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the economics of food safety ● immunization : tunisia means business ● healthy mothers—healthy children ● what a healthy child needs ● mothers first ● message from d g of who ● public interest litigation ● understanding diphtheria

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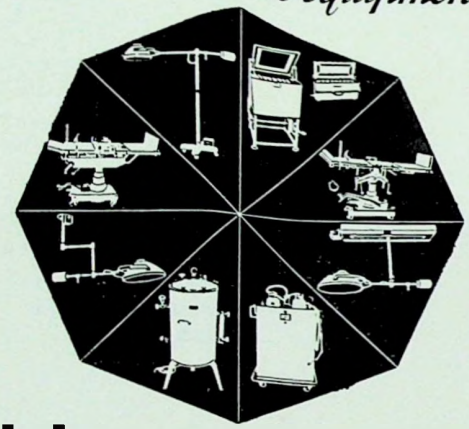

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contents

EDITORIAL

The Easter joy

By the time this reaches you, you will be busy with preparation for the big feast of Easter. The season of lent is a time of preparation, in prayer, fasting and penance. Then comes the Joy of Easter ! However, during this Easter time let us reflect a little and see how far this joy is a reality to millions of people in the world and particularly in our own country. Christ came to this joy to all and not only to a few. But the situation in the world today is so alarming that many a million cannot think of this joy. The reason is because a few want extra joys and comforts at the cost of many.

Let us try to see this year's Easter in a new perspective. A true Easter joy can come only through a true conversion of heart. Our fasting and penance will have no meaning unless it is coming from the conversion of hearts. Isaiah has this to say about fasting. "The truth is that at the time of your fast you pursue your own interests and oppress your workers. Your fasting makes you violent and you quarrel and fight. Do you think this kind of fasting will make me listen to your prayers ? When you fast you make yourselves suffer; you bow your heads low like a blade of grass, and spread out sack cloth and ashes to lie on. Is that you call fasting ? Do you think I will be pleased with that ? The kind of fasting I want is this, remove the chains of oppression and the yoke of injustice and let the oppressed go free. Share your food with the hungry and open your homes to the homeless poor. Give clothes to those who have nothing to wear ....." (Is. 58 : 3-7)

There is no ambiguity in these words to see what is expected of us. This is all the more meaningful today when we see different kinds of bondage and oppression in which millions of people in our country are doomed. Guidelines were given regarding fast and abstinence, by the CBCI during the last general body meeting. More could have definitely be given along the lines what Isaiah has to say about true fasting. Concrete steps need to be taken. True fasting cannot be restricted to lenten season alone. This must be a life time commitment.

What is the type of fasting that we have to undertake in this country : When millions of innocent children are killed before they could see the rays of light ? When 33000 children below the age of 5 years die every day in developing countries ? When 17 millions of our children in India are

condemned to hard labour in inhuman conditions ? When hundreds of thousands of children are condemned to work, sometimes even more than 12 hours a day in tea stalls, restaurants etc. to get a paltry sum of 2-3 rupees a day ? When 3 children die every minute in our country of diarrhoea which could easily be prevented ? When more than 300 million people in our country alone will have to go to sleep every night with a hungry stomach ? When millions of our brethern in this country has no roof over their head except the wide sky ?

We could go on mentioning a few more. That is reality which we face everyday. Against this reality we have to view our fasting and our Easter joy. We can participate in the Easter joy only if we are prepared to be disturbed at these realities. It sounds a litttle bit odd. But the extent of sharing of the Easter joy by millions of our suffering and oppressed brethern will depend on the extent of the willingness from the part of the privilaged ones to be disturbed and to do something about it. Let this Easter be an occasion for each one of us to have a real conversion of our hearts and thereby to do something concretely to fight against injustice and oppression wherever they are found especially if and when we oursleves are responsible for injustice and oppression some times. That is the real conversion of heart. That is true fasting and penance as Isaiah would have it ! And that will bring true Easter Joy for ourselves and for others.

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The Economics of Food Safety

—Lawrence D Smith

Most people in developed countries associate food contamination with an occasional "upset stomach" or with a still rarer major outbreak of food poisoning, as occurred recently in Spain when hundreds were made seriously ill by adulterated cooking oil. It is seldom appreciated just how widespread food contamination is in both developed and developing countries, nor how tremendous are the costs it imposes on society.

No one has yet attempted a global estimate of these costs, but the sums involved are likely to be astronomical. The total bill would have to include the value of crops and animal products wasted or destroyed as a result of contamination; the costs of controlling and treating the problem at source; the cost of treating diseases induced by food contamination; and the loss of output or earnings resulting from illness, disability or premature death as a result of consuming contaminated food.

Such limited information as is available gives some idea of the sums involved. A WHO Report has estimated that in 1977, the economic cost to the Federal Republic of Germany attributable to salmonellosis *in humans and food animals* was 240 million Deutsche Marks or 4 Marks per head of the population. Of course, salmonellosis was not the only form of food contamination, nor was it necessarily the most important.

In the three months from January to March 1980, the United States Food and Drug Administration rejected US$65 million of imported food on safety grounds—and this is one of the few governments which publicaly records such figures. The result was a considerable financial loss to the exporters, many of them in developing countries; but had these foodstuffs been consumed within the United States, the economic consequences of the resulting food-borne illnesses could have been even more severe.

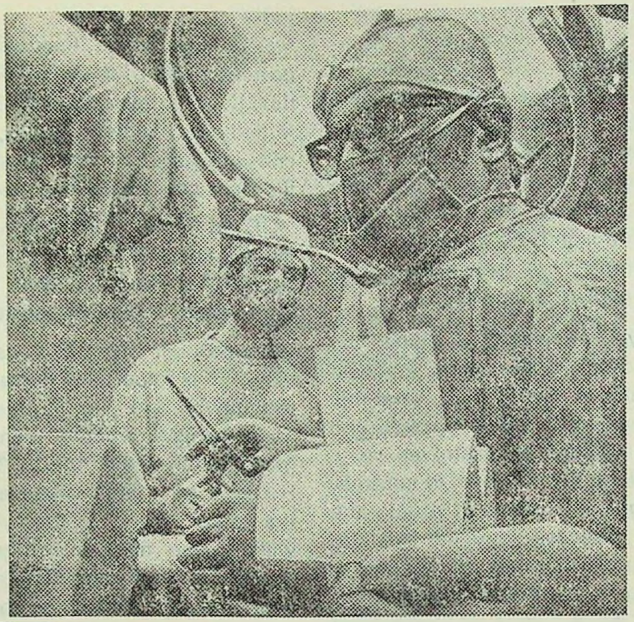
Food safety improvements inevitably involve costs. So one much debated question is whether the individual consumer or the government should pay for them.

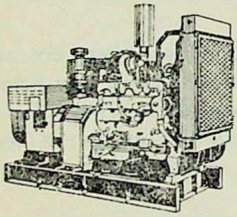
From the individual consumer's point of view, it is important to distinguish between the *desire* and the *demand* for safe food. Most people, whether rich or poor, would prefer to have safer food. This is a desire. However by "demand" an economist means the quantity of a food that a person is willing, and has the money, to buy. To the economist, food safety is just like any other item or service which can be purchased for money.

Thus poor people in low-income countries may desire safe food. But they may have a low demand for it, because they have decided that buying safe food, or buying the means to obtain safe food, is unlikely to be good "Value for money".

At the lowest income levels, people may prefer to spend any extra money on buying more food of the same quality, rather than less food of a higher quality, since their main priority is to stem hunger. In many circumstances it may be difficult to buy safe food cheaply or in small quantities. In some African countries, pasteurized milk can only be purchased in very expensive cartons. Yet a cheap carton would bring safe milk within the reach of many more consumers.

Emergency ?





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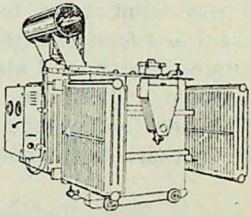

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Some low-income people may think that "safe" products are of little use if the rest of the environment cannot be controlled. There may seem to be little sense in buying a hygienically prepared powdered food if the water that has to be added to it is highly polluted.

Finally, the very poorest members of society, particularly in low-income countries, may be almost indifferent to food safety, because in the marginalised role they play in society they remain completely ignorant of the benefits associated with safe food.

Food safety, or rather its absence, is yet another aspect of the poverty problem. As incomes rise and educational levels improve, so the desire for food safety is likely to increase, and with it the demand. High-income people spend a much lower proportion of their income on food than poor people; consequently they can easily afford to purchase higher quality and safer food than poor people.

However, just because poor people cannot afford to spend their own money on food safety, governments should not ignore their responsibilities in this area. Within their resource limits, they should seek cost-effective methods of improving food safety that are suited to the economic, social and cultural environment and to the food systems in which food contamination occurs. Let us look more closely at the three major food systems.

Low-income rural food systems

In rural areas of low income countries, where a large proportion of the world's population lives, the food system tends to be very simple. Most people grow their own food or buy locally grown food. Only a few essential items such as salt and spices originate outside the area, and nearly all food is prepared with in the home.

One major food safety problem stems from the inadequate drying and storage of staple foodstuffs. This can lead to aflatoxin contamination—the growth of a fungal mould which is strongly suspected as a cause of liver cancer. Poor practices of handling and preparing food within the home represent another problem. Fuel is becoming increasingly scarce in many rural areas (partly as a result of deforestation) and may have compromised some of the traditional cooking practices which helped to maintain food safety. There is considerable ignorance about the cause of enteric and diarrhoeal diseases and the extent to which these may be transmitted in foodstuffs, and about such matters as personal hygiene and appropriate food safety.

So those who live in the countryside have, on the whole, to be taught food safety. This is best done as an integral part of primary health care programmes, and as a component of agricultural and integrated rural development programmes. Traditional methods of food preparation may need to be modified to suit new circumstances, and research may be required into more effective ways of drying and storing foodstuffs.

Low-income urban areas

In the main cities, most foodstuffs now have to be purchased. The food chain is frequently long, and a complex, fragmented food system develops which involves numerous intermediaries.

With rapid population growth, the volume of business expands. The central wholesale markets, vital for the orderly distribution of large and fluctuating quantities of variable quality produce, frequently become congested and increasingly insanitary.

The retail distribution system consists of a multitude of low-volume outlets--including public markets, shops and itinerant street

vendors—which reflect the economic realities of low-income city life. Consumers need neighbourhood shops as they cannot afford to travel far for shopping; retailers are poor and can only finance a small volume of trade; and retailing offers a minimal livelihood to many people who cannot obtain employment in the modern business sector. But, of course, this extremely competitive structure, with its low cost and minimal services, often gives rise to poor standards of food hygiene. This is especially true of street vendors who prepare cooked foods. Large quantities of food may be prepared several hours before being consumed, and may then be held in conditions which encourage rapid microbial growth. Food processing is often carried out by small firms operating in inadequate premises.

Furthermore, the consumers themselves often have to live in squalid conditions. Lack of ready cash may oblige them to cook food only once a day, and to leave some of itin the pots to be consumed later. In high ambient temperatures this can rapidly become contaminated.

How can food safety standards be improved in these situations? Solutions which ignore the economic realities and constraints are unlikely to succeed. Banning street vendors or strictly limiting their numbers would inflict considerable hardship on lower-income people in general. Strict supervision of all retailers is virtually impossible, given their large numbers and itinerant habits. Medical examinations of food handlers are costly and do not guarantee the detection of more than a small proportion of carriers of pathogens; screening for pathogens in stool specimens is not cost-effective.

Raising market fees in order to finance sanitary or infrastructure improvements may encourage traders to move their businesses into the streets, thus only making the situation worse. The higher fees would probably be passed on to low-income consumers.

In such a situation, it seems sensible to concentrate policing efforts on minimising the likelihood of deliberate food adulteration and the sale of obviously contaminated food. But most resources should be devoted to health education : educating food handlers to appreciate the financial benefits they would derive from minimising food losses as well as showing them where their moral responsibilities lie, and educating consumers by incorporating food safety as an integral part of primary health care. At the same time, low-cost food processing and preparation techniques incorporating food safety need to be developed and introduced. And these will call for methods of financing improvements to the infrastructure which do not put an undue burden on low-income consumers.

High-income areas

In many ways, the potential for achieving food safety is greater in high-income areas and countries. The food system is more integrated, a high proportion of food being retailed through supermarket chains. Most foodstuffs are packaged, especially the processed products.

To operate successfully, supermarkets need regular supplies of uniform products of known quality. This requires close integration or coordination with processors and producers, and the institution of quality controls backed up by laboratory testing for contaminants. Because both supermarkets and processors tend to operate on a large scale, they can afford the expenses involved in quality control. Even on a voluntary basis, a reasonably high degree of food safety would probably be maintained in this part of the food distribution system.

In developed countries, moreover, government and local authorities can afford the

finance and manpower to police the system and consumers can afford to pay the costs of inspection services. Indeed, by identifying and monitoring the critical aspects of food production and processing only, there could probably be a reduction and redeployment of public resources with a negligible impact on food safety.

Given this situation, it might seem surprising that food safety problems still remain a serious problem in high income countries. One problem is that with large-scale production and far-flung distribution, and breakdown in quality control can have substantial repercussions. Furthermore, food safety frequently breaks down within the home; many people forget, or are ignorant of, basic food hygiene practices and re-education is a recurrent need.

However, the major problem seems to concern the catering trade, which is still frequently fragmented. Most food contamination problems arise from inadequate cooking and food-holding practices. Substantially more education and policing will therefore be justified in this area, with much stiffer penalties for food safety abuses.

Courtesy WORLD HEALTH

Immunization : Tunisia Means Business

Nedd Willard*

The landrover bounded over a large rut and came to a stop in a small clearing in the middle of the heavily wooded forest. The driver sounded the horn.

Slowly, through the grove of oak trees, people began appearing. Most were mothers or grandmothers, carrying a child in their arms, but some were children themselves with small brothers or sisters clutched in their grasp. They knew why the landrover had come and, holding green "health passports," they walked up to the vaccinators in this wooded and mountainous part of Tunisia.

This quiet spot represented one of the most remote links in the national expanded programme on immunization (EPI). Tunisia's programme was reaching more children all the time. Moreover, the health workers had iron-clad evidence that the vaccine they were using was effective. Though a highly developed country in many ways, Tunisia still has a high rate of infant mortality and must cope with infectious and parasitic diseases. Immunization, it was decided, offered and excellent weapon, and often the only one for fighting some diseases threatening children. Therefore, in 1978, the Ministry of Health made a momentous decision to press ahead with a far-reaching immunization programme.

The role of WHO was modest but important. In 1979, the first Tunisian completed a WHO training course in planning and managing an immunization programme. Fourteen other candidates followed and today the Ministry of Health of Tunisia is fully able to run its own training centres. By 1983, only five years after the decision to strengthen the immunization programme, Tunisia and WHO are cooperating in a nation-wide review which covers not only immunization but other aspects of Tunisian primary health care.

No more Mass Campaigns

Right from the beginning, tough goals were set for the programme. The first was to improve coverage to ensure that more children were being vaccinated and fewer overlooked. The next was to guarantee the equality of the vaccine being used; and this could only be done by setting up a "cold chain". A cold chain is a system that ensures, the potency of the vaccine by seeing that it is kept at the correct, low, temperature from the time it leaves the manufacturer until it reaches the child. This system is under constant surveillance.

A major strategic change was made when the programme of immunization was integrated into the routine activities of the health care system, abandoning the mass campaign approach of earlier years. Fitting closely into the other services offered by the general health care system, immunization became a standard procedure rather than an exceptional measure employed from time to time.

A unique characteristic of the programme was that it was constantly and carefully evaluated as it went along, everywhere and on every level.

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* Information Officer in Charge of World Health Day, WHO Headquarters, Geneva.

Since 1982, almost every child born in Tunisia has been registered with the local authorities and presented with a green "health passport". The passport has space for information about the family, about the weight and growth of the child and the immunization received. Every visit to a maternal or child health centre, a general dispensary or district hospital offers health workers a chance to check the book and give needed immunizations on the spot.

Some populations are too remote even to reach peripheral health services on a regular basis. To make sure their children are immunized, an ingenious system has been worked out. Health authorities discuss the situation with local village leaders who indicate when would be the best time for mobile health workers to visit their village. Sometimes they indicate a "meeting point" like the one in the forest. When the time comes, parents and older children bring those needing immunization and the job is done on the spot. And the system works.

Nothing is perfect. However, in the case of immunizations that require multiple doses, the attendance of children drops at each successive immunization. Also, there are rarely more than the basic facts about immunization recorded in the "health passports". Too often, for example, the growth charts remain as blank as when they were issued. This may be due to a lack of scales, or time or simply to the fact that vaccinators are not aware of how important this information is.

Many mothers understand the importance of immunization. But many others do not. In some cases, it seems that the reason parents bring their children to be immunized is that they know that their children will need the "health passport", with its record of immunization, as an admission card to primary school. More education is needed but, in spite of these shortcomings, the fact remains that almost all of the newborn children in Tunisia are being reached and immunized; this is a remarkable achievement.

Finding the Facts

One thing that strikes an observer is the determined efforts of all the staff of the Ministry of Health and the immunization programme to find out how things are going in the field. They are willing to face facts and constantly try to improve weak links. The cold chain, which ensures that vaccine is still potent when given to children—something still far too rare in most developing countries—is a key to success. As early as November 1981, working in collaboration with WHO' s EPI programme, it was decided to run a nation-wide check to find out if things were working out in practice. Moreover, if the vaccine was being kept cold from the moment it arrived from the manufacturer until it reached the children, it would be a sure sign that there was good organization all along the line.

Means to evaluate the cold chain were kept simple. A small card called a cold chain monitor travelled with the vaccine as it went along the cold chain. Any exposure to temperature above 10°C or 38°F caused the widow on the monitor to turn irreversible blue, going from left to right the farther right spread, the higher temperature the blue stain it recorded.

At each link in the cold chain, at a dispensary for example, the location, temperature and date were recorded on the monitor card so that, at the end of the line, the vaccinator had a complete history of the temperature exposure and could decide whether or not to use the vaccine. Then, the cards were returned to the Ministry for a country-wide analysis.

Staff were quickly trained to use the monitors. Tunisia, with a population of approximately 6,750,000 people has 700 immunization sites. During the study, which lasted seven months, 863 cold chain monitors were distributed.

Amazing success

Ninety-six per cent of the monitors that were returned had a complete time and temperature history from the moment they left the vaccine manufacturer until they reached the immunization sites. Results were amazingly good. It was found that 24 per cent of the monitors reached their destination with no break in the cold chain; the temperature stayed below 10° C during the whole period.

When the temperature in the cold chain exceeds 10°C for a period of one hour to eight days, the most heat-sensitive vaccine, poliomyelitis, must be employed within three months. This does not present any real problem, even for polio, and 74 per cent of the monitors reached their destination with no more than this exposure.

Where the temperature has been allowed to go over 10°C for 8-14 days, the polio vaccine should be tested before using and the other vaccines used up within the next 3 months. Only 2 per cent of the monitors showed exposure to this extent. Finally, no monitor was shown to have been exposed above 38°C which would have probably rendered the vaccines useless.

Thus the cold chain was working, from the airport, or the factory, along the road, all the way to the most distant regions. Some regions were doing better than others and the cards proved to be a sensitive indicator of this.

Surprisingly, instead of resisting the "silent monitors", most members of the programme welcome them. It was planned to use them again with some modifications. They would be simplified, making them cheaper by half, and made more sensitive to the duration of the temperature exposure.

The strongest benefit of the cold chain monitors was not to collect data for the central office but to allow mid-level personnel to carry out self-evaluation and to improve the standards of vaccine care on the spot. And, as part of a team with a high morale, they welcomed the opportunity.

The score-card so far

Although the first goal for covering the child population was 50 per cent, the programme has already gone beyond that. By 1979, over 80 per cent of the children in Tunisia had received BCG, and 60 per cent had received the full series of both DPT (diphtheria, pertussis and tetanus) and polio immunizations.

Even though it is too early to be able to show concrete results, first signs are that the immunization programme is already making an impact in mortality and morbidity. Diphtheria is being beaten back. The number of cases in 1971 was 49, by 1981 the number had dropped to 4 and in 1982 there were only two reported cases in all of Tunisia. Pertussis (whooping cough) is becoming rare as a result of childhood immunization.

Tetanus continues to be a serious problem. Almost half of the cases occur among the new-born. The total number of tetanus cases has declined since 1971, when it was 43, to 27 in 1981.

Polio received tragic national prominence in a widespread outbreak in 1962 that was only stopped by a mass campaign. Since then, in spite of fluctuation, there continues

to be a downward trend. In 1976, there were 12 cases of poliomyelitis. In 1982, there were only six cases and coverage of infants is increasing as part of regular primary health care. Most cases of polio are reported from children under two and that is where a major effort is being made.

Measles was another disease that had an epidemic flare-up as recently as 1981. It presents a serious threat in Tunisia because of the high rate of complication and the frequent risk of death. The most dangerous years are two to six and there is also high risk from nine months to two years. Therefore, Tunisia is going to extend its proection of children with immunization against measles.

Glowing results don't mean that there aren't any problems. There are problem areas connected with BCG vaccination which does not seem to offer as complete a protection as was once assumed. Also. cases of polio still occur in children that have been vaccinated. Research is going on to discover where methods or vaccines could be improved.

What does it cost ?

Health cannot be measured in terms of money but money is a question that must be dealt with when weighing and comparing programmes. There is only a limited amount to be spent, especially in developing countries. Where should it best be spent ?

The Ministry of Health drew up a careful accounting to find out what the EPI really costs. Among the expenses are transport, including fuel, upkeep, salaries, and price of vaccine. The conclusion was that the basic cost to immunize a child against the major diseases—TB, diphtheria, tetanus and pertussis, polio and measles—came out to be less than US$ 3. Surely a price worth paying'!

Tunisia is a country that has a variety of micro climates and scenery open steppes rugged coastlines, large beaches and wooded mountains. The infant mortality rate is still too high, but it is banking on public and preventive health. The country has now four medical schools, 19 paramedical schools and 30000 health workers.

One thing is sure. Wherever you go in Tunisia, whichever dispensary you visit, you will find a clean, well-running fridge, stocked with potent vaccines. There is a constant flow of information and assistance going back and forth from the periphery to the centre. An important investment is being made to ensure the most essential resource a nation has...its healthy children.

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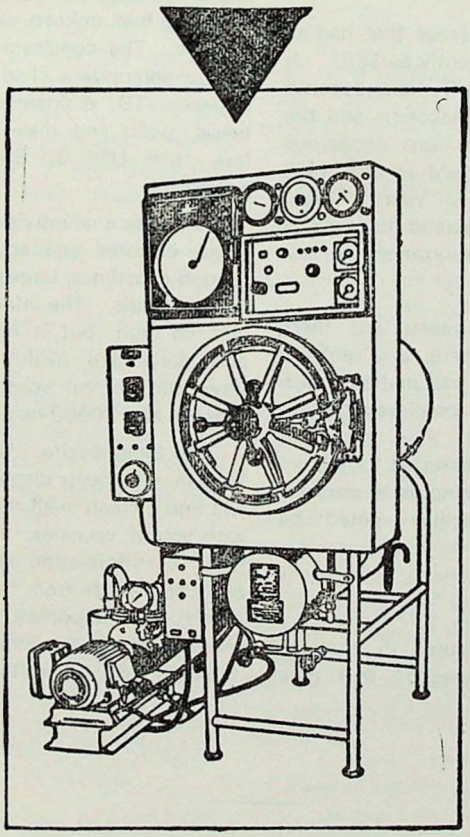

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Healthy Mothers—Healthy Children

Jitendra Tuli*

Built as a pleasure palace by a nobleman over 150 years ago, the beautiful "Chatri" still bustles with activity, but of a different kind. In the red sandstone courtyard, a mother carefully feeds her infant daughter spoonfuls of oral rehydration solution inside the ornate hall, where once the sounds of music and ankle-bells filled the air. another infant loudly wails in protest as he is weighed. In another corner, a health educator patiently explains the nutritional value of green leafy vegetables to a young, pregnant woman.

This is an everyday scene at the Rural Health Centre in Ballabhgarh, about 45 kilometres from Delhi. Run by the Centre for Community Medicine of the All India Institute of Medical Sciences, the facility caters to a population of 108 000 spread over 100 villages in the State of Haryana.

Over the years, the Centre had expanded and now has a small referral hospital attached to it. "Apart from providing the sort of services available at other health centres, we are concentrating on the high-risk pregnant women", says Dr L.M. Nath, Professor and Head of the Centre for Community Medicine, who on one of his periodic visits. "Every Wednesday, we hold a clinic exclusively for such women", he added. During the week, the health educator and other staff at the Centre use the opportunity of the mothers' visit to explain other behavioural factors that can ensure a healtheir life for them and their children. This reinforces the efforts put in by the health worker in the village, who continues to be the first level of contact for those in need of health care in rural areas.

Infant mortality down

The success of this approach can be seen in the fact that the maternal mortality rate in the area served by the centre is less than one per 1000; this is striking when compared to the national average of over six per 1000. As for the infant mortality rate, it is 58 per 1000 which is close to the target of 50 per 1000 to be achieved by the year 2000. And there are even more ambitious goals ahead.

What is stressed repeatedly at this Centre, and others like it throughout the country, and the Region, is that only if mothers are healthy can you have healthy infants. Everyone is well aware that the health of women generally, and especially those about to be mothers, is crucial to the birth and development of healthy children. In several studies conducted in the Region, it has been seen that the most important cause of premature and low birth-weight deliveries is the poor state of the mother's health. Usually, the contributing factors were malnourishment and infections, including malaria or other parasitic diseases.

These, therefore, are the areas that are tackled first. In other primary health centres some novel approaches to involve the community are being tried out. For instance, in a small village about 60 kilometres from Gwalior city in Madhya Pradesh, Central India, mothers-in-law clubs have been established where they are motivated to see to it that their daughters-in-law eat the right kind of food. Accrding to Dr Leela Phatak, Director of the Birla Institute of Medical Research in Gwalior, which runs four health sub-centres in the rural areas, "the idea was

* Information Officer for the WHO South-East Asia Regional Office in New Delhi.

to involve a very influential segment of the population in helping improve the mothers' health". It is well known that mothers-in-law wield considerable influence in the household, "so we thought it would be ideal to have them as health educators". The approach is working, and slowly a change can be discovered in some of the attitudes of these women towards eating habits, superstition and spacing of pregnancies.

Mothers' health essential

Dr Nath, however, is quick to point out that the success achieved in their programme should not be seen only as a success of health services intervention. "It is much more than that. In fact, it underscores what is now being increasingly recognized the world over, that health development, to be successful has to be a multi-sectoral effort. Thus we see that health centres which are adequately staffed and equipped are most effective when there is provision for electricity, water and education". As for material resources, it is interesting to note that effective health care is provided at their health centre for only Rs. 1 (or 10 US Cents) per head.

The crux of effective care, says Dr Nath, is time. "We make it a point to answer any questions the visitor, specially mothers or pregnant women may have. It is not just a case of filling out forms and maintaining records. We know that we are dealing with rural folk who just do not have much time. That is why, if a woman brings her child here and later misses out on a further dose of polio vaccine or other immunization, we follow-up at home".

This approach is working and the message is getting across to the people at last that a healthy child and a healthy mother go together. You cannot have one without the other.

Courtesy: WHO

What a Healthy Child Needs

Professor Michel Manciaux*

Development is the leading characteristic of the child, who is a growing and constantly changing individual. But the child is more than just "the young of mankind," he or she is a person right now, who lives the present moment truly and intensively. "His name is today", as the Chilean poetess Gabriella Mistral put it so well. To meet essential needs of children, day by day, is to ensure their growth and harmonious development and therefore to prepare them for the future.

The development of the child also means health : there can be no satisfactory growth or development if the child's health is chronically impaired, for example by malnutrition. People often look for "indicators," positive indices for describing and measuring health. In childhood they are readily available : measurements of weight and height gain ; the acquisition at given ages of different sensory, motor and mental capabilities, are so many milestones along the road to development, and also indicators of good health at both the individual and community levels.

Sometimes the sequence "needs, demands, response" is used to study health problems. This is hardly suitable for the child, who is not accustomed to formulating requests, at any rate in the terms familar to us. It is up to the adults, particularly those in charge of children, to know their needs and the most appropriate way of responding to them.

It is customary to divide the basic needs of every human being into physical, biological and psychological needs. Such a distinction is practical but somewhat artificial : breast-feeding, for example, is beneficial, not only because the mother's milk is perfectly adapted to the nutritional needs of the infant, but also because it strengthens the bonds of affection between child and mother and leads to highly rewarding exchanges, "interactions," which are difficult to replace.

The need for life

It is the physical needs which are easiest to understand, if not to meet. They essentially relate to shelter, food and clothing. Elementary as they are, they are far from being met for all the world's inhabitants at all ages of life. Children are often the first victims of natural catastrophes and also of the man-made disasters we call famine, conflicts between adults, and wars. The child's first need is truly the need for life, for the survival which is essential not only for the continuation of the species but also for the development of family planning programmes, which are acceptable to parents only when they are convinced that the children already born have good chances of survival. The modern world sometimes seems to forget this need—the most important of all—to judge by the 12 million children who die each year before their birthday : yet is would take very little to save most of them.

As to the psychological and social needs, they have been the subject of many studies and a variety of observations in the last 20 years. In order to develop to the full,

* Professor of Public Health and Social Medicine at the Faculty of Medicine, Nancy, France.

children need love and security, new experiences, encouragement and stimulation and, very early in life, responsibilities they can cope with. There is nothing new in all this, and the countless generations which went before us managed to find out what was good for the young of mankind. But the social upheavals of recent decades have in all countries overturned the traditions deprived from human experience. So it is just as well to remind parents, educators, helath professionals dealing with children, and the decision-makers of what is good for the overall health of children, for their happy development in today's world. Through observation and a detailed analysis of new situations, both in the industrialized countries and in the developing world, novel methods must be devised for meeting these needs in new and changing contexts.

A good example is provided by the early socialization of the child. In many countries more and more children are being entrusted earlier than ever, and for longer periods than ever, to institutions which look after them and educate them. Instead of shaking our heads at this state of affairs, which is no doubt irreversible anyway, would it not be better to try to derive from it the greatest benefit for the child, by providing adequate training for those in charge of him and, above all, by creating educational cohesion between the natural family and these child-care structures ? This is easier when the community itself—village, neighbourhood, group of families—helps to set up and run these institutions. The parents do not feel strangers there and are less tempted to abdicate their responsibilities to the professionals who they think, wrongly in most cases, know better than they do what is best for their child.

One last word about the world we live in. It offers its inhabitants many opportunities and at the same time many risks. The first and foremost beneficiaries of everything we can do to increase the opportunities—of socioeconomic and cultural development, health, peace—and to reduce the risks—of pollution, poverty, ignorance, disease and war—will be the children of today and tomorrow. The needs of the world's children are not merely a list of requirements which we have to try to meet in order to guarantee them the best chance of optimum development : they are rights which the United Nations formally recognized in 1959 and which have been ratified by all countries of the world. It remains to put them into practice, and that is by no means the easiest of tasks : but the future of the world depends upon it.

Courtesy : WHO

Mothers First

Mark A. Belsey*

The birth of a child represents considerable investment—of love, of energy and of expectations by the parents and by society as a whole. The death, disablement or curtained potential of an infant taxes the current generation and denies future resources to the community. The deaths every year of 17 million children under five are tragic, especially as almost all of these deaths are preventable. However, the human loss is even larger than that. Worse in many ways is the aftermath of survival on weakend children who may be stunted or live in blindness : such children may drag out painful lives crippled by polio or be mentally retarded because of a poorly managed delivery. It is our most urgent task to limit this suffering and death and, given the determination, we have the means at hand to do so. Health care systems, as they are now run, too often fail to meet the needs of mothers and children, the most vulnerable group in every society.

Until recently, before the dawn of the concept of primary health care, the usual response of health authorities to the staggering problems mentioned above has been to demand more resources, to equip more hospitals with more advanced technology, and to train still more doctors and nurses. There was a growing feeling of dependency in the society, a feeling of helplessness that looked to physicians and high technology as the only ways to deal with the problems of childbirth and infancy. Today, there has been a shift in approach towards primary health care, and mothers and children will be the first to benefit from it.

Action to promote and protect children begins even before pregnancy, for example by such measures as wide spacing of births, with intervals of two to three years at least, and by delaying a young woman's first pregnancy until she is physically and socially mature enough to cope with it.

Breast-feeding is one of the simplest and safest ways of ensuring adequate spacing of births. Unfortunately, it is on the wane in many places which means that there is a need to use such techniques as the pill (hormonal contraceptives), IUDs and barrier methods for longer periods of time. The consequences of this decline in breast-feeding could be dramatic. For example, if the duration of breast-feeding in Bangledesh were to decline from the current average of thirty months to less than six months, as is already happening in many urban areas of Latin America, then the use of other contraceptive methods would have to increase from 9 per cent, as it is at present, to 52 per cent just to maintain the current fertility pattern.

A newborn's legacy

A newborn's weight when it is born is a legacy for health in infancy and childhood. It may provide a boost; or it may be handicap which can extend for years and represent a threat to the infant's health. Where low birth weight is common, affecting up to 20 or even 30 per cent of the newborn, as many as one-third of such infants die soon after birth and another one-third may perish during infancy. This is a result of their increased vulnerability to infection and malnutrition. Even one-third of those tiny infants who manage to make it to childhood have less capacity for attaining full growth and development. Life for the low-birth-weight infant begins with a serious handicap.

Therefore, families and society should see that each child has a fair legacy by ensuring that women receive sufficient and varied food during pregnancy. They should be allowed rest and not forced to do heavy

* Chief of the Unit of Maternal and Child Health, WHO Head Quarters, Geneva.

physical labour. Finally, conditions such as anaemia, still all too common among pregnant women in developing countries, should be prevented or treated.

"Modern" hospital practices developed in highly ihdustrialized societies often owe more to the convenience of doctors than they do to sound scientific data. Many traditional practices are now being rediscovered as technically sound. For example, delivery in a squatting position, still common in many countries, allows, for an easier delivery with less risk to both mother and infant, than the supposedly "modern" way, with the mother lying on her back.

Dangerous traditional practices

Delaying the first feeding of an infant, and separating it from the mother after delivery, is another dangerous practice that has crept into many countries. On the contrary, putting the infact to the mother's breast immediately after birth helps to contract the mother's uterus and control bleeding. Breast milk itself contains protective substances and antibodies that protect the infant against germs that are present in the environment. Keeping the infant with the mother also allows the infant to build protection to germs in the hospital environment. Therefore, placing newborns in the supposedly safe, hygienic environment of a separate nursery may actually be placing them at greater risk to a variety of germs which are increasingly prevalent in hospitals.

But this is not to say that all traditional practices are good or even safe. One-half to one million infants die each year of tetanus as a direct consequence of the way in which the umbilical cord is cut and treated. By providing the traditional birth attendant with a simplified kit, consisting of a razor blade, two cord ties, clean gauze squares and a small bar of soap, and by stressing the need for cleanliness, tetanus of the newborn and sepsis could be reduced by as much as 95 per cent.

Immunizing all women of reproductive age against tetanus would make this disease as much of a rarity in developing countries as it is in developed ones.

Sharing responsibility

Supported by the health systems with information and appropiate technologies, families, and this includes the fathers, can share much of the responsibility for seeing that a child is growing up correctly. The use of rehydrating salts for home-based therapy can make a dramatic impact on the mortality from diarrhoeal diseases. In the case of fever, a child's mother is usually in the best position to decide whether it is serious enough to require the advice and treatment of a health worker or can be managed at home with sponging and making sure that the child gets enough food and fluid. Parents should know how important it is to keep feeding children during illness because this prevents the onset of malnutrition which so frequently follows bouts of acute diarrhoea or respiratory disease in children. Severe cases of malnutrition can lead to blindness.

Monitoring the growth of children by using a simple chart enables parents and health workers to spot inadequate growth and take action. The failure of a breast-red infant under six months to gain enough weight, for example, can often be traced to the use of supplementary foods that are contaminated and cause diarrhoea. The failure to gain weight after six months may be due to constant infections and the parents' belief that they should stop feeding the child during illness. It may also be the result of not beginning to start supplementary feeding soon

enough. It may be neeessary for health workers to decide the cause but, when used by parents, the growth chart can act as a warning signal.

Immunization against diphtheria, pertussis, tetanus, poliomyelities, measles and tuberculosis can provide a strong shield to protect infants and children. These diseases are killers in their own right but, even when they do not prove to be fatal, they undermine a child's health, making it more liable to death or disability from respiratory diseases and malnutrition. Prevention of these diseases by vaccination is a simple and relatively cheap technique, but it requires good organisation to ensure that enough children are protected and that the vaccine used is effective by being kept at the right temperature from the time it leaves the laboratory. Equally important is convincing mothers of the necessity for bringing their children in for vaccination.

The health of children today is the measure of quality of the next generation. It requires a serious investment now, by the mother, the family and the health professionals of this generation. All have a role to play, and mothers and children will profit best if they form an integral part of the web of health promotion measure that include everyone in society.

It is vital to stress that the full responsibility for dealing with mother and child health does not rest with families alone. Individual can do just so much but their efforts must be helped through the provision of adequate health care available on all levels. This includes being able to supply the essential drugs that are needed to preserve health and prevent death. Moreover, on a larger scale, the environment, which is the responsibility of those at all levels, should be modified in such a way as to make it an ally of health rather than an enemy. The most striking example of this is the provision of safe water to replace the present insufficient water supplies which are the causes of so much illness and death in developing countries around the world.

The foundation of adult health is laid down in childhood and adolescence. The foundation of child health is laid down during the period of pregnancy and soon after birth. Damage incurred during or after childbirth may handicap a child for life in many ways. Therefore it is up to mothers and fathers, as well as health systems using the primary health care approach, to ensure a fairer chance for every child who is born.

Courtesy : WHO

Children are not born by chance. There is always a moment of choice-and the choice is never in the child's own hands. It is adults who decide and it is culture, and sometimes economic insecurity, that influences their decisions. Fear also plays its part—fear that some of the children born will die before they grow up, fear that there will be no one to add to the family's meagre earning power. But if parents really do their best to care for their first—and wanted—child, why should the child die? Health services are improving; and people must use them. But parents can do a lot to protect their children. And if this gives each newborn baby a better chance of survival, does it make sense for so many babies to be born? It is a cruel insurance against preventable loss.

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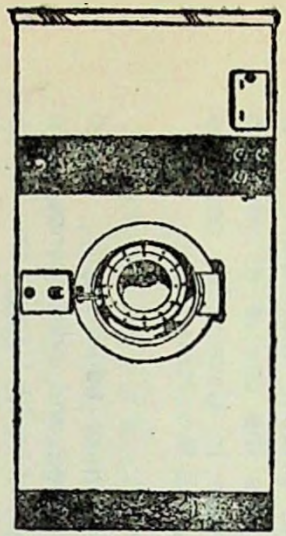

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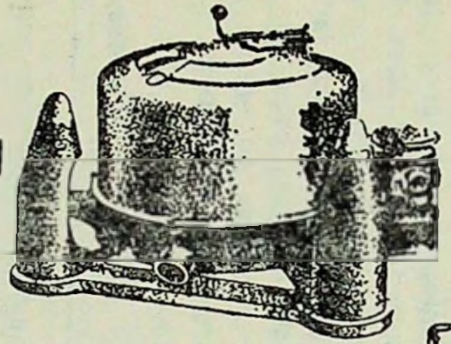

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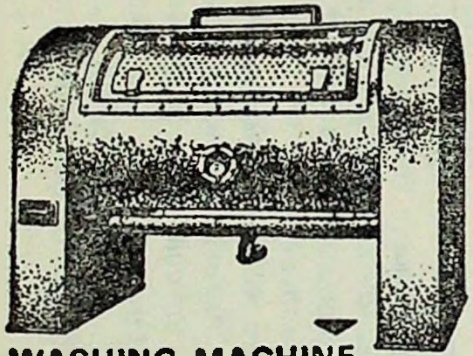

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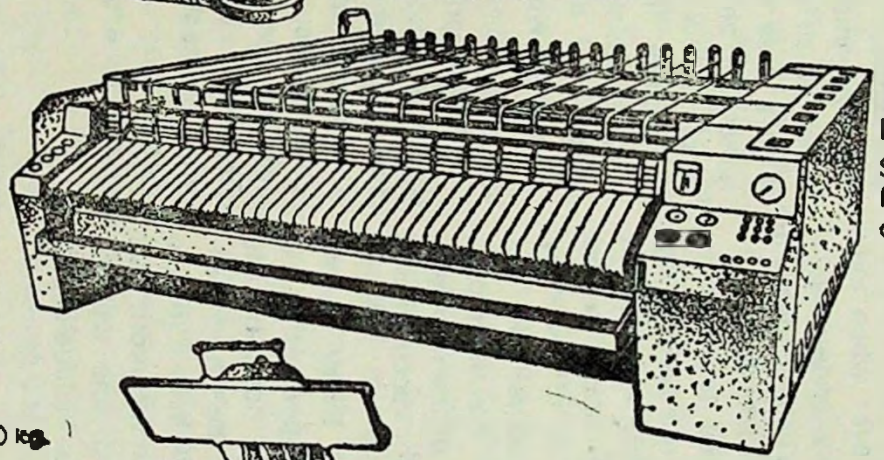

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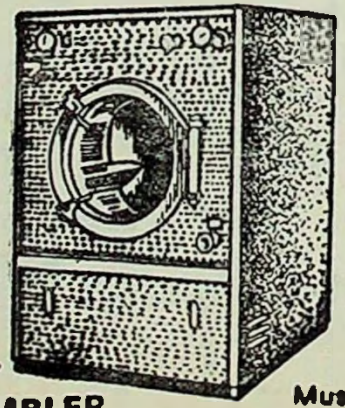

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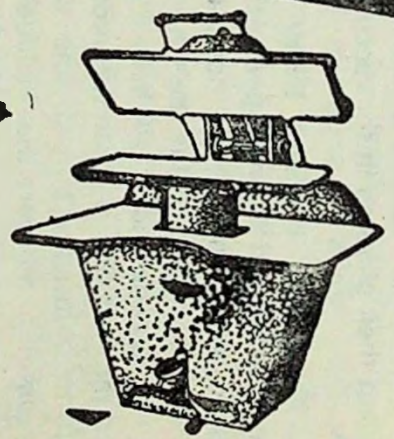

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Message from Dr. H. Mahler Director-General of the World Health Organization for WORLD HEALTH DAY, 1984

Children's Health—Tomorrow's Wealth

The theme affords an occasion to convey to a worldwide audience the message that children are a priceless resource, and that any nation which neglects them would do so at its peril. World Health Day 1984 thus sportlights the basic truth that we must all safeguard the healthy minds and bodies of the world's children, not only as a key factor in attaining health for all by the year 2000, but also as a major part of each nation's health in the twenty-first century.

The investment in child health is a direct entry point to improved social development, productivity and better quality of life. Since men and women themselves are not only the object, but the most important resource and subject of socio-economic development, the focus on child health is a developmental issue *at all times and for all countries*; thus children's health is tomorrow's wealth.

Care for the child's health starts even before conception, through postponement of first pregnancy until the mother herself has reached full physical maturity, and through spacing of births. It continues from coception on, through suitable care during pregnancy, childbirth, and childhood. In the developing countries, the child must be protected by all means available particularly from the mortal diseases. Diarrhoeal diseases represent an everpresent and recurrent menace; the widespread use of oral rehydration therapy by mothers in their homes can save every year millions of young lives throughout the world. A number of infectious diseases that kill or maim children can be prevented by effective immunization. Acute respiratory infections also take a heavy toll and have to be adequately treated. All this implies making the best use of primary health care in communities.

The romantic image of the mother isolated with her child in a closed, loving, caring circle does not reflect the true situation. What happens in the immediate family and community around the mother and child, and even far away in the world, can have direct impact on the health and security of both of them. It must be remembered that all advice given to mothers should be in a context that makes positive action possible. It is pointless to recommend the use of clean water if none is available, or to suggest boiling the water to make it safe if there is no fuel to do so. The mother and child need to be placed in an environment that will ensure their health by protecting the overall setting in which they live, which means providing clean water, disposing of waste and helping to improve shelter. Moreover, nothing can diminish the importance of good food, enough food, and proper nutrition, not only for children but for their mothers.

Beyond the immediate physical needs are the equally important needs for love and understanding which stimulate the healthy development of the child. Good health for mother and child is a measure of a society's capacity for caring; but their health cannot be improved in isolation, or through the mother's efforts alone. The environment must be employed to support health; society must allow the mothers the time they need and a pause from crushing work and poor diet. Improved education, health and the social status of women in general is a fundamental key to the health of children and society as a whole.

The emergence of new health problems of mothers and children both in developed and developing countries, including those who live in urban slums, should be kept in

mind; so too should the problems of "over-development", such as abuse of technology, and medication, and over-professionalization of health care of mothers and children, particularly in the developed world.

Better health services have to be made accessible to all who need them. The concept of primary health care among others has called attention to three important issues. The point of first contact between individuals-in this case mothers and children—and those responsible for health care has been neglected; too much seems to have been spent on high technology, often limited to the capital cities, whereas little care was available for the population at large. Closely related to this is the concept of equity, with a basic level of health care as the right of all people, not only the better-off or the urban populations or one class in society. And, finally, to make this possible, individuals and communities must participate in health. Child's health is the responsibility of the individual or of the family, especially the mother, but the particular role of governments is to provide necessary support which will make it possible for parents, families and communities to fulfil their own responsibilities to children's health for example by providing maternity leave, child care.

Whatever can be done to ensure the health and wellbeing of children helps to lay the foundations of health in adult life and of health for those children's children.

On the grounds of the WHO Constitution and on our common grounds of humanity even on grounds of common biological and economic prudence, I appeal to you all to make this World Health Day the occasion of deep thought, and of irrevocable resolve to construct a better society where the children of the world will have a healthier life and a better chance than we had to achieve more of humanity's potential.

Courtesy: *WHO*

LEGAL EDUCATION—6

Public Interest Litigation

P D Mathew

One of the best things that has happened in the country in recent years is the development of Public Interest Litigation (PIL).

Until the emergence of PIL, justice was a remote reality for the mass of illiterate, underprivileged and exploited persons in the country, most of whom are unaware of the laws and their legal rights. Bonded labourers, tortured persons, undertrials, contract labourers and a host of others could get on justice since none could take up their cases for lack of '*locus standi*'.

In various recent judgements the Supreme Court has given a new interpretation to *locus standi* by stating that all citizens should have a right to enjoy life and liberty guaranteed to them by the Constitution. The Court enlarged the concept of *locus standi* to include the rightful concern of other citizens willing to espouse the cause of their less fortunate countrymen.

The reason for enlarging the concept of *locus standi* was that restricting it only to the affected parties, deprived the weaker sections of their Fundamental Right to justice, since, because of illiteracy, poverty and the high cost of litigation, the Courts were beyond the reach of the poor. Hence, anyone who is concerned about the exploited has a right to approach the Courts for redressal of the grievances of the poor.

Understandingly in some cases the Supreme Court accepted the letters from the victims of injustice, and converted them into writ petitions. The effect of it has been quite noticeable and has helped to make justice accessible to the lowest person as never before.

What is Public Interest Litigation ?

Public Interest Litigation is a new type of litigation initiated by the Supreme Court of India to enable the poor and the vulnerable sections of society to approach the High Courts and the Supreme Court to enforce their Fundamental Rights.

In the opinion of Mr. Justice P.N. Bhagwati, who is the initiator of this new type of litigation, Public Interest Litigation is essentially a cooperative effort on the part of the petitioner, the public authority and the court to secure the observance of the Constitution and legal rights and privileges conferred upon the vulnerable sections of the community and to reach social justice to them. (From the judgement of Asiad Worker's case)

What are the reasons for the Supreme Court to promote Public Interest Litigation ?

* The Court felt that today the protection of law is easily available only to the rich and the politically powerful. The civil and political rights of the people exist only on paper and not in reality.

* The Supreme Court of India which is used by the landlords, business magnates, industrialists, etc. must become the Supreme Court for poor and oppressed Indians.

* The poor and the illiterate are not able to understand their legal problems and to find redress through the traditional type of litigation because of its high cost, complicated and slow procedures.

Who are entitled to file PIL petitions ?

At present PIL petitions can be filed in the Supreme Court under Article 32 or in the High Courts under Article 226 of the Constitution by public spirited persons, lawyers, social workers, journalists and voluntary organisations on behalf of the poor or members of the weaker sections of society. This is possible because of the new scope given by the Supreme Court to the concept of *locus standi.*

What is locus standi ?

These Latin words signify the legal right of a person to file a suit or conduct a litigation in a court of law.

According to the traditional Anglo-Saxon concept of locus standi only the person wronged could sue for judicial redress. But because of the prevailing socio-economic conditions in the country where there is considerable poverty, illiteracy, ignorance, the Supreme Court felt that the traditional approach will result in closing the doors of justice to the poor and the deprived sections of society. So it added a new dimension to the doctrine of *locus standi.* According to the new interpretation, if the legal rights of an individual or class of persons are violated and, if by reason of poverty or disability they cannot approach the Court for judicial redress, any public spirited individual or institution acting in good faith, and not out of vengeance, can move the Court for judicial redress.

Note

This decision on the *locus standi* was taken by the Supreme Court Constitution Bench in the 'Judges Appointment and Transfer Case and it was again confirmed in the Asiad Worker's Case (AIR 1982 SC 1473-92).

Examples of PIL

1. The case of the undertrials in Bihar

Ms. Kapila Hingorani (Advocate) filed a writ in the Supreme Court in 1979, based on a series of articles in *The Indian Express* exposing the plight of about 29,000 Bihar undertrial prisoners. Most of them had served long periods of pre-trial detention. This PIL helped the Court to release many undertrial prisoners through its interim orders.

2. Bombay Pavement Dwellers Case

A writ petition was filed in the Supreme Court in 1982 by the petitioner Ms. Olga Tellis with the help of Ms. Indira Jaisingh (Advocate) in the matter of the demolition of hutments of 50,000 pavement dwellers by the Municipal corporation of Bombay at the alleged instance of the then Chief Minister of Maharashtra. The demolition has now been stayed by the Supreme Court.

The main argument of the petitioner was that the order of demolition of hutments infringed upon the Fundamental Rights of the pavement dwellers under Article 14,19 and 21 of the Constitution, which guarantees a citizen freedom of movement, trade and profession.

It further argues that they have a right to dwell on pavements so long as they do not

constitute obstruction to pedestrains and vehicular traffic on the roads. It stressed the responsibility of the State to provide them with appropriate house-sites as close as possible to their work place.

3. Case against the Superintendent of the Agra Resettlement Home for Destitute Women

This case was brought to the Supreme Court by two law teachers of Delhi. The teachers sent the complaint about the Resettlement Home by post to the Supreme Court as a Public Interest Litigation to ensure to the inmates the right to live with dignity.

According to an enquiry report, the girls have turned mentally ill, contracted T.B. and venereal diseasese and they are all forced to live in a crowded room. The Supreme Court admitted the petition and appointed an expert committee to study the condition of the Resettlement Home and to recommend means to make the administration of the institution more effective to meet the welfare needs of the inmates. Certain problems of the girls of the institution were solved through the intertm orders of the Court.

A similar petition regarding the inhuman living conditions of the inmates of Delhi Women's Home was filed in the Supreme Court by a 3rd year student of the Law Faculty of Delhi University and a social worker.

4. The Case of Naxalite Prisoners

A writ petition was filed by a journalist on bahalf of four Naxalite prisoners of Tamil Nadu for proper medical treatment. The Supreme Court appointed Advocate Kapil Sibal to appear on behalf of the prisoners.

The Court ordered that proper treatment should be given to them in the Madras General Hospital. It also ensured their right to privacy while talking to their relatives and friends.

5. Ban of harmful drugs

Dr. Vincent Panikulangara, Advocate and General Secretary of Public Interest Law Service Society (PILSS) Cochin filed a writ petition in the Supreme Court in April 1983 seeking the ban of harmful and ineffective drugs. He pointed that a committee appointed by the Government recommended the ban of 20 fixed dose combinations of drugs including some of the commonly used drugs. This would work to about two thousand drugs used in connection with several diseases. Some of them are banned or are withdrawal from the market in other countries. However, because of the unethical practices of the multinational drug companies such drugs continue to exist in our country. The Hathi Committee pointed out in 1975 that though there are 15000 drugs in Indian market, the basic health needs of the country can be satisfied by 116 drugs. Similarly from 1977 onwards WHO has been pointing out that the basic health needs of the developing countries can be satisfied by less than 200 drugs.

The petitioner seeks an order from the Court to ban the drugs that are found to be harmful or ineffective on the ground that the existence of such drugsin the market affects his Fundamental Right to life under Article 21 of the Constitution of India. He also points out that though the Directive Principles of State policy cannot be enforced by a court, Government actions contrary to the Directive Principles of State Policy can and must be prevented by judicial actions. The Supreme Court has issued notice to the Government of India, Drugs controllers of the Union, all the States and Union Territories and the organisations of the manufacturers and the medical practioners to present their views on the matter.

6. Eviction of Gudalur Farmers

A writ petition was filed in the Supreme Court against the State of Tamil Nadu by a local advocate, Mr. M.J. Cherian, on behalf of the poor farmers of Gudalur who have been cultivating their lands for several years.

The petitioner alleged that persons who had for many years been cultivating the land were sought to be summarily evicted without adhering to the principles of natural justice contained in the State Forest Act. It was stated in the petition that the forest officers and the police were committing atrocities on the Gudalur farmers.

The Supreme Court ordered that there should be no destruction of crops and no forcible eviction of farmers in the Gudalur Taluk in the Nilgiris district until further orders.

7. Bombay Hawker's Case

About 1,50,000 hawkers of Bombay moved the Supreme Court and got a stay against prosecution for carrying on trade on the city's pavements. This write petition was filed in 1981, by the Bombay Hawkers, Union President and two women hawkers who sell vegetables.

Counsels for the hawkers, Ms. Indira Jaisingh and and Mr. V.J. Francis contended before the Court that the refusal to grant licences violated their Fundamental Rights to carry on trade. They also challenged certain provision of the Bombay Municipal Corporation Act which conferred arbitrary and unguided power to the police and authorities to refuse licence.

8. Madras Slum Eviction Case

In this case the Supreme court stayed the demolition of hutments in the slum areas of Madras city following a writ petition filed by a local advocate and a professor of social work against the State Government, the Madras Slum Clearance Board and the Corporation of Madras.

The Counsel argued that the slums may create a certain amount of unhygenic conditions in the city but what is to be done is to provide them with alternative accommodation and not to throw them out on the street.

9. Case for Giving Alternative Land to Tribals

A writ petition was filed by Ms. Rambika Gupta, MLA of Bihar on behalf of the tribals in Bihar whose lands were taken over by the Coal India Ltd. for the purpose of mining.

The petitioner submitted that the lands were being acquired by Coal India Ltd. at times without recourse to legal formalities. The acquisition of the tribals; ancestral land without giving them alternative sites was destroying the way of life of the tribals. The acquisition was violative of the Fundamental Rights.

The Supreme Court asked the State Government to provide alternative lands in a short time.

The Blinding of Undertrial Prisoners in Bhagalpur Jail

In this case the prison administration of Bhagalpur Central Jail is alleged to have gauged out the eyes of 31 undertrial prisoners. The news item appeared in *Sunday Weekly* (Calcutta) and was later given publicity by the *Indian Express*. Ms. Kapila Hingorani, a senior advocate, filed a writ petition in the Supreme Court for violating the Fundamental Rights of the prisoners under Articles 14 and 21 of the Constitution.

The issues regarding the liability of the State to pay compensation for the victims of blinding and the need for taking action against the officials responsible for the blinding were raised in the writ petition. Certain relief measures like medical treatment, vocational training and maintenance were taken at the expense of the State government. The case is pending for its final disposal.

The case of the Asiad workers

The Delhi Administration had employed over one lakh labourers through contractors for the construction of the Asiad projects. The government agencies and the contractors did not care for the observance of the labour laws related to the contract workers. They were not even paid the minimum wage. The report of a free lance journalist V.T. Padmanabhan of their exploitation by the contractors which appeared in *the Mainstream* (August 1981) accompanied by a letter written by the president of people's Union for Democratic Rights was sent to the Supreme Court. The Court accepted the letter and appointed ombudsmen to study the working conditions of Asiad labourers. The decision of the Court on this case was a landmark judgement which enlarged the scope of *locus standi,* Fundamental Rights and liability of the State. For details of the case please refer to page 33 of *Legal Education Series No. 8.*

The Cases of Bonded Labourers

In the recent past several cases for the relief and rehabilitation of bonded labourers have been filed in the Supreme Court by Bandhua Mukti Morcha. In one of the cases forty of the bonded labourers working in Pichola in Bhiwani district have described in a letter to the Supreme Court the miserable conditions in which they were living. They wrote 'We are all Adivasti Bhils; with great difficulty we are given wages from Rs. 3 to Rs. 5 a day which is just enough for our food rations. Drinking water is supplied once in three or four days. Our huts are worse than those used for keeping animals. We want to go away from here now itself but our master and his goondas tell us that we cannot leave unless we pay back their loan which is Rs. 2000 to Rs 8000 per family. Our master enters our huts and molests our young daughters and also beats them up. Please save us.'

Swami Agnivesh, Chairman of the Bandhua Mukti Morcha forwarded this letter to the Supreme Court. A Division Bench headed by justice P.N. Bhagwati appointed two Commissioners—Mr. Jose Verghese, Advocate, Supreme Court and a journalist—to enquire into the conditions of these labourers and report to the Court. The expenses of the Commissioners were met by the Committee for Implementing Legal Aid Schemes. Through the interim orders of the courts several groups of bonded labourers were released from the contractors.

Mr. Gobinda Mukhoty, Counsel of the Bandhua Mukti Morcha has argued most of the cases on behalf of the bonded labourers.

The Case of the Illegal Detention of Oraon

The Case of Oraon, an undertrial prisoner was sent to the Chairman of the Committee for Implementing Legal Aid Schemes (Justice P.N. Bhagwati) by the Legal Aid Committee of Ranchi through a letter. This letter was treated as a writ petition.

Bhoma Charan Oraon, an undertrial prisoner was sent to the Ranchi mental asylum in 1976 by the sub-divisional Magistrate of Kunti, Bihar. Six months later, the superintendent of the hospital informed the Magistrate that Oraon was sane and fit to be released, but no action was taken in spite of

reminders. Thus Oraon was in the mental asylum for six years though he was sane.

In the order on 11th August, 1983, the Court said 'No amount of money could compensate Oraon for the six years of "living death" in the mental asylum'. But compensation is the only remedy we can give when the Fundamental Rights under Article 21 are violated. It ruled that when the Fundamental Rights to life and liberty are violated anyone complaining of such an infringement can ask for compensation.

The Impact of the Judgement

1. Illegal detentions and torture in jails could invite compensation claims from prisoners.
2. Since Article 21 (Life and Liberty) is very wide and includes human dignity and decency, any violation of the person, physical or mental, could be interpreted in such a manner that the State would be liable to pay compensation.
3. The State governments may have to pay for their police officers' violations of the Fundamental Right to life and liberty of the people.

Note

In this case the Judges (Justice P. N. Bhagwati and Justice Sabyasachi Mukherji) awarded Rs. 15,000 as compensation for Oraon and Rs. 750 for the legal aid lawyer.

In another case of similar nature, Chief Justice Y.V. Chandrachud had ordered the Bihar government to pay Rs. 30,000 to Rudal Sah, who was kept in a mental asylum for 14 years although he was declared sane.

The mode of filing PIL cases

Much of PIL in the initial period (1981-82) has arisen out of letters written by social workers, journalists, law teachers, lawyers, and civil liberty activists to Mr. Justice P.N. Bhagwati in his capacity as Justice of the Supreme Court and Chairman of the Committee for Implementing Legal Aid Schemes. These letters were accompanied by newspaper clippings or investigation reports. These letters were converted into writ petitions and admitted in the Supreme Court. In all the PIL cases the Court has appointed public interest lawyers as *amicus curiae* to conduct the litigation on behalf of the petitioners. When evidence in PIL cases was not sufficient to prove the allegations narrated in the petition, the court has appointed commissions of experts to investigate the matter and to submit reports to the Court. In most cases the Supreme Court accepted the reports of the Commissions and passed orders to give interim or permanent relief to the petitioners.

What is the nature of the PIL cases ?

Most of the petitions admitted in the Supreme Court as PIL dealt with the repression by government agencies and custodial authorities (police and prison administrators). Some of them sought orders from the Court to compel State agencies to discharge their responsibilities to the citizens.

The distinctive feature of PIL petitions is that all of them are filed in the Supreme Court under Article 32 of the Constitution i.e., they are writ petitions for the enforcement of the Fundamental Rights.

Which are the main Fundamental Rights that have become the subject matter of PIL ?

1. Article 14
   (a) Equality before the law
   (b) Equal protection of the law

2. Article 19

   (a) Freedom of speech and expression

   (b) Freedom of Assembly

   (c) Freedom to form Associations or Unions

   (d) Freedom to move freely throughout India

   (e) Freedom to reside and settle in any part of India

   (f) Freedom to practise any profession

3. Article 21

   Protection of life and personal liberty 'No person shall be deprived on his personal liberty except according to procedure established by law.

4. Article 22

   Protection against arrest and detention in certain cases.

5. Article 23

   Right against exploitation by any form of forced labour. Prohibition of employment of children below 14 in hazardous employment.

Note

In most cases of violation of human rights, a combination of Fundamental Rights is infringed; e.g. In the case of eviction of pavement dwellers.

—Articles 14, 19, 21

Blinding of Bhagalpur prisoners.

—Articles 14 and 21

What is the impact of PIL ?

* Through PIL cases the Supreme Court has emerged as the defender and champion of the have nots.

* People are aware that the Court has constitutional power of intervention, which can be used to ameliorate their misery arising from repression, government lawlessness and administrative negligence and indifference.

* Today undertrials, convicted prisoners, bonded labourers, unorganised labourers, Schedule Castes, Scheduled Tribes, exploited women, slum dwellers, victims of police torture and other vulnerable sections of society have access to the Supreme Court and High Courts for securing their human rights.

* PIL has created an awareness among the judges and lawyers about their responsibility to administer social justice to the exploited millions and compels them to take human suffering more seriously.

* The Court decisions based on PIL expose the State to liability for paying compensation for violations of Fundamental Rights.

* Through interim orders and directions the Court seeks improvement in the administration making it more responsive than before to Constitutional ethic and law.

* PIL has exposed the failure of the government to deliver the goods to the poor and this exposure of injustices and tyrany began to hurt the national conscience.

* PIL is a legal device to control government to as not to leave State agencies free to violate the law or be casual or negligent in its enforcement.

* It has awakened the consciousness of the public regarding the dignity of human life, the importance of liberty and the right to equal justice.

It is the beginning of a revolution in our system of delivery of justice and it 'nourishes hope in an otherwise darkening landscape of Indian law jurisprudence.'

* By introducing this new mode of litigation in the judicial system the Supreme Court has demonstrated a non-violent means to prevent the exploitation of the poor and to promote social justice.
* Every individual PIL case is a test case and its judgement affects a whole class of people and the principles involved become precedents for similar cases.

The limitations and problems faced by PIL in India

* It is in an experimental phase and it has not been fully appreciated by most judges and lawyers. It is sustained and monitored by only few judges and lawyers.
* The fact that PIL matters are mostly dealt by Court No. 2 of the Supreme Court has led to factions among the judges. Many Judges are not given a chance to deal with PIL cases. Hence the learning capacity of the Judges is constricted.
* Work-load of Court No. 2 of the Supreme Court with PIL cases causes problems of priority in processing. If priority is not given to a PIL case it will continue to drag on for years like other cases.
* The entertaining of PIL cases and their outcome depend very much on a particular Bench of Judges.
* Some Judges have attacked PIL even before it has taken root.
* Facts relied upon by PIL petitioners are often based on newspaper reports which are not altogether reliable.
* In its decisions or orders the Court promises more than it can deliver, e.g., in some cases the government has not executed the orders of the Supreme Court.
* While the Court speaks much about human dignity, equality, social justice, the actual relief given in many of these cases is very small. e.g., in the Asiad workers' case, though the judgement was a landmark in the history of the judiciary the actual relief obtained by the labourers was nil.
* The Court has suddenly raised the expectation of the poor to get justice without undue delay, yet the actual working out takes a long time. e.g., the Bhagalpur blinding case filed on October 10, 1980 is still pending in the Supreme Court.
* The judiciary is not always able to enforce its decisions. There is no sufficient follow-up with regard to the execution of its orders.
* Very few PIL petitions have resulted in a final verdict.
* PIL is a sort of renovation within the existing system, which is very much elite-clitent oriented and not truth oriented. The Judges operating the present system have been bogged down by the legal technicalities more than truth and justice.
* PIL is now mostly a Supreme Court phenomenon. It has not taken roots at the High Court level.

The evidentiary problem in PIL cases and the means of solving it

In the past, in most PIL cases, the petitioner relied very much on newspaper reports or letters written by the affected people. Since there were not enough document and

investigation reports, the State Counsel often denied all the allegations contained in the affidavits (the veracity of the newspaper clippings). The opposite party, especially the government agencies were unwilling to produce documents on the plea of privilege.

In most of the PIL cases where there was a lack of evidence, the Court appointed Commissions of experts to investigate the matter and submit their reports to the Court. In several PIL cases, social scientists, teachers, researchers, journalists and lawyers, Court officers, doctors etc. were appointed as ombudsmen and their reports were accepted by the Court without being challanged. In almost all cases the State was asked to bear the expenses incurred by the commission.

Examples

* In a case of chamars of Bihar against the Zila Parishad regarding the violation of their rights to trade and profession in Supreme Court appointed Krishnan Mahajan (legal correspondent of the Hindustan Times, Delhi) and Prof. Upendra Baxi (Vice-Chancellor of South Gujarat University) as a Commission of experts to study the problem and to submit a report to the Supreme Court.

* In the case of pavement dwellers, the Supreme Court appointed a Court official of Bombay High Court to supervise the execution of its interim orders.

* In the Kanpur undertrial rape case, the Court has asked the district Judge to investigate the case.

* In the Asiad Workers' Case the Supreme Court appointed three social scientists (Dr. Alfred de Souza, and Dr. Walter Fernandes of the Indian Social Institute and Prof. Das Gupta of People's institute for Development and Training, Delhi) as ombudsmen. The landmark judgement of the Supreme Court was based on the reports submitted by these ombudsmen.

* In the case of 'Bhagalpur blindings' the Court appointed the Registrar of the Supreme Court to interview the victims and to submit a report.

What is to be done to put PIL on a sound footing

* It must become the common policy of the Supreme Court and High Courts to accept and entertain PIL cases on a priority basis.

* The Courts must use their own officials not only to assertain facts, but also to monitor the implementation of the various directions given by the Court. It must create a fact finding machinery as part of its structure.

* Contempt of Court provisions must be strengthened, so that those who lie in the Court can be punished.

* Court orders must be issued to the concerned persons as soon as possible. Certified copies of orders must be made available immediately to those who have to go and make an enquiry.

* With the growing volume of public interest litigation, procedures needed to be streamlined and ground rules established.

* The Committee for implementing Legal Aid Schemes must create a cadre of committed lawyers to conduct PIL cases in the Supreme Court and High Courts and create PIL lawyers' chambers funded by legal aid societies or the public.

* There should be periodic meetings of PIL lawyers to share their experience.

* Cooperation among the lawyers, professors, journalists, social activities and academics must be strengthened so that there can be better inter-disciplinary approach and support to complex PIL cases.

* There is a need of a PIL journal to report all relevant PIL cases and to provide a forum for sharing information and ideas among those who are involved in this field.

* The legal aid programmes at the Supreme Court and High Courts levels must be expanded to meet the expenses of PIL petitions.

* Voluntary agencies must be encouraged to take up PIL to enforce the rights of the poor.

* The occasion of PIL must be used to educate a group or a community and help them to see it as part of its community action for justice.

* The affected people must be helped to participate in PIL so that it can awaken their consciousness.

* Every PIL petition filed in the Court must be the result of Community or group involvement, reflection and decision.

The role of Voluntary Agencies in promoting PIL

PIL is a new phenomenon in India. It has originated from the new awakening of a few judges and lawyers. Its whole-hearted acceptance and promotion cannot be expected from government agencies, 'adjournment-lawyers' and elite groups. This is a boon to the voluntary organisations working at the grass-roots level. This new legal tool can be a great help in their non-violent struggle with the masses to obtain legal justice. Several voluntary agencies and social activists are making use of it as a support in their social action to fight against exploitation of the poor.

For further information in Legal matters contact :

Director, Legal Aid
Indian Social Institute
Lodi Road, New Delhi 110 003.
Tel : 622379, 624760
Gram INSOCIN

Understanding Diphtheria

Diphtheria is caused by a bacteria. The disease affects the tonsils, the pharynx, the larynx, the nose, and occasionally the skin. The source of the infection can be either a patient or a healthy person who is a carrier of the disease.

The bacteria which causes diphtheria is found in the mucus from the nose or throat. The bacteria can also spread by direct contact, or indirectly through personal articles which are contaminated by the nose and throat secretions of the patient.

Symptoms

A few days after contact with an infected person, the following symptoms appear:

— sore throat

— headache

— weakness

— moderate fever

— loss of appetite

— a greyish or yellowish membrane appears in the throat, and the surrounding area becomes dull red. In severe cases, there is a marked swelling of the tonsils, and oedema of the neck. The membrane sometimes blocks the air passage at the back of the throat and can kill the child by suffocation.

Treatment

Take the child immediately to a doctor. Diphtheria antitoxin is the specific treatment for the disease and must be started as soon as possible.

Prevention

Give three doses of DPT between the age of six to nine months, at an interval of four to six weeks each. In order to sustain the immunity, an additional booster dose should be given when the child is one and a half to two years old.

—courtesy UNICEF

World Leprosy Day and Anti-Leprosy Weeks Celebrations at St. Joseph's Leprosy Hospital, Tuticorin

Gandhiji's Martyrdom day is observed as the World Leprosy Day in India. This year as we had planned to have it celebrated in more leprosy endemic areas of our sub centres the actual celebrations were on different dates. But the 30th January was not ignored. Prior to the public meetings elocution competitions for the high school students of project area and essay competition for primary school teachers were conducted. In all 27 students and 37 teachers participated in the competitions from the control area. On the 30th it was kept in Tuticorin Harbour High School for the schools of Tuticorin, Spic Nagar and Harbour Termal project. The meeting began at 11.00 a.m. by observing 2 minutes silence. The headmaster of that school spoke a few words about Gandhiji and his compassionate care for the Leprosy patients followed by an introduction by Dr. M.G. Mohandas our medical officer. We are grateful to the local people who gave a small contribution for purchasing prizes for the winners of the competitions.

Other areas selected for the public meetings were Ottapidaram, Eral where there are 556 known cases, Keelamudimen and Keel vaipur. The former three places are the oldest areas of our control work with the duration of nearly twenty five years and the later nearly thirteen years. The dates of the meetings were 8th February at Ottapidaram presided over by Mr. Koilpillai, Manager and Headmaster of TMBM school Ottapidaram. One the 10th it was kept at Eral presided over by Rev. Fr. Francis Devasagayam, Correspondent of St. Teresa's school on the 12th at Keelamudimen presided over by Rev. Joseph S. Leon, Correspondent of St. Joseph's school Keelamudimen and on the 14th at Keela Vaipur presided over by Rev. Fr. Karunakaran, Correspondent of St. Louis school.

In all there was a good response although in one place it rained throughout the day and by evening we had to shift the meeting into the school hall. At all 4 meetings Dr. M.G. Mohandas gave an introduction as to the purpose of our going there about the actual work. Besides the presidents speech there were felicitations by the well wishers. On the last day of the celebration Dr. Santhammal, District Leprosy Officer of Government Head Quarters Hospital, Tuticorin gave felicitations. Dance programmes were given by the convent schools of the respective area. We are grateful to the sisters of the Immaculate Conception, Sisters of Louis Gonsala and the Servites sisters. A drama was staged by our staff "Let us live and show". A person having early signs of leprosy getting married with a girl after getting cured. It was a challenge. The boy and the girl along with the doctor, who was treating him challenged the girl's father and relatives. It was done very effectively. Congratulations to our staff.!!

Medical Ethics Forum-33

—Fr. George Lobo sj

Mercy and Justice in Health Care

Traditional health care was largely based on 'mercy' or 'charity'. Some noble souls felt compassion for the suffering sick and provided various forms of relief. However, health care gradually became organised and the State entered the field in a massive way. Now medical treatment has become generalized and more and more the element of justice is gaining prominence. The enormous development of medical science and technology gives the impression that man has absolute dominion over nature, including his bio-physical organism. Mercy seems to have no place in this context. Besides, recipients of mercy often feel demeaned by the benevolence of others. Are we then, to discard the motive of mercy altogether and rely only on justice?

First of all, it is true that every citizen has a basic right to minimum health care and society has the corresponding duty to provide it. Isolated acts of benevolence will not meet the demands of the present time. There is need for a system in which the basic health needs of all are met.

However, justice alone is not sufficient. A person's objective needs may be satisfied. But this may happen in an impersonal way, in a beaurocratic setting in which the patient becomes only a 'case'. Further, in a system organised only on the basis of strict justice, a person may be entitled to medical attention in proportion to his utility to society. Patients then would be reduced to instruments or cogs in a vast machine which would lead to massive depersonalization.

That is way, Pope John Paul II has declared that justice needs to be complemented by mercy : "The equality brought by justice is limited to the realm of objetive and extrinsic goods, while love and mercy bring it about that people meet one another in that value which is man himself, with the dignity that is proper to him." (*Dives in Misericordia*, N. 14).

Hence while justice should not be ignored in favour of mercy, it should neither be overstressed to the neglect of mercy. Rather in the words of the Pope "true mercy..... is the most profound source of justice". (*Ibid*).

Rendering justice to others in an adequate way implies an ever present effort to assess the actual condition of people and to remedy evils to the best of one's ability. It is the basic attitude of compassion that gives justice its full meaning. For a Christian, this implies a religious attitude that respects human values and the eternal destiny of man.

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FORM IV

(See Rule 8)

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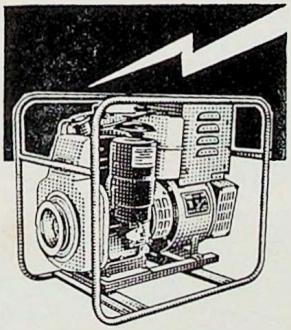

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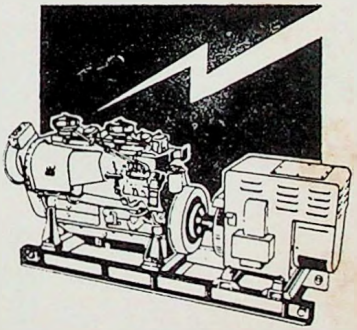

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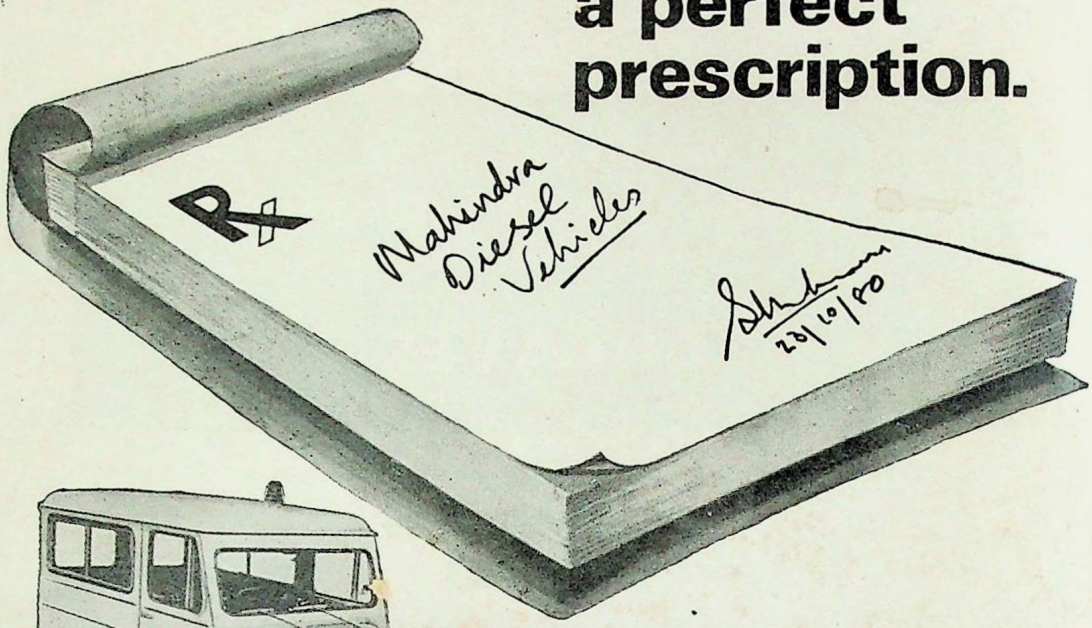

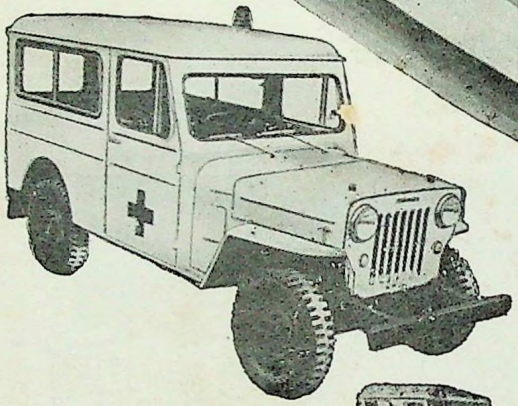

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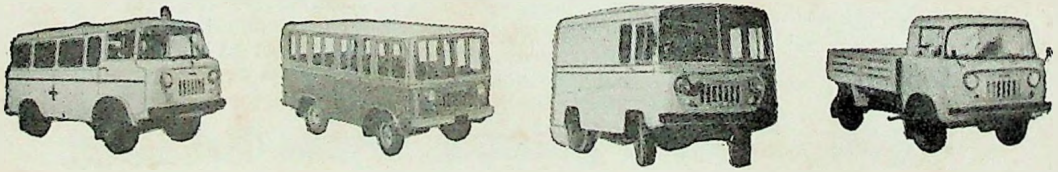

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