HEALTH FOR THE MILLIONS

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COMMUNITY HEALTH CELL
320, V Main, I Block
Koramangala
Bangalore-560034
India

SCHOOL HEALTH

care is the word

Great health news will soon break upon us.

During 1978 and continuing in 1979, a nationally selected group of 15 competent and dedicated persons, have been meeting periodically, to develop a new national health plan. These scholars, planners and men of experience are focusing their energy on ways of providing the maximum possible health care for all the villages of India by the year 2000. The emphasis of the plan is on community health services, particularly for the most deprived people. The draft of the plan is being finalized and a summary of it is likely to be out within a few months.

In the plan, little is being said of hospitals, and much about social justice in the provision and distribution of health care. The spirit of the plan can be perceived from these words of the draft:

> "Improvement in the health status of the population can be achieved only if there is a shift from the hospital-based, disease-oriented approach depending heavily on sophisticated technology, to a system where attitudes, skills and approaches of the trained personnel are in tune with the need of the common man and where the facilities are acessible to the population in physical, social, cultural and financial terms. **For this to become possible, participation of the community in all health activities is of the utmost importance."**

The central thrust of the plan is fourfold : Health **Promotion, Prevention** of illness, **Curative Services** and **Rehabilitation.**

The plan urges that health services should be an integral part of total development. It calls for the maximum co-operation of people actually living in the community, and the best use of local resources.

The plan calls for health education on a wide scale. One of the goals by the year 2000 is to have 100 per cent coverage for inoculations, safe drinking water and improved hygiene. Envisioned also are adequate structures for primary health coverage in all villages and city slums.

Other aspects of the plan are to utilize the knowledge and values available in all the systems of medicine, re-orientation of medical education so that it will be more in tune with the needs of the community, increased maternal and child care, and to work towards some self-sustaining system of health security so that the earnings of individuals are not adversely affected during periods of illness.

The Government feels that India should have its own national health plan as a way of expressing solidarity with the international health goals agreed upon last year by the WHO Conference at Alma Ata, Russia, which is "Health for All by the Year 2000." All the members and supporters of VHAI have reason to rejoice that Dr Raj Arole, the President of VHAI, is a member of the national health planning team. Also Dr Carl Taylor of the Public Health Department of John Hopkins has attended a couple of the meetings. The Chairman of the team is Dr Ramalingaswami, Director of the All India Institute of Medical Sciences. Dr J. P. Naik has contributed his characteristic wisdom and enthusiasm to the team. The Indian Council of Medical Research is highly supportive.

When the plan is published and ultimately accepted by the Government, our consolation will be that ideas of community health and people's participation which VHAI has been promoting for many years will receive official blessing and encouragement.

health by the pupil

a special correspondent

Can the community (Teachers and Pupils) be involved and pursue a system of 'Health by the pupil for a more effective health delivery ? Can the motivated teachers and pupils be used as community health promoters ?

The Kangazha experiment involving 10,000 students has demonstrated how teachers and the pupils can play effective roles in a school based health programme.

A new look at school health problems

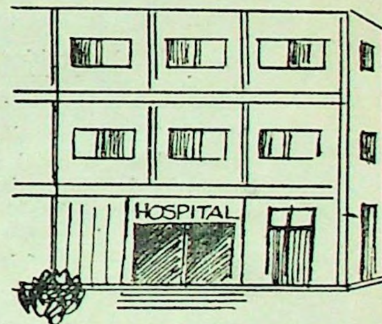
Over 80% of the morbidity in our school children is caused by relatively simple ailments such as deficiency states and skin diseases which are manageable at the school level. Trained teachers are able to recognize them and institute remedial measures. Only less than 5% of the affected morbid group required hospital follow-up. It is also seen that dental caries and other diseases are highly prevalent and therefore dental prophylaxis demands special attention.

functions through a training programme which commences as an institutional training, and continues on an inservice basis. The trained teachers have the following functions.

* Health appraisal and recording of height, weight and vision of all pupils.
* Arranging medical inspection of pupils with visiting school health team.
* Dispensing of medicines.
* First aid, primary care ot common ailments and referrals.
* Promotion of immunisation.
* Prevention of spread of communicable diseases by early case detection and application of quarantine regulations.
* Health education.
* Supervision of student health guides.

Tier I teachers and pupils

Tier II Visiting health team



Tier III base hospital

Programme profile

A three tier organization profile with the school-based health unit manned by teachers and pupil health guides as the first tier, a visiting team as the second tier and the base hospital as the third tier was adopted as represented above.

A phased approach and a strategy of grafting inputs were adopted as shown opposite. In the first two phases as shown here the services were confined to the school. In the third phase the school health guides began functioning in the community.

New functionaries

A trained teacher is the hard core in this programme, and is skilled for the following

Phase	Approach	Target
I	Training teachers	Pupils
II	Training pupils	Entire school community
III	Extended training	General community

The student health guides play an accessary role as follows.

* Record keeping.
* Daily appraisal of health of pupils, and reporting.
* Assist teacher health guides in dispensing.
* Promote immunization.
* Organize school meals, and vegetable gardens.

* First aid.

* Create health awareness.

* Organize health education seminars, exhibitions, film shows.

* Community education in nutrition and environmental hygiene.

Health guide in the making

The teachers and the pupils are enabled to perform the above functions through a skill oriented training, knowledge being limited to optimal levels. Informal education model through group discussions, role playing and demonstrations were found to be more useful than formal methods. The teacher health guide training is offered through a four days institutional training at the base hospital, or health centre followed by inservice training during the school visits of health team. The students' training consist of four half days at weekly intervals at the base hospital. Of late a 'built in' system for student training is adopted where the teachers themselves are enabled in their training to train a batch of students to assist them and only the evaluation of school level training being alone at the institutional level. A primary health centre and health unit can be the venue for training of these guides.

Priorities and inputs

The programme inputs were decided, based on the local priorities. A school based primary curative care facility was considered the first among the priorities in view of the high prevelance of common ailments manageable at the school level. Dental health and prophylaxis, control of communicable diseases, promotion of nurition and health education of pupils were considered important among the priorities. Finally there was felt a need for a newer and simpler system which is primarily school based.

The package of services consists of

* Primary curative care through school based dispensaries manned by teacher student health guides.
* Dental health and prophylaxis.
* Monitoring the growth and development.
* Vision and hearing screening.
* Immunization of school children.
* Nutrition education.
* Special care for scholastically backward handicapped.
* Health education and school sanitation are offered through the programme.

Reaching into the community

In the third phase the health guides are mobilized for general community service through a seven point action programme. This programme was launched as a summer scheme with the following targets for each health guide.

* Immunize ten underfives.
* Vit. A prophylaxis for ten underfiives.
* Compost and soakage pits for five houses.
* Chlorinate five wells.
* Kitchen gardens for five houses.
* Five simple nutrition messages to reach the families.
* A simple lesson in dental hygiene for ten families.

Cost and evaluation

This is a community supported programme. The beneficiaries meet part of the cost by contributing to a special fund formed in the school for the purpose. A contribution of 50 Ps. by a student and equal contribution of 50 Ps. by the institution or government per student per year would suffice to run this programme.

A concurrent evaluation using evaluation models of Goal Effectiveness (GE) realised efficiency (cost benefit analysis) and potency efficiency (PE) revealed very satisfactory results. There was a significant reduction of common ailments like anaemia and other deficiencies, scabies and so on. School attendance has improved. This was attributable to the availability of first aid and minimal medical care at the school level. Improvement in scholastic performance, probably related to correction of anaemia and other deficiency states was also noticed.

Appropriate technology and methodology

A low cost portable dental unit locally fabricated and the school dental service grafted to the school dental programme is a contribution which comes through this programme. A new device for the screening of hearing called cassette record audiometer is another low cost appropriate technology developed. The resourceful participation of the school community make this programme low cost, but of high quality, and hence appropriate for a developing country like ours.

In conclusion a grass root approach of motivating and training teachers and pupils as health guides and establishing school based health units can be an effective method of health care in the school community. The trained teachers and pupils can also play an effective role in other community health action programmes and thereby extend the philosophy of community self reliance in health.

spy games for children

david drucker

Enter any village and children will be seen working. Park a vehicle near any market and the children will want to sell you something or seek casual employment. In fact, a recent report states that in South Asia alone, by ILO standards, 29 million children are gainfully employed.

Another fact is that children **know.** They know an enormous amount and we adults have failed to gather and put to use the very careful **research** undertaken quite unguided and voluntarily by children with their inherent sense of curiosity.

Watch a child staring intently at a parasitic growth on the trunk of a tree; watch him prod with a stick at an insect; listen to him tell about a neighbour's baby, or discuss who died and how they were sick; notice how every little hole is investigated, and every puddle or trickle of water becomes a focus of attention; listen to my sophisticatedly educated son tell me about fantastic and truly obscure "achievements" which he has gleaned from the Guiness Book of Records, or my small daughter tell me her skin is full of tiny, tiny holes — all research, however, academically faulted.

Let me not labour the point — children **know.** But, just as in any community which is to be involved in development, we who are in the development business fail to recognize that those whose lives are, we hope, to be positively transformed, and who have for centuries **known** the local circumstances and condition of their lives, need to assist themselves and educate us by being skillfully encouraged to **know what they know:** what is required is the organizing and presentation of their knowledge and for us together to examine their knowledge in a thorough-going and persevering way. If we can help this to happen we may have earned sufficient trust, so that they might be ready and want to listen to and incorporate any new knowing that we developers think **we** know and we are prepared to humbly and simply **contribute** (with a common touch) to the common pool of community knowing.

We must do this not in an unconsciously arrogant manner of 'we-know-best-really", but in a genuinely egalitarian "how-does-this-fit-in-with-what-you-know" spirit of enquiry, which truly expresses a community development philosophy of partnership. We must remember that we are required to ally centuries of experience which tells communities that much of what is initiated by outsiders is self-seeking and accrues to those up the hierarchy in the high status positions.

If community participation is to have the vitalising effect which rather suddenly all the sectoral programmes are beginning to say is essential to their development projects, it will be necessary to painstakingly generate (with sufficient and appropriately allocated resources and skilled personnel) a process leading to viable community planning mechanisms from the "bottom-up" with Ministries and agencies gearing themselves to the largely unfamiliar role of "support-down".

This brings me a long way round back to the children, for they can most certainly contribute and might even spearhead development. After all they will be around longer than most of us in either enjoying or carrying the burden of all our activities!

Take for example those puddles and trickles of water, and add the wells and the ponds, and the tanks, even storage jars, and the springs and the waterfalls, the creeks and the drains and the rivers that children are the local experts in splashing, floating, falling-in and knowing about. **We** know that contaminated water is the cause of untold discomfort, disease, and is one of the main outriders of death itself for many, many, too many, of these children.

We know a lot about a range of possible technical innovations and technical hardware, drills and pumps and pipes. We know something about the macro-economics of such matters and we know something about how start-up (pump-priming") funds might be assembled.

How can we put all this knowing, both available and potential, together? Well, how about inventing "I-Spy type games"? — pleasurable and exciting games, yet serious as the best games should be. One game would be for the children to spy out and note down every conceivable source of water in the surrounding area. The children could work in pairs or teams and some kind of marker or agreed "secret sign" be left at each source discovered, so that the same item is not claimed more than once by any "player", and so that a proper claim is made of each "find" and can be judged to belong to the first finder. Some kind of points system and reward for the most points should be devised. All the information from this I-Spy Game would then be brought together and displayed on the largest possible area on which an outline map of the village or community can be marked out. It could be the size of the school playground, a sportsfield, a market square, the side of a house??? The map can be outlined in

chalk, or with stones, or bamboo, or scraped in the dry earth. The children can make models (with mud, coconut shells, card, anything**.. Then with sections of the map allocated to pairs of children, they should fill in the map, marking all the water sources which will show the total situation.

A village leader, a health worker or a youth group might organize the whole game. Better still, an enterprising school teacher might use a water I-Spy Game to teach and link many aspects of his curriculum, preferably as a practical activity illustrating what the school is supposed to be teaching anyway—map-making, charts, graphs, handicrafts, hygiene, social studies, essay-writing, etc., etc., or as a valuable learning project in its own right.

For example, children could be asked to write a "24 hours of water use in my family" and be encouraged to describe where it comes from, how it is collected and stored, how much is used for what, and something about the seasonal variations. The art class pupils could be set the task of producing a huge wall mural (children, paired, taking a small section of the wall each) illustrating water use in the village. All of this clearly has direct relevance to the school curriculum. The educational programme itself could be enhanced this way.

From this basic game, we can move on to an "I-Spy Sanitary Inspector Game". Teams are again formed and reward given this time to the team that identifies from all the sources the most water risk danger situations (having been told all about these beforehand, cattle drinking, washing, clothes washing, open wells, defecation, and so on). They must place a sign to mark the danger and to claim the site for their team. The signs could be semi-permanent so that they stood/hung/marked the site until the risk had eventually been eradicated.

How the risks would be added (big red spots?) to the sources plotted on the huge map. These water games might be linked appropriately to local water festivals like Holi. When the whole layout is satisfactorily completed, the village leaders and the whole village should be invited to attend a ceremonial inspection of the map. Then the whole thing will be explained (perhaps by the children themselves) and a full presentation made, on "Our Village Water Conditions and What Might be Done for a Clean Village Water Supply".

Of course, these games and the whole procedure expects much of the school teacher or whoever, and might require a campaign to back them up with an orientation and practice sessions sponsored by the education or welfare (?) or health (?) authorities.

All this information and the community involvement and interest engendered by these "game" activities are the fertile ground upon which can be built specifically local tailor-made plans. In full consultation with a well-informed community, the engineers, the health educators, the community organizers can tackle together a whole range of problems. We would, under these circumstances, have every reason to believe that the community has a full stake and will give a full effort to implementation, for the plans will be a reality to them and a challenge to us to fulfill our part in mutually realistic expectations.

This is only one illustration for a child-contributed approach to planning. Variations of I-Spy can be prepared and experimented within relation to many if not all developmental activity such as malaria control, immunization, nutrition (remember children are the experts in knowing the whereabouts and condition of pre-school children and babies), etc., etc. Other sectors concerned with agriculture, irrigation, forestry, husbandry, transport, markets, and so on could help devise action-oriented exercises in this way.

What we need to do is to try it, learn from real experience in the communities and villages where development activity is to take place and work out some persuasive "How to ...... Guides" complete with kits, check-lists, and so on.

Is there any one listening and interested out there on the knowledge network? Can we get together, hammer out the details, design the materials and try to approach out somewhere in relation to specific projects? Let's hear from you!

a happy healthy school

The idea

Being healthy and staying healthy is a result of good health habits. A community that has good health habits :

is clean and pleasant to live in;

has people who are strong and not often sick;

has people who are kind and care for all who live there.

Children begin to learn the health habits of their community from the time they are young babies. We can encourage the right health practices in children so that they become good habits.

Older children can help develop good health habits in younger children so that they learn how :

to keep their surroundings healthy;

to keep their bodies strong and healthy;

to live in a happy, healthy way with others.

Who can introduce the activity to children ?

Teachers can involve school children;

health workers and volunteer health workers can tell children at school or in out-of-school activities;

Guide, Scout and other youth leaders can help:

Press, radio, posters and songs can all be used to spread these ideas to children.

The activity

A happy healthy school

Children at school or in youth groups can be encouraged to discuss and make up their own rules for keeping their surroundings healthy :

clearing away rubbish and having it in special places; keeping holes free of water and mosquitoes;

storing materials and equipment;

keeping the play areas safe.

They can form 'health patrols' who are responsible for seeing that these habits are kept.

Sometimes children (and adults) lose their tempers or do things which seem cruel or unkind. Discuss these feelings with children :

make up stories and games that help children realise the needs and feelings of others;

let them decide what is the kind thing to do in these difficult situation, for example, when children fight, or steal, or tease each other;

they can make up a play about a difficult situation like this, perhaps based on something that has happened to them. They can tell how it was solved in a kindly way;

the older children can each be made responsible for a younger one to help him if he is in trouble of any kind.

Healthy skin habits

Children often have skin diseases like ringworm, scabies, or itches from insect bites. Good health habits can help prevent these.

The following are some common skin conditions. Children can discuss them and how to prevent and cure them.

Ringworm

This can follow a cut or a prick. On the head hair falls out in a round patch, and a large swelling can grow. On the rest of the body ringworm looks like red scaly rings, sometimes with swellings and spots with yellow matter in them.

If a child has ringworm it is important that other people do not share his comb, brush, razor or scissors.

A ringworm cream from the clinic may help cure it. Often tablets are needed.

Scabies

This is an itchy skin disease. The insect is very small and lives in the skin. The insect bites in the dark, and at night, especially on the fingers, feet and buttocks.

If someone in the household has scabies everyone who lives there will need to be treated. A special lotion from the dispensary is needed. This is put all over the body.

All bedding and clothes need to be changed and aired.

Itching

Lots of insects bite us and make us itch. Flying insects like mosquitoes and gnats bite skin not covered by clothes and make itchy lumps that last a day or so. Some of these insects breed in pools of water, so clearing the water will get rid of the insects.

Insects like fleas and mites get in clothes and on animals, and live in bedding. Keeping animals like dogs, cats and chickens out of the house will help keep these insects out too.

Lice can live in hair and clothing. To get rid of them you need to clean bedding and clothing and to get a special lotion from the dispensary for washing the hair. Treat everyone in the house or class.

The children should learn to recognize these skin problems. They can organize regular inspections at school. If they see other children with any of these skin problems they can tell them how to get the right treatment.

Healthy teeth habits

Children should understand the importance of caring for their teeth every day. They should brush their teeth after eating, with a brush or brushing stick. They should not eat too much sweet food of fizzy drinks. These may rot teeth.

Let the children look at each other's teeth. When children were looking at teeth, did they notice that some teeth were black? Did they notice that some teeth have holes in them? These teeth have decay and are rotting.

The hole needs to be filled by a dental worker. This may not be possible. The children could suggest local pain killers to put on the tooth. However, this does not stop the tooth from rotting.

Teeth go rotten if you eat a lot of sweet food, for example, cakes, fizzy drinks and sweets. Here is simple experiment, if you can find two teeth (for example, teeth from children whose first set is falling out). Drop one in a fizzy drink. Drop the other in water. Leave them overnight. Look at them the next day. The tooth in the fizzy drink rots. The tooth in water does not.

The children can learn to brush their teeth the correct way. If they have a toothbrush show them how to use it.

Practise using the stick or toothbrush. Show the children how to brush up and down the front, back, top and bottom of their teeth. They should not brush from side to side.

The children can bring their brushing sticks or toothbrushes to school each day and brush their teeth together before school.

They can make a brushing stick for their younger brothers or sisters at home and teach them how to brush their teeth well.

The children could learn to make 'toothpaste'. They can make a tooth powder by mixing salt and bicarbonate of soda in equal amounts. Just plain salt can also be used.

To make it stick, wet the brush or stick before putting it in the powder.

Healthy eyes

We all want to have bright, shiny eyes. Care of our eyes is very important.

Children should understand that it is important to eat foods like dark green vegetables and yellow and orange fruits and vegetables.

The children could visit the local market or walk around the village, and make a list of all the dark green vegetables, and yellow and orange fruits and vegetables, such as spinch, cassava and papaya leaves and papaya fruit, mango and many others. Are these foods expensive? Who eats them? How are they eaten? When?

The older children can bring a piece of yellow fruit to school. They can share it with a younger child. They can try to see that their younger brother or sister at home eats some green leafy vegetable or yellow fruit each day.

Often children get sticky eyes. They get dirt or pus in them. Older children can learn to wash eyes with clean water to keep them clear and healthy. If they notice pus in younger children's eyes they should tell an adult. This can help to prevent diseases such as trachoma which may cause blindness.

Healthy ears

Discuss with the children how it might feel if you can't hear well. Ask questions like:

Do you know anybody who does not hear well?

Do you act differently with these people? Why?

How would you feel if you did not hear well?

The children can test each other's hearing in a game like this:

(1) An older child stands several metres behind a line of younger children who are about to enter school.

(2) Besides each young child, an older child stands with pencil and paper.

(3) The first child says the name of an animal VERY LOUD.

(4) The young children whisper the word to their older partner.

(5) And the older child writes it down.

Then the first child says names of other animals, each one in a softer voice than the one before until at last he is whispering.

After a list of about ten animals has been said and the words that the younger children hear are written down, the different lists can be compared.

If any child heard a lot less words than the others he probably has a hearing problem. Let him sit at the front of his class. If possible he should be examined by a health worker, especially if he has pus in an ear or frequent earache.

Older children can help look after the ears of brothers and sisters. They can regularly look in the ears of their brothers and sisters to see that there is no pus or small object. If they do see anything wrong they should tell an older person who should take the child to a health worker for help.

Children can keep a chart and record on it each day if they are green or yellow fruits or vegetables.

Each month they can do a check of their school. Check each class and give a prize for the healthiest group.

They can make a list of 'healthy habits' to notice.

Older children can give a 'brushing' test to children to see if they clean teeth the best way.

Other activities for children

Children can make a list of healthy habits to notice.

The children could do a play about their teeth. The characters could be as follows :

Ravan Germ — a bad man.

Ramesh Molar — a good but rather stupid man.

Shri Dental Worker — two good helpful people who stop.

Shrimati Brushstick — Ravan Germ from attacking Ramesh Molar.

The play can be developed by teachers and children.

Ramesh Molar tells Mr. Worker what it is like to be a tooth.

He says how frightened he is of Ravan Germ.

Ravan Germ appears and tells the audience how he plans to rot Ramesh Molar.

Shri Dental Worker and Shrimati Brushstick discuss how to stop Ravan Germ from attacking Ramesh Molar.

from the depth of a child's heart

by Sr. M. Pia Nazareth, r.j.m.
Frank Bros. & Co.
New Delhi 1978

Pages 112 **Rs. 8 50**

From the Depth of a Child's Heart is a study of children's expectations. It is a collection from the original copies of children's work in middle schools.

This probe into their inner most feelings uncovers the deeper perceptions of the children's world, the homes they would like, their ideals and how they themselves measure up to them. The children do not seek happiness in material goods but in values that generate warmth.

In the International Year of the Child here is a book that reminds us that no education is complete unless the hopes of children are given due consideration.

The article Happy Healthy School is adapted from a chapter in "CHILD-to-child". This 104 pages, profusely illustrated book is published on behalf of CHILD-to-child programme based at the institutes of Education and Child Health at the University of London.

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3. C. V Main, I Block
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India

school health

— more than a footnote

The eye specialist visits the schools, examines the children's eyes, talks to them about how to prevent eye infections and what foods they should eat in order to have good eyes. The dentist visits the schools, examines the children's teeth, talks about mouth care and the danger of eating too many sweets, and calls the children to the dental clinic to have small cavities filled, badly decayed teeth removed. The community health worker visits the schools. He talks about sanitation and cleanliness and the importance of immunizations. The school teacher conducts hygiene classes.

What do the children learn about health in school? Charts and pictures or stories may help them to remember what they are taught. It is important that they do, for they have far more influence on the people at home than the visiting hospital team or the government nurse can. If parents are telling their children that school is important, they must listen to what the children are learning.

Dr. Eric Ram, now with the Christian Medical Commission of the W.C.C. in Geneva, feels that it is a waste of time to lecture to adults. A little girl in a school he used to visit told her grandmother, who was preparing for the delivery of a new baby, "You must not use the sickle. You must boil a new razor blade and use that to cut the baby's cord. If you don't the baby may get tetanus and die." She was so concerned and insistent that the skeptical grandmother complied.

School health is reaching out to the minds of youngsters with a message about how theirs can be a healthier, happier life. If the lesson is clear and convincing, the children will take it from there.

—Ron Seaton

Half the nurses

Do you know that one half of all the nurses in service are girls of from five to twenty years old ? You can see you are very important little people. Then there are all the girls who are nursing mother's baby at home; and, in all these cases, it seems pretty nearly to come to this, that baby's health for its whole life depends upon you, girls, more than upon anything else.

I need hardly say to you, what a charge! For I believe that you, all of you, or nearly all, care about too much not to feel this nearly as much as I do. You, all of you, want to make baby grow up well and happy, if you knew how.

Perhaps you will say to me, "I don't know what you would have me do. You puzzle me so. You tell me, don't feed the child too much, and don't feed it too little; don't keep the room shut up, and don't let there be a draught; don't let the child be dull, and don't amuse it too much." Dear little nurse, you must learn to manage. Some people never do learn management. I have felt all these difficulties myself; and I can tell you that it is not from reading my book that you will learn to mind baby well, but from practising yourself how best to manage to do what other good nurses (and my book, if you like it) tell you.

Florence Nightingale

nursing a slum to health

At the Mid India Board of Examiners Graduate School for Nurses, Indore, M.P. there are courses to prepare graduate nurses to become Ward Sisters, (or Brothers), Nurse Administrators, Sister (or Brother) Tutors and Public Health Nurses. The Director, Miss S. Patras, and faculty members are constantly revising the couse in order to keep up with the cuurent thoughts and ideas in Nursing and Education. This year the public health couse has actually become a community health course and the students' enthusiasm plus the stess on new trends has put up a very strong emphasis on community health, health education and primary health care in all the classes. Here Alice Porter reports what the Nursing Students were able to do within a short time.

The community health course has worked out even better than I had hoped — perhaps it is beginner's luck. The integrated field work with the theory has been a good experience. The students were assigned a slum area to visit at least once a week.

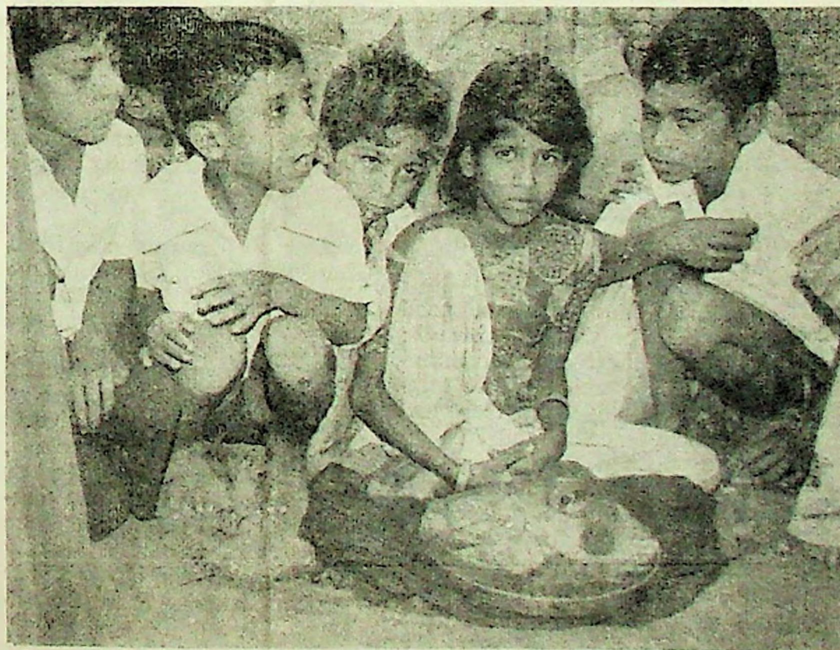
With a little guidance they made their own plans and came back almost every time with such enthusiastic reports. Very soon they were going twice a week and would have liked to go more often.

Their initial visit set the tone — they were rather fearful of acceptance as there was no organized medical work in the area and only through the YWCA were they able to get an entrance. The YWCA does a little work in the primary school each week. The students came back reporting their feelings of "fear and trembling" and uncertainty of how to begin. They also reported their introduction. They were in uniform and were mistaken for the family planning workers who are not too welcome since the forced sterilization programme during the Emergency; however, they soon explained that they were students who had come to learn from the local residents.

By the end of the first visit a number of people said: "Our home is your home. Come any time." One rather older lady had been there for many years and said this was the first time any one had made her feel she was wanted and her opinion counted; needless to say the students were soon learning much. I think they were surprised, as were the residents, that nurses could learn from the village people. They also contacted village leaders, the **dai** (three months trained midwife) and the village priest — all of whom are doing health work in their own way. The students were glad to find the dai especially is doing good work and they could encourage her as well as learn from her.

In the primary school they went to teach and they decided to do eye testing. They found two children each with a severely damaged eye. They were able to get the children to a specialist but unfortunately it was too late to help. They taught hygiene, the "Five Finger" health talk, and the K.G. children marched right out to the girl sitting in front of the school selling channa nuts, etc. The children told her that if she did not get a cover on the tray to keep the flies off they would not buy from her. The next day the tray had a cover! It has been covered each visit since.

On the 15th of August a lesson on food was taught by puppet drama and song. The children repeated it fairly and accurately to the nurses the next time they visited them.



A CONSUMER REVOLT PRODUCES RESULTS. The Girl vendor at the centre agrees to cover the edibles. The kintergarten boys' first lesson in hygeine has not gone in vain.

The students also had to do a family study and the diet analysis of a family for a week. This the students were able to do in the community and so it fitted into the overall plan. One student had very disturbing findings. In the survey they had found a post polio child whose family was subject for study. When the nurse asked about food the mother started to weep — they were starving. The father was out of work and they were eating once a day at that time. The caloric intake for the mother was about 600 and the children still less — per day! Needless to say the parents were extremely thin. Through the church and fellowship groups some help was given and contacts made for possible work. The mother is very artistic so some home industry has been started and she has today started to teach sewing.

About this time I was concerned about continuing the work as were the students and by then the people of the area were also asking, "Who will help us when you leave?" We have been able to arrange with the student nurses in the Christian hospital that they go there for experience and so carry on some work.

When they all went together one lady instructed my students: "Give a good report. You know all about us. Our eyes have been opened and we want someone to help us carry on."

There have been a good number of steps forward: there is much more community feeling and they are talking more together, they had a "town" meeting and 75 signed a petition to get a public latrine and city water connection in the area. Forty persons have signed up for sewing and adult education classes and teachers located. The YWCA is supervizing this project.

A group of about 30 young men who go to night school came and asked the nurses what they could do to help because, they said, they saw the nurses coming each week to help and they decided they too could do something to help their own community. The hope is that they may become involved in the adult education programme which was inaugurated on October 2nd all over India.... The programme is not merely to learn to read and write but to widen the horizons so they can help with development. This will include health and one of the booklets already published for these new literate is on health.

With so many possibilities for advancing good health in the area the students are hating to leave. They are relieved that at least the sewing classes are started and the adult education seems to be fairly sure too. It is the old saying of "being in the right place at the right time," that has made the whole experience so good. After the survey the students decided that the number one health problem was lack of education. So they planned to see what they could do and it is all fitting together. In one way it is good that they were short term as the people know it and realized they had to be prepared to carry on themselves and not depend on the nurse. However, support and guidance is needed and I hope we can give it through the hospital students.

—*Alice Porter*

uttar pradesh

chotabhai and friends

Four kilometres from Bareilly, U.P., is a clump of tall trees decorating fields of sugar cane. The trees shelter a humble ashram inhabited by Deenabandhu and Chotabhai. They live here for the quiet and to allow their spirits to expand.

They visit nearby villages. The village folk return the kindness. In the chats and visits, the needs of the people are revealed.

One obvious need was for a health service. Sisters have been engaged to operate a health centre in nearby village Kareli. A speciality of their approach is emphasis on health education, and the training of village health workers. Their teaching is not by a course, but by on going sharing of learning, experience and mutual help. A doctor visits once a week. The dispensary is tiny and simple, yet in the past year patients came from 32 villages.

Some of these were far away. People could more easily have gone to the city. They come here because of their confidence in Sister Felicia and her companions, and the consolation and courage to face life that they receive from the sisters. There have been a few seriously ill patients, given up as hopeless by the doctors, who have been cured by the sisters praying over them at the dispensary. The sisters customarily pray over patients who ask for it.

The sisters have an under-five centre for less privileged children. A supplementary feeding is made possible for them by the kindeness of Soya Production and Research Association, Bareilly. 120 children are given a daily ration of "Postikahar", a high protein food made especially for children. A village health worker, Urmila Saxena, looks after the feeding.

There are leprosy patients in the area. To cover the cost of their treatment a Leprosy Welfare Association has been formed of leading local citizens. It has at present 41 members. It is open to all people of good will. They contri-

bute and raise enough money to cover the medical care of 240 leprosy patient. The Association has also provided shelter for patients needing it, distributed goats for them to rear and supplied rickshaws to seven men who were able bodied.

For the landless labour and the small farmers who own 1/2 to 5 acres of land, a Small Farmers Welfare Society has been started. The membership is Rs. 10 a year. The Society provides a liaison service with the Government departments. It has provided a movable pumpset for irrigation and a godown to store fertilizers and seeds. It has helped a few farmers to rebuild their houses which fell during the floods of this year. Hand pumps have been installed for poor people who did not have safe drinking water. The Farmers Welfare Society is managed by a volunteer resident in the local community. He is a retired gentleman, competent and highly dedicated.

Deenabandhu and Chotabhai with their colleagues and co-workers, provide us with an ideal small model of community health and development in a village. In all the activities there is community involvement. The energies of the strong are focused, and the hopes of the weak are encouraged.

andhra pradesh

☐ A five day workshop on Community Health was ended in Dichpalli, Victoria Hospital on 11th December 1979. Ms. Simone was the facilitator and consultant. Drs Bas Mesquita, Mrs Mesquita and Mr Rayanna were also in the faculty.

Dichpalli will be again the venue for a similar workshop from March 12-16, 1979.

* **APVHA Educational and Training programmes for the year 1979**

—Seminar on Hospital Administration (5 days).

—Seminar for Departmental Heads (Middle management) —(3 days).

—Workshop on Community Health (5 days).

—Workshop on Record Keeping (4 days).

—Workshop on Human Relations & Communications.

☐ Ms Zina Kidd, is back and will be assisting APVHA as Promotion Secretary (Community Health).

☐ With Village Reconstruction Organization APVHA is working on a Manual "How to Deal with Disastors". APVHA welcomes suggestion from those who have experience in relief and reconstruction work.

☐ Andhra State government employees who undergo sterilization operation under private medical practitioners are eligible for benefit of family welfare incentives. According to a Government of Andhra Pradesh Medical and Health Department memo the sterilization certificate issued by a medical practitioner who performed the sterilization operation has to be counter signed by a Government doctor not below the rank of a Civil Assistant surgeon within five days from the date of operation.

bihar

☐ Armed with roll-up blackboard, a few chalks, slates and pencils and a couple of primers, two ex-students of Xavier Institute of Social Service have launched an adult education centre. They are Ms A. L. Mundu and Mr N. B. Bam.

Adult education was started in June and today 21 adult education centres are run in seven villages. Night classes function in houses, a school building or a community house. People bring their own lamps and contribute 10 paise per week for buying necessaries to keep the centre going. If Government funds arrive the village animators will be paid Rs 50 per month as honorarium.

karnataka

☐ A weekend refresher programme in community health was organized by Voluntary Health Association, Karnataka on October 20, 1978. There were thirty eight participants who were community health nurses, creche nurses, and field officers. The topics covered during the programme were : (i) Dynamics of community health, (ii) Practical aspects of a community health programme, (iii) Common health problems in women and children, (iv) a group discussion on health problems, (v) a discussion lecture on nutrition and balanced diet, (vi) First-aid demonstration lecture, (vii) Principles of mental health and mental hygiene, etc. The function was presided over by Mrs Teresa Bhattacharya, I.A.S., Jt. Director, Personnel Department, Government of Karnataka.

The Government of Karnataka has entrusted the task of contacting voluntary organizations and invite specific programmes for welfare of needy children to the Karnataka State Council of Child Welfare, which will be then presented to the Ministry of Social Welfare.

A three-day workshop, in this connection is to be held in Bangalore during Feb. 23, 24 and 25, 1979 on various aspects such as child in the home/school/society, health

and nutrition of the child, sex education, etc., etc. Interested persons are asked to join hands.

kerala

☐ Management expertise is now at the door steps of Kerala Hospitals.

Kerala Voluntary Health Services has introduced a tentative one year Management training programme for the benefit of hospitals which cannot afford to send their personnel for formal training in Hospital Administration.

This training will be imparted through training Labs, seminars, workshops, etc., conducted every month at local centres. For further information please write to :

The KVHS Organizing Secretary, St. Thomas Hospital, Changanacherry - 636 104, Kerala.

tamil nadu

☐ The seminar on "Rural Nutrition" in Deenbandu Medical Mission organized by Tamil Nadu VHA was attended by seventeen participants. Mrs and Dr Prem C. John conducted the seminar.

w. bengal

☐ At Purulia Leprosy Hospital various types of simple footwear are produced in several designs which will suit the patient and be acceptable to the community.

Many leprosy patients can stay as outpatients by preventing ulcers on their feet if these shoes are worn by them. The rates for this orthopaedic shoes varies from Rs 22 to Rs 45 only.

For further information please contact :

Mr P. K. Roy, Superintendent, The Leprosy Mission, P. Box No. 9, Purulia - 723 101, West Bengal.

unemployed doctors

The Medico Friend Circle discussed this topic at their annual convention, Varanasi, January 26 to 28, 1979.

The purpose of the dicussion was to call attention to the fact that while there is indeed unemployment among doctors, there is also in many states a considerable number of sanctioned rural posts available where doctors do not accept to go.

In a background paper, Dr Vinayak Sen of Rasulia, near Hoshangabad, called attention to a number of interesting facts. One was that from information in the 1971 census there were at that time 1978 men allopathic doctors and 791 women doctors unemployed and looking for a job. This number, therefore, would not include retired doctors, or groups like women doctors who have married and ceased to have an interest in practice.

The total number of economically active doctors in India in 1978, he said, was 170,000.

Dr Luis Barreto, Lecturer Sevagram, near Wardha said: "The most obvious shortcoming of the health system in India is that it caters to the few at the cost of the majority.

In his paper he quoted B. R. Bloom as saying "People are sick because they are poor, they become poorer because they are sick, and they become sicker because they are poorer."

Dr Barreto points out that most medical doctors come from an urban background, and even if they are from a village, during their education they become urbanized. He says that it is but natural that when such students pass out, they will refuse to work in rural areas where amenities like a good house, social life, education for their children, etc., are not available.

He said the number of doctors on the registered roles in India are 200,003. Of these 3,940 have post graduate degrees. This gives a doctor population ratio of 1:4200. Of course, this kind of average can give a distorted picture. The doctors are so heavily concentrated in the cities that in rural areas there are places where there is one doctor to 10,000 reaching possibly as high as 50,000 in a few places.

Relevant to this situation, the goals of the Medico Friend Circle are as follows :

1. to evolve a pattern of medical education relevant to Indian needs and conditions;

2. to evolve a suitable methodology of health care; and

3. to make positive efforts towords improving the non-medical aspects of society for a better life, more humane and just in contents and purposes.

For information about MFC, write to Mr Ashok Bhargava, Convener, Medico Friend Circle, 21 Nirman Society, Vadodara - 390 005, Gujarat.

COMMUNITY HEALTH CELL
326, V Main, I Block
Koramangala
Bangalore-560034
India

farm people of mexico

Mr Martin Reyes, Community Health Programme Coordinator, Sinlao, Mexico lead the discussions on Rural Health at India International Centre on December 15, 1978, Lodi Estate, New Delhi. Jointly organized by the Vountary Health Association of India and the India International Centre, the meeting was attended by leading health ministry officials, health professionals and representatives from various voluntary organizations. Mr. C. R. Krishnamurthi, Joint Secretary in the Ministry of Health and Family Welfare presided.

With the help of a short film titled Health Care by the People. Mr Reyes gave glimpses of the Project Piaxtala, a health care network run by farm people (Compesinos) that covers several thousand square miles of mountain terrain and serves a population of more than 10,000 persons living in more than 100 small settlements and villages. It attempts to involve the mountain communities in a process of meeting their own health needs in a manner that is economically realistic, ecologically sound, and personally humane.

The project is essentially a personal venture founded on friendship, dedication and trust. It has evolved slowly, by trial and error, since 1963 when David Werner, an American biologist and former high school teacher, first hiked through the **barrancas** in search of interesting birds and plants. Struck by the beauty of the landscape, the friendliness of the campesinos (farm people), but also by the enormity of their health problems, David later returned to work with the people.

Villagers—especially some of the enthusiastic village children — were involved with the health work from the start.

Today the community based health programme is run and staffed completely by local villagers. The main referral and training centre is in the small village of Ajoya, at the base of the mountains and accessible by a dirt road. The centre operates an out-patient (and occasionally in-patient) clinic complete with laboratory and X-ray facilities. Also locally trained dental technicians drill and fill teeth, and make dentures. Other activities include primary veterinary services and repair of orthopedic braces. All this work is done by the villagers themselves, most of whom have not gone beyond the sixth grade of formal education. Rosa who is in charge of the clinical laboratory, has never attended school.

Perhaps the most important activity of the programme is the training of village health workers, called **promoteres de salud. These come** from remote **ranchos** and villages farther back into the mountains. Selected by their own communities, they spend two months training in Ajoya. The "learning through doing" approach to training includes preventive and curative medicine, with a strong emphasis on community organization, conscientization (consciousness raising), and teaching techniques. The most recent course was taught completely by the Ajoya village team, headed by Martin Reyes, the project coordinator. David Werner and his co-worker, Bill Bower, assisted as consultants but remained very much in the background.

Now completely self-sufficient in terms of personnel, the village health team is working very hard to achieve financial self-sufficiency. Already the promoters in outlying villages are self-sufficient; they are part-time health workers who continue to earn their living through farming and make very modest charges for their services, providing necessary medication at cost. Their communities even contribute half cost of their room and board during the training programme.

Villagers may pay for health services either with money or with work. During the summer rainy season, "work fiestas" have been conducted in which many villagers pitch into plough and plant fields loaned to the clinic. For each two hours of work, a family receives credit for a consultation, complete with medicine if needed. To keep upgrading their knowledge and to learn new skills, the village team continues to invite doctors, nurses, dentists, veterinarians, lab techs, and other professionls to visit in a teaching capacity. Such visitors are encouraged to maintain a low profile and to limit their contribution to teaching and making suggestions. It is felt important that the visits of professionals be brief (usually two to six weeks) and that they serve as auxiliaries or assistants to the local team that provides the continuity of care.

One of the most recent and exciting developments of the project is that it appears to be self-seeding.

In addition to helping launch a sister project in a neighbouring area, Project Piaxtla has begun a programme of student exchange with other rural health programmes in more distant parts of Mexico and as far away as Honduras. Thus the team in Ajoya is beginning to gather ideas and to have an impact far afield.

As reported earlier Dr Rezia Laila Akbar has taken over as Executive Director of Bangladesh Voluntary Health Service Society.

awards

Dr Shanti Ghosh, till recently, Head, Department of Paediatrics, Safdarjung Hospital, New Delhi has been awarded Dr M. K. Seshadri Award and medal for community medicine by the Indian Council of Medical Research for the year 1979. Dr Ghosh as most of our readers will recall is the author of "Feedding and Care of Infants and Young Children" and "Shishu Palan".

Among other who have won awards are Dr P. M. Udani, Director/Professor, Institute of Child Health, Grant Medical College, Bombay — Dr Kamala Menon award (for Paediatrics) for his work "Tuberculosis in Children in India",

situations

The 200 beded St Luke's Hospital, Tinsukia, has the following vacancies:

1. A physician, MRCP or MD.
2. An Ophthalmologist, MS.
3. A Paediatrician, MD.
4. An Orthopaedician, MS.
5. A Lab technician, well versed in Microbiology as well.
6. A pharmacist.
7. An X-ray technician.

The minimum consolidated salary for posts 1-4 will be Rs 2000 p.m. inclusive all. Higher salary will be given according to the experience and other qualifications.

For post No. 5, 6 and 7 salary to match qualifications and experience.

Furnished quarters will be provided in all categories.

Please apply with complete bio-data to Medical Superintendent, St Luke's Hospital, Tinsukia, P.O. Chabua, Assam - 786 184.

wanted

A qualified young doctor to work in Jhabua with a mobile unit to develop a health project serving 10,000 tribal families and to train 24 volunteers.

Interested persons can contact Mr Purushothaman M., Vikas Yojana (Trust), P.O. Bhabra (Via Dahod), Dist. Jhabua (M.P.), Pin. 457 332.

nutritionist

Wanted a female Nutritionist for an international voluntary organization in Bombay. Qualification M.Sc. Foods and Nutrition or Child development or Community extension. Knowledge of English and Gujarati essential. Apply Director G.P.O. Box 1650, Bombay - 400 001.

training

Paramedical workers training course in leprosy (Duration: likely to be 9 months course instead of 6--months) IXth batch.

4th June 1979 to 26th February 1980.

Physiotherapy technicians course in leprosy (9 months duration) IIIrd batch.

1st August 1979 to 30th April 1980.

Six weeks doctors course in leprosy (VIth batch)

15th October 1979 to 24th November 1979.

Non-medical supervisors course in leprosy (4-months duration) Vth batch

1st November 1979 to 26th February 1980.

Refresher course for Paramedical workers of The Leprosy Mission hospitals (3 weeks duration)

1st September 1979 to 22nd September 1979.

NB: For all the above courses sponsored candidates only will be taken. These courses are recognized by the Government of India and Andhra Pradesh State Government and recognized certificates will be issued.

For further details please contact:

Dr Alexander Thomas, MD.,
Philadelphia Leprosy Hospital,
Salur - 532 501.
Srikakulam Dt.
Andhra Pradesh.

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at the national iyc seminar

The deprived child is alive and ill. Pneumonia and diarrhoeal disorders take the highest toll of children said the discussion paper on nutrition. Yet what this national seminar failed to recognize is the "causal chain" which leads from the hungry child with diarrhoea to the legalized inequities of those in power.

Analyzing the similar predicament of the "wretched of the earth" of Latin America, David Werner wrote "Beyond doubt, anything we can do to minimize inequities perpetuated by the existing power structure will do far more to reduce the high infant mortality than all our conventional preventive measures put together".

The participants all agreed that radical reforms were needed, and mere palliatives would not do. But who will bell the cat? The government officials? Certainly not! "We have our procedures, you see...." The voluntary sector? "We are far too few in number, too isolated to have any impact...."

And meanwhile, the deprived child will continue her — more often than not, the deprived child is "she", not "he" — none too sure precarious battle with life unaided by any of the national seminars, regardless of any number of status papers issued by the state governments. Having decided to bypass this issue, the seminar went as expected. There was the usual disenchantment with the past, realization of the inadequacy of measures adopted at present, the inevitable contempt for cosmetic solutions, a clarion call for radical measures. It was the 109th day of the Internation Year of the Child. The voluntary sector received many positive strokes for its "good" work in child care.

Yet flickers of hope flashed here and there. Dr S. N. Chaudhury, Director, Child-in-Need Institute, presented a paper based on his own experiences in conducting programmes for child welfare — how not to run a child welfare programme. Unfortunately, this paper did not provoke as many thoughts as it should have. Nor did his poignant question—"Do we still want only to reach the deprived child, but not to touch him?"

While a number of states have rejected out of hand, the community health worker scheme, the seminar in its resolutions, unanimously recommended strengthening this scheme. With his usual aplomb, the Health Minister, Rabi Ray called primary health care the **Yuga Dharma** — "duty of our times". He said the central point of primary health care is the child, and hence the mother.

The Regional Director of Unicef, Glen Davies, speaking at the inaugural session, emphasized the need for Integrated Basic Services Approach.

Mr Barnala, the Union Agriculture and Irrigation Minister, showed a lot of interest. He has set aside Rs 1 lakh for the Food-for-Nutrition Programme. Ms Murlidharan, Coordinator, Children's Media Laboratory, Centre for Educational Training, Delhi, has opened anganwadis which she runs under trees, in village courtyards. What is important in this method is the careful institutional training that Balsevika receive before they are sent to the field.

The two-day national seminar, which was organized by the National Institute of Public Cooperation and Child Development, ended in Delhi on April 20, 1979.

this girl i asked for

The Community Health Department of Christian Medical College, Ludhiana, has worked out a methodology for identifying "high risk" children—the "Akkis" in the communities which they care for.

Dr Betty Cowan is the Joint Director of the Department. Her co-author is Dr Jasbir Dhanoa, also working in the same department.

A huge gathering, attended by the President of India, launched the International Year of the Child in India, and thousands of children went to Delhi. For many days the newspapers were full of pictures of children—happy children, who did not look "deprived". The miserable, marasmic and pothellied were conspicuous by their absence.

The special theme chosen by the country for the IYC is a very worthwhile one, "Reaching the Deprived Child". Plans for the year include books for children—but the deprived cannot read. Their mothers have no time to send them to school. Many films suitable for children will be made. Will the deprived ever see these films? Where are these deprived children? How can we find them? Will they attend any of the special programmes for children? Almost certainly not. More than half of the children we care for are not deprived.

Let me tell you about Mangi, a baby girl. The name means "I asked for you". Here is a baby who is much wanted and cared for. Girls are less popular than boys, but in Mangi's home there were already three boys and no girls. It is not a rich home, but there is enough for all. They have some land. Simple food is available. And the buffalo, who occupies part of the courtyard, supplies some milk to all. The home-visiting teams from the health centre tell her mother that the time has come to start giving six-month old Mangi some solid food. This, and other advice such as taking Mangi to the health centre every month for immunizations, is accepted by her mother. So Mangi grows into a healthy little girl, an ordinary village child. It would not be impossible to imagine Mangi amongst the balloon-waving masses of children who inaugurated the IYC.

And now hear about Akki. Akki means "fed up" and this describes the feelings of her mother when the fifth girl arrived in a house where all the previous children were girls. There is very little of anything to spare in Akki's home, very little food, and least of all, time. Nobody has any time to spend on Akki.

People of the socio-economically underprivileged group are fully occupied with the business of existing. They are poor. When he can get work, the father is paid by the day. The house is of mud. The mo-

It's love that weighs. "Mangi"...the much wanted 11 month old boy in the centre weighs 2 lb more than the two three-year old "Akkis" on either side of him.

ther has to go out to the fields to gather fodder for the buffalo —not their own buffalo, but the one which they feed while it is not giving milk—this brings in some money.

Everybody knows how time consuming it is to try and give food to a seven-month old baby. She spits it out. She turns her head away.

How can Akki's mother, with so much to do, not knowing how to modify the food she has so that Akki can eat it, how can she "waste" part of a day in trying to feed Akki, when the buffalo—who brings in money—and the father and other children will be coming in, hungry, looking for dinner? How can she do that when the very thought of Akki makes her "fed up"? And so she does nothing about her, except handing her over to a six year old sister.

The sister should be in school, but very few of her age go to school. The burden of caring for Akki makes her "fed up" too. When the baby cries, there is nothing to give except a piece of sugar cane which the children like to suck. It does not matter if she has to pick it up from the ground —it will keep Akki quiet.

Very soon Akki gets diarrhoea from the dirty sugar cane, and she is very sick. There is no time to take her to the doctor. The local quack gives her something.

A few days later, Akki is better, and her mother tries to give her something before going off to work. But her illness has made her so thin that she will not even try to eat the food. And thus Akki's programme continues — a downward spiral of lack of food, malnutrition, illness, further weight loss, until Akki is one of the 50 per cent of the little girls in this community who spend their second and third years in a miserable state of malnutrition, that is, if they do not die before the third birthday is reached. It is the "Akkis" who make up a big part of those who die in the second half of the first year. No balloon waving for her, nobody will ever know about her, there is nobody to take her to children's clinics or other programmes for the welfare of children. Often she is just a statistic on an infant mortality list.

How many "Akkis" will be reached during 1979 — and after that? Very few, until we change our methods of finding them. There is no point in looking for them in the happy crowds who "come"—Akkis have to stay at home. How many are there? Is this really a problem, or am I describing an insignificant fraction of India's child population?

In the rural community of our programme, there are 50,000 people with approximately 7,500 children under the age of five. Half are the "Mangis"—or the equivalent males, and even of the other half, not all have malnutrition. Let us assume that the underprivileged half has 750 children per year of life. Of these, the

Akki into Mangi. This girl, the third in the family with no boys was frankly not wanted. Her death would have been a blessing. The programme with its detection, nutrition and family planning advice, has turned her into a wanted child. Though still called Akki, this little girl is now well on the Road to Health.

375 who are less than six months, are just fine on breast feeding. The 750 who have passed their fourth birthday, have teeth to chew chapatis and can run about, feeding themselves. This leaves approximately 1600 children. Of these, one-third have severe malnutrition. This means that, in our rural programme, there may be 500 such children. And in India—5,00,000 such children. An insignificant problem? —surely not! The Executive Director of Unicef has said this year 15.5 million children under five will die and of these, 15 million will be in developing countries like India.

Akki—a figure on the infant morality list, Mangi—an eager, healthy, balloon waving youngster. Can we, who are in the health care job in India, or anywhere in the world, be complacent about our achievements in the health field while this huge number of Akkis wither away? Can we do anything?

Has the community health department done anything apart from identifying the Akkis? Have we done anything to prevent babies, whose arrival provoked from their mothers the response of being "fed up", becoming one of the 47 per cent of the little girls in the second and third years of life who are so miserably malnourished?

We believe that we have made a start, a start encouraging enough to make us continue a new approach. In our programme, more than 100 out of every 1000 babies who are born, die before they reach their first year. Half of them die in the first seven days of life. If they survive the first month, the Akkis and Mangis are equally fit for the first five to six months, breast feeding being enough for their needs. Thereafter, their paths diverge sharply. So, as it reaches five months of age, we put on special care every baby of the underprivileged homes. With the help of a village woman, a community health worker who visits the home every second day, we try to change the attitudes and customs of the mother for whom the baby may be a non-priority, so that it receives enough food for good nutrition. The community health worker sees that it gets its immunizations at the right time, and, if it becomes ill, is quickly brought to the health centre.

The first 185 babies, who have had a minimum of three months and maximum of 12 months care—we began this approach only at the end of 1977 — have been evaluated, and we find that something has happened. Before this approach, we found that no baby of this class was receiving enough food by the first birthday, and only 11 per cent were receiving something, but not enough. Previously only 26 per cent of the baby girls in the second year had normal nutrition and 17 per cent had very severe malnutrition. Now 49 per cent have normal nutrition and only 23 per cent have severe malnutrition.

Almost more important than individual babies feeding are the changes in the attitudes of these mothers. Of 60 mothers whose attitude was indeed "fed up", 43 have changed and care for their babies and give them enough food. This is our mission, to be agents of change for good, so that all babies, whether they are called Mangi or not, are wanted.

"throw away" babies

It is estimated that about a million babies out of the 21 million born every year become "throw away" babies, abandoned soon after birth due to various social and economic pressures. Social workers' estimates place the number of destitute, orphaned and abandoned children at between one and five per cent of the total child population. Only about 25,000 of such children are in the care of some kind of institution. In most orphanages, female children outnumber males, reflecting the greater value placed on sons in Indian society.

simple home remedies

Fungal infections of the skin

Take the leaves of Ficus carica (Hindi: anjir; Tamil cheemai agathi) and grind it. Apply the juice three times a day. Boil the clothes and dry them in the sun.

Roundworms

Crush two papaya seeds and mix it with a glass of milk. Give this to the child before he eats anything else in the morning. Do this for two days.

Pinworms

Grind neem leaves to a fine paste. Give the child a marble-sized ball of this paste first thing in the morning for seven days. Do not give this for the next seven days. During the third week, give this paste again before the child eats anything else.

If one child in the family has pinworms, probably the whole family has them. The whole family should take this treatment together.

Chicken pox blisters

Spread neem leaves on the bed of the sick child. These leaves are cooling and antiseptic. Boil the leaves in water, and bathe the sick child with this water. A daily bath is good.

the child's year and medical training

"The challenge of reaching the deprived child is as important as finding a cure for cancer" argue three heads of the Community Health Department at the Christian Medical College, Ludhiana. This article outlines the contributions that India's medical graduates and colleges could make during the IYC and after. The authors are Dr H Dhillon, Director; Dr Betty Cowan and Dr H N S Grewal, both Joint Directors of the Community Health Department.

Will India's medical gaduates be able to make a significant contribution to the International Year of the Child and to the child care in rural areas after 1979? The general theme chosen for the year by India is "reaching the deprived child". The Central Department of Social Welfare proposes to undertake the preparation of a review document on the status of the child in India. This document should reveal, not only the size of the "deprived" group in India, but the etiology of "deprivation", so that effective remedial and preventive measures may be found and implemented.

Speaking at the world's first International Conference on Primary Health at Alma-Ata, Russia in 1978, Dr Halfdan Mahler, Director of WHO, said that nations must give top priority to allocating health resources for the benefit of the most needy communities. Even if these resources are allocated for this purpose in India, how will the needy communities be reached, their needs identified and met? The needy will not come spontaneously to centres where programmes are organized for their benefit.

If we in India are serious in our desire to reach those in the "weaker" section, to identify their problems and raise their standard of health, we can no longer rely on schemes which succeed only partially because their implementation has been put into the hands of those who have not been trained for the task. The answer does not lie in extending the existing health services outward, but in beginning to build at the other end, in villages and slums, mobilizing people themselves to improve health standards.

graduates and vhws

Who will begin this building in the villages of India? The health planners or village level workers? The former, having expertise and an overview of the problem, can plan, but are inevitably remote from the areas where plans have to be implemented. The latter, with excellent acceptance by the people, lack this overview, and are unable to see any need to change situations which they have come to accept with a fatalistic attitude. Who then will bridge the gap between the planners and the people?

India's medical graduates are the obvious choice. A large proportion of today's medical graduates will find their way into the country's health service, but there appears to be some doubt in the minds of the health planners regarding the ability of these doctors to meet the health needs of the community. Moreover, there is a reluctance to commit themselves to community service on the part of these doctors themselves.

In the Republic Day issue of the Indian Express, reference was made to the fact that the post of pediatrician, created especially to intensify the ICDS scheme in Nupur Bedi, Punjab, has been vacant since its inception three years ago. It was stated that "in spite of this having been declared an A-grade project by the Social Welfare Department at the Centre, the medical officer posted invariably managed to 'wriggle' out of a tenure at Nupur Bedi".

Why should this happen? Do doctors feel that they have not been trained for this work and that they will quickly lose touch with academic medicine? Or are they afraid that their contribution will seem of less importance when compared with that of their colleagues in large hospitals or in research laboratories? Many problems which receive a large share of the country's budget for research have much less relevance to India's health needs today than the problem of reaching the deprived child.

"hakims are better"

Many graduates feel that, having been highly trained in scientific methodologies, they can be of best use in large hospitals or training centres. Their skills will be "wasted" in villages since the diagnosis of the community and plans for its treatment appear, of necessity, to be based on vague impressions, hard to accept by someone with professional training. Few are familiar with the concept of community diagnosis, still fewer are trained to make such a diagnosis. Moreover, they see their colleagues moving ahead with residency programmes, post-graduate degrees and research fellowships, with financial rewards as well as promotion, academic attainment, and for some, a reputation for expertise. It is hard for them to contemplate a life of struggle with a community they do not understand, for which understanding there appears to be no guidelines, a people who do not value their services, and whose problems they are unable to identify, and who in fact hold the local hakim in higher esteem.

Mobilization of a country's resources and rigorous training to a high degree of competence, is the only course open to any country when threatened by war. The toll taken by loss of child life in the socio-economically deprived section of the community and the cost to the country of the morbidity of this section of people, however, is as great as the cost of war. Drawing special attention to the urgent health needs of the world's children, Mr Labouisse, Director Unicef, said that 15.5 million infants and children under five will die this year for lack of health care, and 15 million will be in developing countries. "Governments would have to drastically reorder their priorities" if nation-wide health care is to become a reality. This change would have to begin at the top level of government and national leadership. We suggest that this change of attitude could result in the mobilization of India's doctors for community health service, not as reluctant "conscripts" but as eager "volunteers".

community medicine: a prestige speciality

Can we, the medical college teachers, show them that the challenge of reaching the deprived child is as important as finding a cure for cancer? Can we change our teaching methods so that graduates become convinced that we mean it, and that this new approach is not just another gimmick of getting them into a primary health centre? Is it possible for us to convince young doctors that we, the medical teachers, mean to make community medicine one of the "prestige" specialities in India? All our assurances will lack conviction unless we emphasize that a new type of training is mandatory for this speciality.

No time could be more opportune than the present to make this change. Medical colleges are each taking up for care three blocks of the District in which they are situated. Those of us who have been engaged in academic medicine within the walls of a hospital know that, without some training and guidance, the only care we could provide as faculty, will be by means of clinics in rural areas, teaching undergraduates in a village, exactly the same kind of facts that we would have taught in a hospital ward. Some departments might take responsibility for an academic term and might even live for part of that term in the rural area. Those patients who attend the professor's clinic might well be impressed with the seniority of their doctor, but the government health service doctor will be made more aware than ever, of the gulf which separates the academic from the community-based doctor. The latter has to fulfil to his communities and to his superiors certain responsibilities of which college teachers know little.

There is no medical college department in the world today, which would undertake a new speciality, for example renal transplantation, without years of preparatory training for the staff, and gaining experience from earlier workers in the field before setting up such a unit. Has it ever been suggested that faculty members of medical colleges might need training before taking on responsibility for community health? India's health needs are great. Most are in rural areas. Few medical college staff know anything about the problems in these areas. This is the time for the college staff to ask "what are the health needs of the country? What does government expect from colleges? Who will teach us how to know a community and make community diagnosis mandatory if we are to make effective treatment policies?" The reluctance of some medical colleges to commit themselves to block involvement stems from the fact that few experts in their own field know what to do in a village. The leaders in the field of medical education must recognize the need for such training, find centres where it can be given, teachers who can give it, and formulate guidelines for functioning of college departments in a block. Community medicine, practised in three blocks by each medical college, should become a recognized discipline of the college, with a training programme which must have the approval and recognition by the Medical Council of India. Graduates will then have the opportunity to apply for posts in residency programmes leading to post-graduate degrees in this discipline. When this happens, there will be at least some "volunteers". "Conscripts" will not become "volunteers", however, until they see that their teachers are behind them, and that, instead of be-

coming "drop-outs" in a rural setting, they will be accorded as much, if not more, in terms of respect and financial gain as the hospital-based specialist.

conscripts into volunteers

There can be no question of "two streams" of doctors in the blocks which are attached to colleges: medical officers with obligations to the government health service—the "second class physicians"—and the medical college staff, who are happy to leave the administrative problems to the former. This scheme will not work until the government and college staff function as a team.

India has inaugurated the IYC with many laudable aims. Bold and drastic reorganizing of priorities is needed so that the Indian doctors are channelled into the immense task, not only for identifying and rehabilitating those deprived of health, including children, but preventing deprivation by medical and social change.

COMMUNITY HEALTH CELL
326, V Main, I Block
Koramangala
Bangalore-560034
India

housewives promote health care

Housewives in Honduras have invented their own version of "Health by the People". Housewives clubs have for the last six years sponsored female health promoters **(promotoras de salud).** The community-based promotoras do not work set hours; they are on call day and night.

The origin, organization, philosophy and effectiveness of the programme are closely related to the network of housewives clubs, which are the community vehicle for the programme. If a community wants to have a promotora, it must first form a viable club of 10 to 20 women.

A woman, selected by the club and the team, is then trained to work from her home, seeing an average of four patients daily, and visiting a weekly average of four patients in their own homes. Her work is entirely voluntary. The patients pay only the cost price for medicines or a small fee for simple treatments. Injections are only given in conjunction with a medical prescription.

Initially, the club raises an equivalent of approximately Rs 150 via dances or donations, to purchase the wooden medicine cupboard or "botiquin" kept by the **promotora** and stocked with basic drugs and equipment. These are got at wholesale price from programme headquarters. Money resulting from drug sales in the community is kept by the club treasurer until the monthly meeting, where the promotora can replenish supplies. The club is also supposed to assist the promotora with her fare to meetings, and with a food donation. But if the clubs are a strength of the programme, they can also become a weakness. If the club ceases, so does the work of the **promotora.** Of the 60 **promotoras** trained since 1972, 25 per cent left because of club closures and similar problems.

Two thirds of them were between 20 and 40 years of age, and none had more than a sixth grade primary education. Seven communities contained between 40 and 100 houses and three had between 500 and 600 houses.

The community can buy from the promotora 30 vitamin capsules for one and a half rupee as opposed to paying in the commercial pharmacies, for a comparable item, over Rs 30. Antispasmodics can be purchased here at 15 paise a dose, instead of a commercially prepared bottle for Rs 9.30.

The term "health programme" is not sufficiently broad to cover all the activities involved in the reality of the promotra programme, for it is not just a group of rural women selling basic medicines and administering first aid from their own homes. The small general store in nearly every small community could achieve the first function just as well, if not better, and traditional crude home remedies were often largely effective without any extra health training. The objectives of the programme relate not only to the more traditional health goals, but also to concepts like "conscientizing the people concerning the importance of their health in the process of liberation".

any woman can...

Do you know that grandmothers can breast feed infants after a long interval of over ten years since their last pregnancy? Reports from over the world give various instances when such grandmothers, and even women who have not given birth, have successfully breast fed babies when it was necessary. The physiological process by which milk production in a woman, which for some reason has not started, or has lessened or completely stopped, is started again is known as relactation.

Successful breastfeeding needs three prerequisites: (1) a healthy woman who is interested in nursing her infant; (2) a healthy baby; and (3) a support system of some sort. This third prerequisite may include anyone—the father, the grandmother, the midwife, a relative, neighbours, the doctor, or a combination of any of these. This is particularly necessary in the case of a first-born child, as the mother may have some difficulty in breast feeding at the beginning.

To increase or start milk production in women who have not given birth, requires the same three components, the third being of especial importance. The mother has to continue putting her baby to breast, so as to induce milk production. The support of a third person or system has a very beneficial effect on her, and helps her psychologically accept the idea of relactation.

The commonest method of relactation is sufficient suckling by the infant. In many societies, when a mother dies during childbirth, the surviving infant is immediately given to another woman to feed and rear. If the woman is not producing milk, the infant is put to breast many times a day, and a variety of herbal medicines are also given. These may have a combined physiological and psychological effect and help induce lactation.

Although the amount of milk production first may not be adequate, the baby, given additional supplementary feeding, will suckle strongly enough to produce a normal flow of milk within a short period of time. This takes only a few days if the mother had stopped producing milk. In case of women who have not given birth, it may take a little longer. Adequate nutrition for the mother is also equally important.

The Indian government used this method of relactation successfully during the 1971 war, when Bengal was flooded with refugees from Bangladesh, and many intestinal diseases like gastroentritis and diarrhoea were rampant among the infants. During the final months of the Vietnam war, there were an estimated 1,00,000 orphaned children in South Vietnam. A plan to hire women as wetnurses for such infants was presented. The wetnurse would receive, in addition to minimal wages, three meals daily, would stay in the orphanage to assist with the care of infants, and once her milk supply was re-established, would provide milk for two infants. There were many women interested in the programme.

A variety of pharmacological agents are also known to induce relactation—estrogen, progesterone, oxytocin, thorazine, metoclopramide. But these may produce side effects, or may have to be used regularly. Relactation through sufficient suckling is the cheapest and safest method.

do you know

The Adoption of Children Bill was introduced in Parliament in 1972, but has yet to be enacted. Its aim is to provide an enabling law for all Indians seeking to adopt the many abandoned, destitute, neglected and orphaned children in the country.

Under the Factories Act (Section 48), every factory ordinarily employing 50 or more women workers has been obliged to provide and maintain creches for children under six years old. But this stipulation of the Act is openly violated. With the enforcement of the Factories (Amendment) Act of 1976, the obligation has been extended to every factory employing a minimum of 30 women workers.

Strict enforcement of these laws is an urgent need.

Do the staff of some of our hospitals need a creche?

book news

Problems of the Aged—by Col Barkat Narain 98 pp. Rs 10 (paper), Rs 30 (cloth)

The first part of the handbook deals mainly with the physical, biological, physiological and sociological aspects of ageing. Col. Narain suggests ideal standards of nutrition, housing and leisure activities for the aged, mainly in an urban situation. He exhorts the governments and business houses to utilize the experience of people who are retired from active service and are yet in excellent physical and mental health.

The complaints of elderly persons reflect illness, not old age, and in the second half of the book, Col. Narain details these health problems, though he does not specify any remedial action. His major thrust is toward spurring the government on to plan health care facilities for the aged like involving their care as a special subject in primary health work, training community health workers in prevention and curative services for them, and making mass media programmes for them so as to keep them alive to the challenge of living.

See How They Grow—Monitoring Growth for Appropriate Health Care in Developing Countries by David Morley and Margaret Woodland, 241 pp.

Now David Morley and Margaret Woodland in their forthcoming book bring together experiences gained over the years in the use of weighing and weight charting for promotion of child health and caring for children.

The discussion on the importance of the growth curve in the child with diarrhoea highlights a simple technique for rehydration—the use of the salt and water solution. This can be taught to illiterate members of the community for use by them in the early stages of diarrhoea. Many lives have been saved by this therapeutic measure.

According to Dr O. Ransome-Kuti, Professor of Pediatrics and Hon. Professor of Child Health, University of Lagos, Nigeria, the stage is now set for evolving health technologies for rural areas in developing countries. It is the duty of health workers to discover innovative health technologies appropriate for their own setting either through their efforts or by adopting those that are traditionally practised in the community, for example, the practice of cutting the umbilical cord of the newborn with a red-hot knife, in Northern Nigeria's rural areas which virtually eliminates neonatal tetanus. Information thus gathered should be disseminated widely.

The effectiveness of these health technologies will be limited unless a system of health care is designed and instituted which will ensure complete coverage of the community, bearing in mind the available resources. Moreover, the health manpower must be appropriately trained to operate the system. In the introduction to this book, the authors have made a strong case for such a system of health care delivery and the method of training suitable to it. It should be read and studied carefully by decision makers and all levels of health workers involved in the planning and implementation of health services.

More details of these books and the "Road to Health Charts" in all Indian languages and English are available from the Voluntary Health Association of India, C-14 Community Centre, S.D.A., New Delhi-110 016, Price for 250 cards: Rs 55.00. Plastic envelopes for cards: Rs. 50.00 for 250 cards.

The cornerstone of the screening procedure is the commonly used Morley **weight chart.** Voluntary Heath Association of India has made available to many health projects in India cards for each child under five. This enables the VHW to identify those children requiring extra attention. As a result of such selectivity projects have been able to reduce the number of those receiving supplementary rations to as low as 23 per cent of the under five population.

In addition, the weight chart provides an excellent longitudinal record of a child's development (nutritional status as well as morbidity), serves as an educational tool demonstrating to the mother improvement or decline in the child's growth, gives the immunization history, and lists the family members which can serve as a family planning reminder to the VHW. Some projects also utilize a card for the mother which includes a history of previous pregnancies, menstural cycles, weight during pregnancy and important ante-and post-natal observations.

Please note the correct prices of the following ICMR publications listed in our Catalogue of Education material:

Ch 16	Studies on Preschool Children	Rs 3.50
Ch 17	Studies on Weaning and Supplementary Foods	Rs 3.50
E 1	Rural Water Supply in India—review of work done	Rs 3.50
E 2	Diagnosis and Treatment of Pesticide Poisoning	Rs 3.50
E 14	Manual of Standards of Quality For Drinking Water Supplies	Rs 3.50
P 33	Techniques in Blood Group Serology	Rs 3.50

news from the states

andhra pradesh

☐ AP VHA sponsored another Community Health Workshop at Dichapalli from March 12 to 16. Twenty-five participants entered enthusiastically into the learning experiences at the Community Health Project Centre at Victoria Hospital where a good VHW training programme is in operation. Ms Simone Liegeois of VHAI was consulted, assisted by Drs Bas and Joke Mesquita, Mr Rayanna and Ms Nirmala. Ms Zina Kidd was also at hand to help.

☐ The Canadian Baptist Church has started a VHW training programme in Avanigadda area of Krishna District in Andhra. Twenty women are under training. The courses and return meetings are held in a large thatched hall, where the VHWs live. A public health nurse and a fully qualified midwife are faculty. A lot of teaching is done through attractive health songs. Incidentally, while Ms Sadie Cann, the Director of the Mission, has been organizing this, her husband, Rev Roger Cann has been building nine village cyclone shelters and several primary schools.

☐ Divi Seema, Social Service Society continues to give the cyclone affected people of the region new life and hope. The pace of development has been maintained.

Of the two clinics which render medical service in the adopted villages, the one at Mandapakala has completed a full year of admirable service. 83,478 patients have been treated here. The Kammanamolu clinic has served 9500 patients from January to November 1978. The staff of both clinics visit Lingareddipalem, Chintakola and Nalli every week as extension work.

The Society has also started training VHWS at Pathareddipalem. Now each of the seven health workers trained at the first session has a medical kit with medicines and simple equipment to detect and treat common diseases. At present they are working without pay and assist the medical team in immunization, antenatal checkups, midwifery, and MCH programmes.

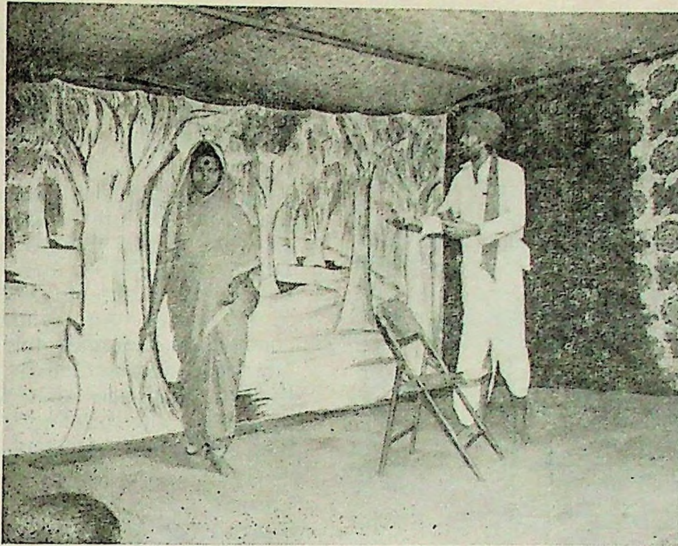
The Society is also involved in other aspects of development including agriculture, adult education, women's welfare and self-employment. Every scheme undertaken is carried out in consultation and cooperation with the village council established in every village by the field officers, There are regular meetings between this council and the DSSSS staff when works undertaken are evaluated, needs expressed and points explained.

madhya pradesh

☐ The Seventh Annual Meeting of the MP VHA was held from February 2 to 3 at Dhamtari Christian Hospital, Dhamtari, in Raipur District. The 66 delegates included hospital managers, medical directors, nursing superintendents, community health nurses, lawyers, farmers and community organizers. The topic of the meeting was "Health, Development and Social Justice".

The two day meeting included many lively sessions on Social Justice in Hospitals, Labour Unions and Hospitals, Participative Management, Development and Justice in Community Health and Action-Oriented Development. Through group and panel discussions, films, sharts and simulation games, the participants faced up to the complexities and challenges in interrelationships between health, development and social justice.

The MP VHA has elected Dr Mahashadbe, Indore, as President, Dr V. K. Ali, Shadol, as Vice-President and Ms P. Brown, Jobat, as Secretary. The participants also thanked Dr E. E. Moss, Padhar and Dr D. W. Mategaonkar of Chatarpur for their service to the Association. Dr Moss will be retiring and leaving India next year.



maharashtra

☐ The six-week Community Health and Development Course held in Jamkhed has ended very successfully. Four of the 26 participants have been chosen for the year-long Residency in Community Health. Plans include extending this course for the whole of South East Asia.

The participants saw the change in the health status in the villages around Jamkhed, and shared with the village health workers their experiences. George Ninan, who was faculty for management principles, says "the transformation of these illiterate women, many of them Harijans and Muslims, from silent sufferers to community leaders is fantastic". One of these is now a Panchayat leader.

The first four weeks of the course were on Principles of Community Organization, selection of VHWs, their training. The last two were on Management Principles and Transactional Analysis, which was taken by Dr Carol Huss of VHAI. Others in the faculty were Drs Arole, Ruth Harner and Simone Liegeois of VHAI, Dr Ron Seaton and Edith Seaton.

☐ The Executive Committee of MVHA met on February 18, 1979, at Ruby Hall Clinic. The VHA plans to bring out a comprehensive directory of government, charitable and private hospitals, and community health projects in the state. Details of training facilities, health care facilities, mobile units, blood bank and other facilities would also be covered in the directory.

The MVHA has also decided to act as a forum to voice the grievances of member institutions to the government. The grievances of one hospital have been taken up with the labour minister of the state. Individual members can use the reference of MVHA to get their rights with the dealers and companies enforced.

Thirty-five new members have been enrolled in the MVHA.

☐ MVHA Workshop on Community Orientation and Development for Health Centres was held in Jamkhed from February 19 to 24, 1979.

With the help of games and exercises, the participants attempted to understand the trends in delivery of health care in India, and the reasons for change; to know the factors which are important in community involvement gaining through participation and sharing of resources; to select the priorities in the many health and development needs recognized by the health professionals and the people; and to teach adults, both the public and the health workers the principles of good health and prevention of illness. Dr Mabelle Arole explained the philosophy of community development with special reference to the project at Jamkhed.

Faculty were Drs Arole,

Ruth Harner, Ron Seaton and Edith Seaton.

bihar

☐ The Kurji Holy Family Hospital has entered into the Year of the Child with a souvenir and two plays for raising funds. Free clinics were conducted at six centres from March 5 to 15, and the total attendance was 1,768 children. Follow up clinics at the same centres have been planned after one month, for three consecutive months.

These clinics will provide immunization, and medical attention will be given where necessary at the Public Health Department of the hospital at concessional rates. The hospital also plans to conduct similar camps in slum areas and villages in the latter half of the year.

The hospital will also be providing free health checkups by specialists in pediatrics, eye, ENT, and dentistry in selected poor schools during the year. The Public Health Department of the hospital will provide follow-up care.

☐ Damien Social Welfare Centre, Dhanbad, celebrated the anti-leprosy week from January 30 to February 5, 1979. Announcements, and communication of slogans such as "Leprosy is curable", "Early treatment prevents deformity", and pamphlets describing the early signs and symptoms of leprosy drove the messages home. Group talks and discusions with small groups at various centres in town helped increase awareness about the facts of leprosy and dispelled some of the myths that surround this disease.

Dr Margaret Owen's Leprosy Education Programme-cum-Exhibition also generated a lot of interest. Such programmes have been responsible for the government's taking notice of the positive work done in this field by the voluntary sector.

goa

☐ The Goa VHA organized a two-day seminar on Hospital Administration, which was attended by twenty participants. Dr Carol and George Ninan were the resource persons. The VHA is also planning a small seminar on Community Health.

tamil nadu

☐ Sr Muriel very successfully organized the General Body Meeting of the TN VHA on February 14, 1979. The office bearers now are: Dr K. V. Rao President), Dr Charlotte Manoharan (Secretary), and Dr Mohan Mallya (Treasurer).

As a part of the meeting, there was a lively discussion on Mini Health Centres with Dr S. A. Kabir. Later the Minister for Health also attended the session. An evaluation committee is formed for the VHA Mini Health Centres, and the few resolutions that were passed in this meeting, are sent to the government for ratification.

☐ Dr Prem John and Hari John hosted the seminar on Rural Nutrition, to inaugurate the Year of the Child. The work and sessions led by Drs John was particularly useful. Dr John is planning to start a Consultancy Account for the benefit of the TNVHA with what he gets as remuneration for the personal help he gives to any institution or project.

karnataka

☐ The state VHA General Body met on February 12 and re-elected Dr Benjamin Isaac, Dr Silgardo and Dr Marie Mascarenhas as President, Treasurer and Secretary. They have formed three sub-committees to deal with seminars, compilation of a directory, and community health and nutrition education kit. The state VHA has also acquired a plot of land in Bangalore, for putting up an office.

kerala

☐ Mr. W. A. Stein of Medical Services, Overseas of Christoffel Blinden Mission (CBM) opened the Outpatient Department of CBM Eye block of the Little Flower Hospital, Angamally on February 6, 1979. His Execellency, Rt. Rev. Dr Sebastian Mankuzhikary, Auxiliary Bishop of Ernakulam,

delhi

☐ Most Rev. Dr Angelo Fernandes, Archbishop of Delhi, inaugurated the formal opening of Ozanam Clinic, a free medical service for the poor, on Friday, January 26, at St. Michael's Church, Pusa Road, Delhi.

☐ Public Enterprises Centre for Continuing Education, Faculty of Management Studies, University of Delhi, and Sri Ram Centre for Industrial Relations and Human Resources, Delhi, conducted a national seminar on Developing Effective Organizations from February 21 to 23, 1979.

The objectives were to review and learn from the experience of innovative Indian organizations, examine the relevance and feasibility of planned change for coping with and adapting to some key problems faced as environmental sensitivity, dysfunctional conflict, authoritarianism, and lack of dedication.

Sr Carol Huss of VHAI was among the group facilitators.

After discussions and case studies, the group arrived at the conclusion that OD efforts in hospitals are more successful than in industries because the people are motivated, interested, and the exchange of external and internal OD agents of change is better.

cost of health care

Restoration of a balance between hospitals and primary health care was the keynote of the B. L. Kapur Memorial Oration this year. Delivering the oration, Dr Daniel Isaac, Secretary of Christian Medical Association of India, told the members of Indian Hospital Association on February 7, in New Delhi that hospitals should become truly a component in the spectrum of comprehensive health care.

According to him, even with the extension service, the hospital today stands alone "segregated as a centre of excellence for episodic care" providing "upto five per cent of the health needs of the people and in the wake of it, expending more than half the resources earmarked for health care provision".

Drawing from the experiments conducted in 280 health care institutions, out of the 400 affiltated to CMAI, Dr Isaac pleaded for the integration of promotive and preventive services with curative services. A process of rationalization is required and the justification for the current organizational pattern of hospitals and its operating style is to be determined.

Healing profession, according to him, has mystified health and disease beyond the general understanding of people. "If people are to be benefitted, by health care facilities, a process of demystification and simplification of health and disease" has to be set in. The hospital should shed its "though fascinating, but often confusing" image, and its cumbersome procedures.

Health care, he pointed out, has sadly degenerated into a "commodity for the consumer to obtain at a price fixed by the provider or subsidized heavily through tax money".

The challenge before us, he continued, is to redefine the role and functions of the hospital in the context of the community.

"Can we rearrange our thinking, where we are primarily concerned about the community and its health and the hospital is a means to support this concern and meet the requirements of the people in the community?"

situations vacant

1. Apaji Arogya Mandir, Mantri, Banasthali Vidyapith, Rajasthan-304 022 requires:

(a) Medical Superintendent: to look after a 50-bed health centre and Rural health project. Remuneration according to qualifications and experience. Age no bar.

(b) Physician (one) and lady doctor (one): M.D., M.S., M.B.B.S. with 2 years housemanship. Pay scale: 750 - 30-1020-40-1300-50 - 1350. Initial start Rs 870 for M.D./M.S. Higher start or grade can be considered for specially suitable candidates.

(c) Staff Nurse (Male or Female): to take independent charge of Operation Theatre. Remuneration according to qualification and experience.

(d) ANMs (four): Grade 355-570.

D.A. and N.P.A. as per rules. P.F., Insurance and gratuity benefits on confirmation. Wearing of Khadi is compulsory on appointment. Apply on plain paper giving details of age, within 20 days to the above address.

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2. BAM India, Garden Reach Community Health Programme, Calcutta, is looking for a laboratory technician. He should be able to carry out sputum (AFB), blood (ESR/TC/DC/Sugar), urine (sugar/protein), stool test, smear examination tests. He will collect samples and draw blood from patients, assist in training community health workers in certain tests, maintain proper records and stock of laboratory material and reagents. He should be at least a matriculate, and trained as laboratory technician or with sufficient experience to carry out the above mentioned duties. Good command over English is ne-

(Contd. on page 16)

opportunities

1. Christian Community Health Centre, Ambilikai-624 612, Madurai District, Tamil Nadu will conduct the following training:

(a) Training Courses for Multipurpose Health Workers Community Health Guides. The course will start on 15 July 1979, and will be of 18 months duration, with 6 months of field experience. Candidates should have passed S.S.L.C. at least. Those with higher qualification will be preferred. Only sponsored candidates are acceptable.

(b) Auxiliary Nurse Midwife's Course: Starts on 1st August 1979, and lasts 2 years. Minimum qualifications: S.S.L.C. (or equivalent) with more than 60% of total marks. Age: Should not have completed 17 years of age.

For prospectus and application forms write to the Director, with a M.O. of Rs. 3.00.

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2. AFPRO will be conducting its Course No. 6 on Dairy Management in collaboration with Agricultural University, Mannuthy, Trichur, from June 1 to 30, 1979. The venue will be College of Veterinary Sciences, Kerala Agricultural University, and medium of instruction Malayalam. The course will cover all factors affecting efficient milk production, and will consist of lecture-cum-demonstrations, farm work, field trips and film study.

The course is open to project staff interested in learning scientific dairy farming, project technicians, farm managers, extension workers.

The participants should have a minimum educational qualification of Matriculation, and should be able to understand and communicate in Malayalam.

Fee: Rs 150.00 per participant includes tution, board, and lodging. Participants are requested to meet their own travel expenses.

Application forms are available with the Livestock Department, AFPRO, Community Centre, S.D.A., New Delhi-110 016. The last date for receiving applications is 15 May, 1979.

situations vacant

(Continued from page 15)

cessary and also knowledge of either Bengali/Hindi. Salary negotiable. Those interested may write with details to the Executive Director, Garden Reach Community Health Programme, J 221/A Paharpur Road, Calcutta-700 024.

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3. Nur Manzil Psychiatric Centre, Lal Bagh, Lucknow-226 001, U.P., requires one Psychiatrist and one Junior Doctor. For application forms write to the Director.

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4. Community Health Project, Victoria Hospital, Dichapalli-503 175, A.P., requires for its rural medical work and socio-economic development:

(a) Programme Director: a senior administrative person with special responsibilities for developmental services, contact with government personnel, reports, accounts, training and evaluation. Relevant experience in health and developmental services essential. Postgraduate degree, medical or other, preferred. Scale: 1025-25-1275-35-1555-55-1905, field allowance 75, rentfree quarters, provident fund facilities.

(b) Medical Supervisor in charge of medical services and consultations with special reference to maternity, child health, and family welfare, and special disease programme for TB, leprosy and malaria. Training and evaluation. Qualifications: MBBS. Scale: 775-25-1025-1305-50-1655, field allowance 75, rentfree quarters, provident fund facilities. Knowledge of Telugu essential.

(c) Accounts Assistant: Qualifications: B Com. or relevant experience. Scale: 240-10-320-15-500, starting salary negotiable. House rent allowance 15 per cent provident fund facilities.

(d) ANM: to work rotating assignment in outpatient, inpatient, village clinics and health education programme. Scale: 180-30-240-16-400-20-440. Minimum salary 200. Field allowance 75, provident fund facilities, rent free quarters.

Apply within 15 days with biodata to the Programme Director, Victoria Hospital, Dichapalli-503 175, Andhra Pradesh.

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