PRIMARY HEALTH CARE AN IMPORTANT COMPONENT OF THE INTEGRATED APPROACH TO CHILD WELFARE

by

Dr. H. W. Butt, Director,
Indo Dutch Project for Child Welfare, Hyderabad.

Indo-Dutch Project for Child Welfare is a joint venture between the Netherlands Foundation, the Government of India and the Government of Andhra Pradesh.

Programmes have been designed to cover the age group of 0-16 for which a concerted effort is being made on many fronts:

To strengthen primary health care services, a new strategy for introducing a trained voluntary local village health agent, viz. the Grama Svasthika to take care of malnourished, pregnant and lactating mothers and work in close collaboration with the Multipurpose Health workers;

Creches have been established for children in the age group of 6 months to 2 1/2 years and are run by locally trained creche mothers under the supervision of the primary health staff;

Balwadies for children in the age group of 2 1/2 years to 5 years run by local trained mother-teachers.

Primary school improvement programmes have been introduced in the local primary schools for

...2...

the age group of 6 - 11 years with a revised syllabus which includes health, nutrition and recreation.

Nonformal education programmes to develop the youth especially those out of school in the age group of 12 - 16 years.

Emphasis is given to women because of the important role they play as mothers. Mahila Mandals have been geared to strengthen and provide support to these aspects.

Nutrition programmes have been initiated to help the local mothers and farmers by introducting back yard poultry units, small dairy units, nutrition demonstration units and school gardens.

Short training programmes in village centres for village women.

Communication process emphasising on simple items on health care, education, nutrition etc.

The detailed aspects of the project will be discussed.

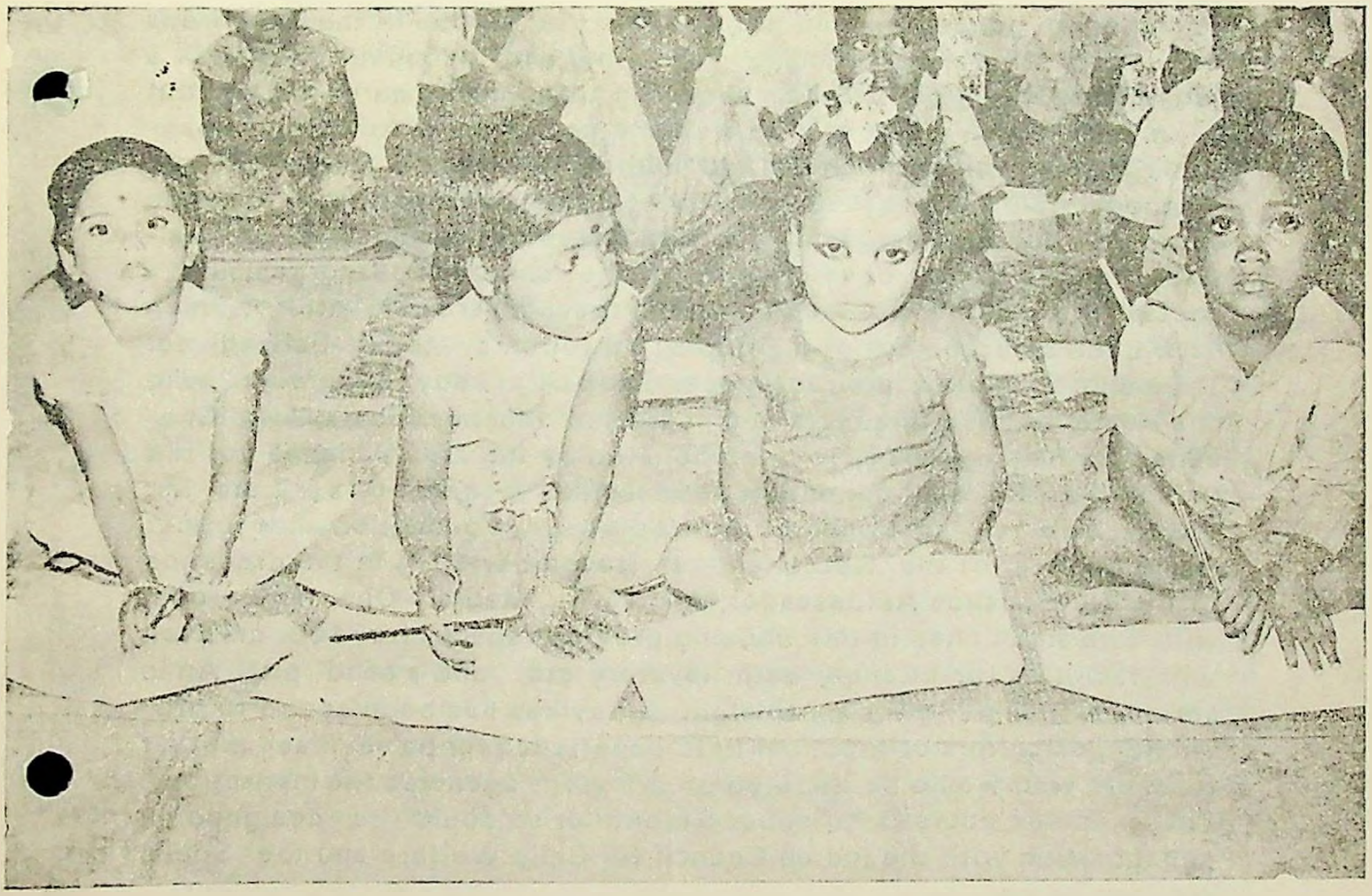
AP2

INDO DUTCH PROJECT FOR CHILD WELFARE

(STICHTING NETHERLANDS KINDERHULP PLAN)

MODEL BALWADI-CUM-FIELD TRAINING UNIT, CHEVELLA

(AN EXPERIMENT WITH "MOTHER TEACHERS")



A CLASS IN SESSION AT THE MODEL BALWADI

INAUGURATION

BY

His Excellency R. D. BHANDARE

GOVERNOR OF ANDHRA PRADESH

In the presence of

His Excellency Tj. A. MEURS

NETHERLANDS AMBASSADOR

on 27th September 1976 at 11.00 a.m.

at Chevella, Hyderabad Dist.

MODEL BALWADI-CUM-FIELD TRAINING UNIT

A new experiment is being tried out in preschool education at Chevella by the Indo Dutch Project in which local women who have passed the 5th grade or more are trained as Mother Teachers* to manage all aspects of the balwadis for the age group of 3-5 years. Past experience in the Chevella Block has shown that most of the balsevikas with their high school education and 11 months training in preschool child education have not been very effective in the rural areas due to lack of practical training in the field and because they lack a sense of belonging to the local area. In many cases parents have not been involved in these efforts who are a key factor for proper psychological, physical and social development of child. By encouraging local talent there is not only a greater possibility of ensuring continuity but also increasing the awareness of the importance of balwadis for the future development of the child. After organising a special one month's course in mother teacher training four women have been selected out of a group of 19 to run a Model Balwadi for 100 children under the direct supervision of a Lady Supervisor who is a Home Science graduate and a trained Mukhya Sevika. In Chevella 1350 sq. yards have been donated by the Zilla Parishad for the Model Balwadi, the foundation of which has been laid by Late Mr. V.G.M. Marijnen, Chairman of the Netherlands Foundation and former Prime Minister of the Netherlands in November 1974 in the presence of the Netherlands Ambassador, Mr. Tj. A. Meurs. One large room with two small ones in this building provide space for 100 children with facilities for kitchen, bath, lavatory etc. and a sand pit. An in service training unit for six to eight balsevikas has been added to provide opportunities of practical field experience for balsevikas / mother teachers who would be deputed by different agencies and institutions. These ad hoc courses for about a month or so could be designed in collaboration with the Indian Council for Child Welfare and the Social Welfare Board.

THE STORY OF THE PROJECT

Aim and origin :

The Indo Dutch Project for Child Welfare has its origin in the personal interest shown by the Queen of the Netherlands. This has taken the form of establishing an integrated child care project in India on the

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*Definition of a Mother Teacher.

A Mother Teacher need not always be a mother but she should have the attitude, patience and love of a mother while teaching the child

basis of an agreement arrived at between the Government of India. the Government of Andhra Pradesh and the Netherlands Foundation. As a pilot Project it started in the year 1970 in Chevella Block Hyderabad district which has a population of 1,17,000 and an area of 961.9 sq. Kms. The main objective of this integrated approach is to improve the quality of human life and to find ways and means of increasing the effectiveness of the existing services in the different fields of child welfare. The programmes drawn up concern the child during all phases of its growth and development. They cover all aspects of child care, health, nutrition and education. The duration of Project 8–10 years with a possibility of extending the period depending on the results and the participation of the people and the Government. The Project aims to develop self-reliance local initiative, leadership and partnership for which it completly rules out dole-outs and charity oriented programmes.

METHOD OF WORKING

In the Netherlands a Foundation has been established which includes representatives of the Dutch branches of UNESCO and UNICEF. This maintains a link with the Indian Advisory Board comprising Secretaries to Government, Union Family Planning Commissioner, Director, Research Government of India, Director of National Institute of Nutrition and representatives from reputed national agencies on social work and child welfare. According to the agreement signed, programmes initiated by the Project would be implemented by the existing staff of the Block & District with the assistance of specialised institutions and would be within the limits of the budget and the departmental plans. Only such programmes would be taken up that are practical repeatable and within the resources of the people and the B lock. Programmes that are successful and fall in line with the general policy of the Government will be taken over gradually or in a phased manner by the concerned Departments and agencies.

HEALTH :

Niloufer Health Team

The Niloufer Health Team which visits the Project villages twice a week, provides the services of preventive immunisation, ante-natal, intra-postnatal services, nutritional services, health education, research, training of auxiliary nurse midwives, doctors, under-graduates and post-graduates. The total number of visits by the children at the pediatric clinics in 1975 is 18,679. In 1975, 9,497 visits have been made by the women in the Project area to the obstetrjc clinics Number of antenatal cases treated in 1975 is 4,801.

Achievements :

1. In a period of three yeers it was possible to eradicate diseases of malnutrition in 7,000 children.

2. Due to regular child care, 212 mothers have come forward to accept a permanent method of family planning in one year.

3. Programmes of practical field training have been arranged in the Project area for senior Pediatricians of the UNICEF, WHO courses from several countries. Research has been conducted in various aspects of mat rnal and child care by post-graduates, interns of the Osmania Medical College.

Multipurpose Health Workers Scheme :

The ANM experiment which was started in four subcentres is now being expanded to the entire Block in 24 subcentres with 48 male and female workers and 12 supervisors for whom special kits with drugs have been designed along with a systematic reporting system.The new role of the Niloufer Health Team will be monitoring this scheme, giving on–the-spot guidance to the personnel and evaluation, This new scheme has been inaugurated by the Health Minister Sri K. Rajamallu on 18th September 1976,

Hyderabad Mix :

This is prepared from locally available ingredients, the composition of which is evolved by the National Institute of Nutrition. The Mix contains jowar, bengal gram, ground-nut or cowpeas and jaggery in the proportion of 4:2:2:1. The protein content of these packets is 10 grams with 250 calories and 50 international units of Vitamin A. They are prepared by the Mahila Mandals and cost 30 paise a packet.

Contributions :

A special feature is the introduction of the contribution scheme where mothers and children register themselves once for an amount of 50 paise which has totalled to an amount of nearly Rs. 5.000/- deposited in the local post office under the name of the Sarpanch and the Block Development Officer so that it could be used by the rural families for drugs etc.

Training of Dais :

Forty six dais have been trained in a special intensive course for one month. This will become a regular feature in which all the dais in the Project area will be trained.

Family Planning Services:

The family planning drive has been encouraging for this area as a result of improving maternal and child health services. It is estimated that 35 per cent of the eligible couples of a priority group with three children and more have been sterilised in the Block. In 1975, 205 tubectomy operations were conducted at the primary health centre while 1984 cases were followed up.

Preschool Education:

There are nearly 600 children on rolls at the 12 balwadis in the project area with an average attendance of 442 children, Every year, about 100 children who have passed the age of 5 are admitted to the primary schools. To encourage a feeling of sharing and partnership, the parents contribute either 50 paise per month or 6 Kilograms of jowar or cook the midday meals for four days in rotation.

Mother Teachers Training Course:

A one month's comprehensive mother teachers training courses have been held for women who have passed the 5th grade, to work as assistants to the balsevikas and craft teachers. These courses provide opportunities to develop skills in teaching children, cooking midday meals, preparing toys and visuals for teaching material. 42 women have been trained so far.

CRECHE:

Two creches have been established in Kanakamamidi and Dhobipet for 50 children in the age group of one-year to provide an effective learning situation to mothers by demonstrating simple methods of child care; to involve mothers in the preparation of supplementary diets with local ingredients and to improve the health of the children by bringing down the mortality and morbidity.

MAHILA MANDALS:

Thirteen mahila mandals (women's clubs) have been established in the Project area to help educate rural house wives in programmes of health, education, nutrition and child care. Economic projects such as preparation of spice packets, protein packets and handicrafts are taught to the members of these clubs.

KEYVILLAGE SCHEME:

A key village scheme has been established in Chevella to which the Project has contributed its share for non-recurring expenditure especially for the construction of 5 key village subcentres.

INDIVIDUAL DAIRY FARMING SCHEME :

This scheme is aimed at involving farmers in programmes of child welfare by encouraging them to use better quality of milch cattle.

INDIVIDUAL BACKYARD POULTRY UNITS :

Six poultry units with 100 birds each have been started by young farmers who have been trained in poultry management. They repay the amount of loan by supplying eggs to the balwadis and creches,

NUTRITION DEMONSTRATION UNITS :

The main objective of these units is to establish a chain of demonstrations from cultivating the required crops by the farmers; utilising the produce in the preparation of midday meals, supplementary foods and protein packets by the members of the mahila mandals and organising an effective nutrition education programme to educate the village community by the balsevikas, craft teachers and the auxiliary nurse midwives,

PRIMARY SCHOOL EDUCATION :

According to the basic design of the Project of involving the age group of 0-16 years a new scheme to improve the quality of primary education has been initiated for the age group of 6-11 years in collaboration with the Department of Education. New text books and guide books have been designed after revising the curriculum by an Expert Group, which will be implemented in 20 schools in the Project area after training 60 primary school teachers.

URBAN PROJECT FOR CHILD WELFARE :

Based on the experience gained on the Chevella experiment a practical and community oriented pilot project has been designed in collaboration with the Department of Health, Municipal Administration in Hyderabad city, in Ward 19 and Blcoks 1 and 2 of Ward 20 for a population of 58,000.

EVALUATION :

The National Institute of Community Development has published the baseline survey and is now engaged in completing its report on evaluating the Project programmes.

For any further information please contact :

Dr. H. W. Butt Director of Indian Bureau
Indo Dutch Project for Child Welfare
6.3.885, Somajiguda, HYDERABAD 500 004
Telephone: Off. 35938 Res. 33408

AP-2

No. 3

Health/C.D.
A.P.

Indo-Dutch Project for Child Welfare
6-3-885, Somajiguda, Hyderabad - 500 004

1. Started in 1969

2. Coverage: Chevalla block (pop. 1,17,000) was first fully covered; confined to four subcentres covering a population of 46,000 in 47 villages of the block. Now covering all SCs under MPW scheme.

3. Activities:

   a. Health - regular medical care;

   b. immunization;

   c. Distribution of nutrition supplements (locally prepared mix);

   d. economic activities for Mahila Mandals such as preparation of protein mix and spice packets; plus other typical activities.

   e. experiments with different types of pre-school education programme (balwadis, nursery schools);

   f. smallscale dairy and poulty units for villagers;

   g. establishment of creches, nutrition demonstration units, vegetable and fruit gardens;

   h. family planning.

   i. MPW scheme: Beginning in September 1976, block has 24 subcentres with 1 male and 1 female health worker per 5,000 pop. This is one of the blocks selected for the new government MPW scheme.

   j. Mother teacher training course. To encourage local mothers to assume responsibilities for child welfare. Some of the successful trainees have been appointed as Asst. Balsevikas or as craft teachers in the mahila mandal;

   k. other developmental schemes - handicrafts, youth clubs and intensive cattle development.

4. Personnel & Training: (7 staff plus postgraduates under a Professor of Social Paediatrics).

   a. Health team under a Prof. of Social Paediatrics from a city college visits the SCs twice weekly, for delivery of health services and for training ANMs and doctors in the programme;

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No. 3

b. PHC/SC staff: ultimate objective is for those to take over the centre work, all ANMs are given a population of 5,000 each. Intensive courses for dais have been held;

c. Special BDO is stationed with the project.

5. Supervision & Records: The systematic reporting system is based on simplified growth cards and family folders plus registers. Monthly meetings are held at the block level.

6. Community & Other Participation: Mahila Mandals actively participate (as above).

7. Sponsorship & Funds. The Netherlands Foundation and GOI, Health Ministry are co-sponsors. Funding is by the foundation with government and institutes' specialized staff.

8. Evaluation. A longitudinal study by the College of Home Science aims to study the progress of the children. NICD is doing the overall evaluation; baseline studies have been done by them earlier.

9. Problems. a) Attitudes of people to participation in view of dependence on government; b) too vast an area for each worker.

11. Contact: Dr H.W. Butt, Director of Indian Bureau, Indo-Dutch Project.

12. Reference: Paper presented at the National Symposium, 1976.

Note: No information available on item 10.

AP-4

No. 2
Rural Devlp.
Andhra Pradesh

Arogyavaram Development Society, Madanapalle Taluk, Chittoor District, Andhra Pradesh

1. Started in 1974

2. Coverage. 350 villages

3. Activities.
   a. Education
   b. Family life
   c. Health Care, MCH
   d. Irrigation
   e. Setting up of cooperative societies for farmers, population studies, etc.

4. Personnel & Training. The Society maintains close association with various faculties of the Venkateswara University and the Medical College of Tirupati.

7. Sponsorship & Funds. Sponsored by the Government of India and Andhra Pradesh and financed by the German Agency Evangelische Zentralstelle Fur Entwicklungshilfe.

Note: No information available on items 5, 6, 8, 9, 10, 11 and 12.

AP-11

No.1
Health & C.C.
Andhra Pradesh

Andhra Mahila Sabha, University Road, Hyderabad

1. Started in 1958

2. Coverage. General centres in the whole state of Andhra Pradesh.

3. Activities.

a. Educational Services:
Balwadis with primary schools attached, high schools, arts & science colleges, functional literacy programmes for farmers in eight districts in Andhra Pradesh. This is integrated with child-care and family welfare programmes.

b. Health:
Hospitals, Family Planning Clinics, ANM training

c. Rehabilitation Centres:
Orthopaedic centres for the treatment, education and rehabilitation of the physically handicapped children.

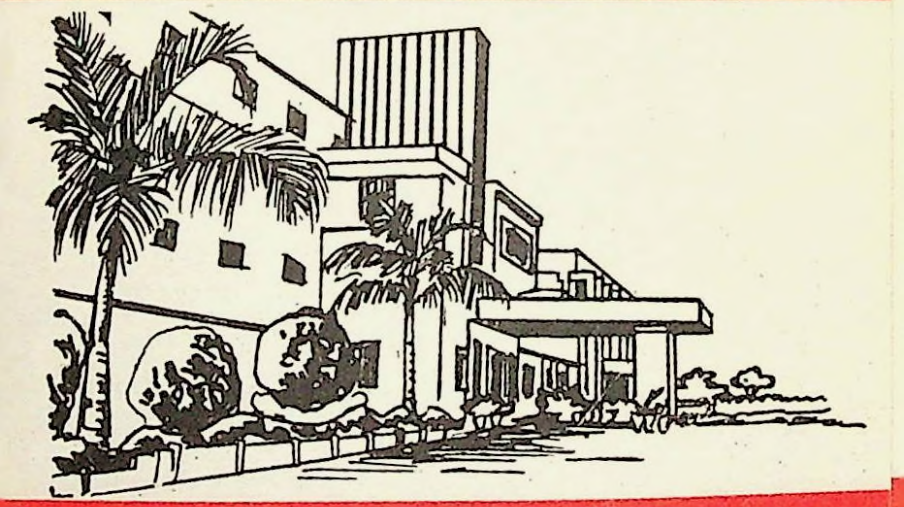
d. Training & Employment Services:
Handicrafts training institute - in printing and dyeing textiles, toy-making, leather-work, packaging and binding

12. Reference. SEIO, UNICEF

Note: No information available on items 4, 5, 6, 7, 8, 9, 10 & 11.

DIAMOND JUBILEE YEAR 1978

ABOUT NIN



NATIONAL INSTITUTE OF NUTRITION
INDIAN COUNCIL OF MEDICAL RESEARCH
HYDERABAD – 500 007, INDIA

AR 9

Diet and Nutrition have a far reaching influence on the wealth and welfare of the people.

Research on various aspects of nutrition began in India in the year 1918, when an "Enquiry into Beri-Beri" was set up under Sir Robert McCarrison at Coonoor in South India. This Unit has now grown into the National Institute of Nutrition (NIN).

NIN is celebrating the 60th Anniversary or Diamond Jubilee this year.

NIN is one of the permanent institutes of the Indian Council of Medical Research (ICMR), Ministry of Health, Government of India.

In earlier years, research was concentrated on studying the diet and nutrition status of various populations; causes of nutritional deficiency diseases and their treatment. Studies on Nutritive Value of Indian Foods were initiated and the results have been compiled into the book 'Nutritive Value of Indian Foods'.

Later, the laboratories expanded the scope of their activities into the clinical, biochemical and public health fields.

The National Institute of Nutrition is now recognised as a centre of Research and Training in Nutrition in India and South East Asia. It functions with the following objectives :

1. Research on various dietary and nutritional problems in the Laboratory, hospital and at the Community level.
2. Evolving suitable methods of treatment and prevention of nutritional problems which would be feasible within the existing economic, social and administrative setup.
3. Operational research connected with implementation of nutrition programmes.
4. To dovetail Nutrition Research with other health programmes of the Government.
5. Continuous monitoring of the Nutrition Situation in India.
6. Training in Nutrition for young scientists, teachers in medical schools, health workers
7. Dissemination of nutritional knowledge,
8. Advising Governments and other organizations on questions of nutrition.

The Institute is now located on a pleasant campus near the Osmania University complex in Hyderabad. It possesses well-equipped modern Laboratory facilities and various sophisticated equipment for biochemical, pathological, isotopic and physiological investigations.

Bed-side clinic facilities and outpatient facilities are available at the two city hospitals – Niloufer Hospital for Women and Children and the Osmania General Hospital.

Field studies are conducted in many villages around Hyderabad as well as in other parts of India. The Central Reference Laboratory of the National Nutrition Monitoring Bureau established by ICMR is housed at NIN.

The Food and Drug Toxicology Research Centre and the Laboratory Animal Information Services Centre are also housed in the Institute.

The Institute has on its staff more than 100 scientists including biochemists, clinicians, geneticists, pathologists, statisticians, social workers, psychologists, anthropologists, dieticians and others.

The Library of the Institute well stocked with books, periodicals, reprints and slides is considered as one of the best scientific libraries in India.

NIN is one of the first Organizations in India to offer training in Nutrition to persons actively engaged in nutrition work at various levels. Seven training courses are conducted every year besides various Adhoc programmes. Participants usually receive fellowships either from UNICEF, WHO, ICMR or ICAR.

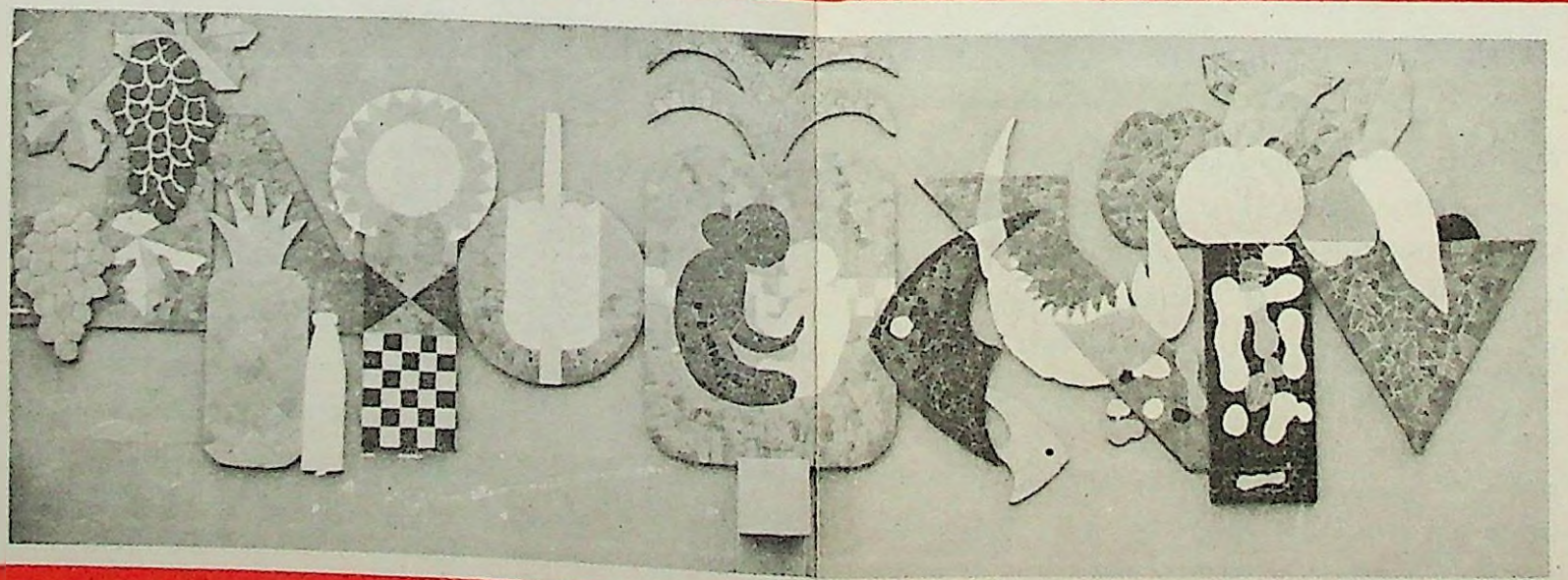
The campus has a well appointed and comfortable International Hostel which provides boarding and lodging for the participants.

A Nutrition Museum housed in the campus highlights different aspects of food and nutrition and also the work done at the Institute. It functions as a good education medium for persons with diverse interests.

The Institute also publishes various low priced periodicals and books. Two popular quarterly Journals "Nutrition" and "Poshan" are also brought out. These journals have a fairly good circulation all over India.

The Institute has made signal contributions in the following areas :

1. Nutritive Value of Indian Foods
2. Nutrition and Growth
3. Nutrition and Work Capacity
4. Welfare of Mother and Child
5. Breast Feeding
6. Nutritional Deficiency Problems
7. Protein Energy Malnutrition
8. Vitamin A Deficiency and Blindness
9. Deficiency of B-Complex Vitamins
10. Anaemia
11. Malnutrition in Relation to Mental Development
12. Drug Metabolism and Nutrition
13. Endemic Goitre
14. Pellagra
15. Fluorosis
16. Lathyrism
17. Food Contaminants and Food Toxins
18. Nutrition Surveillance of Communities



SOCIETY FOR DEVELOPMENT OF SERICULTURE INDUSTRY

The Society at Tirupati 517501, Andhra Pradesh originally started in 1974 for the development of sericulture industry, has now devoted itself to all-round development. In 1976, the institution has taken up, after a socio-economic survey, an integrated development programme for 2,000 families in Chandragiri block in Chittor district, (spread over 21 villages)

Objectives :

The Society will undertake any of the activities mentioned in the 'Constructive Programme'.

Programmes:

Its present programmes are agriculture, education and training, recreation and culture in 21 villages covering 2,024 families. Other programmes like livestock development covers 800 families, village and cottage industries including sericulture-620 families, and irrigation-1,650 families in these villages.

Workers:

It has 11 full-time and 19 voluntary workers.

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AP-12 12 2

No. 5
Rural Development
Andhra Pradesh

Village Reconstruction Organisation, 6/9 Brodipet, Guntur

1. Started in 1969

2. Coverage.50 villages, mostly in Andhra Pradesh, but a few in Orissa and Tamilnadu also.

3. Activities. Construction of houses, health, agriculture education, nutrition and village leadership training.

The VRO objective is towards remaking and adapting rural village communities in such a way as to make them viable and complementary to the urban development. Has worked in cyclone-affected areas.

4. Personnel & Training. Volunteers mostly graduates trained in the field as well as in formal courses. Training of various types- pre-service, in-service, extension etc. are given.

5. Community and other Participation. Programmes start with communal decision processes. The projects organizational structure is matched by a corresponding one for the village.

7. Sponsorship and Funds. Over 30 agencies have pooled together responsibility and funds for VRO. VRO contribution is 30%, governments 50% and public's 15%.

8. Evaluation. Research has just been started with some in-depth socio-economic studies.

9. Problems. Government funds are channelled through various departments and hence not available in time. The social climate is not easily amenable to development.

11. Contact. Professor M.A. Windey S.J., Director

12. Reference. M.A. Windey, "A Rural Reconstruction Movement in India," paper presented at the Seminar on Development Projects Designed to reach the Lowest Income Groups, Paris, June 1974.

Note: No information available on items 5 and 10.

No. 4
Health & C.D
A.P.

Rayalaseema Development Trust, Amantapur, Amantapur District

1. Started in 1975
2. Coverage 14 clinics serving 70,000 population.
3. Activities
   a. Nutrition and immunization for under fives;
   b. safe water supply;
   c. mother care;
   d. Illness care;
   e. C.D.
4. Personnel & Training. Each clinic has a doctor, ANM and ayah.
7. Sponsorship & Funds. Rayalaseena Development Trust.
10. Outlook. Future of project was in doubt in September 1976 due to extraneous reasons.
11. Contact. Father Vincent Ferrer.
12. References. VHAI.

Note: No information available on items 5, 6, 8, 9.

A.P-9

INTEGRATION OF NUTRITION SERVICES WITH THE PRIMARY HEALTH SET-UP

by

Dr. Malathi Damodaran,
Senior Research Officer, National Institute of Nutrition, Jamai Osmania, Hyderabad.

Malnutrition is an important public health problem among infants, preschool children and pregnant and nursing women in our country. Measures to alleviate nutritional problems have largely remained outside the health sector so far. The net-work of primary health centres and their subcentres would appear to be eminently suited to deliver nutrition services to the rural areas. Community health volunteers, envisaged to provide primary health care to all the village level from a link between the governmental health system and the people. Nutrition services are expected to be an integral part of the several preventive and promotive functions undertaken by the CHVs.

The feasibility of integrating nutrition services at three levels of health set up viz. primary health centre, sub-centre and at the village level have been tried out at the National Institute of Nutrition, Hyderabad. The results indicate that community health volunteers can provide useful services to the community, in the fields of nutrition and child health. With proper training and guidance it is possible to integrate nutrition services with M.C.H. activities of the auxiliary nurse midwife. The trials also show that the PHC can be used as a referral centre for management of nutritional problems, with minimum of additional inputs, although at present, the effective coverage by the PHCs levels much to be desired.

ANDHRA PRADESH - 7.

INDO-DUTCH URBAN PROJECT FOR CHILD WELFARE

72-5

(STICHTING NEDERLANDS KINDERHULP PLAN)

This practical and community oriented pilot project has been designed and will be implemented in collaboration with the Department of Health, Housing and Municipal Administration, the Urban Development Authority, the Municipal Corporation and voluntary agencies to aim at improving the quality of life of the child and youth in the age group of 0 to 16 years.

Emphasis is placed on :

1. The overall development of the child;
2. An integrated approach;
3. Self reliance and local initiative;
4. Repeatability and continuity;
5. Effective participation;
6. Local leadership,
7. Strengthening of existing structures and institutions;
8. Public involvement, co-operation and contribution;
9. Training of all concerned personnel;
10. Research and evaluation.

POLICY, STRATEGY AND PLANNING:

1. The *family* will be considered as a unit for an integrated programme of education, health and nutrition.

2. The project aims to cover a population of 55,000 in Ward 19 and Blocks 1 and 2 of Ward 20 of Hyderabad city.

3. There will be no free distribution of inputs but participation in programmes can be in cash, kind or services.

4. No programme will be initiated unless and until there is sufficient response from the people. Families will be free to accept, reject or modify the terms of participation or types of services.

5. Activities initiated will be such that they could be taken over by local agencies later.

6. The criteria for selection of families are : (1) Preference will be given to members of lower socio-economic strata; (2) The participation of parents will be required.

7. Some of the programmes suggested are :

   a. Health Assurance Plan
   b. Creches for children between 6 months and 2½ years
   c. Balwadis for age group between 2½ and 5 years
   d. Improving primary school education 6 to 11 years
   e. Mahila Mandals for young women and mothers
   f. Vigyan Mandirs for youth
   g. Adult Literacy
   h. Library

HEALTH ASSURANCE PLAN

GOALS :

This contributory scheme aims to educate families to adopt basic health practices; improve the health of mothers, eradicate diseases of malnutrition in children and avoid illnesses through :

a) Prevention of diseases

b) Early detection of diseases

c) Prompt treatment

BENEFITS :

1. Home visits by A. N. M.
2. All the pregnant mothers of the enrolled families will be registered and regular checkup and treatment will be provided. Normal cases will be seen by the A. N. M. and abnormal cases by the doctors on their visits to the clinic.
3. Assistance will be given during delivery and in the post-natal care of mother in normal cases.
4. Total immunization for children to prevent smallpox, polio whooping cough, T.B. diptheria, tetanus, typhoid and other diseases will be given.
5. Treatment of minor ailments like diarrhea, scabies, cough, simple eye and ear infection, minor accidents, etc. This will not cover hospitalization, major and chronic ailments.
6. Health education for mothers on personal hygiene, environmental sanitation, nutrition and spacing of children.

PARTICIPATION :

a. Enrolment in the plan will be by sharing 10 per cent of the costs involved per nuclear family per year.

b. Priority will be given to families having pregnant and lactating mothers and children.

CRECHE

GOALS :

This plan aims at providing a healthy and safe environment for children from 6 months to 2 1/2 years and to educate mothers in improved practices in child rearing and preparing cheap and nutritious weaning and infant foods.

BENEFITS :

1. **Day Care :**
   An auxiliary nurse midwife, a mother and one helper will be in charge of twenty children.

2. **Feeding Programme :**
   The children will be provided a balanced and nutritious meal prepared out of cheap and locally available ingredients.

3. **Health Supervision :**
   The ANMS will be responsible for daily health check ups; weekly supervision will be carried out by Health visitor and visiting physician.

4. **Child Care Guidance :**
   Guidance on prevention of diseases, health and diet to the parents will be provided through lectures, discussions, demonstrations and films.

PARTICIPATION/REQUIREMENTS :

a. Enrolment by monthly subscription in cash or kind or services of the mother.

b. A health certificate of fitness will be required before the child is admitted.

c. Children with any infection will not be allowed in the creche at any time.

d. Mothers will send their children clean and tidy each day.

BALWADI (PRE-SCHOOL)

GOALS :

The balwadi provides an opportunity for children between the ages of 2½ - 5 years to learn and play together in a healthy, friendly and clean place.

The children acquire skills through listening, speaking and singing and through motor and other activities that will make learning easier when they are older.

BENEFITS :

1. The balwadi provides an environment which stimulates the child's physical, social and mental development.
2. Day care will be offered by a mother-teacher and a helper.
3. **Feeding programme** will consist of nutritious snacks of locally available ingredients such as sprouted gram and kichidi.
4. **Health care** will include immunizations, treatment of minor ailments and checks on each child's growth and development by an ANM/Health visitor/Physician.
5. **Child care guidance** will be given to parents to assist in the development of the child's mind and body.

PARTICIPATION :

Enrolment by monthly subscriptions in cash or kind or services. Preference will be given to children of participating and/or working mothers.

VIGYAN MANDIR (CENTRES OF LEARNING)

72.4

GOALS :

These centres of learning aim to provide activities for youth that are :

1. For self-improvement ;
2. For Community service ;
3. For recreation and exercise;

INVOLVEMENT IN BENEFITS :

1. Economic projects that help improve their knowledge or skills with an eye to upgrade human resources and not merely for immediate monetary gain. Technical and mechanical skills imparted will be such that are in demand by the youth themselves that they can absorb.
2. Self employment schemes.
3. Educational, cultural and recreational activities.
4. Team work, community service and improvement of local surroundings.
5. Training, coaching, organisation and development of civic responsibilities.

   Department of Industries has offered assistance in securing loans from banks, getting licences and teaching in management techniques.

PARTICIPATION :

Age group 10-16 years.

Enrolment will be on subscription basis and/or sharing the responsibility of serving the club and the community.

The criteria of selection will be on the attitude of the youth who are prepared to contribute their time in serving the community.

MAHILA MANDAL (WOMEN'S CLUB)

GOALS :

A mahila mandal is a training centre that can offer programmes of education, health, nutrition, literacy, recreation.

Members can participate in determining the programmes.

BENEFITS :

1. Education and training
2. Economic Projects and self-employment schemes such as tailoring, embroidery and making spice and protein packets, envelopes etc.
3. Cooking demonstrations and competitions to teach how to prepare nutritious and cheap diets and foods.
4. Adult literacy classes
5. Cultural and recreational activities.

PARTICIPATION :

Enrolment by monthly subscription and/or contribution of equipment/services to any plan of the project.

	Ward-20 Block-1&2	Ward-19 5 Blocks	Total
Population ..	11,901	42,187	54,088
Slum population ..	2,733 (22.96%)	10,268 (24.34%)	13,001 (24.04%)
Children under 0-5 age group	1,412	4,717	6,129
School going children (below 14 years of age) ..	2,296	7,531	9,827
Women under 44 years of age group ..	3,012	9,230	12,242

AREA TO BE COVERED

Ward No. 20. Block No. 1.

Name of the Localities :

1. Behrupia Galli
2. Johari Galli
3. Kokakitatti
4. Gollakhidki
5. Bhagyanagar
6. Pardhiwada
7. Shiv Nagar (Puranapul)

Ward No. 20 Block No. 2.

1. Kabutar Khana
2. Golla Khidki
3. Hussaini Alam
4. Sukhmeer Kaman
5. Shibli Gunj

Ward No. 19 Block No. 1

1. Umda Bazar
2. Dood Bowli
3. Maharaj Gunj
4. Chatakni Pura
5. Bondal Guda
6. Golla Khidki
7. Bahadur Pura
8. Devibag

Ward No. 19 Block No. 2

1. Dood Bowli
2. Kamati Pura
3. Misri Gunj
4. Tad Ban
5. Gulshan Nagar
6. Bibi Gunj
7. Fatch Darwaza
8. Moin Pura
9. Kala Pathar
10. Chandulal Baradari Colony

Ward No. 19 Block No. 3

1. Jahanuma
2. Gazi Banda
3. Fatima Nagar
4. Ottapalli
5. Shamsheer Gunj

Ward No. 19 Block No. 4

1. Hussaini Pura
2. Kishan Bagh
3. Mahmood Nagar Colony
4. Kondareddi Guda
5. Zoological Park Colony

Ward No. 19 Block No. 5

1. Bahadur Pura Colony
2. Nandi Muslai Guda

INFORMATION REGARDING PROJECT ACTIVITIES CAN BE HAD FROM DR. H. W. BUTT, DIRECTOR, INDO-DUTCH PROJECT FOR CHILD WELFARE, 6-3-885, SOMAJIGUDA, HYDERABAD-500004.
TELEPHONE : 35938

INDO DUTCH PROJECT FOR CHILD WELFARE

(STICHTING NETHERLANDS KINDERHULP PLAN)

MODEL BALWADI-CUM-FIELD TRAINING UNIT, CHEVELLA

(AN EXPERIMENT WITH "MOTHER TEACHERS")

A CLASS IN SESSION AT THE MODEL BALWADI

INAUGURATION

BY

His Excellency R. D. BHANDARE

GOVERNOR OF ANDHRA PRADESH

In the presence of

His Excellency Tj. A. MEURS

NETHERLANDS AMBASSADOR

on 27th September 1976 at 11.00 a.m.

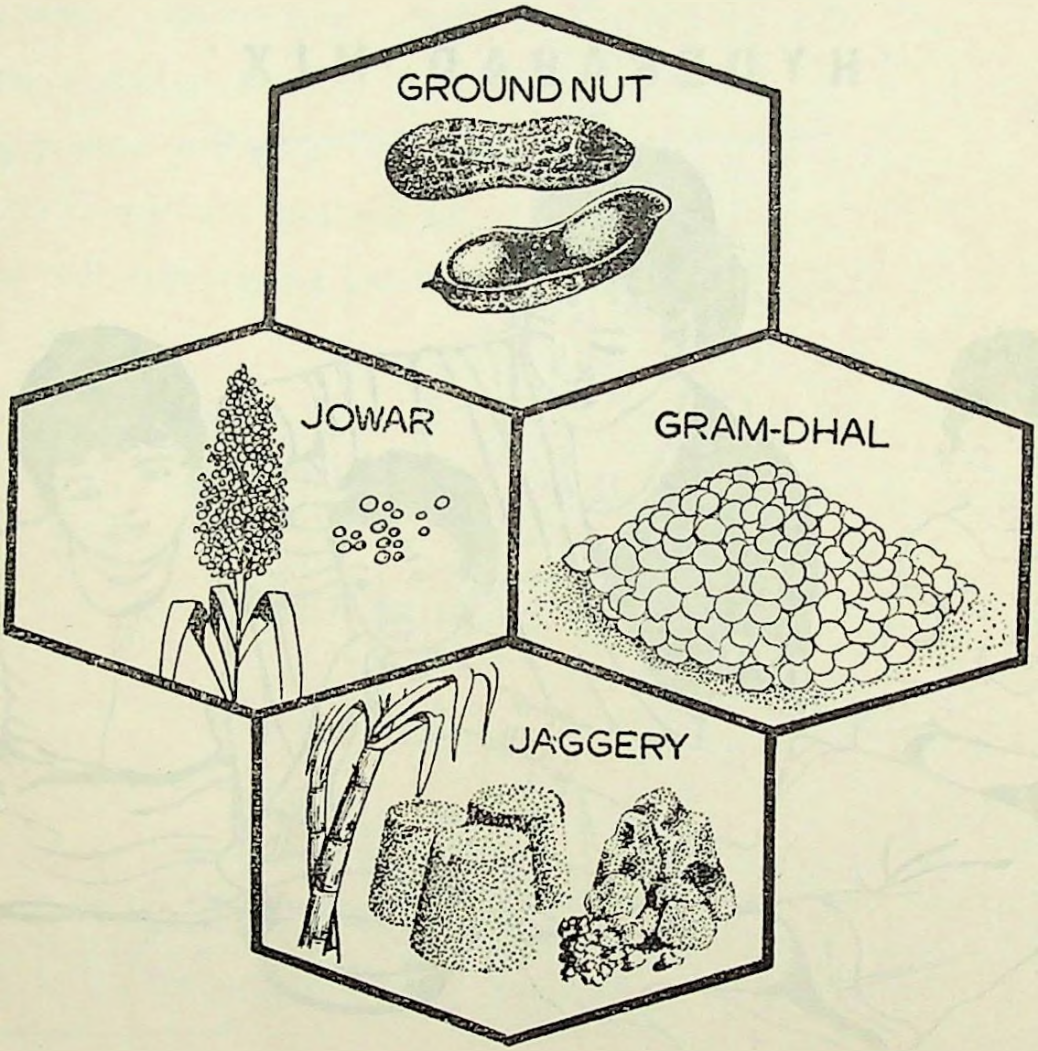
at Chevella, Hyderabad Dist.

FIGHTING
MAL-NUTRITION
WITH
'HYDERABAD MIX'

INDO–DUTCH PROJECT FOR CHILD WELFARE
(STICHTING NEDERLANDS KINDERHULP PLAN)
Chevella Block, Hyderabad District, A. P.

Protein packets made out of local seasonal crops, such as jowar or ragi, gram-dhal, ground-nut and jaggery have helped in eradicating diseases of mal-nutrition in nearly 7,000 children in the selected villages of Chevella Block of Hyderabad District.

Each packet of 70 grams contains:



Wheat or Jowar	... 35.0 gms.	Protein content of	... 10 gms.
Bengal Gram	... 11.0 gms.	Calories	... 250
Ground-nut	... 6.0 gms.	Vitamin 'A'	... 50 IU
Jaggery	... 11.5 gms.		
Defatted Soya Flour	... 6.0 gms.		

Cleaning, roasting and grinding is done by local members of Mahila mandals who earn a marginal profit of about 3 to 4 paise per packet, the monthly consumption being 3,000 packets

The results of using these packets in the past three years are:

Reduction of oedema fluid in first week,

Increase of weight from second week.

Disappearance of oedema, improvement in mental changes, subsidence of diarrhoea and puffness of face in second week.

Increase of weight at the end of 4 weeks (0.66 kg. average.)

Manner of Feeding:

As plain powder, or
with milk as porridge, or
as jaggery balls (laddoos), or
in bread cakes (chapathies).

To convince the villagers that protein packets can be made by them with local ingredients, a nutrition demonstration unit has been established at Kanakamamidi, where seasonal crops are being grown by a local farmer on one hectare land, donated to the Indo-Dutch Project. Mahila mandals will use the produce for preparation of protein packets for the Nursery Schools (Balwadis) and creches. This provides a chain of demonstrations - growing of local high yielding crops, method of preparing protein packets at the village level, utilising the packets in different ways for mothers and childern, controlling mal-nutrition and encouraging local mothers to use this 'mix' at home

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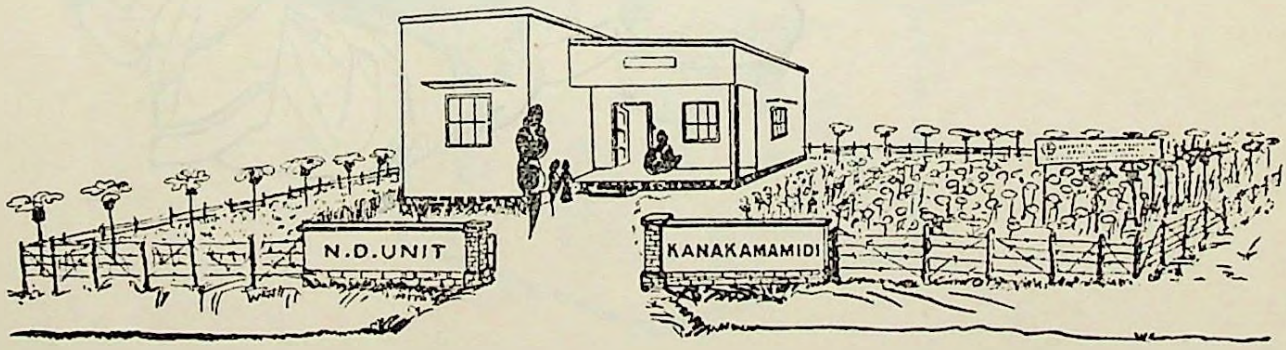
Nutrition Demonstration Unit



Information regarding project acitvities can be had from
Dr.H.W.Butt, Director, Indo-Duch Project for Child Welfare
6-3-885, Somajiguda, Hyderabad - 500 004. Tel. 35938.
Res. Tel. 33408.

NEWS LETTER

INDO-DUTCH PROJECT FOR CHILD WELFARE

A monthly News Bulletin for parents of children of primary schools, balwadis, creches, Mahila mandals, local leaders and farmers.

Volume 2 | July 1978 | Number 2

Doctor, As a Farmer How Can I Keep Healthy ?

(STEPS TO RAISE THE SOCIO-ECONOMIC STANDARD OF OUR RURAL AREAS)

The profession of a great majority of the rural population of our country is agriculture and to know effectively on the health of this category of people, one must understand the depth of their cultural and professional behaviour. The lives of town and country inhab tants differ, in that those living in towns have a greater advantage of more amenties, like electricity and running water, and social facilities, such as cinema, rubbish collection, hospitals etc. The fact that the farmer spends most of his time on the farm and doing manual labour makes him feel that he is stronger, and thus, less likely to become sick. The farmer has a more independent attitude towards life. He sets his own hours and often works alone or only with his family. He teaches himself through trial and errors; his work is varied because of the climate, season and weather, and often he must do his own farm maintenance In his work, he feels that some health risks cannot be avoided and are justified to gain the harvest. If a farmer is injured or wounded, he does not think it is very serious unless the pain is so great that it will stop him from working. He tends to ignore minor wounds, an injured eye or itching skin until they become a major problem. A farmer feels he is better protected against illness or injury than someone who works insice an office. If a farmer begins to feel ill, he feels this can wait. whereas the harvest will not wait Farmers are more conservative. They have their own strong beliefs and traditions and it is difficult for them to change.

In order to improve our health and standard of living, we must improve the economy. We can only do this through better and improved agriculture. A better harvest and increased income will enable a farmer to have clean sources of water by covering wells, to build latrines, to improve his house, to provide for proper disposal of rubbish, to provide more food for himself and his family, to get health care when needed and prophylaxis against some disease.

A healthy approach to agriculture is a healthy approach to life. A farmer is faced with many health problems. Three major ones are improper sanitary practices more common in the rural areas; wounds and injuries and irregular eating habits. Other problems would include contracting diseases from animals, exposure to farm chemicals and other substances such as pollen and grain dust which produce allergies.

Farmers also stand the risk of being directly affected by diseases contracted through improper sanitation. Our biggest health problems stem from parasitic infections and the most common comunicable disease. In looking closely at the modes of acquiring these illnesses, we find that we get them through the method of rubbish disposal, disposal and handling of faeces, types of wells and streams used for washing, cooking and drinking water, the method of preparing food, not washing our bodies properly and the types of houses in which we live.

Disposal of rubbish is often not considered a health hazard, but over one-half of our illnesses come from improper disposal of wastes. The waste disposal situation is worse in bigger towns. Poor disposal of rubbish encouranges flies, which transmit one of the biggest killers in the rural community, diarrhoea.

It is often a common practice in our villages that the women go out to one side of the village to defecate and urinate, and men go out to the other side, This is not good, especially when a village is near a river or stream and the people often defecate and urinate in the water. Very often, the same water is used for drinking, cooking and washing. Children are often permitted to defacate and urinate around houses where people walk. Domestic animals such as dogs, cats and chickens will eat the faecas and then come lick those who live in the houee. Many diseases are transmitted through contact with urine or faeces:

The method we use to wash ourselves, our clothes, food and eating utensils is also important in controlling the spread of disease. For example, sandfly or scabies can be acquired through lack of, or improper washing or, our bodies or clothes. Children do not always wash their hands properly before they eat, and sometimes they have long, dirty fingernails. Mothers also forget to wash their hands before preparing food which their families eat.

Due to the economy, many houses in the rural areas are constructed so that the inhabitants live with their enemies mosquitoes, cockroaches, and rats which transmit the diseases that can kill us. Windows are constructed, but many times, are not opened as the value of fresh air is not known. Because of custom, people with contagious diseases, for example, tuberculosis, measles and leprosy, often live with their relatives in congested family houses. These diseases are then spread more quickly.

Due to the nature of his work, a farmer is more likely to be wounded or injured. He can be cut by sticks, stones, thorns, and his own tools. Insects can fly into his eyes, bite him or sting him. Various plants can give him skin infections. He works with the earth, with plants, and often, not near to clean water. If he is injured he continues to work getting the wound dirty, and making it more possible for an infection to develop. If something goes into the eye, it is removed, and often nothing further is done, unless the eye gets infected. Many people are trying to mechanize their farms and they should also be prepared against diseases such as tetanus which may develop from a wound from rusty metal, and other injuries from moving machines and rotary blades.

Irregular eating habits can cause other health problems faced by the farmer. In former days, family members were more dependent on the head and elders. They would feed the men who laboured for them in the morning before they left for work. Now the farmer being an individual and because of his poverty will often leave for his farm on an empty stomach. He does not smoke proper cigarettes, but eats tobacco, uses snuff and chews betel nuts which will keep him awake on his farm. Often, a farmer will workless, setting smaller tasks and then go home or rest until food is prepared. Not eating at the proper times makes him weak, more likely to become sick and less work is done. Excessive use of cigarettes, snuff and betel nuts also has other effects on his health. They make him nervous, weak and dizzy and will eventually cause chronic constipation gastritis and peptic ulcers.

Farmers are more likely to contract diseases from animals. It is hard to diagnose them as many difficult tests must be performed. Pollen from plants and grain dust may produce allergies. Farmers are often in contact with those substances. With the development of inland swamps, oil palm and tea plantations, there has been an increased use of chemicals which can be harmful to the skin and can cause great irritation, for example, if they get in the eyes. Using them for a prolonged time and breathing their odours can also cause some harm to the former.

A healthy farmer with an increased income, will informed about the causes and prevention of diseases, wiliing to invest to prolong his life, can ensure the security and welfare of his family.

QUESTIONS

Q – Should farmers begin to plant more crops (e.g. beans, onions, tomatoes, potatoes etc.) or, to rear animals (e.g. cows, pigs, poultry etc.) that could improve the nutrition of our people?

Q – Is it possible for the farmers to invest their profit in their own health, such as in planting different foods particularly for the nutrition of their children, or in building latrines. wells, dustbins etc?

Q – Would it not be better to eat a greater variety and quality of these fruits and vegetables than coming to a hospital?

Q – Instead of taking medicine and getting used to always using it, would it not be better to eat more fruit where we can get two effects, first, that of a laxative, and, second, that of nutrition?

Q – Why do people continue to use snuff, cigarettes and betel nuts, when they do not benefit their health or their lives?

Mention was made earlier of the custom where children are permitted to defecate around houses. Domestic animals can eat the faeces, then lick the hands of the inhabitants. Flies can leave the faeces and contaminate food or eating utensils which can then give us diarrhoea.

Q – Is it possible to change this custom if no good effect will come of it?

Q – Why can't we build more latrines?

Q – Can not the owner of a house be responsible for cleaning the area around his own house, especially the yard before his house?

Q – Why can not an individual be responsible for the street and gutters near his house instead of waiting for the Panchayat or others to come and clean it?

Q – Will the farmers begin to ask health personnel (doctors, health visitors, nurses, midwives Gram Svastikas etc) who would be more than willing to explain, about the cause and prevention of the most common diseases transferred by unsanitary conditions?

The Importance of Language in a Balwadi

(A NOTE TO MOTHER TEACHERS & BALSEVIKAS)

'By "language" we mean speaking, listening, reading and writing. These different aspects are all related to each other; for example we need to listen and hear words in order to be able to speak them; likewise when we can speak and understand a language, it is easier to learn to read and write it.

Language gives shape to thought; that is to say, when we express our thoughts in words they become clearer and more exact. Words help us to define, remember, imagine and to reason. They play an important part in mental development.

Language is also a means of expressing feelings. As adults we know what a relief it is to talk about the things that make us happy or sad or worried. It is easy to understand the helplessness of a tiny child who, because he cannot express himself, is unable to tell us how he feels. Speech gives us power to express our emotions. It is also our main way of communicating with other people. If you have ever been in a country where you do not speak the language, you will know how difficult it is to try to explain or find out something with only gestures to help you.

The importance of reading and writing in education is very obvious, for much of our learning depends on these skills. Although we do not formally teach reading and writing to children in the balwadi we help them develop skills which make the later task of learning to read and write much easier. We help them speak and understand the language which they will later read and write. We give them an introduction to pictures and story books; we provide varied activities and creative art work to help them develop muscular control and co-ordination between hand and eyes. In addition, the play experiences in the centre give children opportunities to develop habits of concentrating and persistence which are so necessary to later learning.

In the balwadi we may have many children whose families give them little help or encouragement to speak well. Parents may talk *at* a child, give him directions, make short statements or demands, ask questions or scold, but they rarely sit down to talk with them. Besides this poverty of speech our families rarely read books or newspapers so that the children have no chance to be curious about the written word. Consequently you may have many children in your class whose home experiences have given them little help or interest in acquiring a wide vocabulary, speaking correctly, or developing an interest in books.

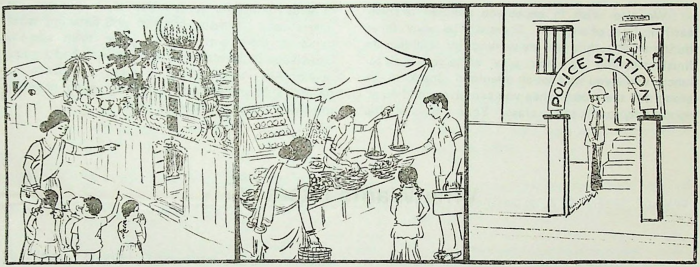
In our programme we must make the most of every opportunity to stimulate children's language development by :

- Providing many interesting experiences to talk about - rich, varied play and creative activities, interesting group celebrations such as holidays and festivals and short trips outside the centre to visit places of interest.
- Providing good picture books and interesting pictures on the walls of the class-room.
- Talking readily with individual children or to a group in order to help children learn to express their experiences in words.
- Encouraging children to talk with each other spontaneously as they play, and more formally to a class group.
- Telling aud reading stories to children.
- Singing songs to and with children.

Let us examine these points in more detail.

It is important to provide interesting experiences which will stimulate children to talk. Play and creative activities also encourage language development; children compare notes, exchange ideas, give each other instructions or just admire their own or other efforts. In planning for festival celebrations there are many opportunities for enriching language experiences.

Taking short traps in the neighbourhood with a small group of children provides rich material for discussion and activities. These trips must be well planned in advance with the other mother teacher. Some suggestions of places to visit are :



Temple
Fruit and vegetables market
Police station
Shoe repair shop
Carpenter's shop
Barber
Elementary school
Small local bazaar
Small local industries : wool-dying, shoe-making, weaving.

Looking at pictures and talking about them is a valuable experience for children. Pictures stimulate interest curiosity, comment, discussion, as well as give information. Sturdy picture scrap books are enjoyed by children and pictures can also be neatly mounted and hung low on walls where children can also be neatly mounted and hung low on walls where children can easily see them.

To learn to speak a language well, a child must hear it spoken. It is very important that you talk to the children clearly and correctly so that they hear a good pattern of speech to imitate in addition, help children increase their vocabulary by putting actions into descriptive words as for example, "How brightly you polished your shoes. It shines like the sun", "The road is slippery today," or "You made the tallest tower of blocks,". This is useful to a child because he then sees and experiences what it is you are talking about. He connects words with action.

Talk about events to the children. If your classroom has been newly painted comment on it ; when a tree in the play yard flowers, call it to the children's attention and talk about the flowers, the colour, what made them bloom. Be alert to what is going on about you which may be of interest to young children.

Encourage children to talk freely to each other and to you. The only time it is necessary to ask them to be quiet is : when you want to give directions or explain something, when you are telling a story or for example when other children are resting. Otherwise, the more they talk the better. Children learn to walk by walking : likewise, they learn to talk by talking. Be an attentive listener, whenever possible give a child your attention when he speaks and respond to what he says. Many young children

often repeat themselves or speak haltingly. Be patient. Give a child time to formulate ideas in his mind. Don't talk for him unless you see he is being frustrated by his own inability to tell you something.

Certain sounds are difficult for children to form, expecially f-v-l-r-th-s-z-j-ch, and often they will substitute another sound for these. Never laugh at a child for such mistakes; you will only make him feel ashamed and perhaps embarrassed. You might repeat the incorrect word correcly after him, but do not ask him to repeat it. We want children to enjoy speaking ; we do not want to inhibit them by stopping their flow of speech to correct them.

We also wish to encourage children to speak easily in front of a group. There will be many times during a day (while you are waiting for children to finish cleaning up after play, while you wait for lunch, while you wait for an afternoon snack to be brought to the room) when you can give children an opportunity to talk to the class. Your job is to offer them something to talk about. Begin by bringing up subjects in which you know they are interested. You may want to ask a question or make a comment. Think before you speak. If you say, "Did you visit any one over the weekend ? or "Did you go to the market with your mother?", all the child con answer is yes or no. But if you say, ,'Tell me where you went over the weekend", you encourage him to begin to talk in sentences and give some information. Or "What did your mother buy in the market this weekend ?" encouragesa child to think and converse.

Show an interest in what children have to say. We want the children to talk; they are not interested or ready for lectures by your own topics which you have chosen. Drawing children out, knowing what to say to them and how to guide them takes a knowledge of the children, their interest, and a good relationship with them. It takes experience to develop skill in leading a group of young children intelligently to converse on a topic.

Who Wants Literacy ?

The District Education Officer got instructions from the State Government to try to get villagers interested in learning to read and write, so he asked the Block Education Officers to look into this. The fact is that the Central Government in Delhi is very eager to help everyone to learn so that there will be no more illiteracy in all of India. A big drive for literacy work is going to be launched all over the country from Gandhiji's birthday, October 2, of this year. So, the Block Education Officer of our Block went about to different villages talking with the headmasters, and the headmasters began talking with the villagers. The Block Education Officer naturally couldn't stay in each village long enough to talk with everybody. In fact, she couldn't even get to every village in the short time given to her. What she did was call a group of headmasters together in each of several larger villages.

In these meetings most of the headmasters said that they thought it would be very difficult to get illiterate villagers interested in learning to read and write. Some said they had already tried, without success, while most of them just felt that way. They said illiterate people are very dull and don't understand what use it is so read and write. The Block Education Officer, however, felt that people absolutely must become literate, so she decided to talk with some of the villagers herself. She took one of the more sympathetic headmasters with her to visit a few houses in the village where he taught. Here is the discussion that took place when they visited Ramniah.

BEO : Namaste, Ramniah, so this is your house. It looks quite neat and nice. Where is your wife ? Could we talk with both of you for a few minutes ?

Ramniah : Of course. Oh, Narsamma come here. The headmaster and a lady have come to see us. Bring us some tea.

BEO : Namaste, Narsamma. Now don't you bother about tea. I don't want you off making tea. I want to talk with both of you. Besides I want to visit a number of homes and I just can't drink that many cups of tea. Tell me, Narsamma, how many children do you have?

Ramniah : We have three sons. One is almost a man now. He helps in the fields. Then there is one about ten years old, and the baby over there.

BEO : What? No girls? Who is the little girl taking care of the baby?

Ramniah : Oh, of course, that's my daughter, and we have another older girl. We are trying to get her married.

BEO : Well, girls are also children, don't forget, and they are just as much of a blessing as boys, so you have five children. Now tell me, Narsamma, how old is your other daughter?

Narsamma : She's grown up, ready to get married.

Ramniah : She must be about fourteen or fifteen.

BEO : But don't you know that its against the law for a girl to be married before she is 18? She should be in school. Has she ever gone to school?

Headmaster : No, she never came to school, at least not since I've been in this village. The little one, there, came a few times after I talked with her father, but most of the time she's absent. So is the second boy for that matter.

BEO : Now I want Narsamma to tell me why her daughters don't go to school. Come, Narsamma, you tell me how you feel about it.

Narsamma : Well, neither of us can read and write, and when even the boys aren't learning, why should girls learn? Besides, I need them to help me, and they don't want to go to school anyway. Hey, Lakshmi, you didn't like shool, did you?

Lakshmi : (hesitantly) I couldn't understand what the teacher was saying. He always stood with his back to the girls and just taught the boys. And, then, I was at home a lot, and the others got ahead of me, so it got harder and harder.

BEO : I see. Well, it looks as if our headmaster will have to see to it that the girls are given attention too. Naturally the teacher must give them as much attention as he gives the boys. Now, Ramniah, what about your sons?

Ramniah : Well, the big boy never went to school. He's a lot of help to me. If he went to school he'd probably get to be a good-for-nothing like Maliah's son. That fellow went to school - wouldn't work after that, and finally went off to the city. My second son goes to school part of the time. The headmaster keeps telling me that he ought to be in school, so I don't mind when I don't need him in the fields.

Headmaster : That's just the trouble. He's out of school so much that he can't keep up with the class.

BEO : You see, Ramniah, you have to know yesterday's lesson in order to understand today's lesson. Children who only come part of the time find it more difficult, just as your daughter told us a few minntes ago. Now, if you could help your son with his school work, he could catch up and take an interest and learn a lot of useful things.

Ramniah : Me! Help my son! I don't know anything about those things—don't need to. I'm a farmer. I have a little land and part of the time I work for a big farmer here, and I know enough to make a living.

BEO : But you could learn more about farming, and about a lot of other things, too, like the new marriage law that tells you what age your children must be before you can get them married, and how to get loans at better interest rates.

Ramniah : Oh, people come here and tell us about a lot of things. Peddiah and Krishniah both know how to read, but they don't know any more than the rest of us do. We all sit together when people come here to tell us things. Sometimes I remember things that they forget.

BEO : Yes that's another problem, since most people in the village are illiterate we don't have enough educational programmes especially for literates. You see, no-one would need to rely on just remembering all the things that are told to him once if he had a little booklet listing all the points or if he could write down the ones he especially wanted to remember. If there were enough literate people you could get that kind of information system in the village. Then you could read your information again and again until you are sure that you have it right. We already have a 40-day course in health, nutrition and child-care for women who can read and write, and we could also have courses that would interest men.

Narsamma : Yes, Peddiah's wife can read and write, and she attended that course. She learned a lot of things, and she keeps telling me. But I can't remember all that she tells me. But I am doing some of the things - like feeding the baby some food besides my own milk, and keeping things cleaner so that the baby will be healthier. She said if I could read and write I could copy her notes, or maybe even take the course myself.

Ramniah : Is that so ? I wondered why things seemed better around the house now-a-days. Maybe we both ought to learn.

BEO : And that big son of yours, and your elder daughter, too: They certainly ought to learn. There are going to be special courses for boys and girls in that age group. They call it non-formal education. It is for teaching those who are too old to go to the regular school, but still want to learn. They can work and learn at the same time.

Ramniah : Wonderful ! I'll tell them about it. Say, I have to thank the headmaster for bringing you here.

Headmaster : Oh, that's nothing. Thanks for talking with us. I've learned a lot, too. By, the way, do send your younger children to school, both the boy and the girl. I'll see that they get the attention they need for catching up with the others in their class. I guess we'll have to be going now.

After the namastes all around, when the BEO and the headmaster were out of earshot of Ramniah and his family, the headmaster looked at the Block Education Officer and said, half in shame and half in joy : "I talked with Ramniah just yesterday and he didn't show any interest at all. Thanks for showing me how to go about this work."

BOOK-POST

PRINTED MATTER

(For Private Circulation only)

To

Sri/Smt. The Editor,
"Science for Villages"
No. 739, J U N
New Delhi (110 067)

With the best compliments of

Indo Dutch Project for Child Welfare & UNICEF
SOMAJIGUDA, HYDERABAD-500 004.

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NEWS LETTER

INDO DUTCH PROJECT FOR CHILD WELFARE

A monthly News Bulletin for parents of children of primary schools, balwadis, creches, Mahila mandals, local leaders and farmers.

Volume 2 | June 1978 | Number 1

Doctor, My Son Shivers with High Fever

(THE MOSQUITO, OUR MOST DANGEROUS ENEMY)

Of all the parasitic and infectious diseases one can think of malaria as the greatest primary or secondary cause of illness. It is counted among the ten major killers of tropital diseases. Today, it is considered one of the six most important infectious, parasitic diseases in the developing countries. Malaria affects the average age of people in the tropics. It has a negative effect on economic development.

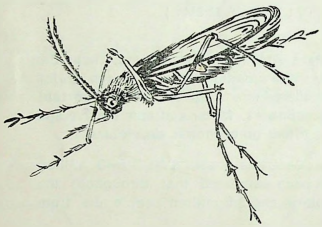
In 1972, the World Health Organisation (WHO) estimated that 1,840 million people live in original malarious areas. It has been estimated that throughout the world 50 million people become sick with malaria and 2.5 million people die from malaria each year.

The thought and sight of a snake frightens nearly everyone in the world. This is because their bite is poisonous. It can make people very sick, cause ulcers, and it can even lead to death. Yet, the number of people who die of snakebite is almost negligible when compared with the number of people who die from malaria. Over three quarters of the people living in malarious areas are **not** aware of the fact that the bite of the anopheles mosquito transmites the parasite (plasmodia) that causes malaria. The mode of life of the mosquito and the methods to prevent them are unknown.

Malaria is caused through the bite of the female anopheles mosquito. Yet the mosquito is not feared even if it is seen on walls, in homes or in the gardens. Due to this disease which is transmitted through the bite of the mosquito, more people die than through any other living creature God created. It should be considered the most dreadful animal. Unfortunately, it is almost considered a domestic animal, some times being more intimate with us than any of the usual house pets such as cats or dogs.

We sometimes sleep with them inside our homes. The noise they make in the evenings and the small bites on the legs, feet or hands are just taken for granted, happening as usual each night.

Mosquitoes lay their eggs in still water, or water that flows very slowly. Therefore, here, where it is warm throughout the year, and, where there are many swamps, uncovered wells, rain, puddles, empty tins, buckets, rain barrels or anywhere water can be found, mosquitoes can flourish. Male mosquitoes live by feeding on plants, while female mosquitoes need human blood.



To eradicate malaria destroy mosquitoes

Since we are living with these mosquitoes right in our dwelling houses, it is difficult to avoid contracting the disease. We must prevent them from entering our houses and prevent them from biting us whereever we go because they are our enemies.

Malaria eradication has been less effective, in our opinion, for the following reasons :

1) Very little attention is given towards improvement to health and sanitation in villages.

2) The high rate of illiteracy, and,

3) lack of community action towards improving environmental conditions.

The malaria parasite transmitted through the bite of the mosquito determines our average birth rate and reduces our life span. It also reduces our rate of economic growth by making people sickly and too weak to work harder. Consequently, it has a direct effect on our economic situation. Many of us can remember, with all of our good intentions of things we planned to do, if someone gets the fever that leads to shiverings, he will not be able to do anything. This is another vicious circle we are caught in that we must find a way out.

QUESTIONS :

The name malaria is common to almsot all people whether literate or illiterate because it is considered such a dreadful disease causing death.

Q—Where do mosquitoes come from ?

Q—How do they breed or multiply ?

Q—How do they enter our dwelling houses ?

Q—Where do they stay in our houses ?

It was estimated that 250 million people get ill from malaria in a year, and 2.5 million people die of this disease in a year. Surely you do not want yourself or your children to be victims of this disease.

Q—Can we make it a point of duty to try to wage war against our enemies, the mosquitoes ?

Q—Would it not be advisable to consult your Health Visitor, Gram Svasthika concering ways to prevent and treat malaria ?

It has been proved that use of sprays such as DDT, and other chemicals used to kill insects (insecticides), have not been very successful with mosquitoes. They have become stronger and developed other strains that are resistant to these chemicals.

Q—Is there any other method to control mosquitoes that would be more successful ?

Q—If our illiterate brothers and sisters know more about the causes and prevention of malaria,

could we make a joint effort to fight against this disease ?

One of the unproductive sectors of any population are the sick people. It is also an economic axiom that prosperity only comes when production increases. But the number of days one is sick particularly in malaria areas is very high.

Q—Are you prepared to accept a poverty status and low production rate to be the normal situation, as it is directly affected by the course of malaria and other parasitic disease ?

What can we do to combat Mosquito nuisance:

You must definitely make up your mind that the mosquito problem must be solved, not only you but members of your community must also resolve to annihilate the mosquitoes.

The most likely habitats of these mosquitoes are water-troughs. broken pots, gutters, barrels or anything that will hold water. The house drain and the cesspool also form breeding places for them — particularly if the sewage stagnates in them.

The average life of the mosquito is about two weeks. The mosquitoes should become rare within Two weeks after the destruction of their breeding places. If it is not so, it indicates that you have overlooked some breeding places.

Ordinarily the mosquito travels within one mile range. Therefore search all possible breeding places within the radius of a mile from your home.

You cannot abate mosquito nuisance by catching mosquitoes and killing them. It is neither practical nor economical. You must eliminate them at the source.

The best thing to do is to fill up the ponds and pools. Keep the drains clean and the cesspools emptied regularly to prevent stagnation.

Sealing of wells that are seldom used will help mitigate the nuisance considerably. If these are in frequent use, allow the workers of Medical and Health Department to enter the premises who will treat the wells once a week. If the wells are not used for any purpose. oil mixed with Keresone or readymade Malarial which is available in the market should be sprinkled or soaked in cotton waste and thrown in the disused wells. It will spread and form a thin layer on the surface of water and stop breeding of Mosquitoes. This should be done once a week.

In streams, a constant flow of water should be maintained by adjusting their levels. Vegetation that obstructs the flow of water, causing stagnation should be removed. Wet cultivation, with a mile's range around the city should be prohibited.

Co-operate with the Health Workers — Stop all sorts of stagnation of water. Avoid Mosquito nuisance.

Our Families

Children : Blessings or Burden ?

Nowadays there is a lot of talk about how many children a family should have. Some people say that two or three are enough. That idea is regarded as modern. Others says that the more children we have the more we are blessed. That is a traditional idea. The real question, though, should not be "how many", but "what kind?". Perhaps you think that this means whether one should have boys or girls,

but that is really completely unimportant if we are fair minded. What we are talking about here is the quality of our children.

Well, you may say, we can't determine either the sex or the quality of our children, so how can we decide anything but how many – and that too, only if we are willing to practice family planning ? Of course, it is true that we can't choose the sex of our children, but their quality is very much within our power to decide, and that is why the sex is less important. The quality of the child - how strong and large and intelligent it will be - is determined to a large extent even before the child is born, but not before you can do something about it.

The first point is the age and health of the mother. If a girl is old enough before she begins to bear children, and if there is time between pregnancies for her to regain her strength, she will bear healthier, bigger and stronger children. Also important is how she is looked after and what she eats. Both husband and wife - and the mother-in-law and father-in-law, too, in case the young couple is living with the husband's parents - should learn more about what a pregnant woman needs to eat, and what food, work, etc , she ought to avoid. They ought to learn the truth about these things from reliable people like the doctor and the health worker, and not go on believing old superstitions which often prevent a pregnant woman from getting the food that she needs for herself and the baby.

If these simple rules are observed they will do much to make our babies healthy and intelligent so that they will not be such a burden to us. That is not all, however, though it is the right way to start. Once you have a baby you must take very good care of it if you want it to become a blessing. While the baby is small it may seem like both a blessing and a burden. It is a blessing because it is healthy and happy, and because it holds out so much promise for the future. At the same time it is a burden because it requires so much care and also expenditure if it is to fulfil that promise. Many parents see the blessing but refuse to accept the burden. That is why things go wrong and the baby fails to become as much of a blessing as it could be.

Right from its birth we must see to the baby's health and safety. We must also give it companionship to make it grow into a happy, friendly child. Not only that, we must cultivate in it regular habits, right tastes, and a certain amount of independence and self-discipline. A baby must be protected in many ways. Follow the doctor's or the health visitor's instructions. Read and follow the helpful hints in the child health calendar. Do not leave a baby all alone. Above all, do not give it opium or other drugs to make it sleep when you want to go away from it. On the other hand, do not pick it up every time it cries, or it will learn to demand such attention. That way it be comes more of a burden than necessary.

In some ways children are to a family what fruit is to a tree. If you want good, ripe fruit, you will not pick the fruit while it is still small and green. If you want children to become useful, co-operative and successful adults, helpful to their parents and to others, and good citizens of their country, you will not expect them to work while they are still children, or get married before they are full grown. You will bear the burden of the child until it is full grown. Only then can it become a continuing blessing. Of course, children can help around the house, or even in the fields, to a reasonable extent. But this helping should be such as to teach the child helpfulness and develop his skills, independence and self-confidence. It should never interfere with his development, which requires play and study as well as work. In fact, play is the young child's work. Through it he learns to use his hands and the other parts of his body, his eyes and other faculties, and his thinking ability. The right kind of play is as necessary as the right kind of food. Parents should also do their utmost to see that their children attend school for as many years as possible, and that the young school goers get both assistance and encouragement with their school work. Finally, do not pick the fruit for marriage too soon. Your children should be fully ready for this momentous step before you thrust ir upon them.

We must also in this connection think especially about our daughters. It is quite wrong to think that only boys need an education, or that girls should be

married off as early as possible, before they get into trouble or before all the eligible boys have been snapped up by other girls' parents. If you bring up both your boys and your girls with the right attitudes there will be no trouble about unmarried daughters. Also, if you educate your girls they will be able to do a good deal for themselves and for you. They may even get jobs and earn their own money to provide the things they will need when they marry. Or they may, with those same earnings, help you and your other children. This is happening more and more nowadays. Far from something to be ashamed of, it should be a pride to parents to have daughters capable of earning at least a part of their own livelihood.

Perhaps now we can think again about that question of how many children we should have. Obviously, we should not have more than we can take good care of. We have no right to enslave small children and blight their lives just because these children are our own. The burden of good care continues for many years before the blessing can come, when our children return that good care. How much burden can you bear - especially all at once ? It would be better to give a gap of a few years between babies, so that the burden at any one time will not be too great on either the mother's attention or the father's income. Also, if you really try to take good care of your children over the years, your good sense will tell you when it is time to stop having children altogether. It's not a matter of being modern or traditional. It's a matter of looking at life in a mature, responsible way.

Primary School Education

(CURRICULUM RENEWAL)

In the year 1975, the Indo Dutch Project under its scheme of improving Primary School Education, conducted a survey of schools in Chevella Block and examined the existing curriculum in the light of the criticisms levelled against the curriculum. The survey was conducted in collaboration with the State Council for Educational Research and Training. The survey reports showed that the curriculum was not relevant to the needs of the pupils and their life situations and does not reflect the aspirations of the people and the national goals. For these reasons, the children were not attracted to the school and some of these who were in school, found nothing in it to sustain their interest and so they dropped out - even before they could complete the Primary Stage. To retain the children in school till they completed the primary stage, it was necessary to offer a meaningful and interesting programme of studies.

With these objectives in view, the curriculum was revised, and instructional materials were also revised and introduced in 1976 in Classes I and II of twenty selected schools, on an experimental basis. The experiment was extended to Classes III and IV in 1977.

In November, 1977 the State Council for Educational Research and Training, in collaboration with the National Council for Educational Research and Training organised a state level workshop on "Curriculum Renewal" sponsored by UNICEF, for revising the curriculum. The main objective of the workshop was to develop an innovative curriculum which is relevant to local conditions and needs and aspirations of the people.

As a prelude to developing a curriculum plan, a socio-economic and educational survey of the communities and schools in the regions proposed for implementation, was conducted. The conclusions arrived at were that the existing curriculum is not need based and is irrelevant to real life situations and that it does not reflect the aspirations of the people. Besides, it emphesises mostly the acquiring

of the '3 Rs' and does not help and retaining them in school.

In the light of these criticisms, the workshop examined the curricula and the instructional material prepared by fhe National Council for Educational Research Training, the Government of Andhra Pradesh and that which are in force in the selected schools in Chevella Block; under the Indo Dutch Project scheme of improving education in primary schools, with a view to revise the currlculum and the instructional materials.

As the Indo-Dutch Project's efforts in this direction had already produced a curriculum revised according to the basic objectives of primary education set forth by the State-level workshop, and the instructional materials have also been revised and prepared and are in use in the schools in Chevella Block, it was decided to keep the same curriculum and instructional materials as base and make necessary changes by way of revision.

The workshop examined this curriculum in Mathematics, Environmental Studies for Classes I and II and Social Studies for Classes III and IV and adopted the syllabus completely except for recasting the syllabus in each unit into major and minor concepts; with related activities. In General Science for Classes III and IV, no changes have been made except recasting the syllabus into major and minor concepts. In first language (Telugu), Health Education and Work experience Projects, the same syllabi have been adopted completely.

This revised curriculum will be introduced under 'Project Curriculum Renewal', in thirty schools of the State of Andhra Pradesh by the State Department of Education, from June, 1978. The project will continue the experiment, of the revised curriculum and the instructional material in the 20 selected schools of Chevella Block at the same time.

The Department of Education and especially the State Council for Eductional Research and Training, have been extremely interested in this experiment of primary school improvement programme. In the short time that the revised curriculum has been introduced, there is evidence of interest on all sides i.e., the students, the teachers, the local community as well as the trainers from the concerned Departments. This scheme has a wide perspective, covering areas that could strengthen and improve the quality of primary school education. Training of teachers, improving physical facilities, establishing school gardens as a means to provide incentives to teachers and students, providing small libraries for the primary schools and contacting the community with regard to the significant features of this new scheme through local meetings and newletter, it is hoped that significant changes can be forthcoming in the near future.

As merely revising the curriculum is not sufficent to improve the quality of Primary School Education, the Project has attempted to improve the other factors that have a direct bearing on this problem, such as improving the quality of teachers, providing suitable teaching material, and teaching aids, demonstrating techniques of teaching, providing spot-guidance and supervision and improving the physical facilities of the school. In addition to these, one of the basic problems is getting the teachers interested in the village, the perents and the community, which is possible only if the teachers reside in the village. To attrect the teachers in this direction it would be necessary for the community to come forward and provide suitable accommodation in the village for the teachers and their families. In many cases teachers do not reside in the villages due to lack of accommodation and assistance from the community in this regard. Another important factor is to provide work-oriented projects according to the revised curriculum. A new experiment is being tried out by the Project in this connection which is the establishment of school gardens according to a definite plan through which the teachers and students could benefit in several ways.

The selected schools in the Project area are being equipped with a fence and a bore-well wherever adequate land is available in the school premises. The 20 villages have been surveyed by the Consultant of Agriculture from this point of view. Eleven have been selected where plots of land with water facilities can be available. Programmes of training in cultivation of vegetables,

nutritive food values, crop rotation, cultivation of leafy and seasonal vegetables, common pests and their control, preparation of soil, application of fertilisers, irrigation, sowing, weeding, spraying, etc., will be organised at each of these selected schools both for the teachers and the students.

A definite plan according to the texture of the soil will be drawn up in consultation with the teachers and students. This plan will provide all the necessary operations of cultivation giving exact quantities of inputs along with a calendar of operation. The plan will also work out the estimated cost per plot including the details of each input as well as the estimated yield and the gross and net income based on the market price in order to get the teachers more directly involved. To take up this responsibility a new experiment is being tried out to get the teachers to invest a small portion of the cost involved. When the crop is ready the produce will be divided into three parts – $\frac{1}{3}$ for the teachers, $\frac{1}{3}$ for the srudents, and $\frac{1}{3}$ to be utilised as a revolving capital. The Consultant of Agriculture of the Project will provide the necessary expertise by visiting these plots on a regular basis. In this way the teachers and the students will be able to get more practical knowledge with regard to the cultivation of vegetables as well as nutrition education.

UNICEF has come forward to collaborate with the Indo Dutch Project in this experiment by providing pumps, fences, tools, equipment, etc., for the selected schools. So far two plots have already been fenced at Tadlapally and at Maharajpet where pumps have also been installed. The teachers have agreed to implement the plan drawn up for this purpose by their active participation.

Creches in Urban Project

(KABOOTHAR KHANA & SWAMI VIVEKANANDA NAGAR)

Two Creches were started in the Urban Project situated in Hyderabad City in Ward 20, Block I and II on the same basic objectives as the Rural Project. Children in the age group of 1-2½ years have been admitted to creches in Block I and Block II. It was felt that it is safer not to include children below one year for several reasons. The main object of providing a creche for this age group in the chain of activites is to help and improve the nutritional and health status of the children and at the same time use them as tools to educate mothers in child rearing practices, nutrition, health and hygiene. Preference has been given to children of the lower socio-economic group and especially of working mothers. In this way, creches could also contribute towards building up a systematic and conducive health status in the community by reducing the incidence of mortality, morbidity and malnourishment.

The first creche was inagurated on the 3rd June, 1976 at Block I and the second on the 2nd November, 1976 at Block II. Before starting the creches a training programme for creche mothers was organised where 29 local women participated in the course. The local mothers were trained in all matters connected with the running of creches such as, the advantages of having your child in the creche, necessary hygiene and sanitaion to be maintained at the creche; methods of cooking simple, cheap and nutritious diets for the children; problems of weaning; type of weaning food; prevention and care of common ailments; child development; importance of play; story telling; songs and preparation of teaching aids and play material. The course was very interesting to the participants because most of it consisted of demonstrations practicals and work experience in the two creches such as, bathiug the children, cooking food, playing and cleaning the creche.

Creche I had a strength of 27 children i.e., 12 boys and 15 girls with an average daily attendance of 23 children. Creche II had 30 children, 11 boys and 19 girls with an average daily attendance of 24 children. Fourteen children who had reached the age of 2½ years were transferred from the creches to the respective balwadis. The diet pattern for the children has been designed by the Nutritionist from the College of Home Science according to the needs of the growing children. They were given 100 ml. of milk on an average per day, per child, in addition to vegetable soup, rice kichedi peanut chekki as

well as eggs and fruits once a week. This diet has costed us 46 paise per child, per day. Regular health check-ups by the health staff with total immunization, has helped the children to grow and develop as normal children inspite of their handicaps while being admitted Two local mothers cook the food for these children and take care of them during the whole day they also maintain regular records to note the progress made in health. The local parents have realised their responsibility of sharing in this experiment. According to the objectives and the Project the local community are gradually taking over the running of these programmes themselves, by their own local women and contributions. It is very encouraging to note that the parents have appreciated, the advantages of these creches and are contributing Rs. 3/- per child, per month which is being used for the payment or remuneration to the mothers and cost of diet for the children.

The children admitted to Block I are from the weaker sections – 68% from the Pardhi Community – 32% from the Harijan families. The Municipal Corporation of Hyderabad has alloted its building situated in Pardhiwada for this purpose. In Block II the local community has come forward to provide accommodation for the creche. 14% of the children at Block I and 28% of the children at Block II are from families whose monthly income is less than Rs. 200.00. 68% of the children at Block I and 48% at Block II are from families whose income is between Rs. 200 to 400 per month. The balance are from families with an income from Rs. 400 to 600. But parents of this income group are contributing a much higher rate to the creche.

The standard of health of the creche children has improved due to the tender care given by the mother teachers and the health check-ups by the medical staff. Children have shown marked improvement from stages of high malnourishment. These creches have proved to be an effective tool to educate the mothers in child rearing practices, health and sanitation. One of the significant achievements of these creches has been the bridging gap between different sections of the community and bringing children of different classes together which can be very significant to imbibe a feeling of togetherness in the children at a tender age.

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BOOK-POST

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Urban Indo Dutch Project for Child Welfare

(STICHTING NEDERLANDS KINDERHULP PLAN)

CONCEPT - POLICY - STRATEGY
AND
IMPLEMENTATION

1977

Urban Indo Dutch Project for Child Welfare

INTRODUCTION

The Urban Project of the Indo Dutch Project was planned with a view of making a comparative study between urban and rural programmes in terms of utilisation, participation and continuation of services by the people. The experience gained from the rural project in Cheveila was the basis in planning a comprehensive approach in a more scientific way by avoiding some of the earlier pitfalls. The co-operation from voluntary agencies, State Departments and the Municipal Corporation of Hyderabad has been treated as an essential feature. From the very early stages of designing and planning the policy and strategy of the Urban Project for Child Welfare, the above mentioned agencies were consulted. Several discussions and interviews were held with the heads and representatives of the Municipal Corporation, Department of Health and Family Planning, Gandhi Hospital and Gandhi Medical College, Department of Industries, Director of Youth Services, Department of Social Welfare, College of Home Science, Nizamia Women's Education Centre, UNICEF, CARE, Rotary Club of Hyderabad, Youth Organisations and other agencies to whom copies of the draft proposals were sent in advance for scrutiny and changes if any. A five day old workshop was conducted in April 1975 with the main purpose of providing an opportunity to the departments and agencies concerned to critically examine the draft proposals before they were fully accepted.

Seven blocks from the old city of Hyderabad near Puranapul at Kokaki Tatti, were selected in consultation with the Municipal Corporation of Hyderabad. These 5 blocks of Ward No. 19 and Block 1 and Block 2 of Ward No. 20 have 11,171 households and a population of 57, 157.

The Bureau of Economics and Statistics conducted a survey to have a closer look at the necessary statistical information of households religion, age-wise distribution, population of school going children, type of economic activity etc.

The following plan for sharing of costs and responsibilities between the different agencies was agreed upon in the following pattern for the first year.

Indo Dutch Project for Child Welfare	Municipal Corpn. of Hyderabad	States Departments	Voluntary Agencies	Local Contributions
60%	10%	10%	10%	10%
Research Training Evaluation Construction Equipment	Building Land Personnel	Personnel Drugs vaccines	Nutritional input equipment Personnel	Services

In the subsequent years, the sharing pattern will change. The contribution from Municipal Corporation of Hyderabad, State Departments, Voluntary Agencies and Communities will increase while the share of the Indo Dutch Project will proportionately decrease and finally phase out in a period of 8-10 years.

Mere statistical information of the area would not be sufficient to implement a programme. Hence, the profiles of the selected area to examine the existing situation were prepared. A group of eight community organisers and social workers collected information about families, existing institutions, health and educational facilities, civic organisation and the pattern of leadership existing in the area.

The community organisers and social workers were given an orientation training with the help of a set of questions and answers. This enabled them to hold a dialogue with the community and explain the families the basic objectives of the Project.

As decided in the workshop and in accordance with the basic policy of the Project it was necessary to get details of willingness or otherwise of the families to participate in the plans before implementing them.

The set of questions and answers given in the following pages also give in a nutshell the basic objectives and philosophy of the Project schemes.

H. W. BUTT
Director

AREA TO BE COVERED

WARD NO. 20, BLOCK NO. 1

Name of the Localities :

1. Behrupia Galli
2. Johari Galli
3. Kokakitatti
4. Gollakhidiki
5. Bhagyanagar
6. Pardhiwada
7. Shiv Nagar (Puranapul)

WARD NO. 20 BLOCK NO. 2

1. Kabutar Khana
2. Golla Khidki
3. Hussaini Alam
4. Sukhmeer Kaman
5. Shibli Gunj

WARD NO. 19 BLOCK NO. 1

1. Umda Bazar
2. Dood Bowli
3. Maharaj Gunj
4. Chatakni Pura
5. Bondal Guda
6. Golla Khidki
7. Bahadur Pura
8. Devibag

WARD NO. 19 BLOCK NO. 2

1. Dood Bowli
2. Kamati Pura
3. Misri Gunj
4. Tad Ban
5. Gulshan Nagar
6. Bibi Gunj
7. Fateh Darwaza
8. Moin Pura
9. Kala Pathar
10. Chandulal Baradari Colony

WARD NO. 19 BLOCK NO. 3

1. Jahanuma
2. Gazi Banda
3. Fatima Nagar
4. Ottapalli
5. Shamsheer Gunj

WARD NO. 19 BLOCK NO 4

1. Hussaini Pura
2. Kishan Bagh
3. Mahmood Nagar Colony
4. Kondareddi Guda
5. Zoological Park Colony

WARD NO. 19 BLOCK NO. 5

1. Bahadur Pura Colony
2. Nandi Muslai Guda

TABLE 6:1 DETAILS ABOUT WARD 19 (ALL 5 BLOCKS) AND WARD 20 (I & II ONLY)

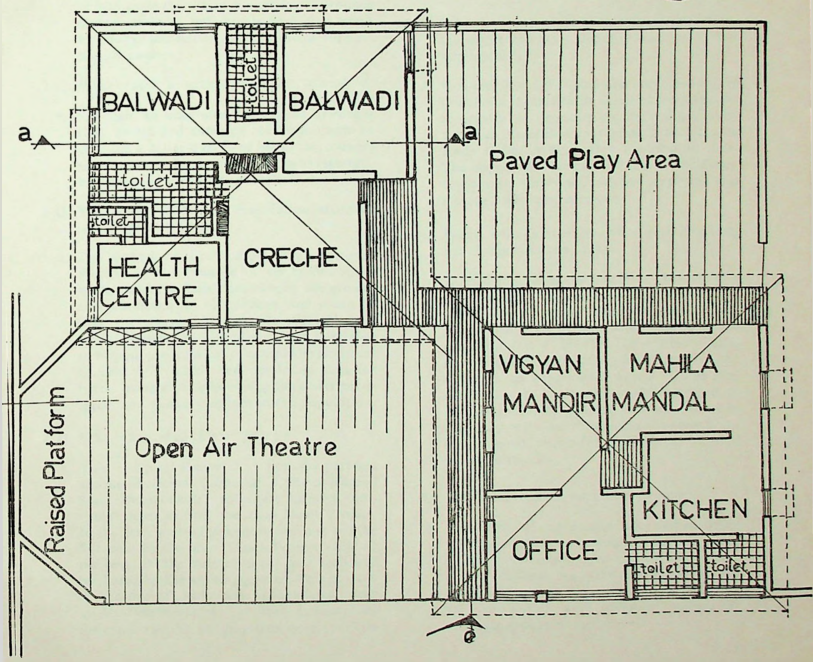
	Block I	Block II	Block III	Block IV	Block V	Total	Block I	Block II	Total	Grand Total
1. Total population	11,182	16,781	13,411	1,953	1,929	45,256	5,669	6,232	11,901	57,157
2. No. of families	2,222	3,251	2,632	389	405	8,899	1,111	1,161	2,272	11,171
3. Average size of family	5.03	5.16	5.1	5.02	4.76	5.09	5.1	5.37	5.24	5.12
4. Literacy rate	52.47%	44.98%	41.95%	32.00%	42.30%	45.26%	37.87%	63.89%	51.56%	46.56%
5. No. of families :										
Hindus	1,242	527	520	82	300	2,671	824	612	1,590	4.261
Muslims	947	2,711	2,101	305	99	6,163	276	530	997	7,160
Others	33	13	11	2	6	65	11	19	40	105
6. Acceptance of plans *										
Health	1,411 (2222)	1,857 (3257)	1,373 (2632)	230 (389)	225 (405)	5,095 (8899)	788 (1111)	739 (1161)	1,527 (2272)	6,622 (11,171)
Creche	509 (987)	733 (1513)	495 (1214)	81 (174)	49 (146)	1,867 (4034)	260 (461)	273 (493)	533 (954)	2,400 (4988)
Balwadi	699 (1225)	1172 (1973)	768 (1587)	95 (251)	76 (204)	2,810 (5240)	473 (687)	507 (678)	980 (1365)	3,790 (6605)
M. Mandal	1,222 (2486)	1,305 (3625)	800 (2780)	138 (411)	110 (405)	3,575 (9709)	689 (1338)	916 (1503)	1,605 (2841)	5,180 (12,550)
Youth club	169 (1601)	162 (2074)	144 (1642)	13 (212)	15 (275)	503 (5804)	79 (668)	204 (879)	283 (1547)	786 (7351)
Not willing	288	427	556	72	94	1,437	146	59	205	1,643

* NOTE : Figures in the brackets indicate the total No. of eligible families / children / persons for the respective plans as described in the following pages as against their acceptance indicated by the above corresponding figures.

INDO - DUTCH

PROJECT FOR CHILD WELFARE

COMPOSITE UNIT FOR 1000 FAMILIES



POLICY - STRATEGY - PLANNING

1 Q. What is the basic policy of this project ?

A. Overall development of the child and youth while focussing attention on the age group of 0-16 years the basic policy is to produce ultimately ideal individuals healthy in mind and body, self-reliant and capable of supporting themselves.

2 Q. What exactly does the Project wish to achieve?

A. Through an integrated programme of education, health and nutrition the Project aims to promote a better quality of life in the younger generations to produce good citizens responsible to society and to themselves.

3 Q. Why is the Netherlands Foundation interested in a Project of this kind ?

A. The Netherlands Foundation, which has been created at the instance of the Queen of the Netherlands, aims at assisting in the growth and development of children and youth all over the world. The people of the Netherlands, through the Foundation, are interested in helping programmes of overall development of the child which can create an urge for better living especially among the under privileged and weaker sections of the population.

4 Q. Who is financing this project ?

A. This is a pilot Project in which the partners are-the Municipal Corporation, the concerned State Departments, voluntary agencies, individual families and the Indo Dutch Project. In the first year 60 percent of the cost will be financed by the Indo Dutch Project while 40 per cent at the rate of 10 per cent each will be shared by the above agencies. This pattern of sharing of costs will change each year as the participation of the communities increases and as programmes develop. The share of the families as well as the role of the agencies will also increase each year when the Project will phase out completely in a period of 8 to 10 years.

5 Q. What is the role of the Municipal Corporation, the concerned State Departments and voluntary agencies ?

A. To share in the planning and implementing of practical and community oriented programmes: to provide the necessary inputs and gradually takeover items that are successful that can be made self-propelling over a period of time. The inputs will consist of land, buildings, equipment, personnel, technical expertise and finances, wherever necessary.

6 Q. What is the area of operation and how long will this project continue ?

A. A contiguous area, preferably a Ward will be selected with a population of 50,000 to 55,000 within the Muncipal limits of the city of Hyderabad. To bring about changes in the community it is felt that the Project should have a duration of nearly 8 to 10 years. The object is to experiment with a sizable area which can be controlled and supervised by regular staff. An impact can be created in this way with an intensified approach to obtain good results for replicability in other Wards of the city.

7 Q. Will this project cover all age groups ?

A. The focus of all programmes and activities will be on children and youth in the age group of 0-16 but this will also include the parents of the children and the members of the community. Other agencies and the Municipal Corporation have plans to include the older age groups as well.

8 Q. How for will the views of the leaders, families, and individuals be accepted in the planning of this project ?

A. One of the basic principles of the Project is to involve the families in the process of planing, to obtain the views and suggestions of the leaders of the communities. The enphasis is on a democratic approach where the families will be free to accept, reject or modify the plans before any programme is implemented. No programme will take off unless and until there is sufficient response from the community which is the basic factor to sustain the programme.

9 Q. Why does not this project help the poor without asking for any contribution from them when the Government and the Netherlands Foundation are coming forward to help the people ?

A. As the Project aims at helping individuals help themselves to become self-reliant, charity will not be conducive to achieve this objective. Emphasis will be given to lower socio-economic groups if they are prepared to come forward with their mite in whatever shape and however small it may be so that there is feeling of partnership between the community and the Project. In this way the younger generation will grow and develop and learn to stand on their own feet without being at the receiving end for hand outs thus becoming more and more dependent in the long run.

10 Q. What do you mean by participation of individuals and families ?

A. Participation means taking active part in the programmes at any level; this can be done in several ways-by contributing personal services; sharing the costs or providing items necessary for programmes, attending classes. demonstrations etc.

11 Q. What kind of voluntary agencies will be in this project ?

A. Voluntary agencies that share the basic concepts of the Project and are ready to collaborate with the Project by providing basic inputs like nutrition, equipment, personnel and other essentials required for the implementation of the plans.

12 Q. Why has this ward been selected ?

A. The criteria of selection is that the Ward should be fairly representative in character. Your Ward has been proposed by the Municipal Corporation as it fits in with the set criteria but the ultimate selection will depend upon the response and willingness of the communities in the Ward. Two other Wards are also being examined in the same manner. The final decision will depend on the proportion of families that accept the programmes suggested.

13 Q. Why should you not concentrate on the lower socio-economic or slum population alone ?

A. The Project aims at all income groups so that a feeling of community living could be encouraged where give and take could become a common feature. For a long term Project children of all communities and all economic groups need attention in the areas of health, education and nutrition.

14 Q. Why not start programmes immediately in areas where people are ready all over the city instead of concentrating on one ward?

A. The Project aims at an integrated approach where overall development is the main objective. Programmes will have to be taken up for all aspects connected with the growth and development of the child. In order to measure results for replicablility it is advisable to concentrate on one specific area which will make it easier to supervise the services, the participation of families and assess the effectiveness of the various programmes. Instead of dispersing these attention on a wider area it is better to focus attention in a limited area to produce results that could be multiplied in other Wards as well by various departments and organisations:

15 Q. How will this project help in developing self-reliance among the people ?

A. By involving local youth and leaders at every stage in the programmes which is one of the main fundamental principles of the Project. By identifying functional leaders and encouraging youth to come forward to take part

in programmes for which they are qualified, the community can become more self-reliant and be able to stand on its own strength over a period of time.

16 Q. Why do you want voluntary organisations to be part of the project ?

A. The partnership of various agencies and voluntary organisations will help in designing and streamlining activities that could sustain themselves in the long run This pilot Project can provide guidelines to voluntary organisations that form part of the Project. These organisations can then repeat such programmes in other areas as well in the State or even in different parts of the country. As the objective of the Project is comprehensive and far reaching and cannot be achieved by any single agency it is better to involve such voluntary agencies that have the same kind of objectives so that together it would be easier to reach the goals.

17 Q. What are the new methods and techniques that will be introduced to improve the effectiveness of the existing services ?

A. Emphasis will be given to improve the efficiency by organising specific training programmes. All categories of personnel working in the different schemes will be trained to develop special skills. Their area of operation, job functions and responsibilities will be spelled out clearly. Necessary equipment will be provided to them: Specialists will be used to guide and supervise the workers. A system of reporting will be designed for periodic assessment of the work done. Regular workshops and conferences will be held for the workers, trainers and specialists to review the existing methods and adopt new techniques to improve efficiency.

18 Q. What kind of training will this project give and for what purposes ?

A. All types of training can be arranged by the Project with the help of concerned departments but these will depend on the types of workers and their requirements. Training programmes will be arranged for youth clubs and mahila mandal members in areas of their special interest. Training will cover leadership, citizenship, management and specialised skills for specific trades and cottage industries etc., adult literacy and any other area the community or group would require.

19 Q Will the economic condition of the people improve ?

A. Although a sound basic educational programme is the dominant feature of the Project, efforts will be made to introduce schemes that aim at improving the economic base of the families. Elaborate production plans to provide relief on a large scale is not the main consideration, although such efforts will not be discouraged if initiated by other agencies. Training skills and trades will improve the earning capacity of the people thus supplementing their existing incomes or providing them job opportunities.

20 Q. As poverty is the basic problem of many families why not concentrate on improving economic conditions alone without bothering about health and education ?

A. Poverty is part of a vicious circle, If poverty has to be eradicated on a long term basis other aspects of human life related to education, health and nutrition have to be taken care of simultaneously. If the families understand the basic philosophy of the Project of an integrated approach and participate effectively in some of the schemes the ultimate result would definitely be the improvement of the quality of life, which would be a more effective method of tackling poverty.

21 Q. How are you going to educate the illiterate masses regarding the benefits of the project ?

A. Several steps are being taken in a scientific manner to educate the families in the proposed area. After collecting the detailed information about the number of households, agewise distribution, religion, educational level, family size, existing facilities in education and health, the following steps are being taken to get the families acquainted with the design for education, health and nutrition.

1. A detailed study of the existing facilities of the proposed area by qualified community organisers.

2. Simplifying the plans to explain the benefits that the families can derive by joining the scheme and the kind of participation expected from them.

3. Discussions with local leaders, heads of families, heads of institutions to explain the objectives of the Project.

4. Consulting the local families regarding their views about the plans.

5. Incorporating the suggestions from the community for changes or amendments in the plans. Preparation of visuals, leaflets to explain the details of each plan.

6. A dialogue to be undertaken by lady volunteers with the families and institutions to help the women understand the implications of each plan and to explain their role.

7. Ample opportunity will be given for individuals and families whether literate or illeterate to get a clear understanding of the proposed plans in order to register their reactions and responses.

22 Q. What will happen to the efforts that are already being made by the other voluntary agencies ?

A. Before the proposed plans are implemented interested voluntary agencies and those already working in the area will be invited to cooperate in a common programme so that overlapping and duplication can be avoided. Programmes and activities in this way could be streamlined if they have the common aims and objectives. Voluntary agencies that have already initiated schemes with the same objectives will be encouraged and strengthened so that they may be capable of continuing on a long term basis.

23 Q. How will the families stand to gain by enrolling themselves in the schemes ?

A. In each scheme the benefits that the families will derive have been spelled out. For example in the integrated health assurance plan if a family becomes a member by paying 10 per cent of the total cost they will get specific benefits of quality service through an ANM who will make home visit under the guidance of a health visitor with periodic checkups by a doctor. The advantages of this scheme include total immunization for the family, domiciliary services for deliveries, treatment of minor ailments, demonstrations and advice in health education, environmental sanitation and family planning. Similarly there are specific benefits that will accrue to those enrolled as members of mandals, youth clubs, creches, balwadis etc.

24 Q. Why not give attention to the basic needs of the community such as drainage, water supply, electricity and housing which need the highest priority ?

A. The Project aims at helping the people to improve themselves. The main emphasis is human development that is to improve their knowledge and skills. There are other agencies such as the Municipal Corporation that takes care of the above basic needs. One of the major problems faced is that communities do not take up the responsibility of using these facilities in a proper way. If such a feeling of community responsibility could be developed the cooperation of the concerned agencies can be sought to provide the necessary requirements for such communities.

25 Q. Why should there be so much attention on education in this project when there are adequate number of private and gevernment schools ?

A. With the increase in population it cannot be said that the existing schools are adequate to cover the demands of the school going children. The Project not only aims to supplement these efforts but also to help in improveing the quality of education in the primary schools through the department of education. Programmes initiated by the Project will aim at an allround education for those in school and out of school. Programmes will include coaching classes to tutor the weak students in schools: to teach literacy and numeracy to those out of school and provide opportunities of learning trades and vocational education to the older youth. Different types of educa-

tion both for the literate and illiterate individuals will be started which is not covered by the educational institutions.

26 Q. How will local agencies be involved in the programmes of this project ?

A. Local agencies that are interested in the proposed plan and are already working in this direction will be directly involved by giving them the necessary inputs to improve their efficiency and skills. Other agencies that would like to join in the programmes could be invited to discuss and plan their roles in specific programmes.

27 Q. Will there be any continuity of the programmes initiated by the Project ?

A. Repeatability and continuity are some of the fundamental principles of the Project. No programme will be initiated unless it is possible to be repeated in other areas and unless its continuity can be assured. It is for this reason that while planning and designing programmes the role and sharing of costs between the Municipal Corporation, the State departments, voluntary agencies and individual families have been clearly spelled out. Each year according to the progress of each programme the responsibilities and continuation of the agencies and individual families will increase while the share of the Indo Dutch Project will gradually decrease till it completely phases out after period of 8 to 10 years.

28 Q. What role can local leaders play in making the programmes more effective ?

A. Local leaders play a major role in the programmes of the project. Efforts are being made to identify genuine and functional leaders who can make the programmes effective. More emphasis will be given to developing local youth and leaders through training and by providing necessary skills. It is through leaders that the programme can become more effective and self-propelling after a period of time.

PLAN NO. 1

PRESCHOOL CHILD EDUCATION

1 Q. Will the balwadis (nursery school) prepare the children for primary school education ?

A. Yes, but in addition to this the main objective of the balwadis to help the children to learn simple factors of cleanliness, hygiene, health and discipline to create a spirit of working and playing together and influencing the parents through the child in health education and nutrition.

2 Q. Is it necessary for a child to be exposed to a balwadi before seeking admission to the primary school ?

A. It is not always necessary for the child to be exposed to a balwadi before being admitted to a primary school but nevertheless it is a great advantage as the child has better opportunities of learning through recreation and informal education which develops the right attitude for primary school education.

3 Q. Why don't you take children from the age of 2 in the balwadis ?

A. Normally children are admitted to balwadis from 2½ to 3 years upto 5 years of age. Below this age group the children can be admitted in the creche which would be more useful especially with regard to nutrition and health.

4 Q. What specific advantage will our children derive by enrolling themselves in your balwadis ?

A. Apart from informal education and forming of healthy habits and developing the right attitude to learning children will be given a supplementary nutritious midday meal which will reduce the high degree of malnutrition causing the high frequency of infection among the preschool child. With total immunization and regular health checkups the child will have an opportunity to live in a healthy atmosphere and acquire a good start in life. There will also be carry over of improvements from the child to the family.

5 Q. Will the children be taught how to read and write?

A. It is not advisable to burden children with reading and writing at an early age of 2½ or 3 years. Indirect methods of recognising letters and numbers etc. will be introduced. Before the child leaves the balwadi it will acquire some knowledge of reading and writing but this will not be the main focus of the balwadi.

6 Q. Will you take up the responsibility to get admission of the balwadi children into the primary schools?

A. As far as possible children who have reached the age of 5 will be sent for admission to the nearby primary school. Assistance no doubt will be given to such children by the teachers but the balwadi will not take up the responsibility as such.

7 Q. Are the balwadis limited to only recreation and games or do the children actually learn something?

A. Learning takes place through recreation, games and informal education at the preschool stage, The child will definitely learn many important things connected with health, nutrition, cleanliness, exercise, songs, and poems-knowledge of animals, birds and plants and many other items that could be taught to the child in a simple but effective way.

8 Q. What exactly is the aim of a balwadi?

A. The balwadi aims at helping children to develop and grow in a healthy situation. Children learn many basic things connected with their surroundings, the homes and environment. The balwadi is also used as a tool to educate parents to give better care to their children, to stress the need for a better nutritive diet and to show how to achieve this from locally available ingredients. In general the balwadi aims to equip the children with everything that is necessary to encourage better quality of students to the primary schools.

9 Q. Why do you insist on sharing of costs by the parents to run the balwadi when funds are made available from different agencies?

A. The main object in insisting on sharing in any form is to create a feeling of partnership between the parents and the Project. Although the contribution of the parents in running the balwadi is nominal when compared to the actual costs per child, it is hoped that gradually the parents and the community will realise the importance of such balwadis and establish them whenever necessary. It is hoped by this partnership that the parents will take up greater responsibility of the different aspects of the balwadi. In this way a community will be developed and all children in the community will be benefited by such institutions that can prepare their children for a new and better life.

10 Q. What kind of diet will be provided during the midday meals and how will this be more nutritious?

A. The midday meals are designed by specialists in food and nutrition. It is not full meal but a supplementary diet. It aims to improve the nutritions intake of the balwadi children by using cheap and locally available ingredients that can be made into a palatable balanced diet. A variety of recipes have been suggested and will be used with different menus each day consisting of pulses, food grains and green leafy vegetables.

11 Q. Will you provide facilities for the children to be brought to the balwadis from their homes?

A. As far as possible balwadis will be situated in a central location of the community itself. It will not be possible for the balwadi to provide facilities to pickup children from their homes unless the parents themselves are willing to contribute towards this facility if and where it is necessary.

12 Q. What will be the language in which children have to talk?

A. The language or medium of instruction will depend on the requirement of the community. By and large two languages will be used but the teachers will have to be trained in the medium of instruction that the parents would desire, Teluge, Urdu, English or Hindi

13. Q. How can poor parents afford to share the cost of the balwadi ?

A. It is for this reason that cash alone is not insisted upon from parents although the amount is very nominal in comparison to the total required per month to run a balwadi. On diet alone an amount of 50 paise per child per day will be spent in addition to salaries, equipment rent etc. Alternatives for this contribution have been suggested in the shape of services or kind. Mothers can contribute by assisting in the kitchen or as a helper to the balsevika or work as a balsevika herself if she has the necessary qualifications. Arrangements for training will be provided by the Project if she has the minimum educational qualifications.

14 Q. What will be the role of the mothers in the balwadi ?

A. Mothers will be invited and encouraged to gradually take up more and more responsibilities in different aspects of the balwadi until they reach the stage of managing balwadis themselves. A committee will be formed of four or five mothers who can supervise and or cook the midday meal. Mothers can effectively participate in programmes of nutrition education. The balwadi can well provide a practical training ground for the mothers where they can learn how to give better care to the children not only from the psychological point of view but also for better health practices and nutrition.

15 Q. Will there be any arrangement to take care of the health of the child ?

A. Yes, the health of the children will be part of the responsibility of the balsevika as the balwadi will be included in the integrated health assurance plan of a composite unit with a systematic procedure for the children to be checked periodically by the ANM, the health visitor and if necessary the doctor who will supervise this unit on a regular basis. The balwadi will be visited periodically by the above health staff not only for health check-ups but also to give the children opportunities to learn about the healthy practices, cleanlines better food habits and all items connected with health education.

16 Q. What kind of children will be selected for admission to balwadis ?

A. Willing parents who are prepared to participate in the programme; preferably children pertaining to the lower socio economic group, working parents who have no assistance at home and physically handicapped children if they are not mentally retarded.

17 Q. Is there any special epuipment that will be used for those balwadis ?

A. Yes the whole set of equipment necessary for the balwadi will be supplied after receiving technical guidance and help from specialist agencies. As far as possible local epuipment prepared by mothers and members of the mahila mandal will be used. It is not the purpose of the Projeet to encourage sophisticated teaching material that is not applicable to local conditions. Experiments will be made to utilise simple items that can play an important part in the education of the children.

18 Q. How many children will be enrolled in each class and how many teachers will be responsible for the balwadi ?

A. It would be proper to have 25-30 children in each balwadi under one trained nursery teacher with one helper. The supervision of the balwadi in the composite units will be organised by the staff of a specialised institution.

19 Q Will the children have any choice regarding their food requirements ?

A. The diet will be planned according to the locally available ingredients catering to the local taste. The menu will vary to provide a choice to the children.

PLAN No. 4

INTEGRATED HEALTH ASSURANCE PLAN

1 Q. What is the basic objective of the health assurance plan?

A. The integrated health assurance plan is designed to provide comprehensive health care especially to children below 5 years and pregnant and lactating mothers through health education and emphasis on preventative measures. The scheme aims to educate the family as a whole to adopt improved standards of health. By providing quality services at home efforts will be made to reduce the need for the family to visit hospitals or depend on the services of a doctor for minor ailments. Families will be taught to take remedial and preventive measures themselves as far as possible. Although families who enrol themselves in the plan (by contributing 10 per cent of the total cost that is Rs 20/- per family of 5, per year) will receive direct stipulated services, the neighbours will also benefit from the educational aspect of the plan. Through a process of diffusion the entire community will benefit either directly or indirectly.

2 Q. What do you hope to achieve in the implimentation of this plan ?

A. If the plan is fully implemented we hope to achieve a better standard of health in the children and mothers by reducing the incidence of mortality; and morbidity, malnutrition to improve the nutritional and health status of the family with better environmental sanitation and an improved dietary patterns to reduce the incidence of disease and encourage spacing and small family norm,

3 Q. How will the services provided under this plan differ from the regular services of the Government hospitals ?

A. The services provided in this plan would comparatively be of better quality as a trained ANM will make regular home visits and will be incharge of only 500 families at the maximum. She will be assisted by a health visitor and supervised by a doctor. Individual services to each family at the house itself will consist of total immunization, preventive measures, health education, postnatal care, home deliveries in normal cases and family planning services.

4 Q. Why do you insist on payment of 10 per cent of the total cost when Government provides free health services ?

A. With a nominal payment the families will be able to receive individual attention and what is more important, learn simple methods of prevention of diseases improved nutrition and better environmental sanitation. It is hoped that when the families are convinced of the quality of services they receive, they themselves will increase their contribution to get still better services that will not be available from regular hospitals.

5 Q. Is there any special type of services that the plan will offer which are not normally available in the city ?

A. The special type of services consist of :

a) Home visits by a specially trained ANM who will take up the responsibility of the children under 5 and the mothers from conception to the postnatal stage.

b) Total immunization and preventive measures.

c) Minimal medical care and periodical medical checkups and preschool checkups.

d) Improvement of nutritution particularly for antenatal women, nursing mothers and children under five.

e) Family Planning.

f) Health education.

6 Q. How will you select the families in the scheme ?

A. Only such families will be eligible who are ;

a) Willing to contribute their share either in the shape of cash or personnel services.

b) Preferable of the lower income groups.

c) Pregnant and lactating mothers and children under five.

d) Target couples with a high risk. No distinction of religion, creed or caste will be made.

7 Q. Will you provide medical aid to the entire family ?

A. Top priority will be given to pregnant and lactating mothers and children under 5 but normally the nuclear family of 5 will receive medical and health care according to the terms laid down in the scheme. The other older members will not be eligible under the scheme but advice can be given. This scheme will not cover major ailments, chronic diseases and cases of hospitalization.

8 Q. What do you mean by minor ailments ?

A. Minor ailments have been broadly defined as simple items that do not need hospitalization. Limited treatment can be given at home by the health staff for ailments under the following heads:

a) Respiratory: cough; cold; bronchits; pneumonia: etc.

b) Gastro intestinal, diarrhoea, dysentry, gastro - enteritis, typhoid, and worm infestations.

c) Communicable diseases-measles, chicken pox, mumps, whooping cough etc.

d) Skin, eye, ear diseases.

e) Minor accidents and ear diseases.

9 Q. Are your ANMs qualified to take care of pregnancies at homes ?

A. Yes, the ANMs will be given special training to take care of pregnancies at home but in case of complications the ANMs will refer the case to the doctor. In general home deliveries will not be recommended.

10 Q. How can you assure us that our children will be protected from all infectious diseases ?

A. All efforts will be made under a programme of total immunization to protect the children against all infectious diseases. In case of any exceptions early detection by the health staff will help the families to get immediate medical attention.

11 Q. Is there any arrangement in your scheme for free consultation in complicated illnesses and emergencies ?

A. For illnesses and emergencies that are not covered under the head of minor ailments, arrangement will be made at a nearby hospital where the patients will be referred to. These services however will not be free at the hospital.

12 Q. How often will your ANM visit our homes?

A. A regular schedule has been prepared for the ANMs and health visitors for maternal health and child care. The number of visits will depend upon the purpose, e.g. for antenantal care the ANM will make home visits at the 24th, 28th, 32nd, 34th and 36th week. For postnatal care daily visits will be made for 10 days and monthly visits upto 12 months and quarterly visits upto 24 months. Home visits will be according to the requirements of medical assistance needed by the registered family.

13 Q. Once we enrol ourselves in the scheme will family planning become compulsory ?

A. According to the Government policy family planning is not compulsory. Efforts will however be made to educate the family regarding methods of family planning which do not necessary include sterilisation alone. Family planning advice will depend upon the requirements and age group of each individual family. Through child care the health staff will try to convince the families that their existing children will survive which should become a good incentive for family limitation.

14 Q. What assistance will we get for a nutritious diet for our children ?

A. Demonstrations will be a regular feature of the programmes during home visits. Efforts will be made to demonstrate menus for nutritions diets for both children and nursing mothers.

PLAN No. 5

CRECHE

1 Q. What is the specific advantage that we can derive by admitting our children to the creche?

A. Children between 1 to 2½ years of age if admitted to the creche will improve their nutritional and health status. The creche will help in laying the foundation for proper social, psychological development of the child. It will reduce the incidence of mortality, morbidity and mal-nutrition. It will help working mothers and enhance the capacity of the mothers and community in general through nutrition education and knowledge of improved child rearing practices.

2. Q. What type of families will be eligible to this facility ?

A Families from the lower socio-economic group and who are willing to accept the terms and conditions of the creche will be eligible. The creche will not be restricted only to working mothers. Facilities will also be provided to mothers to attend meetings of the mahila mandals, balwadis etc.

3 Q. How will the children benefit by the creche ?

A. The nutritional and health status of the child will improve. The creche will try to provide the proper atmosphere for psychological and social development of the child. The children will be taken care of in a proper and systematic manner rather than left on their own or to care of very young or old family members.

4 Q. What kind of diet will be given to these children ?

A. The main consideration in planning the diet for children is to improve their nutritional intake by using cheap and locally available ingredients such as milk. jaggery, kicheri, jawar, flour, green gram, green leafy vegetables, etc.

5 Q. Will the parents be allowed to take their children according to their convenience or will there be fixed timings for the creche ?

A. The timings of the creche will be fixed according to the local requirements and convenience of the mothers.

6 Q. Is the creche only meant for working mothers ?

A. Not necessarly ; although preference will be give to working mothers.

7 Q. Will you take up the responsibility of health and food of your children during the hours of the creche ?

A. This is the main objective of establishing a creche. The children will be taken care of by a trained helper who could also be one of the mothers, supervised by the ANM and health visitor.

8 Q Why do you insist on payment when funds are being provided by the Government and the Municipal Corporation ?

A. Partnership and sharing of costs and responsibilities is the main objective of this Project. Mothers need not contribute oniy in the shape of money but can assist in the running of the creche in different ways in lieu of contribution. In this way it is hoped to make people realise their own responsibility and work together for their own benefit.

9 Q. Does the mother have any responsibilities if her child is admitted to the creche ?

A. Yes, mothers will have to participate in the demonstrations and training programmes held in connection with maternity and child care. They should practise at home the various food habits, cleanliness, health checkups etc, demonstrated in the creche. They should be responsible to leave aud pickup the child from the creche. They should clean the child properly before bringing it to the creche.

10 Q Can you assure us that the health of the child will improve if it is admitted to the creche ?

A. With proper diet and child care. children usually improve in health.

11 Q Who will be responsible to run the creche ?

A. If the number of children admitted to the creche is according to the quota fixed in a composite unit, there will be two ANM's by

rotation-one mother, one helper, supervised by one health visitor and a doctor.

12 Q. Will medical facilities be available to the children who are admitted to the creche ?

A. Yes, a regular health chekup will be made by the health staff. Incase of minor ailments or infectious diseases required medical help will be made available.

13 Q. Why do you insist on the child being properly cleaned before bringing it to the creche-what is the creche for ?

A. The creche is also a tool to educate mothers in maintaining healthy practices, cleanlines, personal hygiene and environmental sanitation If children are not taken care at home the creche alone cannot bring improvement in them. The mothers are expected to practise the items demonstrated on their children at the creche. It is for this reason that a clean child taken care of at home will not only encourage other mothers to follow suit but will help the child to be in the same clean atmosphere both at home and in the creche.

14 Q. Do you expect us to give the same type of diet at home that you give to the children at the creche ?

A. The diets planned and demonstrated at the creche will be designed by the technical staff of the Home Science College. The emphasis is on simple, cheap and easily available ingredients so that the mothers at home can continue the same type of diet without any problem

15 Q. Can we be sure that our children will be entrusted to sympathetic and kind workers during hours of the creche ?

A. The helpers and health staff will be specially trained before they are given responsibility of the children at the creche. As far as possible mothers of the children will be encouraged to take up this responsibility.

16 Q. How should we know that the children have benefitted by the creche ?

A. Regular charts and research with individual records of weight & height will be maintained for each child in the creche to study the impact of this input. Periodic reports will be submited by the concerned staff which show the changes that will appear in each child. Research will be conducted to study the noticeable changes in the physical and mental growth of the child.

17 Q. What can the mother learn by attending the demonstrations at the creche ?

A. Classes, demonstrations and individual guidance will help to enhance the capacity of the mother in taking care of her child.

PLAN No. 8

MAHILA MANDALS (WOMENS' CLUBS)

1 Q How can women spare time to become members of the mahila mandal when they have their own house work ?

A. Members of the mahila mandals can give time whenever convenient to them after completing their own house work. A good example can be the lady volunteers themselves who have offered to spare time to talk to women in the community regarding the plans of the Project. If mahila mandals help housewives to improve house keeping, home management and provide them with opportunities to supplement their income, is it not advantageous to find some spare time ?

2 Q. What specific advantage will the women get in enrolling themselves in mahila mandals ?

A. The specific advantages are as follows :

1. receiving training to improve skills in trades and cottage industries which can help in supplementing family incomes.

2. participating in cooking demonstrations that will improve the nutritional value of foods using locally available and cheap ingredients for the preparation of nutritious diets.

3. learning to work as a team to take up responsibility of programmes for children in the community.

4. improving knowledge and receiving all-round education for better and efficient working in interested fields.

5. developing skills in sewing, stitching, embroidery and other aspects to become self-sufficient and also to earn money.

6. the mahila mandals can decide themselves what type of programmes can be introduced for their benefit and specific advantage.

7. if illiterate then can benefit by attending adult literacy classes.

3 Q. As a member is it necessary for us to be present in the club for fixed hours?

A. The hours of the mahila mandal can be fixed according to the convenience of its members. It may also not be necessary for each member to be present for fixed hours. Timings can be arranged according to the needs of members depending upon the classes that she would like to attend or meetings that she may have to be present.

4 Q. How will the mahila mandal help us in finding jobs to supplement our family income?

A. Programmes of training in specific skills according to the aptitude and requirements of the local women can be organised by the Project in collaboration with institutions and concerned departments, It may not be possible always to help members to find jobs; after acquiring technical skills they will be in better position to help themselves.

5 Q. Can the mahila mandal help us in starting our own business after training?

A. Special training programmes for specific jobs can be arranged provided there is adequate number of members. Members after receiving training can be encouraged to start small trades or business with the assistance of the employment schemes and other agencies.

6 Q. Will arrangements be made to sell the articles or products that the members can prepare?

A. Before starting the prepartion of any product or article the marketing facilities will have to be examined, Only such products or articles will be encouraged if there is a demand for them. As far as possible the mahila mandals will be linked up with agencies that could purchase their products directly, In this way these mandals can stand on their own feet after receiving the encouragement and direction they need.

7 Q. Is there any restriction of age or any qualifications required to become a member of the mahila mandal?

A. Preference will be given to young and active women desirous of learning something that will improve their lives. They must have the spirit of working together for a common aim and the willingness to assume responsibility. They must contribute the membership fee to start with. A specific age limit may not be set unless the mahila mandal so desires. Programmes and activities will however be directed to the younger groups.

8 Q. Is the club meant for learning trades or recreational activities alone?

A. The activities of the mahila mandal can be both educational and recreational. The programmes can be designed according to the needs of the women. They can plan the programmes themselves.

9 Q. Will you have different activities according to age groups and interests or will the club cater to only one group of women?

A. A mahila mandal can organise a variety of programmes to suit different groups. The activities can be designed according to the interests of age groups but need not be restricted to any one group alone. For example some women may be interested only in sewing and embroidery work, some in typewriting while some would prefer the preparation of spice packets or any small trades.

10 Q. Is it possible for the mandal to provide opprtunities of learning how to read and write?

A. Yes, adult literacy and nummeracy will be one of the specific programmes geared to the interests and requirements of the members not merely to make them literate but to help them

to become more efficient in the trade or the craft they are interested in.

11 Q. Will it be possible for the members to be taught new methods of cooking, food preservation and other home recipes that will help young girls to be better housewives ?

A. Yes the technical experts of the Home Science College will design the programmes for foods and nutrition for the mahila mandals. The post-graduate students will demonstrate to the members new methods of cooking nutritive and cheap diets and many other items in home management, child development, food preservation and storage which will equip the mahila mandal members to be more practical and efficient housewives.

12 Q. What type of activities will the mandals be engaged in ?

A. The activities of the mahila mandal will be planned according to the interest and need of its members. Some of the suggestions are as follows ;

1. **Recreational :** Cultural programmes singing, story telling, conducting group games, dramas, music etc.
2. **Educational :** Adult literacy, discussion groups demonstrations, competitions, lectures family planning and health education.
3. **Economic projects :** Small production centers for manufacturing chalk crayons, gauze cloth; spice and protein packets; beedi manufacturing etc.

This list can be amended and improved upon according to existing facilities and local aptitude.

13 Q. What are the facilities that the mahila mandal can provide to its members in economic projects ?

A The members will be assisted in seaking loans and grants-in-aid, epuipment from different concerned departments and agencies. They will be helped in establishing contacts with concerned government, quasi-government and other related agencies for services and financial assistance. Programmes of technical trainlng and knowledge of production and management can be made available with the assistance of concerned departments and agencies.

PLAN No. 7

VIGYAN MANDIRS (Centres of Learning)

1 Q. What can the youth learn in these vigyan mandirs other than the existing educational institutions ?

A. The object of encouraging the establishment of vigyan mandirs is to assist interested youth in gaining knowledge in skills in specific areas according to their aptitude, The emphasis of these centres will be on learning. developing skills and community service. The institutions will develop with the help of the youth themselves gradually and will take its shape according to the sield of interest of the youth. These centres will cater to the needs of school drop outs. illiterate youth as well as those who have had formal education. The programmes will be designed to enrich the youth in a variety of fields of learning.

2 Q. Will the activities of these centres be limited to any one field such as sports, physical exercise, library on cultural programme ?

A. The activities of these centers will cater to the interests of the members. These centres are meant to provide opportunities for the youth to get together, to learn by themselves in groups or through educational and recreational activities. Demonstrations by subject matter specialists could be organised to give knowledge and skills to the youth.

3 Q Will the youth be left to themselves in these centres or will there be someone to provide them necessary guidance and help ?

A. Programmes of these centres will be designed with the help of the youth. They will be involved in the process of planing from the very beginiug on condition that they are prepared to take up such responsibilities and contribute their time and energy. Resource persons will be made available for guidance in different subjects. A suitable person from among the youth themselves and who has the necessary initiative and enthusiasm will be made responsible to run the centre with the assistance of small group.

4 Q. How will the youth be benefitted by joining these centres ?

As centres of learning there will be adequate opportunity for the youth to imrove themselves in the areas of their own interest. Programmes will be designed with the help of resource persons to guide the youth in areas where they need more information. As the activities will be according to the interests of the youth themselves there will be ample opportunity for the youth to benefit from the centres. The youth can benefit through special training programmes through which they could gain knowledge and develop skills for particular trades and industries

5 Q. What methods are you going to use to encourage youth to become members and understand the basic objectives ot the centres?

A. Efforts will be made to discuss with the youth themselves the programmes and activities that ther are intrested in. If a sizable group is interested in any particular programme arrangements will be made to provide the necessary facilities for the training etc, if needed. Through individual contacts and group meetings the co-operation of the youth will be encouraged. When there is adequate response a small begining could be made to start a centre of this kind with the youth themselves.

6 Q. Who will finance the establishment of these centres and what facilities will be provided to start with?

A. The pattern of sharing of costs will be the same as the other plans. The type of facilities will depend upon the interest of the youth and efforts that they are prepared to put into establish a centre of this kind.

7 Q. What will be the functions and responsibilities of the office bearers of these centres ?

A. The office bearers of these centres will be expected to mobilise other members for programmes of common interest. Plans will have to be drawn up with the cooperation of the youth which can be implemented as and when the group wishes to take action. In the begining the office bearers will decide what type of activities can be encouraged depending upon the type of groups and their requirements. Arrangements will have to be made to contact concerned departments and agencies for the type of assistance and expertise that will be needed. The office bearers will have to divide these responsibilities among them with the assistance of the Project.

8 Q. Will the youth be made responsible to run these centres themselves or will you have a seperate staff for this purpose ?

A. As far as possible members of the centres will be made responsible to conduct programmes for the youth.

9 Q Will it be possible to provide technical education, specialised training and skills to those who are in need of them?

A. Efforts will be made to explore such possibilities with the help of technical institutions and concerned departments.

10 Q. What methods will you adopt to convince the youth that a centre of this kind will be useful to them ?

A. A small begining will be made with an interested group of youth for particular programme. Gradually the youth themselves will feel the necessity of a centre to develop any other fields and enrol more youth members.

11 Q. Will it be possible to provide opportunities for self employment, establishment of small business, starting of certain trades etc. ?

A. As far as possible arrangement to provide programmes of traning to develop skills can be considered by rhe Project with the Collaboration of the Municipal Corporation and the department of Industries.

12 Q. To what extent can the youth expect financial assistance from the centres in case they would like to start their own business ?

A. Financial assistance will depend upon the agencies and concerned departments that cater to such programmes to encourage the youth for self-emplomept. All such agencies and departments would be contacted depending upon the requirements of the youth.

13 Q. Will the members of these centres have to pay any fees regularly ?

A. It would be helpful to organise a group for each centre for which membership fees would useful. Such decisions can be taken by the group themselves. Running of these centres will be left to the organised group in charge with a resource person.

14 Q Will there be any specific restrictions in the admission of youth these centres or will you admit everyone who fits into the prescribed age group ?

A. As far as possible admission will be open to all groups without any restriction of caste or creed.

15 Q. What do you expect the youth members to do as their duty towards the centres ?

A. In the efforts to develop themselves it will be considered their attitude to also develop the centres. The centre can be effective only if the youth members take up responsibility of organising programmes to develop their own community besides personal benefit. One of the main objectives of these centres is to develop the feeling of the community service in the youth,

IMPLEMENTATION

In 1976 the Project Co-ordination Committee had decided that an effort should be made to start atleast 2 Blocks in the city to see to what extent these programmes can run on the lines planned. The results of the dialogue with the Community have shown that 59 32% of the families, i.e., 6,622 families from the 7 Blocks were willing to join the Health Assurance Plan, 57.38% of the parents of children of Balwadi age group showed their willingness to send their children to the Balwadis, 48.11% of parents of children of Creche age group were willing to send their children to Creche. As the response of the two blocks of Ward 20 was encouraging, it was decided to start a composite unit in each of these two blocks. The Municipal Corporation of Hyderabad was approached for a building. The first Composite Unit was started in May 1976 at Yadgar Hussain Kunta near Puranapul in the Municipal Hall in Block I of Ward 20. In November 1976, the local Committee of Block II Ward 20, invited the Project to start the second Composite Unit in the building they offered at Kabutar Khana free of rent.

Dates of Commencement of Each Plan

COMPOSITE UNIT - I

Mahila Mandal (Women's Clubs)	Plan 8	January	1976
Health Assurance Plan	Plan 4	May 3rd	1976
Balwadi (Nursery School)	Plan 1	May 17th	1976
Creche	Plan 5	June 3rd	1976
Balgyan Kendra (Non-formal Education)	Plan	June 28th	1976
Adult Literacy Classes	Plan 9	August 19th	1976
Telugu Coaching Classes		Oct. 3rd	1976
Youth Clubs	Plan 7	December	1976

COMPOSITE UNIT - II

Mahila Mandal	Plan 8	December	1975
Creche	Plan 5	November 2nd	1976
Health Assurance Plan	Plan 4	December	1976
Balwadi	Plan 1	February 1st	1977

PLAN - I : Preschool Child :

Balwadis :

Before the balwadi was inaugurated a Mother Teachers' Training Course was conducted in April/May 1976 to utilise members from local community for programmes connected with the integrated approach in the Composite Unit. The balwadi at Block I was inaugurated by Smt. Premlata Gupta, President, Family Planning Association of India, Hyderabad Branch on 17th May 1976 and the one at Block II was inaugurated by Smt. Krishnaveni Sanjivayya, Minister for Women and Child Welfare on 7th February 1977.

Two mother teachers who had earlier successfully completed the training course have been appointed to take care of each balwadi. It was laid down that the mother teachers would cook the mid-day snacks themselves by rotation. Each balwadi is provided with equipment, teaching aids, toys etc, costing about Rs. 2000/- The syllabus consists of nursery rhymes, music with action, story telling, simple number work, acquaintance with the alphabet, painting, clay modelling, cognition to animals, colours, fruits figures and other day-to-day items, games, simple health talks etc. The case history records-cum-progress reports of education, health and behaviour is maintained for each individual child. The strength of both the balwadis is 93 children, 42 at Block I and 51 at Block II, with almost equal strength of boys and girls.

Initially the balwadi hours were from 9-00 a.m. to 12-30 p.m.; with effect from 15th June according to the request of the families the hours are extended from 9-00 a.m. to 3.00 p.m. The children are given light snacks of milk and fruit at 10-30 a.m. and mid-day meals at 12.30 p.m. which consist of "upma" prepared with balahar and green vegetables thrice a week, soaked channa (gram) thrice a week with eggs and fruits once a week. The cost of the diet fluctuates around 35 paise per day per child inclusive of the market value of the supplies from the CARE Organisation. The mother teachers make regular home visits to maintain close contacts with the parents.

Parent's contribution per child is Rs 3/- per month at Block I and Rs. 4/- per month at Block II. The mother teachers from time to time are guided by Lady Voluntary workers and are exposed to learning situations on pre-school education to get new ideas.

Bal Gyan Kendra (Non-formal Education)

This Plan was not contemplated in the proposed draft outline. It had to be designed to suit the pressing need of the older brothers and sisters of the balwadi/creche children. These unfortunate children who are in the age group of 6 - 12 years have either never attended school or were early drop-outs.

In addition to a local teacher, voluntary workers are the main pillars of this plan. A non-formal method of education with emphasis on games, stories, songs and everyday science had to be adopted for this group as it lacked discipline and concentration. Classes are held in the afternoon to suit the needs of these children as they are assigned heavy domestic duties. The group is out-numbered by girls which may be indicative of the neglect of girls' education in the community.

One of the objects of this new effort is to make some of the children eligible for admission to the primary school. For this all that is needed is to bring them up to a certain literacy and numeracy level. The syllabus consists of language, arithmetic, simple science with demonstrations, painting, clay-modelling, music, story-telling, acting and games.

The strength fluctuates around 35-40. The contribution per child is Re. 1/- per month. The group has shown good progress. In August 1976, 28 children and in June 1977-41 children were admitted to the two local Primary Schools, after a short exposure to a course in non-formal education. Some of the children were not able to attend a regular school due to domestic duties These plans are now being revised to accommodate children who cannot attend primary school also.

Construction of Government Primary School :

During 1975 monsoon the existing building of Government Primary School in Ward 20 Block I had collapsed. The Project helped to construct the building to encourage community involvement in a programme of education; to help primary school education which is part of Project plans: to enable to conduct the activities of the Project in this building. It was possible to complete this building within the estimated amount of Rs 31,000/- for which the Project paid Rs. 21,000/- and local community contributed Rs. 10,000/-by way of free labour and material.

PLAN - IV - Health Assurance Plan :

The ANM's clinic is staffed with one part-time doctor at each clinic and 2 ANM's at Block I and one ANM at Block II. The part-time doctor and one ANM have been deputed by Municipal Corporation of Hyderabad and 2 ANMs by the Department of Health. The Health Visitor works in both the Blocks, Two staff Nurses from College of Nursing visit the clinics once a week to train the ANMs. In addition two lady voluntary doctors visit the Units twice a week for pediatric and gynaec cases. The ANMs make on an average 10 home visits to offer treatment for minor ailments, immunization, antenatal/ postnatal services.

The number of families registered after having contributed the prescribed amount in Block I is 217 and in Block II 157.

The ANMs at Block I have immunized 609 children either fully or partially for Polio, DPT, BCG, Small Pox and TABC. In addition a mass cholera innoculation programme was organised from April to July 1977 - 1540 persons - 1250 children and 320 adults in both the Blocks were protected.

PLAN - V - Creches :

Two Mother Teachers' Training courses were organised - one in 1976 and the second in 1977. Three Supervisors from "Mobile Creches" New Delhi had assisted in this course to guide the participants in equipping and establishing the Creche. The strength of the two creches is 57- Block I Creche 27 children and Block II Creche 30 children. Each Creche is managed by two trained mother teachers and one helper.

The equipment for each Creche with cradles, mattresses, clothings etc. costed about Rs. 2,500/-. The Nutritionist deputed from the College of Home Science visits the Creches once a week to guide the mother teachers in the composition and quantities of creche diet. Case history records are maintained for each child A control group has been selected for each creche to study the difference in the growth rates of creche children and other children.

The children are given milk at 10.00 a.m. vegetable soup and rice moong khichadi at 12-30 p.m. and porridge at 3-30 p.m. Eggs and fruit are given once a week. The little older children are given peanut chikki in between. The cost of diet fluctuates around 50 paise per day per child.

PLAN - VII - Vigyan Mandirs (Centres of learning) :

The strength of Vigyan Mandirs varies around 25 members The members are in the age group of 16 - 35 years and are mostly fruit/vegetable vendors, who often face seasonal unemployment. Efforts are being made to work out vocational training courses on a small scale to help the youth to supplement their income.

PLAN VIII - Mahila Mandals :

The strength of each Mahlia Mandal varies around 20 members. One sewing machine has been given to each mahila mandal. Inaddition to the Craft Teachers, the Lady Volunteers guide the members in tailoring, embroidery, cooking demonstrations on differnt nutritious and cheap recipes, weaning foods etc.

Educational Activities :

The staff members from the College of Home Science and Population Education Centre give once a week lectures/demonstrations on nutrition, health, hygiene, maternal and child care, importance of family planning etc. Adult literacy classes are conducted daily from 11.00 a.m. to 12.00 Noon.

Economic Activities :

Preparation of pickle, was undertaken during 1976. Envelope making programme was undertaken in 1977 with the help of Self Employment Scheme of Department of Industries: 15 members were engaged on this job and earned Rs. 401.69/-. In addition the members regularly prepare plastic wire bags, Jute bags and the cloth requirements of creches.

PLAN - IX - Adult Literacy (Night classes) :

These classes in Hindi are held daily from 7.00 p.m. to 8.30 p.m. The strength of the group varies around 30 and is between 14 - 30 years All the members work as vegetable/fruit vendors during the day time. They are taught language and simple arthmetic to help them in their profession. So for 34 members have been made literates.

Direct involvement of families :

The Composite Unit I schemes have involved 525 families under its different schemes during the one year of its presence in the Block. The Composite unit II has benefited 359 families, with 4 schemes implemented during the 8 months functioning in the Block II.

Effective participation :

One of the basic objectives of the Project is to demonstrate to the families in the Blocks that they should directly be partners in the programmes and share the responsibilities so that gradually they could take over the running and management of the activities initiated themselves. Participation by the families has been stressed and defined from the very beginning. Local mothers have been trained and assigned responsibilities in each plan. So far with persistent effort the results of sharing have been encouraging.

The contributions collected under all the schemes from about 30 to 34% of the months recurring expenditure on nutrition and the salaries of the field staff.

Statement Showing the Sharing of Costs by Families

	Families Contribution	Expenditure			Percentage of contribution to total expenditure
		Salaries	Nutrition	Total	
	Rs.	Rs.	Rs.	Rs.	Rs.
BLOCK I					
Total for 1976	3060.33	7653.99	2335.00	9989.99	30.64 %
Total for 9 months of '77	3614.82	8486.50	3624.32	12110.82	29.80 %
BLOCK II					
Total for 1976	1246.00	1575.50	310.58	1886.08	66.10 %
Total for 9 months of '77	3896.00	7178.53	3348.56	10527.09	37-00 %

A.P-2

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

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: Niloufer 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 readily 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 pregnant 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 infectious 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 drum stick etc.
	2. Balanced diet	2. Advise the families on better methods of cooking for prevention of loss of vitamins and minerals.
	3. Supplementary and weaning foods	3. Demonstrate the preparation of supplementary and weaning diets.
	4. Advice on infant feeding	
	5. Beliefs and taboos about food practices	
	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.

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*ssr:

DIRECTORY

of the

Andhra Pradesh

Voluntary Health Association

January, 1979

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Voluntary Health Association

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CONTENTS

"Go to the people Live among them
Learn from them Love them
Start with what they know
Build on what they have :
But of the best leaders
When their task is accomplished
Their work is done
The people all remark
We have done it ourselves"

—Chinese Poem.

Origin and Growth of Voluntary Health Association

Dr. James S. Tong S. J.

The Voluntary Health Association Movement goes back to 1969. In January of that year about thirty leaders of Christian hospitals met in Bangalore for a week of consultation to discuss how they could co-operate better among themselves and with Government. They agreed that some kind of co-ordinating association should be formed. As a result of that meeting, the Co-ordinating Agency for Health Planning was started and began functioning with an office in New Delhi from March 6, 1970.

During July of 1969, the first State Voluntary Health Association was formed in Bihar, at a meeting held in Buxar, attended by about 70 people, some of them Government officers.

The Co-ordinating Agency for Health Planning continued to assist the voluntary hospitals in the various States to organise their State Voluntary Health Associations, till at present there are 15 States, Regional and Union Territory VHA's. They are in Tamil Nadu, Kerala, Karnataka, Andhra, Orissa, Madhya Pradesh, Maharashtra, Goa, Gujarat, Rajasthan, West Bengal, Meghalaya, Bihar, Uttar Pradesh and the North-west Region, which includes Jammu and Kashmir, Himachal Pradesh, Punjab and Haryana.

Finally, at their meeting on September 28, 1974, they federated all these into one national association, called the Voluntary Health Association of India.

What the VHA is ?

From the origin of the VHA movement, we can see that the Voluntary Health Association is a non-profit service association for hospitals. dispensaries, health centres and other health related groups.

It is organised on a State, Union Territory or Regional basis. By region, is meant that if there are not enough voluntary hospitals in one State to form an Association, the hospitals of two or more States could join together and form one Association, but for the most part there is one VHA for each State.

It is called Health Association rather than Hospital Association to indicate that its scope while including hospitals, is broader, because one of its ideals is to assist in providing at least elementary health services in the vast rural areas where it is not possible to have hospitals.

The purpose and value of VHA.

When any one is invited to join an association, the first question he ask is: "What am I going to get out of it ?"

This brings us to some of the activities of the VHA. There are many things that friendly groups can do together which are scarcely possible for individuals to do alone.

The VHA will be primarily a service organization. It offers various services for its members. Each State VHA will do what it can for its members, and the national office staff assists all the State VHA's in broader and more general ways and on a national basis.

Prominent among the services being offered are educational services. Courses of various lengths according to needs are provided in hospital administration, and in the administration of the various departments of hospitals.

Also seminars are conducted related to community health and ways of extending the hospital influence into the surrounding community.

There are consultancy services to help members to deal with labour problems, legal, tax and license matters, and for purchasing.

For seminars, publications and other types of education services in hospital and health care administration, we have a team headed by Dr. Sister Carol Huss, Ph.D.

For Community Health, we have Dr. Helen Gideon, M.P.H., and Dr Murray Laugesen, F.R.C.S plus diploma in Obstetrics and Pediatrics, who has left surgery and devoted his time entirely to Community Health work, recognizing it as a priority for his personal vocation.

For developing new ideas in nursing education we have Miss Ruth Harnar, who has a doctorate in nursing education. Sister Anne Cummins and Miss Simonne Liegeois have a more free movement, working under the general title of Community Development.

We are the advisers to a central puchasing service to help members get the best quality for the best prices, and appropriate discounts for large orders.

VHA provides valuable information. Examples are to communicate to the members any new trends in Government thinking, opportunities available from donor agencies, trends and developments in other countries, etc.

The Association intends to develop low cost community based innovative health programmes, to keep up relationships with health related national and international organizations, and to promote educational services for public health nurses, village auxiliary nurses and numerous paramedical and multi-purpose health workers more suited to reach the large rural areas.

The VHA publishes health related books, pamphlets, journals and newsbulletins for the enlightenment and inspiration of the members and the public. We now publish a bi-monthly bulletin called "Health for the Millions."

Members will be invited to work together in times of emergency, such as floods, fires, earthquakes or other disasters.

The Association will hold conventions and meetings for developing united policies and good fellowship among the members, and to help overcome isolation, communalism and parochialism.

Other activities and services will develop as needs arise, and as the State branches and National Association become more stable and confident.

One of the special inspirations of the VHA movement is that it is open to all

health institutions in the voluntary sector irrespective of religious or community affiliation. For the first time in the voluntary health field, all are invited to join hands and work together as brothers and sisters. Together with the inspiring unity, however, there is also continuing liberty for each institution to maintain its identity, special goals and long standing traditions. The VHA movement does not intend to interfere with personal or community religious persuasions, but only that members assist each other in the common endeavour of trying to provide better health care and more of it, especially for the poor.

VHA exercises a strong thrust towards social justice in the provision and distribution of health services. It proposes the maintenance of health as the broader goal rather than the more limited one of curing illneses. It strongly urges the participation of the people in the development of their own health related services, and expansion of the services to include health education, balanced diet, safe drinking water, hygienic living conditions, and psychological and spiritual health.

As an important thrust of activity the VHA Movement emphasises Community Health as a great need of our time. This is not to say that hospitals are no longer necessary, but we do need simpler and less costly health systems for the rural areas, provided often by people with lower levels of education than that of medical doctors. So much of good health depends on health education, nutrition, and prevention of communicable diseases, guidance in which can be given by more easily available and less paid health workers. In May 1975, the World Health Organization; in their World Assembly, have approved for all the countries of the third world that priority should be given to Primary Health Care.

Following upon the WHO decision, the Christian Medical Commission of the World Council of Churches had their international meeting in Zurich, July 6 to 11, 1975. In this conference, as a directive that will go out to all their related institutions throughout the world, they have accepted the WHO priority of Primary Health Care, and made it their own. I was a participant in this meeting, invited with ticket paid for by the Secretariat for Promoting Christian Unity, Vatican City.

The Medical Commission of the World Council of Churches, in their Bulletin, "CONTACT," has pointed to our Association as a praiseworthy example of incarnational theology.

> "In India, co-ordination has taken a different turn. Initial efforts to bring the Christian Medical Association of India (Protestant) and the Catholic Hospital Associatlon together were not successful, although they took the timid step of having representatives at each other's meetings. In 1969 a new organization was formed, the Co-ordinating Agency for Health Planning, which hoped to serve as a catalyst in bringing the two groups together. It went even further than that, and organized in most of the States a Voluntary Health Association, which is open to all members of the private sector, including Hindus and Moslems. It 1974 the various State associations formed the *Voluntary Health Associotion of India* at the national level, and the Co-ordinating Agency for Health Planning is now submerging its identity in the larger body and serving as its administrative arm. One cannot resist the idea that this may be a truer representation of *incarnatinnal theology* or of the

parable of the seed which was cast into the earth and died (in its identity as a seed) in order to become a great tree".

The Secretariat for Promoting Christian Unity, Rome, has in a new document of thirty pages published this year, entitled "Ecumenical Collaboration," a paragraph on ecumenical activity concerning health care in which there is a note referring to our Co-ordinating Agency for Health Planning, which is now called Voluntary Health Association of India. The following is the exact text :

Co-operation in the Health Field

New concepts of health care are increasingly supplanting earlier attitudes regarding medical work and the place of hospitals. Donor and welfare agencies prefer to supply money for those health programmes which manifest a comprehensive approach. Some governments, as they strive to develop national health services, now tend to refuse to deal with a multiplicity of religious groups. So joint secretariats for the co-ordinating of all church-related medical and health programmes have come into being, set up with the joint approval of the Catholic episcopal conferences and the National Council of Churches. (27) In several places Catholics participate in the work of the nationai co-ordinating agencies recongnised by and reporting to the national councils. (28)"

These implicit approvals from WHO, World Council of Churches and the Vatican as well as general approval of the State and Central Health Ministries of India give us considerable encouragement that we have seen the right vision and that we are progressing towards laudable goals.

We are in a new world tending toward love and fellowship, order and co-operation among all men and women of the whole earth. People with a lesser vision cling to an age that is past.

—*—*—*—*—

Health for Millions

PREVENTION
PROMOTION
CURE
REHABILITATION

Care and not cure

—*—*—*—*—

* From "CONTACT" No. 26, April 1975 : "Interchurch Co-operation in National Health Care Programmes". Published by Medical Mission, World Council of Churches.

(27) Such Secretariats exist in India, Tanzania, Malawi and Ghana.

(28) For example, Philipines, Uganda and Kenya.

History of Andhra Pradesh Voluntary Health Association

The factors that led to the formation of Andhra Pradesh Voluntary Health Association (APVHA) were many and varied. Realising the need for combined efforts and coordinated activities by the existing voluntary health services, in January 1972, orientation visits were held by Dr. James S. Tong, SJ and Sr. Anne Cummins of VHAI in different parts of the state.

The inaugural and constituent meeting of AP, VHA was held in Hyderabad on 6th February 1972. An Ad-hoc Committee which was formed at this meeting was entrusted with the task of framing of the constitution, membership drive and registration of the society. The AP, VHA was officially registered at Guntur under the societies Registration Act of 1860 on 12th June of the same year.

At the first General Body meeting which was held at Hyderabad, on 20th July 1972, the members of the ad-hoc committee were confirmed as the members of the first Governing Board.

Dr. G.A. John	...	President
Dr. R.H. Thangaraj	...	Vice President
Sr. Martin	...	Secretary
Sr. Rose Mary	...	Treasurer
Dr. Hirams	...	Member
Miss Ethel Tharay	...	Member
Prof. M.A. Windey S.J.	...	Member
Dr. Sarala Elisha	...	Member
Dr. Ben Elisha	...	Member

By the year 1974, the membership has gone up to 72 and the need for a full time Sacretary to attend to the requests of members was felt. The Canadian Baptist Overseas Mission Board (CBOMB) came to our rescue in the person of Miss Zina F. Kidd, for a term of three years. The AP, VHA welcomed Miss Kidd at the Third General Body meeting held at St. Theresa's Hospital, Hyderabad, February 1975, as a full time Promotional Secretary.

Miss Zina F. Kidd, by her untiring zeal and influence, with the support and able guidance of the Governing Board, could bring in more cooperation among various churches and health agencies.

At the end of the term of her service, in September 1977, Mr. D. Rayanna was appointed to succeed her. The AP, VHA has widened its horizon through the enthusiastic efforts of the energetic Secretary. The membership has gone up remarkably, the understanding between the Government and the Voluntary sector has improved and the co-operation among the members has increased.

The CBOMB, seeing the achievements of AP, VHA, through Miss Zina F. Kidd, has loaned her, on request, for another term of five years. In November 1978, the Association was pleased at the return of Miss Kidd who came with much courage and new vision to promote the 'Community Health Movement' throughout the state.

Aims and Objectives of APVHA

1. To do works of charity and service aimed at improving the health of the people irrespective of race, religion, caste or community.
2. To promote greater co-operation among voluntary as well as Government health agencies by undertaking joint coverage of community health work.
3. To collaborate with other health agencies working in the area so as to ensure conservation of resources and as wide public-health-coverage as possible.
4. To affiliate other organisations with similar objects or to get affiliated to such organisations or to join with such organisations on such terms and conditions as the General Body may decide upon.
5. To collect, exchange and disseminate health information as well as to do research in the area.
6. To conduct seminars, workshops and conferences.
7. To represent voluntary health institutions engaged in allopathic oriented services in conferring with state-wide organisations relating to health matters and to present the views of voluntary health agencies to legislative bodies, governmental units and national and international agencies active in the area of health.

GROWTH AND ACTIVITIES OF APVHA

Membership :

The basis of membership of APVHA is institutional. However those interested in health care may become personal associate members. Membership is open to all private non-profit health agencies in Andhra Pradesh without reference to religion, caste or community. At present the membership has reached up to 111.

Relationship with the Government :

Good relationship with the State Government health authorities has been developed from time to time. With the help of the State Government, the APVHA is able to supply vacancies and M. C. H. drugs to the member institutions having immunization programme. The association enjoys maximum support from the Government.

Co-operation with other Organisations :

APVHA Co-operates actively to realise the aims and objectives of Voluntary Health Association of India, New Delhi and the Southern Region VHAI and other State VHAs. APVHA continues to co-operate and collaborate with CMAI and CHAI. The Lutheran World Federation has been extending their help and co-operation with APVHA since 1975. The Canadian Baptist Overseas Mission Board extended their co-operation by offering the valuable services of Miss. Zina F. Kidd and continues their relationship with APVHA.

Surveys in Community Health Programmes :

Survey in Community Health Programmes functioning from the member institutions were conducted in 1975 and 1977. This Year a Comprehensive Community Health Survey is being planned. The main purpose of the survey is to have a clear picture of Community Health activities of the members and to encourage, help and work in collaboration with them wherever possible.

Visits to Health Institutions and Agencies :

The Secretaries tour widely in the State to visit health institutions and encourage them towards organisational renewal and to promote the Community Health work movement.

Information Bulletin :

The APVHA circulates regularly the informative Newsletter to all its members and associate members. This newsletter provides valuable inforrmation – Seminars and workshops of APVHA, Southern Region VHAI and VHAI – New Delhi, and the other long term training programmes of VHAI. It provides information of the activities and services to its members. It communicates any new trends in government thinking,

opportunities available from donor agencies, trends and developments in other countries.

Assistance in disaster :

Members come together at all times especially in times of calamities like famine, cyclone, floods etc. In the recent cyclone and tidal wave devastation of coastal A. P. in November 1977, the members contributed their share in the form of personnel, finances vehicles etc., in relief and rehabilitation work.

Educational Programmes :

Educational Programmes are part of VHA activities. According to the demands of times, Seminars and Workshops on a number of topics which arise time and again were organised in different parts of the State. As many as 300 health personnel have been brought to the common platform and were given opportunity to share their experience with each other.

— Workshop for hospital Pharmacists, Pithapuram	— September	1975
— Middle Management Seminar, Hyderabad	— October	1975
— Community Health, Vijayawada	— November	1975
— Workshop for Laboratory Technicians, Pithapuram	— November	1975
— Workshop for Hospital Accountants, Pithapuram	— February	1976
— Workshop for Radiographers, Hyderabad	— August	1976
— Health Based Community Development, Nellore	— October	1976
— Human Relations and Communications, Hyderabad	— November	1976
— Hospital Management, Vijayanagaram	— January	1977
— Clinical Seminar for Doctors and Nursing Administrators, Hyderabad	— March	1977
— Human Relations and Communications, Salur	— August	1977
— Special Workshop to prepare outline Training Course for Village Health Workers in A.P., Hyderabad	— September	1977
— Personnel Management in Hospitals, Hyderabad	— September	1978
— Community Health Workshop, Dichpalli	— December	1978
In Collaboration with Southern Region VHAI.		
— New Horizons in Health Care, Madras	— August	1978
— Financial Seminar for Hospital Accountants, Mangalore	— September	1978

INDIVIDUAL MEMBERS

I. 1 **AROGYAVARAM EYE HOSPITAL**

Sompeta, Srikakulam Dt.

Pin : 532284

Telephone : 34

Short History :

Owner of the Institution : Canadian Baptist Mission

Date of foundation : 1911

Functioned as general Hospital serving in needy areas until early Sixties at which time it became exclusively an Eye Hospital.

Number of Patients : 1976 : 22,301
Number of In-patients : 1976 : 11,486
Number of Beds : 1976 : 120

Specialities : Eye

APVHA Member

I. 2 **PHILADELPHIA LEPROSY HOSPITAL**

Salur, Srikakulam Dt. A.P.

Pin : 532591

Telephone : 100

Short History :

Owner of Institution : The Leprosy Mission

Date of foundation : 1874

This is an international and interdenominational Christian Service Misson. Mr. Wellesly Bailey was the founder; first started at AMBALA of Punjab. The Philadelphia Leprosy Hospital was first started by German Lurtheran Church at Salur and later handed over to the Leprosy Mission.

It has a separate Community Health Programme.

Number of beds : 100

Educational Programmes : The Leprosy Mission conducts regular training programmes at the Philadelphia Leprosy Hospital. There are courses for doctors and para-medical workers.

Specialities : Blood bank, Village work-Survey, education & treatment, Reconstructive surgery, Artificial limb making and also splints, special shoe making.

APVHA Member.

I. 3 **LEPROSY HOSPITAL AND CONTROL UNIT,**

Kuruppam,

Srikakulam Dt. A.P.

I. 4 **CATHOLIC MISSION DISPENSARY & LEPROSY CENTRE**

P.O. Kotturu, Srikakulam Dt. - 532 455

Short History :

Owner of Institution : Catholic Mission, Kotturu

Date of foundation : 1-5-1963

There was no medical facilities available for the people of this area. Assessing the needs of the people, Brother J. Puttur, from the Catholic Mission, started a dispensary. He was a pharmacist and also passed homeopathy. The Government alloted a site for the purpose of this institution.

In course of time this dispensary developed and Leprosy work also was taken up. At present there is one MBBS doctor and a para-medical worker at this centre.

The community health programme of this centre is mostly a MCH programme with the help of CRS.

APVHA Member

II. 1 **ST. JOSEPH'S HOSPITAL**

Mary-land,

Visakhapatnam-530 002

Telephone : 2974

Short History :

Owner of institution : The Medical Society of the Sisters of St. Joseph of Annecy India

Date of foundation : 1962

St. Joseph's Hospital was founded in 1962, with 20 beds. Eminent doctors have contributed their service for the growth of this hospital and developed to 120 beds in 1971. The hospital has 14 religious Sisters who are qualified and experienced as the departmental heads.

The hospital has an out-reach programme, where the Sisters visit the nearby villages and slums around Visakhapatnam to render preventive and curative services.

In Gnanapuram, a branch dispensary is operating where 250 out-patients receive treatment. A small Leprosy clinic and a creche are attached to this dispensary.

Number of out-patients 1976 : 64,500
Number of in-patients 1976 : 3,151
Number of beds 1976 : 180

APVHA Member

II. 2 **ST. JOSEPH'S CONVENT DISPENSARY**

Wailtair R.S. Visakhapatnam-530 004

Telephone : 8347

Short History :

Owner of the Institution : Society of the Sisters of St. Joseph of Anney

Date of foundation : 1903

From the inception of this dispensary there was always a Sister treating the poor patients from the surrounding area.

Educational programmes : We teach health subjects and hygiene to our patients as much as possible.

Number of out-patients : 1976 : 26,026

APVHA Member

II. 3 **ST. ANN'S HOSPITAL**

Bheemunipatnam P.O.

Visakhapatnam-531 163

II. 4 **ST. ANN'S HOSPITAL**

Madugula-531 027

Visakhapatnam Dt.

Telephone : 25

Short History :

Owner of institution : St. Ann's Society

Date of foundation : 1933

Madugula is a village in the agency border.

The hospital was first started in thached sheds. The hospital for women and children was opened on 7th May, 1961 with the help of the Government of A.P. and the Central Government, Ministry of Health, New Delhi. Later the male ward was constructed with donations from the people of Switzerland and opened in 1965. The T.B. block was constructed and opened on 1 December 1970, for which funds were received from several agencies-Misereor, The Episwpal Campaign Against Hunger and Disease, West Germany, H.E.H. and the Nizam Charitable Trust Hyderabad.

A fine Immunizion programme is conducted, especially for Mothers & Children.

Number of out-patients : 1976: 1,43,413
Number of in-patients : 1976: 1,436
Total number of beds : 1976: 110

Specialities : General Hospital with O.T., O.P.D., Diagnostic X-ray, Lab. and T.B. ward.

APVHA Member

II. 5 THE LEPROSY MISSION HOSPITAL

Vijayanagaram
Visakhapatnam – 531 203
Telephone : 2570

Short History :

Owner of institution : The Leprosy Mission "LONDON"

Date of foundation : 1913

This hospital caters to the needs of the leprosy patients for their treatment and rehabilitation. The hospital is involved in anti-leprosy work in villages around this centre.

Number of in-patients: 1976 : 3,660
Number of out-patients: 1976 : 206
Number of beds : 40

Educational programmes : Health education in leprosy

Specialities : Agricultural Rehabilitation.

APVHA Member

II. 6 GREATER VISAKA LEPROSY TREATMENT & HEALTH EDUCATION SCHEME

47–10–17, Dwarakanagar,
Visakhapatnam – 530 016
Telephone : 2309, CODE : GREVALTES

Short History :

Owner of the institution : Greater Visakha Leprosy Treatment & Health Education Scheme (Registered.)

Date of foundation : 1 January, 1975

Greater Visakha Leprosy Treatment & Health Education Scheme working as per the permission accorded by the Government of Andhra Pradesh H.H. & M.A. G.O. Ms. No. 761 Health, dated 23-9-74, started leprosy control work from 1 January 1975 in the city of Visakhapatnam to cater the needs of the people suffering from Leprosy. The area of Visakhapatnam (municipal limits) is 47 Sq. k.m. with a population of 5 lacs approximately.

Ar present there are 10 clinics and 2 sub clinics are functioning.

Aims of the projects :

(a) The objective of the project is to control leprosy in the city of Visakhapatnam in a most efficient and economic way.

(b) To desseminate knowledge and information and to educate the public about the modern approach to Leprosy work.

(c) Existing cases are identified and brought under effective treatment and the apparently healthy population is kept under careful surveillance in order that new cases may be detected as they occur.

Special Programmes :

1. School Survey: As part of the Leprosy control programme, school survey is done every year, inorder to detect the cases.

2. Contact Survey: This is to examine the healthy people staying with the patients & sharing the same kitchen utencils etc. in the same family.

3. Slum Survey: Examination of the people living in the slums also being taken as part of the leprosy control programmes.

Other activities :

1. Weekly general clinic
2. Supply of M.C.R. Shoe to poor leprosy patients
3. Temporary 20 bed ward
4. Rehabilitation of the leprosy patients

Children in all other schools examined.

Number of out-patients :	1976 :	2,683	1977 :	3,237
Number of in-patients :		–	1977 :	48
Total Number of Beds :		–	1977 :	20

Specialities : Physiotherophy & Rehabilitation

Educational Programmes : Health Education – Lectures, Showing subsidized Films.

APVHA Member

III. 1

CHRISTIAN MEDICAL CENTRE

Pithapuram – 533450
East Godavari Dist. A.P.
Telephone : 23

Short history :

Owner of institution : Council of Christian Hospitals, under Canadian Baptist Overseas Mission Board.

Date of foundation : 1904

— 1904 Dr. E.G. Smith started medical work by establishing small dispensary.

— 1907 Dispensary was developed into the Betheseda Hospital for men.

— 1910 Allyn Hospital for women and children was established.

— 1920 Vernacular Grade Nurses training was started.

— 1950 Amalgamation of two Hospitals as Christian Medical centre.

— 1952 Recognition of the school of Nursing for the Higher Grade.

Community Health Programmes

A five year Pilot Project is in progress in a specially selected village.

A Survey and evaluation is done each year.

MCH care, immunization, family planning, health education, Domiciliary mid-wifery and basic treatments are offered.

Number of out-patients : 1976 : 49,148
Number of in-patients : 1976 : 4,985
Number of beds : 1976 : 180

Specialities:

Educational Programmes: Higher grade general nursing and Midwifery

APVHA Member

III. 2 **ST. JOSEPH'S HOSPITAL**

Prathipadu,
East Godavari Dist. 533432.

Short History :

Owner of the institution: Sisters of St. Joseph of Anncey-Waltair of R.S.

Date of foundation : 1952

In 1952, at the request of the local people the Sisters of St. Joseph, opened a general dispensary to attend to the needs of the poor sick people. In 1954, it was developed into a hospital of 24 beds. In 1967, leprosy work, S.E.T. was added to the works of the institution. In 1974, a shed was built for leprosy patients needing Hospitalisation, which later in 1978, resulted into a proper ward of 12 beds.

Number of out-patients : 1976 : 21,288
Number of in-patients : 1976 : 782
Number of beds : 1976 : 26

Specialities: Leprosy work

APVHA Member

III. 3 **SRIKAKULAM LEPROSY HOME & HOSPITAL**

Ramachandrapuram P. O.
East Godavari Dist-533 255 A. P.

III. 4 **HOLY FAMILY HOSPITAL (K. S. MEMORIAL)**

Amalapuram – 533201
East Godavari Dist. A. P.
Telephone : 71

Short History :

Owner of institution : Missionary Sisters of the Immaculate

Date of foundation : 1957

The hospital was started in January 1957 as maternity and children's Hospital. Initially it was started with 60 beds and later increased to 125.

Number of out-patients : 1976 : 10,395
Number of in-patients : 1976 : 1,290
Number of beds : 1976 : 125

APVHA Member

III. 5 **WOMEN'S HOSPITAL**

Ambajipeta – 533 214
East Godavari Dist. A. P.

Short History :

Owner of institution :

Date of foundation : August 1967

Opened with 17 beds in 1967 which has rapidly increased to 130 beds 1974. No further extentions planned at present. New outpatient department was opened in 1970. The Hospital is for women and children. An eye clinic also runs on Friday after noon.

Number of out-patients : 1976 : 26,683
Number of in-patients : 1976 : 2,911
Number of beds : 1976 : 130

Specialities : Obstetrics & Gynaecology

APVHA Member

III. 6 **VISRANTHIPURAM TUBERCULOSIS SANATORIUM**

Rajahmandry
East Godavari Dist. A. P. 533 103
Telephone : 3134

Short History :

Owner of institution : Andhra Evangelical Lutheran Church, Guntur

Date of foundation : May 1926

The T.B. sanatorium was eastablished in 1926 by the missionaries of United Lutheran Church of America. Its bed strength is 175, exclusively for tuberculosis patients. At present it is under the management of Andhra Evangecal Lutheran Church. It has some reserved beds.

The hospital has a community health project, covering 22,177 population. It has 4 mini health centres. There is a separate community health unit.

Numberof out-patients: 1976: 639 1977: 651
Number of in-patients: 1976: 820 1977: 771
Number of beds : 1976: 175 1977: 175

Specialities : Tuberculosis

Educational programmes : Health Education, F.P. Education

III. 7

LUTHERAN HOSPITAL

Rajahmundry–533 102
East Godavari Dt.

IV. 1

STAR OF HOPE HOSPITAL

Akividu, West Godavari Dt.
Pin : 534 235
Telephone : 28

Short History:

Owner of Institution : Council of Christian Hospitals under Canadian Baptist Overseas Mission Board.

Date of foundation : 1898

The Hospital was started by Dr. (Mrs.) Pearl Chute with two beds in the mission compound. Later present hospital was constructed and used as a general hospital. The hospital was under Indian management from 1956. Gradual increase in staff and bed strength achieved, offering general medical and sugical services, maternity, family welfare services, immunity clinics & leprosy clinics.

In 1976 out side community health project started 10 k.m. away from the hospital, with a resident ANM and a weekly clinic.

Number of out-Patients : 1976: 17,676
Number of In-patients : 1976: 4,004
Number of Beds : 1976: 78

Educational Programmes : Ward teaching by nurses to patients and relatives.

—Weekly film and flannel graphs and slides on health and family welfare.

APVHA Member

IV. 2

ST. MARY'S HOSPITAL

Bhimavaram, West Godavari Dt. 534 201

Telephone : 456

Short History :

Owner of the institution : The Missionary Sisters of Immaculate

Date of foundation : 1-5-1954

The hospital was started in 1954 as a small dispensary. Later this hospital with 120 beds was planned with the help of the Bishop of Vijayawada Msgr. De-Battista. The hospital was completed in 1959 wit maternity, surgical, general and male ward and X-ray and lab. The Hospital has an out-patient department.

M.C.H. Programmes as part of community health work.

Number of out-patient : 1976: 20,000
Number of in-patient : 1976: 6000
Number of beds : 1976: 120

APVHA Member

IV. 3

AUGUSTANA HOSPITAL

Bhimavaram A.P.
West Godavari Dt.-534 201
Telephone : 322

Short History :

Owner of Institution : Andhra Evangetical Lurtheran Church

Date of foundation : 1929

The hospital was started as an out-reach from the Lutheran Hospital, Rajahmandry. Dr. Betty M. Nilsen and Dr. Mary Moses were responsible for the growth of the Hospital to the present dimensions. The hospital is fully self-supporting and does not receive money from the Lutheran Church.

The hospital has a community health outreach programme in a nearby village Gunupudi, with 5,000 population. There is a full time paid nurse working for this programme.

The main activities are under-fives clinic, immunization, family welfare and health education.

Number of out-patients : 1976 : 3,786
Number of in-patients : 1976 : 926
Number of beds : 1976 : 50

Specialities : General Surgery

Educational programmes : The hospital is recognised as a field work agency for the M. A. Social Work students of the local post-graduate department.

APVHA Member

IV. 4

NARSAPUR CHRISTIAN HOSPITAL

(G.D.M. Women's Hospital)
Narsapur, West Godavari – 534257.
Telephone : 29 or 35

Short History :

Owner of institution : Trustees-Stewards Association in India.

Date of foundation : 1915

1915 – Started with 2 beds under Dr. Charlotte Pring.
1965 – Golden Jubilee – 150 beds – Dr. Betty D. Holt
1967 – ANM Nursing School started
1975 – Diamond Jubilee, Mens block was inaugurated, Medical Superintendent Dr. C. Prabhakar.

Community health programme is functioning with activities such as under-fives clinic, BCG and smallpox vaccinations in wards, local health clinics with immunisations. Clinics are held in three villages and in slum area of Narsapur.

Number of out-patients : 1976 : 25,146
Number of in-patients : 1976 : 7,035
Number of beds : 1976 : 206

Specialities : Obstetrics

Educational Programmes : ANM Training 20 students a year

APVHA Member

IV. 5

BETHESDA LEPROSY HOSPITAL

Narsapur, West Godavari-543271.
Telephone : 18

Short History :

Owner of institution : Bethesda Leprosy Hospital Association

Date of foundation : 1923

This hospital was started by Dr. Pring of Christian Hospital, Narsapur in 1923. Dr. E. S. Short took over from her in 1951 and remained in-charge until July, 1976 since then Dr. G.B.R. Walke of the BMMF have been in charge.

It has a leprosy survey programme covering 2,00,000 population.

Number of out-patients : 1976 : 6,256
Number of in-patients : 1976 : 1,455
Number of beds : 1976 : 156

Specialities : Treatment of all types and complications of leprosy requiring hospitalisation.

Educational programmes : Primary school for children with Leprosy (residential)

years to its present 25 beds. This hospital is situated at Mogalthuru, Panchayat Samithi centre, with a 10,000 population. Most of the people attending this hospital are poor fishermen.

The hospital has a mother and child programme.

Number of out-patients : 1976 : 6,220
Number of in-patients : 1976 : 788
Number of beds : 1976 : 25

APVHA Member

IV. 11 **FATIMA HOSPITAL**
Fatima puram
Velegalipalli–534 460
W. Godavari Dt.

IV. 12 **DAMIEN LEPROSY CENTRE**
Vegavaram P.O.
Gopannapalem–534 450
West Godavari Dt.

Short History :

The Damien Leprosy centre was started in 1962 by the Missionary Sisters of the Immaculate in a thatched shed with a single room, in a remote corner of the Eluru Town. Soon a plot of land was bought in Vegavaram, nearly three miles from Eluru and in July, 1963 the Damien Leprosy centre was shifted to Vegavaram.

The need was felt to provide hospitalisation to the patients. In 1966, hospital with 100 beds was constructed for the same purpose. Later physiotherapy section was opened in 1971.

The centre covers a population of 3 lakhs and nearly 70 clinics are functioning effectively throughout the Eluru Taluk.

The centre is functioning on the lines of the Government Leprosy Control programme and receives financial support from the German Leprosy Relief Association and Amictdet Lebbrosi, Italy. The centre also gives special care for Leprosy-affected children with the help of LEPRA, England.

Specialities : Physiotherapy,
Reconstructive Surgery.

IV. 13 **BISHOP BATHISTA MEMORIAL HOSPITAL**
Tanuku–534 211. W.G. Dt.

V. 1

ST. ANN'S HOSPITAL

Vijayawada–520 002
Telephone : 74577

Short History :

Owner of institution : St. Ann's Society (Luzern)

Date of foundation : 1940

The hospital was opened in the year 1940 as a maternity hospital, and it was estiblished by 1945 with O.P.D., I.P., operation theatre and the labs. In the same year lower grade midwifery training was started. The increase in the number of patients made the extension work continue and developed today into a 350 bed hospital, giving O.P.D. and I.P. service to a large community.

The school of nursing has been attached to the hospital from 1954 and today it has 126 students on its roll.

Regular family planning clinics in the out patient department are organised. The students in the school of nursing get domiciliary experience at the present health centre, Ajitsingnagar, which was centre for out-reach programme.

Immunisation programme is carried out twice a week.

Number of out-patients : 1976 : 4,76,160
Number of in-patients : 1976 : 17,676
Number of beds : 1976 : 350

Specialities : — Blood bank

Educational Programmes : — School of Nursing.

APVHA Member

V. 2

ANANTHAM HOSPITAL

Buckinghampet P.O.
Vijayawada–500 002
Telephone : 73936

Short History .

Owner of institution : Krishna Godavari Diocese C.S.I.

Date of foundation : Sept. 1947

Anantham hospital was started as a base hospital for the "feeder" hospitals at Vidyanagar and at A-Kandurn.

Number of out-patients : 1976 : 7,603
Number of in-patients : 1976 : 100
Number of beds : 1976 : 20

Specialities : E.N.T.

APVHA Member

V. 3

ST. ANN'S HEALTH CENTRE

Ajitsingnagar, Vijayawada – 520011.
Telephone : 72497,
Telegraph : Vijayawada.

Short history :

Owner of Institution : St-Ann's Society (Luzern)

Date of foundation : 1962

Long before the health centre started in this village, Sisters from St. Ann's Hospital, Vijayawada rendered curative services, laying greater emphasis on preventive health care from 1962. A small building was put up in 1962 and till 1973 it functioned only as a mobile clinic. A full-fledged health centre was built and inaugurated in July 1976, and the health team of this centre is suitably increased.

Four-fold programme of the Health Centre :

1. Medical relief services, 2. Daily home visiting,
3. Health education, 4. M.C. health programme including immunisations and nutrition programme with the help of C.R.S.

Number of out-patients : 1976 : 34,441
Number of in-patients : 1976 : 269
Number of beds : 1976 : 12

Educational programmes : Community nursing experience to the General nursing and midwifery students of the St. Ann's school of nursing, Vijayawada.

APVHA Member.

V. 4

ST. ANN'S HEALTH CENTRE

Kondapalli – 521 228.
Krishna Dist. A. P.
Telephone : (87) 25

Short history :

Owner of institution : St. Ann's Society (Luzern)

Date of foundation : 1961

St. Ann's health centre was started in 1961 at Kondapalli village. Initially the medical needs of the local people were attended be domicilary nursing. Gradually it was found that many T.B. patients attended the dispensary, so a T.B. sanatorium was built along with a small health centre.

Last few years due to lack of T.B. patients at this sanatorium, this centre is run as a general hospital.

Number of out-patients : 1976 : 15,000
Number of in-patients : 1976 : 3,000
Number of beds : 1976 : 40

APHVA Member

V. 5 **ST. CATHERINE'S HOSPITAL**

Tiruvur, Krishna Dist. - 521235

Short History :

Owner of institution : Society of St. Ann (Luzern) Vijayawada

Date of foundation : 21-9-1967

St. Catherine's hospital was started to build and then handed over to Sisters of St. Ann (Luthern) on 21-9-1967. One by one of the present parts were constructed with help of diverse benefactors, mostly from abroad. It was realised by the Bishop of Vijayawada, that a hospital in this area is vitally important since there were no facilities available for patients who needed hospital treatment, X-ray and Lab. tests for doignosis. People from about 100 sorrounding villages come to us.

Number of out-patients : 1976 : 9,300
Number of in-patients : 1976 : 1,563
Number of beds : 1976 : 40

Specialities : An X-ray unit for dianostic purposes and simple lab.

APVHA Member

V. 6 **ST. JOSEPH'S HEALH CENTRE**

Nawabupet, Krishna Dist.

Short History :

Owner of institution :

Date of foundation : 15-9-1976

St. Joseph's Health centre was founded in 1972 by an Italian Priest, of the Vijayawada Diocese. Later this was developed as a health centre founded by Misereor Germany.

M. C. H. Programme.

Number of out-patients : 1976 : 700
Number of in-patients : 1976 : 100
Number of beds : 1976 : 12

APVHA Member

V. 7 **ST. ANN'S MATERNITY HOSPITAL**

Jaggayyapet, P. O.
Krishna Dist. - 521175
Telephone : 23

Short History :

Owner of institution : St. Ann's Society (Luzern)

Date of foundation : 15-2-1945

Jaggayyapet was a neglected and backward area in the western part of the district, with no medical facilities especially for women and children, Sri. M.V. Narasayya Naidu, the then Dy. Tahsildar and the Raja of Muktala with the collaboration of the people of the taluk collected funds and erected a Maternity Hospital. At their request, two Sisters from St. Ann's Hospital Vijayawada came to run the Hospital in 1945. In 1956 a new wing was added as there was a steady increase of patients. In 1959 the staff quarters were improved and in 1961 an operation building was constructed with the help of Misereor Germany. Later in 1970 Men's and children's wards were added to the hospital with funds from the same donor agency. The hospital is developed to 100 beds. Weekly clinics to one of the nearby villages is undertaken as an out-reach programme.

Number of beds : 1960 : 100

APVHA Member

V. 8

BETHEL GENERAL HOSPITAL

Vuyyuru- 521165

Krishna Dt. A.P.

Telephone : 61

Short History:

Owner of institution : Council of Christian hospitals, under Canadian Baptist Overseas Mission Board.

Date of foundation : 1889

The Medical work under C.B.O.M.B. was started at Vuyyuru by a compounder in 1889 as a dispensary. Dr. Gerttrude Hulet came in 1904 and continued with dispensary. A small hospital was built in 1911. First building of the present hospital was built in 1924. The hospital grew gradually with increase in the number of beds and staff. By 1935 the hospital had 110 beds part of it in rented buildings. New buildings were added through the years and at present the hospital has 125 beds and 25 infant cots.

From being a hospital for women and children at the onset it was made into a General Hospital in 1955. Besides hospital building nurses hostel, class room, chapel, out patient department, new private wards, new operating room suite and central sterile supply and physiotherapy department were added through the years. X-ray facilities also are provided.

Hospital was recognised for Midwifery Training in 1941. In 1959 recognition was given for ANM training. At present the training school takes 15 students per year for ANM course.

The hospital has an excellent C.H. centre at a village named Kummamuru with resident nurse and staff. Home visits, basic health care, home deliveries and health education in the village and the local schools are undertaken.

Number of out-patients : 1976 : 42,369
Number of in-patients : 1976 : 5,200
Number of beds : 1976 : 125

Specialities : CYTOLOGY

Educational Programmes : A.N.M. Training school

APVHA Member.

V. 9 **R.C. SACRED HEART HOSPITAL**

Gudivada - 521301 A.P.

Telephone : 339

Short History :

Owner of institution : Missionary Sisters of the Immaculate.

Date of foundation : 1948,

In 1948, a group of sisters came from Italy and opened a small dispensary. The following year, it was developed into a hospital with 20 beds. Gradually the bed strength was increased to 115 as the demand and need of the public was great. Dr. David Ratnam was appointed as the chief medical officer who is still on the staff.

A mobile clinic visits three villages as part of their C.H. programme.

Number of out-patients : 1976 : 5,910
Number of in-patients : 1976 : 1,825
Number of beds : 1976 : 115

APVHA Member

V. 10 **ST. ANTHONY'S HOSPITAL**

Pedavutapalli - 521 121.

Krishna Dt.

APVHA Member.

V. 11 **ST. ANN'S HOSPITAL**

Avanigadda-521121 A.p.

Telephone : 25

Short History :

Owner of institution : St. Ann's Society (Luzern).

Date of foundation : 8-9-1970

St. Ann's hospital at Avanigadda was started as a dispensary on 8th September, 1970. It was developed into a hospital with 14 beds as the patients increased day

by day. Later the bed strength was increased to 35. Many poor patients come to this hospital for medical facilities.

The hospital has a C.H. programme functioning.

Number of out-patients : 1976 : 41,643
Number of in-patients : 1976 : 6,784
Number of Beds : 1976 : 35

APVHA MEMBER

V. 12 **HOLY CROSS HOSPITAL**
Masulipatnam - 521 002
Krishna Dt.

V. 13 **ST. JOSEPH'S HOSPITAL**
Kalindini - 521 344,
Kailakuru Tq. Krishna Dt.

V. 14 **ST. ALYOSIUS DISPENSARY**
Training programme centre,
Gunadala, Vijayawada 520 005.

V. 15 **COL. SKINNER MEMORIAL T. B. HOSPITAL**
Vidyanagar, Penapaka P.O. via Kondapalli
Krishna Dt. 521 228
Telephone :-

Short History :

Owner of institution : Krishna - Godavari Diocese C. S. I.

Date of foundation : 1954

This institution was started as a CMS dispensary for the industrial Colony at Vidyanagar in 1926. Later it served as a general hospital until the second world war, catering to the needs of villagers within 10 miles radius. From 1949 Lt. Col. J. M. Skinner took charge of it, admitting T. B. patients. As it was the only sanatorium in the district many people came from different places for treatment as in-patients. Col. Skinner died in 1954 and the hospital was named after him.

Number of out-patients : 1976:2,091
Number of in-patients : 1976: 28
Number of beds : 1976: 12

Specialities : TB sanatorium

V. 16 **CHRISTIAN HEALTH CENTRE**

Atlapragada Konduru P,O.
Tirivur Taluk, Krishna Dt. 521 227

Short History :

Owner of Institution : Krishna - Godavari Diocese C. S. I.

Date of foundation : October 1966

This health centre was opened in 1966 at the request of the local church and the community. More clinical work is being done in this centre. Now with new ideas on C. H., this health centre is under planning stage for an outreach programme. A small Nutrition programme is already functioning.

Number of in-patients : 1976 : 60
Number of out-patients : 1976 :6,949
Total Number of Beds : 1976 : 3

V. 17 **ASHA NILAYAM HEALTH CENTRE**

Gollapudi - village P.O.
Vijayawada - 521 225
Krishna - Dt.
Telephone : 76864

Short History :

Owner of institution : Sisters of St. Ann.

Date of foundation ; 29th July, 1977.

This health centre aims at helping the poor of this village and neighbouring villages. This centre was started in July 1977. In course of time, health care will become one of the developmental programmes of this main Centre.

APVHA Member

V. 18 **CLIFFARD MEMORIAL HOSPITAL**

Nuzvid - 521 201
Krishna Dt.

V. 19 **CSI CHRISTIAN HEALTH CENTRE**

Konduru P.O.
Kambhampad - Krishna Dt. 521 227

V. 20 **THE DIVI SEEMA SOCIAL SERVICE SOCIETY**

Nagayalanka P.O.
Avanigadda Tq.
Krishna Dt.

Short History :

The DSSS was started by the Catholic Church of Vijayawada Diocese in 1978 in Divi Taluk to ensure a comprehensive development of the area, after the cyclone and tidal wave devastation of November 1977, with Fr. Amal Raj, S. J. as the Programme Director.

The DSSS runs two clinics at present in Kammanamolu and Mandapakala and also M.C.H. programme, immunization programmes, Further plans of the DSSS is to develop a Health Centre at Nagayalanka and training programmes for village health workers.

V. 21 **VIJAYARANI DISPENSARY**

Kanchi kacherla P.O.
Krishna Dt.

Vijayarani Dispensary was started in June 1977 by the Sisters of the Immaculate Heart of Mary.

VI. 1 **KUGLER HOSPITAL**

Kothapet, Guntur-522001.
Telephone : 21808

Short History:

Owner of institution : Andhra Evangelical Lutheran Church

Date of foundation : 1893

This hospital was established by the poineer medical missionary, Dr. Anna S. Kugler M.D. in the year 1893 under the management of the Luthern Church. The hospital has grown to General hospital status. Despite a 100 bed government General hospital and several hospitals and nursing homes which have sprung up over the years Kugler hospital has still place to continue to serve the community providing quality health care.

C. H. programme is functioning in a village 25 k. m. away from the hospital.

Number of out-patients	: 1976 :	28,192
Number of in-patients	: 1976 :	3,988
Number of beds	: 1976 :	150

Specialities : 1) General Surgery 2) Medicine 3) Gynaecology & 4) Paediatrics 5) Detistry

A school of Nursing is attached whereby 12 nurses are graduated each year.

Educational programmes: Health teaching programmes in the community through the hospital, and also teaching programmes through the Mobile Opthahalmic team to prevent blindness in rural areas.

APVHA Member

VI. 2

ST. JOSEPH'S HOSPITAL

Guntur-522004

Telephone: 21700

Short History:

Owner of institution: Society of J.M.J.

Date of foundation : 1905

St. Joseph's hospital started in 1904 as a dispensary and in 1920 Dr. (Sr) Mary Clowery, of the J.M.J. society started working there as a regular lady doctor. In 1923 the then Madras Province offered a piece of land and the construction work started in 1925. It was one of the first Catholic Mission Hospitals in South India. As there was scarcity for trained staff, Sr. Mary started a midwifery training school, and later the training school for nurses, which was recognised by the government in 1947. Besides training of nurses this institution was recognised for training of compounders in the year 1949. As years went by there was tremendous progress in the Hospital and gradually reached to its presents 250 beds. It is functioning as a general hospital serving the people far and near.

The hospital has a cancer unit attached, which was started in 1959.

The hospital has a mobile dispensary which used to visit villages Kaza, Kakani, Gorantla, Nallapadu, Yetukuru, to render medical aid to the village folk. In 1975 a health centre was opened at Vijendla as extention service in order to provide continuity of health care including the preventive, curative and promotive health services to the people.

Number of out-patients : 1976 : 25,060
Number of in-patients : 1976 : 9,300
Number of beds : 1976 : 250

Specialities: Surgical ward Paediatric ward, Premature unit and obstetrical and gynacological ward.

APVHA Member

VI. 3

ST. MARY'S HEALTH CENTRE

Vejendla, Guntur Dt. - 522 212

Telephone : 26

Short History:

Owner of Institution : Society of J. M. J.

Date of foundation : 31-8-1975

This health centre was attached to St. Joseph's Hospital Guntur, for the purpose of training the nursing students in community health services up to 1975. A health centre was opened by the Superior General of J. M. J. seeing the health needs of the people.

Immunization programme is carried on along with mother and child health care, Health education.

Number of out-Patients : 1976: 50,358
Number of In-patients : 1976: 476
Number of Beds : 1976: 8

Educational programmes : Health talks, film show.

APVHA Member

VI. 4 **VILLAGE RECONSTRUCTION ORGANISATION**
COMPREHENSIVE RURAL COMMUNITY HEALTH PROGRAMME

C/o VRO Office Brodipet,
6/9 Guntur A. P. 522 002
Telephone : 21454, Telegraph : VRISIS

Short History :

This organisation was founded in 1969 in Guntur by Prof. M. A. Wimdey S. J., as a central place for coastal disaster/proverty areas for the purpose of providing an economical, village-based devolopment programme wherein health, education, employment and shelter would be linked together. It was expanded in 1972 to Orissa and in 1973 to Tamilnadu regions. At present, mobile medical teams serve in coastal regions and there are 25 health centres with innovative approach, non-hospital based, related to the proorest only.

Specialities : a) Rural education on health, b) nutrition programme, c) rural pathology d) family health care, e) immunization programme.

Educational Programmes : Audio visual health programme, health artist paintings for health work/education.

APVHA Member

VI. 5 **NITHYASAHAYAMATHA HEALTH CENTRE**

Tenali P.O.
Guntur Dt.

This is a small dispensary started in the Catholic Church parish compound, and run by the Sisters of J. M. J. Society.

APVHA Member.

VI. 6

THE SALVATION ARMY EVANGELINE BOOTH HOSPITAL

Box : 2, Nidubrolu – 522123
Guntur Dt. A.P.
Telephone : 7

Short History :

Owner of Institution : The Salvation Army

Date of foundation : Nov. 1935

This Salvation Army hospital was commenced in 1935 at the request of local MLC, Who persuaded a farmer to give land, and was started as a hospital for women and children. It developed irregularly over 40 years to 100 bed hospital. Now it is in the middle of a development project.

Number of out-patients : 1976 : 20,801
Number of in-patients : 1976 : 2,117
Number of beds : 1976 : 92

Specialities : General Surgery, Medicine, Obstitrics & Gynacology and Paediatrics.

Educational Programmes : ANM Training course

APVHA Member

VI. 7

ST. CHARLES DISPENSARY

Chilakaluripet,
Guntur Dt. 522616, A.P.
Telephone : 138.

Short History :

Owner of institution : Mother Imelda

Date of foundation : 1967

Short History :

At the request of the Bishop of Guntur, the Sisters came to Chilakaluripet in 1967. In the begining the Sisters stayed in a rented house and started a small dispensary. By 1970 a new dispensary building was ready with a few beds for emergency cases.

APVHA Member

VI. 8

HOLY MARY DISPENSARY

Thubadu via. Nadendla
Guntur Dt. 522234

Short History :

Owner of institution : Sisters of St. Ann's, Phirangipuram.

Date of foundation : 19-3-68

This despensary is situated in a village with 8 beds for maternity and other emergency care. Patients come from the surrounding villages

Number of out-patients : 1976 : 673
Number of in-patients : 1976 : 360
Number of beds : 1976 : 8

APVHA Member

VI. 9

ST. ANN'S DISPENSARY

Phirangipuram – 522 529
Guntur Dt. A.P.

Short History :

Owner of institution : Sisters of St. Ann's Phirangipuram

Date of foundation . 12th Feb. 1968

Since the beginning, the dispensary made progress and 6 beds are attached, Medical treatment is given at the dispensary to all the people irrespective of caste and creed. By God's grace, all the patients coming to our dispensary are going back with good and quick recovery from their diseases. All possible facilities are created for our patients. The people come from the sorrounding villages to this dispensary.

Number of out-patients : 1976 : 36,210
Number of in-patients : 1976 : 8,902
Number of beds : 1976 : 6

APVHA Member

VI. 10

OUR LADY OF HEALTH HOSPITAL

Narsaraopet Guntur Dist. A. P.
Telephone : 8

Short History :

Owner of institution : Sisters of St. Ann's Phirangipuram

Date of foundation : 18-7-1960

Our Lady of Health hospital was constructed in 1960 with generous contributions received from the Misereor Germany and from the local people. The hospital started with 12 beds. Now it is 125 beds general hospital and with a T.B. ward. The hospital has mobile clinic once in a week.

Number of out-patients : 1976 : 28,742
Number of in-patients : 1976 : 16,318
Number of beds : 1976 : 125

Specialities : 1) Gynaecology and Obstetrics
2) General surgery

APVHA Member

VI. 11

HOLY FAMILY HOSPITAL

Sathenapalle, Guntur Dist. A. P.

Telephone : 8

Short history :

Owner of institution : Sisters of Jesus Mary and Joseph.

Date of foundation : 12th January, 1952.

This hospital started in 1952, by J.M J. Sisters when there was no other Medical facilities in that area. The hospital celebrated the Silver Jubilee in 1978. Now hospital has 150 beds including a separate T.B. centre.

Number of out-patients : 1976 : 5,000
Number of in-patients : 1976 : 3,500
Number of beds : 1976 : 100

APVHA Member

VI. 12

ST. JOSEPH'S HOSPITAL

Piduguralla (post)

Guntur Dist. – 522413 A. P.

Short history :

Owner of institution : Sr. Superior,

Date of foundation : 15th July, 1968

It is a 12 bed hospital. Most of the cases are Obstetrics, Gynacology and paediatric cases. The team of the hospital consists of 1 doctor and 3 nurses. Here T.B., S.T.D. and Leprosy patients predominate.

Number of out-patients : 1976 : 1,700
Number of in-patients : 1976 : 600
Number of beds : 1976 : 12

APVHA Member.

VI. 13

FATIMA DISPENSARY

Dachepalli Post – 522414

Guntur Dist.

APVHA Member

VI. 14

ST. IGNATUS HEALTH CENTRE

Durgi P.O. Paland T.Q.
Guntur Dist. A. P.

Short History :

Owner of institution : Sisters of J. M. J.

Date of foundation : July, 1975

This dispensary started in July, 1975. It has 14 beds and are conducting delivery cases. Many poor patients visit this dispensary as there are no other health facilities available in the surrounding area.

APVHA Member.

VI. 15

ST. XAVIER'S HOSPITAL

Nirmala nagar – P. O.
Vinukonda, Guntur Dist. 522647
Telephone : 84

Short History :

Owner of institution : Missionary sisters of the Immaculate.

Date of foundation : 22nd Sept. 1965

Fr. T. Baliah, S.J., seeing the health needs of this backward area started a small dispensary in 1965 in a rented house. Later it was developed with the help of Misereor, Germany, into a General hospital with 74 beds, X-ray, operation theatre and lab facilities. Sisters of the Immaculate are working in this hospital.

Number of out-patients : 1976 : 19,358
Number of in-patients : 1976 : 1,392
Number of beds : 1976 : 14

APVHA Member

VI. 16

EVANGELINE BOOTH LEPROSY HOSPITAL

Bapatla, 522 101, Guntur Dist. A. P.

VI. 17

ST. THRESA'S HEALTH CENTRE

Patibanda P.O.
Sattenapalli Tq.
Guntur Dt. - 522 402

Short History :

Owner of institution : St. Ann's Congregation, Phirangipuram.

Date of foundation : 15-9-1974

The Centre was started by the Sisters of St. Ann's Congregation in the year 1974, with 6 beds. By 1976 it had developed into a Health Centre with 12 beds.

This Sisters have a home visiting programme to nearby villages.

Number of in-patients	:	1976 :	2,562	1977 :	2,929
Number of out-patients	:	1976 :	840	1977 :	545
Number of beds	:	1976 :	12	1977 :	12

APVHA Member

VI. 18 **ST. XAVIOUR,S DISPENSARY**
Thallacheruvu,
Sathenapalli Tq.
Guntur Dt.

Short Histosy :

Owner of institution : Sisters of St. Ann's Congregation, Phirangipuram.

Date of foundation : 1975

This dispensary started in 1975 in Thallacheruvu village in a small room, in the parish compound. Most of the patients who attend are poor and illiterate.

VI. 19 **CHRISTIAN HEALTH CENTRE**
Macherla - 522 426
Guntur Dt.

VI. 20 **LUTHERN GENERAL HOSPITAL**
Rentachintala - 522 421
Guntur Dt.

VII. 1 **CLOUGH MEMORIAL HOSPITAL**
Ongole - 523 001
Prakasham Dt.
Telephone : 760

Short History :

Owner of Institution : Samavesam of Telugu Baptist churches STBC.

Date of foundation : 1911

This hospital was started in 1911 by Dr. CLOUGH. This is an American Baptist Christian hospital catering to the needs of the public irrespective of caste, creed or race.

Number of out-patient	:	1976:	10,600
Number of in-patient	:	1976:	5,650
Number of beds	:	1976:	100

APVHA Member

VII. 2

ST. XAVIER'S HOSPITAL

Ongole, Prakasham Dt. 523 001
Telephone : 361

Short History :

Owner of Institution : Society of J. M. J.

Date of foundation : 3-12-1967

St. Xavier Hospital, Ongole, started in December '67 by Sisters of J. M. J. with 12 bads. At Present the hospital has a residential M.B.B.S., doctor. Patients come from the surrounding villages. The staff visit the villages and provide immunisation to the children.

Number of beds : 1977 : 20

APVHA Member

VII. 3

ST. ANN'S HOSPITAL

Mariampeta,
Chirala – 523 155
Telephone : 256

Short History :

Owner of institution : St. Ann's Society (Luzern)

Date of foundation : 1962

St. Ann's Hospital, Chirala, was started in 1962 as a small dispensary by the St. Ann's Society (Luzern). Now it is developed to a 12 bed hospital and with a resident doctor. It is a general hospital, though most of the cases are maternity cases.

A small clinic is functioning in a needy down-town area by the same Sisters, and they also visit surrounding villages regularly.

Number of out-patients :	1976 :	4,278	1977 :	3,841
Number of in-patients :	1976 :	570	1977 :	410
Number of beds :	1976 :	12	1977 :	12

APVHA Member

VII. 4

BEAR HOSPITAL (Lutheran Hospital)

Chirala - 523 155, Prakasam Dt.

V(I. 5

ST. ANN'S DISPENSARY

Rayavaram, Markapur Rly. Station.
Prakasam Dt.

APVHA Member

VII. 6

ST. VINCENT'S HOSPITAL

Medarmetla, Prakasham Dt. 523212

Telephone : 12

Short History :

Owner of institution : Sisters, of St. Vincent de Paul

Date of foundation : 20-8-1976

St Vincents Hospital run by Sisters of St. Vincent de Paul has been functioning since April 1977. It is a 12 bed General Hospital with all facilities including well equipped laboratory and operation theatre.

A Community Health outreach programme is being planned and have obtained an ambulance for this purpose.

Number of out-patients :	1976 :	1977 :	6,441
Number of in-patients :	1976 :	1977 :	135
Number of beds :	1976 :	1977 :	12

APVHA Member

VII. 7

RAMAPATNAM BAPTIST DISPENSARY AND HEALTH CENTRE

Ramapatnam, Prakasam Dt. 523291

Short History :

Owner of Institution : Samavesam of Telugu Baptist Churches, Nellore

Date of foundation : 1912

Started as a dispensary to care for the Seminary students and families of the Ramapatnam Baptist seminary. Now they have a community health centre attached to it. There are two clinics in the village weekly.

Number of beds : 1976 : 20

Educational Programmes : Health education to the Seminary students, and rural experience to nursing students.

APVHA Member

VII. 8

ST. JOSEPH'S HOSPITAL & MATERNITY CENTRE

Kanigiri P.O.

Prakasam Dt. - 523 230

Short History :

Owner of institution : Mother Superior

Date of foundation : 22-7-1969

This hospital is situated in a rural area at Kanigiri and mainly engaged in philanthropic, preventive and curtive services. The mobile medical services are functioning in the nearby villages. They render services for eligible couples for Natural Family Planning.

They co-operate with Government immunization grogrammes.

Number of out-patients : 1976 : 26,472 1977 : 28,754
Number of in-patients : 1976 : 529 1967 : 742
Number of beds : 1976 : 12 1977 : 12

APVHA Member

VII. 9 **CHRIST HEALTH CENTRE & CLARK MEMORIAL DISPENSARY**
Podili P.O.
Prakasam Dt. - 523 240

VII. 10 **ST. RAPHAEL'S HOSPITAL**
Giddalur P.O.
Prakasam Dt. 523 357

Short History :

Owner of institution : Church of South India (S.P.G. Mission)

Date of foundation : 24-10-1930

The C. S. I. Hospital was opened in 1930 by Dr. Roberts, with the aid from S.P.G. Mission, London. First it was started with 30 beds and leter grew to 50. It was a known hospital for surgery.

Family pianning and community health programme are with two village clinics.

Number of out-patients : 1976 : 3,500 1977 : 2,500
Number of in - patients : 1976 : 1,500 1977 : 1,000
Number of Beds : 1976 : 50 1977 : 59

APVHA Member

VII. 11 **LUTHERAN HOSPITAL**
Tharlapadu P.O.
Prakasam Dt. 523 332

VII. 12 **ST. ANN'S HOSPITAL**
Donakonda P.O.
Prakasam Dt. 523 304

This hospital has 10 beds.

VIII. 1

ST. JOSEPH'S HOSPITAL

Santhapet, Nellore - 524001

Telephone : 498

Short History .

Owner of institution : Society of Jesus, Mary and Joseph.

Date of foundation : 1911

St. Joseph's hospital was started by the J.M.J. Sisters in 1911 as a dispensary. In 1925 a small ward was opened to admit and conduct deliveries. Ever since the hospital has grown in strength as a maternity hospital. In 1932 a midwifery training school started, and has trained 900 girls. In 1965 the A.N.M. training took its place and is continued up-to-date. At present St. Joseph's hospital is a general hospital with 140 beds with modern diagnostic facilities and having well equipped lab., X-ray and operation theatre.

Number of out-patients : 1976 : 5,400
Number of in-patients : 1976 : 11,987
Number of beds : 1976 : 140

APVHA Member

VIII. 2

BAPTIST CHRISTIAN HOSPITAL

Nellore - 524002

Telephone : 423 *Telegraph* : CHRISTHOS

Short History :

Owner of Institution : Samavesam of Telugu Baptist Churches

Date of foundation : 1893

The Hospital was founded in 1893 and has grown steadily to a fine general hospital of 150 beds with specialities in surgery paediatrics and obstetrics. There is a fine nursing school and successful community health programme.

A large C.H. out-reach programme involves their denominational health institutions (Baptists) in A. P. and has emphasised village health workers training programmes.

Number of out-patients : 1976 : 7,408
Number of in-patients : 1976 : 5,435
Number of beds : 1976 : 150

APVHA Member

VIII. 3

RURAL HEALTH CENTRE

Tallapalem P. O.
Kavali – 524201 Nellore Dist.

Short History :

Owner of institution : Institute of Foreign Mission Sisters of Paris

Date of foundation : March 1971

It was founded by the Institute of Foreign Mission Sisters of Paris and previously named Visvodaya Health Centre. It separated from Visvodaya Inslitution in 1975. At present it is helped by Damien foundation which has accepted the programme as intergrated work, including leprosy for area of 5000 population of Tallepalem.

The rural health centre caters to the needs of the 15,000 population in Kavali town for Leprosy.

As part the Community health programme, 25 villages and hamelts are regularly visited. Under-fives clinics are conducted along with a Nutrition programme and the immanization programme.

Educational programmes : Health education through posters and film shows.

APVHA Member

VIII. 4

AROGYANILAYAM HOSPITAL

Kavali, Nellore Dist. 524201
Telephone : 137

Short History :

Owner of institution : Mother General St. Anns Institute

Date of foundation : 19-3-1973

This hospital was started by St. Ann's Institute as a Health Centre in 1973. Later in 1977, with the help from Misereor, a hospital with 30 beds was constructed and opened in Feb., 1978 as a general hospital including surgery.

Number of out-patients :	1976 :	21,606	1977 :	28,800
Number of in-patients :	1976 :	5,400	1977 :	6,480
Number of beds :	1976 :	20	1977 :	20

APVHA Member

VIII. 5

CATHOLIC MISSION DISPENSARY

Atmakur – P. O.
Nellore Dist. 515 751

VIII. 6 **NIRMALA HARUDAYA BHAVAN – DISPENSARY**

Kondayapalem, P. O.
Nellore Dist.

IX. 1 **KATHERINE LEHMANN HOSPITAL**

Renigunta P. O.
Chittor Dist. 517520
Telephone : 31

Short History :

Owner of institution : South Andhra Luthern Church

Date of foundation : 1928

The Katherine Lehmann Hospital was built with funds provided by the Women's organisation of the American Lutheran Church whose president at that time was Miss. Katherine Lehmann. The cornerstone was laid by Miss. Lehmann in 1928 and the hospital opened in 1933.

Dr. C. Muthaiah, a devout Christian, served as Chief Medical Officer for 30 years. During that time, Laboratory Technician and Auxiliary Nurse Midwife training courses were run but both courses have now been discontinued.

This hospital is one of the institutions under the South Andhra Lutheran Church and is financially self-supporting.

Four villages within 5–7 kms. of the hospital are visited weekly by a mobile clinic as part of community health programme. Immunization programme is emphasised in the villages and in the hospital.

Educational programmes : Health education

Number of out-patients	:	1976 :	14,657
Number of in-patients	:	1976 :	2,210
Number of Beds	:	1976 :	72

APVHA Member.

IX. 2 **C. S. I. HOSPITAL**

Nagari, Chittor Dist. 517589
Telephone : 80

Short History :

Owner of institution : Church of South India, Madras Diocese

Date of foundation : 1906

The medical work was started here on a small scale in 1906. It is interesting to discover that the land and all the buildings were given for the hospital by generous

local donors and that no foreign money until 1947. From that time a regular mission grant has been made and several large special grants and donations have been made from overseas for building. Now the hospital is self-supporting except for diocesan grant and family planning grant from the CMAI.

The hospital is a general care institution of 86 beds.

Number of out-patients : 1976 : 12,642
Number of in-patients : 1976 : 2,759
Number of beds : 1976 : 86

APVHA Member

IX. 3 **CHRISTIAN MEDICAL CENTRE**

Punganuru. Chittor Dt. 517 524

Telephone : 30

Short History :

Owner of institution : Church of South India, Rayalaseema Diocese.

Date of foundation : 1945

This hospital was started by an American medical missionary lady doctor (RCA) Dr. A. R. Korteleng M.D. on a small scale in 1945. Gradually this was developed to the present status of 35 beds, with general medical care. On her retirement, the hospital was taken over by the Church of South India (Rayalaseema Diocese) in 1958 and from then on wards it has been running on a pureley self-supporting basis.

Number of out-patients : 1976 : 23,391
Number of in-patients : 1976 : 701
Number of beds : 1976 : 35

Specialities : Pediatrics, ENT, OG.

APVHA Member

IX. 4 **MARY LOTT LYLES HOSPITAL**

Madanapalle - P.O.

Chittor Dt. 517 325

Telephone : 23 Telegraph : 'Mission Hospital'

Short History :

Owner of institution : Church of South India, Rayalaseema Diocese.

Date of foundation : 1911

Mary Lott Lyles hospital, Madanapalle, was started in the year 1911 for women and children only until 1950, when men's surgical and medical wards were added. The bed strength is 179. This hospital has a school of nursing started in 1912,

which gave lower Grade training in Nursing, and later in 1953 the school received recognition to give higher grade Gen. Nursing. In 1954 school received recognition to give higher grade Midwifery. This hospital has specialities in gynaecology & obsterics, ENT. Skin and Surgery. Usual clinics like anti-natal, ENT and FPP are being conducted.

Number of out-Patients : 1976: 30,102
Number of In-patients : 1976: 5,929
Number of beds : 1976: 179

APVHA Member

IX. 5 **MERCY HEALTH CENTRE**
Mary garden, Galamaner road,
Chittoor 517 001

Short History :

Owner of institution : Fr. John Antheenattu.

Date of foundation : 15-4-1977

The dispensary was opened in May, 1969 for Leprosy patients and later it provided general medical care. In April, 1977 a new hospital building was completed, with facilities for in-patients and maternity. The Sisters from the hospital make regular home visits.

APVHA Member

IX. 6 **SWALLOWS HOSPITAL - CUM LEPROSY RELIEF PROJECT**
Rajupeta, (via) V. Kota
Chittoor Dt. 517 424

Short History :

Owner of institution : Swallows in India, Madras.

Date of foundation : 12-10-1972

Tthe Swallows Hospital of 20 beds was started as the first phase of the Welfare Project for Rajupet area in October 1972, with the help of Swallows in India Sweden and Denmark. The curative work includes medical, surgical and Obstetrics care. Family welfare (tubectomy) operations are being done at this hospital. There is twenty-four hour casualty service for emergency cases coming from a redius of ten kilometres, since the nearest Primary health cenre is ten ten kilhmres away.

The hospital has mobile medical team serving isolated subcentres weekly, situated at a distance of 5-20 kilometres. The aim of the centre is to take care of the poor in this area.

Number of out-patients :	1976 :	65,053	1977 :	55,077
Number of in-patients :	1976 :	916	1977 :	690
Number of beds :	1976 :	20	1977 :	29

Specialities : Surgery.

IX. 7 **AROGYAVARAM MEDICAL CENTRE**

Incorporating
Union Mission Tuberculosis Sanatorium
Arogyavaram P. O.
Chittoor Dist. 517 330
Telephone : Madanapalle : 228
Telegram : SANATORIUM

1. General Hospital of 100 beds with the following Departments :
   a) General Medicine
   b) General Surgery
   c) Thoracic and Cardiovascular Surgery
   d) Paediatrics
   e) Gynaecology & Obstetrics.
2. Domicillary programme for tuberculosis with an urban centre covering a population of about 60,000 in the rural areas around Madanapalle.
3. Opthalmology – Aided by the Christoffel Blinden mission West Germany.
4. Polio Rehabilitation Unit aided by the Andhra Pradesh Social Welfare Fund of the A. P. Government.
5. Family Planning Programme aided by the CMAI.
6. Tuberculosis Expatients Rehabilitation Programme.
7. Medical Education – Postgraduate Diploma Course for the Diploma in Tuberculosis and Chest (D.T.C.D.) affiliated to Sri Venkateswara University, Tirupati, A. P.
8. Paramedical education – Clinical Laboratory Technician's course, sponsored by the Christian Medical Association of India;

APVHA Member

IX. 8 **OUR LADY'S DISPENSARY**

Palmaner - 517 408,
Chittoor Dt.

IX. 9 **LEPER RELIEF WORK**
LEPER REHABILITATION CENTRE

Chittoor

X. 1 **NIRMALA MATERNITY AND GENERAL HOSPITAL**

Masapet, Cuddapah – 516 001
Telephone : 2350

Short History :

Owner of Institution : Sisters of the Society of J.M.J.

Date of foundation : 1969

Nirmala hospital was started as a small dispensary in a rented house in 1969 in the out skirts of Cuddapah town, among slums surrounded by about 40 Villages. In 1970 five acres of land was donated by Cuddapah Municipality to put up the Hospital within three years. The ground floor portion of the Convent is used as a hospital of 20 beds and construction of a new hospital building is under way.

Number of out-patients : 1976 : 11,264
Number of in-patients : 1976 : 4,533
Number of beds : 1976 : 20

APVHA Member

X. 2 **OUR LADY OF FATIMA HOSPITAL**

Porumamilla P.O.
Cuddapah Dt. 516193

Short History :

Owner of institution : Sisters of the Society of J.M.J.

Date of foundation : 1952

The hospital was started in 1952 as a small dispensary to cater to the needs of the people of Porumamilla village which has a population 10,000. Gradually it increased to a 20 bed hospital. But even that was found in-adequate as the people from the neighbouring villages also flocked for medical assistance. The Misereor came to rescue and with their generous help in 1975, a well-equipped modern hospital was constructed with a bed strength of Sixty. At present, the hospital caters not only to the needs of the people of Porumamilla but also to the people of about 120 hamlets around Porumamilla with the help of a mobile medical unit which visits these villages regularly.

Number of out-patients : 1976 : 11,402
Number of in-patients : 1976 : 1,173
Number of beds : 1976 : 60

APVHA Member.

X. 3 **CAMPBELL HOSPITAL**

Jammalamadugu–516434
Cuddapah Dt.
Telephone : 70

Short History :

Owner of institution : C.S.I. Rayalaseema Diocese

Date of foundation : 1895

In the early years this CSI hospital trained L.M.P. doctors but discontinued the programme during 1914-18 war. A lower grade Nursing school was discontinued

during 1939–46 war and started again as higher grade school in 1967. Up to 1952 it was a 100 bed hospital. From 1956 there was rapid expansion to present size of 297 beds under medical superintendent Dr. M D.A. Ratnaraj. Surgical and medical cases of all kinds are treated. Hospital is now self supporting for the last 10 years apart from one missionary salary and occassional gifts. A large family welfare centre is operating for family planning services.

An outstanding Nutrition Education project for under fives is conducted by this hospital, initiated by Dr. William Cutting in 1970 in co-operation with OXFAM. It involves the rehabilitation of malnourished children concurrent with educating the mothers in child nutrition.

The unit also conducts an extension programme of health care and education into 5 villages. Village health workers have been trained and are functioning in these villages, and it will be extended to others to cover about 30,000 population.

Number of out-patients : 1976 : 25,892
Number of in-patients : 1976 : 6,963
Number of beds : 1976 : 297

APVHA Member

X. 4

ST. JOSEPH'S HOSPITAL

Appayapelle P.O. Kamalapuram
Cuddapah Dt. 516289

Short History :

Owner of institution : Society of the Franciscan Sisters of St. Joseph, Madras.

Date of foundation : January 1971

The Sisters started dispensary in a small house in 1971. In 1977, with the help of Misereor a 10 bed hospital was opened in Appayapalle Village, on the main road of Cuddapah-Bellary.

The hospital is surrounded by many villages and has an ambulance to visit them.

Number of out-patients : 1976 : 5,100
Number of in-patients : 1976 : 50
Number of beds : 1976 : 10

APVHA Member

X. 5 **ST. JOSEPH'S HEALTH CENTRE**

Pulivendla P.O. – 516 390

Cuddapah Dt.

Short History:

Owner of institution : Sisters of St. Ann's Congregation, Phirangipuram

Date of foundation : 9-6-1976

This health centre of 16 beds was built by the help of Misereor, Germany. It was started in June 1976. One doctor and two qualified staff are working at the centre.

Number of out-patients : 1976 : 5,500
Number of in-patients : 1976 : 113
Number of beds : 1976 : 16

APVHA Member

X. 6 **ST. JOSEPH'S HOSPITAL**

Sathyapuram, Proddatur - 516360

Cuddapah Dt.

This hospital has 12 beds and a resident doctor.

APVHA Member.

X. 7 **CATHOLIC HEALTH CENTRE**

Maidukuru

Cuddapah Dt.

X. 8 **KURUPAPALLE LEPROSY HOSPITAL**

Koduru P.O. – 516 101

Cuddapah Dt.

XI. 1 **ST. THERESA'S HOSPITAL**

Kurnool 518004

Telephone : 893

Short history :

Owner of institution : Sisters of the Society of J.M.J.

Date of foundation : 1925

St. Theresa's hospital for women and children was started by the J.M.J. Sisters in 1925. The hospital was mainly intended to treat antenatal, postnatal cases and diseases of infants and children.

It was started as a dispensary with out-patient department labour, room and accommodation for 12 beds, mostly maternity. A seprate labour room and ward of 18 beds were added during the year 1934. In the year 1957 a seprate septic ward and Nurses quarters were built.

In the year 1973 an operation theatre, and central sterilisation room were built and well equipped. At present the number of surgical cases are steadily increasing.

A maternal and child health programme is conducted.

Number of out-patients: 1976: 15,325
Number of in-patients : 1976: 6,122
Number of beds : 1976: 75

APVHA Member

XI. 2 **OUR LADY OF LOURDES HOSPITAL**

Koilakunta P.O.
Kurnool Dt. 518134
Telephone: 37

Short history:

Owner of institution: Sisters of the Society of J.M.J.

Date of foundation : 1969

This institution was started by J.M.J. Sisters in the year 1976 mainly for women and children, but as years passed by the need was great to treat all ailments empahasis is given to the villages, with health education and nutrition programmes.

Number of out-patients: 1976 : 11,006
Number of in-patients : 1976 : 1,608
Number of beds : 1976 : 25

APVHA Member

XI. 3 **NIRMALA CATHOLIC DISPENSARY**

Sirvel P. O. Kurnool Dist. 518563

Short History:

Owner of institution: C.M.C. Congregation

Date of foundation: 26th July, 1976.

This small dispensary was started in 1974 to help the poor Harijans in this area and the surroundings villages. It is planned to develop a Health Centre with 8 beds with an outreach programme with preventive care health education.

Number of out-patients: 1976: 7862

APVHA Member

XI. 4

SAN JOE NILAYAM

Pathikonda P. O.
Kurnool Dist. 51830

Short History :

Owner of institution : Sister Superior

Date of foundation : 1st Nov. 1976

San Joe Nilayam is a small dispensary started in a rented house in Nov., 1976. A plan was sent to Misereor in Germany for financial aid to start the construction of a 25 bed hospital with a community health out-reach programme.

Number of out-patients : 1976 : 1,200

APVHA Member

XI. 5

ST. ANTONY'S DISPENSARY

Kavulur P. O. Via Panem–518 112
Kurnool Dist.

Short History :

Owner of institution : Parish Priest, Kurnool Diocese.

Date of foundation : 15th Jan. 1975

St. Antony's dispensary began in Jan., 1975. Kavulur village with the population of about 2,000 has no medical help nearby. The patients have to go Nandyal which is about nine miles for medical aid.

Number of out-patients : 1976 : 1,500
Number of in-patients : 1976 : 200
Number of beds : 1976 : 5

APVHA Member

XI. 6

ST. WERBURGH'S HOSPITAL

Nandyal P. O. Kurnool Dist.

Short History :

This hospital was established in the year 1931, by Mr. Emmet. It has served the people of Nandyal district and especially for surgeries for at least three decades. It has now 50 beds.

There is also a centre for family welfare, undertaking family planning operations.

Number of out-patients : 1976 : 2,354
Number of in-patients : 1976 : 578
Number of beds : 1976 : 50

XI. 7 **HOLY FAMILY MATERNITY & CHILD WELFARE CENTRE**

Polur – 518511, Nandyal, Kurnool Dist.

Short History :

Owner of institution : Sisters of St. Ann's Congregation, Phirangipuram

Date of foundation : 19th March 1977

Polur is a big village of 6,000 population with 25 small hamlets and villages surrounding it. There was no medical facility available for this people except Nandyal town. Since there was a request from the people for a health centre, Fr. J. Boon has accepted the task of providing medical facilities and has obtained funds for a health centre. The sisters of St. Ann's, started working at this health centre from March, 1977.

APVHA Member

XI. 8 **C. S. I. HOSPITAL**

Kavutaluru–518344

Adoni Taluk, Kurnool Dist.

Short History .

Owner of institution : Church of South India, Karnataka

Date of foundation : 1947

The hospital of 35 beds was established in 1947 from the CSI hospital Chickballapur, Kolar District, to serve the backward famine prone area around Kavutaluru, Haloi and Halcholli in Adoni and Sirguppa Taluks (Then both in Bellary Distict). There has always been emphasis on mobile village dispensary work and the hospital has almost ceased to function apart from this. A committee of enquiry which has just visited the Hospital, has recommended that is become a Health Centre serving the community as part of a comprehensive development project.

Number of out-patients :	1976 :	2,400	1977 :	2,168
Number of in-patients :	1976 :	213	1977 :	199
Number of beds :	1976 :	35	1977 :	35

XII. 1 **RAYALASEEMA DEVELOPMENT TRUST**
RURAL COMMUNITY HEALTH PROGRAMME

Bangalore Highway, Anantapur - 515 001

Telephone : 2503 *Telegraph* : FRATERNA

Short History :

The R. D. T. was started in 1969 with CASA participation as a comprehensive Rural Development Project in the District of Anantapur. As part of the programme R. D. T. maintained forty M. C. H. centres in sevaral villages, a 25 bed leprosy centre and a 20 bed hospital for malnourished children.

From 1974 to the present with participation of EZE-KED and CASA, the M.C.H. centres have been extended to 40 villages covering 80,000 population. The main aim of the community health programme is "to bring basic health care facilities within walking reach of each village on a permanent basis" by training indigenous health workers. So far 38 village health workers are trained in 29 villages.

The R. D. T. has taken up feeding programmes, health education and immunization programmes and also provide safe drinking water.

The C. H. programme is part of a fine Community Development Programme.

APVHA Member

XIII. 1 **GRACE CLINIC**

Wanaparthy - 509 103
Mahabubnagar Dt.

XIII .2 **MENNONITE BRETHEREN MEDICAL CENTRE**

Jadcherla, Mahabubnagar Dist. 509302
Telephone: JCL 88

Short History:

Owner of institution: Conference of the M.B. Church of India

Date of foundation : 1952

The hospital was founded by Dr. and Mrs. Friesen of the Mennonite Brethren Church of North America in 1952 at Kaverammapeta, near Jadcherla, when the need for medical ministry was felt around this part of the land. It is a 130 bed general hospital doing a good surgical service. Opthamology service was started in June 1977.

Number of out-patients: 1976: 20,265
Number of in-patients : 1976: 2,366
Number of beds : 1976: 130

APVHA Member

XIII. 3 **METHODIST HOSPITAL**

Chandrakal,
Kondangal Tq.
Mahabubnagar Dist.

This hospital belongs to the Methodist Church, rendering valuable medical services to the needy since its inception.

Number of out-patients: 1976: 1,199
Number of in-patients : 1976: 80
Number of beds : 1976: 12

XIII. 4 **MENNONITE BRETHEREN CHRISTIAN HOSPITAL**

Wanaparthy – 509 103, Mahabubnagar Dist.

Short History :

Owner of institution : M.B. Christian Hospital, Wanaparthy

Date of foundation : 1935

The M.B.C. Hospital started as a dispensary in 1935 and afterwards developed into a full-fledged hospital by American Missionaries. Now it is a 60 bed hospital serving the people of this area and the nearby villages.

Number of out-patients : 1976 : 6,693
Number of in-patients : 1976 : 502
Number of beds : 1976 : 65

XIII. 5 **ST. AGNES HOSPITAL**

Jadcherla – 509 302
Mahabubnagar Dist.

XIV. 1 **ST. THERESA'S HOSPITAL**

Sanathnagar, Hyderabad–500 018.
Telephone : 261311, 261013.

Short History :

Owner of institution : Society of Jesus, Mary and Joseph

Date of foundation : 15-10-1971

The J.M.J. Sisters began small maternity home of 14 beds at Somajiguda in 1958. After 15 years of hard work, in Feb. 1974 St. Theresa's Hospital of 200 beds was opened in this suburban industrial area. This is a modern health institution of highest standard with super specialities of cardiotheracic and plastic surgery.

Several rural extention centres are connected with it, and factories nearby recognize the hospital for comprehensive health care of their employees

Number of out-patients : 1976 : 41,042
Number of in-patients : 1976 : 4,319
Number of beds : 1976 : 200

Educational Programmes : M.C.H. and Family counselling.

APVHA Member

XIV. 2 **VIJAY MARIE HOSPITAL** (CHINTAL BASTI place.)

Saifabad, Hyderabad – 500004.

Telephone : 34486, 220350.

Short History :

Owner of Institution : Sisters of Charity

Date of foundation : 1957

Vijay Marie Hospital was built in 1957 by the Sisters of Charity accommodating 120 in-patients and an equal number of out-patients per day. Now it is expanded to a hospital of 150 beds. The initial efforts of Dr. (Mrs.) Irene Rebello and Rev. Fr. Roch are worthy of remembrance.

The Community Health Programme covers a villags on the out skirts of Hyderabad, involving about 400 families. The programme includes also the slums around the hospital. Home visits, under-fives care and a supplementary feeding programme are offered.

Number of out-patients : 1976 : 37,035
Number of in-patients : 1976 : 6,568
Number of beds : 1976 : 115

Educational Programmes : General Nursing and Midwifery Course.

APVHA Member.

XIV. 3 **MUSLIM MATERITY & ZANANA GENERAL HOSPITAL**

Purani Haveli, Hyderabad – 500002

Telephone : 42005, 40002

Short History :

Owner of institution : Islamic Social Service Society

Date of foundation : April, 1970

This hospital was started in 1970 with 25 beds with a view to provide medical facilities to ladies who observe pardah. There are now 50 beds in the hospital. All operations, gynaecological & general, are performed and a paediatric Unit is attached to the hospital.

Number of out-patients : 1976 : 12,830
Number of in-patients : 1976 : 3,480
Number of beds : 1976 : 50

Specialities : Paediatric unit
Premature unit (Two incupators).

Educational programmes : A.N.M. training school (Recognised)

APVHA Member

XIV. 4

DR. KAKADE CHARITABLE TRUST "HYDERABAD SANATORIUM"

Priya-darshan, Ramanantapur
Hyderabad – 500013
Telephone : 71438

Short History :

Owrner of institution : Dr, R.T. Kakade-Managing Trustee

Date of foundation : 20-12-1955-Hyderabad sanatorium
9-11-1969 Converted to Charitable Trust

The Hyderabad Sanatorium has 25 beds specialising in Tuberculosis treatment. Extensive expension is planned.

Number of out-Patients : 1976: 810
Number of In-patients : 1976: 426
Number of beds : 1976: 25

Specialities : Tuberculosis.

APVHA Member

XIV. 5

HYDERABAD CHARITABLE HOSPITAL TRUST

4 & 5, Durga Bhavan, Rashtrapathi Road
Secunderabad – 500003.

APVHA Member

XIV. 6

THE SALVATION ARMY HEALTH CENTRE

6-D, Walker Town, Himmatnagar,
Secunderabad-500025.

Short History :

Owner of institution : The Salvation Army

Date of foundation : 7-12-1976

This is a free Health Centre began in Feb, 1976, catering for poor people, with Mondays and Fridays clinic in the Health centre, Secunderabad and clinics at saidabad and at Uppal Lambady camps.

Number of out-patients : 1976 : 2,446

APVHA Member

XIV. 7 **RURAL DEVELOPMENT CENTRE, HEALTH UNIT**

Lillipur-509325, Dubbacherla P.O.
Palamakote via Hyderabad

Short History :

Owner of institution : Hyderabad Archdiocese Social Service Society.

Date of foundation : January 1976

This health unit was started in Jan., 1976 as part of the comprehensive rural development programme. In September 1977 the Mobile Clinic was started. Five villages are being visited regularly for curative and preventive work. A good number of villages are covered by this mobile clinic.

Number of out-patients : 1976 : 3,188

Specialities : M.C.H. Programme, Natrition Programme

Educational programmes : Training of village level workers, Health Education to Mothers and school children.

XIV. 8 **MAHAVIR HOSPITAL**

Research Centre
A.C. Guards,
Hyderabad - 500004
Telephone : 34094

XIV. 9 **PRINCESS ESRA HOSPITAL**

Shah ali Bunda,
Hyderabad - 500002
Telephone : 44416

Short Histoy :

A free charitable dispensary was started in 1967 in the same premises. The hospital construction was completed in 1977, and started functioning from August 1978, with 50 beds.

Number of out-patients :	1976 :	42,233	1977 :	49,029
Number of in-patients :	1976 :		1977 :	217
Number of beds :	1976 :		1977 :	50

Specialities : Gynaecology, Eye, E.N.T., Pediatrics and orthopaedics.

XIV. 10 **ST. JOSEPH'S HEALTH CENTRE**

Kammagudem, Turka Emjala P.O.
Hyderabad - 501510
Telephone : 55

Short History :

Owner of institution : Catechist Sisters of St Ann.

Date of foundation : 1967

This health centre of 14 beds was established in 1967 by the Catechist Sisters of St. Ann. There are 20 villages surrounding this centre and patients come from all these villages to this hospital treatment.

Number of out-patients :	1976 :	8,000	1977 :	9,000
Number of in - patients :	1976 :	1,200	1977 :	1,100
Number of beds :	1976 :	12	1977 :	14

Educational Programmes : Film shows on family welfare.

APVHA Member

XIV. 11 **NURSING HOME - ANDHRA MAHILASABHA**

University Road, Hyderabad-500960
Telephone : 60101
Telegraph : MAHILA

Short History :

Owner of institution : Andhra Mahila Sabha, Chairman.

Date of foundation : 1964

Andhra Mahila Sabha Nursing home was established in 1964 as a meternity and child welfare centre. In due course it has developed into a full-fledged hospital of 75 beds and has also a nursing school.

Number of out-patients :	1976 :	29,081
Number of in-patients :	1976 :	6,615
Number of beds :	1976 :	75

Educational programmes : School of Nursing gives training to ANM & GNT.

XIV. 12 **CRAWFORD MEMORIAL HOSPITAL**

Vikarabad P.O. 501101
Hyderabad - Dt.

Short History :

Owner of institution : Methodist church Hyderabad Annual conference

Date of foundation : 1908

This hospital was started in 1908 by the Methodist church, rendering considerable amount of charity work in the field of health care.

They have a mobile clinic visiting villages around the town of Vikarabad. They have another clinic at Gingurthi, 39 miles a way from Vikarabad.

XIV. 13 **ST. ANN'S DISPENSARY**
Mallapur Village
Near Moula Ali
Hyderabad - 500040.

This dispensary is run by the Sisters of St. Ann of Providence.

XV. 1 **C.S.I. HOSPITAL**
Medak. 502110
Telephone : 32

Short History :

Owner of Institution : C.S.I. Medak Diocese

Date of foundation : 1904

This hospital was started in 1904 by Miss. Posnett and Miss. Harris mainly to conduct deliveries and treat minor alinments. It has gradually become general hospital with 20 beds.

Number of out-patients	: 1976 :	11,075
Number of in-patients	: 1976 :	1,550
Number of beds	: 1976 :	20

APVHA Member

XV. 2 **MEDAK DIOCESE FAMILY DEVELOPMENT PROGRAMME**
Under Fives Centre
C S.I. Compound
Medak - 502 110.

APVHA Member.

XV. 3 **VINCENT HEALTH CENTRE**
Alirajpet, Gajwel, Medak Dt.
A.P. - 502278

Short History :

Owner of institution : Congregation of Sisters of Charity of St. Vincent de Paul.

Date of foundation : 28-11-1976

This is a newly started health centre under the Sisters of Charity of St. Vincent de Pual with 8 emergency beds. It provides health care to 7 villages by using a mobile unit.

APVHA Member

XV. 4

C. S. I. HOSPITAL
Ramayampet P. O.
Medak Dist. – 502101

XV. 5

GOOD NEWS SOCIETY CLINIC
Zahirabad P. O.
Medak Dist.

XVI. 1

ST. JOSEPH'S HEALTH CENTRE
Mattampalli, Huzurnagar Tq.
Nalgonda Dist. 508204

Short History:

Owner of institution: Catechist Sisters of St. Ann.

Date of foundation : 1919

Mattampalli is a remote village in Huzurnagar Taluk. Sisters of Divine Providence established their convent some 60 years ago. Since there was not even a small hospital within a day's journey, the Sisters started a small dispensary where they attended the maternity cases and minor ailments. It served nearly twenty villages around this centre.

Eventually, the local people contributed 5 acres of land and in 1976 a 10 bed health centre was opened with financial help from the Indo-German Social Service Society.

Number of out-patients :	1976 :	5,000	1977 :	7,000
Number of in-patients :	1976 :	300	1977 :	500
Number of beds :	1976 :	10	1977 :	10

APVHA Member

XVI. 2

C.S.I. CHRISTIAN HOSPITAL
Panigiri – 508279
Nalgonda Dist.

Short History:

Owner of institution: C. S. I. Dornakal Diocese

Date of foundation : 1923

This hospital was started as a small rural dispensary in 1923 by Miss. Parson of the British Methodist Society of London. Miss. Parson worked for 4 years, was followed by Miss. Midgley who built the maternity section and the O.P. block. The service has continued through the years.

Under-five clinics, Nutrition, M.C.H. & Family Planning Programmes are conducted with the Hospital as a referral centre.

Number of out-patients : 1976 : 4,564
Number of in-patients : 1976 : 3,534
Number of beds : 1976 : 30

APVHA Member

XVI. 3 MAHATMA GANDHI LIFT IRRIGATION CO-OPERATIVE HEALTH CENTRE

Gaddipalli P. O. Huzur nagar Tq.
Nalgonda Dist.

Short History :

Owner of institution : Chairman M.G.L. Co-operative Society Ltd.

Date of foundation : 1973

This health centre was begun in 1973 mainly to promote better health of people in the project area. It renders both curative and preventative services.

APVHA Member

XVI. 4 NIRMALA HOSPITAL

Suryapet, Nalgonda Dt. 508 213
Telephone : 121

Short History :

Owner of institution : Missionary Sisters of the Immaculate

Date of foundation : 30-10-1966

Nirmala hospital began as a dispensary in 1966 in Suryapet town. After two years, a 70 bed hospital was opened with surgical, medical and maternity care facilities to serve the poor of this area.

Number of out-patients :	1976 : 7,600	1977 : 8,000
Number of in-patients :	1976 : 2,500	1977 : 2,600
Number of beds :	1976 : 70	1977 : 70

APVHA Member

XVI. 5 ST. MARY'S HOSPITAL

Kodad – P.O.
Nalgonda Dt. 508 206.

This Hospital is run by the sisters of St. Ann, Phirangipuram.

XVI. 6 **CATHOLIC HOSPITAL**
Huzurnagar – 508 248
Nalgonda Dt.

XVI. 7 **LEPROSY HEALTH CENTRE**
Duppalapalli road – Nalgonda – 508 001

Short History:

Owner of institution : Franciscan Sisters of Immaculate, Nalgonda

Date of foundation : 25 August 1973

Rev. Fr. Luigi Pezzoni, specialist in leprosy, came to Nalgonda in 1666 and established a general clinic and Leprosy clinic. In 1974 he founded the leprosy health centre at Nalgonda outskirts. The same year Father obtained the Visa for two Sisters belonging to the Franciscan Sisters of Immaculate and on 5th Jan. 1978 the hospital was inaugurated. Meanwhile 6 sisters came to India and are working as leprosy nurses in this hospital and Indian Sisters are being trained to join the work.

The Government of A.P. has alloted to this leprosy centre 13 clinics in Miryalaguda taluk and they have also taken up work in five other clinics.

Number of out-patients : 1976 : 3,500

APVHA Member

XVII. 1 **ST. MARY'S C.S.I. HOSPITAL**
Khammam - 507001.
Telephone : 211

Short History:

Owner of institution : Church of South India, Dornakal.

Date of foundation : 1902

The C.S.I. Hospital was built in 1902. A vernacular grade nursing course functioned for some years, and now an A.N M. course is conducted. There are 130 beds in the institution.

Community Health Programme covers an area of one square mile around the hospital serving a slum area of over 9,000 people and 5 nearby villages of 20,000 population. The villages are visited twice weekly. Family planning services are available from the hospital. Under-fives clinics are conducted as part of C.H. programme.

Tuberculosis is a special problem in this area. A Programme of Immunisation for communicable diseases and control programmes for T.B. & Leprosy are conducted.

Health education is carried on to improve environmental sanitation.

Number of beds : 1976 : 130

Educational programmes : A.N M. training course.

APVHA Member

XVII. 2 **LOURDU MATHA HOSPITAL**

Thallada P.O.
Khammam Dt.

Short History:

Owner of institution: Sisters of Charity.

Date of foundation : 8-2-71

In 1958 a small dispensary was established by Fr. C. Radice, P.M.E. It was handed over to the sisters of Charity. Due to increase of patients a new place was selected and opened in 1972 with 46 beds.

Number of out-patients : 1976 : 6,000
Number of in-patients : 1976 : 200
Number of beds : 1976 : 46

Educational Programmes: M.C.H. Programme Health education in schools.

APVHA Member

XVII. 3 **MARIA RANI DISPENSARY**

Bayyaram P.O.
Khammam Dt.

It is a small dispensary conducted by the Cathechist Sisters of St. Ann.

APVHA Member.

XVII. 4 **MISSION HOSPITAL**

Rebbavaram
Khammam Dt.

This dispensary is run by the Cathechist Sisters of St. Ann. Three beds are attached to the dispensary.

XVII. 5 **MISSION HOSPITAL**

Proddutur P.O.
via. Chintakani
Rly. Khammam Dt.

This Hospital with 18 beds, is run by the Cathechist Sisters of St. Ann.

XVII. 6 **PREM SEVA SADAN DISPENSARY**

Cheruvumadaram P.O.
Khammam Dt.

This dispensary is run by the Sisters of Charity.

XVIII. 1 **CHRISTIAN HOSPITAL & RURAL HEALTH CENTRE**

Hanamkonda – 506001, Warangal

Telephone : 7329

Short history :

Owner of institution : Samavesam of Telugu Baptist Churches.

Date of foundation : October, 1976.

This institution has been started a new in 1976 on the premises of the old Victoria Memorial Charitable Hospital which was closed in Sept. 1973. There are 50 beds in the hospital and a C.M. Programme.

Number of out-patients : 1976 : 1772
Number of in-patients : 1976 : 170
Number of beds : 1976 : 50

Specialities : – General Surgery,Paediatrics

APVHA Member

XVIII. 2 **ST. ANN'S HOSPITAL**

Fatimanagar – Kazipet

Warangal – 506003.

Telephone : 7262

Short History :

Owner of institution : Sisters of St. Ann of Providence.

Date of foundation : March, 1954

St. Ann's Hospital was opened by the Sisters of St. Ann of Providence in the year 1954. It is catering mostly to the poor people of the suburbs and surrounding rural areas. In the year 1954 with the efforts of the Religious Congregation and the help of the Bishop of Warangal four rooms were completed to serve as dispensary. Gradually the dispensary took the shape of a hospital, as the number of patients increased. By 1967 it was a full-fledged hospital, with 150 beds. They operate a Primary Health Centre at Appenapeta.

Number of out-patients : 1976 : 25,600
Number of in-patients : 1976 : 16,000
Number of beds : 1976 : 150

Educational programmes : N.F.P. in the hospital

APVHA Member

XVIII. 3 **RURAL DEVELOPMENT CENTRE**
Tarigopala P. O.
via. Jangaon
Warangal Dist.

APVHA Member

XVIII. 4 **ST. ANN'S DISPENSARY**
Reddipalem P. O.
via. Wardannapet
Warangal Dist.

This dispensary is run by the Cathechist Sisters of St. Ann to provide primary health care for the people of this village and nearby villages.

APVHA Member

XVIII. 5 **BISHOP WHITEHEAD HOSPITAL**
Dornakal – 506381. A. P.

Short History :

Owner of institution : C.S.I. Dornakal Diocese

Date of foundation : 1968

This hospital was built in 1928 in memory of the late Bishop Whitehead Madras Diocese. The hospital has 20 beds and provides health care to the student membership of about 700 and outsiders as well. Number of tribals also come to this hospital.

Number of out-patients : 1976 : 16,326
Number of in-patients : 1976 : 755
Number of beds : 1976 : 20

APVHA Member

XVIII. 6 **ST. ANN'S DISPENSARY**
Narimetta P. O.
Warangal Dist.

XIX. 1 **CHURCH OF SOUTH INDIA HOSPITAL**
Mukarampura
Karimnagar – 505002
Telephone : 409

Short History :

Owner of institution : Church of South India, Dornakal Diocese

Date of foundation : 1923

Work among women and children was started by Dr. Joan P. Drake and Sister Alice Hawkins, missionaries of the Methodist Missionary Society of London in the year 1908. Proper buildings for the hospital were built at the present site in 1923. A Men's Ward was added in 1951 by means of gift from the Rank Benevolent Fund. In 1965 a Children's Ward was built from a grant received from the Bread for the World Organisation. During the years 1971 to 1976 a new out-patient Block, new Women's Wards, Operation Theatre, Nurses quarters and staff quarters were built with funds received from the E.Z.E. of West Germany. Immunizations are conducted twice a week at the hospital and in the village clinic.

Community Health out-reach programme is going on in a nearby village with resident A.N.M.

Number of out-patients : 1976 : 33,164
Number of in-patients : 1976 : 3,658
Number of beds : 1976 : 150

Educational programmes : ANM training school.

APVHA Member

XIX. 2

C. S. I. HOSPITAL
Jagtial - 505327
Karimnagar Dist.
Telephone : 221

Short History :

Owner of institution : C. S. I. Dornakal Diocese

Date of foundation : Before 1927

This Mission Hospital was started by the Methodist Missionary Society before 1927 as a small dispensary. From 1930 in-patients received mainly for matetnity cases. From 1974 the hospital is functioning as a general hospital of 25 beds.

A maternal & child health programme is conducted.

Number of out-patients : 1976 : 11,375
Number of in-patients : 1976 : 1,133
Number of beds : 1976 : 25

APVHA Member

XIX. 3

JEEVADHARA HEALTH CENTRE
Shanthinagar Village (Nampalli)
via. Sircilla and TK.
Karimnagar Dt.

Fr. T. Baliah. S.J., the then Regional Superior of Jesuits in A.P., took lead to provide health facilities to the people of this area by inviting the Missionary Sisters of the Immaculate.

This centre was started by the Nirmala Sisters with 10 beds specially to the Maternity cases. Minor ailments are also treated at this centre.

XIX. 4 **ST. ANN'S PRIMARY HEALTH CENTRE**

Appannapeta P.O.
Peddapally Rly. Station.
Karimnagar Dt.

This centre is being run by the Sisters of St. Ann of Providence.

XX. 1 **VICTORIA HOSPITAL**

Dichpalli – 503175
Nizamabad Dt.
Telephone : 25

Short History :

Owner of Institution : Church of south india, Medak Doicese.

Date of foundation : 1915

In 1915 leprosy work was started in this rural area and the hospital was opened in 1927. A leprosy out-patients programme was begun in 1970. In 1973 the community health programme was established ; and also general health care was begun. The name of the hospital was changed to Victoria Hospital in the same year.

The Community Health Project (CHP) extends to a radius of 8 kms. around the hospital, involving 13 villages and approximately 20,000 population.

Activities covered include a project clinic at Victoria Hospital and a community ward. There are also six weekly clinics in six villages and home visiting of irregular TB, leprosy patients. Health education is carried on in Beedy factories in many villages. There is a V.H.W. training programme.

This CHP programme is financed by OXFAM, Oxford England.

Number of beds : 1976 : 137

Educational Programmes : Health education programme connected with community health project

APVHA Member

XX. 2 **LOURDES DISPENSARY**

Dharmaram P.O. 503230
Nizamabad Dt.

Short History :

Owner of institution : Sisters of Charity.

Date of foundation : 9th Feb. 1967

Fr. Dhanraj of Lourd matha Church requested the Sisters of Charity to open a dispensary for the Parishners and the poor of the surrounding villages and this was

inaugurated in 1967. There are 4 beds attached to the dispensary and Sisters make regular home visits.

Number of out-patients :	1976 :	8,400	1977 :	10,300
Number of in-patients :	1976 :	120	1977 :	200
Number of beds :	1976 :	4	1977 :	4

APVHA Member

XX. 3 **CHURCH OF SOUTH INDIA HOSPITAL**

Dudgaon – 503219 Nizamabad Dist.

Telephone : 63

Short History :

Owner of institution : Church of South India, Medak Diocese

The C.S.I. Hospital at Dudgoan has a bed strength of 80 and serves effectively in a needy area reaching about 1,500 in-patients and 5,500 out-patients in a year. They also operate two village clinics.

Number of out-patients :	1976 :	5,427
Number of in-patients :	1976 :	1,406
Number of beds :	1976 :	80

APVHA Member

XX. 4 **JEEVADAN MEDICAL CENTRE**

Lingampet P. O. 503124

Nizamabad Dist.

Telephone : 27

Short History .

Owner of Institution : Jeevadan Projects

Date of foundation : 22nd May 1975

Lingampet is a village of 11,000 population. Even though the village had developed economically, there were no medical facilities at all with in a radius of 20 kms. The village community requested a clinic in the village in 1975. The same year Lakshmikanthamma, a Philanthropist, donated 10 acres of land for the construction of e hospital. Jeevadan Projects constructed the building for 5 beds. The emphasis is on community health programme in the villages and especially M.C.H. services.

Number of out-patients :	1976 :	17,143
Number of in-patients :	1976 :	220
Number of beds :	1976 :	5

Educational programmes : Education for married women in the villages, Natural Methods of F. P.

APVHA Member

XX. 5 **JEEVADAN HOSPITAL**

Kamareddy P. O. Nizamabad – 503111

Short History :

Owner of institution : Jeevadan Projects

Date of foundation : 18-6-1978

Kamareddy is a Taluk head quarters having a population 24,000. There is a Govt. Hospital and several private practioners and still the people felt the need of a Mission hospital and approached the Jeevadan Project. The Project started a hospital in June 1978 with 5 beds with large out-patient service.

It has become a referral centre for the surrounding 30 villages for M.C.H. services.

Number of out-patients	: 1978 :	2,050
Number of in-patients	: 1978 :	75
Number of beds	: 1978 :	5

Educational programmes : Health education and Natural Family Planning.

APVHA Member.

XXI. 1 **CATHOLIC RURAL HEALTH CENTRE**

Gudlabori P. O. 504299

Adilabad Dist.

Short History :

Owner of institution : Parist Priest, Vijayanagaram

Date of foundation : 15-10-1969

As there was no other health centre for more than 30 villages around Vijayanagaram, a dispensary was begun in 1969 and named as the catholic Rural Health Centre. It treated over 6,300 patients in 1977.

Number of out-patients : 1977 : 6,325

APVHA Member

XXI. 2 **CHURCH OF SOUTH INDIA HOSPITAL**

Luxettipet – 504215

Adilabad, A. P.

Short history :

Owner of institution : Church of South India, Medak Diocese

Date of foundation : 1929

This hospital started about fifty years ago as a small dispensary for villages around Luxettipet. In 1929 it became the only hospital for the whole taluk. The hospital has progressed with the addition of a new maternity block to the present strength of 33 beds.

Number of out-patients :	1976 :	1,971	1977 :	3,448
Number of in-patients :	1976 :	290	1977 :	301
Number of beds :	1976 :	33	1977 :	33

APVHA Member

XXI. 4 **C. S. I. DISPENSARY**
Nirmal P. O.
Adilabad Dist.

XXI. 5 **CATHOLIC DISPENSARY**
Indravalli P. O. Utmoor Tq.
Adilabad Dist. 504 311.

This dispensary was started in 1977 by the Charity Sisters of St. Francis of Assisi.

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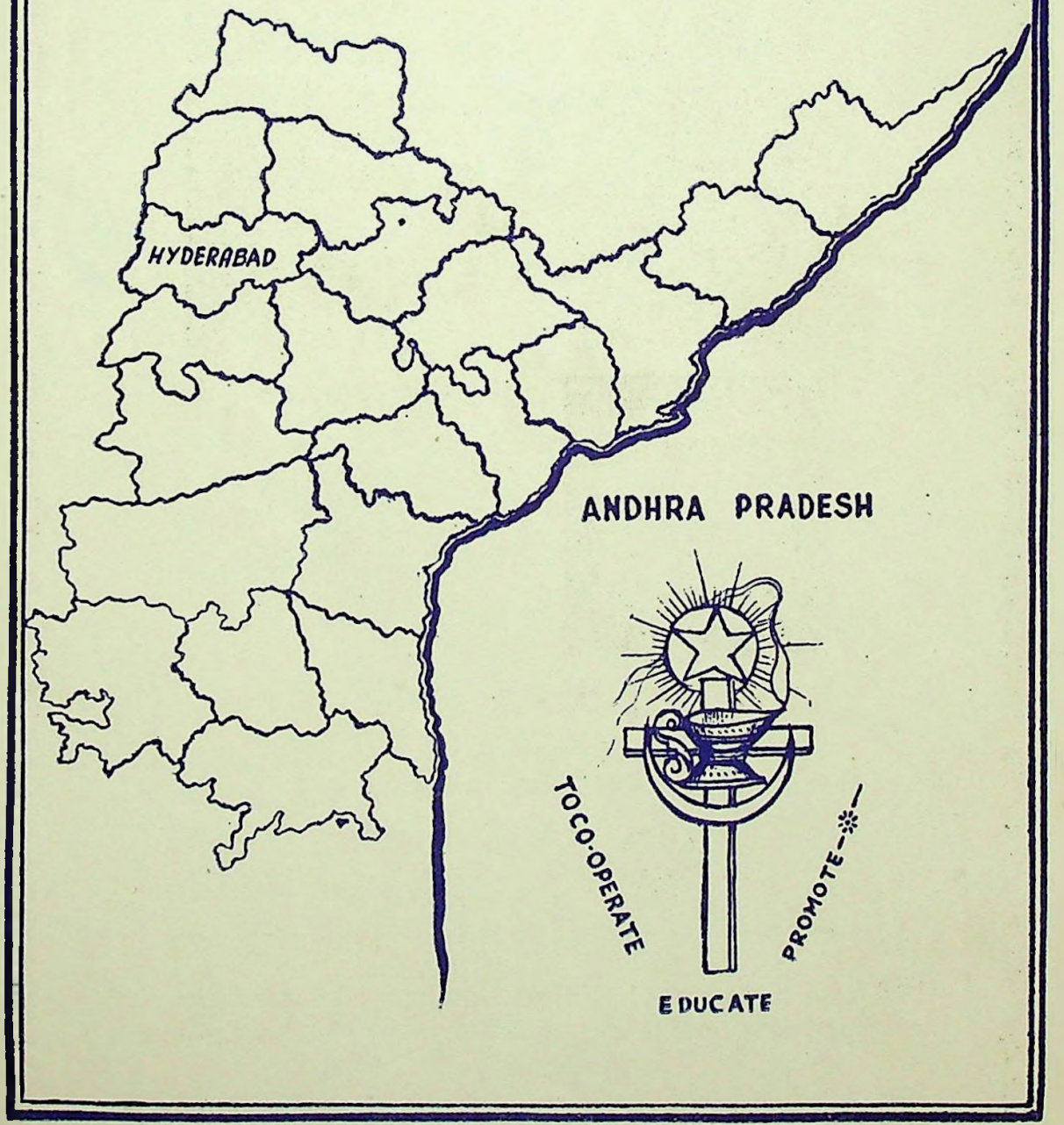

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THE KILLARI QUAKE

Marathwada, Maharashtra, 1993

A CHAI Response

On October 6, 1993 an urgent meeting of the Planning Committee for the Golden Jubilee celebrations of the Catholic Hospital Association of India (CHAI) and the staff of CHAI was called.

The mood was solemn. The question :

> "Should CHAI drop all the celebrations in view of the terrible disaster that struck Killari and the surrounding regions of Marathwada in Maharashtra ?"

The decision was unanimous :

> "We will drop all the celebrations."

It was a very difficult decision. Preparations for the Golden Jubilee celebrations had been going on for the past two years. All arrangements had been finalised. The various committees had been working hard and giving the final touches. Large number of delegates and participants were due to come from the country and from abroad. The resource persons for the themes for the different days, seminars, symposia, workshops and public meetings had agreed and the programmes had been worked out in detail; cultural programmes for each day had been decided upon.

After serious reflection, it was decided that

(1) the programmes for the first 6 days will be cancelled, including the various meetings and cultural programmes;

(2) there will be the annual convention for two days (November 6 and 7);

(3) the opportunity will be utilised to

1. have a final reflection on the CHAI Golden Jubilee Evaluation Study, which had been discussed at various forums (regional, professional and others) utilising the discussion document "Seeking the Signs of the Times" so as to lead to action at various levels—local, regional and national;
2. discuss the amendments to the constitution, to make the organisation function more effectively and efficiently;
3. initiate a process of preparedness against disasters, natural or man-made, and
4. focus our attention and efforts on bringing relief to the victims of the disaster and rehabilitate them.

An initial commitment of rupees ten lakhs was made towards relief. The members of the staff committed themselves to donate a portion of their salary.

The Situation

In the morning of September 30, 1993, Killari and the surrounding regions experienced the worst earthquake taking a toll of tens of thousands dead, many more injured and colossal damages to houses, buildings and property. The earthquake measured 6.4 on the Richter scale. There were five tremors; the first occurred at 3.56 hours and the fifth at 07.45 hours. These were followed by aftershocks for several days.

The number of dead was variously estimated at between 10,000 and 30,000; the more accurate one may be nearer the latter one.

The damages caused were mainly in Latur and Osmanabad districts :

44 villages in Latur and 32 villages in Osmanabad were soverely affected.

The loss of lives and damages were unusually high.

Causes :

1. The densely populated area
2. Unsuitable house construction
3. The nature of the soil
4. The disaster ocurred in the early hours of the morning.

The response

There was massive response from everywhere—local, national and international, in kind, human resources and money. The Government of Maharashtra swung promptly into action; so also various voluntary organisations. There was an unprecedented and growing groundswell of humanitarian aid of every description. Food, water, clothing, disposal of dead bodies, safety of property, temporary shelters, electricity and other needs were attended to. Health and medical care received attention. The armed forces were requested to help in the relief and rescue operation. They did an excellent job.

The response though massive, was still inadequate. More help was called for.

CHAI team

CHAI responded to the call. They were assisted in this by the Sanghi group of Industries. The CHAI team with volunteers from the Andhra Pradesh Conference of Religious India, Andhra Pradesh Bishop's Conference, Forum of Religious for Justice and Peace and CHAI member institutions set up a relief camp at Nandurga village on October 10, 1993. It was called the CHAI-SANGHI Earthquake Relief Camp.

Priorities for the CHAI relief team

1. Provide medical and health care.
2. Help in the psychological, social and spiritual needs.
3. Attend to hygiene and sanitation.
4. Mobilise relief materials for villages that needed them.
5. Plan for long term rehabilitation.

The Camp

The relief camp was set up at Nandurga village, 50 Km away from Latur. The team functions and operates in the villages around within a radius of upto 10 Km.

Initially life in the relief camp was difficult. Incessant rains gave sleepless nights. There was ankle deep water inside; the black cotton soil was slushy. Things improved in a couple of days. More volunteers arrived. Medicins Sans Frontieres, a Natherlands based organisation provided basic medicine kits and tents(3) for the team. Government also provided 2 tents. There were, additionally, three tin sheds for kitchen and other purposes. One additional subcentre was opened in Sarani to serve Sarani and Lotta.

Organisational set-up

Two teams have been set up to co-ordinate the relief operation.

Core team at Hyderabad

The following organisations besides others are represented in the core team at Hyderabad (names of representatives given) :

- The Catholic Hospital Association of India : Fr John Vattamattom, svd
- Sanghi group of Industries : Mr Girish
- Andhra Pradesh Conference of Religious India : Fr Bosco sj and Bro Thomas Aquinas
- Andhra Pradesh Bishops Conference : Fr Francis Thumma
- Forum of Religious for Justice and Peace : Bro Varghese Thekanath, SG

The core team is responsible for mobilisation of resources, co-ordination and implementation of the programmes

Action team at the site

The action team has two co-ordinators :

* Administrative co-ordinator : Fr Joy Kochupura : Responsible for liaising with the core team, government, voluntary organisations, procurement of materials and general administration of the camp.

* Field co-ordinator : Bro Varghese T : Responsible for relief and rehabilitation in the field and personnel management.

The two co-ordinators will consult each other before arriving at major decisions.

Fr Amal Raj sj along with the co-ordinators and members of the core team will periodically evaluate the relief organisations.

Medical Care

A large number of people have been availing of medical care provided by CHAI team. As soon as the medical tent was put up, a throng of patients queued up. The medical work was organised into

1. an outpatient department at Nandurga and later at Sarani, about 15 Km away from Nandurga, and
2. mobile clinics and health extension programmes in

   Hasalgam
   Sankarala
   Jangaonwadi
   Sarani
   Lotta
   Limbada
   Tanda
   Magrul
   Haragoan.

The number of patients attended to by the doctors averaged 400. There were fractures of limbs, spine and pelvis. Many had infected wounds. There were many patients with diarrhoea, scabies, cough, cold and fever. They were all attended to by our teams. Our teams had doctors, nurses, social workers and other volunteers, who were drawn from different parts. The doctors were specialists (orthopaedic surgeon, paediatrician, gynaecologist) and generalists, depending on the perceived needs in the field. The nurses were well qualified and experienced. Special mention must be made of the human resource contributions from St. John's Medical College and Hospital, St. Martha's Hospital and St. Philomena's Hospital, Bangalore, the Community Health Cell, Bangalore, Scholastics from the Papal Seminary, De Nobili College and SVD Seminary, Pune and the St. Theresa's and Vijay Marie Hospitals, Hyderabad beside many others.

Patients requiring immediate surgery or hospitalisation were referred to

District Hospital, Latur

Vivekananda Hospital, Latur and

St. Theresa's Hospital, Hyderabad

The team doctors followed up the patients ensuring that they received the required treatment. There was excellent co-operation. The Maharashtra Health Minister visited our medical relief camp. He appreciated our work and entrusted the curative medical care to our team. In addition to curative care, attention is given to the preventive and promotive aspects as also community health. Health education programmes are conducted with the use of audio-visual aids, street plays, role plays and songs. Local resources are being mobilised for health education.

The district medical officer has requested our team to co-operate with the anti-malarial programme. We have been assigned 8 villages for the antimalarial programme.

Psychological needs

The people of the affected areas are striken with deep grief, as part of the Post Trauma Stress Syndrome. Our social work team has been reaching out tothe families in our efforts to rehabilitate them. As a result of personal interaction with the people, a good rapport has been built up.

The team has been able to help in improving the psychology and attitude of the people. The team is in the process of organising people at different levels—school children, women, youth, men.

Hygiene and sanitation

The villages had been shifted to temporary settlements provided by the Government. Hygiene and sanitation were lacking. A subteam of the CHAI team was formed to look into the area of hygiene and sanitation. The team has done very good job in providing proper drainage system, constructing platforms for washing clothes, protecting water supply sources and the environment. The people are also educated in hygiene and sanitation.

Material relief

Though the news is that materials are pouring in, the reality is that the basic minimum needs are not met in the case of many people. These people have lost everything. A lot more of relief materials are needed. They must reach the needy. The team has provided food materials wherever there was acute shortage. The core team at Hyderabad mobilised necessary materials. They have been distributed in Sarani, Lotta, Sankrala and Wadi. Rice, dal, wheat flour, oil, masala and potato have been supplied. Other materials included clothes, blankets, blackboards, benches and educational materials.

Survey

Our survey team has completed the survey of six villages and collected pertinent information and data.

Situation after one month

The situation continues to be grim. The people who have lost everything have to be rehabilitated, besides continuing relief. Agriculture consists mainly of cash crops. The production of food grains is not much. It will take atleast a month to harvest. Until then, scarcity of food will be experienced. Once the crops are harvested, some of the basic needs will be met. Until then, supplementary food and other relief have to be continued.

Housing is an area which has to be taken up seriously and quickly. Arguments on design and materials can cause delay. Life for the villagers will be tough till these houses are constructed and occupied. It is understood that many voluntary organisations have come up with projects to construct between 8 and 9 thousand houses. But the number of houses which have been damaged wholly or partly is estimated to be 1.23 lakhs. Massive reconstruction has to be taken up by the Government and voluntary agencies.

Future plans of CHAI

- Relief to be continued, to the extent required.
- Provide curative, preventive and promotive care,
- Concentrate on the psychological, social and spiritual rehabilitation, bringing the people back to the normal stream of life, using appropriate strategies.
- identify potential leaders and train them to continue the activities.
- organise women, children and youth as also cultural and recreational programmes.

Collaboration with other agencies

The CHAI team has been happy to collaborate with Government and Voluntary agencies. The representative of the team was attending the weekly co-ordinating district level meetings convened by the District authorities. The District and State authorities have appreciated the work done by the CHAI team and requested CHAI to continue the good work. BHEL and ICRISAT made use of the infrastructure and contacts of CHAI for distribution of relief packages of household utensils, clothes and chickpea seeds. Other voluntary agencies donated drugs for use by CHAI team in their medical work. Two doctors from Banaras Hindu University worked with CHAI team. The collaboration with the Sanghi group of Industries has been wonderful and fruitful.

Conclusion

The magnitude of the disaster and its impact on the people in the affected area are yet to be fully assesed. There is need to continue the efforts, on more scientific and humane lines, in the coming weeks and months, keeping in mind the long term needs and problems of the affected.

Credits : Reports of Dr. Mani Kalliath (CHD),
Bro. Varghese Theckanath (Field Co-ordinator)
and Fr. Joy Kochupara (Administratjve Co-ordinator).

Declaration of

The Catholic Hospital Association of India

on the occasion of

The Golden Jubilee 6.11.1993

Jeevan Jyothi Retreat House, Begumpet
Hyderabad, A.P.

****

Preamble

In the mercies of God and as part of the body of Christ, the Catholic Hospital Association of India (CHAI) has been blessed to attain its fiftieth anniversary this year. In the course of this half century, the Association has grown from "Out of Nothing" into a network of over 2500 institutions which facilitates the services of thousands of Catholic health care centres and hospitals all over India. More significantly, it has undergirded the vocations of tens of thousands of God's children called to serve through Christian medical care, for the whole or parts of their lifetime. Such abundant fruitfulness and usefulness in the last 50 years demand from us that we use this occasion to prepare for greater obedience and further effectiveness in the coming years through deliberate reflection on our past, thoughtful analysis of our present and renewed commitment to our future under the guidance of God. For this purpose a comprehensive study was entrusted to Dr Thelma Narayan. She and her colleagues have done an excellent job during the last two years, with full co-operation of the member institutions.

Over the past one year the Association has undertaken an exhaustive process of study, reflection, analysis and consultation, with professional help and wide participation. The Association has courageously and openly appraised its strengths and its weaknesses, seeking information and opinions from every member institution. With the aid of a widely representative panel of experts from outside the CHAI, it has also sought to arrive at an informed and broad-based consensus on the future health needs of India and the distinctive role to which God may be calling CHAI in that situation. The output of these two processes were circulated to the general membership of CHAI, who discussed and prioratised them in regional and sectional meetings.

The outcome of these studies and discussions have been spelt out in the detailed reports of these processes. Specific courses of action will have to be based on these reports as well as the preferences and priorities arrived at by the regional and professional group discussions on these reports. But as a guideline to all these activities, we need to identify and commit ourselves to the overall directions emerging from these processes.

...2

Six major concerns

While a large number of desirable objectives and mechanisms have been identified in the course of the study and evaluation process, six major concerns have emerged as of fundamental importance :

(a) A holistic concept of health, healing and wholeness

The member organisations of CHAI are involved in health care in its various aspects, While they all subscribe to the concept of wholeness or fullness of life in all the dimensions of the human being, in practice the emphasis is predominently on the cure or relief of physical ailments through a bio-medical approach. Thus the unique and distinctive whole person approach to health and healing arising from our faith is not always evident in the services of our institutions. A deliberate and consistent pursuit of holistic healing ought to characterise our member institutions, whatever their size, location or level of technology.

(b) The preferential option for the poor

The gospel is good news to the poor, and the church's healing ministry is part of that good news. But in the practice of medical care, the socio-economic resources of the patient tend to determine his access to medical care. In our institutions, there must be a preferential option for the poor, channelling our resources to meet their needs and adapting our care to the best possible within their resources. This also requires a deliberate placement of our institutions in the areas of the greatest need in the country. At present only a little over 25% of CHAI member organisations are in the BIMAROU states. And the majority of our institutions and projects are in the states which are better served in health care. But poverty is also deprivation due to physical, mental, behavioural and societal handicaps or abnormalities; these areas of dehumanisation deserve the preferental involvement of CHAI institutions. Poverty can also be/belonging to high risk but neglected groups such as children and women. A deliberate focus on all forms of poverty ought to characterise CHAI institutions. /in

(c) The concept of Community Health

Though the community health approach has been emphasised by CHAI from the late seventies, the bulk of our activities continue to concentrate on care and cure of the individual in an episodic manner. Most of our hospitals are better at curing or relieving the sick who come to them, than in enabling communities to become healthier and more wholesome by their own efforts and according to their resources and

and circumstances. Community orientation needs to become a basic commitment and not an optional activity of CHAI institutions.

(d) Role in education and human resource development

The achievement of these priorities depend on the staff of our hospitals having the requisite commitment to these goals as well as the necessary know-how. They are products of the prevalent patterns of education and training which do not emphasise these concerns. So CHAI needs to develop appropriate educational and training mechanisms. This can be broadly at two levels. Firstly, the member organisations which offer training in the health professions must be helped and induced to give priority to these concerns in all their educational and training programmes. The process must be modified to ensure that they can be depended on to assimilate these priorities. But such training is a demanding task and CHAI needs to develop a highly competent Educational Section to fulfil these roles in education and human resource development.

Continuing Education : Health personnel, who have been trained earlier, need to update and refresh their knowledge, skills, and attitude. Otherwise, the care they give becomes obsolete. There is urgent need for continuing education for doctors, nurses, allied health professionals and all others involved in health care.

(e) Organisational changes

Since the directions prioritised above are not new, the inadequacies in following them must be ascribed inpart to organisational deficiencies. On the one hand, there is need for greater integration and co-ordination among the member organisations. If they can truly work as members one of another in an all-India body, the shared resources, expertise and commitment can help to achieve these goals. If our larger teaching institutions can modify their curricula and their own style of functioning to incorporate our priorities, the trainees will in due course become attuned to and competent in them and disseminate them in the CHAI network. On the other hand, there is need for de-centralisation of the CHAI structures in order to facilitate decision making and more effective implementation of the objectives at regional levels. The officers at both the national and regional levels must be made accountable to their respective constitutuendes and respond to the needs of the regions. All this would also call for improving the CHAI structure and leadership in quantity and quality.

(f) Religious sisters and CHAI

In any evaluation of CHAI, it is clear that its foremost strength is the total devotion of the individual "religious" members in the service of their Lord and master through the healing ministry. But at the same time, they are primarily committed to the "charism" of their respective

congregations and to their organisational practices; the involvement in health care is subject to these considerations. A major requisite for the development of CHAI and health and healing in the country in the coming years is a greater recognition and affirmation of their role and objectives by the religious orders. This could occur at two levels.

The congregations could contribute to the leadership of CHAI and to the necessary improvement of CHAI staff in quality and quantity. They could also give greater emphasis and priority to the staffing needs of the health centres and hospitals, in the overall scheme of the training and disposition of their members. Such an increasing involvement in the ministry of healing may benefit the congregations too, by attracting to them committed believers by offering them a challenging and meaningful vocation with ample space for initiative and creativity. Mechanisms must be evolved for strengthening this mutually beneficial symbiotic relationship between the CHAI and the religious congregations. At the same time, the health care centres, based as they are on the "religious" need to recognise and facilitate the ministry of the laity and even of committed persons of others faiths or no faith, as part of the mission of the church.

These six major issues encompass the majority of the recommendations and conclusions emerging from the evaluation and discussion process. Each of these recommendations have a number of ramifications as also linkages with the other recommendations. Each needs to be worked out in specific detail with aid of the full reports, by CHAI and within the CHAI membership at various levels.

At the General Body meeting on the 50th anniversary of the CHAI, it is necessary that the membership commits itself to these broad directions by affirming the following declaration .

The Golden Jubilee Declaration

The Catholic Hospital Association of India looks back with gratitude on all that the Great Physician has wrought through this Association in the past half century. In His mercy CHAI has become a well-established organisation linking over 2500 hospitals and health centres of various sizes and capabilities in diverse parts of India. Through them thousands of believers find and fulfil their vocation.

From time to time in this eventful history, the Association has redefined its goals and priorities according to the needs and opportunities of each stage of its development. At the milestone of its Golden Jubilee, the Association commits itself to direct and evolve its activities in the coming decade, around the following priorities :

1. In the context of the progressive depersonalisation, fragmentation and commercialisation of health care in India, CHAI will strive further to develop and practise holistic health care, serving the total need of the whole person, irrespective of the size, location or level of technology of its member institutions.

2. CHAI accepts that the primary calling of its member institutions is to serve the needs of the poor, the disadvantaged and the marginalised, giving special attention to the disadvantaged regions of the country and to the neglected and unpopular areas of dehumanisation due to ill health and handicaps.

3. CHAI reaffirms its commitments to the promotion of health and wholeness, by enabling the community to achieve for itself the conditions and resources essential for life in its fullness. While continuing to offer the best that they can for the relief of pain and the cure of ailments, CHAI health care centres and institutions will concern themselves increasingly with community-based health care.

4. CHAI shall try to promote these priorities by appropriate reorientation of the educational and training programmes of its member institutions and by developing suitable continuing education programmes of its own for the various health professionals and workers.

5. CHAI recognises the need for restructuring its own organisation to promote greatef integration at the national level for the sharing of resources and

experience on the one hand, while also decentralising its activities as much as possible on a regional basis and introducing greater accountability to the membership on the other,

6. CHAI was brought into being by regligious sisters and its greater strength is the total devotion of the individual "religious" members to the healing ministry. In the coming decade, every effort will be made to strengthen this relationship so that CHAI is better able to pursue its priorities in the member institutions while the congregations too may be enriched by a greater involvement in the healing ministry.

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National Academy of Medical Sciences

Medical & Non-Medical Dimensions of Health.

by

Dr. N. H. Anitha.

NATIONAL ACADEMY OF MEDICAL SCIENCES

NAMS—ACADEMY ORATION
April 4, 1987, New Delhi

Medical & Non-Medical Dimensions of Health

By

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Twenty Fourth Annual Convocation, New Delhi
4th April, 1987

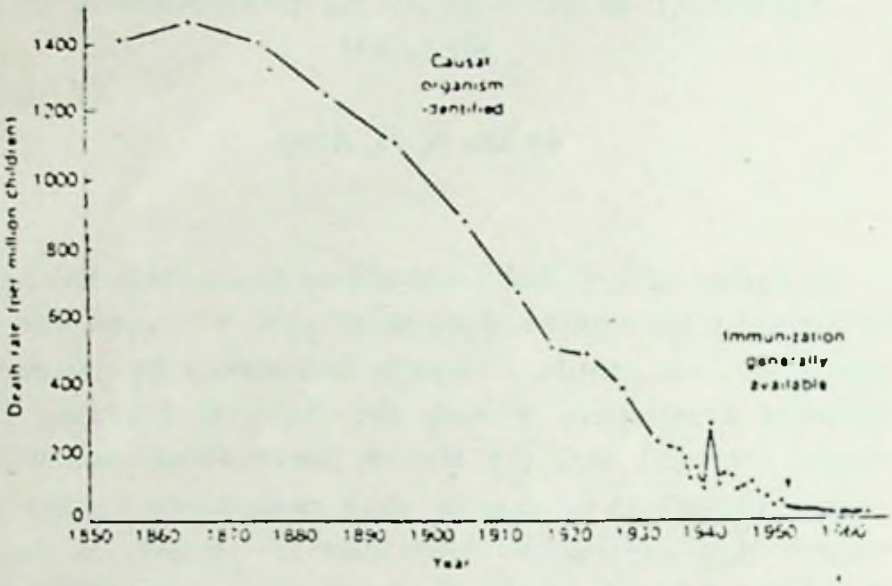
MEDICAL & NON-MEDICAL DIMENSIONS OF HEALTH

by Dr. N. H. Antia

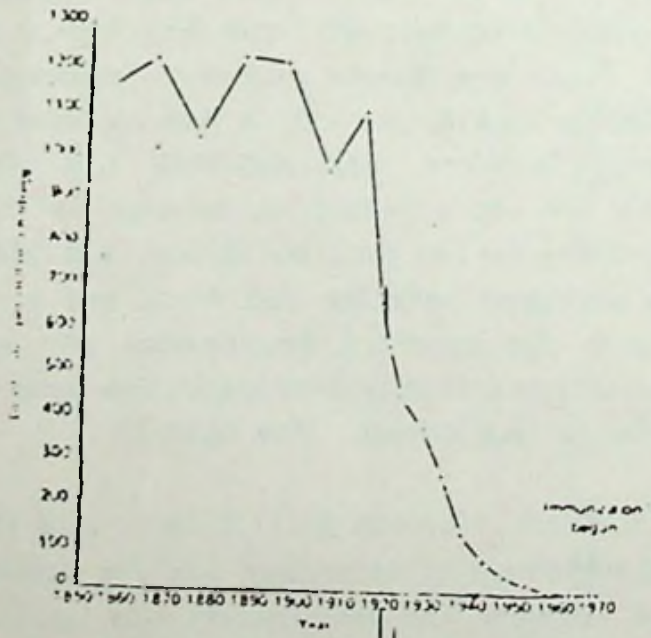
At Independence, India was indeed fortunate in having two of the most far-sighted documents ever produced for the health of our people. Though undertaken by two entirely different committees namely the National Planning Committee (N.P.C.) and the Health Survey Development Committee (Bhore), their reports were remarkably similar even though they represented such diverse interests as those of the Congress and of the British rulers. Since 92% of the people lived in the villages and small towns, both reports clearly stated that the limited available manpower and resources had to be decentralized and function as far as possible within the community, with the people as active participants. Since the disease pattern was predominantly of a communicable nature, prevention had to have precedence over curative services. This was both cost effective and could also provide a permanent solution to the perennial problem of diseases like malaria, cholera and plague which not only produced suffering and death but were a major hindrance to the economic development of the country. These committees evidently drew inspiration from the example of countries like Britain. (See Table 1).

The Chadwick reform in the U.K. in the mid-19th century for the improvement of sanitation was the brainchild of a perceptive engineer and interestingly was opposed both by the medical profession and the city fathers as a waste of public resources. The remarkable improvement in the health

(Table. 1)

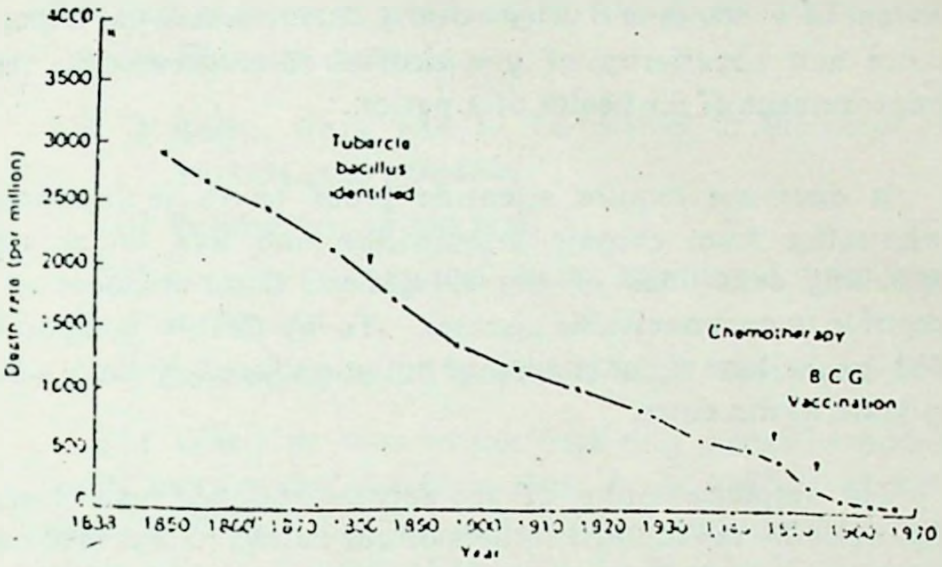


Whooping cough : death rates of children under 15, England and Wales

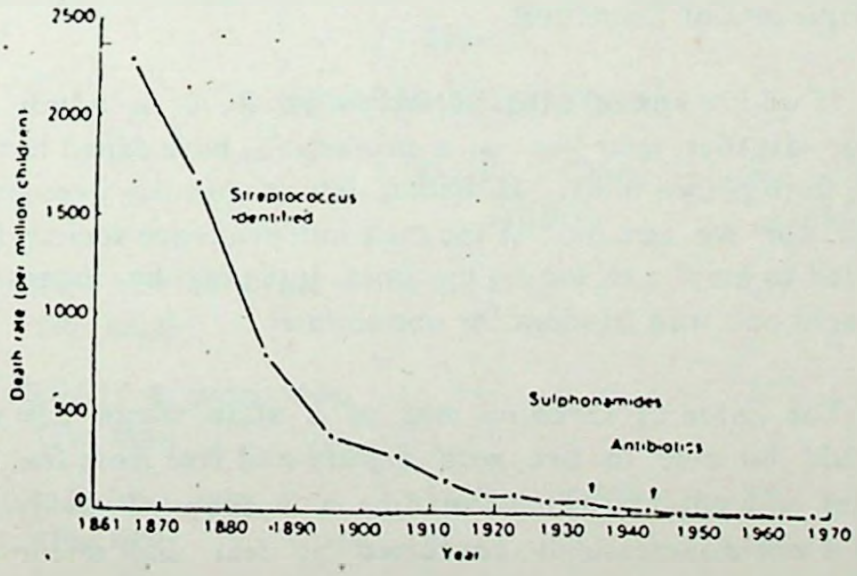


Measles : death rates of children under 15, England and Wales

(Table 1 Conted.)



Respiratory tuberculosis : death rates, England and Wales



Scarlet fever : death rates of children under 15, England and Wales

of the British nation and the marked reduction of the major communicable diseases even before the discovery of their causative agent, as well as their virtual elimination before the advent of vaccines and drugs, clearly demonstrates the importance and superiority of non-medical interventions in the improvement of the health of a nation.

It does not require scientific proof to realise that those who suffer from chronic malnutrition and live under the appalling conditions of our villages and slums are more susceptible to communicable diseases. Today this is compounded by the hazards of industrial pollution faced by those who migrate to the cities.

The implementation of the above-mentioned reports was entrusted by the founder fathers of our nation to the medical profession, a profession which was dominated by the allopathic system of medicine and some of whose members had participated in the struggle for independence. This was the result of the implicit faith placed in this profession that it would dedicate itself to the betterment of the health of the people and of the nation.

If we are honest with ourselves we have to admit that four decades later we, as a profession, have failed to fulfil the faith placed in us. However, let us not be over-repentant for we as a part of the post-independence society have failed to build a nation on the lines intended by those who fought and won freedom for our country.

The vision of Gandhiji was of a state where everyone would be able to live with dignity and free from fear and want, in a country which would be a beacon of civilization for a world increasingly consumed by fear and terror and where the lure of materialism would eventually transcend human values; of a civilization which would be judged not

by the wealth of the rich but by the care and concern for the less fortunate. It is interesting to note that the vision of Gandhiji was to a great extent similar to that of Mao Tse Tung in China in that—

i) Health work had to be geared to the needs of the workers, and peasants;

ii) Putting prevention first;

iii) Uniting doctors of both traditional and western medicine;

iv) Combining health work with mass movement.

The difference was in the faith they placed in those who would be entrusted to achieve these goals. While Gandhiji's vision of Trusteeship was more humane and idealistic, subsequent events have proved Mao Tse Tung to be the pragmatist, for China under Chairman Mao implemented the Indian reports with a marked improvement of the health of its people as compared to that of our own country.

(Table 2)

HEALTH INDICATORS

	India (1950)	China	India (1981)	China
Infant mortality rate (Per 000)	134[b]	—	121	35
Child (1-4) death rate (Per 000)	—	—	11[d]	2[d]
Crude birth rate (Per 000)	40[b]	37[b]	35	21
Crude death rate (Per 000)	27[c]	17[c]	13	6.4

(Conted.)

(Table 2 Conted.)

Life expectancy at birth (yrs.)	32	—	52	67
Population growth rate (mill)	—	—	2.1[e]	1.5[e]
Total Population	361	542	742[d]	1029[d]

b: figures for 1950-51; c: figures for 1951: d: figures for 1984; e: figures for 1971-81.

LIVING STANDARDS

	India (1952)	China	India (1982)	China
Literacy per cent	16.7[h]	20[h]	36[j]	69[j]
Per capita availablity Foodgrains (gms/day)	384	542	450[k]	669[k]

h: figures for 1951; i: figures for 1951-52; j: figures for 1980; k: figures for 1983; l: figures for 1981-82.

HEALTH INFRASTRUCTURE

	India (1950)	China	India (1983)	China
Per 10,000 population				
No. of physicians	1.65	6.7	3.9	13.4
No. of nursing persons	0.23[f]	0.6[g]	2.1	6
No. of hospital beds	3	1.5	7	21

f: fiures for 1946; g: figures for 1949.

(Table 2 Conted.)

AGRICULTURE

	India (1950-51)	China	India (1984)	China
Cultivated land (mill. hect.)	119	141	143	144
Irrigated land (mill. hect.)	21	20	53	44.5
Total food production (mill. tonnes)	55[a]	164[a]	150	407

a: figures for 1951.

It is interesting to study the reasons for the marked disparity between the present health status of China and India as shown in Table 2 since both countries gained Independence at about the same period and and started with similar problems. Though both countries were the cradles of civilization with well-established indigenous systems of medicine, their large and predominant rural populations were steeped in poverty and disease. Drained of their vigour and wealth by imperialist exploitation and internal dissension they had limited resources to solve the multitude of problems with which they were beset. Both countries also had well established nuclei of allopathic medicine, the legacy of the departed western rulers. Following independence China faced military threats from the United States and Russia. This not only placed an enormous drain on their scarce resources but also cut them off from foreign aid and access to the latest advances of in western science and technology. India was more fortunate for it faced no such threats, had substantial financial reserves left by the departing rulers and had almost unlimited access to science and technology of the west, It also received substantial foreign aid including that in the field of health.

China faced with what seemed almost insurmountable problems had no option but to gird its loins and develop its intrinsic strength which lay in the vastness of its population and faith in its ancient culture. In the field of health it

developed a decentralized approach very similar to that recommended by the Bhore Committee, enlisted the people in the care of their own basic health, popularly known as the barefoot doctor approach and with small county hospitals distributed all over the country. While using the simple readily avilable knowledge of allopathic medicine, especially for the control of communicable diseases, it encouraged its own traditional systems of medicine and health care. This Primary Health Care approach with its emphasis on prevention and education was supported by simple but effective decentralized curative services using a combination of indigenous western systems of medicine.

Yet there is no doubt that the present health status of the Chinese nation is as much or more the result of the transformation of its feudal oppressive and exploitative society to that of an egalitrian state. The resulting mobilization of its human resources, not only in the field of medical care but also in areas like the production and distribution of food so essential to health. China with less cultivated land produces 400 million tons of grain as compared to our 150 million tons; more important, it has ensured its equitable distribution. It has also achieved over 70% literacy as opposed to our 36% and has raised the status of its women. It has also provided basic services and facilities like housing, water supply and sanitation to all its people. Mobilization of the masses has resulted in actions like eradication of the four pests, the clearing of snail infected canals and universal immunization. This has to a great extent controlled, if not eradicated, most communicable diseases, which continue to plague us to this day. With relatively modest financial inputs China is at present in a very fortunate state of health for it has neither the diseases of poverty nor those of affluence.

In contrast, India after four decades of independence, has failed to provide even the basic necessities of food, cloth-

ing, shelter, water, sanitation and education to the majotity of its people who are malnourished and continue to live in poverty in the 600,000 villages and proliferating urban slums. They continue to suffer and die from communicable diseases like tuberculosis, leprosy, malaria, filariasis and poliomyelitis, while a small urban and even smaller rural elite live in a style which apes the West and suffers from the same diseases as of the affluent countries. The aggregate statistics which are presented to us in such a polarized society conceal more than they reveal, such as the tragic conditions of the lowest two or three deciles (like the tribals and scheduled castes) whose conditions have actually deteriorated in a dehumanized competitive market economy. If the Infant Mortality Rate (IMR) in Kerala is 36 then the IMR in U. P., Bihar and similar backward states, must surely be much higher to achieve the aggregate national rate of 110. The village IMR is usually twice as high as in the urban setting and the IMR among the poorest in the village is also higher than the average of the village. Since the recording of deaths in a backward state with low literacy is less accurate than in a state like Kerala, the actual figures would be even worse. It must therefore be understood that while aggregate statistics reveal the state of affairs in an egalitarian society they must be treated with great circumspection in a country like ours, more so when pressures are exerted to reach national targets.

Why is it that with all our advantages, the health situation in our own country is so much inferior to that of China? The reason I believe, lies in the very openness of our society where the much vaunted freedom means freedom for a few to exploit and the rest to starve. For the elite like the doctors to emigrate to affluent contries after being trained at public expense, or on return to propagate the latest technologies of the west which are inappropriate for all but a miniscule of our population, thereby diverting scarce resources from basic

health care and preventive and promotive medicine to expensive, curative services. This has also created many moral and ethical problems for the majority who really cannot afford services like kidney transplants, coronary bypass surgery and intensive care but now feel they must go into debt to save or prolong the life of a dear one. In the prevailing market economy devoid of moral considerations, health has also been converted into a lucrative trade in peoples illness, for it is an area where consumer resistance is at its lowest The pharmaceutical and instrumentation industry and the corporate sector have not lagged far behind and have now overtaken the medical profession in their greed for profits.

In a free economy which still terms itself as socialist, it is up to the State to ensure that preventive and promotive care as well as basic curative services be provided to those who cannot afford the services of the private sector. Unfortunately, this is not so. The public sector fails to attract the necessary talent in competition with a lucrative private one. It has also mystified health and treats the people as incapable of participating in their own health care. The public sector has by and large failed to deliver the goods and besides its inefficiency has shown a remarkable lack of accountability to the people who they are paid to serve.

That curative medicine is a bottomless pit is clearly demonstrated by the fact that the USA spends over $ 300 billion ($ 1225 per capita) for such services, which is next only to armaments. Yet its status is twelfth as measured by the scale of IMR, and tenth in life expectancy among the countries of the world. This only demonstrates that illness can be converted into a lucrative business by the profession and the health industry without commensurate benefit to the health of the nation. It also creates the new hazard of iatrogenic diseases and in poor countries also diverts money from food, clothing and shelter and often reduces whole families to destitution

under the guise of freedom of choice. This results in the public perceiving the medical profession as a necessary evil and given the opportuntiy, they have no compunction in suing the doctor. Is this to be our goal as well?

While the health status of communist countries shows what can be achieved even with limited resources, the example of Sri Lanka and even in our own state of Kerala reveals that the achievement of health by all the people is possible even under the existing constraints in the non-communist countries provided human welfare activities like education and improvement of the status of the woman are given due attention. The much superior health status of Kerala, even in the early 70s, when it was the poorest state before the Gulf boom as compared to Punjab, the richest state, indicates the importance of these non-medical factors in health. This not only permits the people to better utilize the available resources but also to monitor those that are provided by the state and private sector and exert the necessary consumer resistance which is the only defence available to the people in a market economy. Only thus can they protect themselves from the malpractics of being given unnecessary and dangerous drugs and injections and subjected to unnecessary investigations which have reached frightening levels in our country today; all under the cover of mystification and freedom of choice.

While it is evident that the medical profession can and should play an important role in all aspects of health it is important to redefine their role. It is unfortunate that the profession with good intention or otherwise has mystified health and created a sense of abject dependency among the people. There is also an unfortunate belief that the uneducated are unintelligent and incapable of looking after their own welfare. For this there is no rational explanation except the the ignorance of the elite.

Several studies including ours at Mandwa, have clearly demonstrated that the illiterate are as intelligent as any other segment of our population. They have a clear and practical thinking not confused by inappropriate education and the false values that this engenders. We have far too long failed to appreciate the people's ability to look after their own interests including their health and have tried to appropriate what are legitimately their own functions. In the process we have not only failed miserably as is evident in almost all fields, but have succeeded in converting health into a profitable business.

Let us therefore try to examine the various factors that are responsible for the health of the people and on that basis determine the role of the medical profession, the people, the health services, as well as of the political and other agencies. The achievement of Health for All can no longer be accepted as the prerogative of the health services.

Let us first consider the group of factors which though seemingly non-medical play a predominant role in determining the health status of the people. The four most important of these are nutrition, education, environment and women's status. While each of these may justify a dissertation by itself they are so selfevident that I shall only try to highlight some of the more significant features of each in order to discuss the role of those who can help in their solution

It is a *sine qua non* that no one can be healthy without proper nutrition. Since the traditional Indian diet is very well balanced, for the 37% of our population who live below the poverty line of 2400 (rural)/2100 (urban) calories per day this means that what they require is enough money to purchase adequate food. The myth of the protein gap

and resulting mental retardation has been thoroughly exploded and only serves to further exploit the poor by the multinational corporations. What we need is not only increase in the production of food but more important, its distribution. No amount of economic jargon can justify that half our population goes hungry to bed when 30 million tons of grain are rotting in storage and have to be exported to earn foreign exchange, most which gravitates into the pockets of the haves. We are informed that since our population will increase to one billion by 2000 A.D. we will have to step up grain production from 150 to 250 million tons and that this can only be achieved through investment in high technology like genetic engineering, the latest panacea for all ills! Yet China with less cultivable area and using conventional agricultural technology is already producing 400 million tons of grain! Why, have we not undertaken research into the crops grown in the drought prone areas and the economics of distribution of the increased production? Are we going to depend on the illusion of the 'trickle effect' supported by 'nutrition programmes' which seldom reach the targeted group and in any case are an insult to human dignity by doling food to those who have been reduced to starvation? Nutrition can only be achieved through full employment and paying adequate wages for labour. Common sense dictates that the present policy of urban industrialization producing goods for the elite using capital intensive technology will further polarize our society and aggravate the tensions of which this is the root cause. It will force increased migration from the villages to urban slums where people are forced to survive under inhuman conditions.

The medical profession can either play an important role in drawing public attention to the cause and effect of poverty and malnutrition and help the people to take the necessary action, or medicalize nutrition into another scientific exercise

and business of predigested proteins, vitamins, tonics and micronutrients, for which they will receive support form the pharmaceutical industry. Let us not underestimate the influence of our profession in moulding public opinion in the field of health for better or for worse.

Education for health which is a prerequisite for any health programme has been converted into another futile effort by the Central and State Health Education Bureaux which have proved their ineffectiveness over the decades. That the majority of our people, including those who have received higher education, are unaware of the basic information about the commonest health problems like tuberculosis, leprosy, gastroenteritis and oral rehydration, clearly demonstrates the almost total failure in this field. These special agencies have neither the expertise in education nor in communication which is part of the general education and communication services of our country. Nor do they know communication and spread of information occurs in the village which is chiefly by word of mouth around the village well. Even if they did, they would be unable to reach the information to the people due to their bureaucratic set up.

Withholding information and mystifying health is an effective method for creating dependency among the people and can lead to their exploitation. Consciously or unconsciously this is what we have succeeded in achieving. Even the educated, leave aside the illiterate, are easy prey as can be seen by the way they have been hooked on to unnecessary and often dangerous injections and drugs even for trivial self-limiting ailments rather than encouraging them to use the same money for more health-giving products like cheap nutritious food.

The misuse of the mass media like television by the private pharmaceutical and food industry, utilizing vast sums of

money can hardly be combated by a few pamphlets doled out at the health centres by the State and Central Health Education Bureaux. There are lessons on health in the school curriculum which make little impact because of their poor quality and lack of relevance to their daily life. School health is still a time-worn ritual of checking by a doctor which only perpetuates a sense of dependency rather than participation. Why cannot students and teachers undertake most of their own check up with only a supporting role by the professional?

This lack of health information together with the counter information has not only reduced the people to medical gulliblity but also prevents them from questioning the professionals and demanding the correct services which are due to them. It would be interesting to know how many of our people are aware of the function and working of the Primary Health Centres and hospitals as well as the duties and responsibilities of the staff and the expenditure incurred in the name of their health, as well as the duties and responsibilities of the staff. How can they exert their rights in this atmosphere of secrecy which is the major cause of lack of accountability of the public sector and malpractice in the private one?

The importance of environment is also self-evident. Can one realy expect to improve the health of our people if they have to continue to live in the foul slums or in the unhealthy conditions of our poverty ridden villages? The present Minister of Agriculture, Mr. M. S. Dhillon, states that 2.27 lakh villages still have no proper source of potable water and few of our slums have sanitation. What is provided is often non-functional because of lack of maintenance and repairs.

The advent of pollution of air, water and food by industry and the uncontrolled use of pesticides and fertiliziers

pose a new hazard to those who have no alternative. The safety record of most industries leaves much to be desired and the government and its supervisory staff have shown their inability to stand up to the money power ranged against them. While the medical profession may not be directly able to effect any changes they can surely draw the attention of the State as well as of the public to the consequences which they see daily in their hospitals and clinics. Unfortunately, we often fall prey to the tempting offers of the same business and industry to build more hospitals like a Chest Hospital in Chembur to appease the public. Is it moral to support those who create these hazards and help them to project a false benevolent public image?

Forty-five per cent of our population consists of children and half of the rest are women. Since the majority of the problems of health and disease affect women and children, it is evident that this is the section of our population which should receive the most attention. Unfortunately, in our male dominated society and culture, the female is the most oppressed whether it be in nutrition, education or legal rights. Yet it is the woman who bears the risk of childbearing and the burden of childrearing, expends the greatest amount of energy in the dual duties of caring for the home as well as helping in the field and carrying head loads in the EGS schemes. For this she is treated like a chattel, battered by her husband, raped by the contractor and police and burnt as a bride. Yet it is she who is responsible for the physical and mental development of the next generation. No programme for health can succeed unless it actively involves the female population and does not treat them as mere targets for the MCH and Family Planning Programme.

This is why it is essential for a woman to be made fully aware of her own ability to do anything and when bringing

up her children to make no difference between the sexes, males or female. To let her daughters feel they are capable of doing whatever her sons can do. If a woman is treated like a chattel or a sex object it is because she herself accepts the situation. It is not necessary to go on morchas. etc., and make loud noises to prove their equality, and make demands for equal rights. What is required is for a woman in her own little environment to show that she is capable and confident of her ability to contribute to society as well as to the health of her family in which she must play the crucial role.

Even though these are essentially non-medical areas the medical profession can play a useful role not only as responsible members of society but in view of the public confidence, they enjoy in all areas concerned with health.

They can act as catalysts for change by educating the people in understanding the importance these factors play in determining their health and encouraging and supporting them in bringing about change through their own effort. We can also draw the attention of the politicians, planners and the bureaucracy, but ultimately, it is only the people themselves who can solve their problems in these fields.

Let us now turn to those areas where the medical profession can and should play the dominant role. This is evident in the case of acute medical and surgical emergencies. Also in those conditions where the skills and facilities that are required are beyond those which can be reasonably expected of the people themselves and can only be provided in hospitals for secondary and tertiary care. Even in these areas which are predominantly medical, it is important to see that basic medical and surgical facilities for the common problems are made available to all at the community level in what the ICSSR/ICMR report has designated as the Community Health Center. This report estimated that about 98% of preventive,

promotive as well as curative care can be undertaken at the taluka or block level leaving only a small percentage of the most difficult problems for the district and medical college hospitals.

Unfortunately, our present priorities favour the latter which cater to the rich and affluent at the cost of basic services for the majority. Such institutions which compete for the latest expensive western high technology curative services not only divert scarce resources but also set a pernicious trend which percolates to the periphery. It also creates tensions and unpleasant ethical problems for those who cannot afford such services for their loved ones. Commercialization of curative medicine has also led to unethical practices like excessive investigation and unnecessary treatment which has already reached alarming proportions. The percolation of high technology medicine to the medical college hospitals is particularly harmful as it inculcates wrong values and ultimate disillusionment in the students, most of whom will eventually have to work under far less ideal conditions.

With the existing pattern of diseases and where our population is distributed in the rural areas, the simple cottage hospitals which were the backbone of curative medicine in the west in the early part of this century, as well as the present day country hospitals of China are much more suited for our present needs than the modern disease palaces of which we are so enamoured. Even in our own country, we have examples of highly efficient small rural hospitals in the voluntary sector which provide excellent care for most medical and surgical problems at a reasonable cost which the country can afford. They provide services which are often more efficient than in our unmanageable large urban institutions, under far more humane conditions and at a fraction of the cost. Experiments have demonstrated that even in

the treatment of major problems like extensive burns, fractures, reconstructive surgery and head injuries, results can be achieved by a general surgeon with basic medical and surgical facilities in the community hospitals. Unfortunately the training in the urban medical colleges is totally divorced from the actual needs of the majority of our people so that our modern doctor is ill suited to provide the service our country needs most. It would be hard to devise a more in appropriate medical education to meet the health needs of our country.

While the more difficult aspects of curative medicine lie chiefly in the domain of the medical profession even here it is important that the decisions on the type, location and extension of such services cannot be left entirely to them or as experience shows even to the government. Local people's committees should help in determining what is in their best interest and the profession provide them the appropriate information and guidance.

Besides the predominantly medical and non-medical areas lies a large zone of medical care which needs joint attention from the professionals as well as the people. The control of communicable diseases is a classical example for such a joint effort. We have for too long tried to medicalize problems of tuberculosis, leprosy, poliomyelities, filariasis, guineaworm, gastroenteritis, malaria and a host of similar problems which represent the major cause of mortality and morbidity in our country today. Except for small pox and partially in the case of malaria, these diseases continue to take their relentless toll despite the fact that we have the knowledge and tools for their prevention, control and cure. Most of this knowledge and technology is so simple, effective, cheap and safe that several examples are available in our own country where semi-literate village women have proved their ability to absorb this knowledge and use the technology, provided this is

given to them in a simple manner which they can comprehend. They have also demonstrated that in this they are the most effective agents for the control of these diseases.

The reason why the more highly trained and far more expensive professionals and their services are unable to achieve what simple village folk have done is because the problem is not of knowledge and technology but in its delivery which requires close proximity and a high level of cultural affinity with the people. While the villager can readily use the basic tools if made available to them it is virtually impossible for the professionals to reach the masses because of the physical, and even more important, the cultural distance between them and the people. This gap is directly related to the extent of training between the doctor and the ordinary man. The over-production of doctors in the hope that there will be a private practitioner in every village has only resulted in the increase of malpractice and exploitation of the people and the diversion of scarce resources from food to medicine and injections without much improvement in their health for by and large they have played no role in the preventive and promotive aspects which have been relegated to a separate cadre. Even the mere multiplication of Primary Health Care Centres without determining the reasons for the failure of the existing ones has only multiplied our mistakes with merely marginal improvement in health. The doctor who is the leader of the health team has neither the training in epidemiology or managerial skills nor an understanding of cultural, political and human dimensions which play the most important role in determining success or failure. Not willing to face this unpleasant reality, we have clutched at a series of straws like unipurpose and multipurpose workers, vertical and integrated services, management information systems and targets, community health workers under ever changing names and, health education. In final desperation we have sought community participation by

which we mean that the community must line itself up and help us to achieve our targets such as in family planning or immunization. Family Planning has not only failed to achieve its targets (the growth rate has hovered at about 2.2 for over two decades) but has virtually demolished all other health programmes and even education in schools due to the excessive coercive pressures exerted on all government staff to meet the targets.

"The Mandwa Experience"

Several Community Health Projects have demonstrated that most communicable diseases can be controlled even under the existing socio-economic conditions. In the Mandwa Project thirty village women given simple knowledge through weekly discussions under the village tree, and with a simple supportive service were able to achieve this. Let me illustrate with a few examples. They took finger prick blood smears of any patient suffering from fever with rigors and gave them four tablets of chloroquine. If the smear were positive they gave Primoquine treatment. More than that they drew the attention of the village to control the mosquito vector. They were remarkably efficient in suspecting tuberculosis in individuals with the classical symptoms especially if they were contacts of known cases. If the diagnosis was established on examination of the sputum or X-ray they gave the 90 streptomycin injections and supervised the regularity of the other antituberculosis treatment by convincing the patient of its importance not only for himself but also for the rest of his family. They also taught other simple measures like disposal of sputum to prevent the spread of the disease.

These women diagnosed twice as many leprosy patients as the full-time leprosy technicians, ensured that regular treatment with Dapsone was taken after confirmation of diagnosis and since these were in the early stages, there was not a single new case of deformity; the old deformed patients were helped

to return home and take regular treatment, for on having seen the germs under a microscope they were able to convince the village of chemical sterilization by regular treatment and induced confidence by visiting the patients in their homes and partaking of their meals.

There was a marked reduction in deaths from gastro-enteritis not only because of ORT but because of the creation of an epidemiological consciousness in the villages for being prepared for the monsoons.

The immunization rate for triple antigen rose from 15% to 92% when the village health workers started giving them injections on their daily rounds. Since all pregnant women were identified and immunized there was not a single death from tetanus in five years. No mass campaigns were ever undertaken in this project, yet the so-called targets set by the PHC were over-reached even in family planning.

This people-based approach even succeeded in the detection of cancer, mental illness and in rehabilitation of the disabled, all without campaigns and camps and at a fraction of the normal cost of our health services.

Let us not minimize the role of the profession and services in such a participatory approach. Their main function should be of teaching and encouraging the people to look after themselves to the extent possible and overcome the fears inculcated through professional mystification. Another important role is to provide the necessary supportive service for those few problems which require skills and facilities of a higher level. Their's is not to appropriate the functions which rightly belong to the people, for experience has shown that they cannot undertake these functions themselves even at a far greater cost. The present approach has only led to exploitation of the people's health by the private sector and

lack of accountability of the public sector without much impact on the health status as revealed by our statistics.

The supportive professionalized services have also to be of a graded nature starting with the paramedical worker at the subcenter to the surgeon and physician at the Community Health Centre. The primary role of the Community Health Centre should nevertheless be of monitoring the peoples health with priority to the promative and preventive services. The ICSSR/ICMR report has estimated that about 98% of all health and illness care can be undertaken within a 100,000 population covered by the Community Health Centre at a cost of about Rs. 30 per capita per annum leaving only a marginal sector for tertiary hospital care. Also that this can be achieved only if the people have the financial and administrative control over their health services with guidance and support by the professionals.

I know that this is a radical departure from the existing situation and may not be readily acceptable to those who believe that all decisions on health must be left only to the medical profession. But four decades experience in an independent India has clearly demonstrated that we have not been able to achieve the desired result despite the vast expansion of medical services in both the public as well as the private sector.

In conclusion let me quote from our own National Health Policy of 1983 for there is no better statement of the medical and non-medical problems of health as well as the guidelines for their solution.

"In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious and urgent concern. The mortality rates for women and children are still distressingly high; almost one third of

the total deaths occur among children below the age of 5 years; the extent and severity of malnutrition continues to be exceptionally high. Communicable and non-communicable diseases have still to be brought under effective control and eradicated."

High incidence or preventive and infectious diseases, lack of safe drinking water and poor environmental sanitation, poverty and ignorance are among the major contributory causes of the high incidence of disease and mortality.

The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and establishment of curative centres based on the western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital-based disease, and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of the health care.

The existing approach instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policies in regard to the education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve the individuals and families in establishing a self-

reliant community. Also, over the years, the planning process, has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people connot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes.

It is necessary to secure the complete integration of all plans for health and human development with the overall national socio-economic development process, and specially in the more closely health related sectors, e.g., drugs and pharmaceuticals, agriculture and food production, rural development, education and social walfare, housing water supply and sanitation, prevention of food adulteration, maintenance of prescribed standards in the manufacture and sale of drugs and the conservation of the environment to provide universal comprehensive primary health care services, relevant to the actual needs and priorities of the community at a cost which the people can afford.

Why is it then that we continue to give priority to sophisticated curative services in the cities which are chiefly utilized by the rich and influential while neglecting preventive, promotive and basic curative services for the majority? Why do we produce 60,000 formulations of drugs worth Rs. 2,500 crores which reach only 20% of the population when WHO recommends only 253 drugs and Rs. 750 crores worth would suffice for all our people if used in an ethical manner? Why do we permit almost unlimited import of expensive medical equipment like CT scanners costing over one crore of rupees when we find it difficult to provide basic medicines, X-ray plates and simple equipment to district leave aside the rural hospitals?

The annual cost of operating a single CT scanner is about 4.5 lakhs, which helps in the diagnosis of only 3000 patients. This is equivalent to the annual expenditure on five small 100-bedded or one large 400-bedded district hospital treating 5 lakh patients undertaking 2,600 surgical operations, or the annual cost of operating 9 Primary Health Centres serving 2.7 lakh population.

Why do the seniormost representatives of our people, lend their support to this type of technology which is condemned by our government, by inaugurating these 5-star hospitals while proclaiming that we are next to none in medical technology, yet when it comes to personal treatment they have no hesitation in going abroad for medical care at the taxpayer's expense.

~~BH~~ IH-4.

Main identity

From: "DIRECTORATE" <chai@pol.net.in>
To: "Community Health Cell" <sochara@vsnl.com>
Sent: Saturday, October 18, 2003 11:18 AM
Attach: invitation card-final.doc, conceptpaper-DJ.doc, Diamond Jubilee-write up.doc
(taken) (APQV) (SPQV)

pl. punch
21/10/03

Dear Sr Thelma Narayan

Please find attached the invitation card, concept paper on Universal Access to Health and a write up on our Diamond Jubilee.

With best wishes

Yours sincerely

Fr Sebastian Ousepparampil
DIRECTOR

20/10

THE CATHOLIC HEALTH ASSOCIATION OF INDIA
157/6 STAFF ROAD GUNROCK ENCLAVE SECUNDERABAD 500 009

cordially invites you to the

DIAMOND JUBILEE CELEBRATIONS

&

LAUNCHING OF UNIVERSAL ACCESS TO HEALTH

ON

25 - 26 OCTOBER 2003

At

Smt Juloori Vajramma Kalyana Mandapam
Near Karkhana Police Station, Secunderabad

Fr Sebastian Ousepparampil
Director, CHAI

Telephone: 27848293 27848457 27841610 27898756
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[Programme overleaf]

SATURDAY 25 OCTOBER 2003

INTERNATIONAL CONSULTATION ON
UNIVERSAL ACCESS TO HEALTH

Chief Guest: *Dr Nina Unwantzf, Misereor, Germany*

INAUGURAL FUNCTION

09.45 am – 09.50 am	Invocation [Welcome Dance]
09.50 am – 09.55 am	Lighting of the Lamp
09.55 am – 10.00 am	Welcome Address - *Sr Mercy Abraham, President, CHAI*
10.00. am – 10.30 am	Presentation on CHAI & High lights of the Consultation - *Fr Sebastian Ousepparampil, Director, CHAI*
10.30 am – 10.40 am	Presidential Address - *Bishop Thumma Bala* *Bishop of Warangal*
10.40 am – 10.50 am	Message by Guest of Honour - *Dr Rabia Mathai, Global Director of Programmes, CMMB, New York*
10.50 am – 11. 00 am	Address by the Chief Guest - *Dr Nina Unwantzf, Misereor, Germany*
11.00 am – 11.05 am	Vote of Thanks - *Sr Fatima PBVM, Associate Director (P & M), CHAI*
11.05 am – 11.30 am	COFFEE

SCIENTIFIC SESSIONS

11.30 am – 01.10 pm	Scientific Sessions
01.10 pm – 02.30 pm	LUNCH
02.30 pm – 03.30 pm	General Discussion
03.30 pm – 04.00 pm	TEA
04.00 pm – 05.00 pm	Plenary Sessions
05.00 pm – 05.05 pm	Vote of Thanks - *Sr Dr Vijaya Sharma, Councillor, CHAI*

AWARD NIGHT

06.00 pm -- 06.05 pm	Prayer/Welcome Dance
06.05 pm – 06.10 pm	Welcome - *Sr Sunita Antony, Secretary, CHAI*
06.10 pm – 06.15 pm	Introduction - *Fr Sebastian Ousepparampil , Director CHAI*
06.15 pm – 06.20 pm	Presidential Address - *Archbishop M Joji, Archbishop of Hyderabad*
06.20 pm – 06.30 pm	Address by the Chief Guest - *Dr N Janardhan Reddy,* *Hon. Minister for Panchayat Raj, Govt. of AP*
06.30 pm – 06.40 pm	Folk Dance *{from CHAT Region}*
06.40 pm – 07.20 pm	Presentation of Award to outstanding individuals
07.20 pm – 07.30 pm	Mime *{from CHAKE Region}*
07.30 pm – 08.00 pm	Presentation of Awards to outstanding Member Institutions
08.00 pm – 08.10 pm	Puppet Show on LPG *{from RUPCHA Region}*
08.10 pm – 08.35 pm	Presentation of Awards to outstanding Member Institutions
08.35 pm – 08.45 pm	Folk Dance *{from NECHA Region}*
08.45 pm – 08.55 pm	Presentation of prizes of National Essay Competition
08.55 pm – 09.05 pm	Skit on Malaria Control *{from CHAMP Region}*
09.05 pm – 09.10 pm	Vote of Thanks
09.30 pm – 10.00 pm	Dinner

SUNDAY 26 OCTOBER 2003

DIAMOND JUBILEE CELEBRATIONS

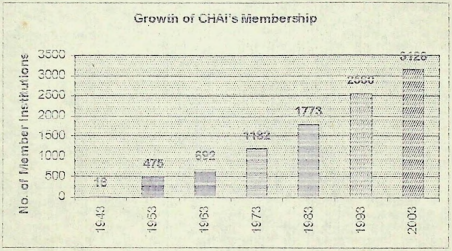
Chief Guest: Prof Ummareddy Venkateshwarlu
Hon. Member of Parliament

09.00 am – 09.05 am Vandemataram

09.05 am – 09.15 am	Welcome Dance
09.15 am – 09.20 am	Lighting of the Lamp
09.20 am – 09.30 am	Welcome address - *Sr Mercy Abraham, President, CHAI*
09.30 am – 10.00 am	Diamond Jubilee Highlights. Universal Access to Health - Thrusts - *Fr Sebastian Ousepparampil, Director, CHAI*
10.00 am – 10.10 am	Presidential address - *Archbishop Alphonsus Mathias, Archbishop Emeritus, Bangalore*
10.10 am – 10.30 am	Felicitation Speeches
10.30 am – 10.45 am	Address by the Chief Guest - Prof Ummareddy Venkateshwarlu Hon. Member of Parliament
10.45 am – 10.50 am	Commitments & Oath
10.50 am – 10.55 am	Vote of thanks - Fr Abraham Vadana, Associate Director (Fin), CHAI
10.55 am – 10.57 am	National Anthem
10.57 am – 11.30 am	COFFEE
11.30 am – 12.30 pm	Cultural Programmes
12.30 pm – 12.40 pm	Vote of Thanks - President of CHAI
01.00 pm	LUNCH

Diamond Jubilee

The Catholic Health Association of India is celebrating its diamond jubilee. The organization has grown in terms of its memberships, services and expanded the scope for encompassing and achieving the mission for which it was established in 1943. The organization has been shaped and nurtured by the visionaries who directed it as well as by the impact of national and international happenings. There have been paradigm shifts to meet the needs and to fulfill the vision and mission of reaching the poor and marginalized.



Genesis

The Catholic Hospital Association was founded in 1943 when the world was at war; and when Bengal was in the grip of a raging famine caused not due to the lack of food but due to disorganisation; casualties were too many and sick and displaced were pouring into Calcutta. The Japanese bombs had shocked Calcutta. It was a year of great medical need. Army hospitals had been set up in India with neither enough infrastructure nor manpower. The archbishop of Madras was bringing in sisters and securing permission for them to practice medicine.

Inspired by the teaching of Pope Pius XII to 'organize the forces of good' and the medical associations in India and abroad, the sisters from the Congregations of St. Anne and the Society of Jesus, Mary and Joseph came together in 1941 for an informal meeting at Guntur which eventually led to the formation of the Catholic Hospital Association.

Silver Years (1943 – 1967)

On Thursday 29th July 1943, 16 sisters came together for the first meeting. The resolutions of the meeting:

1. To establish a Catholic medical college and a collegiate course in nursing.
2. To publish a pamphlet or magazine and
3. To appoint a Board of Examiners in Nursing and Midwifery.

The Catholic Hospital Association (CHA) was registered in 1944 covering India, Burma, Sri Lanka and Pakistan (after partition till 1956). Reporting the event, an editor in Tiruchirapally headlined it as the **"Genesis of a Great Initiative".**

Sr. (Dr) Mary Clowrey was appointed the President and she continued till December 1951. She was on the Board as the first vice-president till October 1956, six months before her death.

CHA walked with the times. It was instrumental in obtaining the recognition of the Nurses and Midwifery course and the Pharmacist-Assistance course. CHA was represented at national and international levels. Professional associations were established with Catholic Hospital Associations of other countries, Catholic Relief Services, International Catholic Confederation of Hospitals, and Indo-German Social Service Society – Misereor for evaluating projects and were in contact with 16 Eastern Countries outside India. CHA was granted "B" (associate) membership in the World Convention of International Federation at London in 1965.

During the first general body meeting in April 1944 at Bangalore, it was decided, "to publish a pamphlet or magazine". The in-house bulletin named **'Catholic Hospital'** was published. The magazine was registered by the Post Master General, Bihar and Orissa Circle on February 13, 1945, in Patna. Under Sr. Laetitia's editorship, the sixteen-page magazine began the circulation in November 1944 and continued through 1948 to 1953 as a bi-monthly. The magazine was subsequently registered in New Delhi under the new title **"Medical Service"**, the Official Organ of the Catholic Hospital Association — India, Pakistan, Burma and Ceylon. "Pakistan" first appears in the title on the January-February 1959 issue. The articles projected what was going on in medical circles around the world, and involvement in contemporary medical movements.

In July 1957, Fr.Tong summarized CHA's statistics as "We have in the country approximately a hundred Catholic Hospitals. They vary in size. At least ten have over 100 beds. The rest average roughly between 20 to 40 beds... careful observation shows that the most acutely felt need is for qualified doctors".

The Annual Conventions of catholic hospitals were organized every year with the following objectives:

1. To hold the business meetings of the association, namely the Annual General Body Meeting which is a mandatory requirement,
2. To discuss current topics on health and health related issues, and
3. To provide for an exchange of views and experiences at individual and group levels.

For many years, CHAI functioned from the CBCI Centre, New Delhi.

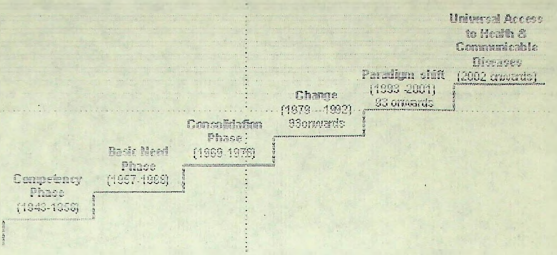
Golden Years (1968 – 1993)

The golden era of CHAI was marked with two important meetings that initiated thinking regarding the Church's role in health, healing and wholeness. A landmark meeting took place in 1968 in Bangalore with CMAI and CMC. It resulted in establishing a Coordinating Agency for Health Planning (CAHP) in 1969, which grew into Voluntary Health Association of India.

The late 60s and early 70s witnessed the development of pioneer community health projects by NGOs in the country. This was also the early phase of structural analysis of society in India to understand the root cause of malnutrition, ill health, sickness and early death.

In the mid-seventies, three new departments evolved namely, Hospital Pastoral Care Service, Legal Service Department and the Medical Moral Affairs Department. A year later, the Central Purchasing Service (CPS) was initiated to assist health organizations in India to procure indigenous equipment for health services against payment in foreign exchange. During this time, CHAI was also involved in providing educational services (information regarding seminars and courses available), representations in India and abroad, evaluation service to funding agencies regarding projects, rendering emergency services assistance, especially in recruiting voluntary nursing and medical personnel during natural disasters.

The Alma Ata Conference jointly organized by WHO and UNICEF in 1978 was an important event. India along with the other nations committed itself to working towards the goal of "Health for All by 2000 AD" using primary health care as a major strategy. CHAI as one of the three main national level co-coordinating agencies of the voluntary health sector in India adopted for itself the goal of "Health for Many More".



The Phases of Development of CHAI

The Eighties witnessed several events. CHAI began to focus more specifically and analytically on problems and needs of the poor and marginalized. It articulated a new vision of health and developed strategies and programmes to achieve the same. Community Health was identified as a priority and considered as a major thrust area. Thus, a community health department was initiated in November 1981 and was expanded in 1983, equipping members all over the country through training and promoting training for village health workers. Attempts were made to form regional units of CHAI. Besides the existing unit in Kerala, new units were started in Karnataka, Bihar, Orissa, Tamil Nadu and Andhra Pradesh. Later additions units were NECHA (North Eastern CHA covering the seven North Eastern States) and RUPCHA (Rajasthan, Uttar Pradesh CHA).

The in-house magazine "Medical Service" evolved into "Health Action" brought out under a separate society registered in 1987 called "Health accessories for all (HAFA)". *Health Action* is the monthly magazine brought out by the publication wing of CHAI.

The eighties also witnessed another major change. The headquarters was shifted to Secunderabad from Delhi in 1986 and the registered office continued to function in CBCI Campus, New Delhi.

Golden Jubilee Celebrations

The 50th annual conventions was organized in 1993 at Secunderabad, celebrating the Golden Jubilee. This reflected the paradigm shift in the Association. While promoting Community health, CHAI's members felt challenged to involve themselves in the struggles of the poor. They began to view health as a basic human right.

The evaluation (Golden Harvest) done as part of the celebrations had clearly marked the thrust. In place of the Alma Ata slogan of *Health for All by 2000*, CHAI coined a more realistic motto: "Health for many more by many more". As part of this motto, the mission statement of CHAI was developed. In the light of the mission, The Catholic Hospital Association of India was renamed as Catholic Health Association of India.

Diamond Years (1994-2003)

CHAI felt the need to develop a three-tier – national, regional and district (diocesan) levels -- approach to tackle the issues. It developed new strategies such as decentralization, bottom-up approach and networking in realizing its vision and mission of building healthy communities.

The decentralization process led to autonomy at the national, regional and diocesan levels in the area of functions, finances and administration. The regional units have become active and are able to plan and monitor the process. Decentralization was strengthened through amendments to the constitution, planning at the regional level, forming core teams and redefining roles; facilitated to develop plans of action for the coming five years; enhanced methods of planning, monitoring and evaluation for effective and efficient functioning; the units are equipped with knowledge and skills through capacity-building programmes such as regional resource training and other programmes on areas like leadership, governance, perspective building, financial management, alternative systems of medicine, communicable diseases, strategic planning and management skills and others.

We also initiated and developed management information system (MIS) both at central and regional levels. Baseline data on the membership (region-wise) and the health and socio-developmental areas in Indian scenario is available.

Intensified efforts in disaster management area led to the formation of Disaster Management Cell. The Legal Aid Cell was initiated as new laws regarding hospital and related areas are being brought into effect. Documentation process is given a separate identity to meet the needs of times.

Networking and collaboration with international and national organizations such as Catholic Medical Mission Board, World Vision India, Catholic Relief Services, Maitesar, UNIDAS, People's Health Assembly (PHA), National AIDS Control Organisation, State AIDS Control Societies of Andhra Pradesh, Maharashtra and Tamil Nadu; Sight Savers, Government of Andhra Pradesh etc. Active involvement with CBCI in the World Day of the sick and others like AIDS Rally organized by World Vision. The organization is involved in addressing issues at national level, thus, enhancing its credibility.

The population is rocketing. By 2050, our population will have swelled to one and a half billion which means more people and more poverty. More poverty will lead to more ill health. To avert a health crisis then, health has to be viewed now in a broader perspective and universal access to health seen as the right of every citizen. A changed outlook combined with strong political will and prudent policy-making will answer the problem.

Universal access to health

Fr Sebastian Guseppanampil

The poignant facet of the vision and struggle for universal access to health for over the last quarter of a century is a disturbing story that has currently landed us in a global health crisis characterized by growing inequities within and between countries. Despite the tremendous medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people all over the world. Enduring poverty with all its impacts and, the renewed onslaught of communicable disease and the HIV/AIDS pandemic are leading to reversals of previous health gains. This development is associated with widening gaps in income and shrinking access to social services as well as persistent racial and gender imbalances. From a number of countries in South Asia, Sub-Saharan Africa, Latin America and Central and Eastern Europe there are reports of growing morbidity and mortality among vulnerable sections of the population, including indigenous peoples. Traditional systems of knowledge and health, as well as well-established, social systems in the North are under threat. It is also a chronicle of governmental double talk, lack of political will and commitment and bureaucratic betrayal which resulted in progressive debilitation of public health system the world over. These trends are to a large extent also the result of the distorted structure of the world economy, which has been further skewed by structural adjustment policies, the persistent indebtedness of the South, inequitable world trade arrangements and uncontrolled financial speculation — all part of the rapid movement towards globalization. In many countries these problems are compounded by lack of co-ordination between governments, bilateral and multilateral agencies as well as extensive duplication of work among these institutions. Within the health sector, failure to implement primary health care (PHC) policies as originally conceived at Alma Ata has significantly aggravated the global health crisis coupled with the unprecedented growth of privatized health system.

The Indian health scenario is appalling as the statistics show.

"Of 25 million children born in India every year, nearly 2 million die before reaching the age one.

"Of 16 million tuberculosis case worldwide 12.7 million are in India. Each year 5000 new infections 1.8 cases emerge in India. 4,000,000 die each year.

"There are 4.5 million cases of HIV/AIDS.

"Water-borne diseases like diarrhoea, typhoid, cholera and infectious hepatitis account for 80% of India's health problems and every forth person dying of such disease is an Indian.

"Every third person suffering from leprosy is an Indian!"

Urban-oriented

It is true that over the last 56 years a vast network of health care services and personnel has been built up in our country. Special mention should be made of the top quality institutions of research and training and highly specialized and super-specialized services often based on Western models. Besides, it is largely a service dependent on urban hospitals with a curative approach. Despite the establishment of large number of primary health centres (PHCs) and rural hospitals, its urban bias is still pronounced and disproportionately large expenditure is still incurred in urban areas. Bulk of the medical practitioners and services are concentrated in the urban areas. The principal beneficiaries of these Medicare services are the upper and the middle classes. And the poor living in urban slums and rural areas who form about a third of India's population remain outside the purview of health care services just as the other benefits of development. In short, the present modern health services are generally urban-based and elite-oriented. Doctors trained at huge public cost are not available to serve the rural areas. Globalization, privatization and liberalization has made health care services beyond the reach of 90% of the population.

Pro-profit private sector

By the mid-eighties the Indian healthcare systems got polarized sharply into two: an inadequate state medical care and an extravagantly adequate pro-profit private medical care, juxtaposed, their stark contrasts were only too obvious. One would think that such a visible divide would have prompted the State to rethink its health policies and administration and look to innovative means to revamp its existing infrastructure. But, instead, our politicians and bureaucracy began wooing the private sector of medicine in the name of progress. And with blatant political and financial support given to the pro-profit private sector the corporate sector began to grow bigger and better with each business group vying with each other to create five star luxury hospitals boasting of designer carpets and imported equipment to cater to the therapeutic needs of the wealthy. The bulk of their work was composed of extravagantly priced health check ups or as head to toe computerized investigations with often times no coordinated human clinical inputs or as financially daunting packages in the field of transplantation, cardiac surgery etc. It is true that even within these profit oriented institutions there are decent medical professionals and businessmen who put health care above profit and take justifiable pride in the quality of work they do and the educational and research activities they have generated. But, by and large, health had been turned into illness and illness into business.

In the process of planning for health and health services we failed to take note of the socio-economic, political and cultural realities. Consequently the network of health services happened to be top-heavy, over-centralized over-medicalized, over-westernized, over- professionalised and over-bureaucratized, heavily curative in its approach, expensive, and dependency - creating. These shortcomings call for a total overhaul of the system as well as an integrated plan for health and development.

Alternative perspective

The alternative perspective should integrate promotive, preventive and curative aspects of health and should be community based, people-oriented, decentralized, democratic and participatory. Above all, it should take into account the inner strength, vitality and resilience India has with its own systems of medicines. In this endeavour the Panchayati Raj institutions at the grassroots level are required to be strengthened and empowered with adequate funds, power, responsibility, and requisite information at all

levels. The health of a society is intimately connected with its value system, philosophical and cultural traditions and its social economic, and political organizations.

The fifties and the sixties really witnessed a considerable shift towards *"Health for All"* especially in the developing countries. In India, the Bhore Committee recommended a decentralized Primary Health Care approach to make health accessible to marginalized and the underprivileged. At the dawn of Independence, this was adopted as the basis for India's health care policy. The focus of peoples health in people's hands was overlooked and people's health ended up in specialists' hands. The strength and resilience of Indian systems of medicine and the social, cultural and economic factors too were ignored. It goes with out saying that today the public health system is in disarray characterized by inadequate capacity in the field, organizational fragmentation and disjointed decision making. Thus we failed to mobilize people to play a vital role in their own health and health care set-up.

Health is a function not only of medical care, but of the overall integrated development of the society — cultural, economic, spiritual, educational, genetic and environmental. And it is a multifaceted phenomenon.

Health has to be viewed in a broader perspective and universal access to health seen as the right of every citizen. A changed outlook combined with strong political will and prudent policy-making will answer the problem.

The setting up of Indian Council of Social Science Research (ICSSR) and Indian Council of Medical Research in the seventies again kick started the thinking process to bring people oriented health care to the forefront. The report of this panel is unique in that, it represents the joint deliberations of national experts from both medical as well as social sciences. The report clearly defines the role that people can play in this set up. The 73rd and 74th amendments of the Constitution has really made it possible to have such a viable, alternative model today. And health is one of the subjects under the Panchayat Raj system under Section 11 of the Schedule and it provides ample opportunity to inaugurate a nation-wide move for universal access to health in the third millennium.

(The author is Director, Catholic Health Association of India, Secunderabad, 500 003, Andhra Pradesh)

Global health situation

Gains and set-backs

Life expectancy at birth has increased from 46 years in the 1950s to approximately 65 years in 1995 and the total number of young children dying has been restricted to approximately 12 million instead of a projected 17.5 million.

Despite these gains, however, there have been setbacks. Although in aggregate terms child mortality and life-expectancy have improved in all regions of the world disaggregation of these data reveals that the gap in mortality rates between rich and poor between and within countries has widened significantly for certain age groups.

The past two decades have also witnessed the alarming resurgence and spread of old communicable diseases once thought to be well controlled e.g. cholera, tuberculosis,

malaria, yellow fever, trypanosomiasis, dengue, etc. while new epidemics, notably HIV/AIDSs, threaten this century's health gains in many, mostly developing countries.

Child health care provision has increased greatly over the past two decades with the vigorous promotion of certain selected "Child Survival" technologies: growth monitoring, oral rehydration therapy, breastfeeding and immunization (GOBI). Of these, immunization has shown the most dramatic improvement, with global coverage of children under one year increasing from 20% in 1980 to 80% by 1990. This impressive progress notwithstanding, there remain areas for concern. These include stagnation in immunization coverage between 1990 and 1993, and declines in coverage in most regions of the world by 1000 with the most difficult – to-reach population being the group experiencing a disproportionate burden of vaccine preventable disease; the reappearance of diphtheria in the Newly independent States as a result of vaccine shortage and poor programme management and less than 50% coverage of pregnant women with tetanus toxoid vaccine.

The nutrition situation in developing countries remains serious with almost 200 million young children being malnourished and almost a billion people receiving less than their basic daily requirements of energy and protein.

Acute respiratory infection (ARI) and diarrhoea diseases are the two leading causes of death in children under 5 globally with the overwhelming majority of cases occurring in developing countries. Standardized management guidelines have substantially reduced fatality rates but the impact has been less than anticipated due to interrupted and inaccessible supplies of oral dehydrations solution, improper usage and an unabated high incidence of diarrhoea as a result of minimally improved environmental hygiene and persisting malnutrition .

Maternal health has received far less attention than child health, with levels of maternal mortality and morbidity from largely preventable causes in developing (particularly the least developed) countries remaining unacceptably high.

David Sanders
