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THE CHILD-IN-NEED INSTITUTE

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The Child-in-Need Institute (CINI) is a voluntary organisation, registered under the Societies Act. It has two basic objectives:

* To provide integrated health and nutrition services to the child in need:
* To act as a catalyst in promoting socioeconomic developments of the poor and needy.

Apart from programmes in nutrition supplementation and primary health care, provided to mothers and children in the villages and slum areas of South Calcutta, a concerted effort is being made to improve socioeconomic conditions of needy families and improve the status of women. Funding comes partly from the community for services rendered and partly as donations.

The child in need in the Indian context usually brings into focus a malnourished child below the age of six years, suffering from intercurrent infections and living in a poor family in a village or the sprawling slums of metropolitan cities. The logical intervention from the humane point of view is to break the vicious interaction between malnutrition and infection by providing low cost nutritional supplement to vulnerable groups, along with primary health care.

A pediatrician and a nutritionist with the help of on the job trained MCH workers, set up mother and child health clinics in Calcutta's slum areas in late 1974 and CINI was born.

Clinics, set up in various poverty pockets in villages and slum areas of South Calcutta, train groups of mothers to prepare a low cost nutritious food supplement from a cereal pulse mix (CINI nutrimix). Both at the clinics and during home visits, the mothers are told about better child care and low cost nutritious foods with the help of posters, flannellographs, puppets and slides.

Food Supplementation

Wheat/rice along with moong dal (Phaseolus aureus Roxb) is roasted over coal fired chulas (ovens), ground at the local mill and packed into 500 gram polythene packets. These are provided at subsidised rates every week to malnourished children selected by weight-for-age criteria (below 50 percent of Harvard).

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The children provided supplemental food are immunised against preventible ailments and treated for minor ailments with low cost medicines and their weights and nutrition status are monitored regularly on parent retained weight-for-age cards.

Severely undernourished children (kwashiorkor, marasmus, marasmic kwashiorkor, vitamin A deficiency), referred by CINI workers or seeking care on their own, are admitted with their mothers to the Nutrition Rehabilitation Centre. Intercurrent infections (diarrhoea, chest infection, etc) take about one to two weeks to be treated.

A further six to eight week stay at the Centre, Where the mother is trained on low cost food, improves the child sufficiently to be discharged and to be followed up regularly at the (weekly) MCH clinics: Mothers of the admitted children participate in cooking, cleaning and working at the kitchen garden plots during their stay at the Centre.

Prenatal and postnatal care is provided to village mothers through prophylactic immunisation, nutrition supplementation and monitoring the health status of pregnant/ lactating mothers. A low cost delivery kit (costing fifty paise) from old sarees, razor blades and cord tie, all autoclaved, are made available to pregnant mothers. Trained dais use the kit to help deliveries at home.

Home based income generation projects are encouraged. Mothers are trained in skills such as weaving, umbrella assembly, sewing and kniting. Traditional means of supplementing the family income by goat rearing or having a kitchen garden in a small backyard plot, are encouraged. Sometimes repayable loans are given to initiate small businesses such as vegetable/ fish selling, puffed rice making, plying rickshaw vans, setting up barber shops, etc.

Balwadis, where children are fed a supplemental meal and involved in preschool activities, are also conducted by mahila mandals in different village centres, Regular meetings with mahila mandal members ensure participation and representation of the members in village development.

A survey of village primary schools, in the two blocks covered by CINI's developmental activity, showed inadequate facilities in terms of class-rooms and teaching aids, and a high dropout rate among school children. A school welfare committee was organised with representation of teachers and CINI staff. Gradual improvement of facilities has taken place following the advice of this committee.

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With the expansion of child welfare programmes in rural and slum areas by the Department of Social Welfare in many states, there is a shortage of trained workers at the grassroots level. CINI trains anganwadi workers for ICDS programmes and also provides orientation in child care to other categories of government workers such as BDOs, MO of PHC, etc. Innovative training strategies and practical case studies from admitted cases in the Nutrition Rehabilitation Centre are employed.

Community nutrition and child care programmes conducted by CINI also provide learning opportunities during field visits. The training unit is staffed by fulltime workers from the areas of pediatrics, nutrition, sociology, anthropology, graphics, and community health and development. A total of 1722 workers from the government as well as voluntary organisations were trained in 1980. Some of them were trained at CINI, others at the block level by the Mobile Training Team.

A CINI team of two pediatricians left for Karamoja in Uganda during 1980 to volunteer in the massive famine relief programme launched there for three and a half months. The team worked in nutrition rehabilitation centres, in a government hospital to provide temporary medical manpower, and organised the movement of food to famine stricken areas as requested by the World Food Programme and UNICEF. During late 1979 a CINI team worked in the Kampuchean refugee camps on the Thailand-Kampuchea border sharing its expertise in the rehabilitation of children and adults who are severely malnourished

Under CINI's Research and Evaluation Programme:

* A detailed study on 2000 families covered by CINI activities has just been completed. The data are being analysed to determine health, nutrition, literacy and other socioeconomic indicators of the community.

* A study was undertaken last year in collaboration with the Government of West Bengal, UNICEF and the All India Institute of Hygiene and Public Health to determine the impact of the Mother and Child Care Programme, launched as a postflood rehabilitation effort, in 30 blocks in the state.

* A study on infant feeding practices is now going on, under the sponsorship of the Nutrition Foundation of India.

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THE MOTHER IN CHILD HEALTH CARE IN RURAL COMMUNITY

by

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The Child In Need Institute [CINI] from its accumulated experience of conducting mother and child care programme during the last six years has evolved a strategy of community participation in all spheres of its activities. Keeping in view the low income profile that is prevalent in the rural areas and urban slums, CINI has evolved income generation programmes for rural mothers generating approximately Rs. 50/- per month. This will help in potentiating CINI's effort in providing mother and child care services to the deprived child. Linkages have also been established between different aspects of CINI's programmes such as functional literacy, nutrition and health education and primary health care to provide an integrated programme of mother and child care at the 'grass root' level. Details of the programme will be presented and discussed.

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THE MOTHER IN CHILD HEALTH CARE IN THE RURAL COMMUNITY

S. N. CHAUDHURI *

A. GENERAL APPROACH AND PHILOSOPHY

A nutritionist and a pediatrician both concerned at the prevalence of malnutrition in children belonging to rural areas outside Calcutta and its peripheral slums, decided to set up weekly under five clinics at two different points in the city in 1974. A low cost indigenously prepared cereal pulse mixture (CINI – NUTRIMIX) providing daily approximately 200 calories and 10 grams protein, was given out at the clinics to malnourished children and their weights monitored on weight for age health cards. Primary health care including immunisation, treatment of common childhood ailments, referral and treatment at a nutrition rehabilitation centre for severely malnourished children, health education for the mothers through home visits by trained mother and child health (MCH) workers formed the components of the services. By 1975 approximately 2,400 children were covered in 8 centres, 3 of which were in the slums and 5 in the villages.

In 1976, CINI – Child In Need Institute was registered as a society with the following objectives –

1. To provide integrated health and nutrition services to the child in need.
2. To act as a catalyst in promoting socio-economic development of the poor and needy.

Financing : A contribution for services availed at the clinic (30 p./visit) and during food distribution (30 p./pkt.)

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* DIRECTOR

was insisted right from the initiation of the project. Occassionally due to poverty the contribution had to be waived on the recommendations of the MCH workers. These contributions generated approximately 15-20% of the running cost and the balance was met from overseas donors.

B. DESCRIPTION OF THE PROJECT

A countrywide survey on pre-school children conducted by Indian Council of Medical Research established the prevalence of malnutrition in this vulnerable group. This coupled with the failure of the existing health care services to reach the child in need, promted the initiation of an integrated child care services in the community. Till 1977 the emphasis was on the child in need. The project was then evaluated internally. One of the recommendations was for the promotion of increased participation by the mothers and other members of the family in CINI's child welfare projects.

Amongst the factors hindering participation, illiteracy and lack of opportunities to improve family income in mothers were felt important enough to warrant intervention CINI's programme was then designed to include these non health inputs to make it a truly integrated mother and child care programme.

At present the programme is functioning in the following manner with inter project linkages.

I. Nutrition Supplementation Programme

Malnourished children below 6 years, pregnant/lactating mothers are provided a nutritious supplement at periodic intervals.

(a) CINI - NUTRIMIX Programme - A low cost nutritious food made by the village mothers out of 400 grams of wheat and 150 grams of Bengal gram is provided through the static under five's clinic conducted in the village and slum centres. It provides 1,992 calories and 79.6 grams protein over a week. During 1979, 37,188 packets have been distributed. Approximately 800 children and 200 mothers receive this food on a regular basis.

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(b) Nutritious food supplement using imported foodstuffs are provided to 2,500 children on a continuous basis through 8 centres, both the programmes the weights of the children are monitored on parent retained weight for age cards. Local youth clubs, mahila mondols are involved during food distribution.

II. Health Care through Mobile and Static Under Five Clinics

306 such clinics were held around 15 kms. of the centre over the year and children were provided immunisation, oral Vitamin 'A' supplementation, iron and folic acid tablets. Approximately 3,000 children below 6 years are covered under this health care programme from the nearby villages and slum centres. Trained MCH workers follow up these children by regular home visits.

III. Nutrition Rehabilitation Centre

Severe cases of protein energy malnutrition and other deficiency diseases are rehabilitated at this centre over 6 to 8 weeks to ensure survival. Mothers while at the centre, are given nutrition and health education and are trained in low cost nutritious diets. Mothers also help in cooking and house keeping during their stay. In 1979 152 cases were rehabilitated.

IV. Antenatal and Post Natal Care

A total of 544 mothers were registered in the antenatal clinic of CINI where they are provided immunisation, supplementary foods and health education. Cases are referred to the Govt. hospital for family planning measures. The mothers are encouraged to deliver at home with the help of trained village "dais". An indigenous low cost delivery kit developed at CINI, is purchased by mothers for safe delivery at home.

V. Nutrition and Health Education in the Community

Trained MCH workers carry out health education on different pre-selected topics by group discussions, cooking demonstrations, posters, flannelographs etc. 340 classes were held at different village and slum centres during 1979. A group of village mothers who are

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II. Health Care through Mobile [U]nits

motivated on child care (selected from beneficiaries) also join the trained MCH workers in visiting their neighbours to discuss health and nutrition topics with them.

VI. Community Action Programmes for Socio-Economic Development

(a) Family Helper Project

500 needy families selected by the community receive help and a school going child in each family is provided direct benefits in the form of clothing, books, medical care and nutritions supplement. The families are provided income generation opportunities in order to improve their quality of life. Goats, coconut seedlings, ducks are provided to these families as a one time grant.

The whole village community shares the benefits through repair of existing schools, provision of teaching aids such as blackboards, maps etc. Usually some of these families also receive the benefits of the nutrition supplementation programme for pre-school children and thereby cross-linkages are established. The funds for this project are directed by many overseas sponsores through Christian Children's Fund, INC.

(b) Mahila Mondols

Most of the future income generation programmes in the villages will be organised through womens groups. Three such groups in 3 villages have been formed who have taken up functional literacy programmes. Sewing, weaving and umbrella assembly units of CINI will now be incorporated through these mahila mondols

VII. Training of Mother and Child Health Workers

(a) Sishu Kalyanis - At the request of Govt. of West Bengal and UNICEF, CINI has undertaken a training programme for MCH workers. Each worker is in charge of 200 children below 6 years in a village and has been selected by the panchayat. She provides nutrition supplement, health education to mothers, refers the children for immunisation and treatment to the local PHC. 1,500 workers are being trained in 30 community development blocks all over West Bengal through a mobile training team from CINI. This has led to an improvement in nutrition and health status of approximately 3,00,000 beneficiaries all over the State.

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(b) PHC doctors, BDO's, Project Officers of mother and child care programme in 30 blocks as above are also provided orientation in integrated mother and child care at CINI.

VIII. Functional Literacy Programme

The first batch of 120 mothers who had commenced classes in 1978, completed their course in September 1979. The topics covered present day village situations such as poverty, safe water supply, money etc. as well as diarrhoea, malnutrition etc. All the classes are preceded by active discussions. These classes are now held by mahila mondol groups where it is linked up to income generation opportunities such as sewing, umbrella assembly, weaving, kitchen gardens, fish rearing etc.

EVALUATION:

In 1977, an internal evaluation of CINI's objectives and programme recommended active participation of the mother. It is well known that the child is accessible to institutional intervention only to the extent that the mother allows him to be so. Involving the mother in mahila mondols through which much of these integrated package of services can be channellised is a sure way of reaching the child in need. Apart from a general improvement in nutritional status and specifically no incidence of severe PEM(marasmus and kwashiorkor) in the area, there has been a change in attitudes of the mothers over the years. More children are being brought to the clinic for immunisation and preventive health care. In the absence of a base line study, the improvements are difficult to quantify.

TRAINING OF GOVT. M.C.H. WORKERS

It is well known that the bulk of primary health care is being rendered through the Govt. infrastructure involving different categories of workers. It is possible to improve the efficiency and motivation of these workers through training in integrated programmes. By training Shishu Kalyanis (MCH Workers), their supervisors, ANM, PHN, Project Officers, PHC doctors there is sure to be an improvement in the existing MCH services. CINI has been able to initiate and sustain such training programmes at the block level. Nurses, interns and post graduate students from different medical institutions are also being given brief orientation to mother and child care programmes at CINI.

LEVELS OF COMMUNITY PARTICIPATION IN CINI'S PROGRAMMES

1. The mothers willingly accept the new formula without milk powder although

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milk has such a status value as a baby food.

2. An enhanced contribution of 50 paise is paid now by the mothers for the premix and also for clinic registration, decreasing subsidy from CINI.

3. Immunisation acceptance spontaneously by mothers is the rule in the under five clinics.

4. The mothers have accepted the MCH workers even for treatment purpose at the under five clinics.

5. House delivery by dais using low cost delivery kits which mothers buy from CINI.

6. Return of two goats (one mother and one female kid) for recycling to other families at the end of one year.

7. Committee of local primary school teachers who allocate funds for school welfare projects in the area.

8. Village based mahila mondals contribute part of their earnings for development work.

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TAGORE SOCIETY FOR RURAL DEVELOPMENT

RANGABELIA PROJECT

[Development through Peoples Participation]

by

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Rangabelia is one of the isolated islands of the Sunderbans. It is part of the delta face between the Hooghly and Padma-Meghna estnaries. It has its own special topographical and ecological characteristics and problems.

The island is surrounded by rivers full of saline water, which often breaches the protective ambankments, resulting in influx of saline water. It is among the poorest sections of West Bengal. About 90 percent of the population is engaged in agriculture which is predominantly monocropped, and earn an avorage income of Rs. 170/- per annum. Scheduled Castes and Tribes account for 63 percent of the total population. There is no electricity, no industry and communication facilities are deplorable. Medical facilities were non-existent.

In 1974, the local school conducted a detailed socio-economic survey of the three villages on the Rangabelia island. Comprehensive development plans were prepared with the help of the local villagers. In 1975, the following activities were initiated: Two crops a year with better seeds, Animal husbandry of different kinds, Pisciculture, Weaving, Agro-services and irrigation and cooperations etc.

After deliberations, a comprehensive health care project was initiated, details of which will be discussed. Two special features of the project are: a] Complete involvement of educational institutions of the area in development work; and b] Involvement of people at every stage from decision making to implementation.

Criteria for Health Services
1. No dependence on Doctors/Hospitals
2. Village based health effort
3. Health Education
4. Involvement of Youth

Objective
1. 20% of Housing
2. Indigenous material - based latrine
3. Safe water supply
4. Under 5 PCM 6 VLW
5. TB patients

SEVA BHARATI

Seva Bharati, P.O. Kapgari, Dt. Midnapore, West Bengal, came into existence as a voluntary organisation, in the wake of independence, in 1947. Registered in 1953-54, it engaged itself in the task of education and rural reconstruction. Its establishment was inspired by ideals of Indian heritage and culture expressed in the form of such institutions as gurukulas and gurugrihas for imparting knowledge to young people in a congenial atmosphere which was in striking contrast with the present condition of the country. Even though India still lives overwhelmingly in the villages, the old cultural leadership is miserably missing, and so its cultural moorings have been lost. The institution is an attempt in recapturing those old but eternal values through education and rural reconstruction.

Objects and Programmes :

Objectives of the organisation as given in the constitution are :-

/ing 1. Establish a centre of education and social work equipped with schools and institutions for general and vocational education. For this it will work for:-

a) evolving a system of education which would provide the local community with a viable economic base;

b) modernising agriculture by bringing science and technology to its aid and by linking agriculture with industries including Khadi in an organic way so that it may not only be self-sufficient but also profitable;

c) bringing about that socio-economic transformation in which a self-generating economy may be possible through full mobilisation and full employment of all the natural resources - human & material;

d) ensuring everybody in the community full, fair and equal scope for total development of personality, inculcating the feeling of oneness among all, laying stress on the values that make life rich and worth living, and promoting universal brotherhood.

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Programmes :

Agriculture: A Farm School was first initiated in 1948 and since expanded with support of Gandhi Smarak Nidhi in Anchal No. 3 Jamboni Block, District Midnapore.

Live-stock Development: Now developed as a Krishi Vigyan Kendra (with ICAR support). Also a PAD(I) Centre is in operation.

Village and Cottage Industries: Work initiated in 1948 and expanded in 1954 under the Farm School Scheme. Attempt is afoot to develop it as the "J.C. Kumarappa School of Village Industries", inaugurated in 1975.

Education and Training: Schools of liberal and vocational education - Pre-basic, Jr. Basic, Sr. Basic, Secondary, Higher Secondary and Vocational Agriculture H .S. School, Degree College and a Research Centre.

Community Health: A Government Health Centre established since 1962.

Family Welfare: Adult Education Centre (both for men and women established).

Appropriate Technology: This occupies special attention of Seva-Bharati. It has made some breakthrough in respect of development of water resources, water lift and other agricultural operations.

Recreational and Cultural Programmes: Sports, music, drama, and other cultural programmes. A Centre of folk arts (including dance and music) initiated.

Any other:

i) Orphanage;

ii) N.S.S. programme;

iii) a Sarvadharma Samanvaya Centre.

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PROJECT REPORT

I have been engaged in this area for 5 years now. The first two years I worked as a practitioner and a village development worker in formally and individually. Informally, because I did not have any formal organisation nor did I have very clear cut plans. At that time I only had certain inclinations and ideas which I wanted to test out. At this time my resources included about 2 acres of family landed property in the village, my own meagre income from private practice, a saving of Rs.1500/- from my internship days and a donation of about Rs.200/- from friends and well wishers. The next year I worked in a S.H.C. about 8 miles from this village as a Medical Officer and there was a break in the continuity of my work in this village. It is only over the last two years that I am working on a somewhat more formalised project under a Registered organisation. An amount of Rs.25,000/- has been provided for this by a foreign funding agency called 'The Bread for the World'. The project I am running has not focussed on health activity as such. The reason is that even as a student, when I was trying to assess the relevance of my training and to contemplate future action, I realised that health was dependent on something else i.e. economic development, and my subsequent experiences has made me aware of other dimensions on which health is dependent namely social cultural. I shall try to illustrate this through an example. Hence, it is very commonly held belief that a woman is filled with fluid ('rasa') at the time of delivery. Hence, the logical course after delivery (during the early puerperium) is to dry her up. She is given as little water as possible; is allowed to eat a diet of rather dry, fried and unnutritious food. She is also kept near the fire place almost all the time. The result is the drying up of breast milk, (also breaking down of the mother's health). Hence the child is put either purely on a solution of thin arrow-root or of palm candy or a combination of both. If the quantity and concentration are sufficient the child will grow for a time but finally becomes a book picture case of protein-calorie-malnutrition. Now let us examine our next book solutions in relationship with the situations. Perhaps adequate quantity of cow-milk will be the first choice. But this is an unrealistic

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solution for people where I am working . Milk production has been steeply dwindling in this area and the price of milk being high is beyond the reach of the c ommoner. Moreover, pure milk is an unknown commodity, unless one owns a milch cow. The next preference will perhaps x go to milk constituted from ground nut and soya-bean. These two crops are not grown here. However, ground-nut is available in the market; but the suggestion itself seems pre-posterous to these people. The third solution is early introduction to soiid food. Even this is a cultural taboo before the 'annaprasana' ceremony which is x scripturally supposed to take place not earlier than the age of 6 months for male and 7 months for female children. The most important prevantive factor is parent education and to induce the mother to take plenty of fluids and nutritious diet soon after child birth. But in these matters the control and decision making power lies with the grand old woman of the family whose attitude to young doctors like us is somewhat like this 'Pooh' You urchin of yesterday, come here to teach us child rearing. Haven't we oursel ves reared half a dozen (or may be a dozen) children suc essfully by this same old method and we had enough milk to breast feed our children up to 2½ years even 4 or 5 years. These young women of today god knows what has happened to them. This is 'Chora Kali'.

To any one who has faced such situation often it will be clear that mere improved technique or financial assistance will not do. This involves intervention in matters like tradition, culture, social and famili power relationship and whole gamut of subtle social, economic and cultural interrelationships. Hence, instead of approaching health problems directly I am trying to reach them indirectly by trying to communicate a different of view of life. and a new style of living - a style of wholesome, healthful living taking into consideration the changed circumstances of the times - and this specially through the younger generation.

At present our group consists of 16 persons including myself. There are persons of all ages from 6 to 42 years; three are married - two with children, there is a widow with two children and the rest unmarried youn men. Apart from these there are other young boys and girls from the community who come and join in the work sometimes.voluntarily, sometimes with wages depending on t e nature of the work. Only

two of them have class X level of education, five of them had crossed primary school, other eight were totally illiterate or almost so when they joined, but about half of them have now acquired proficiency enough to do the daily accounting and keep daily records of work.

We are mostly dependent on agriculture and weaving for livelihood; but apart from these we render curative services form men and animals mostly against remuneration and help to bring governmental preventive services to the village people. One of the two with class X level of education has acquired proficiency enough to be called a 'bare-foot doctor' - there are two others in the making one of them as a veterinary and live-stock adviser.

II. Background Information

We do not have a very definite project area as such but our target population is the people of the village of Chaksimultala and surrounding it. This is a village some 8 miles south of the Sub-divisional town of Tamluk with which it is linked by a fair weather bus route. Otherwise walking or cycle are the main mediums of communication. There is a canal which is navigable in the rainy season and sometimes afterwards and is the main source of transportation during the rainy season. The village is a 100 % Scheduled Caste village with a population of 465 and a growth rate of 2.6 % with 40 % literacy according to the 1971 census. The village is dependent almost exclusively on agriculture. There is no mentionable village industry. Paddy is the staple food crop and betel is the chief cash crop. Sweet potato is another crop widely grown mainly for cash partly consumed as food. Khesari is the most popular pulse crop. 90 % of the land is single cropped. This village is situated in one of those rare areas where land reform had some genuine impact. Absolutely landless people are rather few though their proportion seems to be increasing day by day. Most are marginal subsistence or non-viable farmers. There is no family in the village with a huge land-holding. But there is a new class who by virtue of their education has taken up professional jobs (mostly teaching) who seem to be monopolising the power hierarchy.

The people like in mud houses with roofs thatched with straw rather badly lit and damp. Ventilation seems to be poor. The houses of the relatively well to do are spacious, well lighted and often has tiled or tinned roofs. There is no provision of privy except in one or two houses. People are used to defaecating in the fields and on the bunds. Recently we have started the practice of defaecating in pits, composting it and using it as manure; but the practice has not yet shown any spread effect. During the late fifties and sixties almost every village in this area had a tube-well. But over the last six or seven years they are going out of commission and no serious attempt has been made on the part of the government to replace them. However, in our village the villagers, our group and the Block office collaborated to resink the tube-well two years back and it is still working well, and this event has brought a remarkable fall in the morbidity and mortality from severe diarrhoea. Rice and khesari were the staple cereal and pulse respectively in the diet of the people here. Now wheat scares an equal place with rice except in more well to do houses. Small amounts of fish are available depending upon the season ~~the~~ Consumption of meat, eggs, milk etc. are almost negligible. Some amount of palm jaggery and vegetables ~~xxxxxgare~~ are available. In the relatively backward area of the village palm toddy has almost taken the place of the staple beverage. Alcoholism and illicit liquor production seems to be steeply rising in this portion of the village. Men mostly wear sarees without blouse or petticoat except on special occasions. I have previously mentioned that the village has 40 % literacy but this is only about 10-15% among women. Considering its size this village has quite a high proportion of college and university educated people mostly confined to one particular portion of the village.

As far as the caste stratification is concerned the village is more or less homogeneous one. All the families belong to the Scheduled Castes 96% to the Namasudra, 3% Bagdis and 1% Napit. Most of the occupants of the neighbouring villages belong to a higher caste called Mahishya. Though there are subterranean caste feelings these are not very

vehement. Intercaste and love marriages have begun to be accepted, though this requires quite a bit of struggle on the part of couple concerned. Though most of the institutions are dominated by the local rich, their hold on these has started weakening.

The reaction of the local government officials including the B.D.O. and S.D.O. has been favourable. This may be because of my personal back ground and as because we have not yet come into very direct contact. The village power group has a suspicious attitude towards us but has not yet come out with any serious aggressive posture.

III. Relations with other Health Agencies

Other health agencies in the locality include an I.M.F. doctor in a neighbouring village, a B.H.W., and some unqualified practitioners of various pathies. The I.M.F. doctor's reaction is quite favourable. The B.H.W. comes about once in a month; but there is little preventive work being done except small pox vaccination and occasional triple antigen inoculation. Recently there has been some D.D.T. Spraying in the locality. The B.H.W. is not uncooperative but not very co-operative either. The relationship is rather casual. Our relationship with the local unqualified practitioners, specially those practicing modern medicine, is a rather uneasy one. They seem to feel threatened by our presence. However, they have not yet shown any aggressive posture. But our relationship with those practicing traditional medicine is not an unfavourable one, and it seems possible that in the near future it may be possible to form a co-operative relationship. The local veterinary authorities are much more co-operative and it is because of this we have been able to do better preventive work in animal health.

People are very resentful about governmental health agencies because of their inhumen dealings, low efficiency and non-availablity at the proper time. Though the medical skill of the local un-qualified practitioners is not regarded very highly they are better accepted because of their easy availability. People seem to be aware of their money making designs but seem to be helpless in absence of any better alternative. In this area people's awareness about health services seem to be high in certain respects; for example it is not unusual to find groups of people organizing a call on the B.H.W. to vaccinate them

towards the end of the winter. It is also not unusual to find people expressing their resentment to visiting government officials about non-availability and lack of maintainance of drinking water facilities. Their awareness about triple antigen etc. is rising though it is by no means unusual to face question like 'why should a child be injected in absence of fever or illness'?.

IV. Medical Health Care Work

The various diarrhoeas and intestinal parasitic infestations form the major health problem of the area. Peptic ulcer, respiratory infections (including tuberculosis) are quite common. Scabies and various forms of fungal infestations of the skin are very common. Anemia and white discharge are quite common in women, P.C.M. and vitamin A deficiency are common in children next to various forms of infant diarrhoeas. Hypertension, Asthma and chronic respiratory infection are quite common in the aged.

We deliver health education and preventive advice mostly as an adjunct of curative service; though we have initiated community action on resinking a tube-well and now trying to initiate community action on sanitary disposal of night soil and other village refuse. We try to bring out the connection between insanitary disposal of night soil and the diarrhoea during our informal discussion with the villagers.

V. Evaluation

We do not have any 'inbuilt system of evaluation' as such; but we review our work in the evening meetings held every alternate evening. Then we have more wide ranging periodic reviews. We change our patterns or style of work accordingly.

Though objectively speaking health promotion and disease prevention work has a greater effect on community health, people tend to consider curative service to be more important to the community. This may be because of several reasons. One is the concept of a good doctor. A good doctor is one who can effect quick and miraculous cure, i.e. one who can bring back almost dying patients. This again may be due to something like 'on the spot demonstrative' effect of curative work, whereas the effect of preventive work is more imperceptibly spread over a longer period of time. Hence, pure preventive work has a low acceptability and has to be administered as an adjunct of curative work. Such

~~ideas of the people affect the doctor as well~~, who in his search for prestige and greater subjective satisfaction tend to project himself as a miracle man. It also happens that preventive advise given by one who is not considered a 'good doctor' is not much headed to, but the same advice by a 'good doctor' has a much greater acceptability. This is a contradiction which does not seem to have an easy resolution in the near future.

In curative work the cost of modern medicine is a formidable barrier; then ideas about these medicines being ' strong' and 'hot' makes it very difficult to follow a proper course of a particular medicine. To me it seems that the latter is a subjective defence mechanism to the former. If it be possible to bring down the cost of medicines within the reach of the ordinary man then the ideas about their being 'strong' and 'hot' will gradually disappear

It is often detrimental for a doctor to take up the role of project administrator as well, unless he has a good standby because the two have two different kinds of demands. The project administrator has often to wander out of the project area, whereas a doctor is expected to be available on the spot. For this reason it seems to me that the two activities should be handled by two different persons of equal competence.

Fund raising is a big problem for us. We have not yet been very successful in tapping local resources. Hence we have to depend on external funds. We are attempting to become self-reliant through our economic activities like agriculture and weaving. It is possible to foresee self-reliance in the near future. Another reason for this weakness is that we have not been able to elicit wide peoples participation. To a certain extent this is because of our calculated seclusion from the day to day community activities. I had mentioned beforem that it is our objective to imbue the community with a new view of life and living-specially the youth. This being so it requires a cadre who have at least glimpse of the reality and the desired direction and are inspired by this vision. Till now our work has been confined to this cadre formation. It is believed by us that in this phase it require a certain amount of detachment from the

routine of community life. But we have already started emerging out of this self imposed seclusion and there are silver linings which indicate greater people's participation in the near future.

One of the strongest points of our group is that all the members are rooted in the rural community. All except myself are from very poor families. This has done away with much cultural alienation and alien hostility. Hence, we do not see any serious problem in reaching the lowest rung of community except their buying power. This strong point is at the same time its weakest point too because running a project required certain managerial and other skills and discipline, and a new vision requires a new language and a new pattern of interaction. These things they find against their grain and find it difficult to acquire. However, this is not unsurmountable; this is a matter of time and proper leadership. Another weakness of this project is that it is an one person centred project - that single person being myself. This may lay the roots of individual domination and personality cult.

VI. Future Plans

Now that we are emerging from our preparatory phase, we plan to embark on community action. For this we are now conducting a thorough survey of the village in order to formulate a micro-level plan and embark on community action. All this survey and planning is being done and will be done by the group in collaboration with the villageers. We plan to embark on our new programme by the beginning of the next year.

(L.K. Khamra)
Tamluk : Midnapore
West Bengal.

Lokasiksha Parishad

Report by the Ramakrishna Mission Ashrama, Narendrapur (24-Parganas), West Bengal.

TRUE to the ideals of the Ramakrishna Mission that service to humanity is the best form of worship, this Ashrama, a branch of the Mission, is carrying on welfare activities through its Institute of Social Education & Recreation (Lokasiksha Parishad).

The Institute also known as Lokasiksha Parishad stepped into 20th year of its existence during the year 1976-77, vigorously pursued its multipronged programme of social education, child and youth welfare, and village uplift in the rural areas mainly through 86 rural youth welfare centres in the districts of 24-Parganas and Midnapore.

All the centres are run by local people, mostly youths, with guidance from this Parishad. It is worth mentioning that 17 are in the backward area known as the Sundarban in 24-Parganas District. The population in the area where these 17 centres are located are mostly of Scheduled Castes and Tribals. Most of the other centres (in the districts) are in the backward area of the districts.

Acting on the ideals of Swami Vivekananda that education should be taken to the doors of the villagers the importance of adult literacy was recognised by the Ramakrishna Mission long ago. Keeping this in view this Parishad had been running a number of adult literacy centres since its inception.

During the year 20 centres were maintained for 440 students. During the year 118 persons were examined and declared to have been made fully literate in the effective sense. They were found suitable for class IV of high school in all subjects including Arithmetic but excepting English which is not taught in adult literacy centres. They were so prepared that they could read newspapers and publicity bulletins in simple language, maintain household and farm accounts and fill up application forms of banks and co-operative societies.

Those who pass the First Examination know the alphabets, can write simple words with the letters. They can also do simple additions and subtractions.

Those passing the Second Examination are able to form sentences, write the same, and also read and write short paragraphs.

Apart from adult literacy the centres maintained courses especially intended for young school drop-outs with 308 such students.

In many of our literacy centres the pupils organised and took part along with studies in dramatic performances, musical entertainment, rural indigenous games like Ha-du-du (very similar to Kabadi). In several cases these adult pupils were found to be active in development efforts such as earthwork for construction and re-construction of roads, bundhs, canals, tanks, etc.

A very important feature of the adult literacy centres was the fact that discussion forums were frequently organised with guest speakers on various facets of rural life such as agriculture, animal husbandry, fish-culture, co-operative societies, help from banks, medical care and public health, communication etc. Students of the centres and other villages always took active part in the discussion.

In all 420 such forums were held with 1,520 students and villagers participating.

An adult night high school was started in 1971 with the object of educating up to the school final examination those who are engaged in factories, fields and other occupations during the day and are thus unable to attend the regular day schools During the year there were 200 students on the roll. Three appeared in school final examination, two passed.

With the increase in literacy, library services become imperative so that the neo-literates do not revert to illiteracy for want of suitable reading materials. Moreover, books go a long way in building up good character, a national integration and a sense of values so necessary for the citizens of tomorrow. Keeping all these in view library service was encouraged in the centres. As many as 70 of our rural centres now have their own library.

The Institute also regularly publishes a Bengali monthly magazine named "Samaj Siksha" which is now in its 20th year of publication. The object of the magazine is, as its name implies, social education, and is intended mainly for the rural people.

From 1974-75 larger emphasis has been placed on the neo-literate section by bringing it at the beginning of each issue. It is hoped that this will mean greater attraction to the neo-literates, draw more of their attention and make them feel that the magazine is their own.

It is accepted on all hands that suitable follow-up literature is an essential item in any adult literacy programme. With this end in view the publication of a number of volumes suitable for adult neo-literates has been taken up by the Farishad. So far 18 volumes have been published.

In order to encourage the habit of good reading and maintain this, particularly amongst women, children, school drop-outs, neo-literates and others in rural area, a mobile library was established in 1973-74. At the end of 1976-77 it has been possible to establish 119 distribution centres. 1,222 books were purchased during the year bringing the total number to 12,966.

The number of readers—women, children, school drop-outs, neo-literates, and others increased considerably showing that our efforts have been bearing fruit. Total number of books issued during the year was 47,600.

Tutorial classes were arranged in several welfare centres to help the students to be well up in the subjects of study. In many instances good students of senior classes in the school or of nearby colleges or teachers themselves came forward in the work. Students in far away colleges coming home on vacations were also found rendering necessary help. The most heartening feature is that the workers are all voluntary and the benefited students did not have to pay any fees for the coaching they received. Nearly 1,000 children get the benefit.

Free textbooks and financial aid were given to 21 needy children. Eighteen needy children were awarded scholarships.

Textbook banks at Narendrapur headquarters and 4 of the village centres maintaining high schools continued their activities in this regard vigorously benefiting more than 1,000 students to whom textbooks were given on loan. A book bank was maintained at Narendrapur headquarters as well. 1,189 books were given to these textbook banks in the shape of assistance from the Parishad. Besides this the Adult night high school at Narendrapur gave on loan all the required textbooks to all the studets on the roll.

Emotional satisfaction on the right lines contributes to a great extent to the development of a total child and youth leading him to be a fit citizen of tomorrow. Further, in a country like India where the large majority lives in villages and is still today illiterate education has to be non-formal. This non-formal education and emotional satisfaction in villages have been carried out over the ages through India's rich heritage of folk music, devotional songs like 'Kirtan' and 'Baul', musical renderings of the universal truth of religion like 'Kathalmtha', 'Ramayana Gan' and 'Yatra' dramas. These had also been fostering the sense of eternal values of discipline, patriotism, home life. All those go to form what we know as rural culture and entertainment. These are still prevalent in the rural areas and to a large extent in the cities too. Great care is taken for the promotion of these activities, since, otherwise, there would be a void in the cultural life of the rural society.

A PROJECT FOR THE DELIVERY OF HEALTH CARE TO RURAL CHILDREN AND MOTHERS AND ASSESSMENT OF NEONATAL AND INFANT MORTALITY AND MORBIDITY IN RURAL WEST BENGAL

by

Dr. Sisir K. Bose, Director,
Institute of Child Health, Calcutta.

A pilot project involving 11 villages and 1300 families in the Memari area of Burdwan district of West Bengal is in progress, which is in keeping with the spirit and general directives of the Alma Ata Declaration on Primary Health Care.

The project is the product of experience gained from exploratory health camps in a number of rural areas of West Bengal run in collaboration with a Society of Rural Reconstruction with on-going programmes in a broad socio-economic field. It is also meant to be supplementary and complementary to all official and non-official efforts. The Institute of Child Health seeks to provide the maternal and child health component to the socio-economic development programme of the area on the broadest possible basis.

The size of the project, in order to be replicable, is neither too big nor too small. It covers 11 villages in the Memari area of Burdwan district about 90 kilometers from Calcutta. We are concerned with 1300 families in all consisting of around 7000 men, women and children. The Tagore Society of Rural Reconstruction has been carrying on the work of social development in the area. Community grain depots or Dharmagollas have already been established in these communities, cooperative irrigation facilities have been promoted and literacy campaigns undertaken. Thus, the project has the advantage of having a target community of families who have already been at least partly motivated and prepared to receive integrated primary health care.

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The principal target of the project are the newborns and their mothers. The morbidity and mortality of the newborns will be studied.

In accordance with the concept of the project, there will be inputs from the popular as well as the professional fronts. The principal organs of the popular contribution are the Palli Unnayan Samiti [Village Development Society] and the Mahila Samiti [Women's Association]. The professional inputs will be provided by the professional staff of the Institute of Child Health and the para-professional staff recruited locally. Details of these inputs will be presented.

For purposes of continuous evaluation, base-line data on all possible aspects of the life of the community are being collected by detailed questionnaires in simple Bengali which have been drawn up and circulated.

Evaluation will proceed on the basis of follow-up questionnaire and statistical analyses will be carried out with the assistance of the Indian Statistical Institute and the Institute of Management, Calcutta University.

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TAGORE SOCIETY FOR RURAL DEVELOPMENT

Inspired by Rabindranath Tagore's concept of rural reconstruction, this institution was founded in 1949 by Sri Jayaprakash Narayan and Sri Pannalal Dasgupta "to bring back life in all its completeness, making the village self-reliant and self-respectful, acquainted with the cultural tradition of their own country and competent to make an efficient use of modern resources for the fullest development of their physical, social, economic and intellectual conditions."

In fulfilment of the above ideal, the Society undertakes action programmes for economic, social and cultural development of selected rural communities, helps them and other voluntary agencies to undertake agricultural development schemes. It cooperates and collaborates with international and national agencies/working in rural areas and undertakes and conducts training and research programmes leading to the formation of new occupational skills, functional literacy and aesthetic development.

Objectives :

As already stated, rural reconstruction is the main concern of the society. These two words mean planned development and social change. These then constitute the main objective of the society.

The manner in which the objective is sought to be fulfilled is, however, two-fold: first of all, the Society seeks to experiment with certain methods and techniques of rural development and to secure through the application of such techniques in selected areas, known as pilot projects, substantial improvements in the functioning of the total productive system. This stage of experimentation and direct service is wide, for they cover large tracts of human habitat and lands so that the application of techniques even in the experimental stage will add to the total production of the area, if not

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the state and the country as a whole.

Secondly, the Society makes an evaluation of the techniques and methods it has evolved in the light of the concept of rural reconstruction of Rabindranath Tagore, as well as in the context of the corpus of knowledge known as planned social change.

Programmes :

The emphasis of the programmes is on providing an immediate agricultural break-through for a rapid economic recovery to be achieved by individuals and social efforts of groups of individuals inhabiting an area. The Society is aware that nothing short of a total programme of rural reconstruction would serve the ultimate purpose of development. The projects that it has undertaken so far are with this approach to total programme.

The Society is running 4 such projects in Bolpur, Simulpur, Rangabelia and Tapan, all in West Bengal.

The Bolpur project was initiated in 1974 with emphasis on developing infra-structure for agriculture and creating irrigation facilities by constructing check dams, tanks and shallow tube wells. Presently the programmes cover 25 villages and is planned to cover 170 villages when all programmes are in full swing.

Other programmes are fishery and livestock development and introduction of poultry, piggery and goatary for marginal farmers and landless labourers. Necessary training is given in agriculture, irrigation and animal husbandry etc. Exhibitions and annual fairs are organised as part of its recreational and cultural programmes.

The Simulpur project was initiated in 1974 with the same objectives as above. It benefits about 1500 families. A new programe in Simulpur is the promotion of handicrafts. For this purpose, loans are advanced to the poor artisans engaged in various village crafts.

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The Rangabelia project, started in 1975 covers 5 villages consisting of 671 families and 5000 population. Provision for irrigation and drainage, demonstration and training in agricultural practices and methods, storage and marketing through cooperatives, development of fisheries, goatery and piggery are its main programmes.

The Tapan project was started in 1977 in a group of 5 villages with stress on agricultural development and promotion of village crafts.

Workers :

The Society has two technical advisers, one a retired chief engineer of the Government of West Bengal, and the other a electrical engineer belonging to the State Electricity Board. In all, there are 134 workers, of whom 44 are full-time paid workers and the rest are voluntary workers.

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GANDHI VICHAR PARISHAD, BANKURA

Started as a Tatva Prachar Centre of Gandhi Smrak Nidhi in 1958 and adopted by Gandi Peace Foundation in 1962, Gandhi Vichar Parishad became an autonomous institution in 1975 when it was registered as a Society. It is located at School Danga, P.O. and District Bankura 722101, West Bengal.

Objectives:

Its constitution enumerates 21 items which more or less conform to the areas listed in the"Constructive Programme". As such its main emphasis has been on the generation of consciousness among the town people with whom the centre had worked in its earlier Tatva Prachar phase and thereby on creation of an active group of people who are not just interested but actually involved in rural development.

Programmes :

As already indicated, the earlier life of the institution as a centre for disseminating Gandhian ideas was confined to the urban area with the Gandhi study circles and other town-based activities. It was an example of how town people could be interested in rural development after they were exposed to Gandhiji's ideas of village development.

The first experience of the centre in rural development was through relief work thrust on it by the government. Although the centre was aware that test relief was not an answer to recurring problems of drought, unemployment, poverty and ignorance, it undertook the responsibility at some villages where the centre did spectacular work with the help and cooperation of various student groups led by teachers of local colleges. This afforded not only the opportunity to work in village but also provided necessary training for students in village conditions which inspired them into more coordinated efforts in years to come.

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This resulted in its first 10 villages integrated development scheme with emphasis on agricultural improvement, creation of irrigation facilitiesand introduction of a number of subsidiary industries in order to augment the villagers' income and to provide work to the unemployed. At present these programmes are in progress in all the 10 villages covering 450 families.

A village council composed of representatives from these 10 villages functions as an open body of the individual village councils composed of all adults which really function at the village level.

Workers :

The institution has 11 full-time paid workers including two experts in rural development and agriculture who have recently joined it after their retirement from government service.

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West Bengal - Health & Dev' - Projects

1. Dr S N Chaudhari
Child in Need Institute
ICMR + VHAI Daulatpur village
P.O Amgachi, via Joka.
24 Parganas
W. Bengal.

2. Seva Bharati (WB 5) — Proj. Pavitra K. Sen
GPF P.O. Kapgari,
Dr. Midnapore
WB

3. Gandhi Vichar Parishad (WB 9)
GPF School Danga,
P.O. Bankura, Dr. Bankura
722101 - WB.

4. Tagore Society for Rural Dev' (WB 10.) — Dr Tushar Kanjilal, Project Director
ICMR + GPF Village & PO Rangabelia
Via Gosaba, 24 parganas,
WB
(also in Bolpur, Simulpur & Tapan)

5. Dr L.K. Khanna, Chhandabrati (WB 6) — Dr Lalit Kumar Khanna
MFC Tamluk
Midnapore
WB - 721636.

6. Institute of Child Health (WB - 8) — Dr Sisir K. Bose & Dr S N Chowdhury, Director
ICMR Calcutta
(RFPA - Memari area, Burdwan Dt)

7. Lokasiksha Parishad, (WB-7)
AVARD RKM Ashrama, Narendrapur
24 parganas WB.

8. BAM - India (WB - 2) — Mr Manab Chakrabarty.
VHAI J/221/A Paharpur Road,
Calcutta. - 700024

9 Vivekananda Seva Sadan (WB-4) — Dr Ghosh.
AIMS. Village & P.O. Mandra
Dt Hooghly
WB.

10. Consortium for Rural Development — Mr Chatterjee.
NIHFW. Aurobindo Sarini
Calcutta - 700006

11. All India Institute of Hygiene & Public Health — Dr. N. S. Deodhar
ICMR 110 Chittaranjan Avenue
Calcutta

12. Indian Ass' for the Cultivation of Science — Dr. SN Sen.
Ramakrishna Palli,
IIM. P.O Narendrapur
24 parganas WB - 743508

13. President WB-VHA — Dr BN Roy
VHAI 11/7A, Ramakrishna Das lane
Calcutta - 700009

14 Sec WB - VHA — Dr. Ben Eliza
VHAI C/o The Assembly of God Hospital & Research Centre
125/1, Park Street, Calcutta - 700016.

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JALPAIGURI WELFARE ORGANIZATION

Health Education in Rural BENGAL

Souvenir For Health Education.

1985

RN
26/12

Sunil Mitra

DEPUTY COMMISSIONER
JALPAIGURI

No.....

Dated September, 1985

I am happy to learn that a souvenir on health education will be brought out by Jalpaiguri Welfare Organisation, Keranipara, Jalpaiguri. The souvenir, I am confident, will be of interest and of educative value to its readers.

I wish this endeavour of the Organisation, all success.

Sd/ =
(Sunil Mitra)

সম্পাদকীয়

জলপাইগুড়ি ওয়েলফেয়ার অর্গানাইজেশন একটি রেজিস্টার্ড ভলান্টারি অর্গানাইজেশন। (রে জিঃ নং— এস/৪৪৭৩৫)

এ সংগঠনের বয়স হলো ৩ বৎসর। এই সংগঠন একটি দাতব্য চিকিৎসালয় ও একটি প্যাথোলজিক্যাল লেবরেটরি চালু করতে পেরেছে।

এই সংগঠন ভবিষ্যতে একটি কমিউনিটি হেলথ ডেভেলপমেণ্ট প্রকল্প ও বয়স্ক ব্যক্তিদের দেখাশোনার জন্য প্রকল্প গ্রহণ করতে প্রয়াসী। জলপাইগুড়িতে একটি টি. বি, উচ্ছেদ পরিকল্পনা গ্রহণের জন্যও প্রয়োজনীয় পদক্ষেপ গ্রহণ করতে প্রয়াসী হয়েছে এই সংগঠন।

বর্ত্তমান সুভেনীরটি আসলে স্বাস্থ্য বিষয়ে শিক্ষার নিয়মিত বুলেটিন প্রকাশ করবার সূচনা। অর্থের সংস্থান হ'লে এই সংগঠন অবশ্যই উপরোক্ত প্রকল্পগুলি রূপায়ন সক্রিয় হতে পারবে। এবং একটি স্বাস্থ্য শিক্ষা বিষয়ে নিয়মিত বুলেটিন প্রকাশ করতে পারবে।

যাঁরা বিজ্ঞাপন দিয়ে এই সংস্থাকে আর্থিক সাহায্য করেছেন এবং যারা অন্যান্য সব সহযোগিতা করে চলেছেন তাঁদের এবং এই শহরবাসীকে, আন্তরিক ধন্যবাদ জ্ঞাপন করছি।

জলপাইগুড়ি ওয়েলফেয়ার অর্গানাইজেশন
কেরানীপাড়া, পোঃ + জেলা ঃ জলপাইগুড়ি
পিন - ৭৩৫১০১ পশ্চিমবঙ্গ

কৃতজ্ঞতা জানাই

- প্রথিতযশা গবেষক ডেভিড ওয়ার্ণারকে, আমরা তার গবেষণার ফসল হাতে পেয়েছি এবং তা ব্যবহার করেছি।
- গনস্বাস্থ্য কেন্দ্র, বাংলাদেশ, মাসিক গণস্বাস্থ্য থেকে আমরা দিক নির্দেশ এবং প্রয়োজনীয় লেখা পেয়েছি।
- ভলান্টারি হেলথ এসোসিয়েশন অব ইন্ডিয়া
- ওয়েস্ট বেঙ্গল ভলান্টারি হেলথ এসোসিয়েশন
- মেডিকো ফ্রেইন্ড সার্কেল, ব্যাঙ্গালোর।
- ছাপাখানার কর্মীবৃন্দকে।
- জলপাইগুড়ি শহরবাসীকে ও আমাদের প্রিয় ডাক্তারবাবুদের।

কিছু লোকগাথা এবং গৃহ–নিরাময়সম্পর্কিত প্রশ্ন ও উত্তর

এটা কি সত্য যে কোন ডায়রিয়া রোগগ্রস্থ শিশুর মাথার উপরের নরম দাগটি যখন ভেতরের দিকে চামড়া টেনে নেমে গেছে তখন বাচ্চাটির মৃত্যু ঘটবার সম্ভাবনা আছে, যদি তাকে বিশেষ চিকিৎসা না করা যায় ?

হ্যাঁ এটা প্রায়শই সত্য। নরম দাগটি শুকিয়ে মাথার ভেতরের দিকে নেমে যায় তখনই যখন বাচ্চাটির শরীর থেকে প্রচুর তরল পদার্থ বেড়িয়ে যায় এবং তা হয় ডায়রিয়াতে। যদি তাকে প্রয়োজনমতো তরল (লবন+জল) না খাওয়ানো যায় তবে তার মৃত্যু ঘটতে পারে।

এটা কি সত্য যে চন্দ্র গ্রহণের সময়ে গর্ভবতী মহিলারা রাস্তায় বা খোলা জায়গায় থাকলে তাঁর সন্তানের দৈহিক অথবা মানসিক রূপ বিকৃত হতে পারে ?

এটা সত্য নয় কারণ গ্রহণের চাঁদের আলো মায়ের গর্ভস্থ সন্তানের ওপর কোন প্রভাব করেনা সুতরাং গর্ভস্থ সন্তানের সেই কারণে দৈহিক বা মানসিক বিকৃতির কোন কারণ থাকতে পারেনা।

এটা কি সত্য যে প্রথম সন্তানের জন্মের পর প্রথম দুদিন মায়ের বুকের দুধ শিশুকে খাওয়ানো উচিৎ নয় ? কারণ প্রথম দুদিনের বুকের দুধ শিশুর পক্ষে ক্ষতিকারক ?

এটা সত্য নয়। এই ধরনের জলের মতো দুধকে বলা হয় 'কোলোস্ট্রাম' এটা শিশুর পক্ষে খুব ভালো। কোলোস্ট্রামে প্রচুর পরিমানে প্রোটিন এবং এন্টিবডি থাকে যা বাচ্চাকে সংক্রমণের হাত থেকে রক্ষা করতে পারে।

শিশু জন্ম দেবার পর মায়ের কতদিন পর স্নান করা উচিৎ ?

শিশু জন্ম দেবার পরের দিনই মায়ের গরম জলে নিজেকে পরিস্কার করা উচিৎ। এক সপ্তাহ স্নান না করবার প্রথা রোগ সংক্রামিত করতে পারে।

এটা কি সত্য যে সন্তান প্রসবের সময় অন্ধকার ঘরে প্রসব করানো উচিৎ ?

এটা সত্যি কারণ অল্প আলো মায়ের এবং সদ্যোজাত শিশুর চোখের পক্ষে ভালো। কিন্তু অবশ্যই ঘরে ততখানি আলো থাকা চাই যাতে ডাক্তার অথবা ধাত্রীর কাজের অসুবিধা না ঘটে।

এটা কি সত্য যে মায়ের বুকের দুধ আধুনিক বোতলের দুধের চাইতে ভালো	হ্যাঁ সত্য। বুকের দুধ অনেক ভালো খাদ্য এবং তা বাচ্চাকে সংক্রমনের হাত থেকে বাঁচায়।
ইহা কি সত্য যে ঠাণ্ডা অথবা জ্বরের সময় কমলালেবু, পেয়ারা এবং অন্যান্য ফল খাওয়া ক্ষতিকারক ?	না, সমস্ত ফল এবং ফলের রস জ্বর বা ঠাণ্ডায় খাওয়া উপকারী। এগুলো শরীরের কোন ক্ষতি করেনা।
এটা কি সত্য যে শরীর দুর্বল থাকলে স্নান করা উচিৎ নয় ?	না সত্য নয়/শরীর দুর্বল থাকলেও প্রতিদিন গরম জলে স্নান করা উচিৎ।
এটা কি সত্য যে কোন ব্যক্তির প্রচণ্ড জ্বর হলে তাকে ভালোভাবে ঢেকে রাখা উচিৎ যাতে দেহে বাতাস না লাগতে পারে ?	না সত্য নয়। কোন ব্যক্তির প্রচণ্ড জ্বর হলে তার শরীরের সমস্ত ঢাকা দেয়া কাপড় এবং বস্ত্র খুলে দিয়ে তার শরীরে হাওয়া বাতাস লাগতে দেয়া উচিৎ। কারণ হাওয়া বাতাস তার জ্বর কমাতে সাহায্য করবে।

প্রথিতযশা গবেষক ডেভিড ওয়ার্নারের
'Where there is no doctor' থেকে
বঙ্গানুবাদ।

শিশুদের রোগ প্রতিরোধ সম্পর্কে কিছু কথা

ডাঃ অমলেন্দু মণ্ডল—এম, বি, বি, এস এম, ডি (মেডি)
শিশুরোগ বিশেষজ্ঞ

সারা পৃথিবীতেই রোগ প্রতিরোধ প্রকল্পগুলি, এমনকি গুটি বসন্তের মতো ভয়ঙ্কর রোগকেও সাফল্যের সাথে নির্মূল করতে সক্ষম হয়েছে। একই সাথে হাম, পোলিও, ডিপথেরিয়ায় শিশুদের আক্রান্ত হওয়ার সংখ্যাও অনেক কমিয়ে এনেছে।

কথিত আছে " প্রিভেনশন ইজ বেটার দ্যান কিওর " অর্থাৎ রোগের চিকিৎসার থেকে রোগ প্রতিরোধ করাই বেশী ভালো। সত্যি কথা বলতে কি রোগ প্রতিরোধ রোগের চিকিৎসার চাইতে অনেক কম যন্ত্রনাময় এবং কম ব্যয়সাপেক্ষ। একটি টিটেনাস রোগীর ক্ষেত্রেই এর উদাহরণ পরিস্কার বোঝা যাবে। একটি টিটেনাস টক্সয়েড ইঞ্জেকশান টিটেনাস রোগ প্রতিরোধ করে এবং যার জন্য খরচ পড়ে মাত্র চল্লিশ পয়সা, আর এরকম চারটে ইঞ্জেকশান নিলে শরীরে টিটেনাস রোগের অনাক্রম্যতা জন্মায় যার মোট খরচ দাঁড়ায় মাত্র একটা ষাট পয়সা অথচ একবার টিটেনাস রোগে (ধনুষ্টঙ্কার) আক্রান্ত হয়ে গেলে চিকিৎসার মোট খরচ যা দাঁড়াবে তা অন্ততঃ প্রতিরোধের জন্য খরচের চাইতে কুড়িগুণ বেশী এবং বলা বাহুল্য তাতে জীবনের ঝুঁকিই থাকবে সবচাইতে বেশী। তাই আমাদের প্রত্যেকেরই উচিৎ রোগ হবার অনেক আগেই রোগ না হবার জন্য সচেষ্ট হওয়া। গ্রামে-গঞ্জে-শহরে প্রত্যেক জায়গায় যেসব ডাক্তারেরা শিশুদের চিকিৎসা করে থাকেন তাঁদের উচিৎ শিশুদের রোগ প্রতিরোধ কর্মসূচী গ্রহণ করা। প্রত্যেক প্র্যাকটিসিং ডাক্তার, যাদের সাথে পরিবারগুলির যোগাযোগ আছে তাদের পক্ষে এই কর্মসূচী গ্রহণ করা বেশী সুবিধাজনক।

রোগ প্রতিরোধের ক্ষেত্রে ' ইমিউনাইজেশন কার্ড ' খুব গুরুত্বপূর্ণ। প্রত্যেক শিশুর জন্য আলাদা ইমিউনাইজেশন কার্ড তৈরী করতে হবে। ইমিউনাইজেশন কার্ডে শিশুর নাম, বয়স, প্রতিষেধক দেবার মাস, তারিখ, বৎসর ইত্যাদি লিপিবদ্ধ থাকবে। কারণ বেশী অথবা কম প্রতিষেধক শিশুর পক্ষে মারাত্মক হয়ে উঠতে পারে, ইমিউনাইজেশন কার্ড সেই সমস্যা দূর করতে সহায়ক হবে। ইমিউনাইজেশন কার্ড সম্পর্কে শিশুদের মাতা-পিতাকেও ওয়াকিবহাল করে তুলতে হবে যাতে তাঁরা গুরুত্ব সহকারে সেই কার্ড সংরক্ষণ করেন।

ইদানীংকালে অনেক বেসরকারী এবং সরকারী সংস্থা শিশুদের রোগ প্রতিরোধ প্রকল্পে কাজ করছেন। প্রত্যেকেরই যত্নসহকারে শিশুদেরকে প্রতিষেধক দিতে হবে কারণ সামান্য অসতর্কতার কারণেই প্রতিষেধক টিকার কোন ফল নাও পাওয়া যেতে পারে।

কয়েকটি প্রতিষেধক টিকা সম্পর্কে নির্দেশিকা

* প্রতিষেধক টিকা খুব কম তাপমাত্রায় রাখা উচিৎ এমনটি এক জায়গা থেকে অন্য জায়গায় নিয়ে যাবার সময়েও এমন বাক্সের ভেতর নিয়ে যাওয়া উচিৎ যাতে ভেতরের তাপমাত্রা খুবই কম থাকে। কারণ উচ্চ তাপমাত্রায় প্রতিষেধক টিকার কার্যকরী শক্তি হ্রাস পায়।

* প্রতিষেধক টিকা এক জায়গা থেকে অন্য জায়গায় নিয়ে যেতে হ'লে লবণ এবং বরফের হিম মিশ্রনের ভেতর বহন করা উচিৎ। সাধারণ ভ্যাকসিন ফ্লাস্কে দু-চার ঘণ্টার বেশী প্রতিষেধক বহন করা উচিৎ নয়।

* প্রতিষেধক টিকায় যেন সূর্য্যের আলো না লাগে।

* বি, সি, জি, এবং গুটিবসন্তের প্রতিষেধক টিকার অ্যামপুলে খোলার পর একদিনের ভেতরেই তা ব্যবহার করতে হবে এবং অব্যবহৃত ওষুধ ফেলে দিতে হবে কারণ তা আর পরে ব্যবহার করা যায় না।

* পোলিও মহামারীর সময় ইন্ট্রা মাসকুলার ইঞ্জেকশান পরিহার করা উচিৎ ॥

* খুব অসুস্থ শিশুকে অসুস্থতা থাকাকালীন প্রতিষেধক টিকা দেওয়া উচিৎ নয়।

* কোন শিশুর কোন প্রতিষেধক টিকায় প্রতিকূল প্রতিক্রিয়া থাকলে তাকে সেই প্রতিষেধক টিকা দেয়া উচিৎ নয়.

সদ্যোজাত শিশুর ক্ষেত্রে টিটেনাস রোগ প্রতিরোধ

আমাদের দেশে শিশুদের মধ্যে প্রায়ই টিটেনাস রোগে আক্রান্ত হয় এমন শিশুর সংখ্যা কম নয়। সদ্যোজাত শিশুর টিটেনাস রোগে আক্রান্ত হবার প্রধান কারণ হিসেবে দেখা যায় যে ঐ শিশুর নাভী কাটবার সময় আমাদের গ্রামেগঞ্জে অজ্ঞতার কারণে অবৈজ্ঞানিক পদ্ধতিতে বাঁশের ধারালো কঞ্চি ব্যবহার করা হয় যার ফলে প্রায়শই সদ্যোজাত শিশুদের মধে টিটেনাস দেখা দেয়।

সদ্যোজাত শিশুকে টিটেনাস রোগের আক্রমণ থেকে রক্ষা করবার জন্য শিশুর মাকে তাঁর গর্ভাবস্থায় পর্যায়ক্রমে ৩নটি টিটেনাস টক্সয়েড ইঞ্জেকশান দিতে হবে। যদি মায়ের আগে থেকেই টিটেনাস রোগ প্রতিষেধক দেয়া থাকে তবে সন্তান জন্মের দু-সপ্তাহ আগে কেবল একটি বুস্টার ডোজ নিলেই চলবে।

এইভাবে মায়ের এবং সন্তানের একই সাথে টিটেনাস রোগ প্রতিরোধ করা সম্ভব।

শিশুর রোগ প্রতিরোধের জন্য একটি আদর্শ প্রতিষেধক তালিকা

শিশুর বয়স	প্রতিষেধক
১ম মাস	বি, সি, জি
২য় মাস	ডি, পি, টি, এবং ওরাল পোলিও ভ্যাকসিন (প্রথম মাত্রা)
৩য় মাস	
৪র্থ মাস	ডি, পি, টি, এবং ওরাল পোলিও ভ্যাকসিন (দ্বিতীয় মাত্রা)
৬ষ্ঠ মাস	ডি, পি, টি, এবং ওরাল পোলিও ভ্যাকসিন (তৃতীয় মাত্রা)
৯ম মাস	মিসিলস
১৮ মাস	ডি, পি, টি, এবং ওরাল পোলিও ভ্যাকসিন (প্রথম বুস্টার মাত্রা)
৫ বৎসর	ডি, পি, টি এবং ওরাল পোলিও ভ্যাকসিন দ্বিতীয় বুস্টার মাত্রা
প্রতি ১০ বৎসর	টি, ডি, (বয়স্কদের টিটেনাস ও ডিপথেরিয়া ভ্যাকসিন)

★ ডি, পি, টি, ভ্যাকসিন সপ্তম জন্মদিনের পর আর দেয়া হয়না।

★ " EVERY BLOOD OWNER IS A BLOOD DONOR " —

Know Your Blood Group

* Purpose of Blood Grouping

Tne main purpose behind doing grouping is to prepare blood for transfusion–or to have information that will make easier or quicker to available blood for transfusion at a future date.

Who is a donor

Persons above 18 Years and less than 60 Years can give blood as best donor.

Persons can donate blood every three months interval. Persons having jaundice, Syphilis, Tuberculosis, Malaria, etc are not taken as donors.

Chart showing the nature of donors and receipients in blood transfusion.

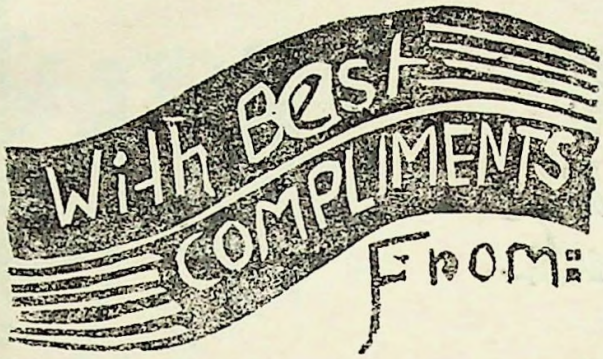
Persons belonging to Blood Group	Can donate blood to Persons belonging to group	Can receive blood from persons belonging to group.
A	A. AB	A.O
B	B. AB	B.O
AB	AB	A.B.AB.O
O	A.B.AB.O	O

In order to keep Blood Donation as a safe, harmless procedure, we must keep it in mind that–

i) Donation Must Be Harmless to The Donor.

ii) The Blood Donated Must Not Be Harmful To The Patient Who Receives It (The Receipient) And Further It Should Be Helpful.

卐 ❀ 卐



HILLOL DAS

PANDAPARA : JALPAIGURI.

প্রথিতযশা গবেষক ডেভিড ওয়ার্নারের Where there is no doctor হইতে অনুবাদ

দাঁত ও মাড়ীর যত্ন

দাঁত ও মাড়ীর যত্ন নেওয়া অত্যন্ত গুরুত্বপূর্ণ কারণ—

* মজবুত দাঁত খাদ্য চিবিয়ে খাবার জন্য অপরিহার্য এবং খাদ্য পরিপাকে সহায়তা করে।
* সুন্দরভাবে দাঁতের যত্ন নিলে দাঁতের যন্ত্রনাময় ক্ষত এবং মাড়ীর ক্ষত প্রতিরোধ করা সম্ভব হয়।
* পরিচ্ছন্নতার অভাবে দাঁতের যে ক্ষত হয় তা কেবল দাঁত নয় শরীরের অন্য অংশকেও ক্ষতিগ্রস্থ করে তুলতে পারে।

দাঁত ও মাড়ীর স্বাস্থ্য সুরক্ষায় যা করতে হবে :—

১) বেশী মিষ্টি খাওয়া কমানো উচিৎ এবং নরম মিষ্টি জাতীয় খাবার খাওয়ার পর দাঁত ভালভাবে ব্রাশ করা উচিৎ।

২) প্রত্যেকদিন ভালভাবে দাঁত ব্রাশ করুন এবং মিষ্টিখাবার খাওয়ার পরেই দাঁত ব্রাশ করুন। বাচ্চাদেরও দাঁত ব্রাশ করা অভ্যাস করুন এবং কেমন করে দাঁত ব্রাশ করতে হয় শিখিয়ে দিন।

৩) কমলালেবু, লেবু, পেয়ারা, টমেটো এই জাতীয় খাবার খান কারণ এই জাতীয় খাবার দাঁত ও মাড়ীর মজবুত রাখতে সাহায্য করে।

আপনার যদি টুথব্রাশ নাও থাকে তবে একটি নিমের ডাল কেটে নিয়ে একদিকে চিবিয়ে সেই-দিকটিকে ব্রাশের মতো ব্যবহার করতে পারেন।

আপনার যদি টুথপেষ্ট না থাকে তবে খাদ্যলবন আর বাইকার্বনেট অব সোডা [খাবার সোডা] সমপরিমান মিশিয়ে টুথপাউডার বানিয়ে নিন। ব্রাশটি ভিজিয়ে ঐ টুথপাউডারে লাগালে ব্রাশে পাউডার লেগে যাবে। এই পাউডার দিয়ে দাঁত মাজুন। আপনি যদি বাইকার্বনেট অব সোডা না পান তবে কেবল লবন দিয়েই দাঁত মাজুন।

দাঁত মাজার নিয়ম--

ব্রাশে পেষ্ট লাগিয়ে সেই ব্রাশটি দাঁতের গোড়া থেকে মাথা পর্যন্ত টানুন। এইভাবে উপরের পাটি আর নীচের পাটি দাঁত পরিস্কার করুন। ব্রাশ পাশাপাশি চালালে দাঁতের ফাঁকের ভেতরের ময়লা বার হয়ে আসেনা। তাই উপর নীচ পর্যন্ত ব্রাশ চালানো উচিৎ। উপরের পাটি আর নীচের পাটি ঐ ভাবে পরিস্কার করবার পর সমস্ত দাঁতগুলিতে কয়েকবার Clockwise এবং কয়েকবার Anti clockwise ব্রাশ চালাতে হবে। এইভাবে উপরে, নীচে, ভেতরে সমস্ত জায়গায় ব্রাশ চালাতে হবে।

দাঁতে ব্যাথা এবং ঘা

ব্যাথা কমাবার জন্য–

* দাঁতের চোয়ালের গর্ত ভালভাবে পরিস্কার করুন এবং সেখানে জমে থাকা খাদ্যকণা পরিস্কার করে ফেলুন।
* ব্যাথা কমাবার জন্য এসপিরিন জাতীয় ব্যাথা কমাবার ট্যাবলেট খান।
* লবঙ্গ চিবালেও কিছুটা উপশম হতে পারে।

ব্যাথাযুক্ত এবং রক্তাক্ত মাড়ী

সুস্থ মাড়ী শক্তভাবে দাঁতের চারপাশে সুন্দরভাবে লেগে থাকে। আপনার মাড়ী যদি লড়বড়ে, রক্তিম অথবা দাঁত পরিস্কারের সময় তা থেকে রক্ত ঝড়তে থাকে তাহলে বুঝতে হবে তাতে সংক্রমন হয়েছে। মাড়ীতে আক্রমণ হলেও তাকে বলে মাড়ীর রোগ (Gum disease)

মাড়ীর রোগ থেকে সংক্রমন দাঁতের গোড়া এবং হাড়ে ছড়িয়ে পড়তে পারে। আপনি কিন্তু মাড়ীর রোগ থামাতে এবং এর পুনরাওমন প্রতিহত করতে পারেন। এজন্য দুটি কাজ আপনাকে করতে হবে ঃ-

দাঁত ভালভাবে পরিস্কার করুন এবং মাড়ী শক্ত সমর্থ করুন।

আপনার মাড়ী আরো শক্ত এবং সাথে সংক্রমণের বিরুদ্ধে লড়বার জন্য ঃ

* বেশী করে টাটকা ফল এবং সবুজ শাকসব্জী খাবেন, হালকা, নরম খাবার পরিহার করতে হবে।
* লবন গোলা গরম জলে গুলি করুন। এটা প্রতিদিন করবেন– মাড়ীতে আরাম বোধ করবার পরও এই প্রক্রিয়া বন্ধ করবেন না।

ডাইয়োরিয়া ও তার ঘরোয়া চিকিৎসা

রঞ্জত শুভ্র দেবদাস

> The person with diarrhoea is like a pot of salt water with a hole in the bottom. A dead patient is like on emty pot, It is most important to keep the pot full.
>
> Primary level guide, WHO

প্রতি বৎসর ১৪০০ মিলিয়ন শিশু এশিয়া, আফ্রিকা এবং ল্যাটিন অ্যামেরিকায় ডাইয়োরিয়ায় আক্রান্ত হয়। এদের মধ্যে প্রত্যেকের বয়সই ৫ বছরের কম। প্রতি ছয় সেকেণ্ডে একজন করে শিশু ডইয়োরিয়াতে প্রাণ হারায়। এবং প্রতি দশজন শিশুর মধ্যে একজন করে শিশু পাঁচ বছর বয়সে পৌছানোর আগেই মারা যায় উন্নয়নশীল দেশগুলিতে। ভারতবর্ষে প্রতি বছরে ১'৫ মিলিয়ন শিশু ডায়োরিয়াতে আক্রান্ত হয়ে মারা যায়

ডাইয়োরিয়া কি ?

সহজ কথায়, যখন কোন ব্যক্তির পাতলা পায়খানা অথবা জলের মতো পায়খানা হয় তখন তার ডাইয়োরিয়া হয়েছে বলা হয়। যদি পায়খানার সাথে রক্ত এবং আমাশয় থাকে তবে তাকে ডিসেণ্ট্রি বলা হয়। ডাইয়োরিয়া অল্প অথবা ভীষণ আকারে দেখা দিতে পারে।

ডাইয়োরিয়া শব্দটির মানে—(Dia = Water, rrhoea = Pass out) প্রায় ৬০—৭০ শতাংশ ডাইয়োরিয়ার আক্রান্ত শিশু মারা যায় এই কারণে যে তাদের শরীর থেকে প্রচুর পরিমানে জল বেড়িয়ে যায় এবং শরীরে জলের ঘাটতি দেখা দেয়। শরীরে এই জলের ঘাটতিকে বলা হয় ডিহাইড্রেশন (Dehydration)। শরীরে এই জলের ঘাটতির সাথে সাথে কতকগুলি গুরুত্বপূর্ণ লবণেরও ঘাটতি দেখা যায়। লবণগুলি যথাক্রমে—সোডিয়াম (Sodium)। পটাশিয়াম (Pottassium) এবং বাইকার্বোনেট (Bicarbonate)। সুতরাং ডিহাইড্রেশন হলে শরীরের জলীয় পদার্থে বিভিন্ন লবণের সমতা (Electrolyte Balance) বিঘ্নিত হয়। এই ডিহাইড্রেশনকে তিনটি পর্যায়ে ভাগ করা হয়। প্রথম অবস্থাকে (Mild) দ্বিতীয় পর্যায়কে (Moderate) এবং সর্বশেষ পর্যায়কে Severe ডিহাইড্রেশন বলা হয়।

ডাইয়োরিয়ার চিকিৎসা (The Treatment of Diarrheea)

প্রথম ধাপ :— কোন্ পর্যায়ে ডিহাইড্রেশন হয়েছে তা নির্ণয় করা।

- লক্ষ করুন ডায়োরিয়ার আক্রান্ত রোগীর ডিহাইড্রেশন কোন পর্যায়ে আছে। Mild, Moderate অথবা Severe.
- অন্যান্য গুরুত্বপূর্ণ বিষয়গুলি লক্ষ করুন—আমাশয় এবং রক্ত, পায়খানার সাথে রয়েছে কিনা, জ্বর, বমির ভাব অথবা বমি, অজ্ঞান অথবা প্রলাপ, অন্য অসুবিধা, দ্রুত অথবা গভীর নিশ্বাস প্রশ্বাস, শরীরের পুষ্টি, সংক্রমাণ, ইত্যাদি আছে কি না।

দ্বিতীয় ধাপ :— রিহাইড্রেশন (Rehydration)

- ডাইয়োরিয়ার ফলে শরীর থেকে বেড়িয়ে যাওয়া জল এবং লবণের সমতা শরীরে রক্ষা করার নামই সহজ কথায় রিহাইড্রেশন রিহাইড্রেশন পানীয় জল এবং লবণগুলির দ্রবনেই প্রস্তুত করা যায় এবং অবশ্যই তা বাড়ীতে বসেও বানানো সম্ভব।
- রোগীকে প্রথমেই রিহাইড্রেশন পানীয় দেয়া দরকার। ইতিমধ্যে পায়খানার সাথে যেটুকু জল এবং লবণ বেড়িয়েছে সেটা আবার রোগীর শরীরে ফেরৎ পাঠানো দরকার ; যা এই দ্রবণ খাইয়ে সম্ভব।
- Severe ডিহাইড্রেশনের ক্ষেত্রে এই রিহাইড্রেশন ছয় ঘন্টার মধ্যে সম্পূর্ণ করতে হবে।
- রিহাইড্রেশন ইন্ট্রাভেনাসও দেয়া হয়ে থাকে, তবে Mild এবং Moderate ডিহাইড্রেশনের ক্ষেত্রে ওরাল রিহাইড্রশনেই যথেষ্ট কার্যকরী।

তৃতীয় ধাপ :— চিকিৎসার ধারাবাহিকতা

- জল এবং লবণগুলির ঘাটতি পূরণের জন্য যতক্ষণ ডায়োরিয়া থাকবে ততক্ষণ পর্যন্ত রোগীকে রিহাইড্রেশন ড্রিঙ্ক (Rehydration Drink) পানীয় দিতে হবে যাতে ডায়োরিয়া থাকলেও ডিহাইড্রেশন আবার না হয়।
- শিশুকে মায়ের বুকের দুধ খাওয়ানো আরম্ভ করতে হবে অথবা ভালো-ভাবে সেদ্ধ ভাত বা অন্য সহজপাচ্য খাবার দিতে হবে।

※ অন্য সংক্রামন থাকলে বা জটিলতা থাকলে তার জন প্রয়োজনমতো ওষুধ ব্যাবহার করতে হবে।

রিহাইড্রেশন ড্রিঙ্ক (*Rehydration Drink*)

ডায়োরিয়া হ'লে শরীরের জল এবং লবণ বের হয়ে যাবার ফলে শরীরের জলীয় পদার্থে যে ঘাটতি হয় (Electrolyte Imbalance) সেই ঘাটতি পূরণ করবার জন্য রিহাইড্রেশন ড্রিঙ্ক ব্যবহার করা হয়।

ডায়োরিয়ার শুরুথেকেই প্রচুর পরিমানে জল এবং রিহাইড্রেশন ড্রিঙ্ক রোগীকে খাওয়ালে রোগীর ডিহাইড্রেশন হবার সম্ভাবনা থাকেনা এবং মৃত্যু হবার সম্ভবনা শতকরা ৭০ ভাগ কমে যায়।

এই রিহাইড্রেশন ড্রিঙ্ক বাড়ীতেই বানানো সম্ভব এবং খুবই সহজ। আগে থেকে ফুটিয়ে ঠান্ডা করা এক লিটার জলের সাথে চা-চামচ চিনি অথবা মধু এবং আধা চা-চামচ লবণ মিশিয়ে নিলেই রিহাইড্রেশন ড্রিঙ্ক তৈরী হয়ে গেল। বাজারে যে Electral এর প্যাকেট পাওয়া যায় সেটাও আসলে Rehydration Drink তৈরী করবার জন্যই প্যাকেটে পাওয়া যায়।

ডায়োরিয়া রোগীর পথ্য—

শুকনো চিড়া কাঠখোলায় ভেজে নিয়ে তারপর গুড়ো করুন। পরিস্কার জলে ২০ গ্রাম মতো চিড়ার গুড়ো দিয়ে সেই জল ফুটিয়ে নিন। আধ চা-চামচ পরিমান লবণ সেই চিড়ার জলে মিশিয়ে নিন। ঠান্ডা হবার পর একটু লেবুর রস দিয়ে দিন। এই পথ্য রোগীর Dehydration বন্ধ করবে।

উপরোক্ত পথ্য ছাড়াও ছোট শিশুদের ক্ষেত্রে মায়ের বুকের দুধ সবচাইতে উপযোগী। যখন রোগী খেতে সমর্থ তখন তাকে পাকা কলা অথবা রান্না করা কলা, সুজি, আলু, পেলে খুব ভালোভাবে সেদ্ধ করে দেয়া যেতে পারে।

—রজত শুভ্র দেবদাস

কমিউনিটি হেলথ বনাম আজকের গ্রাম

ডাঃ দিপক দাস

পৃথিবীর মোট জনসংখ্যা বিরাট অংশ এখনও সুস্বাস্থ্য পাবার অধিকার থেকে বঞ্চিত। বিশেষ করে উন্নয়নশীল দেশগুলির গ্রামবাসীরা আরও বেশী স্বাস্থ্য সমস্যা জর্জরিত। এই সমস্যার তারতম্য যেমন এক দেশ থেকে অন্য দেশের মধ্যে আছে তেমনি একই দেশের লোকদের মধ্যেই এই সমস্যা বিদ্যমান। বিশ্ব স্বাস্থ্য সংস্থার শ্লোগান "দুই হাজার সালের মধ্যে সকলের জন্য স্বাস্থ্য" এবং এই শ্লোগান বাস্তবে রূপায়ন হওয়া নির্ভর করছে প্রত্যেক ব্যক্তি, সম্প্রদায়, স্বাস্থ্যকর্মী এবং জাতীয় সরকারগুলির ওপর।

এক জন ছাত্র হিসেবে আমাদের দেশের কমিউনিটি হেলথ সারভিস এবং তার বাস্তব রূপায়ন সম্পর্কে আমি আমার অভিজ্ঞতার কথাই উল্লেখ করতে চাই। আমার মনে হয়েছে, সর্বপ্রথমেই আমাদের জানা উচিৎ স্বাস্থ্য কাকে বলে? স্বাস্থ্য সম্পর্কে বিশ্ব স্বাস্থ্যসংস্থা যে ধারণা আমাদের এঁকে দিয়েছে তা কেবল দেহে কিছু রোগের অনুপস্থিতি নয়, তা দৈহিক, মানসিক এবং সামাজিক অগ্রগতির কথা।

এখন কমিউনিটি হেলথ প্রসঙ্গে আসা যাক। পাবলিক হেলথ, প্রিভেনটিভ মেডিসিন এবং সোস্যাল মেডিসিন এই গুলি কমিউনিটি হেলথের অন্তর্গত। অপরপক্ষে বর্তমান কমিউনিটি হেলথ সমস্ত সম্ভাব্য হেলথ সারভিসকেই তার অন্তর্গত করেছে। যেগুলি হলো মেডিক্যাল কেয়ার, মাদার এণ্ড চাইল্ড হেলথ, ফ্যামিলি প্ল্যানিং, এনভাইরনমেন্টাল স্যানিটেশন সার্ভিস, লেবারটরি সার্ভিস, ডিজিস কন্ট্রোল প্রোগ্রাম, হেলথ এডুকেশন ইত্যাদি। কমিউনিটি হেলথ আসলে কিউরেটিভ ও প্রিভেনটিভ মেডিসিনের এক সুসামঞ্জস্যপূর্ণ স্বাস্থ্যপ্রকল্পের সংযোজন। কিন্তু বাস্তব অবস্থা একদম অন্যরকম। রোগ প্রতিরোধ প্রসঙ্গেই আমরা বাস্তবে যা দেখি তা হতাশাব্যঞ্জক। প্রতিষেধক টিকা সংরক্ষণ কোন্ বৈজ্ঞানিক ভিত্তিতে হয়না। গ্রামে গঞ্জে বা শহরে কোথাও প্রতিষেধক টিকা বৈজ্ঞানিক পদ্ধতিতে কম তাপমাত্রায় রাখা হয়না। সুতরাং এটা আন্দাজ করা মুশকিল যে সেইসব প্রতিষেধক টিকা কতদূর রোগ প্রতিরোধে সক্ষম হবে। প্রতিষেধক টিকা দেবার জন্য যে সময়ের দূরত্ব দরকার বেশীরভাগ ক্ষেত্রেই তা বৈজ্ঞানিক নিয়ম না মেনে দেয়া হয়। স্বাস্থ্য বিষয়ক শিক্ষা না থাকবার জন্য গ্রামের সাধারণ মানুষ না জেনেই প্রতিষেধক গ্রহণ করতে অনিচ্ছুক হন। আর এ সমস্তগুলিই আসলে জনগনকে এইসব কাজে সক্রিয় অংশ নেবার জন্য সুপরিকল্পনার অভাবেরই ফলশ্রুতি।

রোগের চিকিৎসা প্রসঙ্গে আমরা বাস্তবে যা দেখি তা আরও বিতর্কযুক্ত। গ্রামের যে কয়টি হেলথ সেন্টারের বিল্ডিংগত অস্তিত্ব আছে সেগুলির অনেকগুলিতেই ডক্টর নেই। অনেকখানেই স্বাস্থ্য কর্মী বা ফার্মাসিস্টই গ্রামের লোকের ভরসা। রোগ নির্ণয় করবার চাইতেও লক্ষণ অনুযায়ী চিকিৎসা

প্রনালী বেশী চালু। কোনখানে কোন বিশেষ রোগের প্রভাব হলেও কোন নথি লিখিত পাওয়া যায়না যার ফলে এক জায়গায় অনেক লোক না মারা যাওয়া পর্যন্ত মহামারী সম্পর্কে কোন তথ্যও পাওয়া সম্ভব হয়ে ওঠেনা। যেসব তথ্য থাকলে অনেক রোগই মহামারী আকার ধারণের আগেই প্রতিষেধক নানা ব্যবস্থা গ্রহন করে মানুষের মৃত্যুর হার কমানো সম্ভব হবে। এই রকম ভাবে ফ্যামিলি প্ল্যানিং, এনভায়রনমেন্টাল স্যানিটেশন বা ডিজিস কণ্ট্রোল এবং লেবরেটরি সার্ভিস সম্পর্কেও বাস্তবে যা দেখা যায় তার সাথে কাগজের কর্মসূচীর ফারাক প্রত্যক্ষ করা যায়।

এনভাইয়রনমেন্টাল স্যানিটেশন এক গুরুত্বপূর্ণ বিষয়। কিন্তু সমস্যা সেই তিমিরেই রয়ে গেছে। ভারতবর্ষের শতকরা আশি ভাগ মানুষ বাস করে গ্রামে। কিন্তু বাস্তবিক এই গ্রামের মানুষেরা জানেনই না যে পানীয় জল কাকে বলে। এবং বলা বাহুল্য এখনও পর্যন্ত গ্রামের মানুষের পানীয় জলের কোন ব্যবস্থা করা সম্ভব হয়নি। অপরদিকে গ্রামের মানুষেরা মলত্যাগের জন্য পায়খানা ব্যবহার করেন না, বেশীরভাগ গ্রামের মানুষই মলত্যাগের জন্য মাঠ ব্যবহার করেন এবং যার ফল স্বরূপ আমাদের দেশে নানান আন্তিক রোগ এবং কৃমির (Hook Warm) আক্রমনের শিকার হন ব্যাপক মানুষ।

লেবরেটরি সার্ভিস সম্পর্কে পরিস্কার বলা যায় যে গ্রামে ঐ ধরণের কোন সার্ভিস চালু নেই। কারণ লেবরেটরি কেবলমাত্র শহর অঞ্চলগুলির হাসপাতালগুলিতেই আছে। অথচ লেবরেটরির গুরুত্ব সম্পর্কে আজকাল কারও অজানা নেই।

সর্বশেষে, আমার মনে হয় স্বাস্থ্য বিষয়ক শিক্ষাই কমিউনিটি হেলথ এর প্রকল্পকে বাস্তব রূপ দিতে সহায়ক এবং সক্ষম হবে। তাই আমাদের আরও আরও দরকার শিক্ষার, স্বাস্থ্যশিক্ষার। স্বাস্থ্য বিষয়ক শিক্ষার লক্ষ সম্পর্কে বিশ্ব স্বাস্থ্য সংস্থা বলেছে—

১) স্বাস্থ্যকে যে কোন সম্পত্তির মতো মূল্যবান মনে করতে হবে।

২) জনগণকে দক্ষতা, অভিজ্ঞতা এবং জ্ঞান দ্বারা সজ্জিত করতে হবে যাতে তাঁরা নিজেদের স্বাস্থ্য সমস্যা নিজের কাজ এবং প্রচেষ্টা দ্বারা নিজেরাই সমাধান করতে শেখেন।

৩) স্বাস্থ্য সেবার সঠিক ব্যবহার এবং উন্নয়নের জন্য তদারকি চালাতে হবে।

কানের থৈল পরিষ্কার করার পদ্ধতি

কানের থৈল পরিষ্কার করার নিয়ম।

সাধারণ সিরিঞ্জের সাহায্যে কান পরিষ্কার পদ্ধতি সহজ এবং বহুল ভাবে প্রচলিত। তবে এ পদ্ধতি প্রয়োগে অত্যন্ত সতর্কতা অবলম্বন প্রয়োজন।

বিধিনিষেধ

মধ্যকর্ণের তীব্র সংক্রমণে অথবা কর্ণপটহের ঝিল্লীতে ছিদ্র হবার সম্ভাবনা থাকলে সিরিঞ্জ ব্যবহার করা উচিৎ নয়। এক্ষেত্রে আঁকসী বা ছোট চামচের মতো কিছু দিয়ে কানের থৈল অভিজ্ঞ ব্যক্তির তত্ত্বাবধানে চেঁচে পরিষ্কার করা যেতে পারে।

বহিঃকর্ণের প্রদাহে সিরিঞ্জের সাহায্যে কানের সুরঙ্গের থৈল পরিষ্কার করা যেতে পারে। তবে কাজ শেষ হবার পর কান যাতে ভেজা না থাকে সে ব্যাপারে অত্যন্ত সতর্ক থাকতে হবে।

কানের থৈল নরম করবেন কি ভাবে।

সংক্রমণজনিত কারণে কানে ছিদ্র হয়েছে এমন কোন সন্দেহের উদ্রেক হলে সিরিঞ্জ ব্যবহার না করে অন্য কিছু ব্যবহার করতে হবে। তবে এক্ষেত্রে সোডিয়াম বাইকার্বোনেট অথবা জলপাই তেলের (অলিভ অয়েল) ফোঁটা দেয়া যেতে পারে। সংক্রমনজনিত ছিদ্রে কখনই ডায়োকৃষ্টাল সোডিয়াম সালফোসাকসিনেটের দ্রবণ কানে দেয়া উচিৎ নয়।

জলপাই তেল পাওয়া না গেলে দু-চার ফোটা সরিষার তেলও দেয়া যেতে পারে।

থৈল বের করার পদ্ধতি

যে সিরিঞ্জ ব্যবহার করবেন তার মুখনল (Nozzle) যেন ভালোমত লাগে এবং প্লাঞ্জার অবশ্যই যেন বায়ু রোধক হয়। সিরিঞ্জের জলের তাপমাত্রা হবে ৩৭° সেন্টিগ্রেড অর্থাৎ মানুষের শরীরের তাপমাত্রার সমান। কর্ণপটহের ঝিল্লী অত্যন্ত স্পর্শকাতর। অতিরিক্ত গরম অথবা ঠান্ডা দ্রবণের সংস্পর্শে এলে বমি-ভাব, বমি এবং মাথা ঝিম ঝিম উপসর্গের উদ্ভব হতে পারে।

সিরিঞ্জের মুখ কর্ণকুহরের (Auditary meatus) ঠিক কাছে এবং কিছুটা উপরমুখী অবস্থানে রাখতে হবে। তাহলে চাপ দেবার পর সিরিঞ্জ থেকে নির্গত জলের ধারা বহিঃ শ্রবণ নালীর মধ্যে দিয়ে বাহিত হ'য়ে কানের থৈলের পেছনে আঘাত করবে। ছবিতে সিরিঞ্জের অবস্থান দেখানো হয়েছে।

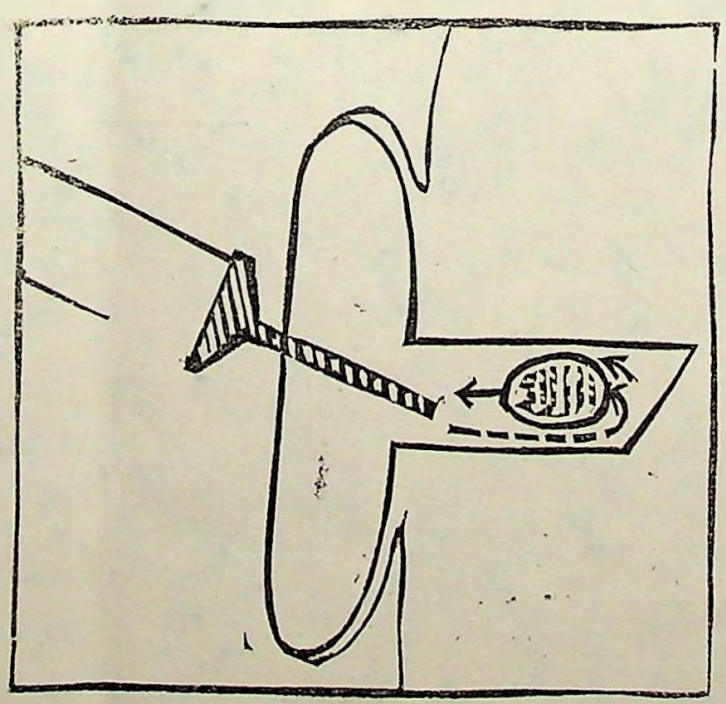
সিরিঞ্জ সোজাভাবে রেখে চাপ দিলে প্রবাহিত জলের অত্যধিক চাপে কানের পর্দা ফেটে যেতে পারে বা আঘাত লাগতে পারে।

এ সময়ে কানের লতি ধরে সামান্য উঁচু করে ঘুরিয়ে আবার নীচে টেনে আনতে হবে। এর ফলে কানের থৈল কিছুটা আলগা হয়ে আসে। অতঃপর নীচে রাখা কিডনী ডিসে (না পেলে অন্য কোন পাত্রে কাজ চলতে পারে) কান থেকে বেড়িয়ে আসা জলে কানের ভিতরের ময়লা বা থৈল জমা হবে। দ্রষ্টব্য : এই পদ্ধতিতে থৈল ছাড়া অন্যান্য অনাহুত ময়লাও বের করা যায়।

উৎস : অষ্ট্রেলিয়ান ফ্যামিলি ফিজিসিয়ান, আগষ্ট ১৯৮৩

লেখক : লেস মিলার।

মাসিকগণস্বাস্থ্য, জানুয়ারী ৮৫ হইতে পুনর্মুদ্রিত।



"আমরা করবো জয়"

চন্দন ব্যানার্জী (চাঁদ)

বেলাকোবা ও জলপাইগুড়ি।

"The Dedication Of Jalpaiguri Welfare In Service Of Suffering Humanity is Highly Applauded."

Ranjit Roy

JALPAIGURI DOORS MINI BUS OWNERS' ASSOCIATION

Printed at Jagriti Press, Beguntary Jalpaiguri

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WEST BENGAL VOLUNTARY HEALTH ASSOCIATION
8 SAROJINI NAIDU SARANI CALCUTTA 700017

WBVHA NEWS-LETTER JUNE/JULY'82

WBVHA NEW OFFICE ADDRESS

The office of the Executive Secretary, West Bengal VHA has been shifted to 8 Sarojini Naidu Sarani (Rawdon Street), Calcutta 17 from 1st July 1982. We therefore request you to note this change of address and correspond in the new address. We shall greatly be encouraged to have you in our new office in any day in between Monday to Friday from 9-30 a.m. to 5-30 p.m. All VHAI publications and other educational materials are available with us. May be some of them will be of much help to you. Why don't you make an appointment to visit us. We hope to see you.

WBVHA ANNUAL SUBSCRIPTION

From our register we are able to make out that many of you so far have not yet paid the yearly subscription for 1982. We request you to help us with your contribution as early as possible. Please note that members failing to pay their annual membership fees by 30th April shall automatically forefiet their membership in the association. Such members may re-instated at the discretion of the Executive Board on payment of their dues.

VISIT TO YOUR PROJECT

Two persons from WBVHA Central Purchase Unit will be visiting your project in the month of July/August in connection with fixing up the mode of supply of medicines and also the purchase of handicrafts if any produced by you. We hope you will extend your whole hearted co-operation in order to help us to make this project successful.

IMPORTANT APPEAL FOR YOUR GENEROUS DONATION TO WBVHA

While we are grateful for your kind co-operation and contribution to WBVHA we desire to let you know one of our practical difficulties. You must be aware that WBVHA is a voluntary organisation and an association of associations in the State of West Bengal. Till today WBVHA is being run with the contribution made by our different well wishers. We feel greatly honoured to know that you are one of them and your co-operation and contribution has largely helped WBVHA in it's growth and expansion.

In the Executive Board Meeting of WBVHA in the last year it was decided to purchase a scooter for WBVHA. We could not buy it due to shortage of fund. We were advised by some of our well wishers to make appeal to you all for your generous support. A donation of Rs.100/- or more or less as per your convenience can help us and lead to the purchase of a scooter for WBVHA. We are sure that your good self will come forward with your helping hand to help WBVHA. We shall appreciate any amount payment in cheque payable in favour of West Bengal Voluntary Health Association.

Looking forward to your kind response.

A GLIMPSE OF TRAINING PROGRAMMES ORGANISED BY WBVHA BESIDES ORGANISING DIFFERENT SEMINARS AND WORKSHOPS

Sl.No.	Training Programme	No. of Participants	Duration	Dates	Venues
1.	Community Health and Development	27	20 days	8-28th Sept'80	Dhyan Ashram 24 Prgs.
2.	Community Health and Development	30	10 days	10-20th Nov'80	Ananda Bhawan Howrah.

..... 2.

Sl.No.	Training Programme	No. of Participants	Duration	Dates	Venues
3.	Community Health and Development	26	1 month	24th Aug -22nd Sept 1981	E.S.I.I. Durgapur Burdwan
4.	Community Health Orientation and Follow-Up of 1st batch trainees	11	2 days	22nd & 23rd Nov 1981	Bandel Church, Hooghly
5.	Community Health and Development	21	1 month	15th Feb -17th Mar 1982	Ananda Niketan, Howrah
6.	Nutrition and MCH	31	7 days	14th -20th Apr 1982	Bishop's House Krishnanagar Nadia.

POPULATION EDUCATION TRAINING IS ON PROCESS

It has been now well realised by all political parties and personalities that all our efforts to ameliorate the condition of our people even after the increase in production and our ceaseless strides to provide them with better standard of living cannot be accomplished if we are not able to balance the resources with the curb on our population. As such all those who are responsible for expressing the aspirations of the people and leading them to attain their goal for better living have to join hands in educating the masses about the population problem. The Family Welfare and Population Education Institute, Calcutta, a sister concern of our member organisation, Calcutta Family Welfare Programme has started an one week training programme leading to a certificate on Population Education from 5th July. Those who are working in villages and 10th Class passed are eligible to participate. Course fee is Rs.20/-. This is a non-residential training and will be conducted every month from 3 - 5 p.m. If interested please get in touch with us for further details.

FORTHCOMING TRAINING PROGRAMMES

Sl.No.	Training Programme	Duration	Dates	Venues	Fees
1.	Poultry Management	15 days	7-21st July 1982	Ramakrishna Mission Ashram Narendrapur Dt. 24 Prgs.	Rs.125/-
2.	Human Relation and Communication	5 days	26-30th July 1982	Retreat House Begumpet Hyderabad.	Rs.150/-
3.	Pottery Training for Artisans	10 months	1st Aug'82 -30th May'83	Regional Pottery Training Centre. Gramodaya Sangh. Bhadrawati, M.P.	Stipend will be given Rs.150/- per month.
4.	Workshop on Holistic Health	5 days	26-30th Apr 1982	Dhayan Ashram Madras	Rs.150/-
5.	Community Health and Development	20 days	16th Aug -4th Sept'82	Ananda Niketan Bagnan, Howrah	Rs.200/-

..... 3.

Sl.No.	Training Programme	Duration	Dates	Venues	Fees
6.	Village Development for Social Workers, Field Workers, Community Organisers and Development Workers.	10 days	17-28th Aug'82	Xavier Institute of Social Service	-
7.	Workshop on the alternative strategy for the Health for all by 2000 A.D.	3 days	27-29th Sept'82	Dhyan Ashram 24 Prgs	Rs.45/-
8.	Workshop on Psychiatri and the Psychological Problems.	2 days	11th & 12th Oct'82	Dhyan Ashram 24 Prgs	Rs.30/-
9.	Community Health and Development	1 month	1-30 Nov 1982	E.S.I.I. Durgapur Burdwan	Rs.325/-
10.	A residential condensed course on Homeopathy leading to a certificate for rural health workers from all over India and abroad.	45 days	1st Dec'82 -15th Jan'83	Dhyan Ashram 24 Prgs	Rs.450/-

If interested we request you to get in touch with us. Candidates who come first will be given first preference. All payment should be made in favour of West Bengal Voluntary Health Association.

HEALTH EQUIPMENT MAINTAINANCE TRAINING PROGRAMME ORGANISED BY VHAI,NEW DELHI.

Applications are invited for the one year following a two year diploma in electrical trade or refrigeration and airconditioning. For sponsored trainees the duration could be less than one year, or more than one year, depending on the needs of sponsoring institution.

For one year programme the minimum qualifications are:

1. A two year National Council of Vocational Trades (NCVT) diploma in electrical trade, or refrigeration trade and airconditioning or equivalent.
2. An understanding of simple English and ability to read and write simple technical English.
3. An aptitude and interest in equipment technology and maintainance.

Requirement 1 can be waived for sponsored candidate who show strong technical aptitude. But in such case a science background (Physics and Maths) in high school is essential.

Also VHAI would be willing to consider specific short term requests for training in specific areas of health equipment. In such cases the details are worked out by mutual agreement between sponsoring institution and Voluntary Health Association of India.

Cost, Fees, Stipends etc.:

The total cost of course is R.555.00 per month, i.e. Rs.6,660.00 per year.

Some financial aid is available in form of stipends:

Candidates sponsored by the hospital would be required to contribute a part or the whole of this cost. This would be decided based on the

size of the hospital. However, a minimum contribution of Rs.225.00 per month is expected from all sponsoring institutions. In addition the sponsoring institution will have to bear the cost of travel, special outstation allowances etc., when the candidate is placed in Chandigarh and other places for training. This cost would normally not exceed Rs.1,000.00 per year per student.

VHAI and NTI are making possible the above subsidy because of a small grant from donor agencies.

The application should reach by July 1982.

Application form and prospectus can be obtained from:

The Programme Co-ordinator
Health Equipment Maintenance Training Programme
Voluntary Health Association of India
C-14 Community Centre
Safdarjang Development Area
New Delhi 110 016.

SUPPLY OF VACCINES FROM GOVERNMENT OF WEST BENGAL THROUGH WBVHA

We are glad to inform you that the authority of the health dept. of Govt. of West Bengal has kindly given their consent that through WBVHA vaccines could be made available to it's member organisations only who are not able to get it from Government for various reasons and therefore would like to collect it from WBVHA are earnestly requested to furnish us the following informations at the earliest.

1. Name of the Institution
2. Address
3. Name of responsible authority
4. Activities in details of the institution
5. Population covered
6. Are you in position to collect, store and provide vaccines and preventive medicines, if so, please state details. How you would like to collect it?
7. Are you already engaged in providing vaccines. If so from where and how you get it? Do you still like to get the vaccines from WBVHA?
8. Reasons for taking vaccines from WBVHA.
9. Requirement in quantity of vaccines and preventive medicines.

Date:

Signature

Institute:

Seal

The moment we hear from you we shall take every steps to negotiate this matter with the Health Dept. of Govt. of West Bengal, and let you know the progress.

We are looking forward to hear you.

REPORT OF VHAI CONVENTION HELD AT AHMEDABAD ON APRIL 27 - 28TH '1982.

The theme of the convention was "The Great Health Robbery". It called attention to commercial exploitation of five identified vulnerable groups.

Infants from whose mouths monter's love and milk are being snatched away by the ruthless infants formula companies, and feeding bottle manufacturers.

Consumers who are persuaded to take drugs they do not need, and in greater quantities than needed.

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People who need medicine often essential medicines such as for malaria, leprosy, polio, tuberculosis are not available due to less profit in these.

Women, who as a group have been neglected and exploited.

Workers, especially with regard to dangerous occupational hazards.

Averthanus D'Souza, Executive Director of Voluntary Health Association of India, in a statement characterised the deliberate promotion of harmful drugs as a gross violation of human rights. He called upon people to inform themselves about the indiscriminate use of drugs. He alleged that drugs companies use their economic strength to subvert national interests and corrupt medical practitioners. He called on all alert people to give force and focus their efforts to prevent the Great Health Robbery.

Poster Exhibition: The first day April 27 / began with Ruth Harner, Augustine Veliath and other explaining the significance of the poster exhibition. It was over two floors of the meeting hall.

SEWA: Ms. Ela Bhatt represented that Self Employed Women's Association (SEWA). This means the un-organised section of women workers, small traders, those engaged in low skill services, street side vendors, handicraft producers etc. Many of these need a small capital. To save them from exploiting money lenders, the Association has started a women's bank. This is a unique institution. All depositors and borrowers are women, all the employees in bank are women. There has been struggle through the Association for the women to get the stipulated minimum wage.

AWAG: Ms. Amina Amin presented a paper in the name of the Ahmedabad Women's Action Group (AWAG). This paper gave numerous examples of exaggerated claims in advertising that result in health robbery of women and children.

Mr. N.D.Zaveri spoke of low wages and health hazards suffered by tobacco workers, especially women who roll bidis.

Village Law Service: Father Mathew Kalathil spoke on a village law service, with which he is connected, and which has its headquarters at the Rajpipla Social Service Society in Bharuch District. The law group are primarily concerned with the casses of exploitation, especially of land aggression. As a part of the service, selected young men from the villages are trained to do simple things like searching for all the facts, making petitions, being liasion between the society and the village people. The society has a senior advocate to present their cases in court, and to pursue them as far as necessary even all the way to the Supreme Court.

Consumer Education Research: Ms. Rani Advani represented the Consumer Education Research Centre. They expose false misleading advertising, adulteration and sub-standard quality articles on the market. If necessary, they make a lawsuit against the malafide preparators of such social injustices.

Drugs Excesses and Pricing: Dr. Samuel Joseph and Dr. Ashwin Patel spoke on the excesses in pricing and prescribing on undue amoung of drugs.

Discussion Groups: In the evening, five groups were formed for discussions and their reports were given next morning.

Membership Fees to VHAs and VHAI: It was recommended by the Executive Board and resolved at the 8th General Body Meeting of VHAI at Ahmedabad that the State and regional VHAs be firm that voting rights in their General Body be related to the payment of agreed membership fees. Procedures for setting membership fees ensuring payment need also to be worked out. Annual membership fees of state and regional VHAs, as in the Constitution of VHAI have also been reviewed. There is obligation for each member to pay an annual membership fee. The amount to be paid is not stated in the Rules, but is determined by the General Body.

The General Body may, from time to time, determine the membership fees to be collected from members and associate members.

Annual fees shall be for the calender year, and shall be payable by 31st January of each year.

Next VHAI Convention: VHAI Annual Convention 1983 will be held in Pune. At

..... 6.

VHAI management meeting on May 14, a suggestion that 'Communication in Health' should be the theme of this convention was proposed. This would be appropriate as 1983 has been designated as International Year of Communication by the U.N. VHAI invites opinion from you all so that a note based on them can be presented to the Executive Board.

THE WAR OF BABY FOODS

The National Alliance for the Nutrition of Infants (NANI) recently formed for the promotion and protection of breast-feeding, has an interesting component in its plan of action: "Immunisation of health workers and institutions against the potentially harmful effects of commercial baby food promotion". The idea is to challange the "unquestioning acceptance of gifts, samples, trips and conferences from the big baby food firms," by doctors, nurses and other health professionals, who, more than the advertisements, have acted as a potent channel in reaching the baby food message to mothers.

NANI, whose members include health groups, consumers association and development action groups, is an Indian counterpart of the many such pressure groups that have formed all over the world in the last decade to fight against unscrupulus promotion of baby foods.

NANI is initiating a nation wide campaign in which every person who believes in the cause has been urged to join. Two health groups in this new association are the Medico Friend Circle (MFC) and the Voluntary Health Association of India (VHAI) both of such have been active in the recent campaign against hormone drugs that harm unborn babies.

(Excerpt from 'SUNDAY' 20-26 June'82)

INDUSTRIAL DISPUTES ACT (AMENDMENT) BILL 1982

The Industrial Disputes (Amendment) Bill, 1982 has just been introduced in Parliament. It redefines 'industry and excludes hospitals, educational institutions etc. from the purview of this term. But the workmen employed in these establishments also need protection. A machinery for the resolution of their individual and collective industrial disputes has been provided for. If you wish to get a copy of the HOSPITAL AND OTHER INSTITUTIONS (SETTLEMENT OF DISPUTE) BILL, 1982, kindly write to C.B.C. Commission for Labour, Catholic Centre, Armenian St., Madras - 600 001 with Rs.2.50 per copy plus postage.

Urgent: Since the Bill has already been tabled and is likely to come up for debate in the session of Parliament which begins in early July, it is urgent that any suggestions for improvement in the Bill be sent to VHAI at the very earliest.

WE NEED YOU IN THE MOVEMENT OF WBVHA

Are you a family member of the WBVHA in it's low cost health care movement? If not, why not join today? WBVHA services may also be helpful to you. Kindly fill up the form below given and return to us at the earliest. If you are already a member, we request you to handover this form to some one whom you know and who is interested in WBVHA and would like to be associated with WBVHA. Please remember you cannot if you do not.

..... 7.

PROSPECTUS FOR COMMUNITY HEALTH DEVELOPMENT TRAINING FOR VILLAGE HEALTH WORKERS AND SUPERVISORS AT THE PREMISES OF SEVA KENDRA, 52B, RADHANATH CHOUDHARY ROAD, CALCUTTA-15 FROM 1st TO 30th NOVEMBER 1982.

Dear Friend,

The need for Community Health is being rapidly recognised. The entire health system is getting oriented towards a community approach. Do we understand what it means? How do we really put these ideas into action. WBVHA is committed towards this approach to health for the people.

We recognise that there are many dispensaries and small institutions in rural areas trying hard to work towards this goal. This commitment and enthusiams of these people make them a very important resource in the health care system.

To make "Health for all by the year 2000" an attainable objective, many organisations both in voluntary and Government sectors have launched programmes in primary health care in the village and slum areas. Apart from funds, there is now shortage of adequately trained and motivated worker who could provide leadership and know how to run these community health projects. Unfortunately the teaching curriculam in most training institutes, do not provide optimum field experience to their trainees. Also enough exposure is not given for the growth of "teamwork spirit" which is so essential to their subsequent liking to work in community health programmes.

This training course will provide an on-the-job learning experience in the field of community health care both for workers and supervisors. This experience will hopefully make them realise the immense job satisfaction oppertunities which are attainable in working with programmes of community health care. This will open up new oppertunities in community health programmes specially in the field of human relation, communication, community approach, health education, mother and child care, prevention of diseases, environmental sanitation, socio political analysis, income generating projects and management concepts.

This training is designed for those people who are in the rural areas, who would like to know the concepts, principles and skills required in organising and management of community health work.

Who can participate :

* Any one who is working or plan to work in health centres, hospitals, dispensaries or other health care programmes in rural areas of West Bengal.
* Any one who is interested and going to be involved in community health and development work.
* Candidate must be able to speak, read and write Bengali and understand English preferably.
* Candidates must be recommended by any voluntary organisation where they are working or intend to work.

We wish to limit the total number of participants to twentyfive only. Preference shall be given to participants from the institutions of West Bengal.

DURATION OF THE TRAINING COURSE	:	1st to 30th November 1982.
VENUE	:	SEVA KENDRA, 52B, RADHA NATH CHOUDHARY ROAD, CALCUTTA - 700 015.
FIELD TRAINING	:	- CINI (Child In Need Institute) - RKM (Ramakrishna Mission)
COURSE FEES	:	Rs. 375/- (Rupees Three hundred Seventy-five) only. This includes food, lodging and expenses for tution but not any other expenses. This is a subsidised fees for the voluntary health institution our actual expenses will be Rs.750/- per candidate. Travelling expenses has to be bourne by the candidate.
LAST DATE OF APPLICATION	:	30th September 1982.
APPLICATION TO SUBMIT	:	Please send the application form along with the cheque of Rs. 375/- in favour of WEST BENGAL VOLUNTARY HEALTH ASSOCIATION. Many of you did not get chance in our last training programme. Therefore please book your seat as early as possible to avoid disappointment in the last moment. The complete application form must be submitted by hand or by post to Mr. B. Bose, Training Co-ordinator, West Bengal Voluntary Health Association, 8 Sarojini Naidu Sarani, Calcutta 700 017. Please pass on this information to those whom you know and will be interested in this type of training programme.
PHONE NO	:	WBVHA - 43-2468 SEVA KENDRA - 21-2641

THANKING YOU,

DR. JOYCE BISWAS
SECRETARY, WBVHA

MR. D.P. PODDAR
EXECUTIVE SECRETARY
WBVHA

Dated 31st August 1982.

TRAINING COURSE OUTLINE

* Self Introduction by participants
* Introduction to the C.H.Training Programme
* Introduction to WBVHA/VHAI/CUS/RKM/CINI
* Thoughts on Community Development
* Definition of Health - Community
* Human Relation and effective communication essential for C.H.Programme.
* Components of Community health programme
  - Preventive and promotive aspects of health.
    a. A general talk on Community health and its main components, what these are and how they influence health.
    b. Health Education and Alvs.
    c. Nutrition
    d. Maternal & Child Health Services
    e. Environmental Sanitation
    f. Common minor ailments
    g. Common & Communicable diseases Thoughts i.e. T.B., Leprosy etc.
    h. Simple record keeping and its importance
    i. Training methods - Talks, discussion, preparation of charts and posters, cooking demonstration, MCH clinics.
    j. Leadership/Mahila Mandal/Deshi Davai/Weight Card.
* Mental health community's responsibility
* Community health and development problems, what are its cause and how to prevent it
* Role of VHWs/CHVs and how to select them
* Survey and survey report/selection of villages
* Approaches to community involvement and community organisation
* Socio political analysis
* Role of adult education in the total development
* Analysing community/community needs and priorities
* The role of community and the team in community health programme
* Over all view of Govt. policies and programmes at all levels
* Administrative structure of health services at the local and state level and how to co-ordinate with them
* Planning a low cost health programme
* Slide show/film show/puppet show/posters/flash cards/Role play /drama/case studies on different aspects of health ahd development.
* Income generating projects
* Management concepts
* First Aid
* Field work, report writing on field work and discussion on field work experiences.
* Training programme evaluation and certificate distribution.

****

(PLEASE FILL IT UP AND SEND BACK AS QUICK AS POSSIBLE)

APPLICATION FOR TRAINING IN COMMUNITY HEALTH.

1. Training programme applied for.....

2. Name.....

3. Address : Present:.....Permanent.....

....

....

PIN ..... PIN .....

PHONE..... PHONE .....

4. Age ..... 5. Sex ..... 6. Marital Status.....

7. Education (including Technical/Progessional qualification, if any)

Name & Location of Institution	Date of Study (From - To)	Name of Degree/ Diploma	Date Received

8. Service Experience (Start with present employment)

Name & Location of Institution	Title of Position	Inclusive dates of employment

9. What language do you know?

Read : ....

Write : ....

Speak : ....

10. A statement of your plans for utilizing the proposed training and experience. What are your specific expectations in this training programme.

Date.....

Signature of applicant

Seal

Signature with designation of the sponsoring authority

PROSPECTUS
FOR
COMMUNITY HEALTH DEVELOPMENT
TRAINING

ONE MONTH RESIDENTIAL TRAINING ON COMMUNITY HEALTH DEVELOPMENT LEADING TO A CERTIFICATE ORGANISED BY WEST BENGAL VOLUNTARY HEALTH ASSOCIATION, A STATE UNIT OF VHAI (VOLUNTARY HEALTH ASSOCIATION OF INDIA, NEW DELHI) WITH A GROUP OF EXPERTS FROM DIFFERENT PROJECTS OF VOLUNTARY ORGANISATIONS AND THE HEALTH DEPARTMENT OF THE GOVERNMENT OF WEST BENGAL.

WEST BENGAL VOLUNTARY HEALTH ASSOCIATION
8, SAROJINI NAIDU SARANI
CALCUTTA - 700 017.

SOMETHING ABOUT WBVHA WHICH YOU MUST KNOW

WBVHA is a non-profit registered society. Its constitution is secular. WBVHA assists in making health a reality for all the people of West Bengal with their involvement and participation through the voluntary health sector. Membership in WBVHA and opportunity for its services are open to individuals as well as all health and health related institutions in the voluntary non-profit sector of health care irrespective of religious affiliation.

Community health is WBVHA's main thrust. WBVHA promotes and provides the education of village based COMMUNITY HEALTH VOLUNTEERS.

WBVHA helps people to develop or extend Community Health Services and Programmes, conducts seminars, workshops, meetings, conference and Training Programmes. It helps its member institutions to plan, to implement and to evaluate different programmes. Also helps in providing consultancy and Resource Persons according to the need.

WBVHA provides liaison for members with related Govt., National and International organisations. It strives to keep members informed through its monthly news-letter on the latest development in Community health care and Govt. Policies. Representing to Govt. bodies the problems of member organisations. Promoting the highest possible level of health care through planned use of available resources in collaboration with Govt. and other agencies. Keeping contact with numerous, local, national and international organisations and encourage the formation and development of associations similar to ours in the different districts of West Bengal. Co-ordinators from WBVHA's state office and VHAI's central office keep in contact with the organisations scattered all over West Bengal and assists them with their activities.

Interested persons are invited to write for any further information required.

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WEST BENGAL VOLUNTARY HEALTH ASSOCIATION

8 SAROJINI NAIDU SARANI CALCUTTA 700 017

MEMBERSHIP APPLICATION FORM

1. Name of Organisation/Individual:
2. Address:
3. Phone No.:
4. How to reach your place:
5. Type of Organisation:
6. Activities:
7. Do you have any training facility in your organisation, if so, what: (Please give details).
8. What are the successes of your organisation:
9. What are the problems & failures:
10. What future do you see:
11. How many bedstrength you have:
12. Do you want to get help from us in providing training on Community Health to your staff and others:
13. Do you have Community Health Development Programme, if so Please give details:
14. Type of membership you want:
15. If you want individual membership, are you related to any social welfare organisation, if yes who are they. How is your relation with them:
16. As individual member, what do you expect from us and what would you like to do for us:

I/We do hereby declare that the information furnished in this application form are true to my/our knowledge and I/we do hereby agree to fulfil all terms & condition of your association to become member . I/We will be ready to pay membership fees in time.

Enclosed herewith a cheque of Rs..... in favour of West Bengal Voluntary Health Association for membership for the year 198...

Dated.....

_____
Full Signature of the applicant

_____
Designation

RATE OF ANNUAL SUBSCRIPTION:

Any Individual : Rs.25/- , no voting right.
Any Institution/Dispensary/Clinic/Registered Society: Rs.75/- , one voting right.
Any Hospital : Rs.120/- , one voting right.