MCH. - nutr -
- Health planning.

- A community health programme which stresses health, not disease & focusses less on the individual than on the community as a whole
- Very simple changes in the way of life can do much to fight diseases.

World Health March '73

- Health begins at home.
- The health impact of family planning occurs primarily through the following effects on human reproduction
  i) The avoidance of unwanted pregnancies & births & the

occurrence of wanted births that might otherwise not have taken place
(ii) a change in the total number of children born to a mother
(iii) variation in the intervals between pregnancies
(iv) changes in the time at which births occur particularly the first + last, in relation to the age of the parents, especially the mother

WH '75

Young World Health
In many countries less than 15% of the rural pop^n + of the under privileged groups have access to health care of any kind
only a privileged minority mainly from the cities, is treated in hospitals like those - National / Regional Hospital

The rest of the pop^n that receives health care of any kind is attended to in establishments like these

Village / Community Health Worker
In remote areas far from large cities & towns sick people

Refer to the community health worker in his/her hut or room. CHW's play an essential role in health care because nearly 75% of the worlds people live in the countryside. Moreover hospitals are expensive: a hospital bed costs ten times as much as a rural health unit.

Who is the CHW? - Anyone, man or woman, young or old provided primary education has given him/her the ability to read & write the person is selected by the villagers - or with their agreement - to deal with health problems of both individuals & the community.

What are his duties?
What training is required?
Where does the training take place?
Is he paid for the job?
From whom does the VHW report to?
Is there a clinic?
What are the working hours.

PHC - foreward by Dr Mahler. "A voyage towards Health" by Dr Gunaratne.

1. Can we look forward to a better quality of life of which health is an essential ingredient.
2. The time has come to pull our health from the backwaters + give it its rightful place in the forefront of socio-economic development activities.
3. Technology that can be used to subserve this goal
4. A social goal
5. It is an outward response to a growing international health conscience about the gap between the health have + health have-nots

How long do I continue to be a health have-not

6. More than half the worlds population have no access to any permanent form of health care + many more have access to forms of care that are

less than conducive to human develop-

4. It is there/here where people live + work that health is made or broken

It means that health begins at home, in schools + factories.

It means that people will use better approaches than they do now for preventing disease + alleviating unavoidable illness + disability + better ways of growing up, growing old + dying gracefully

It means that there will be an even distribution among the population of whatever health resources are available + applied

It does mean that ~~accessible~~ health care will be accessible to all individuals + families in an acceptable + affordable way + with their full involvement

It does mean that people will realize that they themselves have the power to shape their lives + the lives of their families free from the avoidable burden of disease

aware that ill health is not
inevitable
- But to gain progressively such an
understanding a minimum level of
health is essential
community involvement
"Health as if people mattered"

- Health for all does not mean that in the year 2000 doctors + nurses will provide medical repairs for everybody in the world for all their ailments; nor does it mean that in the year 2000 nobody will be sick or disabled.

7. It is for the underprivileged first + foremost that the concept of health for all is so important.

8. In trying to move forward along the road of social + economic progress humans have committed gross errors in their relationships with their environment. They have brought on themselves retributions in the form of slowly developing but insidious ill-health such as lung cancer + cardiovascular disease as a result of our smoking, high accident rates

mental illness to the extent that vast numbers live on tranquilizers & high suicide rates in those countries that consider themselves the most socially advanced.

9) Health for all is a moving target to be reached by a continuing process. As a certain health status is reached people will try to reach higher level & so on; the road to the year 2000 the does not end at the year 2000

10 All those who are undertaking the voyage towards health - every woman, man & child on the spaceship earth - should know that, although the voyage may seem long & arduous, the destination can & must be reached. It can be reached if governments & people work together in a common determination to reach it; it must be reached if mankind is to enter the new millennium not only as Homo sapiens - knowledgeable man - but also as Homo dignificatus - dignified man.

11th The philosophies have brought us to the threshold of universal mass action for health

— Halfdan T. Mahler

This is not a task that an individual, an organization or even a single country can achieve in isolation. It calls for a collective undertaking, with all round cooperation, unqualified commitment, full fledged coordination & concerted action

1. CARE FOR THE SICK, PROTECT THE HEALTH OF THE PEOPLE AND LOOK AFTER COMMUNITY HYGIENE.

2. GIVE CARE AND ADVICE TO ANYONE WHO CONSULTS HIM, IN ACCORDANCE WITH THE INSTRUCTIONS CONTAINED IN THIS GUIDE OR GIVEN BY HIS SUPERVISOR.

3. SEND PATIENTS TO THE NEAREST HEALTH CENTRE OR HOSPITAL (EVACUATION OR REFERRAL) IN ANY CASE IN WHICH THE GUIDE INSTRUCTS HIM TO DO SO AND IN ANY CASE NOT COVERED BY THE GUIDE. THE PHW SHOULD, THEREFORE CONFINE HIS CARE AND TREATMENT TO THOSE CASES, CONDITIONS AND SITUATIONS DESCRIBED IN THE GUIDE.

4. WITH THE AUTHORIZATION OF THE LOCAL AUTHORITIES, VISIT ALL DWELLINGS AND ADVISE THE PEOPLE HOW TO PREVENT DISEASE AND LEARN GOOD HABITS OF HYGIENE.

5. MAKE REGULAR REPORTS TO THE LOCAL AUTHORITIES ON THE HEALTH OF THE PEOPLE AND ON CONDITIONS OF HYGIENE IN THE COMMUNITY. GET FROM THE LOCAL AUTHORITIES AND THE PEOPLE THE SUPPORT HE NEEDS FOR HIS WORK.

6. KEEP AS CLOSE CONTACT AS POSSIBLE WITH HIS SUPERVISOR SO AS TO BE ABLE TO GIVE OF HIS BEST IN HIS WORK AND TO OBTAIN THE EQUIPMENT AND SUPPLIES HE NEEDS

7. PROMOTE COMMUNITY DEVELOPMENT ACTIVITIES AND PLAY AN ACTIVE PART IN THEM.

TO DISCHARGE THESE FUNCTIONS THE PHW:

(a) IS AVAILABLE AT ALL TIMES TO RESPOND TO ANY EMERGENCY CALLS
(b) ACTS IN ALL CIRCUMSTANCES WITH COMMON-SENSE AND DEVOTION TO DUTY, AND IS AWARE OF HIS LIMITATIONS AND RESPONSIBILITIES
(c) DOES NOT LEAVE THE COMMUNITY WITHOUT FIRST INFORMING THE LOCAL AUTHORITIES
(d) TAKES PART IN THE TRAINING ORGANIZED BY THE HEALTH SERVICE

THE PHW SHOULD SPEND SOME TIME WITH OTHER SOCIAL/DEVELOPMENTAL WORKERS CONCERNED WITH IMPROVING AGRICULTURAL PRACTICES, FOOD PROTECTION, WATER SUPPLY, HOUSE ECONOMICS, ETC. HE MUST KNOW ABOUT SERVICES AND OPPORTUNITIES FOR DEVELOPMENT AVAILABLE IN HIS DISTRICT AND KEEP HIS COMMUNITY WELL INFORMED.

IT FOLLOWS THEN THAT THE PHW IS THE PRACTICAL EXPRESSION OF A COMMUNITY'S DETERMINATION TO BE RESPONSIBLE FOR ITS OWN HEALTH CARE AND TO MAKE UP FOR ANY DEFICIENCIES THAT MIGHT EXIST IN THE HEALTH SERVICE COVERAGE. THE PHW SHOULD IMPROVE THE COMMUNITY'S PARTICIPATION IN WHAT WILL BE PART OF A PROVINCIAL/ NATIONAL HEALTH PROJECT PLANNED AND RUN BY THE NATIONAL HEALTH AUTHORITIES WITH THE ACTIVE CONTRIBUTION OF THE PEOPLE.

Health for all by 2000

— a call to bring about a social revolution in c. Hlth. Old ways of dealing with health problems had proved to be highly inadequate in countries at all stages of development, & the inequalities in health status & in the distribution of health resources throughout the world were intolerable.

The situation today is that nearly one thousand million people are trapped in the vicious circle of poverty, malnutrition, disease and despair that saps their energy, reduces their work capacity & limits their ability to plan for the future. For the most part they live in the rural areas and urban slums of the developing countries. The depth of their deprivation can be expressed by a few statistics. whereas the average life expectancy at birth is about 70-75 yrs in the developed countries, it is only about 45-55 in most developing countries. Of every 1000 children born into poverty in the least developed countries, 200 die within a year, another 100 die before the age of five and only 500 survive to the age of 40.

— To bring about this revolution will require reforms not only in the health sector but also of a political, social & economic nature. A more equitable distribution of resources for health can be the first of a series of such reforms in all sectors. The health delivery system itself has become a neglected child. In keeping with the principle of paying greater attention to the underprivileged, urgent action is needed to change that situation. Hence the health infrastructure must be reorganized so as to play a leading role in forging together the different health programmes into one unified system, however tough the struggle will be. This should be done particularly in rural areas & urban slums.

— The eight essential elements of primary health care are: — education concerning prevailing health

problems + the methods of preventing + controlling them ; ② promotion of food supply + proper nutrition ③ an adequate supply of safe water + basic sanitation ; ④ maternal + child health care, including family planning ; ⑤ immunization against the major infectious diseases ; ⑥ prevention + control of locally endemic diseases ; ⑦ appropriate treatment of common diseases + injuries ; ⑧ and the provision of essential drugs.

- Halfdan Mahler
World Health - Feb/March '81

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Health is a way of life :-

"There is a growing conviction that in all hospitals, even in those which are best conducted, there is a great and unnecessary waste of life, and that, as a general rule, the poor would recover better in their own miserable dwellings if they had proper medical and surgical aid, and efficient nursing, than they do under more refined treatment in hospitals."

Florence Nightingale 1863
1820 – 1910.

Science Today - May 1981.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

H Copies

36

Class | Roll No.

Semester | Subject

Examination | Date

World Environment Day June 5th 1990

Exhibition ~~of~~ on Environmental Pollution (Ross Institute)

Catalogue of posters

(1) "Space ship earth" is an encapsulated planet within whose confines man and his fellow lodgers – the beasts + even the bugs have to live together. If we foul up that living space, ~~vitiate~~ vitiate the atmosphere, poison the water, restrict our food rations, tamper with the heating system + wallow in the excrement, domestic + industrial, + our tenancy will be limited. We can irreversibly damage the biosphere on which all life depends. (Ref – World Health Aug-Sept 1971)

(2) Pollutants in air and effects on human health –

i) oxides of sulfur – aggravation of existing respiratory diseases; impairment of lung function; sensory irritation

ii) airborne particles – Increase in the effects of gaseous pollutants such as sulfur dioxide; possible toxic effects depending on chemical composition (eg particles containing lead or asbestos.

(iii) Oxidants including ozone – Eye irritation; possible association with asthmatic attacks; impairment of lung function in diseased persons.

(iv) carbon monoxide – By combining with haemoglobin deprives tissues of oxygen; individuals suffering from cardio-respiratory disease more sensitive; psychophysiological effects.

~~(iv)~~

(3) Air pollution – contd

(v) Lead – Intake through food + water + air enhances the total body burden of this element; in excessive amount it may develop poisoning.

(vi) Asbestos A possible factor in the incidence of lung disease along with other air pollutants + smoking; pleural

P.T.O.

calcification observed also in non-occupational exposure

(VII) Beryllium - "neighbourhood" cases of chronic beryllium poisoning observed near beryllium production plants.

(4) Car Exhaust gases -

1) 150 different chemicals have been identified in car exhaust
2) Carbon monoxide is the most abundant of these
3) In heavy city traffic concentrations of 500 ppm are common. 100 ppm is the accepted maximum concentration for working conditions.
4) Lead tetraethyl added to petrol is absorbed by the body & accumulates especially in brain tissue
5) Children are particularly sensitive to lead poisoning
6) Two British research workers have recently stated that average lead levels in urban dwellers are very close to the levels which cause enzyme inhibition in human metabolism
7) The lead industry in this country takes 80 mg % per cent in the blood as the level at which to show concern
8) In Russia after extensive research the industrial limit has been reduced to 10 mg. per cent
9) Polycyclic hydrocarbons are more abundant in diesel engine exhaust. They are amongst the most potent cancer causing chemicals known.

(5) Industrial

1) Coal & oil are still major sources of power. Electrical generating plants using these fuels produce colourless sulfur dioxide in large amounts. It is claimed that there is not an economical way of removing it. Brickworks & metals melting also produce SO_2.
2) Dissolved in water sulfur dioxide produces an acidic solution.
3) Areas of Northern England are uncultivable due to acidic rainfall. The sulfur dioxide comes from the Manchester industrial complex
4) Sulfur dioxide also blackens & "eats" away stone buildings.

5) Combustion of one ton of coal releases 150 lbs of "soot", 80 lbs of Sulphur dioxide, 8 lbs nitrogen dioxide, 30 lbs of acids, 20 lbs miscellaneous substances.

6) New York city burns the equivalent of 32 million tons of coal each year.

(6) Pollutants in Land + effects on human health

i) Human Excreta - Schistosomiasis, Taeniasis, hookworm + other infections.

ii) Sewage - urban filariasis, flies + other disease vectors

iii) Garbage + vectors inhabiting it - Rodent-borne diseases; pollution of water + air from disposal practices.

iv) Industrial + radioactive waste
Effects from stored toxic metals + other substances through food chains.

v) Pesticides
contamination of vegetation and secondary foodstuffs + entry into food chain.

(7) Pollutants in food + water + effects on human health

Microorganisms

i) Bacteria - Epidemic + endemic gastro-intestinal infections (Typhoid, cholera, shigellosis, salmonellosis, leptospirosis etc)

ii) Viruses - Viral infections eg epidemic hepatitis, possible eye + skin inflammation from swimming.

iii) Protozoa + Helazoa - amoebiasis, Schistosomiasis, hydatidosis + other parasitic infections.

(8) Pollutants in food + water - contd.

Chemicals

i) Metals - Lead poisoning, methyl mercury poisoning (through food chains); cadmium poisoning (through food chains) arsenic poisoning ("Blackfoot" disease)

ii) Nitrates - Syan- methaemoglobinaemia (a condition caused by changes in the haemoglobin molecule)

iii) Fluorides - Mottling of teeth when in excess, fluorosis.

iv) Oil, petroleum, phenols, dissolved solids
Impaired potability.

(9) Pollutions child

In 1953 the world saw in its horror, the accumulative effects of dumping mercury polluted water into the sea at Minamata, Japan. Minamata disease was born - the first sign of the horror was when the local cats began to go berserk. Some even killed themselves by plunging into the sea. Soon after the people began appearing in the streets twitching with paralysed hands + grotesquely dilated pupils, many children were affected since their mothers had eaten polluted fish + mercury had affected the child in the womb. Although its symptoms were fatal + absolute - there is no known antidote - its long term implications are not fully understood. After a major trial Chisso Chemical company lost the case + the victims got compensation after 20 years.

(10) Oil (i) Man puts at least 3 million tons of crude oil into the oceans each year.
(ii) There is an estimated 1 million tons at present floating on the surface of oceans.
(iii) The "do-it-yourself" motorist uses over 20 million gallons of oil each year, 40% of which goes down drains + into river systems

(11) Sewage -
i) The biggest polluter of fresh water is sewage
ii) It makes enormous demands on the oxygen capacity of the water.
iii) Nitrates from sewage + fertilizers + phosphates from sewage and detergents overstimulate plant growth. This causes deoxygenation of the water which kills most of the life forms present.
iv) In Switzerland bathing has been banned in lakes Lugarno, Constance, Geneva, Bienne, Luzern, Wechatel, Thun, Zurich, + Zug because of pollution.

(12) Toxic chemicals + heavy metals -
i) In the U.S. 12,000 toxic compounds enter the natural water system via sewage discharge + only a portion is removed by normal sewage treatment.
ii) 14 States in the U.S. have reported cases of mercury poisoning in recent years.
iii) Minamata Bay, Japan - 112 cases of mercury poisoning (44 deaths) as a result of eating fish caught in the bay.

contd (12)

iv) Bristol University School of Chemistry recently reported "exceedingly high levels of cadmium" in the Bristol Channel (550 ppm in limpets)

v) Symptoms of mercury poisoning – low levels – headaches, fatigue, insomnia, anxiety, lethargy, loss of appetite. High levels – blindness, deafness, convulsions, coma, mental retardation.

vi) 6,000 poisonous products flow down the Rhine, including 16,150 tons of sulfates everyday. The river deposits 70 tons of mercury in Holland each year.

vii) In the North sea recently a layer of dead fish was discovered stretching 30 miles + packed several yards thick. The fish had been killed by pollution.

viii) In 1970, the world catch of fish was lower than in 1969.

(13) Anti-pollution measures

Environment education
Anti-pollution checks/surveillance
Exhaust emission control devices in vehicles.
Clean air/water/land legislation.
Environmental sanitation measures
Reduction of use of pesticides, fertilisers, detergents

(14) Economics of Pollution

Higher medical costs
Reduced or destroyed crops
Loss of livestock.
Higher food bills
Higher cleaning costs
Greater absenteeism
Costlier equipment
Increased maintenance costs.

Environmental deterioration has continued and accelerated until it has reached the point of crisis. We must understand the problems we face if we are to solve them. It isn't too late to learn. The more we know about our world, the more effectively we can work to save it. It's the only one we have. National Geographic

Government Action – for conservation of natural resources, and protection of air, water + land from pollution. – In order to evolve + promote national policies relating to environmental preservation, the Govt of India constituted the National Committee

on Environmental Planning & Coordination (NCEPC). Some of its terms of reference are — identification & proposing solutions for problems of the human environment; reviewing policies & programmes having bearing on the quality of the environment; advising govt departments, public authorities & industries on environmental matters; promoting environmental research, public awareness & cooperating with the UN & other international agencies on action to safeguard the human environment. Quite a few research ~~pro~~ projects in environmental preservation & biosphere studies have been identified & funded by this National Committee.

WHO is developing an international environmental surveillance & monitoring network. The incoming information received from organizations, institutions, laboratories or national health services is treated by WHO. It is analysed & interpreted so that any change of importance should be noticed & instantly signalled. The network is still in its initial stages. When the components play their full part it will be a sensitive alert system for detecting adverse changes in the environment.

(15) Is pollution the partner of economic progress? Must man pay for his economic well-being with foul water, noxious fumes and nerve-jarring noise? Can we achieve the material benefits of industrialization for all the people of the world without jeopardising our health & despoiling our environmental heritage?

(16) For centuries we have treated land, sea & sky as though they were limitless. They are not.

We have pumped millions of tons of particulate matter & noxious gases into the atmosphere..... polluted most of our rivers & lakes ---- produced so much trash that we're running out of places to put it..... allowed pesticides to build all through the food chain ..... accumulated, mercury, lead, DDT & strontium 90 in our bodies

We have disrupted natures systems - the self renewing cycles that have automatically rejuvenated our land, water & air. When we tamper with these systems we threaten the basis of life itself.

— x —

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class	Roll No.
Semester	Subject
Examination	Date

Anti-Alcoholism - posters

(1) Destructive Alcohol ---

It is known that excessive drinking destroys brain cells. Now there is evidence that even "social drinking" destroys brain cells.

"When a drinker begins to feel even slightly giddy, a few brain cells are killed. A heavy drinking bout can kill as many as 10,000 such cells"

Dr Melvin Knisely, Prof of Anatomy Medical College South Carolina at the 28th International conference on Alcohol & Alcoholism.

[US Dept of Health, Educ & welfare

(2) Look, I can't go home drunk
what kind of example would that be

(3) Look, schools already hard enough.
why would I want to get drunk & make it worse?

(4) I have to keep myself in top condition
Alcohol can't help me there - physically, mentally ---
(athlete)

(5) We can march, run or crawl to freedom
but we cannot stagger to freedom
Rev Jesse Jackson

(6) Help prevent alcohol abuse

(6) My baby will be strong --- healthy
Why take any chances?
Consider before taking alcohol.

(7) If you drink a lot of beer,
you drunk a lot.

PTO

8. getting drunk doesn't make you ....
tall ... rich ...
strong .... handsome ....
smart .... witty ....
sophisticated .... or sexy ....
..... just drunk
In fact it doesn't do a thing for you — except get you drunk.

9. Ten Terrific hangover cures

1) Vitamins — Some say superdoses of vitamins will build up your body's ability to fight off the hangover. It doesn't work.

2) Tranquilizers — The only thing you might accomplish this way is an overdose of tranquilizing drugs on top of the overdose of alcohol.

3) Drink alcohol — "A bit of the hair of the dog that bit you", they call it. Of course if you drink enough, today's cure can become tomorrow's hangover.

4) Oxygen — Inhaling pure oxygen is supposed to help your system oxidise the alcohol. No good. In fact your hangover is partly the result of oxidising alcohol.

5) Exercise — Ugh. Suffering may help your guilt feelings but your hangover will survive the exercise better than you will.

6) Eat! Stuff yourself with a gigantic breakfast and if you keep it down, you will still have your hangover .... plus a full feeling.

7) Drink something disgusting — After you concoct the awful drink and manage to swallow it, the taste is supposed to make you forget your hangover but nothing tastes that bad.

8) Don't think about it — If you ignore your hangover, it will go away. Or will. But very, very slowly.

Anti-alcoholism posters - Cont'd.

ST. JOHN'S MEDICAL COLLEGE, BANGALORE

Class	Roll No.
Semester	Subject
Examination	Date

9) Lie still - don't get out of bed. Don't go to work. Millions of Americans use this cure ..... to the tune of about ten billion dollars in lost work every year. Too bad, because this cure doesn't work either

10) The cure! - At last, modern medical science has found the perfect, fail-proof, 100% effective cure. You guessed it: preventive medicine. The only way to cure a hangover is before it happens.

If you don't drink too much, you don't get a hangover.

- x -

11

WHO Day Exhibition
1978
on

~~[illegible]~~

"Donor with High Blood pressure"

Compl^n - contd.

i) There is an increased mortality associated with a modest rise of B.P.

ii) Stroke [cerebrovascular accident] is one of the major consequences of hypertension + control of hypertension is one of the best ways of preventing stroke.

iii) Coronary heart disease - [CHD occurred about 13 times + heart disease about 6 times more frequently in subjects with hypertension than those with normal B.P]

iv) Heart failure

v) Kidney failure.

vi) Retinopathy.

- THE HIGHER THE PRESSURE THE GREATER THE RISK.
- Presence of additional risk factors increases the risk of dying.
- CHART.

daily & recording standing & lying BP.
Repeat BUN every 48 hours.
Aim for gradual reduction of B.P.
When reduction achieved substitute oral reserpine 0.25 mg OD/BD for maintenance.

② If BUN is normal begin with hydrochlorothiazide, hydrallazine & blockers drug simultaneously, with frequent checks of BUN after diastolic falls to 120 mm Hg or less.

③

outline of drug therapy of the ambulatory hypertensive patient

Degree of hypertension.	First drug to be given	If not effective in reducing B.P. more than 20 mm Hg add following
Mild, labile	chlorothiazide 500 mg BD.	Rauwolfia.
Mild, stable	chlorothiazide + Rauwolfia 2 mg BID X 1 wk then BD	Hydrallazine 25 mg BID, ↑ at weekly intervals
Moderate	chlorothiazide + rauwolfia	Hydrallazine and/or ganglion blockers
Severe	chlorothiazide + rauwolfia	ganglion blockers 1.25 mg mecamylamine or 20 mg pentolinium tab. ↑ dose progressively till control achieved

(D) If home/office BP is well controlled withdraw rauwolfia after 1 mth. Restore only if BP raised again.

(E) If not controlled with above 3 discontinue hydrallazine but continue chlorothiazide + Rauwolfia add ganglion blocking drugs & increments if necessary.

Pentolinium comprule, ↑ by 20 mg
Chlorisondamine 10-20 mg, ↑ by 10 mg.
Mecamylamine 1.25 mg ↑ by 1.25 mg.
↑ every 2-3 days till BP falls.

(F) After 3 mths of adequate control try withdrawing Rauwolfia, after 6 mths " " ganglion blocking agent.

II Treatment of severe hypertension

(A) Hospitalize & record BP 4 times a day.

(B) If diastolic > 140 mm Hg give 2-4 mg reserpine IV, 4-12 hourly according to need.

If BUN < 70 mg %, but above normal, add chlorothiazide 500 mg BD + hydrallazine 25 mg tds elevating dosage to 50 mg after 48 hours.

If diastolic BP falls to 120 mm Hg or less follow BUN & lighten Rx if latter is rising

If BUN stabilizes below 70 mg % add, ganglion blocker, raising dosage

OUTLINE OF TREATMENT FOR ESSENTIAL HYPERTENSION

I Cases generally excluded from antihypertensive treatment.

a) BUN above 70 mg% in the absence of C.C.F.

b) age > 70 yrs unless diastolic pressure is quite high.

c) Home / hospitalized B.P. normal (diastolic < 90 mm Hg) with no sig. P. of organic damage.

II Treatment of mild-moderate hypertension

(A) Chlorothiazide, 500 mg B.D. initially

(B) If not controlled after 1 week add reserpine 0.25 mg B.D. for one week then OD. Next add hydrallazine 25 mg tds orally in sequential fashion ie OD for 2 days, BD for 2 days then tds.

If necessary raise hydrallazine dose to 50 mg tds. Do not exceed 150 mg/day for long term therapy or 300 mg for short term therapy of less than 2 months duration.

(C) If B.P. not controlled continue therapy with home blood pressure checks twice daily for 2 wks ~~unless this~~

(47) Some motivation for returning to an independent life is one of the most important elements in the rehabilitation programme.

There may be half-way homes between hospital & home.

(48) Knowledge of basic management + rehabilitation of stroke patients should be a part of medical education.

(45) Spasticity - a physical and psychological handicap is approached by - local nerve blocks with phenol.
- surgical adjustment of muscle length.
- resectioning of nerves.
For eg Patients can learn to manage with one hand only.

(46) Behavioral sequelae
- intellectual deficits.
- emotional lability.
- perceptional distortions.
- impairment in learning ability.
- problems in self-conception
Many of these regress completely. Most improvement is seen in the first 3-6 mths after which the personality is rather fixed.
It needs patience & understanding from all members of the family and co-workers.

(43) Initial phase

a) early tilting of bed a few times daily.
b) passive movements of all joints.
c) exercises of intact limbs against resistance
d) breathing exercises.
e) prevention of contractures by physiological positioning of limbs.
f) prevention of bedsores.
g) encouraging self-feeding and self hygiene
h) Developing bowel & urine control.
i) Bioelectric stimulation

- AVOID any "SICK-ROOM" ATMOSPHERE.
- The family should also be involved.
- Rehabilitation techniques are simple, requiring no equipment, just common sense and medical thinking on the lines of prevention.

- When rehabilitation is neglected at the early stages a higher degree of dependance develops.

(44) When the dominant hemisphere is affected, breakdown in speech or communication occurs.

Recovery is related to

- Degree & type of disorder
- Degree of physical involvement.
- general status of the patient.
- Degree of neurological deficit.
- Emotional adjustment.
- Family involvement & reactions.

They must receive some means of communication as soon as they become conscious eg picture cards, written instructions.

The patient must be taught and not conditioned.

(41) Rehabilitation includes nursing, physiotherapy, occupational therapy, speech therapy + psychotherapy. There are new trends with orthosis technicians, orthopaedic surgeons, medico-social workers + vocational counsellors

(42) Neurologically nerves destroyed hand no capacity for regeneration
the only consistent source of improvement is spontaneous compensation.

Therapists must stimulate all the existing peripheral proprio-ception + interoception reactions in the best possible way.

(40) REHABILITATION OF STROKE PATIENTS

IN THE COMMUNITY

After a stroke there is
- severe damage to all vital functions
- muscular skeletal impairment with functional handicaps.
- threat of a new attack.
- emotional instability
- changed social attitude.
Sometimes breakup in family life.

STROKE DEMANDS long term rehabilitation.

Rehabilitation starts 2-4 days after the attack - when the life threatening stage is over.

Even in the acute stage some breathing exercises can be done by a physiotherapist.

(37) Other aspects

i) Periodic home visits by the nurse / social worker may be indispensable to motivate patients to continue therapy.

ii) Information services to first line physicians about progress & modern concepts of diagnosis & treatment are also necessary.

iii) Health education to the public regarding the seriousness of the disease & complications if not treated.

(36) Role of ophthalmoscopic examination

No doubt of its usefulness in clinical medicine, but the quality + amount of additional information in mass screening has yet to be demonstrated.

(35) For Mild Hypertensives

- yearly checkups.
- Those with risk factors of family History / hyperlipidemia, should be considered for active treatment.
- Health education.

A report by Brunner, Laragh + coworkers on high, normal + low renin levels is another approach to differentiate hypertensive patients with different degrees of risk, ~~which~~ which is awaiting further tests + confirmation.

(34) How can we distinguish secondary hypertension which will benefit from treatment from the total population of hypertensives

The possible benefits should be weighed against the tremendous logistic problems of making detailed examinations of a large number of patients.

Early detection using simple diagnostic methods need to be developed.

(33) A W.H.O. Stroke register was initialed as a pilot study.

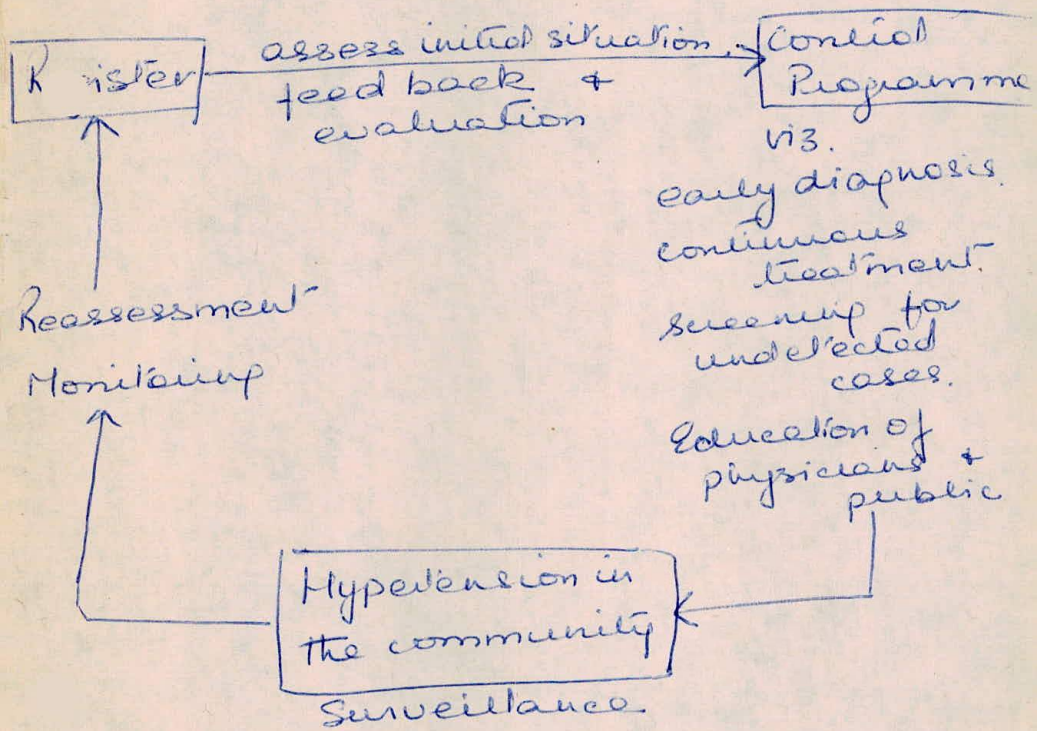
a) Identification + registration
b) Personal conditions
c) Past medical history
d) Early stages of present attack
e) clinical state at time of maximum impairment on date of attack.
f) Diagnosis at 3 wks after onset + examination performed.
g) Transfer of patient since previous interview.
h) Medical history between regular follow-up interviews.
i) activities of Daily Living.
j) Death / Autopsy findings.

Other Data.

i) Did patient know that he had hypertension prior to stroke.
ii) was he on treatment
iii) Number hospitalized.
iv) Number who had rehabilitation treatment.

(32) Disease registers are usually the backbone of many community control programmes.

Function of Registers -



The register is thus the "memory" and in a certain sense "the brain" behind the community control programme.

utilization of local lay voluntary bodies and associations with active participation of local inhabitants (as receptionists, for registration etc) & orientation of local leaders is important.

In Japan the cooperation of people was obtained by organizing a "Health Promotion club".

* Early detection using simple diagnostic methods need to be developed.

A report regarding high, normal & low renin levels is another approach to differentiate hypertensive patients with different degrees of risk, is awaiting further tests & confirmation.

(28) Allied health personnel can also play a role in detection & follow up viz.

- Doctors other than internists
- Nurses.
- Volunteers under a physician's supervision.

Automatic sphygmomanometers were introduced in sports physiology and in space medicine for continuous monitoring of B.P. They provide the possibility of

- economizing on doctors & nurses time. Non-medical personnel can do the measurement
- self measurement by the patient.
- standardization of measurement and reducing measurement errors.

(30) For mass-screening Blood Pressure is measured only once. If high values are obtained the person is designated for detailed examination.

(31) Steps in mass examination

1. Interview by physician / public health nurse
   - Demographic information
   - Medical history.
   - Family history.
   - Symptoms.
2. Height & bodyweight.
3. B.P. — sitting after 15 min rest.
4. Physical examination — for CVD
5. Urine — Albumin / sugar.
6. ECG — Minnesota code
7. Fundus examination.
8. Cholesterol / Serum lipids.

To reach the majority of the community for diagnosis needs an organized approach.

Possibilities ways of doing this are :-

(1) large scale screening of the whole population.

(2) Measurement of B.P. at every medical consultation maybe a cheap alternative approach to mass screening. i.e part of routine health care

(3) Maybe more practical to search in certain occupational groups

(4) Perhaps in cooperation with occupational health services.

Special attention is paid to the high risk group. - over the age of 35 yrs.

fats which raise blood cholesterol. They are largely of animal origin. eg whole milk, cream, butter, cheese, meat, fat etc.

Unsaturated fats (of vegetable origin) tend to lower blood cholesterol. eg sunflower, cottonseed, maize, fat of fish.

(5) cutting down obesity by diet, exercise etc.
1800 cal is sufficient for an average Indian < ♀ ♂.

– Height / weight Table

(6) Prevention of Diabetes.

(7) Yoga + Meditation.

Health education regarding these points should be given especially to mild hypertensives.

(26) Primary prevention is hindered by lack of knowledge of the etiology/pathogenesis etiology. Research is needed in order to prevent or treat it without imposing on a patient drug treatment for possibly his life time.

However, preventive steps can be taken concerning the predisposing risk factors. viz.

1). Stress - by leading a calm, peaceful life with good utilization of leisure time.

2) Smoking should be out for any person interested in avoiding heart disease.

3) Regular physical exercise suited to age & condition of the person.

4) Avoiding high fat content in the diet - especially saturated

(25) CONTROL OF A DISEASE implies

- prevention of the disease or its complications.
- Early diagnosis
- treatment
- Rehabilitation
- Health education
- Research to acquire more knowledge of the disease.

(23) WHO has initiated single and multiple factor prevention trials for ischaemic heart diseases, cardiovascular disease registers, and a study of the early signs and symptoms of acute myocardial infarction in a number of National centres, particularly in Europe.

Control measures should be adapted to local conditions. The best method for 1 place at 1 time may not apply to another place at another time.

(24) COMMUNITY SERVICES.

Mass health examinations are necessary for the community control of hypertension and stroke, with the condition that once risk subjects have been identified by screening they must have adequate medical supervision.

It may even be harmful first to warn them while depriving them of effective treatment and to give cause for anxiety without relief

(21) Comprehensive approaches are essential in any community action, and cardiovascular disease control is meaningful only when it can be integrated into a part of the general national health programme. X

(22) We are still far from mastering any of the methods of community intervention. The programmes are experimental undertakings. More research is needed.

(20) There is no doubt that mass phenomenon need mass approaches.

A community problem involves

- Acceptance, willingness, cooperation of the entire medical corps.
- Understanding and participation of the Govt. at various levels.
- as well as of the general public.

Hypertensive patients comprise 10 - 20% of adult population in many countries & their management requires a community approach

thousands of people may not be as spectacular and appealing as one heart transplant, even if the latter is a failure

PREVENTION.

(18) In the latter half of the century important changes have occurred in our knowledge regarding treatment, prevention & epidemiology of cardiovascular diseases,

BUT ONLY A FRACTION OF THE AVAILABLE KNOWLEDGE SEEMS TO BE IMPLEMENTED. FOR THE BENEFIT OF THE ENTIRE POPULATION. X

(19) The concept of PREVENTIVE MEDICINE is being increasingly accepted even in NON-COMMUNICABLE DISEASE CONTROL

Everybody agrees that prevention is better than treatment and is perhaps achieved at a much lower cost

BUT, TO Know is one thing, X
To DO another

PREVENTIVE CARDIOLOGY NEEDS MORE SUPPORT.

The successful saving of lives of

! Very high costs both of drugs and medical supervision involved in managing all cases of mild hypertension.

? DO the BENEFITS of treatment OUTWEIGH THE DISADVANTAGES of prolonged life long treatment with drugs.

Proofs of benefits of therapy on a widespread scale in Borderline/mild hypertensives has not yet become available

∴ in these cases

- Have yearly checkups.
- If the patient has other risk factors eg family history, hyperlipidaemia etc consider the benefits of medical treatment
- Health education regarding prevention of ~~risk~~ predisposing factors [see prevention]

with treatment
- ~~heart failure affected~~ incidence of stroke + heart failure was reduced
- advance of kidney failure was halted.
- in many, lesions of retina healed completely
- malignant hypertension though an emergency can be cured if the Rx begins soon enough before kidney failure has occurred.

ie the VALUE OF TREATING SEVERE HYPERTENSION is OBVIOUS.

However - incidence of myocardial infarction is little affected by treatment of severe hypertension and M.I IS THE COMMONEST MAJOR COMPLICATION IN THE TREATED HYPERTENSIVE PATIENT. There is interest in β-block. I. ē maybe able to lower the inci: of both stroke + M.I.

IN MILD HYPERTENSIVES. - problems are
? WHAT are the risks of ~~no~~ NOT TREATING the patient.
? WHAT REDUCTION OF THE RISKS is to be expected from treatment.
? WHAT if any are the disadvantages & disabilities which may result from treatment

All drugs at present available for treatment of hypertension have some disadvantage and most still require comparatively skilled administration.

It is also important to identify hypertension resulting from known causes as the possibility of radical curative therapy increases.
(guide of sec. hypert: in points)

Yoga & meditation should be considered as alternative modes of management — for PREVENTION in HR cases & TREATMENT OF EARLY STAGES when stress and environmental factors are the main causes.

~~Problem of mild hypertensives~~
~~Number of potential patients is very large, therefore increasing the cost of treatment + follow ups~~

(16) THERAPY

The last quarter century has seen a revolution in the therapeutics of high blood pressure.

*
- chart.
- ? Salisbar - classification
- ? Trade names of common drugs.

In severe hypertension drug treatment relieves symptoms, prolongs life and reduces the incidence of many morbid events. Modern antihypertensive drugs therapy can reduce high blood pressure effectively & can reduce the excess risk significantly.

Antihypertensive drug therapy is symptomatic necessitating continued therapy.

To diagnose SEVERITY - assess functional status of brain / heart / kidney. Look for peripheral vascular disease + aortic aneurysm

(15) ~~RECORD~~ INVESTIGATIONS + DIAGNOSIS

a) History.
b) Past medical history; family history.
c) Symptoms pertinent to certain diseases (for sec hypertension).
d) Physical examination
e) B.P. - sitting, after 15 min rest.
(+) - Height + bodyweight. (g) urine < Albumin Sugar.
f) ECG - Minnesota code.
g) Left ventricular hypertrophy
by < physical ex
CxR
ECG
h) Fundus by < ophthalmoscopy
Fundus camera.
Scheie or ~~Keith~~ Keith-wagner's classification.
i) serum lipids / cholesterol

Further investigations :-
a) B.U.N. / serum electrolytes
b) plasma renin activity
c) aldosterone in blood / urine.
d) urinary catecholamines.
e) X ray - IVP, arteriography, venography.
f) Radioisotope ex - Renogram, scintigram

④ Hypertension in INDIA.

Infectious diseases, and malnutrition still remain major health problems.

BUT, cardiovascular disease has become an important cause of ill-health.

Most common – Rheumatic H.D.
Next – Ischaemic H.D.
Third – Hypertension.

Prevalence in Rural India varies from 3-15% and in urban/industrial areas 4-15%.

Recent data from All India Institute of Medical Science show that 15% of 40,000 patients in Delhi were hypertensive. ie

⑥ WHAT IS HIGH BLOOD PRESSURE.

Refer: (cyclostyled sheet).

W.H.O criteria

- Casual B.P. over 160 mm Hg systolic and/or 95 mm Hg diastolic is considered hypertension.
- Systolic B.P. of 140 - 159 mm Hg and diastolic of 90 - 95 mm Hg is defined as BORDERLINE.

SINGLE casual B.P. measurements have epidemiological significance, however. SEVERAL measurements should be taken before THERAPY is started.

⑤ clear evidence that hypertension is not an inevitable part of the ageing process

CHALLENGES US TO DO SOMETHING ABOUT IT.

Environmental changes play a Key role in determining its occurrence.

Low risk populations of in the Pacific are characterized by their isolation from the MODERN WORLD of INDUSTRY, RUSH and AFFLUENCE.

(7) HISTORY.
(Dr. Manuel Fernandez).

(8) B.P. APPARATUS. - SPHGMOMANOMETER.

(9) PHYSIOLOGY. Wide range in healthy subjects usually from 100-145 mmHg systolic + 60-96 diastolic.
- chart.
- Varies with age + sex.
- Temporary elevation may be a homeostatic response
- ~~Varies~~ fluctuates with environmental physical & psychological.
- There are diurnal & seasonal variations.

⑨ Etiology

In the majority of cases the CAUSE of hypertension is UNKNOWN.

There are certain RISK FACTORS or predisposing factors.

(i) Heredity.

(ii) Stress - It is a "high executive disease"

(iii) Smoking - Death rate due to heart-attack is 100-150 times higher in smokers. Smoking is often "the matchstick that sets off the fire" & should be definately "out" for any person interested in avoid heart-disease. Alcohol.

(iv) Standard of living / Drinking

(v) Obesity - 50% increase in heart-attacks in overweight people.

(vi) Hyperlipidemia / Hypercholesterolemia

(vii) Diet - salt intake.
- fat intake
Saturated fats raise blood cholesterol

PTO

AGE DISTRIBUTION.

	No. of cases.	Age groups in years.									
		0–10	11–20	21–30	31–40	41–50	51–60	61–70	71–80	81–90	91–100
Hypertensive	5,560	0.2	2.0	3.9	11.4	32.8	26.3	13.1	8.6	1.4	0.6
Coronary	4,277	0.05	0.5	2.0	17.8	31.9	22.0	14.3	9.7	1.2	0.4

SEX DISTRIBUTION.

	No. of cases	Male	Female.
Hypertensive	5,560	65.6%	34.4%.
coronary	4,277	77.4%	22.6%.

INCIDENCE OF HYPERTENSION - Some Indian Studies (%)

	Sanjivi 1946 Madras 616 cases.	Luchand 1946 Lahore 112 cases	Vakil 1948 Bombay 1860 cases.	Malhotra 1950 Amritsar 692 cases.	Kumavati 1959 Delhi 2360 cases.	Mathur 1960 Agra 3272 cases
Hypertension	16.5	25.0	33.4	25.4	21.1	18.5
Coronary ~~disease~~	13.0			~~23.4~~	~~13.3~~	~~16.9~~

IN percentages.

ETIOLOGICAL CLASSIFICATION OF CARDIAC CASES. K.S. Mathur 1976 (9813 cases)

	Total cases	Hospital cases	Private cases
Hypertensive	16.4 %	14.8 %	19.8 %.
Coronary	26.4 %	18.2 %.	44.5 %.
Rheumatic	28.1 %.	32.7 %.	17.8 %.

(10) SECONDARY HYPERTENSION –
ie. resulting from known causes
is more likely in younger patients

- Chart
- BUT, hypertension with an identifiable cause is RARE.

(11) PATHOLOGY

- CHART

(12) EVOLUTION of hypertensive disease

O green – Hypertension without organ damage

O orange – Hypertension with changes in heart & arteries only

O red – Hypertension with other organ damage

The first TWO STAGES are most important for taking PREVENTIVE ACTION.

(Etiology - contd)

They are largely of ANIMAL ORIGIN eg whole milk, cream, butter, cheese, meat, fat. etc.

UNSATURATED FATS (of vegetable origin) tend to lower blood cholesterol eg: sunflower, cottonseed + maize oil + fat of fish.

(VIII) Sedentary stressful life -
Regular physical exercise suited to age and condition of the person is preventive as well as remedial.

(IX) Diabetes.

Refer Harrison's etc.

(4')

On a recent survey of European and N. American adults.

— 10-15% were hypertensive

— ONLY 50% of these were known to the medical profession.

— Of the 50% ONLY 30% were under treatment

— Of those treated only a minority had their B.P brought down to a safe level

This is the situation in countries with highly developed medical services.

(4'') Comparative study of awareness + Rx of hypertension
(– graph in WHO bulletin).

③ Hypertension or high blood pressure is a silent, secret threat to the health of people around the world.

AS BLOOD PRESSURE GOES UP

LIFE EXPECTANCY GOES DOWN.

according to Metropolitan Life Insurance Company figures

For a male - aged 45 yrs.
The average life expectancy is a little over 30 yrs

WITH B.P. OF 150/100. REDUCED TO 20 yrs.

For a female - Av. life expectancy 35 yrs.

WITH B.P. 150/100 REDUCED BY 8.5 yrs

③ SIZE OF THE PROBLEM.

High Blood pressure is a prevalent condition in most parts of the world with few exceptions

Hypertensive patients comprise 10 - 20% of the middle-aged population

an estimated 22 MILLION are affected in the USA.

With industrialization, ~~change in environment & dietary habits~~ ~~the pattern of~~ + Westernization the disease pattern in developing countries is approaching that of the west.

Emblem

① 7th APRIL 1978.

WORLD HEALTH DAY.

MARKING THE ANNIVERSARY OF THE ~~UNO~~ CONSTITUTION OF THE WORLD HEALTH ORGANIZATION IN 1948.

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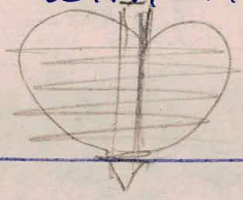
② SLOGAN FOR 1978.

"DOWN WITH HIGH BLOOD PRESSURE"



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③ YOUR HEART IS PRECIOUS.

— SAVE IT.

7th April 1978.

WORLD HEALTH DAY