Appendix 'C'

APPLICATION FORM FOR TRAINING COURSE FOR SEMINARIANS/PRIESTS/BROTHERS/ RELIGIOUS SISTERS IN COMMUNITY HEALTH AND MEDICINE

Name: Age: Sex: Male/female

Full postal address:

Qualification:

Present appointment (period of service including details of work done in provision of primary health care in urban and rural areas)

Details of previous health training obtained, if any:

Indicate special areas of interest in the health field:

Date and time of arrival at Bangalore:

Signature of sponsoring authority
Place:
Date:

Signature of applicant
Date:

Request regarding food requirement:

I am a ~~vegetarian/non-vegetarian~~

Signature

TRAINING COURSE FOR SEMINARIANS/PRIESTS/BROTHERS/RELIGIOUS SISTERS IN COMMUNITY HEALTH AND MEDICINE, ORGANIZED BY THE FACULTY OF ST JOHN'S MEDICAL COLLEGE AND ITS HOSPITALS

1. Venue: St John's Medical College and Hospitals

2. Faculty:
   i. Dean, St John's Medical College
   ii. Hospital Administrator and staff of St John's Medical College Hospital (SJMCH)
   iii. Staff of Depts of Anatomy, Medicine, Physiology, Surgery, Paediatrics, Obst & Gynae., Orthopaedics, Dermatology, ENT, Opthalmology and Psychiatry
   iv. Staff of Dept of Community Health and Ross Institute Unit of Occupational Health
   v. Medical Officer in charge of Primary Health Centre/Units at Dommasandra and Mallur
   vi. Visiting Lecturers from the Indian Institute of Management, Bangalore, Govt. Health and other Departments, Natural Family Planning Unit and St John Ambulance Brigade

3. Programme Director: Major General B Mahadevan, PVSM AVSM
   Director of Rural Health Services and Training Programmes, St John's Medical College Hospital

4. Duration of Course: 12 weeks (72 working days)

5. Course Components:
   i. Concepts of Community Health Care - total health care, maternal and child health, family welfare, nutrition and food hygiene, environmental sanitation including village and home sanitation, health education, control of communicable diseases
   ii. Clinical sessions in management of common problems and emergencies in Medicine, Surgery, Paediatrics, Psychiatry, Orthopaedics, Obst & Gynae both in the hospital and community. Treatment of common ailments with simple drugs.
   iii. Organization and management of health services - simple techniques involved in the delivery of Primary Health Care to individuals and community. Maintenance of medical records - basic concept of health economics - social security - health legislation

6. Course Capacity : 25

7. Date of commencement : April 3, 1978

8. Date of completion : June 24, 1978

(g) Participate in community development activities by discussing community problems with local leaders and working out solutions for improving the quality of life of the population

(h) Refer to appropriate centres all cases and problems outside or above his/her competence

(i) Maintain basic medical records of vital events (births and deaths in the community)

3. Course Components

A programme of lectures/group and trainee/staff discussios, clinics, field visits, practical sessions and films on community health subjects as per attached appendix 'A' & 'B'. The whole course is designed and spread out over a period of 12 weeks of which 3 weeks will be at the urban location and 9 weeks at a rural set up. While certain topics and training will be imparted at St John's Medical College and its Hospitals, most of the subjects pertaining to community health matters will be dealt with in the rural field centres, where it will be possible to expose the trainees to problems and various approaches in community health. Participants will be involved in practice of actual procedures like immunizations, disinfections, conduction of antenatal and under five clinics and treatment of patients for common complaints with simple drugs. The acquisition of basic knowledge, attitude and skills will receive full attention throughout the course. Time will be given for participants to speak, so that the faculty gets to know their problems and find solutions to the same. Their active participation at all stages will be ensured.

4. Registration

All candidates attending the course will duly fill in the attached proforma (Appendix 'C') and mail the same along with boarding and lodging charges for the period of the entire course in favour of Dean, St John's Medical College, through their Diocese, before the end of March 1978.

5. Boarding and Lodging

Wwill be provided at St John's Medical College Hostel/Hospital at the following rates:

Room - Rs.5/-
Meals etc. - Rs.7/-

(The duration of the course will be for 12 weeks)

6. Transport

Transport for trips between the college and hospitals and for field visits to rural areas, will be provided for the participants and accompanying staff members.

7. Library facilities, teaching aids and equipments

The course participants may use the library during the duration of their stay. Loan cards for reference in the library will

The necessary teaching aids and equipments available in the hospitals and in the Depts of Anatomy, Physiology, Pathology, Microbiology, Preventive and Social Medicine of St John's Medical College will be made use of.

8. Venue

For all lectures/discussions/films shows will be in room nos. 116, 117 of the ground floor and 241 of the first floor of St John's Medical College.

Clinics will be arranged at SJMCH. Suitable places will be earmarked for teaching at the various rural health centres and Action Group Areas.

9. Expenditure

Expenditure incurred on transport, audiovisual equipment, stationery and faculty time is expected to be Rs.900/- per participant for the entire course and must be paid in advance along with the boarding and lodging charges.

N.B. During the course, summer conditions will prevail in Bangalore - temperature varying from 16 deg C. to 35 deg C. Summer clothing will suffice. Candidates are requested to bring mosquito nets, bedding and linen.

Appendix 'A'

SUMMARY OF CONTENT OF LEARNING OF COMMUNITY HEALTH WORKER

(Mainly extracted from the Manual for Community Health Worker issued by Ministry of Health and Family Welfare, New Delhi).

1. Malaria

a. Identify fever cases
b. Make thick and thin blood films of all ~~fever~~ cases
c. Send the slides for laboratory examination
d. Administer presumptive treatment to fever cases
e. Keep a record of the persons given presumptive treatment
f. Inform the Health Worker(Male) of the names and addresses of cases from whom blood slides have been taken
g. Assist the Health Worker(Male) and the spraying teams in spraying and larvicidal operations
h. Educate the community on how to prevent malaria

2. Smallpox

a. Identify cases of fever with rash and report them to the Health Worker(male)
b. Inform the Health Worker of infants aged zero to one year requiring primary vaccination as follows:

i. In the intensive area inform the Health Worker(female)
ii. In the twilight area inform the Health Worker(male)

c. Assist the Health Worker (male/female) in arranging for primary vaccination
d. Follow up cases who have been given primary vaccination
e. Educate the community about the importance of primary vaccination

3. Communicable diseases

a. Inform the Health Worker(male) immediately an epidemic occurs in his/her area
b. Take immediate precautions to limit the spread of disease
c. Educate the community about the prevention and control of communicable diseases

4. Environmental sanitation and personal hygiene

a. Chlorinate drinking water sources at regular intervals
b. Keep a record of the number of wells chlorinated
c. Assist the Health Worker (male) in arranging for the construction of the following:

i. Soakage pits;
ii. Kitchen gardens
iii. Compost pits;
iv. Sanitary latrines
v. Smokeless chulhas

d. Educate the community about the following:

i. Safe drinking water
ii. Hygiene methods of disposal of liquid waste
iii. Hygienic methods of disposal of solid waste
iv. Home sanitation
v. Kitchen gardens
vi. Advantages and use of sanitary latrines
vii. Advantages of smokeless chulhas
viii. Food hygiene
ix. Control of insects, rodents and stray dogs

5. Immunization

a. Assist the Health Worker(male/female) in arranging for immunization
b. Educate the community about immunization against diphtheria, whooping cough, tetanus, smallpox, tuberculosis, poliomyelitis, cholera and typhoid

6. Family planning

a. Spread the message of family planning to the couples in his/her area and educate them about the desirability of the small family norm
b. Educate the people about the methods of family planning which are available
c. Act as a depot holder, distribute nirodh to the couples and maintain the necessary records of nirodh distributed
d. Inform the Health Worker(male/female) of those couples who are willing to accept a family planning method so that he/she can make the necessary arrangements
e. Educate the community about the availability of services for Medical Termination of Pregnancy(MTP)

7. Maternal and child care

a. Advice pregnant women to consult the Health Worker(female) or the trained dai for prenatal, natal and postnatal care
b. Advise pregnant women to get immunized against tetanus
c. Educate the community about the availability of maternal and child care services and encourage them to utilize the facilities
d. Educate the community about how to keep mothers and children healthy

8. Nutrition

a. Identify cases with signs and symptoms of malnutrition among pre-school children (one to five years) and refer them to the Health Worker (male/female)
b. Identify cases with signs and symptoms of anaemia in pregnant and nursing women and children and refer them to the Health Worker(male/female) for treatment
c. Assist the Health Worker(male/female) in administering vitamin A solution as prescribed to children from one to five years of age
d. Teach families about the importance of breast feeding and the introduction of supplementary weaning foods
e. Educate the community about nutritious diets for mothers and children

9. Vital events

a. Report all births and deaths in his/her area to the Health Worker(male)
b. Educate the community about the importance of registering all births and deaths

10. First aid in emergencies

a. Give emergency first aid for the following conditions, refer these cases to the Primary Health Centre as necessary and inform the Health Worker(male/female)

i. Drowning; ii. Electric shock

v. v. Scorpion sting; vi. vi. Insect stings;
vii. Dog bite; viii. Accidents

b. Carry out procedures in dealing with accidents
c. Keep a record of first aid given to each patient

11. Treatment of minor ailments

a. Give simple treatment for the following signs and symptoms and refer cases beyond his/her competence to the Subcentre or Primary Health Centre

i. Fever; ii. Headache;
iii. Backache and pain in the joints
iv. Cough and cold v. Diarrhoea;
vi. Vomiting vii. Pain in the abdomen
viii. Constipation ix. Toothache;
x. Earache xi. Sore eyes
xii. Boils, abscesses and ulcers
xiii. Scabies and ringworm

b. Keep a record of the treatment given to each patient

12. Mental Health

a. Recognize signs and symptoms of mental illness and refer cases to the Health Worker(male/female)
b. Give immediate assistance in emergencies associated with mental illness
c. Educate the community about mental illness

13. Community Development :

a. Block Developmental activities
b. Extension Education
c. Agriculture, Pisciculture, Veterinary and live stock
d. Transportation

Appendix 'B'

PROGRAMME FOR TRAINING OF SEMINARIANS/PRIESTS/BROTHERS/RELIGIOUS SISTERS IN COMMUNITY HEALTH AND MEDICINE, ORGANIZED BY ST JOHN'S MEDICAL COLLEGE

FIRST WEEK

DAY	9.00 am to 12 noon	1.00 pm to 4.00 pm		
MONDAY	Inauguration, Registration and pre-evaluation St John's Medical College (SJMC)	Anatomy	Physiology	First Aid
TUESDAY	Common ailments - Out Patient (Medical) St Martha's Hospital (SMH)	"	"	"
WEDNESDAY	-do-	"	"	"
THURSDAY	-do-	"	"	"
FRIDAY	Common ailments - Out Patient (Psychiatry) SMH	"	"	"
SATURDAY	Group discussions on common ailments - SMH			

SECOND WEEK

DAY	9.00 am to 12 noon	1.00 pm to 4.00 pm	
MONDAY	Common ailments - Out patient (ENT) - SMH	Anatomy	Physiology First Aid
TUESDAY	Common ailments - Out patient (Oph) - SMH	First Aid lecture demonstration	
WEDNESDAY	Common ailments - Out patient (Surg/Ortho) - Accidents SMH	Population Dynamics and Family Planning (Natural Methods)	
THURSDAY	Common ailments - Out patient (Dermatology) - SMH	1.00-2.30 pm Anatomy Test	3.00-4.30 pm Physiology Test
FRIDAY	Common ailments - Out patient (Obst & Gynaec) - SMH	First Aid test	
SATURDAY	Group Discussion		

.....2

THIRD WEEK

DAY	TOPIC
MONDAY	General management of patients - Home Nursing - St John's Medical College Hospital (SJMCH)
	Lecture Demonstration at SJMCH
TUESDAY	Multiple etiology of diseases Role of socio-economic factors in health and disease
WEDNESDAY	Visit to Community Development Block, Yelahanka
THURSDAY	Visit to Poultry, Piggery, Fishery etc.
FRIDAY	Visit to Poultry, Piggery, Fishery etc.
SATURDAY	Group Discussion (socio-economic aspects and health)

FOURTH WEEK - (RURAL HEALTH CENTRE)

DAY	TOPIC
MONDAY	Introduction to Rural Health - role of Health Care - Administration, Organization and Functions
	Health and Environment (Introduction) - and survey and discussion
TUESDAY	Water supply and waste disposal - survey and discussion
WEDNESDAY	Insects, rodents and live stock - survey and discussion
THURSDAY	Industries - survey and discussion
FRIDAY	Housing and accommodation - survey and discussion
SATURDAY	Survey of major resources and facilities for health and welfare

FIFTH WEEK

DAY	MORNING	AFTERNOON
MONDAY	Introduction to Maternity and Child Health	Maternity and Child Health Services and Components*
TUESDAY	Survey of antenatals	Registration
WEDNESDAY	Survey of antenatals	Registration
THURSDAY	Antenatal Clinic	Discussion

SIXTH WEEK

DAY	MORNING	AFTERNOON
MONDAY	Water borne diseases (brief introduction)	Survey of drinking water wells
TUESDAY	Disinfection of water in wells	Discussion
WEDNESDAY	Faecal borne diseases	Survey of latrines and methods of waste disposal (manure pits, compost etc)
THURSDAY	-do-	-do-
FRIDAY	Laboratory examinations of urine and faeces	Analysis of findings
SATURDAY	Group discussions	

SEVENTH WEEK

DAY	TOPIC
MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY	Relation of food and nutrition with health (Topics: Introduction, balanced diet, energy requirements, dietary patterns, infancy (well fed and ill fed), pregnancy, lactation, cocking and culinary practices, food hygiene and food borne diseases, malnutrition and under nutrition, education on nutrition and national applied nutrition programme survey, lectures, ~~demonstration~~, films, discussions etc

EIGHTH WEEK

DAY	MORNING	AFTERNOON
MONDAY	School health - introduction	Visit to school and check up of environmental factors etc
TUESDAYS	Immunizations - procedures and practice	Visit to School and other community health organizations
WEDNESDAY	-do-	-do-
THURSDAY	-do-	-do-
FRIDAY	-do-	-do-
SATURDAY	Group discussions -	

NINTH WEEK

DAY	MORNING	AFTERNOON
MONDAY	Clinic - study of common diseases and treatment	Education in community, Personal hygiene, diarrhoea, vomitting
TUESDAY	-do-	Pregnant women, lactating mother
WEDNESDAY	-do-	Diet and nutrition
THURSDAY	-do-	Diet and nutrition
FRIDAY	-do-	Scabies, leprosy etc.
SATURDAY	Group discussion on common diseases and their treatment	

TENTH WEEK

DAY	TOPIC
MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY	Morbidity enquiry in the community - Drugs & Treatment

ELEVENTH WEEK

DAY	TOPIC
MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY	Assignment of studies and data collection - analysis and report writing

TWELTH WEEK

DAY	TOPIC
MONDAY TUESDAY WEDNESDAY THURSDAY	Visit to Primary Health Centre - Study of structure and functions, job responsibilities
FRIDAY SATURDAY	Group discussion on primary health centre

Appendix 'C'

APPLICATION FORM FOR TRAINING COURSE FOR SEMINARIANS/PRIESTS/BROTHERS/ RELIGIOUS SISTERS IN COMMUNITY HEALTH AND MEDICINE

Name: Age: Sex: Male/female

Full postal address:

Qualification:

Present appointment (period of service including details of work done in provision of primary health care in urban and rural areas)

Details of previous health training obtained, if any:

Indicate special areas of interest in the health field:

Date and time of arrival at Bangalore:

Signature of sponsoring authority
Place:
Date:

Signature of applicant
Date:

Request regarding food requirement:

I am a vegetarian/non-vegetarian

Signature

dept of community medicine
st john's medical college,
BANGALORE 560034

INTERN'S POSTING

Date:_____

Name of intern:

Date of duty report at the Dept of Community Medicine:

The above intern is posted for training at the following Centres and Institutions for the period shown against each. The intern will report himself/herself for duty to the Officer-in-Charge of the Centres/Institutions. Detailed instructions will be issued separately.

(Maj Gen B Mahadevan PVSM AVSM)
Professor and Head of the Dept of Community Medicine

Sl. No.	Institution or Centre to which posted	RURAL From	RURAL To	URBAN From	URBAN To	Remarks
1.	Mallur					
2.	Siluvepura					
3.	Uttarahally					
4.	Action Group Area:					
5.	Student Health Service					
6.	City Family Planning Bureau					
7.	National Tuberculosis Institute					
8.						
9.						
10.						

cc to: 1.

The attendance of the interns with their dates of relief at Centres may be despatched along with other technical, project and administrative reports etc., etc.

2. Intern's file

DFA

3/EC/1080 /77-78 February , 1978

Your Lordship,

Sub: Training of Seminarians/Priests/~~and~~ Brothers/
Religious Sisters in village level health work

Ref: Correspondence resting with my letter
No.3/EC/5048/77 dated August 17, 1977

I am attaching herewith a copy of the programme we have arranged for training of seminarians/priests ~~and~~ brothers/religious sisters in Community Health and Medicine. The programme includes organizational details. I hope the schedule meets the requirement.

//We will undertake this training course more as a pilot project and consider the feasibility of conducting more three months courses at Bangalore for various dioceses in India. Once a nucleus of Communiy Health Workers is built up, refresher courses could be conducted at other centres in India.

//We should also, in due course of time, consider the feasibility of building up a cadre of teachers in Community Health and Medicine by organising suitable teacher training programmes at Bangalore, for selected supervisory staff of dioceses including doctors and nurses. Such trained teachers could then assist the mobile teams from this college and hospital in running refresher courses for their community health workers, from time to time.

//If the dates scheduled for this course ~~is~~ are approved, participants may please be asked to comply with the organizational instructions contained in the same. Selection may be made from amongst persons who are motivated and dedicated to serve, especially those who are already serving in peripheral areas.

//With best wishes,

Yours sincerely,

CM 9/2

(CM Francis MBBS PhD)

Rt Rev Patrick D'Souza
Bishop of Varnasi
Bishop's House
45 Varanasi 221002

8/2/78

MINUTE SHEET

Ref: P.U.C. (1)

Placed opposite is the letter addressed to Rt Rev Patrick D'Souza, Bishop of Varnasi, regarding training of seminarians/priests/brothers/religious sisters.

For your signature please.

Director of Rural Health Services and Training Programmes

11.2.78

Dean
MC Bangalore

Please discuss this with me

Discussed. CM 14/2

14/2/78

Com H 32.2

Topics to be dealt with (Common conditions & techniques).

① Com. Diseases.
- Vaccns.
- Feverishness
- Diarrhoea
- Respty diseases.
- Epidemics.

② Maternal care
- Pregnancy
- Delivery.
- After delivery
- Family welfare
- Diseases of women

③ Child Health
- Nutrition
- Well fed child
- Ill fed child

④ Accidents
- Burns
- wounds
- vaccines
- Bites.

⑤ Village + Home Sanitn.
- Water supply.
- Excreta disposal
- Waste ~~disposal~~
- Food protection

⑥ Other Common Condns
- Skin, Eye, Headache, Belly pain
- Pains in the joints, Intestinal worms
- Weakness + tiredness. Diseases of mouth + teeth
- Lumps under skin, Mental diseases, V.D.'s

⑦ Community Dev.
- Food stuffs
- Transport + Communication

⑧ Medicines

⑨ Techniques
- Temp taking + Pulse taking
- IM injn + SC injns
- Bandages.
- Other techniques –
  - Neck is stiff
  - Spl liquid against Diar
  - Determining age of Pregcy
  - Confirming – Swollen feet.
  - What to do at time of delivery
  - How to tie + cut the cord.
  - Hot compress.
  - How to wash a baby
  - Drawing a growth chart
  - Spl drink for marasmic child
  - Cleaning + dressing a burn
  - " " a wound
  - How to make a splint
  - How to treat a dog bite
  - " a snake bite
  - Proper Latrine
  - What can you do with Waste
  - How to put eye ointment
  - Mouth wash
  - How to build a stretcher

ST.JOHN'S MEDICAL COLLEGE AND HOSPITAL

BANGALORE-560 034

ORIENTATION COURSE FOR COMMUNITY HEALTH WORKERS

TRAINING MANUAL

Red - Trainers Manual.

Blue - Resource Material for Trainers/Trainees.

—

(Extracted from MANUAL FOR COMMUNITY HEALTH WORKER, published by the UNICEF

ComH 32-3

BRIEF NOTE ON THE ORGANISATION OF TRAINING COURSE FOR PRIMARY LEVEL HEALTH WORKERS (VILLAGE LEVEL HEALTH WORKERS)

1. The Course will be primarily meant for those persons who are already motivated and dedicated to serve, especially those, who are already serving in the peripheral areas. A Primary Health Worker need not necessarily be a member of the conventional health service staff. He/she may be a villager.

2. The Course will be for a period of 12 weeks with programmes for 5½ days in a week.

3. While certain topics and training will be imparted at the St John's Medical College and Hospital most of the subjects pertaining to community health matters will be dealt with in the rural field centres where an exposure to problems of priority is possible and the various approaches in community health could be demonstrated. The participants will be involved in practice of actual procedures like immunizations, disinfections, conduction of antenatal and under five clinics, treatment of patient etc. The acquisition of basic Knowledge, Attitude and Skills will receive full attention throughout the course.

4. Objectives:

Broad: To train a primary health worker male/female - who can deal with problems of individuals and the community.

Specific: To impart knowledge about

(a) Communicable Diseases;
(b) Maternal Care;
(c) Child Health;
(d) Nutrition and Food Hygiene;
(e) Village and Home Sanitation;
(f) Treatment of simple and common ailments;
(g) Health Education; and
(h) Simple techniques involved in the delivery of this Primary Health Care to individuals and community.

5. Faculty

It is proposed to draw members of faculty from various institutions and organisations to provide the required expertise (vide Appendix I).

.....2

6. Curriculum content of the Course:

The whole course is designed and spread out over a period of twelve weeks of which three weeks will be at the urban location and 9 weeks at a rural set up. Each week will be a 5½ days week with 6 hours a day as already remarked (for details Vide Appendix II).

7. Methodology: Group discussions, seminars, use of audio-visual equipment with pre and post course evaluations.

8. Accommodation for teaching

i. At St Martha's Hospital: Since most of the teaching is in the form of demonstration of cases ailing from common diseases, the out patient rooms of the respective departments will be made use of for teaching. When discussions and seminars are organised, they could be in the lecture hall or its annexe at St Martha's Hospital whichever is free at the time

ii. At the St John's Medical College: The room Nos 116 and 117 of the ground floor could be used.

iii. At rural centres: A suitable place will be earmarked

9. Teaching aids and equipments

The necessary aids and equipments available at St Martha's Hospital and in the Departments of Anatomy, Physiology and Preventive and Social Medicine of St John's Medical College will be made use of.

C O N C L U S I O N

Since this is the first attempt at organising a course of this type for Primary Health Workers, the various arrangements and teaching schedules are likely to be of a nature which may not be actually fitting to the requirements. Evaluation at each stage and the comments of the trainees as to their requirement etc., will have to be given full consideration. There should be no hesitation to modify or alter the programme now drawn in the light of experience gained. We are organising the programme with full knowledge of problems that may arise and we are prepared to find solutions to the best interests of the trainees in their work. The future batches will certainly be benefited.

///

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///

FACULTY

i. St John's Medical College :
- a. Pre-clinical - Depts of Anatomy and P
- b. Para-clinical - Depts of Prev & Soc M may be invited specia
- c. Clinical - Depts of Medicine, Pa Obstetrics & Gynaecol Opthalmology

ii. St John's Medical College Hospital : Nursing Superintendent - Home Nursing

iii. St Martha's Hospital and School of Nursing

iv. Others: :
- a. Dept of Community Development
  - (i) District Development Officer/Bloc
  - (ii) Extension Educator
  - (iii) Agriculture, Horticulture, Piscic Live stock (officers of the Depts at Block Level - Block Level peop
- b. Public Health Laboratory - Food adult
- c. Natural Family Planning - Dr (Mrs) M M
- d. Director, Institute for Social and Ps Identity of leadership and role of le of community development and health p
- e. Regional Coordinating Organization - Programme, Jayanagar - Dr RG Roy
- f. Regional Home Economist, Govt. of Ind
- g. St John's Ambulance
- h. Indian Institute of Management
- i. Leprosy - Surg Capt JT Marshall

TRAINING OF VILLAGE LEVEL HEALTH WORKERS

FIRST WEEK

Day	9.00 am to 12 noon	1.00 pm	
MONDAY	Inauguration, Registration and Pre-evaluation -- SJMC (St John's Medical College)	Anatomy	Ph
TUESDAY	Common ailments - OUT PATIENT (Medical) St Martha's Hospital (SMH)	Anatomy	Phy
WEDNESDAY	-do-	-do-	-do
THURSDAY	-do-	-do-	-do
FRIDAY	=do-	-do-	-do
SATURDAY	Group discussions on common ailments - SMH		

SECOND WEEK

DAY	9.00am to 12 noon	1.00 pm
MONDAY	Common ailments - OP SMH (ENT)	Anatomy
TUESDAY	" " OP SMH (Oph)	First Aid Lectu
WEDNESDAY	" " OP SMH (Surg/Ortho)	Population Dyna (Natural Method
THURSDAY	" " OP SMH (Derm)	1.00-2.30 : Anat
FRIDAY	" " OP SMH (Dermat. Leprosy)	First Aid Test
SATURDAY	Group discussion	

THIRD WEEK

MONDAY	General management of patients - Home nursing
	Lecture Demonstration at Hospital
TUESDAY	Multiple etiology of diseases
	Role of socio economic factors in health and disease
WEDNESDAY	Visit to C.D. Block, Yelahanka
THURSDAY	Visit to Poultry, Piggery, fishery etc.
FRIDAY	Visit to Poultry, Piggery, fishery etc.
SATURDAY	Groupdiscussion (Socio economic aspects and Health)

FOURTH WEEK (RURAL HEALTH CENTRE)

MONDAY	Introduction to Rural Health - Role of Health Centre - Admini and functions
	Health and Environment (Introduction) - and survey and discus
TUESDAY	Water supply and waste disposal [redacted] - - Survey ar
WEDNESDAY	Insects, rodents and live stock - - Survey and discussion
THRUSDAY	Industries - - Survey and discussion
FRIDAY	Housing and accommodation - - Survey and discussion
SATURDAY	Survey of major resources and facilities for Health and Welf

FIFTH WEEK

	Morning		Af
MONDAY	Introduction to Maternity and Child Health	-	Maternity and Compon
TUESDAY	Survey of antenatals	-	Registrati
WEDNESDAY	Survey of antenatals	-	Registrati
THURSDAY	Antenatal Clinic	-	Discussion
FRIDAY	Under five survey		
SATURDAY	Under five survey	-	Analysis a

* Demonstration of conducting delivery and postnatal visits and care will be organised

SIXTH WEEK

	MORNING	AFTERNOON
MONDAY	Water borne diseases (brief introduction)	Survey of drink
TUESDAY	Disinfection of water in wells	Discussions
WEDNESDAY	Faecal borne diseases	Survey of latri of waste dispos compost etc)
THURSDAY	do-	-do-
FRIDAY	Laboratory examinations of urine and faeces	Analysis of fin
SATURDAY	Group discussions	

SIXTH WEEK

	MORNING	AFTERNOON
MONDAY	Water borne diseases (brief introduction)	Survey of drink
TUESDAY	Disinfection of water in wells	Discussions
WEDNESDAY	Faecal borne diseases	Survey of latri of waste dispos compost etc)
THURSDAY	do-	-do-
FRIDAY	Laboratory examinations of urine and faeces	Analysis of fir
SATURDAY	Group discussions	

SEVENTH WEEK

MONDAY	Relation of food and nutrition with health
TUESDAY	(Topics: Introduction, Balanced Diet, energy r
WEDNESDAY	dietary patterns, infancy (well fed and ill fe
THURSDAY	lactation, cooking and culinary practices, foo
FRIDAY	food borne diseases, malnutrition and under nu
SATURDAY	education on nutrition and national applied nu
	survey, lectures, demonstrations, films, discu

EIGHTH WEEK

	MORNING	AFTERNOON
MONDAY	School health - Introduction	Visit to scho environmental
TUESDAYS	Immunizations - procedures and practice	
WEDNESDAY	-do-	
THURSDAY	-do-	
FRIDAY	-do-	
SATURDAY	Group discussions — Immunization procedures	

NINETH WEEK

	MORNING	AFTERNOON
MONDAY	Clinic - study of common diseases and treatment	Education in comm Personal hygiene,
TUESDAY	-do-	Pregnant women, l
WEDNESDAY	-do-	Diet and nutritio
THURSDAY	-do-	Diet and nutritio
FRIDAY	-do-	Scabies, leprosy
SATURDAY	Group discussion on common diseases and their t	

TENTH WEEK

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY	Morbidity enquiry in the community - Drugs and treatment

ELEVENTH WEEK

MONDAY	
TUESDAY	
WEDNESDAY	ASSIGNMENT OF STUDIES AND DATA COLLECTION--
THURSDAY	ANALYSIS AND REPORT WRITING
FRIDAY	
SATURDAY	

TWELTH WEEK

MONDAY	
TUESDAY	
WEDNESDAY	VISIT TO PRIMARY HEALTH CENTRE - STUDY OF STRUCT
THURSDAY	JOB RESPONSIBILITIES
FRIDAY	
SATURDAY	GROUP DISCUSSION ON PRIMARY HEALTH CENTRE

Compiled and edited by : Ravi & Thelma Narayan

Contributors (other than resource papers)

Fr Heredero	Luis Barreto
Maj Gen B. Mahadevan	
Prof S. V Rama Rao	
Dasa Amar	

CHW's & Students from their ~~project~~ Reports

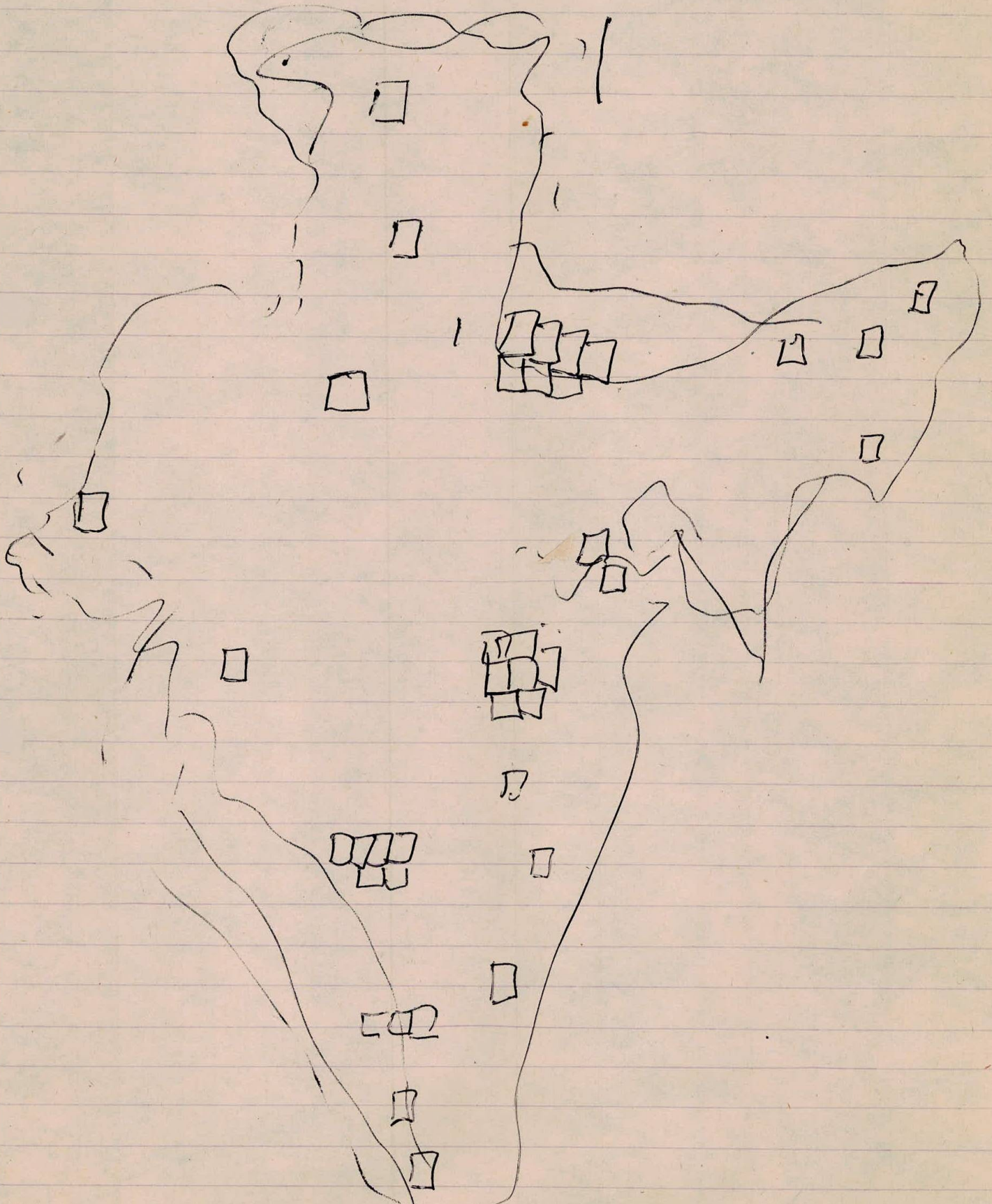
—

(Based on Experience of Basic Courses 1 → 8 conducted by DRHSTP at SJMC Mar 78 – Dec 81)

Content

Sections	Sub sections	Source

Dedicated to
150 GIRLS
trained by us



For Manual

(1) Compile information relevant to
Village Culture — Dai Tradition
MCH Practice — Herbal Medicine
for CHW Project Reports
& RoP Student Reports

(2) Photographs of CHW at work

(3) Line drawings by Tarana

(4) Collected Visuals

—

Project:

"Reaching Out"

Book of hymns, poems, meditation.

I N D E X

Com H 32.4

Village Level Health Worker

Schedule of Training

1. Inauguration
2. Objectives - Pre-evaluation test
3. Anatomy and Physiology : Health - introduction
4. " " : Health and environment
5. " : Determinants of health & disease
6. " : Health problems in India
7. " : Health Service in India
8. " : "
9. Group discussions :
10. Seminar on Community health, role of Community leaders - involvement of Community; voluntary efforts.
11. Food and nutrition : The well-fed baby
12. " : The poorly-fed baby
13. Caloric needs : Important nutritional diseases
14. Blanced diet : "
15. Diet in pregnancy : "
16. Horticulture - demonstration
17. Fishery - "
18. Piggery - "
19. Poultry - "
20. Food hygiene & protection : Food borne diseases
21. Cooking practices : "
22. Food adulteration : "
23. Nutrition education - Applied nutrition programmes
24. Group discussion on food and nutrition
25. Emergency care-medicine : First aid
26. " -surgery : "
27. " -surgery- : "

✓31.	Emergency care-E.N.T.	: First aid
✓32.	Diseases of mouth and teeth	:
✓33.	First aid examination	:
✓34.	Midterm evaluation	:
✓35.	Control of insects and rodents	: Action group for Social Welfare
✓36.	"	: "
37.	Rural housing	: "
38.	"	: "
✓39.	Population dynamic	: Visit to family planning clinic
✓40.	Natural Family Planning	: "
41.	"	: Seminar on Family Planning
✓42.	Common ailments	: Home nursing
	Common Symptoms -	
✓43.	Headache, Stomach-ache Joint pains	: "
✓44.	Weakness & tiredness	: "
	Lumps under the skin	:
✓45.	General management	:
✓46.	Communicable diseases	: Diarrhoea
47.	Epidemics	: Gastro-enteritis
✓48.	Disenfection and disinfectants	: Respiratory diseases
49.	"	: Pulmonary tuberculosis
✓50.	Immunity & immunization	: Fevers
51.	"	: " (Malaria, typhoid)
52.	"	: Jaundice
✓53.	Skin diseases	: Worm infestations
✓54.	Leprosy	: "
✓55.	Sexually transmitted diseases	: "

58. Rabies - poisons and bites PSM

59. Group discussions > Dept of Pharmacology

60. Common drugs & their use : Health education - methods & skills

61. " : "

62. " : "

63. " : "

64. " : "

65. " : "

Bureau of Health Ed.

66. Post-evaluation test

67. Examination

68. Valedictory Session.

12 weeks - 72 days

72 x 6 hours = 432 hours

.....

Common drugs etc. and their cost

Sl.No.	Name	Bulk packing	Approx.cost	Manufacturer
			Rs. Ps.	
1.	Triple Sulpha - 0.5 G sulpha triad	1000	98.00	M & B
2.	Sulphaguanidine - 0.5 G	1000 tab	104.49	IDPL
3.	Metronidazole - 400 Erazol	10 x 10	51.00	EROSPH
	- 200		29.00	EROSPH
4.	Piperazine citrate liquid (Helmacid)	450 ml (bott)	9.36	GLAXO
5.	Bephanium hydroxy naph thxoate	10 packets	25.68	BURROUGHS
	Alcopar	1 box		WELCOME
6.	Aminophyllin tablet	1000	23.83	B.W.
7.	Tedral tablet	500	58.72	WARNER HINDU
8.	Cough Syrup - Sedative and Expectorant	5 lit	51.72	ARAVIND PHARMA
9.	Paracetemol 100 mg	1000		
10.	Aspirin 75 mg Baby aspirin	1000	20.00	INDIAN NATIONAL DRUG COM.
	300 mg.	1000	12.11	MIT LAB
11.	A.P.C.	1000	31.55	IDPL
12.	Phenobarbital (30 mg)	1000	17.42	IDPL
13.	Chlorphenamine maleate	1000	22.88	INGA
14.	Chlorpromazine (largactil)			
	(10 mg)	10 tab	0.53	M & B
	(25 mg)	10 tab	0.78	M & B
15.	Multivitamin	5000		RALLIS INDIA
16.	Calcium Gluconate or Calcium sandoz	1000	27.55	NATIONAL DRUG COM
17.	Ferrous Fumarate (NORI-A)	500 tab	14.83	BURROUGHS WELLCOME
18.	Vit A & D Caps (glaxo)	1000 tab	29.25	GLAXO
19.	ISONEX 300 mg	5000 tab	106.74	PFIZER
20.	INH Isonex Forte 300 mg	1000 tab	64.05	PFIZER
21.	Thioacetazone - 75 mg } ISOZONE -150 mg } Forte	1000 tab	113.39	PFIZER
22.	Dapsone	5000 tabs		
23.	Chloroquin - 150 mg base	1000	116.00	SOUTH INDIA CHEMICALS
24.	Aluminium hydroxide (Gelusil)	500	34.83	WARNER HINDU
25.	Carminative mixture	-	-	-

EPIDEMIOLOGY AND MANAGEMENT OF DIARRHOEA IN A VILLAGE COMMUNITY

(Madiwala, Bangalore, India)

PURPOSE OF STUDY AND SERVICE

Diarrhoea occurs predominantly in children under five years age. It is often sporadic rather than epidemic, and the aetiology in 60 to 80% is not due to bacteria and parasites normally associated with diarrhoea.[1,2,3] Recently a significant proportion of gastroenteritis cases in industrial countries have been associated with an entericreovirus-like particle, the orbivirus, rotavirus or duovirus.[4,5,6,7]

No epidemiological studies have reported using techniques to detect this viral agent or agents in communities, but preliminary reports suggest that a similar virus may be an important cause of diarrhoea in tropical and developing countries.[10, 11, 12, 13, 20, 23]

In these countries diarrhoea in children is a major cause of disease and death.[8, 9] There is evidence that simple rehydration can greatly reduce the mortality if it is started early enough.[26, 27.] The reports so far indicate the technique is valuable in hospitals, but it is uncertain how effective this therapy would be in a village home situation.

Aims of the Project

1. To examine the aetiology and epidemiology of diarrhoea in tropical communities with an emphasis on the viruses affecting the alimentary tract

2. To compare the effects of nutrition, diet, and hygiene on viral and other diarrhoeas in children

3. To relate the episodes of diarrhoea in children to other illnesses in the individuals and families

4. To test how effective early oral rehydration is in the domiciliary management of children with diarrhoea.

.....2

3 WKS in B'lore & 9 WKS in Rural area. 6×6×9 = 324 hrs.
→ 6 hrs/day × 6 × 3 = 108 hrs.

Total 1084 / 324 / 432 hrs

Anatomy 8 hrs.
Physiology 8 hrs.

Grp discussions — 2 hrs.

Health — Introdn —
Env.
Determinants
Problems
Services
} 5 hrs.

Field-Visit & demonstration 15 hrs.

Seminar — C.H — 3 hrs.

Food + Nutrition
Well Fed ill fed Baby
Imp. Nutr. diseases
Food hyg
Cooking
Food adulteration
} 6 hrs.

Demonstration & clinical cases
Visits.
} 15 hrs.

Demons — 2 hrs.

First aid — 12 hrs.

Demons — 3 hrs
" 1 hr.

Control of Insects & Rodents } 2 hrs.

Rural housing — 1 hr.

Popln dynamics — 1 hrs.
Nat. F.P. method — 1 hr.

Seminar — 3 hrs.
Visits — 3 hrs.

Common med. ailments — Lecture 3 hrs

Demonstration & cases } 6 hrs.

Com. Diseases. Immunizations Disinfn } 6 hrs.

Visits — Isolation Hosp — 3 hrs.
Leprosy — 3 hrs.
STD — 3 hrs.

Community Dev. — Talk + Visits — 3 hrs. Grp discussions 3 hrs.

H. Edn. — 3 hrs.
Post Evln test — 1 hrs.
Exam — 3 hrs.
Valedictory — 2 hrs.

130 hrs

Com H 32

MARIHUANA SURVEY QUESTIONNAIRE

Instructions

The use of marijuana has become a major health issue. We feel that it is important to determine the opinions of a group of public health professionals in training concerning this issue. Accordingly, we request that you cooperate by answering the questionnaire below. All replies are ANONYMOUS and CONFIDENTIAL. Your participation is greatly appreciated.

1. How would you rank marijuana as a problem?

   _____equal to narcotics (eg heroin)

   _____equal to prescription drugs (eg., tranquilizers)

   _____equal to tobacco or alcohol

   _____not a serious problem

2. Where did you get most of your information about marijuana?

   _____personal experience

   _____experience of others (eg., clinical experience, experience of friends)

   _____communications media (eg., radio, TV, magazines, newspapers)

   _____professional sources (eg conferences, clinicians, journals)

3. In your opinion, which of the following effects are produced by marijuana?

	Yes	No	Don't know
a. Has habit forming qualities (addictive)	____	____	____
b. Potentially poisonous (due to its high toxicity)	____	____	____
c. Decreases inhibitions	____	____	____
d. Develops increasing tolerance to the drug	____	____	____
e. Causes permanent mental disorders (eg., insanity)	____	____	____
f. Lowers achievement	____	____	____
g. Provides unusual perceptual experiences (lightheadedness, time distortions)	____	____	____
h. Increases aggressions	____	____	____
i. Improves social interaction and sociability	____	____	____
j. Increases sensitivity (eg to food, music, sex)	____	____	____
k. Increases passivity	____	____	____
l. Worsens social relations	____	____	____
m. Increases sexual desire	____	____	____
n. Leads to other drugs (especially heroin)	____	____	____
o. Increases self knowledge	____	____	____
p. Leads to mental deterioration	____	____	____

5. What position would you advocate concerning future marijuana laws?

-----a. Not available legally under any circumstances
-----b. Available by prescription only (and for medical research)
-----c. Same availability and legal status as tobacco and liquor
-----d. No restrictions on its use

6. What is your general attitude toward marijuana now?

-------favourable -------unfavorable -------mixed feelings

7. How often have you used marijuana?

------never ------tried it a few times ------upto 3 times per week
----- more than 3 times per week

8. (a)If you DO NOT use marijuana, and it were legalized, would you then use it?

-----yes -----no -----undecided

~~8~~xxExxx

(b) If you DO use marijuana, and it were legalized, how would your pattern of usage change?

-----increased use ----decreased use ----=remain unchanged

9. Have your attitudes toward marijuana changed since you have been in the School of Public Health?

-----yes, more favorable toward marijuana
-----yes, less favorable toward marijuana
-----no, unchanged

10. If you have used marijuana, at what age did you first use it? ---------

11. Which of the following drugs have you ever used "recreationally" (ie., not medically prescribed)?

------Opiates	-----Amphetamines ("pep" pills)	-----Cigarettes (nicotine)
------Mescaline	-----Tranquilizers	-----Alcohol
------LSD	-----Sleeping pills	-----Coffee (caffeine)
------Cocaine	-----Other (specify)	

12. What percentage of public health students do you think have tried marijuana? ----%
What percentage of law school students do you think have tried marijuana? ----%

13. Do you think that marijuana has potential for medicinal purposes?

----yes (if yes, please specify below) ----no ----don't know

14. Do you think that marijuana has potential for medicinal purposes?

----yes ~~(if~~xxxx ----no

15. What would you advocate as American policy in Vietnam?

-----increased military escalation
-----limited de escalation
-----complete and immediate withdrawal

16. How do you feel about present abortion laws?

-----a. abortion should not be legalized
-----b. abortion should be legalized under certain extenuating circumstances
-----c. abortions should be legalized
-----d. abortion should be legalized and funded by the government

17. How do you feel about the Gay Liberation Movement?

-----favorable -----favorable -----undecided

Sex: -----female -----male age_____
Academic status: -----student -----faculty
College major : ----------
Usual occupation:----------

Citizenship:----------

Ethinic group (please specify):_____
Estimate inwhich of the following social class category your parents would fall:

-----lower lower class ----upper lower class -----lower middle class

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b. Potentially poisonous (due to its high toxicity)	_____	_____	_____
c. Decreases inhibitions	_____	_____	_____
d. Develops increasing tolerance to the drug	_____	_____	_____
e. Causes permanent mental disorders (eg., insanity)	_____	_____	_____
f. Lowers achievement	_____	_____	_____
g. Provides unusual perceptual experiences (lightheadedness, time distortions)	_____	_____	_____
h. Increases aggressions	_____	_____	_____
i. Improves social interaction and sociability	_____	_____	_____
j. Increases sensitivity (eg to food, music, sex)	_____	_____	_____
k. Increases passivity	_____	_____	_____
l. Worsens social relations	_____	_____	_____
m. Increases sexual desire	_____	_____	_____
n. Leads to other drugs (especially heroin)	_____	_____	_____
o. Increases self knowledge	_____	_____	_____
p. [illegible] to mental deterioration	_____	_____	_____
q. Any other effects (specify)	_____	_____	_____

4. How do you feel about pr sent marijuana laws?

5. What position would you advocate concerning future marijuana laws?

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~~9xxHxxx~~

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------Cocaine -----Oth r (specify)

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Sex: -----female -----male age_____
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College major : ----------
Usual occupation:----------

Citizenship:----------

Ethinic group (please specify):_____
Estimate inwhich of the following social class category your parents would fall:

-----lower lower class ----upper lower class -----lower middle class

INDO-DUTCH PROJECT FOR CHILD WELFARE

(STICHTING NEDERLANDS KINDERHULP PLAN)

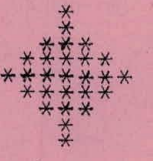
6-3-885, SOMAJIGUDA
HYDERABAD - 500004
PHONE OFF. 35938 RES. 33408

TRAINING PROGRAMME

for

GRAM SVASTHIKAS

(Village Health Agents)



By

Dr. H. W. Butt

Director, Indian Bureau

32.5

TRAINING PROGRAMME FOR "GRAM SVASTHIKAS"
(Village Health Agents)

INTRODUCTION:

For the past 5-6 years the Indo Dutch Project has been functioning in 47 villages of the Chevella Block focusing attention on health, education and nutrition. For the health inputs, the Niloufer health team has been paying regular visits twice a week to four subcentres. The Auxiliary Nurse Midwife experiment with an extra input of training in skills as well as by reducing the area of operation of each ANM to a population of 5,000 has helped in using this important functionary more effectively for health education, care of minor ailments, referrals, family planning, health and sanitation with a greater emphasis on the preventive sice. Emphasis on health education and nutrition has been stressed not only by the ANM but also the balsevika and the mother teachers which has resulted in a multi-pronged impact on the rural families. This experiment has now been spread to the entire Block under the new Multipurpose Health Scheme. The Project Working Group consisting of representatives from the National Institute of Community Development, Niloufer Health Team, Department of Health and Family Planning, College of Nursing, College of Home Science, the District and Block staff reorganised the centres of the entire Block. Twenty four subcentres have been now formed to be manned by a male and female health worker to cover a population of 5,000 per unit. Six zones have been formulated with a male and a female health supervisor to be in charge of each zone to provide guidance and supervision to the health workers in four subcentres in each zone. This new scheme was inaugurated by the Minister for Health, Andhra Pradesh at Shankerpalli in September 1976 when all the sixty health workers were provided newly designed kits with drugs by the Project in addition to the special training organized for them by the Medical Department.

ROLE OF THE NILOUFER TEAM:

Instead of the regular visits to the four subcentres, the new role of the Niloufer Team will be monitoring, training, evaluation and on the spot guidance to the Health staff of two zones covering eight subcentres manned by 16 health workers and four health supervisors covering an area of 34 villages.

THE VILLAGE LINK -- GRAM SVASTHIKA:

One of the main objectives of the Project has been to encourage local mothers to come forward to take up responsibilities connected with health, education and nutrition. Local mothers have been trained by the Project totrun creches and balwadis as mother teachers. In order to strengthen the hands of the health workers, it has been decided to select and train suitable village women who have the minimum educational standards (at least 5th grade) for one month to serve as effective assistants to the health workers of the new scheme in two zones. After considering several names for this village woman the Working Committee felt that the term "GRAM SVASTHIKA" would be appropriate to bring out the main concept of a village health worker who will have complete information about the pregnant and lactating mothers, number of malnourished children and the details of births and deaths in the village. This GRAM SVASTHIKA will be expected to fill in the cultural gap that exists between the city doctor/nurse/paramedical workers and the illiterate rural families. It is planned to select 34 village women to serve in the 34 villages of the two zones after they have been trained at Shankerpalli for a period of one month. The main role of the GRAM SVASTHIKA will be to carry the message of health, education, nutrition and family planning to the rural families and act as a guide providing the elementary information required for health education so that the time of the health programmes could be better utilised during their visits to the concerned villages.

Preference in selecting suitable women will be given to those who have already been trained as mother teachers or indigenous mid-wives. An honorarium ranging from Rs. 30 to 50/- for parttime work will be given to these women which will not be considered as a salary but as an incentive for the work and interest shown by them.

FUNCTIONS:

a. The worker should have details of the names of families and houses specially of women who are in the age group of 15-44; also vital statistics (births and deaths).

b. She should make home visits on a regular basis to build up a close rapport with the families and be informed of their welfare and supervise the under five feeding programme; indentification of malnourished children.

c. She should be able to attend to minor ailments, dressing first aid etc. and give necessary advice for maternal and child care, deworming, vitamin A, follow up T.B. and leprosy patients and family planning.

d. She should have complete information about the programme of doctors' visits to the key villages as well as the working hours of the Auxiliary Nurse Midwife/Balsevika and Craft Teacher.

e. On a routine basis she should take with her a few families to the ANM subcentre for health checkups.

f. In case of emergency, she should inform the ANM/Health Visitor to visit the village and also to inform the Medical Officers.

g. In case of referrals and complications, she should accompany the cases to the primary health centre.

h. She should act as an agent for family planning and use indirect methods to encourage families to use the proper method suitable to them.

i. She should provide necessary information with the help of flash cards, flannel graphs to the families in the village for health

education and emphasize on the priorities of the Project viz., encouraging antenatal care for expectant mothers, nutrition and immunisation.

j. She should be aware of the type of diseases, epidemics and any other outbreaks in the village so that she could inform the subcentre and the primary health centre.

k. In addition to health, she should also encourage mahila mandals (women's clubs) and balwadis on the same lines as in the key village.

l. She should act as an agent to provide the necessary information about the integrated programme. The rural families should look up on her as a guide in cases of health, education and nutrition.

TRAINING PROGRAMME FOR GRAM SVASTHIKAS:

Period of training: 12 working days on every Mondays, Wednesdays and Saturdays during the period from 19th February to 21st March 1977 excluding holidays.

Venue: Shankerpalli, Chevella Block.

Trainers: Nilofere Health Team, PHC Staff, Block Staff and Specialists from the Department of Health and Family Planning, the College of Home Science and the College of Nursing.

METHODOLOGY:

The syllabus for this course has been designed according to the jobs to be performed by the Gram Svasthika. The following are the units showing the weightage given to each in terms of days and hours.

Units	No.of days	No. of hours for Theory	No. of hours for Practicals
1. Maternal care	2	6	4
2. Child care	2	6	4
3. First aid	1	3	2
4. Nutrition education	2	6	4
5. Health and sanitation	1	3	2
6. Family Planning	1	3	2
7. Records, reports and vital statistics	1	3	2
8. Collaboration with PHC workers and other IDP workers in the Block	2	6	4
Total	12	36	24

After a brief introduction the trainers will spend more time in demonstrations and field practicals. Each trainee will be given an opportunity to complete the registers and other data as group assignments in Shankerpalli village and as individual assignments in her own village under the guidance of the concerned multipurpose workers. A set of simple registers will be prepared for each trainee along with simple visuals that she could make use of in her village.

JOB FUNCTIONS:

1. The Gram Svasthika will make frequent visits to houses in the village, assigned to her, in such a way that each child and each woman are seen at least once in a month, and that those needing special care are seen every week.
2. She will detect pregancies early and fill in the list of pregnant women, so that early care during the antenatal period and labour can be provided.
3. She will ensure monthly sequential weighing of children atthe time of visit by Multipurpose worker and recording of their weights on charts for evaluation of their growth and nutrition.
4. She will maintain a list of children 'at risk' and a list of other persons in need of special attention.
5. She will render first aid where necessary and refer sick children mothers and other adults to the Multipurpose Health Supervisor

(male and female) for checkup and treatment.

6. She will help the Multipurpose Health Worker (female) in examination of arm-girth of children with coloured bands etc. and distribute nutrition supplements like tablets, protein packets (Hyderabad Mix) entrusted, if any, to her, and ensure on the spot consumption of the material by the beneficiaries, as far as possible, either individually or in groups.

7. She will organise immunisation compaigns with the help of the local community, and will collect children and women for immunisation when the Multipurpose health worker visits the place.

8. She will give nutrition education to the families based on food materials available easily in the village and teach them better methods of cooking to ensure balanced diet and demonstrate the preparation of weaning diets and supplementary diets.

9. She will educate the families on Health and Sanitation with particular reference to personal hygiene, clean drinking water, treatment for scabies and other minor ailments of common occurrence.

10. She will motivate the people to plan their families and bring to the notice of the Multipurpose health supervisors (male and female) such cases of eligible couples as are not neadily coming forward to accept one or the other method of Family Planning. It within a fortnight of a missed period, termination of pregnancy is desired, she will refer the case to Multipurpose worker for menstrual regulation.

11. She will collect information on births and deaths occurring in the village and maintain a record of the events.

12. She will help the Multipurpose Worker (female) in examination of pregnant women and will distribute under guidance of the Multipurpose Worker (female) Iron and Folic acid tablets for 100 days from the seventh month of pregnancy or to the extent possible as instructed by the Multipurpose Worker (female).

RECORDS TO BE MAINTAINED:

1. List of regnant women
2. List of children under five
3. List of other unhealthy persons needing attention
4. List of births and deaths
5. Particulars of immunisation and issue of Hyderabad Mix.
6. Drugs and equipment received and extent of utilisation.

(H.W. Butt)

DETAILED SYLLABUS FOR TRAINING OF GRAM SVASTHIKAS (VILLAGE WELFARE AGENTS) WORKING UNDER THE INDO DUTCH PROJECT - HYDERABAD.

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Sl.No.	Name of the Session	Theory	Practicals.
1.	Maternal Care:		
	1. Antenatal care	1. Importance of early registration of all Antenatal cases	1. Prepare a list of pregnant women 2. Make sure that they are registered by the Multipurpose Worker (F) 3. Ensure that they are getting antenatal care
		2. Detailed examination of all Antenatal cases at frequent intervals to take extra care on the high risk cases	4. Take the list of all high risk cases from the Multipurpose Worker and see that they get special attention.
		3. Systematic follow up of the cases with administration of Tetanus toxoid Vitamin tablets, Iron & Folic acid tablets etc.	5. Act on instructions of the Multipurpose Worker in distributing Iron & Folic Acid tablets.
	2. Postnatal care	1. Importance of watching the health of the mother and child during and also after delivery	1. Report emergencies connected with delivery to the MPW(F) or MPS(F) or the Medical Officer of the PHC 2. Report all changes in the health of the mother and child to the MPW(F)
		2. Taking care of the health of mothers delivered by dais & Unskilled persons.	3. Report deliveries conducted by local dai to the MPW(F)

3 Care of lactating mothers.	The need for nutritional supplements to lactating mother, the advisability of breast feeding	1 Act on instructions of MPW in distributing iron and folic acid tablets and other nutrition supplement to lactating mother. 2 Introduce the right technique of breast feeding.
2. Child Care:		
	1 Importance of special care for the health of all children under five years of age.	1 Prepare a list of children under five years of age. 2 Get them registered with MPW (F) 3 Assist the MPW(F) to take the weight and give the card by charging 25 paise
	2 Combating malnutrition in children under 5	4 Identify cases of malnutrition with the help of arm bands and prepare a list of children needing protein packets.
	3 Special care to ensure proper growth and development in children	5 Arrange for procuring Hyderabad Mix packets from Mahila mandals through the PHC Medical Officer and distribute these to the needy cases as instructed by the MPW(F)
	4 Checking eye diseases & defects in children	6 Prepare a list of children needing various kinds of immunisation & administer oral Vitamin A once in 6 months to cases requiring it.
	5 Preventing infections diseases	7 Collect children for immunisation against infectious diseases & particularly DPT and Polio
	6 Treatment against worm infections.	7 Collect children for de-worming when MPW (F) visits the village.

3. First Aid:	1. First Aid in General emergencies	1. Attend on cuts, burns, falls & fractures, Drowning-bites.
	2. First aid in communicable diseases	2. Attend on scabies/conjunctivitis
		3. Attend on fever, diarrhoea and vomitings
	3. First aid in other minor illnesses leading to de-hydration etc.	4. Prepare a list of sick persons (other than under fives and pregnant women) who require special attention by the M.P.Ws.
4. Nutrition Education:	1. Knowledge about foods available in villages	1. Promote the practice of growing plants of papaya and drumstick etc.
	2. Balanced diet	
	3. Supplementary and weaning foods	2. Advise the families on better methods of cooking for prevention of loss of vitamins and minerals.
	4. Advice on infant feeding	
	5. Beliefs and taboos about food practices	3. Demonstrate the preparation of supplementary and weaning diets.
	6. Importance of green leafy vegetables.	
5. Health & Sanitation:	1. Personal Hygiene	1. Give proper bath-Keep nails teeth skin and hair clean. Put on clean cloths.
	2. Clean drinking water	2. Prevent water pollution and drink purified water.
	3. Disposal of waste water	3. Educate the families on proper utilisation of latrines, drains & soakage pits.
6. Family Planning:	Preparation and maintenance of family survey registers and eligible couple registers; and using them as the basis for deriving from them the lists of couples that can be treated as target for any particular method of Family Planning.	Prepare lists of target couples in consultation with MPW(F) and MPW(M) based upon the eligible couple register. Educate the couples regarding the DF.P. method appropriate to each one of them. (Permanent-Semipermanent or temporary as the case may be)

/..4

Circumstances in which it is advisable to recommend induced abortion or menstrual **regulation.**	Motivate the families to adopt Family Planning and bring to the notice of MPW (F) and MPW (M) those that are resistent. Refer willing cases for menstrual regulation to MO, PHC early after 15 days of missing periods and if abortion is desired arrange for it early preferably within 3 months of gestation.

7. Records, Reports and Vital statistics:

1. Basic records like Family Health Registers, Family Folders, Individual cards and charts and daily diaries. 2. Reports such as monthly progress reports. 3. Importance of vital statistics and prompt and complete registration of births and deaths.	Prepare list of births and deaths occuring in the village and show it to MPW(F) to facilitate follow up action wherever necessary. Maintain a record of the supplies of medicines and equipment received showing therein the extent to which each of these items are utilised.

8. Collaboration with other workers of the PHC and other institutions of the Indo Dutch Project:

1. Organisational set up of the PHC and particularly that under the MPW Scheme and the activities. 2. The set up of Indo Dutch Project Institutions like balwadis creches mahila mandals & youth clubs and their activities. 3. The concept of Integrated approach for development of child welfare and improved socio-economic status of the rural folk. 4. Collaboration with all other workers.	Observe the activities of MPW (M&F), Balsevika, Craft teacher, mother teacher and associate with them.

-:::-

*ssr:

CHW Course - (Background)

??

1. 3/EC/5048/77 dated Aug 17 1977.
(Dean Vs Bishop Patrick)

2. Brief Note on organisation of training course For Primary level health workers Objectives/ Faculty Programme — PSM/83/1021/77 dated 3rd Sept From Prof SVR To Dean

3. Village Level Health Worker Schedule of Training — by Prof SVR
List of 68 Topics = 72 days = 432 Hr

4. 3/EC/1080/77-78 dated 10th Feb 78
Letter from Dean Vs Bishop Patrick.
Sub: Training of Seminarians/Priests Brothers/Religious Sisters in Village level Health work

Includes
- Programme details
- Organisational details
- Summary of Content of Learning (GOI)
- 12 week Programme Application Form

Cyclostyled

Prepared under direction of MGM

[redacted]

REF: (1) & (11)

I have prepared a short brochure on the training programme for Community Health Workers in Community Health and Medicine(P.U.C. 1).

I would like you to go through it and make any changes you desire.

For the time being, we could cyclostyle about 100 copies of this training programme brochure and send it to all concerned. The cover page would have to be printed with the College emblem, as the same could be utilised for other directives/brochures.
The detailed training programme of lectures, clinics etc. could be handed over to the trainees when they report at the Institution.

You may like to have a look at the Indo-Dutch Project for Child Welfare brochure which is placed below on which our brochure has been patterned to some extent(P.U.C.11)

19.5.78

Director of Rural Health Services
And Training Programmes

The Dean
St.John's Medical College
Bangalore.

Hospital Administrator
SJMC Hospital
Bangalore

ST.JOHN'S MEDICAL COLLEGE
AND
TEACHING HOSPITALS/RURAL HEALTH CENTRES

Johnnagara
Bangalore - 34

Phone: 40561 & Ext: 265

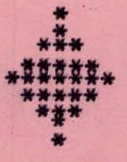
TRAINING PROGRAMME

for

COMMUNITY HEALTH WORKERS

in

COMMUNITY HEALTH AND MEDICINE



By

Major General B Mahadevan
PROGRAMME DIRECTOR

TRAINING COURSE FOR COMMUNITY HEALTH
WORKERS IN COMMUNITY HEALTH & MEDICINE

I N T R O D U C T I O N :

Our Country is hopefully entering an era of social and economic revolution. The Union Minister for Health and Family Welfare, Sri Raj Narain, has said in this context that "The soul of our country lives in the villages. The progress of the country depends on the progress of the villages. Unfortunately the steps taken so far for the development of villages have not been adequate. In fact, people's cooperation was not sought to make rural development a success. They were not given the opportunity to participate in the activities sponsored by the Government nor were they given the opportunity for doing these jobs themselves".

Since independence, we have made substantial investments in the production of medical manpower but the health status of our people is still far from satisfactory. Health service hithertofore has been basically a service "distributed" by a group of health professionals to a community whose role was that of a passive recipient. There has been very little participation from the community in solving its own problems. It is true that Primary Health Care delivery is a difficult task. Health is not a primary felt need. Economic development and agricultural improvements are two more important sectors to the people and only after improvement of these priority sectors, would health become a relevant issue for the community.

In many gigantic tasks in the control of important social diseases like tuberculosis and leprosy and in nation wide programmes connected with Maternity and Child Health(including family planning), Care of the Handicapped, Rehabilitation and Nutrition, Voluntary Agencies all over the world, including our own country, have provided the necessary lead. In the field of medical and paramedical education also,missionary educational institutions have contributed a great deal in supplementing governmental efforts and programmes and have functioned as active partners in such enterprises.

Teaching institutions should play their role in

...2/-

training the required number and type of Community Health Workers to participate as "Comprehensive Grass-roots health agents within the Community" who will find the needs, problems and potentials in the Community in the field of health as well as other aspects of life, thereby giving the required priority to community participation in the planning and implementation of various nation building programmes.

The Community Health Workers Training Programme being organised at St.John's Medical College and associated Teaching Hospitals/Rural Health Centres envisages such a coordinated effort. Our Community Health Workers will join the Army of Community Health and Multipurpose Workers being trained by Government to develop, expand and extend Primary Health Care Services in rural areas and urban slums. They will function as essential links between the Community and established health agencies to make rural health programmes effective. This programme of training has become possible due to the dynamism and perseverance of our administrators, the Dean, Dr.C.M.Francis and the Hospital Administrator, Sr.Carmelann ably supported by the Governing Body of the Catholic Bishops Conference of India Society for Medical Education and various sponsors.

The training programme of 3months duration has been made as practical, problem solving and action oriented in nature as possible. Emphasis is being laid on understanding basic health measures, nutrition, education, under five care, family planning and welfare and environmental sanitation. Nearly two months of their training is in rural areas, and therefore, the boundaries of problem solving and action are limited to actual village situations, avoiding unnecessary general and "academic" discussions. The workers will be given various practical assignments to equip them with the necessary skills for identifying and solving health problems.

Selection of trainees is made fwom amongst persons with a basic qualification of SSLC or equivalent, motivated and dedicated to serve and who are already engaged in social, developmental and health fields, in peripheral areas.

....3/-

After conducting an adequate number of such Basic Courses, it is proposed to run Refresher Courses for these workers and finally Teaching Training Courses for Doctors, Nurses and selected CHWs. Refresher Courses will be conducted at suitable centres in India. As the trainees hail from all part of India, the medium of instruction is necessarily in English. For the time being, selection for Basic Courses is being made from amongst Seminarians/ Priests/Brothers/Religious sisters of various Diocese and Congregations in India.

LEARNING OBJECTIVES OF THE COURSE :

The training given will enable the worker serving a Community to

(a) Control communicable diseases by:
- identifying, treating, advising and when necessary, referring patients with fever, diarrhoea and respiratory diseases
- preventing the spread of epidemics and notifying such diseases
- undertaking vaccinations as approved

(b) Provide maternal care by:
- identifying pregnant women in the community, advising them and referring abnormal cases to the health centre or to the hospital
- preparing for delivery, assistance at child birth, giving first care to the mother and baby, calling for assistance or referring cases when necessary
- giving post natal care, advice and family planning information
- advising, treating or sending sick women to the hospital

(c) Provide child care by caring for both well and badly fed children and promoting nutrition education

(d) Give primary care in case of burns, wounds, fractures, bites, accidents and refer them when necessafy

(e) Concern himself with environmental health problem by advising the community on water supply, excreta and waste disposal, food protection and by promoting health education in these areas.

...4/-

(f) Cope with the following health problems by identifying, treating with simple medicines provided and referring cases when necessary; skin diseases, eye diseases, headaches, belly pains, pains in the joints, intestinal worms, weakness and tiredness, diseases of the mouth and teeth, lumps under the skin, mental and venereal diseases

(g) Take an interest in and participate in community development activities of various types including animal husbandry, agricultural, horticulture, poultry, pisciculture, piggery and so on, by discussing community problems with local leaders and working out solutions for improving the quality of life of the population

(h) Refer to appropriate centres all cases and problems outside or above his/her competence

(i) Maintain basic medical records of vital events(births and deaths in the community).

COURSE COMPONENTS :

A programme of lecture/group and trainee/staff discussions, clinics, field visits, practical sessions and films on community medicine and health subjects has been organised. The whole course is designed and spread out over a period of 12 weeks of which 3 weeks will be at the urban location and 9 weeks at a rural set up. While certain topics and training will be imparted at St.John's Medical College and its Hospitals, most of the subjects pertaining to community health matters will be dealt with in the rural field health centres, where it will be possible to expose the trainees to problems and various approaches in community health. Participants will be involved in practice of actual procedures like immunisations, disinfections, conducting of antenatal and under five clinics and treatment of patients for common complaints with simple drugs. The acquisition of basic knowledge, attitude and skills will receive full attention throughout the course. Time will be given for participants to speak, so that the faculty gets to know their problems and find solutions to the same. Their active participation at all stages will be ensured.

...5/-

One of the highlights of the training programme is the intensive exposure of trainees to various model development activities in Karnataka's rural areas, including economics of the same. Information on how to start small scale projects in rural areas on Poultry, Piggery, Dairy, Agriculture, Horticulture(Applied Nutrition Programmes), Pisciculture and Animal Husbandary is provided to them. The Community Health Workers thereby understand that Health and Development are closely linked areas for the total development of a Community.

In the words of the Dean, Dr.C.M.Francis, the participants will have at the end of the training -

" 1. an elementary knowledge of the working of the body in health and disease
2. acquired the attitude, skills and knowledge for health education at the individual and group levels in the community
3. developed an attitude of social concern for the disadvantaged and sick
4. obtained some insight into the social effects of illness on the individual and the family and the role of socio economic factors in health and disease
5. acquired skills in making out the signs and symptoms of the common ailments in the community and the general management of patients
6. an elementary knowledge in the organisation and management of primary health care for a community, including water supply, environmental sanitation and immunisation
7. knowledge of the working of the national health programmes including nutrition and maternal and child health programmes
8. obtained an idea of population dynamics and family planning and
9. developed an attitude of thinking of development as a whole and not health in isolation".

Venue :

i) St.John's Medical College and Hospital, Johnnagara, Bangalore 34

ii) Rural Health Centres, Karnataka O - Dommasandra(Anekal Taluk)
- Mallur(Sidlaghatta Taluk)

...6/-

FACULTY :

(i) Dean, St.John's Medical College
(ii) Hospital Administrator and staff of St.John's Medical College Hospital (SJMCH)
(iii) Staff of Departments of Anatomy, Physiology, Medicine, Surgery, Paediatrics, Obst & Gynae, Orthopaedics, Dermatology, Otorhinolaryngology, Ophthalmology and Psychiatry
(iv) Director, Rural Health Services and Staff of Department of Community Medicine and Ross Institute Unit of Occupational Health
(v) Medical Officers and staff of Primary Health Centre/Unit at Dommasandra and Mallur
(vi) Staff of Providence Convent and Holy Cross Convent
(vii) Visiting Lecturers from:
Indian Institute of Management, Bangalore
National Institute of Mental Health and Neuro Sciences, Bangalore
Natural Family Planning Association of India, Bangalore
St.Johns Ambulance Brigade, Bangalore
(viii) Directorate of Animal Husbandry and Veterinary Services, Bangalore
Ministry of Agriculture and Irrigation(Regional Home Economist), Bangalore
Directorate of Indian Institute of Horticulture Research(ICAR), Hessraghatta, Bangalore
Director, Indo-Dane Project, Hessraghatta, Bangalore
Water Supply and Sewerage Board, Bangalore
Social Welfare and Labour Dept, Bangalore
Directorate of Health and Family Welfare Services, Bangalore
Directorate of Fisheries, Bangalore
Dept of Women and Children's welfare, Bangalore
Dept of Public Instructions, Bangalore(Chief School Medical Inspector)

Com. Dev. Block Anekal 2

Duration of course - 12 weeks
Course Capacity - 20

....7/-

Boarding and Lodging :

Course is fully residential. Trainees are accommodated at St.John's Medical College Hospital/Rural Health Centres(Dommasandra and Mallur)

Room	-	Rs. 5/- per day
Meals	-	Rs. 7/- per day

Transport :

Transport for trips between the College and Teaching Hospitals/Rural Health Centres and for field visits, will be provided, for the participants and accompanying staff members.

Library Facilities :

Course participants are permitted to use the College Library for the duration of the Course.

EXPENDITURE :

Expenditure incurred on transport, audiovisual equipment, stationery and faculty time.

Each participant is required to pay the Course Fees of Rs.900/- to meet the expenditure incurred on transport, audiovisual equipment, stationery and faculty time. The course fees will be paid in advance along with the boarding and lodging charges.

Registration :

All candidates selected for the course are required to fill in the attached proforma(Appendix A) and mail the same along with the boarding and lodging charges for the period of the entire course in favour of the Dean, St.John's Medical College, through their Diocese/Congregation.

Training Programme :

The detailed Training Programme of Lectures, Clinics, field visits, practical sessions, films on Community Medicine and health subjects, Topics of Group/Trainee and staff discussions, will be handed over to the candidates on joining the course.

...8/9

COURSE CERTIFICATES :

Course Certificates will be presented to candidates successfully completing the course in Community Health and Medicine, First Aid and Natural Family Planning.

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DRHSTP and CHW Courses 1978-82

- a review

① Background

a) 1975 - Srivastava Report on Medical Education and Support Manpower, ~~[illegible]~~ — Recommends training of community-based local semi-professional part-time workers to provide a whole range of basic health services.

b) 1977 — Perspective Report to CBCI, ~~[illegible]~~ - suggests training of seminarians as village health workers in response to the Government of India proposal

c) 1977-78 Guidelines for CHW training courses, learning objectives and areas of expertise for trainees — outlined by Dr C.M Francis, Maj. Gen B. Mahadevan, Prof S.V Rama Rao in consultation (through correspondence) with Bishop Patrick of Varanasi in 1977-78.

d) February 1978 - Directorate of Rural Health Services and Training Programmes established by CBCI Society of Medical Education with Gen. B. Mahadevan as its first Director. Also a decision was taken that the directorate would work in close collaboration with Dept of Community Medicine

e) ~~April~~ 1978 - First pilot course for 3 months held at St Johns Medical College Hospital and rural centres for 20 religious priests and sisters mainly from Varanasi Diocese.

② Policy Guidelines and Plan (Ref Correspondence 3/EC/1080/77-78.)

Guidelines	Implementation
a) CHW Basic training course of 3 months duration for Religious priests and nuns.	8 basic courses till Dec 1982 have been conducted (155 participants)
[illegible] course for basic	3 refresher courses

c) Exploration of feasibility to conduct such courses in other parts of India.

Matter discussed with CHAI in a consultation in 1981.

d) Mobile team from college to run courses at diocesan / state level.

e) Building up Diocesan level training / support teams of doctors / nurses / experienced CHWs.

Feasibility considered during 1982 project year of Drs Ravi & Thelma Narayan

F) CHW's to work in close collaboration with Government health workers and also as links between communities and established health agencies

Partially Evaluated during 1982 project through questionnaires and some field visits

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(B4) Participant / Trainee Characteristics

155 trainees who have attended the basic course in the last four years are spread out all over India as follows.

a) Geographical Distribution

More than 20: Karnataka (39)

More than 10: U.P (18), Andhra (16), MP (11), Tamilnadu (12), Bihar (12)

Less than 10: West Bengal - 9, Orissa - 8, Kerala - 7, Maharashtra - 7, Assam - 3, Gujarat - 3

One each in Gujarat, Haryana, Kashmir, Manipur, Mizoram. Four are abroad - one each in Nepal, Ghana, Sudan and U.S.A.

	Policy Guidelines	Implementation 1978-82
1.	3 month CHW training course as pilot project	8 courses (3 mths each) conducted from March 78 to Nov 81.
2.	Exploration of Feasibility to conduct more such courses in other parts of India.	Discussions with CHAI in 1981.
3.	Refresher courses for basic course participants at Bangalore and other centres	3 refresher courses
4.	Mobile team from college to run courses at diocesan level	Feasibility studied during 1982 project tour of Drs Ravi & Thelma Narayan
5.	Building up supervisory teacher teams of Doctor/ Nurses/CHW at diocesan level	
6.	CHW's to work in close collaboration & Govt MPW/CHW and act as link between community and established health agency	only Partially implemented

3. Selection Criteria

From the beginning

2. SSLC - basic qualification
1. Seminarian/Priests/brothers/Religious sisters of various dioceses and congregation in India
3. Working knowledge of English ~~which was~~ (medium of instruction because of trainees from all parts of knowledge
4. No previous medical/nursing training.
5. Sponsored by Congregation/Bishop

Later from BC-2

6. Kanada/Telugu ~~speaking~~ language facility - given preference
7. ~~S~~ome experience/exposure to rural life (6mths-1yr)
8. Engaged in teaching, social work or development activity in ~~rural~~ peripheral area
9. Person from same congregation/Diocese of previous trainee so that some team support or extension of work or replacement is possible.

DRHSTP and CHW - Courses

a review 1978-82

1. Background

a) 1975 — Srivastava Report on Medical Education and Support and Support Manpower (Govt of India, 1975) recommended "Training of community based - local semi professional part-time workers to provide a whole range of basic health services"

b) 1977 - In a perspective report to the CBCI, Dr C.M Francis, Dean suggested that the college should undertake the training of seminarians as village health workers in response to the Government of India proposal.

c) 1977-78 Dr C.M Francis, Prof S.V Rama Rao, Maj. Gen B. Mohanlal drew up in consultation with Bishop Patrick of Varanasi drew up certain policy guidelines for CHW training course, learning objectives and areas of expertise. (Refer brochures)

d) Feb 78 - Directorate of Rural Health Services and Training programme was established by CBCI with Maj Gen B. Mahadevan as its first Director.

e) Manual of Community Health Worker ( ), Primary Health Worker (WHO Manual) and Co-operation publication from Vatican on New orientation of health services with respect to Primary Health

e) March 78 - First pilot course for 3 months held at St Johns Medical College and Hospital and rural centres for — participants mostly from Varanasi Diocese.

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2. Policy Guidelines for Directorate

(Ref correspondence 3/Ec/1080(77-78)

(3) Selection Criteria For Participants of Courses.

From BC-1

a) Seminarians / Priests / Brothers / ~~Religious~~ Sisters from various dioceses and congregations in India

b) SSLC - basic qualification

c) Working knowledge of English

d) ~~No previous medical/nurse~~ Sponsored by Congregation / Bishop.

From BC-2

e) No previous medical / nursing training.

f) Knowledge of Kannada / Telugu preferred

g) Some experience of rural life (6 months to a year)

h) Engaged in teaching, social work or developmental activity in peripheral areas

Since BC-6

i) Person from same Congregation / Diocese as previous trainee so that team support or extension of work possible

j) Person recommended by previous CHW trainee.

Since BC-9

k) Lay people or Diocesan Health Team or Sponsored by Congregation / Bishop / Institution

---

	Non metric	SSLC	Higher	Med.	21-30	31-40	41+
1	1	10	5	4	13	7	–
2	2	8	9	1	14	6	–
3	1	13	5		13	6	–
4	–	12	6	–	9	9	
5	–	16	5	1	10	10	2
6		13+1	7+2	–	9	9	3
7		11	6	–	4	8	5
8		10	8	–	7	6	5
	4	94	53	6	79	63	15

157

157

CH WS

Who (Total + Batchwise)

1. Sr / Br / Fr
2. State / Diocese
3. Congregations.
   Comment on Trends

Refer Catholic Directory

4. Summary of Selection procedures
   i) As evolved
   ii) Break up by selection criteria
5. Field involvement
   i) after course a) State/Diocese
   ii) Attrition → areas of other work
   - Further training
   - Other jobs.

b) Types of work.
- Dispensary
- MCH - CRS
- School
- Homes (Rehab)
- Classes for women / Youth.

→ Types of Problems

6. Support Framework
   a) Congregational Plan
   b) Diocesan Plan
   c) Finances
   d) Contact ± Mission Hosp
   e) Contact ± Govt PHC etc
   f) Contact ± College - correspondence pattern
7. Contact with People
8. Exceptional cases / unplanned results
9. Problems faced in the Field.
10. Overview
    i) Trends
    ii) changes in course - Target group
    - objective
    - methodology
    - content

4. Characteristic of Trainees (by batches and overall)

a) Fr/Br/Sr/Lay

	Fr	Br	Sr	Lay	Totals
BC-1					
2					
3					
4					
5					
6					
7					
8					
Total					

b) State/Diocese

c) Age characteristic

	1	2	3	4	5	6	7	8	Fr	Br	Sr
20-30											
30-40											
40-50											

M^4

d) Congregations/Groups (more than 3 trainees)

F.m.m. – 5
Society of Jesus – 4
Sisters of Charity
Missionaries of charity – 4
Daughters of Re Cross – 4
St Thomas Mission-2 Sr (4)
Queen of Re Apostles
Holy Cross sisters

e) Applied/Selected

No No
A isely

5. Follow up

a) After completion — Rural / Tribal / Slum
1. CHW work
2. School
3. Rehab centres
4. ~~Homes~~/Hotels
5. Others

b) Transfer/change of
1. Geographical
2. Type of work
3. ~~Post/Karry~~ in Hierarchy

c) Other courses
- Nursing
- Health related course
- ~~Diversdepment~~
- Others

6. Details of CH work

Components of work (Health Activity / Development / Training Program)

~~Coverage~~
~~Area/People~~ — furthest dist
Villages —
~~Population~~ —

Hours of work

Support/Supervision
a) Team
b) Support — ~~Govt~~ PHC / Mission Hosp / Supervisor / Any other
c) Division Plan

Chickmagalur Wynad

c) Congregational Distribution

155 trainees represent ____ congregations

4 are diocesan priests.

The following religious congregations have sent more than five trainees.

The trainees by status are 12 priests, 22 brothers and 121 sisters.

d).

Missionary Srs of the Queen of the Apostle - 6 (Varanasi diocese)
Franciscan Missionaries of Mary - 1
Missionaries 4 Charity - 4

Jamshedpur

West Bengal - Varanasi 1+1+12
Ranchi - Marianhill - 1+1+1+1+1
Mangalore - 2+1+1
Karwar - 1+1+1+1+1
Calcutta - 1+1+1+1+1
Chikmagalur - 1+1+1+1+1
Cuttack/Bhuv - 1+2
Ernakulam - Belgaum - 1+1
Goa - 3+1
Sundergarh - 2

Mandya 2

COMH-32.

The visit of the Advisory Committee for planning the peripheral health facilities and the Community Health Department of the proposed Christian Institute of Health Sciences, Miraj.

Members: Drs. R.S. Arole, George Joseph, Abraham Joseph, Kalindi Thomas and P. Zachariah. (Dr. Irwin Samuel had been invited but was unable to come).

The group met together for the first time on the evening of February 2, 1989 in Solapur. (Dr. Arole joined the group the next day at Pandharpur.) The plans for the field visits were finalised and the demographic data and health statistics which had been collected on these areas were circulated. There was also an opportunity for meeting the Dean and Professor of Community Health of the Solapur Medical College, Dr. Mrs. Shantabai Warerkar.

Traveling down from Solapur by road, the group stopped at the Rural Hospital at Mangal Wedha in Solapur District. The hospital was in a hired building, but a permanent Community Health Centre with about 30 beds was under construction. The doctor in charge was able to provide a good account of the organisation of the health care system at the level of the Rural Health Centre (Cottage Hospital/Community Health Centre) and the Primary Health Centres, its administrative structure, its strengths and weaknesses. The adequacy of the present MBBS programme and internship in preparing graduates for work at this level was discussed.

The group then visited the former Mission Hospital Compound in Pandharpur also in Solapur District, about 125 KM along good roads from Miraj. This is a well-planned and well constructed hospital complex with space for about 50 general beds, quarters for staff and about 7 acres of land. The whole complex is not in use and is in the possession of the elderly Christian doctor who was running it successfully for a long time. If desired, it would probably be available as a long-term lease. The surrounding community is not impoverished and this hospital does not have any outreach work. About one KM from this hospital, a well designed P.H.C. with accommodation for staff etc. is almost complete in Kasegau. The group also visited the Pradhan of the neighbouring rural community as well as the present P.H.C. for Kasegau and the new one under construction. The Pandharpur town is a famous pilgrimage centre for Hindus and the local community is predominently Hindu. The local Christian congregation has only some 10 to 15 families. Reviving the Christian Hospital under the auspices of MMC would certainly be possible, but it will to begin a new. Developing a community health project attached to this hospital will not be easy and perhaps not relevant because of the new PHC coming up next door. After considerable discussion, the group felt that in spite of the ready availability of the physical infrastructure, Pandharpur would not be the first choice for development into the "independent" peripheral facility (see below).

(Dr. George Joseph had to leave at the end of the first day due to unavoidable reasons of a personal nature).

On the second day, the group visited Kavathe Mahankal, a partly developed Taluka in Sangli District, 45 KM to the northeast of Miraj accompanied by the District Health Officer. There is a well developed Community Health Centre there with provision for three doctors and about 30 beds, and three outlying Primary Health Centres A very well planned CHC is coming up nearbywith adequate quarters

of the Co-operative Sugar Mill in the neighbourhood. Though this is not exactly an impoverished area, its optimal distance from Miraj, the good physical infrastructure for CHC and PHC's and the co-operati and effective local leadership make this a good governmental taluka health care set up for use by MMC, provided it can be completely handed over to MMC. Atpadi is a neighbouring taluka to the north of Kavathe Mahankal (85 KM from Miraj) with similar socio-economic, health care and leadership characteristics. Jath Taluka is less developed and sprawling taluka about 80 KM from Miraj. The need for health care is greater there and the socio-economic conditions more adverse. It is on the border of Karnataka State and the two language groups are vying for dominance. So there is no stable political leadership with which a voluntary agency like MMC can easily co-operate.

The group was also informed of the centre being developed by MMC in Bedag, 12 KM outside Miraj with a grant of Rs. 21 lakhs from DANIDA. A PHC type facility with a few inpatient beds and accommodation for one doctor, one public health nurse and 20 students is being built. It will also have its own conveyance for serving the surrounding population of 25,000. The Community Health Unit of MMC has fairly good roots in this community and this miniblock is within easy access from Miraj.

Following these visits, the group had extensive discussions at MMC, in which the Director Dr. C. Thomas and Dr. Shaila Jacob, Nutritionist in the Community Health Unit of MMC, also participated.

SUMMARY OF RECOMMENDATIONS

A. Clinical and Community Health facilities

For the purpose of the proposed undergraduate programme, the following structure of health care is suggested:

I. Referral Centre: This may consist of the subspeciality departments in Wanless Hospital or, eventually, a separate Speciality Hospital. Undergraduates will have only limited contact with this area, but should learn at what point cases must be referred to this level.

II. The Tertiary Care Centre: This would consist of the Departments in Wanless Hospital dealing with the subjects in which an undergraduate is normally examined. Eventually, this may become a separate General Hospital with only these departments. Such a hospital, physically separate from the Speciality Hospital and in the same campus as the Medical College, will have a number of advantages. Especially, the students could see the basic clinical specialities taking care of most needs of patients while also referring patients to subspecialists where necessary. (According to the MCI requirements, Departments of Radiology and Anaesthesiology and Units of Chest Diseases, Dermatology, Psychiatry and Dentistry must also be available for undergraduate teaching. Some of them like Radiology and Anaesthesiology may have to be duplicated. Others may be based in the Speciality Hospital, but also serve the General Hospital as necessary). The undergraduate should not spend more than 50% of his "contact" hours (i.e. hours spent in health care facilities of all kinds) in the Tertiary Care Centre.

III. "Peripheral facilities"

Obstetrician) and acting as referral centre for the PHCs or other primary care facilities serving a rural community of 75 to 100,000. The nursing and paramedical services in these areas should be fully integrated with the clinical and community health services and accountable to the heads of these two services. At the community level, health care should be integrated as far as possible with comprehensive multisectorial development activities.

The "integrated" peripheral area should be a relatively underdeveloped taluka in the Sangli District between 30 to 50 KM from Miraj, where MMC should receive from the government the whole health care infrastructure and organise it as effectively as possible. The Community Health Centre in this block should be manned by the four basic specialists: MD/MS for Surgery and Medicine and diplomates for Child Health and Obstetrics. If possible, this Centre should be built up to a bed strength of 50 to 60. It would be good to keep the staff strength and budget as close to the governmental pattern as possible exceeding them only if that becomes indespensable for the efficiency and effectiveness of the programme as a model programme for the training of students. Of the three talukas of Sangli District mentioned earlier, Kavathe Mahankal seems to be the most suitable for the field area which is to be incorporated into the medical college programme in co-operation with the government.

It is expected that many of the MMC students will later serve in health facilities set up by the churches or other voluntary agencies. Therefore it would be good for them to have part of their peripheral training in a suitable Christian hospital with its own outreach programme and adapted for this role. Such an arrangement would also make up for any deficiencies that may develop in the other "integrated" peripheral programme. This "independent" peripheral programme could be based on the St. Luke's Hospital in Vengurla, Sindhudurg District, which is in the underdeveloped Konkan coast. This hospital with about 100 beds and a school of nursing has a considerable clinical load from the surrounding area where the health care facilities are inadequate. It has a modest community health programme in neighbouring villages. MMC is to come to an agreement with the present management of the hospital such that it can be incorporated into the medical college project. The staffing of the hospital is to be increased to the five basic specialists (including Community Health) and the outreach work expanded to cover about 70 to 100,000 population.

The main function of the two base hospitals (in Kavathe Mahankal and Vengurla) should be to train the students in good secondary level care outside the tertiary care centre, offering experience of almost all clinical material that an undergraduate should reasonably know. The student should not only observe the clinical work but increasingly share in it. Though the clinicians have expertise in one speciality or other, they must practise and teach multicompetent clinical care. These hospitals should also demonstrate the referral chain from the community to secondary level hospital to tertiary care centre. The clinical staff of the MMC should spend about 25% of their working time in the base hospitals of the peripheral areas demonstrating the challenge of delivering fairly expert care under the limited conditions in these hospitals. The student should be posted for 25% of their practical hours in these hospitals, and another 25% in the community itself (i.e. in the Primary Health Care facilities and other activities relevant to the promotion of health).

It would be good to begin MMC's involvement in these communities through health related developmental activities so as to develop meaningful links with the people and to ensure that the programme

Both these secondary care centres would be so distant from Miraj that they will have to handle most of their clinical problems on their own, referring to Miraj only the cases which need speciality care. But these distances will also require the scheduling of the curriculum such that the students can be posted at these centres for some weeks at a time ("block postings").

As soon as government sanction for starting the medical college was assured, MMC should appoint two suitable Project Officers for developing the two field areas as outlined above.

There would be aspects of CH teaching in which field exposure is needed as a regular part of the schedule while the students are at Miraj. It may also be good for each student to have some families they are related to throughout the MBBS course. For these purposes, the clinical facilities and the field programme in Bedag should continue to be developed as presently envisaged, with staffing from the CH Department of MMC.

B. The Community Health Department

It was suggested that MMC should plan for the following faculty for a large Community Health Department.

(1) Head of the Department: A Senior Professor with commitment to the goals of this venture, and the necessary experience and expertise.

(2) Four lower level faculty members, each chosen with expertise in one of the following special areas, with the intention that each will develop his subspeciality within the larger department:

Biostatistics
Epidemiology
Health Education
Behavioural Sciences
Health care management
Nutrition

Dr. Kalindi Thomas has been associated with the Community Health activities of MMC almost from their inception and has the MPH degree from Johns Hopkins University. But this degree is not recognised by the Medical Council of India (MCI) as a postgraduate degree in Preventive and Social Medicine (PSM). So she should be ennabled to take MD in PSM through a neibouring medical college or the Diploma of the National Board in Community Health. She indicated that she could then be responsible for the Epidemiology subsection of the Department. Dr. Shaila Jacob, also on the staff of the Community Health Unit of MMC, has a Master's degree in Nutrition. It was recommended that she too should acquire a recognisable postgraduate qualification in PSM and plan to be in charge of the Nutrition subsection of the Department.

C. The Preselection Sandwich Programme

The present position of the Medical Council of India is that even innovative programmes should conform to the pattern of the subject-based I, II and Final MBBS examinations. So the group favoured a one year preselection training/orientation course preceding the 4½ years MBBS programme. Only students who fulfil the minimum requirements for admission to the MBBS course should be selected for this sandwich course. During this selection course:

(1) The students should receive a good exposure to what community

oriented Medicine really means and what the role of the doctor is in such an approach. They can then decide with greater understanding whether they wish to be trained for such a career.

(2) The college can also assess the candidates for their suitability for such a programme in terms of their maturity, motivation and commitment.

(3) The candidates should also acquire the following knowldege and skills to prepare them for the proposed "innovative" MBBS programme:

(a) Working knowledge of local language

(b) Knowledge of English sufficient for acquiring necessary information from standard sources.

(c) Basics of the following three Bs:

(i) Behavioural Sciences
(ii) Biostatistics
(iii) Biology (human) - This is to facilitate problem-based, student-centred learning from the first year of MBBS.

* * * * *

Working Towards Recognition Of Dai Tradition

A Report on a Consultative Meet of NGOs working with Dais (Traditional Midwives) in Gujarat State

India

May 2000

Organized by

CHETNA, Ahmedabad

CHETNA Women's Health and Development Resource Centre Chaitanyaa

Background

In most rural and remote areas of India, traditional midwives, popularly known as *dais* play a critical role during pregnancy, childbirth and in newborn care. They are respected and trusted for the care they give to the people. In addition they are easily available, affordable and culturally acceptable particularly in interior tribal areas.

Dais are an integral part of the community health resource and therefore their support in reaching out to people is greatly sought. Despite their valuable contribution at the community level, *Dais* continue to work in isolation from the mainstream primary health care system. Their integration with the primary health care system is not formalized and their role in preventing deaths in rural and tribal areas is questioned by several experts.

Before and soon after independence, the Government of India (GOI) initiated efforts to train the Dais with a view to reach out to the community and make a significant difference in the high maternal and infant mortality rates.

During the second five-year plan, in 1957 the Government of India initiated Dai training program under the Maternal and Child Health Scheme. The effort was to train women from rural areas for a period of six months and a remuneration system was worked out. In the subsequent plans, various changes were introduced and in the fifth five-year plan, the duration of training was reduced to one month and work in association with the Primary Health Center, under the supervision of ANM/LHVs. Other changes include strengthening her information base, involvement in Ante natal and post natal care, family planning counseling, provision of delivery kits and remuneration for normal child births and referrals. Despite various efforts, not all the dais could be trained. Little efforts were made to make Emergency Obstetric Care (EmOC) accessible in remote and rural areas. (For detail information please refer in Annexure-II)

While the Government Dai training program has yet to show significant changes, the NGO experiences have been largely positive indicating the need to integrate the Dais in the primary health care system. A need to systematically document these experiences has been felt.

For more than a decade, CHETNA has been actively involved in building capacities of Dais and the **Trainer's of Dais**. The experiences have lead to a realization of the critical role that Dai play in reproductive health of women and men. Their role has been important to reduce the neonatal and infant mortality, and also in reducing maternal deaths when supported up by Emergency Obstetric Care (EOC). There is a need to recognize the role of Dais and integrate them with the Government primary health care system. Dai is a **traditional resource** and her training needs to build on her traditional knowledge, skills and wisdom. Keeping the above in view, CHETNA organized this consultation.

Objectives of the meeting

- To share experiences and concerns that relate to Dais, their needs and problems.
- To review dais' role in the **Reproductive and Child Health (RCH)** program.
- To design strategies to identify Dais role in primary health care system

Background of the participants

A total of 23 participants comprising activists, researchers, medical practitioners and consultants from various NGOs across the state of Gujarat participated. Most NGOs were pioneers in initiating Dai programs in remote and rural areas. The discussions were held in Gujarati. (Please refer to Annexure-I for the list of participants).

Proceedings

Ms. Pallavi Patel, Deputy Director, Women's Health and Development Center (WHDRC) of CHETNA warmly welcomed the participants. She highlighted the critical need for Dais in the coming years and expressed a concern over lack of recognition of Dais in the primary health system. She also pointed out the need to define the role of traditional systems in understanding Dai practices and building their skills and capacities.

After introduction, Vd. Smita Bajpai, Coordinator (traditional health practices), WHDRC- CHETNA, traced the role of *dais* in a historical perspective.

The presentation highlighted the fact that how, through the process of change, people's knowledge and wisdom has been grossly marginalised. She explained at length how, since time immemorial *dais* particularly in rural and remote areas have been performing a critical role particularly during pregnancy and childbirth. Though majority of Dais is women, men were also called in some interior adivasi and tribal areas to give a helping hand in case of difficult birth.

Giving details about their social and economic profile, she added that *dais* generally belong to the oppressed classes with little or no education, are poor because they work mostly as agricultural workers and cater to the poor class and receive very little money in return for their services.

Considering that Dai conduct 60-70 percent of deliveries in rural and remote areas of India, she elaborated on the efforts of the government to train *dais* and involve them in providing health care to women and children under the various five-year plans. The government initiated Dai training and has provided them with safe delivery kits and remuneration.

But of late, a shift in governmental policy from home to institutionalized deliveries (in order to bring down infant and maternal mortality rate), *dais* have received a major setback, their significance notwithstanding. Vd. Bajpai also discussed in brief the role played by various NGOs in promoting *dais* firstly through training them and secondly through linking them up with the health system for services and supplies.

In the discussion that followed, the participants shared their experiences and expressed opinions and concerns about *dais*, their involvement and future.

Highlights of the Experiences of Working with Dai

- SEWA-Rural, Jhagadia, Bharuch is a pioneering organization that has effectively demonstrated the functioning of the primary health care system. Dai has been identified as a key resource at the field level and her capacities have been strengthened. Coordination between Dai, Angan Wadi Workers and Auxiliary Nurse Midwives has been strengthened and the Dai is actively involved with the Primary Health Center.

- SEWA (Self-Employed Women's Association) Ahmedabad has been training Dai and strengthening linkages with the primary health center. They are actively involved in registration of the Dai by regular contact and dissemination of information of the Government Dai training in their area. In addition they have organized Dai and formed their cooperatives to ensure quality care from Dai and coordination with Government functionaries.

- St. Xaviers Social Service Society, Ahmedabad are identifying Dais in Ahmedabad slums and upgrading her information and skills. They have observed that registration of Dais and getting a registration card has build the self-esteem of Dai.

- Tribhuvandas Foundation, Anand, Kheda have strengthened the coordination between the Dai and *gramin swasthya sahayika* or village health worker and they are able to bring down the Infant Mortality Rate in their area.

- SARTHI, Panchmahals has identified Dai in the remote tribal areas and trained them. They are linking the Dai with the Primary Health Care system by taking a proactive role in registration of Dai and ensuring appropriate remuneration.

- CHETNA has been actively involved in building capacities of Dai in Gujarat and Rajasthan in association with local NGOs. The training is based on strengthening her traditional knowledge, skills and wisdom. Dai trainers in the two states have been trained and efforts are being made to strengthen Dai training programs. A comprehensive, multimedia kit has also been developed, which is useful in building the capacities of Dai.

Major concerns and issues raised by the participants are:

- Remuneration that *dais* receive from the government is very little and also irregular, and so is the community contribution.

- A strong emphasis on referral has started posing serious problems to *dais* as they have started losing their self-confidence and esteem. Many Dais have now started referring cases to First Referral Units (FRUs), even if it is normal and within their capacity to manage. What was once available at the doorstep has now become outside the reach and expensive.

While the need for referring critical cases and making EOC accessible cannot be overlooked, in the present state of primary health care system, when even Dais, who are already playing a critical role in reproductive health of women and men, start to shrug their responsibilities, the poor communities are at loss.

- Delivery kits always seem to be in short supply. Tribhuvandas Foundation, involved in producing and distributing Disposable Delivery Kits, shared that indent for the delivery kit from government comes very late and thus it affects the regular and timely supply.

The requirement could directly reach the production unit rather than going through the bureaucratic system.

- In the primary health care system *dais* are viewed as mere appendages than integral part of the health system. Very often, they are not even allowed in the labor rooms and although they are an integral part of the primary health care delivery system, they are not recognized or appreciated. When the Dai brings the women at PHC or FRU level, often she receives humiliating treatment from the medical professionals. This adversely affects her self-esteem and self image at the village level.

A need to sensitize the doctors and other health functionaries and create a positive environment was strongly expressed. There is a need to ensure better coordination of PHC with the local Dai. Where available, ANMs, Dai and AWWs need to work together at the field level.

- *Biases* based on caste and class and attitudinal problem often leads to the poor treatment or neglect of *dais*. She is viewed as one who collects and cleans dirt. The consequence is that her health needs remain largely ignored. There is no provision of health check up of the dais. Many traditional Dais, who are good in their work, are facing health problems like cataract, which directly affects their profession.

There is a need for special health care for Dais.

- With modern medicines making deep inroads, the indigenous treatment adopted by *dais*, which is in-built in their system, is on a decline. Therefore, Dais are finding them delinked in the process of delivering primary health care.

Dai training needs to be sensitive to Dais worldview and knowledge systems. Involvement of other traditional systems viz. Ayurveda, Unani, Siddha could contribute a great deal in strengthening Dais capacities.

- Dais and communities, in some areas are practicing some harmful methods like applying pressure on abdomen during childbirth and giving injections to speed up the process labor.

Continuous training and monitoring on the same is required.

Action plan for promoting Dai tradition

The later part of the session was chaired by Ms. Mirai Chatterjee, Secretary, SEWA who revealed that most government officials felt that despite extensive training and special fund allocation to Dai training, they have not been able to reduce the mortality rates of new-borns and the mothers. The environment is not in favor of promoting Dai traditions and practice.

Training of TBA alone, in the absence of back up support from a functioning referral system and support from professionally trainbed health workers is not effective in reducing maternal mortality- WHO 1999

Ref: Reduction of maternal Mortality- WHO/UNFPA/UNICEF

The group very strongly expressed that maternal mortality is a complex issue, which cannot be addressed, by *dais* alone. It has to be linked with strengthening the referral system and making emergency obstetric care available in remote and rural areas.

However, a positive experience has been observed in reducing Infant Mortality Rate by NGOs. However they need to strengthen their information base regarding Dais and develop proper intervention tools.

Some suggestions to strengthen Dai's role

Most of the participants suggested that *dais* should be involved in ante and post natal care after receiving adequate and appropriate training, guidelines and basic information. A suggestion was made to involve the Dai in reproductive health care. There were several participants who felt that *dāis* should be involved in treating minor ailments by way of which their acceptance in the community will improve. There were some who also felt their integration in the primary health care system is possible if they are made to work along with Auxiliary Nurse Midwives or Angan Wadi Workers in a team.

All the participants agreed that there should be a regular updating of statistical information on *dais* and they should be given identity cards as a token of recognition as well as incentives for referrals.

Regarding Dai training

- Dai usually does not receive regular refresher training. She needs to be invited to the Primary Health Center (PHC) meeting wherein she can share her experiences, difficulties and coordinate effectively with other team members of PHC. During Dai training they need to be made aware that for what kind of condition, where to refer the patient. This will save the time and lives of women.

- Dai training needs to include information on preparation of women and helping families plan for delivery, importance of motivating pregnant woman for saving for emergency and updated information on available communication facilities to contact PHC or FRU (which telephone at the village is in a working condition, phone numbers of PHC and FRU etc).

- Dai has knowledge of the structure and function of the reproductive system, some common complaints of Reproductive Tract and of the people in the communities who are suffering from it. This situation can be strategically utilized in treatment and prevention of Reproductive Tract

Infections, particularly in the RCH program.

Linking up with the Panchayat system

- Panchayats can play an important role in providing necessary facilities and support to the Dai. The women member of the Panchayat can be motivated to take up this issue at the Panchayat level.

Providing Delivery kits

- Each district needs to calculate the local birth rate and estimate the requirement of delivery kit. 25% extra delivery kit can be added to the calculated figure and the kits could be regularly supplied at the district level.

- Supplying delivery kit to the woman, during pregnancy is essential and it has proved to be useful in the past. There was a further suggestion that all the family members need to be made aware of its use. This will generate awareness among the community members and they will start demanding the same.

Registration with Government Health System

- The group felt that NGOs working with Dai should take up a campaign to register their names. For registration it is mandatory that Dai participate in the Government training. The NGOs need to make sure that their dais attend this program and as a result of which become eligible for registration. Meanwhile, NGOs can continue providing training input and identity cards to Dais in their area. An idea of creating training schools for Dais also came up.

The participants strongly felt the need to discuss Dai experiences with the health department. In this context, it was suggested that

- NGOs involved in working with *Dai* should prepare case studies and substantiate the findings with statistics to lend authenticity to advocacy.

- Institutions such as the Indian Institute of Management can be approached to mediate and organize a meeting between GOs and NGOs where these case studies can be presented. The presence of *dais* and beneficiaries can be worked out to strengthen case studies.

- A list of traditional/Ayurvedic/herbal medicine, which can be provided to the Dai's for primary health care needs to be prepared. Its affordability and availability needs to be ensured. They will try to provide necessary statistics and research data. The Government Ayurvedic department can also develop a training curriculum for Dai based on the principles of Ayurveda. Similarly other indigenous systems can be involved in strengthening the Dai tradition.

(Vd. Parul Joshi and Vd. Ila Deshpande from Akhand Anand Ayurvedic College have taken a lead to suggest herbs to be kept with Dai)

- The group decided on a coordinating committee consisting of the following NGOs:

Tribhuvandas Foundation at Kheda; SEWA in Ahmedabad; SEWA-Rural at Jhagadia; SARTHI at Panchmahals, Dr. P.C. Shah, Public Health Consultant, Crime Prevention Trust and CHETNA.

Role of coordination Committee

- Contribute in planing and organizing the GO-NGO meeting.
- Finalize case studies of NGOs on experiences of **NGOs.**

CHETNA's Role

- Overall facilitator of the process and information dissemination.
- Edit the case studies and coordinate with the NGOs, if additional information is required.
- Organize a meeting with Dr.Dilip Mavlankar, IIM and discuss the possibility and details of GO-NGO meeting.

Conclusion

Over the entire group expressed that the Dai training can be effective when supported with a program to ensure better care during pregnancy and after childbirth and with Emergency Obstetric Care within reach. While sharing the training experiences the NGOs actively involved in this area mentioned that practical exposure of Dai in a hospital situation is critical to strengthen her skills.

If the Dai, as a resource has to be utilized optimally, then certain issues need to be debated and clarified at the conceptual level. Some of these issues relate to the integration of Dai in the primary health care system, role of traditional formal systems of health care in Dai training, skills enhancement, remuneration, sustainability and linkages with the health system.

The meeting provided an unique opportunity to share experiences and concerns related to Dai tradition and how to strengthen it. Willingness of NGOs to coordinate and work on this issue is bound to bring effective results to strengthen the role of Dai.

Update

- CHETNA has already communicated to the participants as well as other organizations that have been working with Dais inviting them to join this collective effort.
- A preliminary meeting with Dr.Dilip Mavlankar, IIM Ahmedabad has been organized. IIM has shown keen interest to host the meeting where in the NGOs working with Dais and concerned government functionaries can be invited for a day's meeting with an objective to develop a concrete strategy to strengthen the role of Dai in health programs. He suggested that once we receive the documents from NGO's, a planning meeting could be called to review the case studies and plan the meeting. He suggested having the preliminary meeting in the month of June 2000 and the final GO – NGO meeting in the month of August 2000.

ANNEXURE-I
LIST OF PARTICIPANTS

Ms. Manjula Patel Ms. Mercy Christian	St. Xavier's Social Service Society, Post Box No. 4088, Navrangpura, Ahmedabad- 380009 Gujarat Phone: 7417654
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Ms.Mirai Chatterjee Ms. Madhu Solanki Dr. Renuka Patwa	Self Employed Women's Association(SEWA), Victoria Garden, Ellisbridge, Ahmedabad-380001 Gujarat
Dr. Shobha P. Shah	SEWA-Rural Jhagadia- 393110 District Bharuch Gujarat Ph: 20021
Dr. P.C. Shah (Public Health Consultant)	Crime Prevention Trust(CPT) 42/436, Green Park Apartment Sola Road, Naranpura Ahmedabad- 380063 Gujarat
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Vd. Ilaben Deshpande Vd. Parul Joshi	Akhand Anand Ayurvedic College Lal Darwaza, Ahmedabad- 380001 Gujarat Ph: 6753303
Ms. Pallavi Patel Ms. Ila Vakharia Vd. Smita Bajpai Vd. Lakshmi Bhatt Dr. G.K.Trivedi	CHETNA Lilavati Lalbhai Bunglow Civil Camp Road, Shahibaug Ahmedabad 380004 Gujarat Ph: 2866695/8856

Strengthening Dai (traditional midwife) Tradition

Vd.Smita Bajpai and CHETNA team

(Draft not to be quoted)

The Historical Perspective

Since ancient times, pregnancy and childbirth has been women's domain. Women conceive and give birth in homes, with support and encouragement of elderly, experienced and skilful women in neighborhood. They are called Dai, Dayan or Dai Maa, meaning one who gives. Women have been nurturing the communities since thousands of years, throughout Asia. In most rural and remote areas of India, particularly where modernization has not yet reached, Dai play a critical role to support other women in giving birth. Exclusively handled by women otherwise, men are sometimes called to give a helping hand in case of difficult birth or to expedite the process.

The Social and Economical profile of a Dai

Dai or Dayan is usually a middle-aged woman of Dalit or the oppressed caste and poor. In the lower strata of the society, certain sub-castes perform the role of Dai. In many states, women of the naai (barber) caste may perform the Dai's role perhaps because of the association with their surgical tradition and instruments. Similarly, women from chamar, basod or vankar (weaver) caste may perform the role of Dai. In some communities, Dai is a member of the community.

Among Rajput Thakurs, experienced and wise women of the house support childbirth and Dai is called to cut the cord and clean up. In some tribal areas, men may perform the role of Dai.

Most Dai's have hardly got an opportunity to go to school. Hence most of them are illiterate or barely literate. However, their learning from life experiences provides necessary skills to be able to support pregnancy and childbirth. Mostly, the Dai learn her skills through apprenticeship and experience. A Dai usually has the experience of giving birth to several children of her own. As a young girl she accompanies her mother, mother-in-law or an elderly aunt and observes. Gradually she starts assisting her and later on when she gains the confidence, delivers the child on her own, with another learner by her side. Usually, the Dai have a 5-10 years of formal learning, before she takes on the tradition. However, some start the work, when they are compelled to support a woman in crisis.

Most of them are engaged in labor or agriculture work. They support labor as a part of their duty towards the community and assisting the woman in need. Hence most of the Dai are economically poor. They cater to the poor class and therefore and expect remuneration according to the condition of the family. Many times they wait for hours together, barely drink a cup of tea and rarely get enough money. With more and more families adopting the small family norm, the number of deliveries is also reducing, which directly affects their meager income.

We do this work because it is dharam ka kaam. We walk distances, wait for hours together, risk our lives to go at any time and toil with the woman, still we get paid very little. If the family is poor, we get a cup of tea or not even that. Some families give us little grains or clothes whereas some give us 50-60 rupees. (A Dai from Maharashtra during healers meet organized by CHETNA)

Where as some Dai's do benefit from the remuneration provided by the Government, but for most, this money is difficult to obtain. At times, she has to wait for an entire year before she gets money for her work.

Realizing the potential role of Dai during childbirth, the Government as well as NGOs has made various efforts to strengthen the Dai tradition. This is in terms of training, providing delivery kits, remuneration and referral services.

Government's Efforts to Strengthen Dai Tradition

Dais represents the critical role being played by women in nurturing the health of communities, particularly around pregnancy, childbirth and newborn care. There are about 60,000 Dais in India. Official sources state that 50-60% of birth are attended by Dais in rural areas (NIHFW, 1983). Studies indicate that as high as 90% or more of births are attended by Dais (Kakar, 1972).

Over the years there has been a change in this practice to some extent. In the areas where obstetric care is available within community's reach, the number of deliveries in the hospital has been on rise. With more and more families accepting the small family norm, the number of births being facilitated by the Dai's is gradually declining.

During the pre independence, Dai training program were organized as an integral part of maternity and child welfare. During the early post Independence days, the Government of India initiated Dai training under the purview of the MCH (Maternal and Child Health) program by the state Government.

During the second five-year plan, the Government of India initiated Dai training program under the MCH programs as a centrally sponsored scheme. UNICEF

assisted project of training Dais began in 1957 and a remuneration system for referring women for ANC or PNC was worked out. However, not all the dais identified could be trained

The scheme continued during the subsequent five-year plans and during the fourth five-year plan period it was transferred to the family planning department. Till the end of 4th plan, only 40-42% of the set target was achieved (15,000/35,000).

During 1967, the Government of India, through a program assisted by USAID made efforts to stimulate the Dai training program. Components like provision of special midwifery kit were added with a focus on motivation for family planning. India was probably the first country to utilize Dai's in a national family planning program. Another effort to boost the scheme was made in 1971 by a decision to train 75,000 Dais. However, due to various reasons like duration of the training, lack of backup support, delay in distribution of kits and stipend etc. the scheme did not catch up.

During 1973, the Government of India appointed a subcommittee to examine the functioning of Dai training scheme. As a consequence, in the fifth five year plan, the training content was expanded to include reproductive system, and care of mother and child during pregnancy, birth and after birth, The duration was reduced from six to one month and dais were to attend the PHC/SC twice a week and for remaining four days under the supervision of the ANM/LHVs. The stipend was revised to Rs.300/-- per month and a kit was provided free of charge at the end of training. In addition she was entitled to a payment of Rs. 2/- for registration of each antenatal case at PHC and Rs. 1/- after each delivery.

Its emphasis from April 1978, financially supported by UNFPA, has been to promote acceptability of small family norm, reduction in the rate of Infant mortality and to improve community participation in Government health services delivery.

Subsequently, The Government of India's prospective pan for development of health humanpower seeks to..."ensure one TBA for every 1,000 population (India, 1981)

These efforts continued in the subsequent years, with changes in Dai's remuneration, introduction of Disposable Delivery Kits and training with an emphasis on coordination with the local health care system.

With the Government of India's decision of implementing the Reproductive and child health program in 1997, the role of Dai has become all the more critical to address women's health concerns. Under this program, efforts are being made to identify and register Dai's in every village. These Dais', after training are

being recognized by the Government and paid due remuneration. With a view to institutionalize all deliveries, a decision has been made to stop training and recognizing new Dais.

Efforts of NGOs to strengthen Dai tradition

Realizing the crucial role of Dai in the community and the inadequacy of Governments Dai training, various NGOs all over the country are training and supporting Dai's. Most of the training follow the curriculum laid down by the Government. Additionally, there is a lot of follow up support.

NGO initiated efforts can be broadly categorized in to two

- Providing training input to Dais and linking up with the health system for services and supplies.
- Initiating their own program including services, supplies and training.

Specific efforts have been made to organize Dais and form their cooperatives (Sewa in Gujarat) with a view to empower Dais and make them self-reliant.

Few NGOs have researched for Dai practices and are making efforts for evolving a more sensitive and appropriate model for Dai training.

Discussion and concerns

A case of mismatch

Dai training in India, by the Government and to some extent by the NGOs, has been a case of mismatch. We have linked a traditional practitioner, who has her own worldview, experience and way of thinking and working view with a system based on an entirely world, view. This system fails to understand and do justice to the Dai tradition. Hence most Dais a re laden with information that has been given to them with little effort to learn what they know and practice. The training has almost no space for Dais knowledge and expertise of herbs and rituals. Some practices like applying force and pressure on the abdomen, lack of emphasis on asepsis, calling a person to give stimulating drugs have adverse effects on woman and the baby but there are quite a few like giving stimulating and energy promoting decoctions, providing support and encouragement to the woman, massage, stimulating the placenta for new born resuscitation are a few to indicate the positive aspects of Dai practices.
The formal traditional systems of medicine have been isolated and hardly contributed to the Dai program, an area where their contribution could be maximum.

Often, one gets to hear that they have to counteract with a variety of deep-rooted traditions, which are difficult to change. Despite this fact, the Dais continues to be trained byANMs/LHVs/Medical doctors who have little or no idea of Dai practices.

The outlook towards Dai

Most communities have the idea that the woman is untouchable during menstruation and childbirth and therefore is isolated. Some argue that these practices allow rest and prevent infections. However, such practices lead to a demeaning attitude towards women throughout their lives. The Dai supports women when their families, but even she isolate them, as a woman has to bear the brunt. Class, caste and gender biases lead to shabby treatment towards the Dai. She is viewed as one who collects and cleans the dirt, which has been collected since nine months. The consequence is that her own need remain largely ignored.

In a healer's meet organized by CHETNA during 1999, the Dai's voiced the following needs:

We want to get a health check up done, we require transportation to move to far places, we need torch to be able to see in bad light, we need foot wear, glasses to wear to be able to see clearly. But where do we get these

This attitude also affects the decision for referral. More often that not, the Dai is held responsible for delay in referral in case of complications. However, a study done by LSPSS/CHETNA in 12 states indicated that the Dais are generally aware of their limits, however, the decision to take the women to the hospital largely depends on the money available in the house, the family's attitude and value for the woman, available of the transport system and the distance of the hospital.

The formal health care system views Dais as community workers who are obliged and expected to support the program and accomplish the task allotted to them. As a result Dais are made appendages to the formal health system with few efforts to integrate them in the program. On the contrary, Dai's have been meeting the community's health needs since thousands of years and they need the support of strong and functional back-up systems.

The impact of Dai training

The impact of Dai training has been felt in two clear-cut areas, one reduction in neonatal mortality due to Tetanus and in improving the referral system. The most common criticism to the Dai training scheme has been the fact that it has not been able to reduce maternal mortality rates. It is important to note that for almost 50 years after independence, we have concentrated to training Dai's with little or no efforts to strengthen the referral system and making obstetric care available in the remote and rural areas. In addition, maternal mortality is a complex issue, which cannot be addressed with a one-point intervention.

Dai's have surely benefited from the training in terms of increased recognition in the community, breaking the barriers of class, caste and religion, learning aseptic measures and so on. However, it is important to note that this has to some extent hampered the Dai profession. As a Dai in Gujarat says:

Now we do not do much work. We do not like to take the risk, so when a woman comes to us, we ask her to go to the hospital. We are not responsible if something happens afterwards.

This standardization of referral has proved costly to the community. What once was available at the doorstep has now become distant and costly. As is clear from the statement of a Dai in Gujarat.

If they go to the Doctor, they would easily have to spend one to two thousand rupees help them at their door step and they need to spend a hundred rupee or so.

Conclusion

The Dai's have a critical role to play in the coming generations. It is important that the tradition of giving births at home continues in the years to come. However, there is a need to strengthen and upgrade the skills of Dais on an ongoing basis.

It is important that the Dai training is based on her own knowledge, skills, practices and experiences. The traditional systems of medicine (Ayurveda, Siddha, Unani, Yoga, and homeopathy) play a critical role in understanding the Dai practices and designing the curriculum of Dai training.

The Dai training program should be backed by strong and competent referral system, including transport and obstetric care.

Economic viability of Dai tradition is another area, which requires lot of thought. While the remuneration provided by the Government is essential but inadequate, community remuneration is essential. There is a need to work out locally acceptable remuneration systems, in terms of cash and kind. This will also help to portray Dai tradition as a trade and encourage new Dais to take up this profession.

Lastly, meeting the Dais own needs of health care and other supplies besides the delivery kit is another concern. Some of the needs could be taken care if an acceptable remuneration system is set up. However, there is a need to look seriously to the health needs of the Dai.

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NGO organises meet for midwives in Ahmedabad

EXPRESS NEWS SERVICE
AHMEDABAD, APRIL 18

IN a fitting tribute to dais (midwives), the Centre for Health Education, Training and Nutrition Awareness (CHETNA), a non-governmental organisation, organised a meet for them on World Heritage Day in Ahmedabad.

More than 70,000 dais play a critical role in pregnancy and childbirth in the remote rural areas as well as the city slums in the country.

The Centre has been taking various efforts to strengthen the tradition of dais.

In Gujarat alone, out of 12 lakh deliveries annually, eight lakh take place in the rural areas and 80 per cent of the rural deliveries are assisted by the midwives.

Even in urban areas, about 50 per cent of the child-births take place in the slums and are assisted by the midwives.

Mirai Chatterjee of SEWA revealed that most government officials felt that the dais, in spite of extensive training and special fund allocation, have not been able to curb the mortality rates of both the new-borns and the mothers.

Another participant in the meet Dr P C Shah, however, pointed out that a significant rise in the number of gynaecologists also has not brought down the mortality rates.

Dr Shah felt that midwives could contribute to reduction in reduction of female mortality.

Shah felt that midwives should have adequate information about the facilities available at various Primary Health Centres (PHC) and Civil Hospitals.

The main aim of the development and support of dai programme is to bring a reduction in both female and infant mortality rate.

Since 100 per cent institutionalised deliveries are not possible in the country, efforts are being made to make delivery easier for the women in far-flung corners of the country.

About 30 dais and several non-governmental organisations working towards training the midwives attended the day-long meet to exchange views and debate one the existing problems.

The representatives of SEWA Rural, a pioneering non-governmental organisation in the field of training midwives, brought relevant points to notice.

The organisation has taken the help of the local hospital in training dais.

Swatiben said this ensured that a rapport and co-ordination evolved between the midwives and the hospital authorities and nurses besides giving the former more credibility.

Apart from this, the expectant mother and her family members are trained to handle delivery in emergency situations.

Dai kits are also being provided to expectant mothers to facilitate easy delivery. However, it was largely observed that the 'injection culture' is present among the rural population.

Concerns were also raised about the prevalent dai-doctor nexus.

A representative said that these doctors are called after the delivery and they gave injections which were not required and charged a hefty fee for the same.

CHETNA

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