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HEALTH FOR ALL BY THE YEAR 2000

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I am a regular reader of **Swasth Hind** and I have been reading it for the last 10 years. This journal is very useful not only for the medical men but also for any lay man. Every issue gives new information regarding health.

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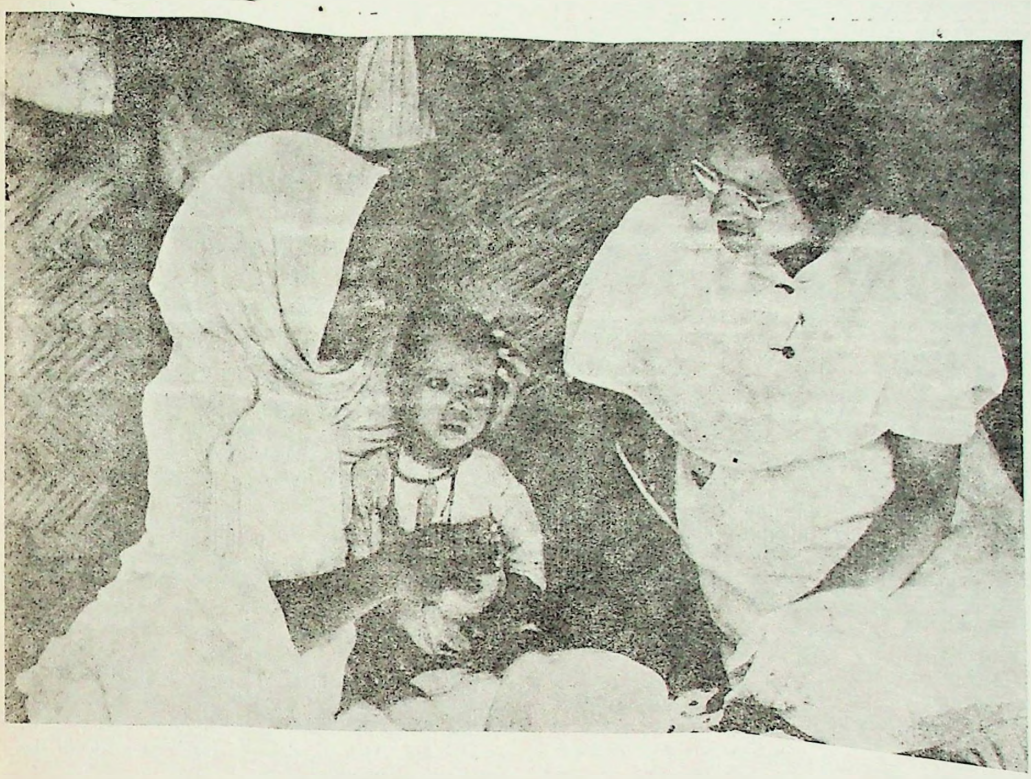


HEALTH FOR ALL

—The Count-down has Begun

Now is the time to evaluate the progress achieved in respect of various health programmes with regard to the overall development, updating and implementation of the strategy for achieving the social goal of health for all by the year 2000. It is in this context that the World Health Organization (WHO) had chosen the theme for the World Health Day-7 April, 1983 as "HEALTH FOR ALL : THE COUNT-DOWN HAS BEGUN".

May 1983

THE country witnesses significant progress in health and family welfare work since independence. In the recent years the emphasis has been on 'primary health care' denoting a positive and promotive health status, with protection to people against risk of diseases or illnesses that can be prevented. The family welfare programme is aimed at reducing birth, death and infant mortality rates and improving the health status of the nation, especially of women and children.

New 20-Point Programme

The key element of the goal 'Health for All' is the provision of primary health care (PHC) to all people, especially to those sections of the community who continue to be trapped in poverty and ill-health. The new 20-point programme announced by the Prime Minister Smt. Indira Gandhi on 14 January, 1982, pinpoints areas of special thrust which would show immediate tangible results for the various segments of the population. It includes health and family welfare programmes concerned directly with the health of the people and the universal augmentation of primary health care facilities. These health and family welfare programmes are:

- Substantially augmenting universal primary health care facilities.
- Supply of safe drinking water to all problem villages.
- Improving the environment, especially of slums.
- Promote family planning on a voluntary basis as a people's movement.
- Control of leprosy.
- Control of T.B.
- Control of Blindness.
- Accelerating programmes of welfare for women and children and nutrition programmes for pregnant women, nursing mothers and children, especially in tribal, hill and backward areas.

Primary health care

Indian health infrastructure aims to provide primary health care to all people who are as yet unserved or underserved. To achieve this, the government is not only revamping the organizational set-up for rural health care by strengthening primary health centres, but is also intensifying training activities for a variety of primary health care workers in keeping with their specific needs. The emphasis is now on the active involvement of the community in the ongoing health programmes, especially at the grass root level through Health Guides. The Health Guide Scheme has been converted into a 100 per cent centrally sponsored scheme in order to make the health guides more oriented towards family welfare.

An integrated approach to the health problem through preventive, promotive, curative and rehabilitative measures along with effective linkages, with other programmes like safe drinking water supply, improvement in sanitation, nutrition education has been adopted under the Sixth Plan. The rural health infrastructure is being strengthened and remodelled. For every 1000 people in villages there will be a trained Health Guide who will provide health education to the people, including family planning, treat minor ailments, and refer cases requiring attention of a doctor to the nearest primary health centre. There will be a sub-centre for every 5000 population (3000 in hilly and difficult areas). A primary health centre will serve roughly a population of about 30,000 (20,000 in hilly and difficult areas). A referral service will be built up right from the village level to take care of patients requiring specialist attention at the Community Health Centre or District/Medical College Hospital nearby.

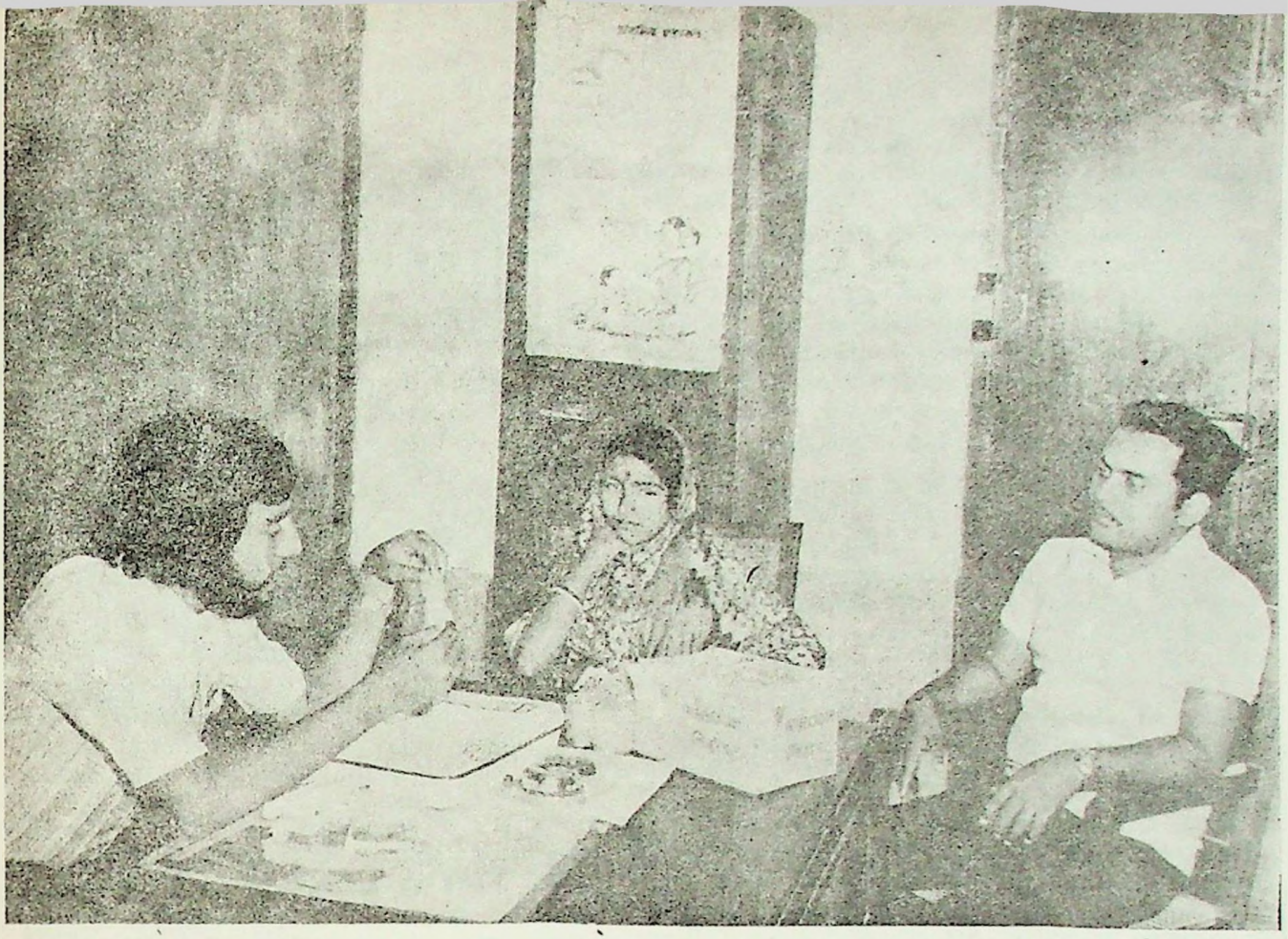
By 1979-80, the country had 1.4 lakh health guides and 50,000 sub-centres, 5,400 primary health centres and 340 rural hospitals (community health centres). The programme in the Sixth Plan is to add another four lakh health guides, 174 rural hospitals (CHCs), 40,000 sub-centres and 1600 PHCs/Subsidiary Health Centres. These form part of the Minimum Needs Programme for which provisions have been made in the Central/State Plans.

Supply of safe drinking water

Lack of safe drinking water continues to be a major cause of water-borne diseases like cholera, typhoid dysentry and diarrhoea and is responsible for high incidence of guinea worm. Almost 80 per cent of all diseases in the developing world are linked to unsafe water. Also linked to this is the problem of sanitation which needs to receive more attention.

It is proposed to ensure safe drinking water to villages suffering from chronic scarcity or those with unsafe sources of water. Based on the nationwide survey during 1971-72, a total of 1.52 lakh villages in the country were identified, as being without safe and assured sources of drinking water.

Between 1972-73 and March 1980 as a result of the larger investments made in the rural water supply sector, about 95,000 problem villages have been provided with safe drinking water. The latest data re-



Family Planning : *Service facilities and supply of contraceptives are being expanded in both rural and urban areas.*

ceived from the State Governments show that as on 1st April, 1980, there are 2.31 lakh villages in the country which need to be provided safe water supply facilities on a priority basis.

During the Sixth Plan the effort is to cover all the identified problem villages with at least one source of safe potable water available throughout the year.

Improving the slums

Environmental sanitation is another important problem of our country, which has a direct bearing on the health status of our people. Diseases like diarrhoea, dysentery, cholera, and diseases of the chest and worm-infestation can be controlled if the environmental sanitation is improved along with the supply of safe drinking water.

A scheme of environmental improvement of slums was launched in 1972 under the central programme of Special Welfare Schemes. From the commencement of the Fifth Five Year Plan, the scheme became part of the Minimum Needs Programme and was transferred to the State Sector.

It is visualized that the total slum population by 1990 would be around 37.87 million. Of this, a population of 6.8 million has been covered under the scheme up to March 1980 and efforts will have to be made to cover the balance of slum population, estimated at 31.07 million by 1990.

The facilities that would be provided are water supply, storm water drainage, paving of streets, street lighting and provision of community latrines. Areas inhabited by Scheduled Castes are to be given due priority. So also the residential areas of scavengers.

Family Planning

Family planning is essentially a people's movement. The people now realise the benefits of a small family. The Government's role is to educate them in the methods of contraception so that they are motivated to accept, on their own, any one of them. Trained Government personnel have been deployed in all rural and urban medical institutions in the country for educating and motivating the people. Service facilities and supply of contraceptives are being expanded in both rural and urban areas to enable the people to adopt any method of their choice including sterilization, IUD, conventional contraceptives and oral pills.

It is necessary that a voluntary effort is intensified at every level, *i.e.*, from the village upwards to the national level. The energies of all social, political, religious and cultural organizations and organizations of youth, women employees, etc., have to be channelled and utilized in the process of educating the people and making them adopt the small family norm.

Control of leprosy

A programme for control of leprosy is being implemented as a centrally sponsored scheme founded by the Centre on 100 per cent basis. The objective of the programme is to detect at least 90 per cent of the cases and arrest the disease in at least 40 per cent cases. It has since been decided to draw up and implement an intensive programme for the eradication of this disease before the end of this century.

The campaign for the eradication of the disease will have to be launched with vigour and continued till the objective is achieved. In this, the entire nation is to play its role to tackle the problem. People's participation can come in many ways for case detection, case holding and rehabilitation of the leprosy patients.

Control of tuberculosis

Tuberculosis continues to be one of the most serious public health problems in our country, but it is no longer the frightening disease it used to be not long ago. Effective tools to treat and prevent this disease are now available, new methods of control have been developed and anti-bacterial drugs are found to be effective in curing even advanced cases. Still we have nearly 10 million people suffering from this disease, of whom about one fourth are active cases requiring intensive treatment. Furthermore, about two-and-a-half million fresh cases arise every year and about half a million die of this disease annually.

To tackle the problem of tuberculosis, 353 fully equipped and staffed district TB centres have already been set up covering more than 95 per cent of the rural population.

It is a pity that a large number of our people suffer and die of TB when they can be saved if proper precautions are taken and infection avoided. Health education can play a vital role in the prevention of the disease. Making the people aware of the problems of the disease, its spread, treatment and prevention will go a long way in improving the health status of our people.

Control of blindness

The National Programme for Control of Blindness has also been converted to a 100 per cent centrally sponsored scheme.

Under the current programme of control of preventable blindness on account of disease, nutritional deficiency and cataract, the target in the Sixth Plan is to bring down the incidence of blindness from 1.40 per cent in the base year to one per cent by the end of 1984-85. There is a back-log of 60 lakh cases of cataract and ten lakh cases are added each year. The present capacity for dealing with cataract cases has to be augmented. The thrust of the blindness control programme is on development of preventive care at the periphery to prevent blindness on account of nutritional deficiencies and development of curative facilities at the primary health centre and district hospitals. Mobile clinics will also be provided for eye care including operative treatment. Voluntary organizations will continue to be given grants for conducting eye camps.

Maternal and child care

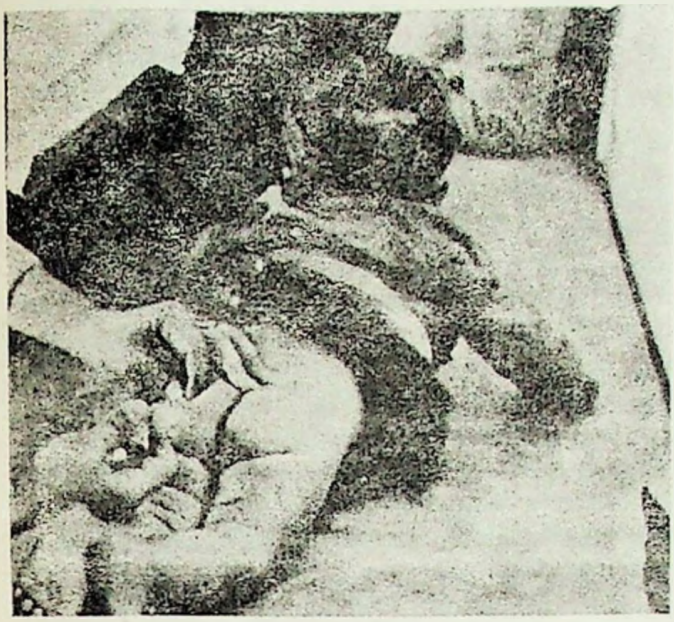
The Sixth Plan for the first time includes a separate chapter on women, and development programmes for the social and economic upliftment of women will receive greater attention. Priority attention will be given to expand facilities for the improvement of education, health and nutrition for both women and children.

In spite of expansion of the health infrastructure and educational programmes in the country, the knowledge about health and nutrition education and child rearing practices continues to be quite low; particularly in the rural areas.

Infant mortality is very high among lower socio-economic groups. For tackling these problems a scheme of Integrated Child Development Services was formulated and initiated during 1975-76 on an experimental basis in 33 rural and tribal blocks and urban slum areas. The scheme aims to provide a package of services consisting of (i) supplementary nutrition, (ii) immunization, (iii) health check-up, (iv) referral services, (v) nutrition and health education, and (vi) non-formal education to children in the age group of 3-5 years. Functional literacy programme for young girls and mothers has also been taken up in these blocks to promote non-formal education that is functionally relevant to child care, nutrition and health education. Programme for supply of safe drinking water will also make a contribution to this objective.

This shows that India's health development efforts are progressing well. However, these efforts need to be stepped up if the goal of 'Health for All' is to be achieved. The most important aspect is that the political and professional leadership should work vigorously and jointly to support and sustain the health and welfare efforts with the active involvement of the community and should also sweep aside any barriers that might thwart the progress of the revolution that is just building up.

—M. S. Dhillon



EXPANDED PROGRAMME ON IMMUNIZATION

DR R. N. BASU

Expanded Programme on Immunization involves several tasks like organization of disease surveillance, development of cold chain, community participation, training of personnel, supply of equipments, periodic monitoring, in addition to expansion of vaccination coverage.

THE Expanded Programme on Immunization (EPI) was started in the country in January 1978. With this, continued progress has been achieved in the development of EPI at State, district and primary health centre (PHC) levels. However, it will be worthwhile to find out how far the programme is behind achieving the goal "Health for All by 2000 A.D." Immunization is a basic activity of primary health care. It is rational to identify the major areas of progress and shortfall after the programme has been operated for five years.

Survey to estimate disease incidence

A sample survey to collect baseline data on poliomyelitis and neo-natal tetanus was organized in the country. Out of the planned 16 urban and 15 rural units, surveys have been completed in all but three urban and rural units each. Surveys have yielded useful epidemiological data:

(i) Data from routine reporting system is considerably under-reported and, therefore, difficult to use either for planning or evaluation. The annual incidence rate of poliomyelitis in children varied from 1.5 to 1.9 per thousand children of 0-4 years. Based on this rate, about 1.40 to 1.90 lakh children developed poliomyelitis every year. Less than one out of every 15 cases is reported to Central Bureau of Health Intelligence.

(ii) Results have conclusively shown that poliomyelitis is as serious a problem in the rural areas as in the urban areas. Poliomyelitis was the single major cause of lameness in children (62%). Majority of the cases of poliomyelitis occur in children under two years of age (70%).

(iii) As expected the incidence of neo-natal tetanus was more in the rural areas as compared to the urban. In some States, the neo-natal tetanus amounts to more than 30 per cent of the neo-natal deaths in the rural areas.

Cold chain

Major constraint in extending the vaccination services is the limited cold storage facilities in the rural areas and in many small towns. The erratic power supply (electricity not available for about 12 hours a day in some areas), large number of non-functioning refrigerators, difficulties in getting ice, multiple storage points are some of the problems.

Following steps have been taken to improve the cold chain:

(i) Two workshops on cold chain were organised for the programme officers to identify problems and formulate proper remedial measures.

(ii) A booklet on the use of cold chain equipment and their maintenance was circulated to all the concerned officers, who are confronted with many problems relating to the maintenance of existing facilities for their maximum utilization.

(iii) An inventory of refrigerators available at the various levels has been prepared and is being updated from time to time.

(iv) One national course for refrigerator repair technicians has been organized, who will be able to provide maintenance services in their areas. A crash programme of survey and repair of refrigerators to remove the backlog has been taken up in three States.

(v) The present strategy is to have a cold room for bulk storage at State/regional level (in big States), a bank of refrigerators/deep freezers at district level and a working refrigerator in each primary health centre. Vaccine carriers will be used in sub-centres.

(vi) All vaccines are supplied by air by the manufacturers to the States/regional stores. Polio and measles vaccines are sent in cold boxes packed with ice.

Production of vaccine

India is now self-sufficient in the production of all vaccines except polio and measles vaccines. Pasteur Institute, Coonoor, has started to produce DPT vaccine from 1982. Action has been taken to increase the installed capacity for production of DPT vaccine at Central Research Institute, Kasauli. Indigenous manufacture of polio vaccine has started and the batches are being tested for quality, including neurovirulence test. Polio vaccine at present used in the programme, is imported in bulk concentrate and diluted, blended and ampouled in the country.

The epidemiological impact of the polio vaccination programme will be greater if a large percentage of children under two years of age in the selected areas are covered with three doses of polio vaccine.

Measles immunization project

A measles immunization feasibility study is being carried out in 34 selected medical colleges in the country to determine the need for and the administrative feasibility of introducing measles vaccine in the routine immunization services. The study includes the monthly follow up of over 10,000 children, 9 to 23 months of age for two years to find out if measles, directly or indirectly, influences the morbidity and growth pattern of children of this age group and whether measles vaccination will influence this by preventing the disease. The data is being analyzed using computer at the National Informatics Centre, Delhi. Measles vaccination will be included in the services delivery programme whenever specific epidemiological conditions warrant.

Results have conclusively shown that poliomyelitis is as serious a problem in the rural areas as in the urban areas. Poliomyelitis was the single major cause of lameness in children (62 per cent). Majority of the cases of poliomyelitis occur in children under two years of age (70 per cent).

Monitoring of the programme

Vaccination coverage assessment surveys give objective data on the coverage of children under two years of age. Such surveys are regularly carried out using the cluster sampling technique by interview of mother or observing the vaccination card. These surveys were organized in nine areas in 1979, 19 areas in 1980, 20 areas in 1981 and 21 areas in 1982. In the urban area, many of the children are being covered by voluntary organizations and private medical practitioners, which are not reflected in government reporting. In the routine reporting the age-wise vaccination is not indicated. Thus the survey findings helped to know how many were vaccinated in right age group and completed the immunization schedule.

Training

About 28,000 former National Smallpox Eradication Programme (NSEP) Staff were retrained in 1978 to take up various activities under Expanded Programme on Immunization (EPI). National training courses on planning and management of EPI were organised in different States for the medical officers responsible for implementation of EPI at the district level. 516 officers have attended 31 courses held between May 1980 and July 1982. 65 medical officers of the State level and the centre (including national institutes) and 35 principals of the Regional Health and Family Welfare training centres participated in the WHO training course on the planning and management of EPI organized during 1978 to 1982. The modules used in the training courses have been integrated in the curriculum of the postgraduate students of D.P.H. and M.D. in Public Health at All India

Institute of Hygiene and Public Health and in courses in Epidemiology at the National Institute of Communicable Diseases.

Areas needing urgent action

High drop-out rate—The drop-out rate from the first to the third dose of DPT and polio vaccine is high (more than 30%). Community participation has to be ensured so that the mothers are well motivated to bring back their children repeatedly to the health centres. The health workers should use every opportunity to immunize eligible children. The great majority of the children attend health centres for treatment of minor illness, frequently combined with malnutrition, and should be considered eligible for immunization. Some of the reasons for drop-out rate are (i) public not being adequately informed to return for the subsequent dose, (ii) repeat visits for the second and third dose missed in case of outreach operation or campaign, and (iii) people not returning for fear of side reactions.

Neo-natal tetanus—National survey has shown that neo-natal tetanus remains a serious public health problem in some states of the country. Each Primary Health Centre [P.H.C.], district and State should aim for a neo-natal tetanus mortality rate of less than one per 1000 live births by 1990. The successful control of neo-natal tetanus should include both improved maternity care and immunization of pregnant women with tetanus toxoid. The immunization programme of infants with DPT, school entrants with DT and the children leaving primary school (10 years) and high school (16 years) with TT, will protect the population against non-neo-natal tetanus.

Control of poliomyelitis—Considering the severity of the problem of disability caused by polio, it has been proposed for faster expansion of polio vaccination programme. The following year-wise coverage has been planned:

Year	No. of beneficiaries
1982-83	50 lakhs
1983-84	75 ,,
1984-85	100 ,,
1985-86	150 ,,
1986-87	200 ,,

Intensification of polio vaccination

Special polio vaccination drive was organised during winter in 1981 in the Integrated Child Development Services (ICDS) blocks (tribal and blocks in remote rural areas) and other selected areas, to have wider coverage of the eligible population. During 1981, the coverage was on an average 61 per cent and it was 84·1 per cent in one block of Maharashtra with three doses of polio vaccine. Similar campaign has been organized from November 1982 to vaccinate:

i) child born after last campaign;

ii) children under two not covered during the last campaign;

iii) children who received only one or two doses.

The timing of the programme had advantages of low ambient temperature and lesser incidence of diarrhoea. The period also preceded the seasonal outbreak of the disease.

By the year 1987, it should be possible to immunize 85 per cent new borns in the country. The coverage of a large number of children who were at maximum risk of getting the disease is expected to result in the reduction in the incidence of poliomyelitis in these areas. The surveillance of poliomyelitis must be strengthened to monitor the programme effectively. All health workers in close contact with community should report any suspect polio cases, which have to be investigated by the medical officer.

Expansion of vaccination coverage—Different strategies could be adopted in different areas depending on local conditions, which can be broadly classified in two groups.

(i) increase in the number of centres (fixed station) where vaccinations could be made available routinely on a daily or weekly basis, along with other immunization and health services.

(ii) organizations of short-term intensive outreach operations during winter in selected areas, where additional inputs can be made available.

The present problem especially in BCG vaccination is that large number of children vaccinated are above two years of age. Emphasis has to be given on vaccination of children before first birthday with three doses of polio and DPT and one dose of BCG vaccine. The use of immunization card will help the health workers during domiciliary visits in reminding the mothers for completing the dosage schedule. △

GOITRE CAN BE PREVENTED

DR P. C. SEN

Endemic goitre has been reported from all over the World. In 1960, about 200 million people in the world were estimated to be suffering from goitre, since then a number of countries in Centrai and South Americas have introduced control measures and reduced the prevalence of the disease.

In India alone, it is estimated that about 120 million people live in the known goitre endemic areas, out of which nearly 40 million are suffering from varying degrees of goitre.

ENLARGEMENT of thyroid gland caused by an insufficient intake of iodine is known as goitre. Goitre is known to occur universally with very few countries entirely free from it. From the public health point of view, it is assumed that endemic goitre exists —when the sample survey shows a goitre prevalence rate of more than 10 per cent among the population in any circumscribed area.

It is universally agreed that lack of iodine in foods is the primary cause of goitre. Other factors such as excessive intake of certain goitrogenic vegetables, increased demand for thyroxin hormone during puberty, pregnancy and lactation, etc., may play contributory roles. However, studies have shown that when iodized salt has been introduced, endemic goitre has been reduced to a large extent. Endemic goitre is apt to appear in mountaneous and isolated places where a monotonous diet is consumed for long periods. The cause of deficiency of iodine in the soil may be related to flooding and other geophysical characteristics.

Epidemiologically endemic goitre is associated with endemic cretinism, deaf mutism and with mental retardation of the new borns whose mothers are suffering from goitre.

Locally endemic disease

Endemic goitre has been reported from all over the world. In 1960, about 200 million people in the world were estimated to be suffering from goitre, since then a number of countries in Central and South Americas have introduced control measures and reduced the prevalence of the disease.

These measures have narrowed the geographical distribution of the disease and in the map of the world goitre can be described as a locally endemic disease.

In India alone, it is estimated that about 120 million people live in the known goitre endemic areas, out of which nearly 40 million are suffering from varying degrees of goitre.

Endemic belt

The endemic belt of goitre in India exists along the Sub-Himalayan Region including the States of Jammu and Kashmir, Himachal Pradesh, Punjab (2 districts), West Bengal (5 districts), Sikkim, Assam, Mizoram, Meghalaya, Tripura, Manipur, Nagaland and Arunachal Pradesh. Incidence of goitre has also been found in Aurangabad district of Maharashtra, Bharuch district of Gujarat and Shahdol and Sidhi districts of Madhya Pradesh.

The average prevalence rate of goitre in the endemic areas of the

country is estimated to be 30 per cent.

Classification of goitre

Usually the classifications distinguish between visible and palpable goitre. While visible goitre indicates a moderate to severe deficiency of iodine, its presence in children indicates severe iodine deficiency. Similarly nodular goitre may also be found in areas where the deficiency of iodine has been marked for a very long time. Nodular goitre is more common among the elderly.

Prevention of goitre

Fortification of common salt with iodine has been accepted to be the effective and most economical method for the control of goitre. Nearly 40 countries in the world have been implementing the salt iodization programme for the prevention of goitre out of which 22 countries of the world have compulsory iodization of kitchen salt and have eradicated goitre.

Alternative methods for controlling goitre are also being tried out. For example in Argentina, New Guyana, Peru, Zarie and Nepal, injections of iodized oil is being tried. Prophylactic trials with iodine tablets have been tried in Burma and in some other countries. In the South East Asiatic region introduction of iodized salt was done in 1959 in India, 1962 in Thailand, 1970 in Burma, 1973 in Nepal and 1977 in Indonesia.

Fortification of common salt with iodine has been accepted to be the effective and most economical method for the control of goitre. Nearly 40 countries in the world have been implementing the salt iodization programme for the prevention of goitre out of which 22 countries of the world have compulsory iodization of kitchen salt and have eradicated goitre.

In India, fortification of common salt with Potassium Iodate is being implemented since 1959. Surprisingly cases of goitre have been found even in those areas which were previously thought to be goitre free such as coastal regions. So it is assumed that no part of India can be called, goitre free and the whole country is goitre prone.

In order to achieve the goal of eradication of goitre, it has been recommended to supply iodized salt as a total replacement of kitchen salt in a phased manner giving highest priority to the hyper-endemic zone. Approximately eight lakh MT of iodized salt is required for the people already living in known endemic areas. Twelve iodization plants are functioning under the control of Salt Commissioner, Jaipur, Ministry of Industry, for this purpose. The Ministry of Health and Family Welfare give grant in aid to manufacturing units for the cost of iodization and plants are supplied by UNICEF. The number of plants which are in operation is meagre to produce the total requirement. Government is trying to decentralize the plan of operation and bringing the State Governments of hyper endemic regions to build up their own plants so that the iodization is possible near to the consumption points.

The problems of transport, a regular indent for the iodized salt to the plants, banning entry of common salt except iodized salt in the area are some of the operational problems of the programme. The question of quality control of iodized salt from the point of manufacturing to the point of consumption is also another problem. There is a possibility of deterioration of iodine content during transit in the hot and humid tropical climatic conditions in India.

The Government of India is fully aware about the problems and trying to solve it through Technical Review Committees of the National Goitre Control Programme, where members of the different Ministries are present to take decisions.

The problem in India is gigantic as far as goitre control is concerned as it requires co-operation of salt industry, International Agencies, different Ministries and community at large. A strong political will and commitment is needed to give Goitre control a top priority and only then it can be eradicated by 2000 A.D. ○

Health problems and socio-economic problems are intimately interlinked

—Thirty-fourth World Health Assembly

Dr (Smt) Daksha D. Pandit

HEALTH PROBLEMS IN ELDERLY FEMALES

Ageing is a natural phonemenon which, as far as is known, affects all higher forms of life and perhaps all living things. But it is not a disease. However, chronic diseases become more common with increasing age. Cardiovascular diseases, cancer, mental illnessess, diseases of locomotor system, ear and eye diseases, fractures are few which are very common to both males and females. But there are certain disorders which are specific to females.

For centuries women have been programmed to accept their ability to reproduce the children as their prime function in life. Even today, any woman who resists in asserting her identity to the detriment of her conventional role, runs the risk of being ridiculed. Because of these deeply ingrained sexist attitudes together with our society's pre-occupation with youth, is it any wonder that many women regard the menopause as the beginning of the end? At no other time in woman's life is there such a complex interplay between physical and psychological factors as during the menopausal years.

After 40, various physical and harmonal changes take place which are the result of manifestation of various symptoms at the time of menopause. Strictly speaking, the menopause should be defined as the time at which menstruation ceases, and not used synonymously with the climateric which is the phase of waning ovarian activity and may start two or three years before the menopause and continue for two to five years after it. The climacteric is thus a phase of adjustment between active and inactive ovarian function and may occupy several years of a woman's life. The menopause occurs between the ages of 45 and 50. There are variations in the time of the onset in different individuals. The three classical ways in which the periods cease are:

1. Sudden cessation.
2. Gradual diminution in the amount of loss with each regular period until they disappear.
3. Gradual increase in the spacing of the periods until they cease for an interval of six months. Any patient who bleeds after a gap of six months must be considered to be suffering from post-menopausal bleeding and treated as such. Continuous bleeding, menorrhagia, i.e., excessive bleeding, irregular bleeding or other menstrual abnormalities are not normal. They must be investigated despite the common belief that they are "signs of the change".

It is a common misconception that irregular and excessive uterine haemorrhage is a characteristic symptom of menopause. Even to this day cases of carcinoma of the uterus are missed in their early stages because the irregular haemorrhage caused by the carcinoma is regarded as menopausal.

Besides these, there are other menopausal symptoms:

1. The most common and noticeable symptoms are hot flushing, sweatings and palpitation.
2. Paraesthesiae, which take the form of sensations of pins and needles in the extremities, are again very common. Headaches and noises in ears are complained of Psychical disturbances which take the form of irritability and depression are frequent.
3. Sometimes there is flatulent distension of the colon which is associated with tendency to constipation.
4. There are changes in the genital tract also. There is atrophy of the vulva, vagina and cervix. Because of this, sometimes intercourse becomes painful. Uterus diminishes in size. Ovaries also shrink in size.

There is a fear of the cancer, a fear of end of sexual life and fear of being rejected by the husband. This is the time when she needs

To many people, old age appears to be a time of chronic illness, failing mental abilities and stagnation. But the problems associated with old age are not medical problems only; they have social, cultural and economic ramifications that affect the life of the individual and the community.

Ageing people need the same social interaction, emotional support and health care as the rest of society. There is also a need for innovative measures to provide social security, fixed income, housing, meals, and other services within the community. Therefore, helping the elderly must be given greater prestige in national health and social services. There should be a drive to bring people of all ages closer and together.

reassurance, support from the husband and feeling of being wanted by the family members.

Sexuality in woman over fifty.

There is a misconception that beginning of menopause is an end to sex life. The enjoyment of the sex act during or after menopausal years will depend upon the previous coital experiences and self image. Women can enjoy sex and remain orgasmic all the days of their life. In fact, for some women, sex is even better after menopause, because by this time most women reach their middle fifties and their major family responsibilities are over. Thus, with less worry, more spare time and perhaps financial security at last realised, many women can enjoy sex on a more mature and emotionally gratifying plane.

Cancer of breast

If the breast cancer is detected in very early stages then it can be cured, and there is a very simple method by which breast cancer can be detected by a woman. They should examine the breasts with their hand for any difference in size, shape and contour. If any change is noticed, any nodule is there in the breast the doctor should be consulted immediately.

Cancer of uterus

For the cancer of the uterus or any other part of the genital tract the warning is the irregular bleeding. In such cases doctor should white discharge, spotting after intercourse or post-menopausal bleeding. In such cases doctor should be consulted immediately without wasting time. Sometimes when the cancer of the genital tract is in very early stage, no symptoms are there but it can be detected by a 'papsmear test'. All women above 40 to 45 years of age should go for this test every three to five years to rule out cancer of the genital tract in very early stages.

To remain healthy, the following principles should be practised:

- Regular physical check up at least twice a year is very important in this age group. It will help to detect the early onset of the diseases and sometimes may even spot the disease which can be dangerous and incurable if not treated in the initial stages.
- Regular physical exercise
- Balanced diet.
- Avoiding obesity.
- Protection from accidents.
- Avoidance of mental stress and strain.

Prize for work on communication

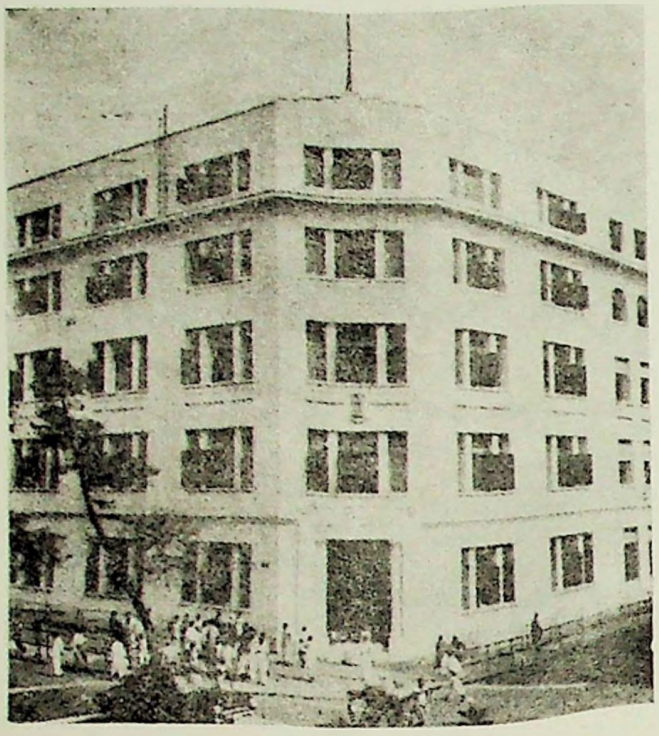
Under UNESCO's patronage, an international prize for work in communication, the McLuhan Teleglobe Canada Award, will be presented this year for the first time. The prize, worth 50,000 Canadian Dollars, will be awarded every two years to an individual, or a group of individuals working as a team, who make an exceptional contribution to better understanding of the influence of the communication media and technology on society in general and on the cultural, artistic and scientific life.

The prize has been established by the Canadian Commission for UNESCO in association with the Teleglobe Canada Corporation.

A five-man jury of Canadian citizens will select winners from candidates nominated by National Commissions for UNESCO. Deadline for submission of candidatures for 1983 is 31 July.

Herbet Marshall McLuhan who died in 1980, was born in 1911 in Edmonton, in the province of Alberta, Canada, and became famous for his theories on communication and the media.

U. N. Weekly Newsletter, 4 February, 1983



Golden Jubilee Year

ALL INDIA INSTITUTE OF HYGIENE AND PUBLIC HEALTH CALCUTTA

Dr A. K. Chakraborty

The onset of plague in 1896, roused the colonial Government from their apathy and plague commission was appointed. It submitted report in 1904 and its recommendations paved the way for development of public health departments and research in India. In 1912, the Government of India formulated an important declaration of sanitary policy, establishing research on a sound basis, and giving grants to local Governments for the augmentation of their sanitary staff. The Government of British India insisted that candidates for Assistant Directorship of Public Health should have a British Diploma of Public Health. Health Officers of first class towns were also required to have a British Diploma of Public Health. After the publication of plague commission's report, Calcutta University decided to institute the Diploma in Public Health (DPH) in 1907 to encourage the study of public health.

Sir Leonard Rogers of Calcutta Medical College conceived in 1914 the idea of establishing an institution in India for post-graduate study in tropical medicine and hygiene. Owing to his perseverance and enthusiasm Calcutta School of Tropical Medicine was established in 1920 for teaching and research in tropical medicine and hygiene. Sir, Leonard had to leave India because of ill-health and Sir John Megaw became the first director of the School. He was quick to start the DPH course at the School from October 1922. A Professorship in Hygiene was established in the School and Lt. Col. A.D. Stewart held that post.

As the concept of public health was gradually expanding and diverse subjects were included in the DPH course, it was felt that a separate institution was needed to deal purely with public health subjects. Dr. W. S. Carter, Associate Director of the Rockefeller Foundation in his periodic tours of India and the Far East, met Major General Megaw and Major-General Sir J. D. Graham, Public Health Commissioner, with the Government of India on various occasions and became deeply impressed with the necessity for establishing an All India Institute of Hygiene. Much of the teaching in basic subjects such as bacteriology and protozoology for the Diploma of Public Health is similar to that for the Diploma of Tropical Medicine and as this was being taught in the School of Tropical Medicine. Dr Carter grasped the obvious advantage of Calcutta as a location for an All India Institute of Hygiene and Public Health and a site close to the Calcutta School of Tropical Medicine, where basic subjects would continue to be taught. The Institute was formally opened on 30 December, 1932 by Sir John Anderson, Governor of Bengal.

FIVE DECADES OF PROGRESS

THE All India Institute of Hygiene and Public Health, Calcutta (AIIH&PH), started with four departments, *viz.* Public Health Administration, Malariology and Rural Hygiene, Vital Statistics and Epidemiology, Biochemistry and Nutrition. Number of seats for Diploma in Public Health was 24.

During the fifty years, with the expansion of the horizon of public health, the Institute grew in size and activities. The number of Departments rose from four to thirteen and of academic courses increased from one to twelve and of students admitted annually increased from 24 to 300 approximately.

Objectives of the Institute

The chief objectives of the Institute are: (a) to develop health manpower by providing post-graduate facilities of the highest order; (b) to conduct research directed towards the solution of various problems of health and disease in the people; (c) to evolve and develop methods for optimum utilization and application of the results of both pure and applied research towards promotion of health, effective and efficient delivery of health care services.

Organization

The Institute is under the control of the Director General of Health Services (DGHS) in the Ministry of Health and Family Welfare of the Government of India.

The Director is the executive Head of the Institute and is assisted by the Deputy Director and the Faculty Council in academic and technical matters, and by an Administrative Officer and three Superintendents in Administration.

The Institute is well equipped and has well qualified and experienced teaching faculty on its full-time staff. There are thirteen Academic Departments each under the control of a Professor, and two health centres, one rural and the other urban. The departments are Behavioural Sciences, Biochemistry and Nutrition; Maternal and Child Health; Health Education; Epidemiology; Microbiology; Occupational Health, Public Health Administration; public Health Nursing; Sanitary Engineering; Preventive and Social Medicine; Health Statistics; and Veterinary Public Health.

The Post Independence phase of the development of the Institute was marked by significant augmentation of training facilities both by way of increasing the seats for the Diploma in Public Health and by way of introducing new academic and refresher courses in subspeciality subjects.

Taking over the responsibility of Rural Health Unit and Training Centre, Singur, in 1944; MCH Project, a joint venture of the WHO, the UNICEF and the Government of India in 1953; establishing Urban Health Centre, Chetla, in 1955; RcA Project at Singur with the help of Ford Foundation in 1957 are some of the significant landmarks in the development of the Institute.

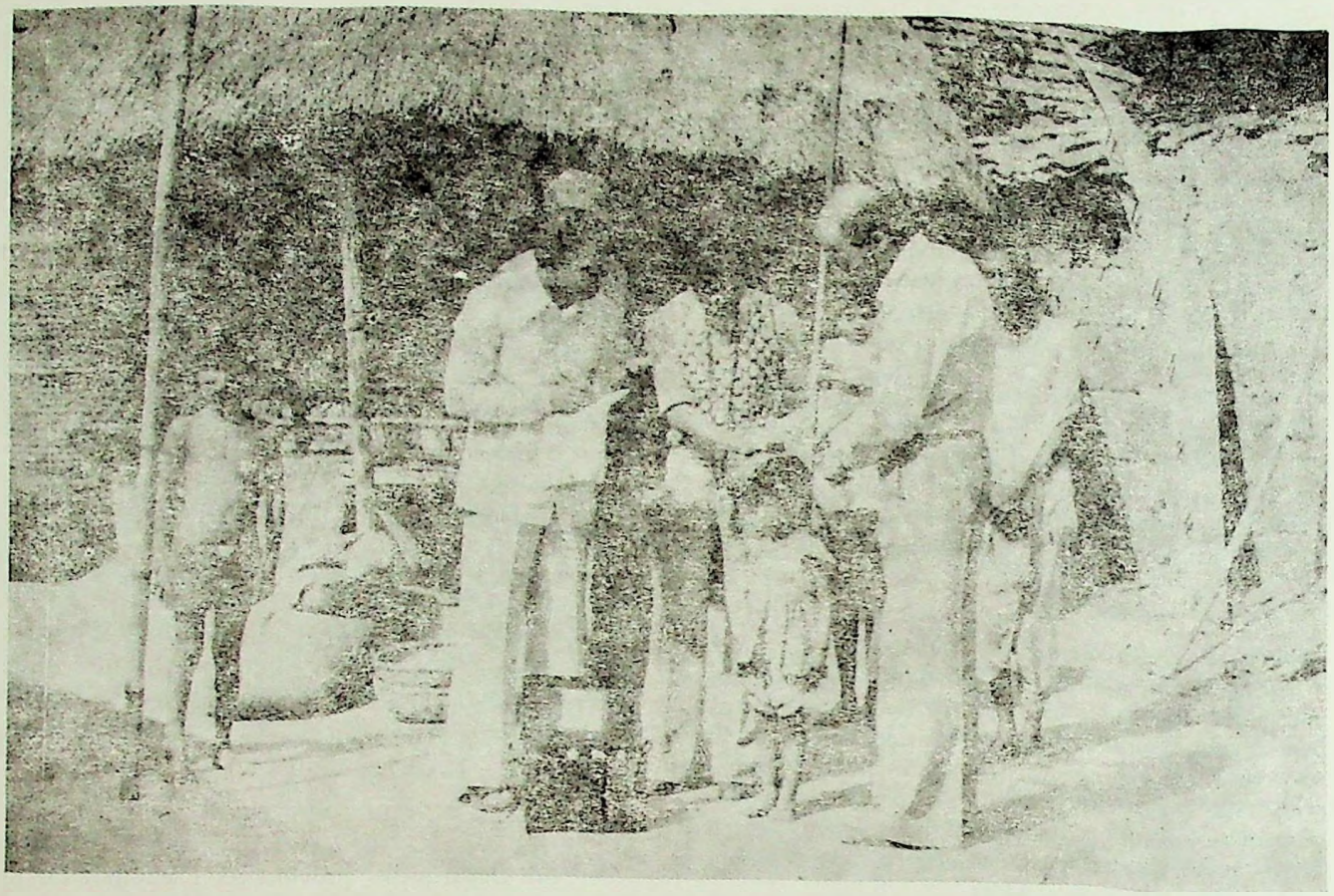
All the Departments provide good facilities for research in various health and allied sciences.

The two field practice areas at Singur and Chetla are the population laboratories and form special features of the Institute. They provide excellent opportunities for field training, research and learning all aspects of community health care in a true setting.

Each department has its responsibility in the rural and in the urban practice fields. While the technical guidance is given by the departmental heads, the administrative control rests with the respective Officer-in-Charge of Administration, who reports to the Director. The participation of the people is ensured through the Local Health Councils in the urban area and *Panchayat Samities* and Local Health Committee at the village level.

Library

The Institute library is one of the few reference libraries on health sciences in India. It has a collection of 41,634 books and back volumes of journals, 307 current journals and periodicals and 12,226 reports and research papers. The staff and students of the Institute also avail full facilities of the library of



Field Training : *The Rural Health Unit and Training Centre at Singur, serves as a rural practice field area for various categories of health personnel.*

the School of Tropical Medicine, across the road, through a coordination programme.

Training

The Institute is affiliated to the Calcutta University which confers degrees and diplomas in several sub-specialities of public health.

This Institute is the only one in India where multi-professional, post-graduate training is made available in various disciplines to medical doctors, engineers, nurses, nutritionists, dieticians, health educators, veterinarians, statisticians, demographers, social scientists, epidemiologists, microbiologists, etc.

The Institute conducts three Doctoral Degree courses, two Masters Degree courses, seven Diploma courses, three Certificate courses and many orientation training programmes supported by the Government of India and/or National and International Organizations such as Indian Council of Medical Research (ICMR), World Health Organiation (WHO), etc. About 300 students from various States and Union Territories of India and other Asian and African countries are trained every year.

Academic courses conducted by the Institute

Courses	Sanctioned seats
Doctor of Science (PH)	No fixed number
Doctor of Philosophy (Epid)	No fixed number
Doctor of Medicine (PSM)	7
Master of Engineering (PH)	30
Master of Veterinary Public Health	10
Diploma in Public Health	60
Diploma in Industrial Health	10
Diploma in Maternity & Child Welfare	30
Diploma in Dietetics	20
Diploma in Health Statistics	5
Diploma in Health Education	35
Diploma in Public Health Nursing	40

Total number of students trained in degree and diploma courses upto 30 June, 1982:

Course	Year of commencement	Cumulative total upto 30 June, 1982
Doctor of Science (PH)	1936	5
Doctor of Philosophy (Epid)	1958	32
Doctor of Medicine (FSM)	1973	43
Master of Engineering (PH)	1948	858
Master of Veterinary Public Health	1970	67
Diploma in Public Health	1932	2158
Diploma in Industrial Health	1950	211
Diploma in Maternity & Child Welfare	1933	330
Diploma in Dietetics	1949	482
Diploma in Health Statistics	1966	74
Diploma in Health Education	1966	470
Diploma in Health Public Nursing	1976	235

As many as 379 students from 40 countries of Africa and Asia have been trained so far in this Institute.

The teaching at the Institute comprises class room lecture-discussion, seminars, problem solving exercises, laboratory sessions and field experiences in both urban and rural practice areas.

The students of different training programmes have obligatory block placements at the Rural Health Unit and Training Centre, Singur. In addition, students from other institutions also use the facility. Main objectives of the field placements are understanding and diagnosing health problems of the community, providing solutions to some of them, and evaluating health programmes. Developing professional skills is stressed in the assignments.

Field experiences of varied nature are given at the Urban Health Centre, Chetla, to the students of different courses of the Institute as well as to those from other institutions. Family care programme, where suitable families are assigned to students for a period; observation visits; participative assignments in clinics and community, and block field placements for longer periods are some of the types of field training being given.

Research

The Institute has provided ample facilities within its field practice areas and laboratories both for applied and fundamental research. Research activities of the Institute have steadily increased to cover wide

Training : *Students of a training course participating in a seminar.*

fields giving shape to new concepts and to developments of methodology for tackling community problems. Collaborative studies between diverse fields and different departments of the Institute have catered to meet the health needs of the community. The Institute has collaborated with State governments to find solutions to problems particular to the area. Areas in which research has been conducted are: communicable diseases; nutrition; sanitation; maternal and child health; occupational health; Family planning; health services; demography; veterinary public health; community participation; epidemiology, health services and health care delivery.

Some studies which have gained wide acclaim are in the field of cholera, protein hydrolysate, epi-

Health Services : *A health worker taking blood-slide in Singur area.*

(*continued from page* 112)
cutaneous diphtheria in natural immunization was established.

6. *Rural latrine*: An acceptable design of a pit type latrine for rural area under the Research-cum-Action projects was worked out. This type of latrine has been accepted all over the country as a low cost sanitary latrine, especially for the rural areas.

7. *Stream pollution surveys*: Realizing the importance of developing an overall water pollution control programme for the country, the Institute carried out surveys on Hooghly, Sone, Daha, Damodar and Gomti rivers. These surveys yielded data on the pollution status of the rivers and their self purification capacity. This prompted enactment of prevention of water pollution act of the Government of India.

8. *Air pollution*: Nature and extent of air pollution in Calcutta were studied. The levels of such potentially harmful contaminants as sulphur dioxide, ammonia, oxides of nitrogen, etc., were determined and fluctuation over the different seasons were noted.

9. *Health survey*: A methodology for health survey was developed in order to obtain an integrated picture of the health conditions of the community. First survey was carried out in Singur in 1944. Subsequently many surveys were carried out in different parts of the country.

10. *Rural population control*: The objectives of the study were to develop suitable methods of approaching rural population with acceptable methods of family planning and to test the effect on the birth rate of the community. The study was conducted in Singur. The study showed perhaps for the first time in India that the subject of family planning could be discussed freely among the village people by social workers and health staff. It demonstrated also the most appropriate methods for approaching the rural people and persuading them to accept methods for control of family size. It was shown that there was usually a lag of several months between acceptance and regular practice of any method of family planning. During the intensive phase the birth rate showed a slow but steady decline.

Rural Health Unit And Training Centre, Singur

The Rural Health Unit and Training Centre at Singur was established in 1939 as a joint project between the Government of Bengal, District Board, Hooghly and Rockefeller Foundation. In 1944, All India Institute of Hygiene and Public Health, Calcutta, assumed full administrative responsibility of the area.

Singur is located about 40 Kms. North-West of Calcutta, off Calcutta-Delhi National Highway. The area of operation under the Centre is 60 Sq. Kms. located in the Singur Block of Chandernagore Sub-

Nutrition : *A Nutrition Clinic at a rural health centre of the Institute.*

Primary Health Care : *A tubewell being repaired in the Rural Health Centre area, Singur.*

division, Hooghly District. A population of 60,000 residing in 61 villages are provided comprehensive health care.

Objectives

- To serve as a rural practice field area for various categories of public health personnel undergoing post-graduate training.
- To organize rural communities for self-help and for increased participation in solving health problems and supplementing government efforts.
- To conduct research on rural health problems and to evolve and apply practical methods for solving them.
- To provide comprehensive health services to the rural population.

Organization

The Rural Health Unit and Training Centre, comprises main campus where the administrative block, students' hostel, polyclinic, padiatric unit with eight beds, chest clinic, public health laboratory, radiology unit and engineering workshop are situated. It also includes two health centres, one located in Dearah with 16 beds and another in Anandanagar with eight beds and sub-centres at Nasibpur, Paltagarh and Balitipa villages. An upgraded Primary Health Centre at Singur provides both indoor (60 beds) and outdoor services.

The total area is divided into twelve units, of about 5,000 population each. A unit has one male health worker and one female health worker. A male and a female supervisor supervise the work of four units. The Supervisors in turn are responsible to the Medical Officers of the Health Centres serving the units.

Basic services

Primary health care is provided in the area taking the family as a unit for service. Such care comprises provision of water supply through tubewells; sanitary disposal of excreta maternal and child health care family welfare services; control of communicable diseases including immunization of vulnerable groups; health education; provision of nutrition services, medical care at the home, and at the health centres both outdoor and indoor and referral services. These components are supported by public health laboratory, radiology, ambulance and statistical services.

Community participation

Rapport with local leaders and the people has been well established over the years. Village Health Com-

(continued on page 123)

WORLD COMMUNICATIONS YEAR: development of communications infrastructures

1983

"Everyone has the right... to seek, receive and impart information and ideas...through any media."

(Art. 19 of Universal Declaration of Human Rights dopted by the United Nations General Assembly on 10 December, 1948)

Next only to food, shelter and energy on the list of vital needs for human survival, communications constitute the life blood of today's world and serve as a constant reminder of the oneness of human destiny.

The past half century or so has witnessed an exponential growth in the world's communications capability: yet, with the introduction of every new service, man's needs grow even faster and the spiralling demand for more and more communications facilities is a reflection of man's endless search for a better life.

The development of communications infrastructures all over the world is the primary objective of the world communications year. The world of today is getting smaller and smaller, thanks to the constant growth of communications net-works in many countries. However, there exists an imbalance in the development of communications infrastructures in various parts of the globe. Only through the redress of this imbalance by a more even development of communications infrastructures everywhere can the peoples of the world be brought together, thus creating more stable conditions for the maintenance of international peace and security.

A World Year for what purpose?

Better communications.....
.....through improved infrastructures

The result of any move to improve communications infrastructures is an improvement of the communications which are essential to most human activities:

posts and telecommunications; broadcasting, television, press, etc.; transport (air, sea, rail, road); industry; trade, agriculture; health; education ....

Better communications mean.....
..... better living conditions.

Communications infrastructures include:

All the fixed and mobile installations—building and equipment —needed to make communications work.

For example: *Telephone exchanges, radio stations on ships, aircraft, satellites and manned space vessels, transmitters, antennae, cables. Post Offices, postal vehicles, etc.*

World Communications Year 1983

emanates from the determination clearly expressed by all States to intensify the endeavours of the United Nations system to promote balanced social and economic development by speeding up the establishment of communications infrastructures. It will be given practical expression in programmes of reflection and action at the World, regional and national levels.

The General Assembly

....

Recognizing the fundamental importance of communications infrastructures as an essential element in the economic and social development of all countries.

Convinced that a World Communications Year would provide the opportunity for all countries to undertake an in-depth review and analysis of their policies on communications development and stimulate the accelerated development of communications infrastructures.

Endorsed the proposal made by the Economic and Social Council in paragraph 1 of its resolution 1981/60 and proclaimed the year 1983 World Communications Year.

(Extract from United Nations General Assembly resolution 36/40 adopted on 19 November, 1981.)

COMMUNICATIONS: a potent force for change

SALIM LONE

More than a medium, more than a message, communication is the total process whereby people understand each other, and each other's environment and aspirations. Correcting misperceptions, and placing real communication at the centre of development programmes, can help overcome the obstacles that stand in the way of social change.

. . . There is the growing realization in the international community that a major shortcoming of many development efforts of the past two decades has been the absence of close communication between all those—planners, professionals and the population—involved in development programmes.

Not that awareness of the importance of communication wasn't there. But just as the process of development was seen primarily as the provision of goods and services to the people, communication was conceived as a static, one-way flow of information from the "professionals" to the masses. Enormous amounts of energy and resources were spent on developing a technology which would make "communication" as instantaneous and far-reaching as possible and the whole exercise was predicated on the notion that those providing this technology were also the ones to provide the ideas and the solutions for those at the listening—receiving—end.

The sophisticated new systems—new generations of satellites being launched, submarine cables being laid, optical fibres and lasers being harnessed for information transport—actually emphasize the technological mastery of one group and heighten the fear of scientific incompetence of the other. They have even sometimes become the instruments for hindering the very participation and interaction that communication is meant to promote.

Third World Communities

It is from the development arena that some of the strongest challenges to the established communication structures are emerging. One element of the challenge comes from those struggling to place communication between the deprived communities and those providing them expertise, at the centre of development planning. Contending that human communication is the pivot on which balances the success or failure not only of individual programmes but of the whole process of development, these protagonists argue that traditional societies are socially literate. Over generations, they established their own norms and technologies, which were dynamic and constantly propelled the societies to higher stages of production. Not to understand this, and to perceive third world communities as helpless bystanders who are too backward to understand the interventions that are being organized on their behalf, is a sure recipe for failure.

The argument would seem painfully obvious were it not for the fact that even to this day, the vast majority of development programmes are conceived and executed without a serious communication component.

Communications personnel are rankled by this "plan first, communicate only after initial failure" syndrome. But as more and more of

those after-the-fact appeals are heard, it is becoming clear to planners that communication is not merely another hardware component consisting of posters, radio messages, and so on, but a central and decisive factor of any programme. Whether it is an effort to reduce the death rate from water-borne diseases in West Africa or an attempt to increase the rice yield in Asia, the communication of the ideas involved does not take place automatically. On the contrary: not only is their value far from self-evident to programme recipients, but their displacement of an existing set of strongly-held ideas is a complex undertaking.

Helping communications gain a more appropriate place in the development context has been enormously helped by recent evidence about its impact. We have seen, for example, the massive shift away from breastfeeding in just one generation. The aggressive use of marketing techniques and the mass media to convince mothers of the merits of formula feeds has contributed to the breastfeeding decline. In a Latin America study we have seen how two groups of children from identical, impoverished social classes show markedly different nutritional status, thanks in the main to the ownership of radios by the healthier families. And we have seen the yearning in many countries for expensive imported clothing inferior in quality to locally made garments, on the strength again of the myths and lifestyles promoted by their communication environment. We are now realizing that **when we talk of communications in the context of social and behavioural change, we need to consider not only the "medium" and the "message" but also all those ideas, habits and aspirations acquired through social contact and interaction.**

Means and ends

Amongst those who have been advocating a more careful study of communication for social development is Andreas Fugelsang, a development specialist who learned a great deal from the cultures in which he lived. Noting the tenuousness of traditional culture, which "is a carefully balanced man/environment interaction system, in which every detail has both technological function and spiritual significance and cannot be disrupted without drastic repercussion for the function of the whole," Fugelsang argues that the *way* new systems, processes and ideas are introduced into a way of life is as important as the benefits which those new systems and ideas hope to generate. To introduce what seems eminently logical to the outsider might in fact strain the recipient community's delicate fabric of socio-economic cohesion.

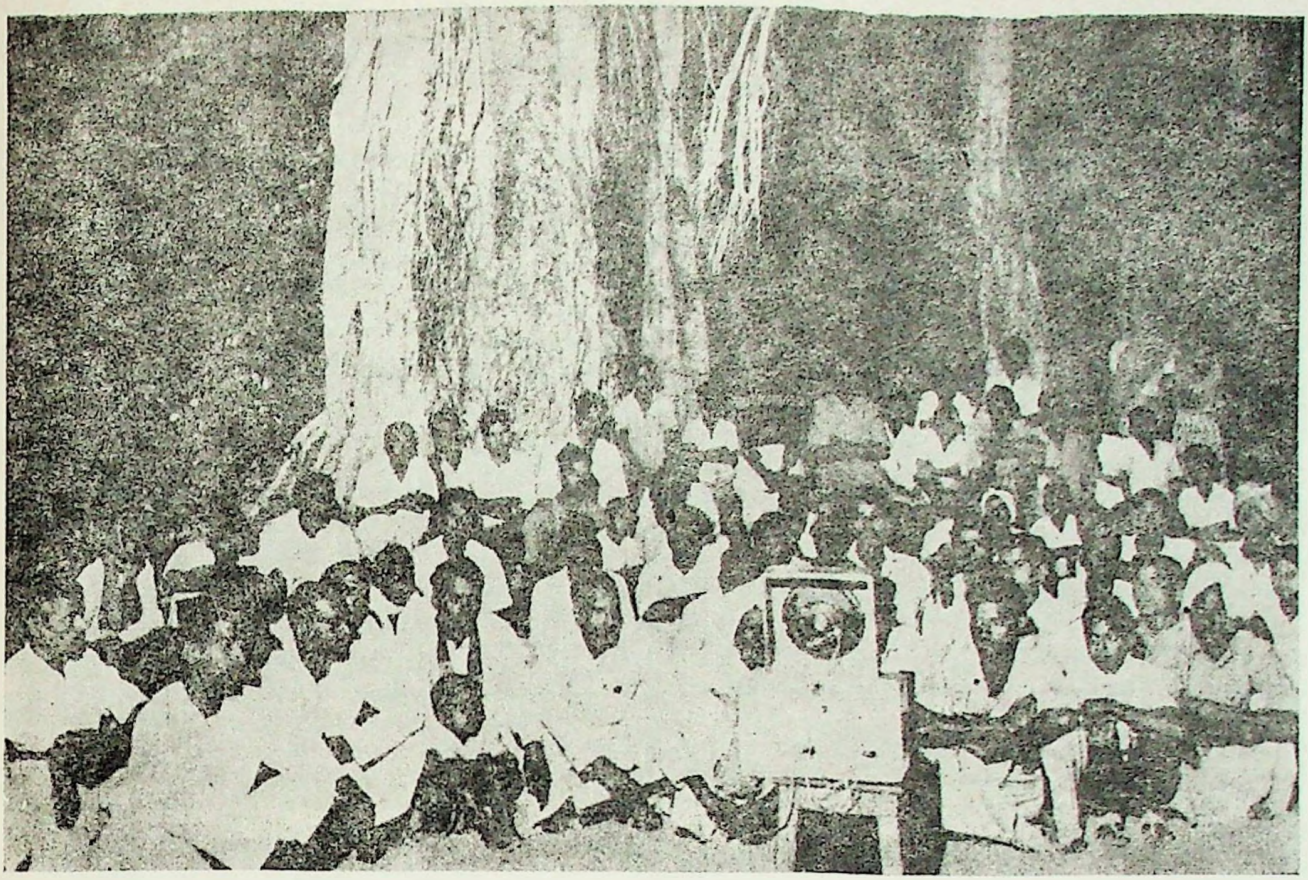
To work in these traditional environments, Fugelsang argues insistently, requires sensitive and astute workers who can sympathetically comprehend the web of social relations of the group. Villages are not the collection of individuals that industrial, urban populations tend to be, and their attitude towards their leaders is different too. Modern societies allow professionals to lead them not necessarily for what they are intrinsically, but for their position in the system. But in the village, a professional will have credibility problems until he or she has proved his worth on a purely human basis. "Villagers live in communion," says Fugelsang, "and life there is characterized by intense communication and interaction".

The distorted view of traditional societies that Fugelsang and others have in the last decade tried to correct was responsible for the hierarchical approach typical of so much development work. This approach is closely related to the paternalistic method of teaching described by Brazilian educator Paulo Freire as a "banking" system, where information is passed down from the active teacher to the passive recipient. In Freire's view, this "prescriptive teaching" diminishes the learner who is encouraged not to act upon his or her world, but to reflect back the ideas given by the teacher. Freire counters this with the notion of "liberating education" which treats learners not as objects but as subjects who act upon their world to change it. The tenets of Freire's thought are **that no-one can teach anyone else; no-one learns alone; people learn together, acting in and on their world.**

Freire rejects conventional education as the tool ruling classes use to discourage the poor from learning and understanding the bases of their deprivations. The learning experience's primary purpose is to help change society, says Freire, particularly that aspect which has denied the illiterates an opportunity to participate in their own destiny.

The commercial communicators

Among those who must be classified as successful in fully investigating their target-group and understanding how to communicate with them are the commercial manufacturers. Their advertising campaigns have revolutionized consumption habits and life-styles across the world. They have saturated the media with advertising carefully researched to gauge the concerns of their audience, and have succeeded far better in changing behaviour than have consciously-designed development programmes. In most third world countries, companies marketing agricultural products have reached remote farming communities with weed killers, fertilizer and insecticides. But try asking the same villagers if they know what is the



Telecommunication media could be used advantageously to promote better health, and to encourage greater utilization of the existing health services.

best remedy for diarrhoea. And in many poor urban areas people will pay hard-earned cash for snacks and junk food, persuaded by commercial advertising that they are somehow "better" than vegetables from the backyard.

A growing number of voices, recognizing the impact of commercial advertising, are therefore advocating that their techniques be adopted in the promotion of social development. They argue that not to do so is to abdicate the print and air waves to those whose primary aim is profit and whose objectives are in direct conflict with the development propagandists. Richard Manoff is an experienced advertising man who has used his commercial skills to promote developmental messages in the third world. Against the enormous power of the mass media to fashion food habits via advertising, the nutrition educator confined to traditional channels doesn't stand a chance", he asserts.

Manoff begins with a religious conviction that there is no idea that cannot be promoted as are commercial products. The way to get your message across, he says, is to create one which is short and confined to a single idea. 'If you look through history, you will find that the great messages have been simple and short. Moses only had 10 commandments and they hardly add up to 60 words and the 17 Rock Edicts of Ashoka are equally brief and to the point.

"Since we are not trying to make the rural mother a nutritionist or a doctor, I don't see why so many of you are writing books or pamphlets which few people except your colleagues are going to read", he says. "The development worker's approach is often too serious and academic, and therefore less impactful. For example, when I was helping promote oral rehydration therapy in Nicaragua, we tried to make the message simple and catchy. We just said: "Make *super lemonada* at home—it will fight diarrhoea'. The lemonade concept was one most mothers related to immediately, and that is basically what anti-dehydration is: lemon, salt and sugar. And we didn't give it any formal name such as ORS, either. The reach of the message was enormous".

Participation and communication: two sides of one coin

While many educators and communicators do not accept Freire's ideological analysis, his emphasis on participation reflects what is probably the strongest new orientation in development work. The whole

(Contd. on page 124)

Priorities in Communications Research in Asia

THERE has been a growing awareness of the need for research in the field of communications.

Instructional communication

Research in this area is important because of the vast number of applications for communication and communication technology for instructional purposes. In several Asian countries, media are used for formal as well as non-formal education. "Open" Universities have been established in a number of Asian countries. Educational Television is also being used in nearly all Asian countries. Media technology is applied for instructional and demonstration purposes in development campaigns at village level.

Projects which may be studied in this area are: Analysis of ETV (formal and non-formal) systems in selected countries relating to coordination, utilization, and feedback; Principles and techniques of distance learning; Development teaching and training programmes in instructional communication and technology; and Feasibility/Application of low-cost media for instructional purposes.

Media economics

In view of the scarce resources of Asian countries, the relatively heavy investment in various media require justification and rationalization especially where such expenditure has pressing alternative uses. Research can be done to improve the cost effectiveness of media. Some research questions which may be asked are as follows: Which of the media or media mix are most cost-effective for different purposes? What is an optimal investment strategy in the financing of communication technology? What is the economic trade-off between investment in communication as against other sectors, such as transportation?

Areas covered include: Alternative financial support systems for different media; Communication investment strategies among and between media; Production of media output; Economics of the communication/information media sector(s).

Communication technology

Increasingly rapid development of new communication technology and its fast rate of acceptance and change, have confronted developing nations in this region with new problems at various levels and in all aspects of life. This growth is expected to continue and will bring forth new problems which will need immediate solutions in the future.

Communications research is urgently needed to answer current pressing questions and anticipate developments to come. Among the priority areas are: Technology transfer: Implications of technology for interpersonal and mass communications; Social preparations for future trends in technology; Uneven and inequitable access to information due to disparity in technology; Social costs of technology; Appropriate and alternative technologies.

Institutional studies

Communication institutions can be distinguished by several features: (a) the employment of technology; (b) the rapid production and management of creative material; (c) the demanding circumstances such as pressing deadlines.

Research on the influences and effects of these factors can help us understand and manage such institutions better. These studies can examine themes such as: decision-making processes; gate-keeping functions in the flow/refraction of information; influence of institutional cultures on media personnel and performance programme management.

Communication for development

All Asian societies have adopted the goal of rapid socio-economic development. Most of them also exhibit an imbalance between urban and rural areas. Thus communications have been looked upon as a tool in engineering change, particularly in the rural sector.

Unfortunately, due to socio-economic disparities that exist in Asian societies, such efforts have not been informed by adequate knowledge of: (a) actuality of rural socio-economic conditions, and (b) processes of communication in rural areas.

Without such data, investment on social change becomes wasteful. The participation of 'actors' in the development effort is not obtained. Following are some of the areas that need to be researched further: Participatory modes of communication; Indigenous communications network such as religious networks which affect rural behaviour; Social marketing techniques for development messages; Role of mass media as against other message systems in affecting behaviour in villages; 'Exposure limits' for media in rural societies; Social structural factors that affect the perception of developmental messages, particularly local stratification systems.

Impact studies

The phrase *impact study* is used here deliberately to indicate that it denotes more than 'effects' study.

A large number of 'effects' studies, mostly correlating a few variables, have been done in the region. However, there remains the need to take a critical look at the strengths and weaknesses of these basic studies. They need to be collated, classified and codified so that theory, with predictive value, can be evolved.

At the same time, efforts should be made to fill gaps in existing research in this field and examine new aspects of impact studies.

Among areas which need investigation are: Relationship between communication processes and behavioural change, on the basis of integrative studies; Media content studies or critical analyses of various media "content" and their effect on individual behaviour, Differential impact of communications media; Multivariate studies; Studies on model or theory construction on media impact on development.

Sociology of knowledge in the field of communications

An analysis of decision-making regarding research priorities, funding, utilisation of research and the relationship between researchers, policy-makers, and value structures that impinge on such relationships, leads us to the area of the Sociology of Knowledge. This is an area which has not been examined at all in the Asian Communications context. But priorities in seeking and using knowledge are related to so many sociological and cultural factors, particularly in an area so multi-faceted as Asia.

An examination of Asian communication research shows a lack of systematic studies on values affecting opinion, attitudes and perceptions, among decision-makers and researchers.

Areas of research may include: public opinion polls or attitude surveys of the sources and receivers of communication toward important national areas of concern; psychological studies of key personnel, collation, analysis and synthesis of existing research data on the subject; structural analyses; various modes of disseminating data; the flow of information from initial sources to receivers; utilisation of data by various intended levels of users.

Communication and culture

Communication occurs in a given culture. It has been shown to both affect media as well as be affected by media. Even so we see a trend towards mass cultures.

In Asia, very little research has been done in the area of communication and culture. A number of countries in the region are multi-lingual, multi-religious or multi-ethnic, which makes communication and its understanding more difficult. As the introduction of modern communication technology aims at bringing about social change, it is important to know what the media can do and cannot do in given social contexts.

Studies that should be done include: Profiles of potential audiences: Communications subcultures: Attitudes, beliefs, values of production personnel: Cultural autonomy: Cultural considerations influencing media production dissemination and use.

– Extracts of the Report of AMIC Seminar held at Singapore, 17-21 May, 1982, AMIC, June, 1982.

Communications for development at the village level
A SPECULATION ON THE BAREFOOT MICROCHIP

1983 is a World Communications Year and it is also the tenth birthday of Development Forum, *the United Nations monthly newspaper on economic and social affairs. As a contribution to the Year and to mark the anniversary of Development Forum, the Government of France has hosted an Anniversary Colloquium in Paris on 23-24 February, 1983 with the support of several former contributing governments to the DESI Trust Fund and other organizations. The subject was communication at the village level in the Third World in the light of the current and and expected technological revolution—"A speculation on the barefoot microchip".*

The idea of the most sophisticated modern technology having any relevance to Third World rural development problems may seem, at first sight, absurd and provocative. For such a development could well be merely the latest example of inappropriate technology applied to development which, like tractors, big roads and green revolution plants are capable of doing more harm than good. However, the microchip is a little different. It is a channel of knowledge and it may multiply manifold the supply of the scarcest resource in development—that of knowhow.

The Colloquium lasted for one and a half days and explored the subject by drawing on resources of the foremost electronics industries and on the accumulation of experience in field communications gathered in the Third World.

The Colloquium covered:—

I. *Technical and economic horizons for village level and rural area communications to the year* 2000, *and the technological/commercial state of the art*:

The panelists touched on remote terminals' reliability and likely costs by year 2000; rural telecommunications, lower power radio transmission; data bank accessing, voice or keyboard (for, for example: the barefoot radio doctor and computer-assisted diagnosis—weather advice for harvesting or disaster warnings—inter-village local market advance intelligence—inter-village-self-help, e.g., techniques, services, personnel exchanges, etc.—construction and repair consultations—regional availability of spares stocks etc.); radio transmitters at village level; storage and editing of radio material; satellite input prospects for village level TV and necessary power sources.

II. *Review of lessons learned about village level communications and how to apply them*:

Do we know the basic rules of programming—how to communicate—at village level—ground rules in the field? How can communicators plug into the experience that has been accumulated? What will be specifically new *vis-a-vis* programming and does not derive from previous radio/TV/teaching machine etc. programming experience? Recapitulation of the programme experience gained in applications technology satellite experiments. Methods of avoiding irresponsible commercialism—conserving the public service element.

III. *Synthesis*:

What could be the scene, in the year 2000, in an idealized/archetypical village? What are the obstacles; Government and aid donors' lack of understanding; political problems arising from local misuse of communications for development; economic factors in the world electronics industry as a whole—is there any chance of developing the right technology for the village level or of making appropriate modifications?

— United Nations 'Development Forum' Tenth Anniversary Colloquium.

(*continued from page 115*)

mittees are means of maintaining liaison with the health programmes and the people. Enhanced status recently awarded to *Panchayats* has enthused leaders to take on further responsibilities for the people's welfare.

The Urban Health Centre, Chetla

The Urban Health Centre, the first urban health centre in India, was established at Chetal in December 1955 under the joint auspices of Government of India and of West-Bengal, Calcutta Municipal Corporation, WHO and UNICEF. It is located approximately 7 Kms. to the south of the Institute and covers an area of 2.17 Sq. Kms. in Ward 86 and part of the wards 78 and 85 of the Calcutta Corporation. It serves a population of about 68,000 and provides total health care and training facilities similar to those at Singur.

Objectives

Main objectives of the Centre are: (a) to serve as an urban practice field area for students of various courses of the Institute; (b) to organize primary health care delivery with the family as the basic unit; (c) to provide domiciliary care through follow-up services and to care for high risk groups; (d) to promote and conduct research in public health.

Organization

The service area is divided into three units of approximately 24,000 people per unit. Medical officers of the Health Centre, look after the Unit Health Clinics Services. Health care services both clinic based and domiciliary are provided to the families residing in the area. They include treatment of the sick, immunization, care during ante-natal and post-natal periods, care of the under five and school children, and family planning services. Special referral clinics for tuberculosis, sexually transmitted diseases, diseases of eye, ear, nose and throat, dental problems and mental illnesses are conducted at the Centre. An Industrial Health Clinic is conducted for workers from small scale industries. A Rehabilitation Workshop for tuberculosis patients and their families, a nursery school and a Women's Work Therapy Centre are run by the Urban Health Centre as part of community Welfare Services.

Community participation

Community participation is ensured in the health activities and training programmes of the centre through the local health council and zonal health committee members and through voluntary and social welfare agencies. ○

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