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MEDICAL SERVICE

the change and challenge of the family in the 80's ● disability versus employability ● bringing eyecare to villages ● people, pills and prescriptions-I : the drug dilemma ● chai news and notes ● legal education-8

vol 41 no 5 may-june 1984

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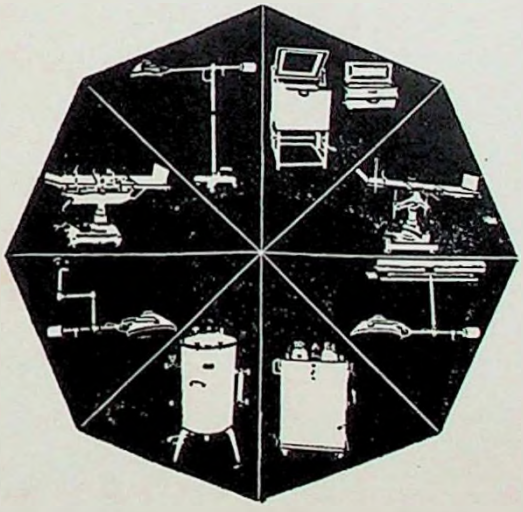

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contents

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Guest

EDITORIAL

Over 10,000 national and international companies rule the medical system today. Of these 10,000,110 of them control over 80 per cent of the world's multibillion drug market. The biggest of them have annual turn over that exceed that of many developing countries or many Indian states.

For long the health profession and the health system have been willy, nilly agents of the colossal pharmaceutical industry. While all of us have been unconscious and unaware victims of sophisticated marketing practices to such manipulation by accepting free samples, free lunches, momentos and in rare cases even costly gifts.

Of late among the conscientious practitioners of medicine there is this urge to seek a rational therapeutics or the essential drugs programme

In CHA's search for a more humane and more Christian practice of medicine, we would naturally always associate ourselves with any such quest for medicines that are:

* efficient
* safe (with low incidence of side effects)
* low cost and
* easy to administer

To bring our readers uptodate on this aspect of health care we are now starting a regular column (see page 23)

We hope to use the expertise those in our own institutions as well as friends outside to make this column possible.

If you have something to say about essential drugs or low cost drugs, do please write to us. If you have a question on this topic, do let us know. We shall seek the answers together.

The Change and Challenge of the Family in the 80's

Rev. C.D. Hurley

The socio-cultural revolution of our times has set us in a state of unrest; the machine surges far ahead of man's wisdom concerning himself. The pressing circumstances make it necessary for us to learn the "difficult art of dwelling together is unity, like brothers".

The form of the family as old as the human species moulds itself to the conditions of life which dominate at a given time and place. There is nothing fixed or immutable about the family except that it is always with us. In one sense, we have had thousands of years on which to grow accustomed to it and yet in another sense each generation in turn must learn again how to live with it.

Biologically the family serves to prepetuate the species. The relations of male and female and sexual mores play a lesser role than the care of the young. The evolutionary shift from hunting to agriculture as a way of life brought with it a shift from the matriarchal to the patriarchal family and the development of property value.

Psychologically the members of the family are bound by mutual interdependence for the satisfaction of their respective affective needs. Economically they are bound by mutual interdependency for the provision of their material needs.

The family is a flexible unit that adapts itself deliberately to influences acting upon it both from without and from within. In its external relation it must adapt to prevalent customs and mores and must make wide and workable connections with racial, religious, social and economic forces. But internally the family must also come to terms with the basic biological bonds of man and woman and of mother and child.

Concretely, the social purposes served by the modern family are :

1. The provision of food, shelter, and other material necessities to sustain life and provide protection from external danger, a function best fulfilled under conditions of social unity and cooperation ;
2. The provision of social togetherness which is the matrix for the affectionate bonds of family relationships ;
3. The opportunity to evolve a personal identity, tied to family identity, this bond of identity providing the psychic integrity and strength for meeting new experiences ;
4. The patterning of sexual roles, which prepares the way for sexual maturation and fulfilment ;
5. The training towards integration into social roles and acceptance of social responsibility;
6. The cultivation of learning and the support for individual creativity and initiative.

Clearly the configuration of family determines the forms of behaviour that are required in the roles of husband and wife, father, mother and child. Mothering and fathering, and the role of the child, acquire specific meaning only within a defined family structure. Thus the family moulds the kinds of

persons it needs in order to carry out its functions, and in the process each member reconciles his past conditioning with present role expectations. Clearly this process is a continuing one, for the psychological identity of a family changes over a period of time. And within the framework of this process, each member at times conforms and, at other times and within limits, actively alters these role expectations.

The family may be regarded as a kind of exchange unit : the values exchanged are love and material goods. Within the family sphere there is a flow of these values in all directions. Usually the parents are the prime givers. The whole process of distribution of satisfactions in the family is governed by the parents. If, the family atmosphere is full of sudden turns and shifts, deep feelings of frustration may result, inevitably accompanied by resentment and hostility. The interchange of feeling between family members revolves centrally about this oscillation between love and hate.

However, the experiencing of some measure of disappointment the development of tolerance to frustration, and the acceptance of less than complete fulfilment are essential to emotional growth. Without these there would be an insufficient spur to new experience and new achievement.

The family's task is to socialize the child and foster the development of his identity. There are two central processes involved in this development; first, the movement from a position of infantile comfort and dependence towards adult self-direction and its attendant satisfactions; second, the movement from a place of infantile, aggrandized, omnipotent importance to a position of lesser importance, that is, from dependence to independence, and from the centre of the family to the periphery. Both processes are psychological functions of the family as a unit. In the interests of the emotional health of the child it is essential that these processes be imperceptibly gradual. The family provides the specific kind of learning experience that enable a person to fit himself into a variety of life situations. The home is the arena in which a person acquires practice and increasing dexterity in filling a wide range of social roles.

The interrelations of individual and family behaviour need to be scrutinized in these dimensions : (1) the group dynamics of the family, (2) the dynamic processes of emotional integration of the individual into his family role, (3) the internal organization of individual personality and its historical development.

Family, Identity, Stability, and Breakdown

The psycho-social dynamics of family life may be operationally defined. They are guiding concepts that attempt to answer for the dynamics of family functioning : the who and what of family life, the how, and the resulting functional patterns of the family. These concepts are in brief, the following : (1) psychological identity, which subsumes strivings, expectations and values, (2) stability of behaviour, expressed as (a) the continuity of identity in time, (b) the control of conflict, (c) the capacity to change, learn and to achieve further development; adaptability and complementarity in new role relationships :

Identity

The concept "psychological identity and values" refers to direction and content of striving, while stability refers to organisation and expression of behaviour in action.

Any human entity—possesses a unique psychic representation. I speak of this as

identity. It is part of the cycle of life that people strive to express and fulfill the potentials of their identity in the context of ongoing social relations. Psychological identity refers to a self-concept, expressed in the strivings, goals, expectations, and values of a person or a group of persons. It answers the question : who am I ? or who are we ? in the context of a given life situation. It qualifies a particular kind of person or persons, what they stand for, where they are going, their purpose and meaning in life.

The psychological identity of an individual or of a family is its psychic centre of gravity. It is the "I and Me" or the "We and Us", the unique configuration of psychic self representation around which all interpersonal experience is woven and by which this same identity is further modified in the passage of time. At a given point in time the individual has an image of his personal identity and his family identity, both continuously being influenced by the images which outside persons hold of these same identities. At each stage of development, personal identity is linked to and differentiated from the identity of parents and family in a special way. This relationship begins with the symbiosis of the child—mother pair, it is moulded by a process of primary identification of the child with the parents, and it undergoes further change as the child gradually differentiates his separate self and expands his identification with other family members. The organisation of individual identity at any point of time, therefore, epitomizes a corresponding family identity.

In the context of a family relationship or group, psychological identity refers to elements of joined psychic identity-the strivings, values, expectations, actions, fears and problems of adaptation, mutually shared in or complemented by the role behaviours of members of the family group. In essence this is a segment of shared identity, reflected in layers of joined experience, and enacted in the receprocal or complementary family role behaviours of these persons.

It is this feature of family living that gives form to the standards and deals of the family—the lines of authority, sexual differentiation, division of labour, and child-rearing attitudes. The psychological identity of a family determines the manner in which elements of sameness and difference among the personalities of family members are held in a certain balance. In some families, the interplay of members in their various family roles emphasizes the trends toward sameness over the trends towards difference. In other families, the opposite pattern may prevail. In disordered families, differences may be so intensified as to create a formidable barrier, which critically impairs the matrix for joined identity.

Stability

Stability of behaviour is itself the end-product of complex, interdependent processes. The more important of these are: the continuity of identity in time, the control of conflict, the capacity to change, learn, fill new roles, and achieve further development, and finally, the complementarity of family role relations.

Stability in its first phase epitomizes the capacity to maintain the sameness or continuity of a person or a group of persons through time. It is the maintenance of the integrity and continuity of identity under the pressures of changing life conditions. It assures the intactness and the wholesomeness of personal behaviour in the face of dangers in new experiences. This is the conservative phase of the function of stability. Its internal aspect is represented in the regulation of the balance of intrapsychic forces.

Stability in interpersonal relations is a function of the interplay of the orientation to self and to the group. The inter-action of family members in their respective family roles governs the quality of stability of family relationships. It affects the capacity to cope with family conflict and restore balance following an emotional upset. Such stability may be maintained on the basis of a relatively static or rigid pattern of family role reciprocity or on the basis of a more flexible capacity to accommodate to change and achieve a new and improved level of reciprocity. One aspect of the function of stability fulfills the conservative requirement of protecting the sameness and continuity; another aspect must make room for new experience, learning, and further development. The receptivity to new experience, the capacity to learn and grow, is the more open, more adventurous aspect of life adaptation. It entails risk, but without risk the power to adapt to change and to grow is lost. Effective adaptation requires, therefore, a favourable balance between the need to protect sameness and continuity and the need to accommodate to change. It requires preservation of the old combined with receptivity to the new, a mixture of conservatism and an emotional readiness to "live dangerously." Evaluation of the relations of individual and family requires assessment of both aspects, stability in its conservative, relatively stoic phase, and stability in its more open, flexible, adventurous phase, which makes possible adaptation to new experience, learning, and further growth of personality.

The achievement of stability in these aspects is, in turn, influenced by the capacity to cope with conflict. The control of conflict is a special dimension relevant to the relations of individual and family. The failure to find effective solutions leads to adaptive breakdown and emotional illness.

Within the individual, conflict, anxiety, and symptoms defectively controlled represent vulnerability to adaptive breakdown and mental illness. Co-existent with these forces are the potential capacities for finding solutions to such conflict or for establishing a protective equilibrium or compensating for the effect of conflict. Of special importance in this connection is the ability to achieve patterns of family complementary role. The term "complementarity" refers to specific patterns of family role relations that provide satisfactions, avenues of solution of conflict, support for a needed self-image, and buttressing of crucial forms of defenses against anxiety.

Breakdown

The seeds of mental illness are sown in the family of childhood; but the growth of these bad seeds into emotionally twisted adults becomes meaningful only as we study the relations of individual and family in adolescence and adult life as thoroughly as we study these relations in the family of childhood.

Psychiatrists have acquired adaptness in the retrospective study of mental illness, in the minute examination of family histories. But they have not yet cultivated an equivalent skill in the study of family process, here and now.

Psychiatric disorders are neither static nor isolated entities. While the pattern of vulnerability to illness is laid down in childhood, the fate of this vulnerability is determined by the interpersonal experiences of later life adolescence is notoriously a phase of transitional development within which the vulnerability to breakdown is intensified. The struggle to entrench personal identity and to integrate personal drives with the conditions of social living, and the tension of harmonizing the requirements of family roles with

those of extra familial roles play a tremendous part indicating the destiny of these predispositions to illness.

When an individual reaches adult age, marries and creates a family, the pattern of his adult family may be similar to or differ from the family of his childhood. In adulthood the individual may perpetuate an old and familiar pattern or defensively take flight to a radically different one. In choosing a marital partner and raising children, he initiates a new set of close relationships which may either give him added protection again mental illness or aggravate his inclination towards it. A circular process is involved. Conflict internalized at earlier phases of family integration influences the present patterns of conflict in family relationships, and contemporary conflict in family relations influences the expression and fate of the older levels of conflicts.

Of special significance in relation to the contemporary rise of juvenile delinquency is the investigation of psychopathic tendencies, as these are influenced by the phenomena of family life. Johnson and Szurek have illumined some aspects of this problem with special emphasis on the induction of delinquent behaviour in a child as a response to the unconscious expectations of the parents.

The community at large is not yet tuned to the idea of viewing emotional illness as a problem of the entire family group. Families as families do not present themselves to mental health practitioners as sick units. They follow rather the traditional habit of referring one member of the family with emotional difficulties for study and treatment. But this first referral calls attention to the psychopathological disturbances of the entire family group.

Values and Family Structure

Values are personal and yet they are social too. They do not have a private origin, but they become privately treasured. As individual may defend his values as he defends his own self. He may even sacrifice his life to protect these values. Values are born out of the assimilation of the individual into group living. They provide orientation to the relations of individual, family and society. They give meaning to a person's position in life. They are the compass which provide a sense of direction from birth to death.

Values by their very nature tend to be polarised in sets of opposites. They present a problem of choice which may be readily illustrated in a series of pairs :

Creativity	versus	Destructiveness
Freedom	versus	Compulsion
Strength	versus	Weakness
Independence	versus	Dependence
Courage	versus	Caution and retreat
Adventure	versus	Security
Cooperation	versus	Competition
Social responsibility	versus	Self-indulgence
Orderliness	versus	Disorderliness
Generosity	versus	Parsimony
Inner reality	versus	Appearance
Spiritual enrichment	versus	Material acquisition
Equality and mutual regard	versus	Inequality and a striving for power
Respect for the human being	versus	The human being as a thing, a pawn, a tool.

There is a wide range of component value trends as expressed in the functioning of contrasting types of families. There are families where the dominant value orientation emphasizes the inner spiritual life of the family, a dedication to the worth, dignity and personal development of each member. There

are others which accentuate the outer facade of the family, its external image in the eyes of the surrounding community. Such a family often pays scant interest to the internal relations among family members. Sometimes its outward appearance presents the semblance of a fine, stable, closely-knit group; it may earn for itself in the community the reputation of a well-functioning respectable family group, whereas actually its inner emotional substance may be rotten to the core.

There are certain families whose component value trends stress pleasure, the joys of the moment. By contrast, others live off the glories of the past; they cherish the reminiscences of the family attainments of long ago. Still others concentrate on building for the future.

The value orientation of some families reflects a striving for freedom of expression, spontaneity and creativity. Others emphasize discipline, duty and self-control. Occasionally such families reveal a profound defensive antipathy to pleasure. They fear it as a dangerous contamination.

In some families the dominant value orientation is to power, status and money. Family relations are structured according to a hierarchy of prestige representations, mainly moulded by the power position of each family member, competition is intense. It is each man for himself and the devil take the hindmost. The striving is for success, whatever the cost to the emotional health of family relations.

In some families where such strivings are defeated, the family epitomizes social degradation and failure. The members of such families are contagiously invaded by the atmosphere of family failure. They become deeply identified with it. A sense of inferiority pervades the personal identity of the members; in consequence of this they feel profoundly ashamed of their families.

To contrast with this, there are families in which the value trends accentuate a bond of family closeness, devotion, cooperation, and sharing. Here the identity and value orientation of individual and family are closely linked. Strong trends towards family unity may reflect a condition of positive emotional health, or a negative, suspicious, defensively toned value pattern which reflects a fear of life.

In its positive aspect, family cohesion is expressed in warm, close, cooperative family relations. This may lead to a strengthening of its members and promote free and creative personal development. In its negative aspect, a compensatory and excessive barricading of the family group may intensify the anxieties of its individual members. It may enormously magnify their perception of the outer world as harsh and dangerous. Under such circumstances, individual members of the family may not derive a sense of protection from the family closeness. Instead they may be choked by it. Their excessive dependency may be linked intensive resentment towards their families, which ultimately induces a sense of alienation and disrupts family unity.

Family Healing in a Troubled World

The disorders in society, caused by radical changes include the combined impact of technology, a state of continuous war, racial conflicts, violence, the invasion of personal freedom, the decline of humanistic and spiritual values, and the loss of human connectedness.

Effects of Society's Disorders

From these influences emerge the "mass man", the orientation to power, manipulation, acquisition, and a trend towards deperson-

alization and the weakening of moral fibre. People are being mechanized, dehumanized, brutalized and rendered numb to the sufferings of others. They no longer seem to care. Whereas fifty years ago the problem was to much conscience, today it is not enough conscience.

The malady of the modern family shows itself in many ways : 1. A form of family anomie, reflected in a lack of consensus on values, a disturbance in identity relations and a pervasive sense of powerlessness. 2. Chronic immaturity, the inability to assume effective responsibility, and an impaired potential for viable family growth. 3 Discontinuity and incongruity in the relations between family and society.

The pollution of the social environment magnified the forces of fragmentation and alienation in family relationships. The work pressures of contemporary society remove the man from his family. The conflicts of the community divide husband and wife, parent and child, parent and grandparent, parent and teacher, parent and community leader. There are rising complaints of feelings of emptiness, meaninglessness, loneliness, despair, and deadness. In alienated persons, the incidence of delinquency, addiction, mental illness, violence, and suicide are rather high.

Conflict of Social Forces

Charles Peguy states gloomily that modern society debases the dignity and values of life. The social patterns of the modern community are in an acute state of flux. There are clashes of social forms and ideals everywhere about us. On the gloomy side we might consider the statement of Char les Peguy : "The modern world debases. It debases the state, it debases man, it debases love, it debases the family. It even debases a particular kind of dignity, the dignity of death". On the more optimistic side, we might point to the social participation and protest of our youth. Disregarding the actions of a minority we might look with pride at the dignity, determination, intelligence, and idealism of the major segment of our nonviolent, protesting youth. The youth of our times live out both sides—the healthy and the pathogenic elements of our patterns of family, society, and culture. In short, youth does not want to adapt to a sick society. It wants to change it.

Lines of Defense

What is involved here is a progressive shift from the rational to the irrational, from the appropriate to the inappropriate, in the coping with danger. When the equilibrium of man and society falters and fails, there is a forced movement towards deeper levels of irrationality and more destructive patterns. In our social fabric we are in danger of moving into the third and fourth lines of defense.

Helping Processes

It may be pertinent here to list some of the self-healing family trends :

1. A shared search for suitable solutions to conflicts in family relationships.

2. A strengthening of family unity, integrity and functional competence through an enhancement of the bond of love and loyalty, and with this a consolidation of sound family values.

3. Mobilization of external support for family unity, stability and growth through community and social service like religious guidance, psychotherapy, marriage counselling etc.

4. Reintegration of family role relationships through the tightening of the family organisation : rigidification of authority, sharper division of labour, constriction and compartmentalisation of roles.

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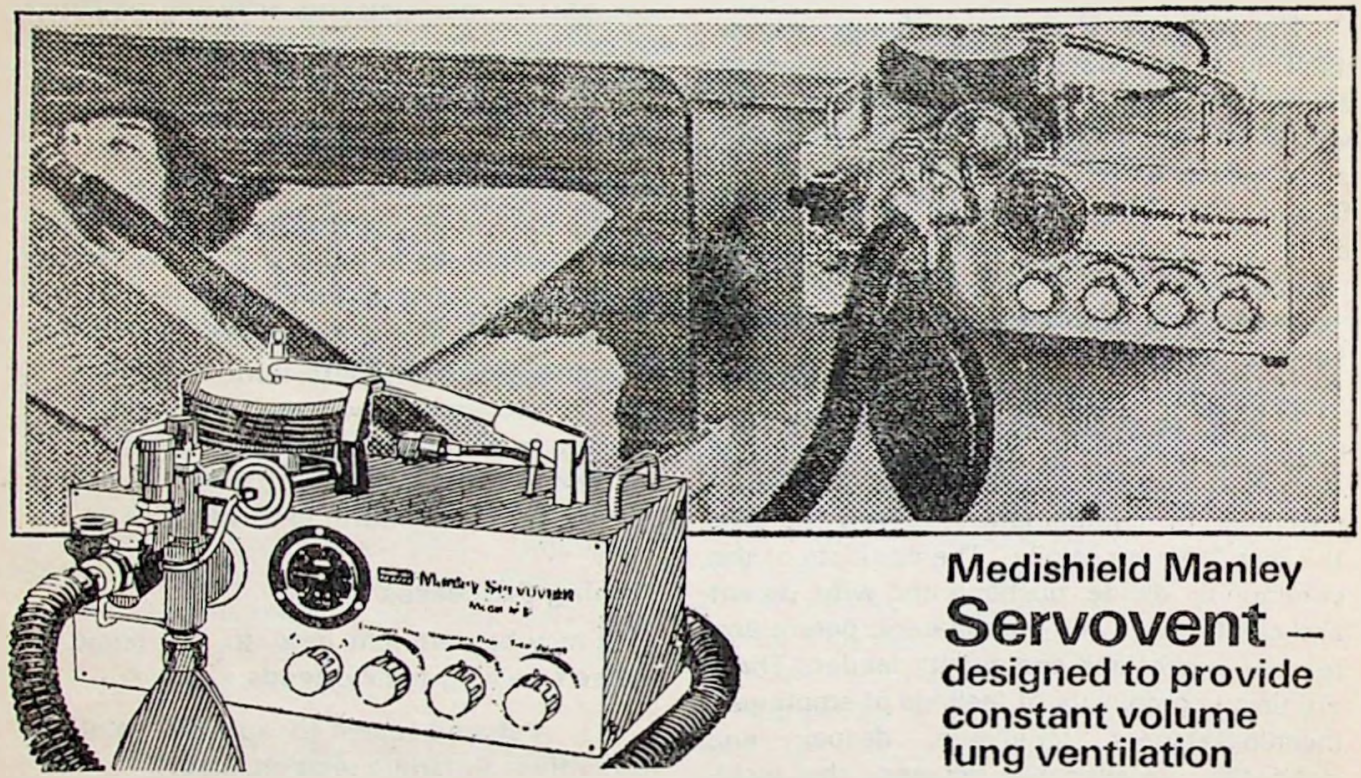

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5. Reintegration of family role relationships through a loosening of the family organization : dilution of the family bond, distancing, alienation, role segregation; thinning of the border between family and community and displacement of family functions from inside to outside.

6. Realignment of family relationships through splitting of the group and scapegoating of a part of the family.

7. Reduction of conflict and danger through avoidance, denial and isolation.

8. Reduction of conflict and danger through compromise, compensation and escape i.e. sexual escapades, delinquency, alcohol, drugs and so on.

Family healing encompasses a wide range of restitutive, regenerative forces in family life as these occur in nature. In essence, these forces are spontaneous self-healing processes. There is a significant healing potential in such events as family gatherings, religious observances, rituals of confession, and atonement, feasts, festivals, games music and dance, initiation ceremonies, weddings, deaths and the rituals of mourning. The healing potential in these events pertains to the family within the community and to some version of the extended family integrated into the community, but not to the nuclear family in isolation. Family therapy, on the other hand, refers to a systematic method of professional intervention on the multiple, interlocking emotional disorders of a family group. As a professional procedure, it tries to catalyze an optimal expression of the natural self-healing processes of family life.

Conclusion

The family is surely here to stay but must find a creative rebirth. This change in family living can happen only within a larger change, a creative rebirth of the entire social community.

In the last analysis, the only real test of a healthy family within a healthy community is its orientation to the problem of values. The major question is, now to move away from an orientation to power, acquisition, and a master-slave pattern of exploitation to a humanistic set of values : for life not against life, for peace not for death and destruction, for respecting the dignity and worth of all persons, regardless of race, colour or creed, for sharing and cooperation, not destructive competition; for openness, honesty and intimacy in human relations, not isolation and alienation, for recognizing the creative values of differences not fostering prejudice and violence, for a meaningful place and function for youth and for senior citizens in society; and for a relevant educational programme that promotes growth and fulfil ment in the new world. Within the superhuman universe, we must try to create human cells, teams, groups, and neighbourhood groups, which join people through common goals and activities. Within such groups we must nurse a new kind of connectedness and mutual caring.

Courtesy:The First International
Congress for the Family
of Asia and Australia

Disability Versus Employability

P.C. Hurkat

[Society does not go unpunished for its irrational and prejudiced attitudes towards the disabled. The economy suffers to the extent that the skills of a part of humanity go untapped and unutilised. The relatives, friends and social welfare institutions must supplement and supplant the reduced earnings of the disabled, besides bearing extra medical and personal care expenses—all at a cost to society. What a different picture would it be if the disabled were employed, whether possible, on their merits!]

Man is a physical being and therefore anatomical perfection within the range of normalcy has been one of the main criteria for fitness. Outward appearance in terms of well-developed muscles, complexion, proportionate development, etc., are still considered important assets in terms of social acceptability. Any defect in body perfection, viz., deformity, loss of limps, loss of vision, incapacity to hear or to speak, etc., often lead to certain complexes which produce a sense of incompleteness and overwhelm the sufferer from remorse, guilt and rejection. The disabled, therefore, tend to lose their self confidence and suffer at physical as well as mental levels.

Adding insult to injury the employers equate physical disability with helplessness and total dependence on others. They do feel sympathy but hesitate to give them employment since they consider them unfit. Employers in private and public sectors believe that giving employment to physically handicapped involves higher cost by way of increased compensation expenses or inflated medical and insurance premiums. They agree that disabled are more reliable and honest but they fear involuntary absenteeism, poor turnover or productivity and lack of flexibility in job assignments. Studies on job performance in India and abroad have proved that their views are irrational and discriminatory.

The author admits that disabled do suffer from lack of flexibility in job assignments because they have limited openings and capacity for certain jobs. This deficiency is, however, more than compensated by their insensitiveness towards diversifying stimuli and more concentration on the work in hand. If they are given the right job after proper training, they will rarely do mistakes, and with proper incentives and encouragements, productivity can be made to increase.

Loss of manpower: These facts are often overlooked under the cloud of prejudice—the attitudes which have become facts of life, and difficult to change. The employers prefer able-bodied. These unhealthy attitudes are the main cause why disabled workers have lower earnings and lower labour force participation rare. A study in the U S A revealed that the mean annual earnings of disabled workers are roughly 7/10 as compared to those of non-disabled, and a household with a disabled adult must go with 1/3 less income than other households. Behind bleak figures lie untold personal misery, resulting from the loss of work status and independence. These data are the facts of life in all countries—developed or underdeveloped.

The society does not go unpunished for its irrational and prejudiced attitudes towards the disabled. The economy suffers to the

extent that useful skills go untapped and unutilised. Relatives, friends and social welfare institutions must supplement and supplant the reduced earnings of the disabled besides bearing extra medical and personal care expenses—all at a cost to society. For example, it was found that 2.5 million disabled were receiving disability benefits in the U S A. No such figures are available in India, but the cost in terms of loss of manpower and relief must only be colossal.

Give them a chance : Activity limitation survey amongst disabled and nondisabled by Social Security Administration, U.S. Department of Health, Education and Welfare conducted some time ago revealed that about 4/5 of the disabled suffered from some physical limitation 2/5 had trouble in walking, 3-5 in lifting more than 10 pounds; half could not stand for long periods or had difficulty stooping and kneeling. The majority of persons with such physical impairment were disabled, especially those who had trouble in walking or reading. The disabled also were more frequently the victims of multiple limitations. It is, therefore, a fact that disabled cannot function as well as their non-disabled counterparts. But the fact is that given proper education, training, encouragement and, above all, proper adaptive skills and implements, most disabled, even with serious conditions of multiple functional handicaps, are not only able to work, but work efficiently. History is full of names of several handicapped who reached the highest ladder or proficiency in the fields of cultures, art, science and politics. The author has written several articles and a book despite substantial loss of function in his lower extremities and spine (100%). Besides having standing, walking, climbing, sleeping, sitting, stooping and kneeling difficulties, he cannot remain in chair for more than an hour at a stretch, and often suffers from tantrums of backache, shooting in legs and or arms. It has to be duped by bouts of pain killers, shortwave diathermy and hot foamentations.

The Government of India and the State Governments have definitely taken steps in this direction, and special employment exchanges have been established across the country for exclusively catering to the employment needs of disabled. The normal employment exchanges are also rendering a helping hand in this task of national importance. However, they have not been able to do much. It is extremely shocking to note that most States could not give employment to not more than two physically handicapped out of a hundred applicants. This is so, despite the proclamation that most States have reserved 2-3% posts in civil services for them. The employment exchanges cannot be blamed for this dismal picture of utter failure. The real guilty are the employers. They reject them on one pretext or the other, not once, but several times. The employers must look for abilities over disabilities and worthiness over worthlessness in the physically handicapped and give them the jobs which they can perform without jeopardising the efficiency. This may need a little rescheduling, alteration and modification of equipment, but it is an absolute truth that they can do some jobs without loss of efficiency. What is desired is rightful use of their residual abilities. It is not the plans and policies but their speedy implementation which can give them relief. It is probably with this background that Vocational Rehabilitation Centres (VRC) were started in the country. These Centres cater to the needs of clients who are orthopaedically handicapped with substantial loss of function, blind and deaf and or mutes. While Vocational Rehabilitation is the ultimate goal of these Centres, they also help them through a package of services. They evaluate their physical and mental skills and capacities in order to find out their suitability for various types of jobs through psychological

and workshop evaluations; make available expert medical advice to improve their physical handicaps with progressional appliances, arrange vocational training programmes with stipend and an all out effort to place them in suitable jobs or prepare them for self-employment.

Restoring lost productivity : An ideal vocational rehabilitation seeks to restore lost or stunted productivity, thereby increasing earnings, independence and well-being of the disabled and reducing the need of public support. To achieve these goals medical, prosthetic, psychological counselling, vocational training, work experience, placement, etc. are combined. These Centres, therefore, work on the notion that the efforts will improve employability and result in long term benefits to society and individuals.

The data are disappointing and reveal a dull picture of social scenario of handicapped in India. The employment profile of blind and deafmutes is by far the most gloomy. The lion's share goes to orthopaedically handicapped. This fact is further attested by latest revelations of Calcutta VRC which has so far evaluated 2,370 clients and rehabilitated 500 orthopaedically handicapped, 167 deaf-mutes and 72 blind persons through training, self-employment and paid jobs.

The working of rehabilitation programme is no better in developed countries either. An analysis in the working of vocational rehabilitation centres in U.S.A. had revealed that 3/4 of the disabled who had received rehabilitation services felt that the services had helped in some way as improving mobility, self-care capacity, self-confidence and employability but it is only 11% of the clients who could actually get the jobs because of their training and assistance. Most of them felt that much time was spent in arranging services and processing paper work rather than providing help and guidance. The public funds spent by way of salaries and other benefits on the staff of special employment exchanges, social welfare departments and national vocational rehabilitation centres is, therefore, far more in amount than the actual relief rendered in the form of training of job placements. They have thus become self-care and self-welfare centres for the ablebodied themselves.

How can this malady be set right ? The author suggests that 50% of the staff of spe cial mployment exchanges, social welfare departments and vocational rehabilitation centres be recruited from amongst the physically handicapped so that they can understand the problems of the disabled better, besides generating employment for them. These centres, must be run on the basis of industry rather than an office and that they must have less holidays and strict eight hours working. They must develop a chain of services in counselling, physical restoration, education, maintenance, work adjustment, placement, help in establishing a small business, social services and other aids. *No one should mistake that the importance of vocational rehabilitation does not lie in combating the consequences of disability but in restoring tha residual abilities. It aims at inducing self-confidence and self care activities and above all in creating self-awareness about their abilities, worthiness and usefulness*— may be in a limited sense of term.

At the end of the queue : The disabled population is however, at the end of the labour queue in all lands and at all times including that of India. In the circumstances competitive employment is a distant unattainable goal. Most severe mentally and physically handicapped, therefore, need special arrangements for preparing them for entry into labour market. Advanced countries have solved the problem by establishing a network of sheltered workshops. They are truly the last resort for giving employment to physi-

cally handicapped with serious loss of functions. They focus on unskilled, labour-intensive work after proper training such as packaging, bench assembly, wood working, metal working, inspection, custodial work, manufacturing jobs, reclamation, salvage operation etc. India has not yet experienced in this field. Sheltered workshops are indeed indispensable and will go a long way in ameliorating the difficulties of handicapped for these are the final major component of the rehabilitation system and provide employment for those who have few options in the competitive labour market. *Sheltered workshops are thus not only the employers of last resort but also a source of service for those most in need—welfare for workfare in its true sense.* The magnitude of services rendered by sheltered workshops will be obvious by the fact that they employed nearly 1 million separate clients during the last decade in U.S.A. While the manpower and veteran's programme together reached about 500,000 handicapped in the same duration.

The government must, however, be cautious from the very beginning to see that the employment programme designed for the disabled may not become employment programme for the able bodied workers. It is suggested that the ratio of the staff in sheltered workshops must be 50:50 between disabled and able bodied workers, and that, they must work on the principle of industry and commercial establishments. The products and services created by these workshops subsidised by the Government of India to make them competitive and be sold on the pattern of Khadi Gramodhyog. These workshops must also provide non-vocational services to the clients like developing skills of independent living—such as personal hygiene, speech therapy, homemaker training, training in mobility, adult education, psychotherapy, transportation, housing and homebound employment. Such services by sheltered workshops will go a long way in inculcating a sense of workfare and will wean them away from public relief and charity. The private sector employers can do a wonderful job by providing suitable placements to the physically handicapped in their industrial and business establishments. Such an endeavour will crack down on the age old prejudices towards handicapped to conserve their profits because the then Finance Minister had introduced a new clause ii (a) in Subsection (1) of Section 36 of I.T. Act during the budget proposals for the year 1980-81. As a result of this amendment, an assessee carrying on a business or profession will be entitled to a weighted deduction in respect of any salary upto Rs. 20,000 per annum paid by him to an employee who as at the end of the relevant previous year was totally blind or who is subjected to or suffers from a permanent physical disability, other than blindness which has the effect of reducing substantially his capacity to engage in a gainful employment or occupation. The weighted education would be allowed only if the employer produces before the I.T. Office in respect of the first assessment year for which the deduction is claimed under this clause, in the case of an employee who is totally blind, a certificate as to his blindness from a registered medical practitioner being an oculist and in the case of an employee suffering from any permanent physical disability a certificate from a registered medical practitioner. The then Finance Minister deserves a warm pat for a correct step in right direction.

Right man for right job: Based on the principle "RIGHT MAN FOR RIGHT JOB" following jobs are listed for placement of different categories of physically handicapped by private, public and government sector employees:—

1. *Loss of Function in Lower Extremities;* These persons must be able to move about

with some sort of walking aids (a) Teaching jobs in schools, colleges and technical institutions, (b) Research, data compilation and processing, statistical evaluation, jobs requiring use of complicated machines and instruments, jobs in laboratories, etc. (c) Clerical, executive and administrative jobs including accounts, sales, etc. but they should entail no or less moving about. (d) All skilled, semi-skilled and manual jobs requiring use of upper extremities, but less or no moving about such as liftman, compositer, proof-reader, relephone operator, salesman, waterman, typist, stenotypist, peon, clerk, accountant, receptionist, electrician, plumber, cashier, technician, tailor, painter, artist, moulder etc. (e) Technocrats such as doctors, enginers and other professional executives, judges etc.

2. *Loss of Function in Upper Extremities*: These persons must have one useful hand. There may be partial or complete loss of function in another hand or arm. (a) Teaching jobs in schools, colleges and technical institutions. (b) Research data compilation, statistical evaluation in various categories of research institutions, laboratories, offices etc. but requiring little or no use of instruments or complicated machines or tools. (c) Clerical and senior administrative executive jobs requiring no or little use of instruments but moving about. (d) Public prosecutors and government advccates. (e) Semi-skilled and unskilled jobs which can be handled with one useful hand along with prosthesis in the other hand such as liftman, waterman, proof reader, peon, clerk, accountant, receiptionist, artist, chowkidar (Ex-service man most suitable for this job). Jobs requiring visual attention with one hand such as in factories where quality is to be checked at regular intervals, traffic control by observation and electric signals and delivery of instruction through public address system.

3. *Deaf Mutes* : They may be very suitably employed in the following jobs on temporary or permanent basis. (a) Fixing stamps, putting seals, mail sorting etc., in post office. (b) Writing addresses, counting currency notes, checking of accounts, comparison of statements, sorting and destruction currency notes, typing etc. (They are thus very useful for employment in banks and reserve bank branches). (c) Liftman, photographers, artists, tailors, gardeners, factory workers, copying and composing jobs. (They are most suitable for composing and printing of confidential material) and all precision and manual jobs. (d) Teachers in deaf and dumb schools, (e) Factory jobs requiring collating, stuffing, packaging, mechanical assembly, inspection, salvage and reclamation operations. (f) Custodial, wood and metal works, weaving, knitting, hosiery, and skilled and unskilled jobs are some of the other areas where they can be suitably employed.

4. *Blind :* Employment of blind persons is a real problem firstly because vision has a very vital role in man's life and his activities and secondly, because the capacity of one blind varies considerably from that of another. Music (vocational and instrumental), law, teaching, journalism, general and business administration, physiotherapy, computer programming, stenography, telephone operators (using digital telephones) and public address systems are some of the professions where blind persons can be found very suitable.

No record and statistics are available to reveal the quantum of disabled work-force currently under employment in India vis-a-vis productivity, efficiency and lapses by way of absenteeism, accidents, poor turnover, bloated medical bills, increased insurance compensation, etc. excepting that one from Vijay Merchant, the ace cricket player, who employs in total about 113 disabled workers (19 blind, 20 deaf, 38 orthopaedically handicapped—including 2 paraplegics, 10 mentally retarded, 29 leprosy arrested and 3 cancer cured). His

experience is that disabled give equal production, good quality work and fewer accidents.

Example from U.S.A. : Similar encouraging reports have come from U.S.A. General Motor Company alone employs 25,000 disabled workers out of its total work force of 580,000. They most systematic and encouraging report is from Du Pont Company which goes on to read, "Du Pont employs more than one lakh workers in the United States, roughly 15,000 of them are physically handicapped. Their job titles range up and down the corporate ladder from labourers to managers.

So far as safety is concerned, 50% of the disabled workers proved to be above average, just 4% were below average. In attendance 79% were average or above. In job performance, rated by their supervisors, 37% came out above average and just 9 were below average," The study concluded that nature of the handicaps did not prevent workers from doing good job. Some of the best performers had the most severe handicaps. It is, therefore, hoped that above cited authentic reports, both from India itself and abroad, are forceful enough to convince that if disabled persons are suitably employed in the jobs which they can perform the productivity and efficiency will remain optimum. *It is time that public and private sector enterpreneurs must shed their age old prejudice and false beliefs so that they make forceful efforts for providing more and better employment to the physically handicapped. By doing so, they will not only be serving Gandhiji's last man in line, but also be involving in mammoth cause of social reconstruction. This will help them to save income tax on their earnings on one hand, and will make them the heroes—the torch-bearers for the future.* The light so lit will disperse the cloud of prejudice and will illuminate the path for those rejected by the society into a secure and bright future.

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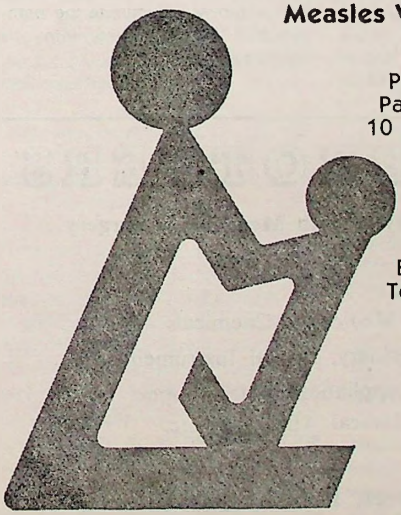

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Bringing Eyecare to Villages

S. Kannan

[Studies show that lakhs of people are functionally blind in rural India on account of cataract—a condition that is reversible through surgical techniques perfected over years, yet bulk of the people do not get the benefit of surgery just because they live in rural areas from where access to these surgeons is difficult or they are too poor to afford the treatment and associated transport cost, food and the like and, also due to a certain extent, fear complex connected with the operation and aftercare.]

Ramaswamy, working as a clerk-cum-salesman in a village cloth shop in Madurai District for the past quarter century, had been feeling that his eyes were letting him down gradually. One fateful morning, feeling pretty depressed, he stopped going to work. He had been the sole bread—winner of the family and the stoppage in income was a severe jolt to his family. His four children were still in the school stage and to keep his family going he had to pledge whatever he had, even his wife's meagre jewellery.

Things went on like this for almost a year and when his economic ruin was almost complete, one fine morning he heard of a free eyecamp, conducted by the Arvind Eye Hospital, Madurai, being held in the nearby village school premises. He wasted no time and went there.

The doctor who examined him said that his vision has been impaired by cataract and could be restored with an easy operation. Ramaswamy did not anticipate such a thing. Being financially broke, he hesitated and was wondering what to do to meet the expenses for the suggested surgery. Sensing his predicament, the doctor assured him not to worry and that he would be taken care of fully. It was a blessing in disguise for Ramaswamy. He gave his consent for undergoing the operation and the hospital did the rest. After another operation on the other eye, he is no back at work and efficient as before. The whole family is jubilant. He is only sorry that he wasted so much time just doing nothing to get back his sight. He wished somebody had told him much earlier so that his ailment could have been got over, thereby preventing the associate hardships.

Well, this is not a stray case. It has been the case with thousands of people in rural India. There have not been much of concerted efforts to motivate the villagers, who are often ignorant, skeptical apathetic to seek the real remedy, which is actually within their reach. With a good chance to restore the vision, in most cases, should they be allowed to be depressed and remain blind throughout the rest to their life, as a burden to their relatives and society, certainly not. Our villagers have taken to modern farming methods and are capable of taking good care of their work animals and even their bicycles, sprayers and pump-sets. They should not be allowed to neglect their personal faculties as well.

Recent estimates show that about 90 lakhs of people are functionally blind in Rural India due to cataract—a condition that is reversible through surgical techniques that have been perfected over the years, yet bulk of the people do not get the benefit of sur-

gery because they live in rural areas from where access to an eye doctor is difficult or they are too poor to afford the treatment and associated costs of transport, food, etc. and also due to a certain extent, fear complexes connected with the operation and aftercare.

Fortunately the concept of eyecare has changed over the years and today the eye hospital is no longer an isolated ivory tower, confined to the urban elite. It is today very much an integral part of community programme, according to Padmasri Dr. G. Venkataswamy, Founder-Director of the Arvind Eye Hospital. Necessary help is rendered at the rural doorstep, where the problem is acute

To alleviate the problem, the Government and several private organisations have been organising free eye-examination and operation camps in villages. The Tamil Nadu Government had fixed a target of one lakh cataract operation during 1983-84 in the state.

The eye camps, organised by the Arvind Eye Hospital, ever since 1977-78, have been unique in many ways. In all their camps there is an active community participation. Service organisations like the Lions club, Rotary club, Bhagwan Sri Sathya Sai Seva Organisations arrange for these camps and enlist patients through propaganda. The hospital proposes to do 15,000 free cataract operations this year. The hospital bears the entire expenses towards surgery, medicines and period of stay for the operation, while the service organisations provide the patient with spectacles and a food allowances amouting to Rs. 25 per head, besides meeting the transport cost for travel to Madurai and back. The average length of stay at the hospital for the cataract patient is seven days.

A beehive of activity, the hospital is run by the Govel Trust, a non-profit charitable organisation founded in March 1976 by the former professor of Ophthalmology, Madurai Medical College, Dr. Venkataswamy. The object of the Trust is to establish and run hospitals to end need less blindness. Started with a 20 bed facility it is today a modern building with 300 beds, totally costing Rs. 60 lakhs.

The hospital has the infrastructure for all types of sugery including surgery to set right retinal detachment, catract and glaucoma, vitrious surgery, corneal grafting, physical and surgical correction of squint and opthalmic plastic surgery. It had modern imported equipment so that the ophthalmic care given to every patient will be the best.

As an adjunct to the main building another five-storey 300-bed free hospital is nearing completion. The new unit will be a three - in - one institution, viz., hospital, research centre and training wing. Research projects are proposed to find out how best they can improve the delivery of eyecare to the rural people, how to plan and provide eyecare facilities; and above all how to motivate the patients to come forward to utilise the facilities—

It will also train rural people as health educators who will ultimately organise the rural eyecamps and motivate their suffering bretheren to get rid of their malady in time.

The hospital has bus and three vans for the medical team to visit the village and also transport patients to and from the hospital.

Free rural eye screening camps are almost a daily routine and the people who need operations are brought to the main hospital for surgery. Surgery camps are also conducted where there are great number of cases. During 1982, they conducted 214 eyecamps, treated over 40,000 patients. Several service organisations give a helping hand in the restoration of sight to the poor.

The Royal Commonwealth Society for the Blind, U.K., supported 132 camps where 30,608 patients are treated and 5,348 operations performed. Diwaliben Mohanlal Mehta Charitable Trust supported 82 camps where 19,423 patients were treated and 3,399 cases operated. In addition to these, several industrialists, rural organisations, colleges and schools helped the hospital in arranging these camps and providing shelter to the patients.

In one of the most ambitious programmes in December 1982, the hospital conducted a free eyecamp in the Maldive Islands. The camp was organised under the auspices of the World Health Organisation. The Medical team camped at Kulhudufusshi, a long boat journey from Male for the team of three doctors, four surgical scrub nurses, one refractionist and one theatre assistant.

The team led by Dr. (Mrs) G. Natchiar Senior Medical Officer, examined about 1,800 patients and performed about 250 operations during its stay. The camp was conducted to serve the 62 northern—most islands, covering a population of 33,619. The entire exercise took an enorous amount of organisation and care of minute detail both in Madurai and in the Maldives. The hospital has plans for two more such camps and it has also a proposal to bring Maldivians to the main hospital to be trained as ophthalmic nurse or assistant who can work in the islands in community—oriented prevention of blindness programme.

Opening of satellite clinics is also an important programme the hospital is contemplating to reach out to the masses. After all the eyecamps, temporary in nature with a limited service facility, cannot go on for ever. Already the hospital bestows its technical service to Seethalakshmi Hospital at Gobichettipalayam (Coimbatore District) and the Blisy Hospital at Udhagamandalam (in the Nilgiris). A branch hospital and a peripheral clinic are functioning at Theni (Madurai district) and Sankarankoil (Tirunelveli district). The hospital is to set up 30 more satellite clinics spread all over Tamil Nadu. Each will have an operation theatre, a central fertilisation room, an out—patient clinic, 30 beds for paying patients and 30 beds for free patients.

These satellite clinics will serve as a base for conducting camps in remote villages for screening eye patients and bringing them to the clinic if surgery is needed. They will also facilitate regular and better follow-up care and also cut transport cost for the patient and medical team.

The hospital is diffusing ophthalmic knowledge far and near. It is affiliated to the Madurai Kamaraj University to conduct two-year diploma courses in ophthalmology. It is also recognised by the National Medical Board to train candidates to become members of the Academy of Medical Sciences in ophthalmology. The Indian Medical Council has recognised it to train senior house surgeons. It is also a centre for research leading to Ph. D. of the Madurai Kamaraj University.

The W.H.O. chose the hospital to offer training for a batch of 10 Nepalese last year to become ophthalmic assistants. After training they have returned home and this year another batch of 10 Nepalese have come for a similar purpose.

In fine, the Arvind Eye Hospital has earned a name in a short span of less than a decade since its inception and it has become a force to recon with in the field of rural ophthalmology, thanks to the foresight, visionary and missionary zeal exhibited by the nearly two dozen doctors and over 100 para medical staff. It is waging a silent but determined war on blindness. It is certainly the cynosure of all eyes.

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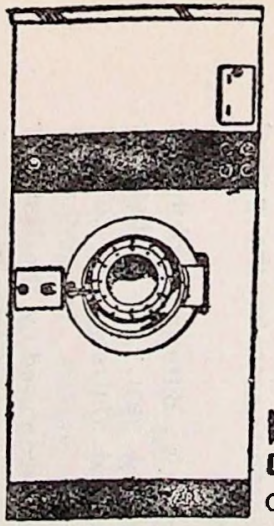

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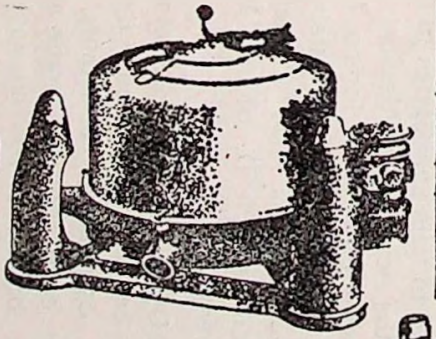

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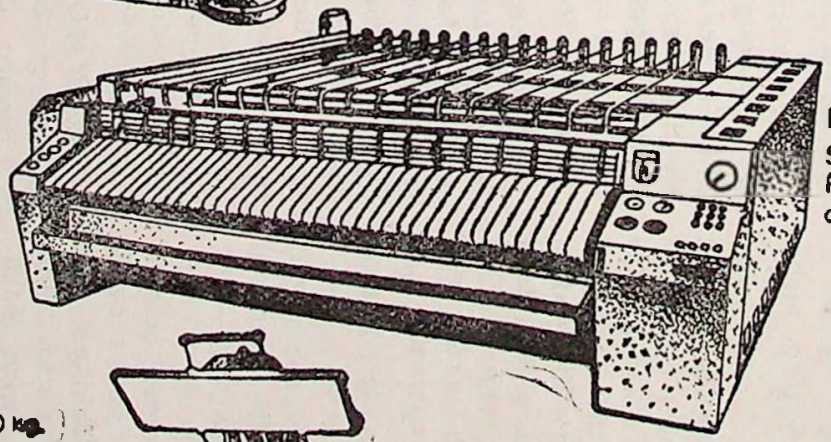

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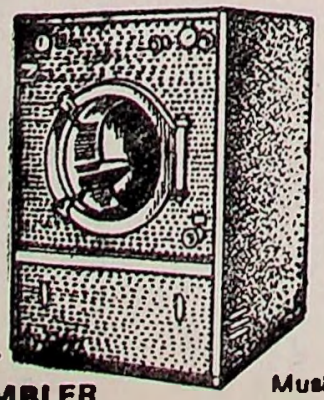

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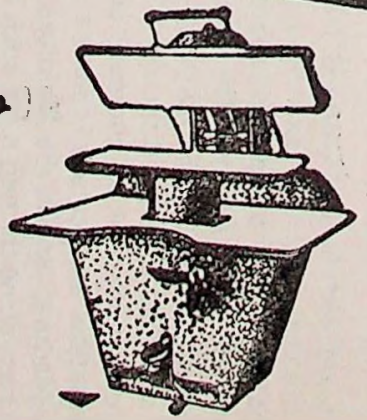

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PEOPLE, PILLS AND PRESCRIPTIONS-1

The Drug Dilemma

—Ravi Narayan

The CHAI's goal has been and will always be a 'Healthy Community'. In our new vision, we seek 'to promote social justice in the provision and distribution of health care'. With the increasing emphasis on "Primary Health Care" we are all in an increasingly important quest for PRIORITIES. We have to seek "clean water before antibiotics, food before vitamin pills, vaccination before kidney machines, mother's milk before powdered baby foods mixed with dirty water, and health for villages and slums before more hospitals for the affluent suburbs of capital cities". The dilemma before many of our members is how to shift priorities from our historical commitment to hospital systems to our new vision of community health care.

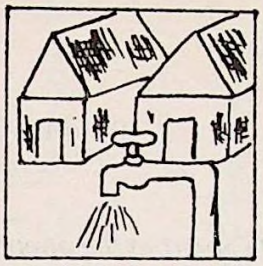
One of the big problems we are facing in our hospitals is the INCREASING COST OF DRUG BILLS. Drugs are becoming the mainstay and main cause of expenditure in our hospital system. Any shift of priority can only result from a concerted action on our part to look at drug policy and drug costs. We have to see whether we can as a group of voluntary health workers, do anything to *reduce the drug bills as a first step towards shifting priorities. Can we change our prescribing policies? Can we stock low cost drugs? Can we produce lowcost drugs?*

The ICMR/ICSSR study on "Health for all—an alternative Strategy" warns us that *"eternal vigilance is required to ensure that the health care system does not get medicalised, that the doctor-drug-producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill health".*

Can CHAI Members do anything about this individually and collectively?

To find an answer to this growing problem, we are starting a column on drug issues in the Medical Service, to discuss some of the following matters :

* The pattern of drug production should be oriented to the disease pattern in India, with an emphasis on the production of essential and basic drugs. *If we agree, what can we do about it?*
* We cry for drugs needed by poor and underprivileged groups which should be produced in adequate quantities and sold at cheapest possible prices. *How may we bring about this? What has been the experience of the Central Purchasing Service?*
* One of the most distressing aspects of the health service today is the habit of doctors to overprescribe or to prescribe glamorous and costly drugs will limited medical potential. *Can the medical profession in our hospitals be made more discriminating in prescribing habits? Can we commit ourselves to rational therapeutics?*
* The small scale drug industry needs to be encouraged and expanded subject to strict quality control. *Can we produce low cost alternative in our hos-*



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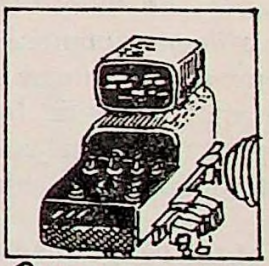

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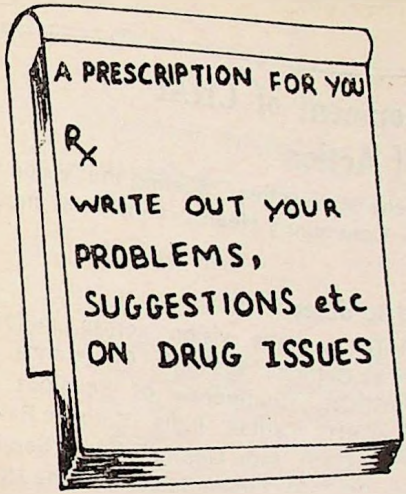

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pitals, health projects and village communities ?

* Thirty thousand branded drugs are on sale in India. But a Government Committee on Drugs and Pharmaceutical Industry (1975) believes that health needs can be met by only 116 drugs. *Can we agree to a simple standardised low cost pharmacopia for the Voluntary Health Sector* ?

* A Government Committee looking at drug costs has recommended acceptance of

— A basic drug list

— Generic Prescribing practice
— Bulk purchasing
— Local formulations
— Use of indigenous drugs

Taken separately; each policy is a powerful weapon for change; taken together, they build into an integrated strategy. *Can we consider these and accept them to change the drug scene in our hospitals* ?

* Do you know that drugs banned all over the world are still prescribed in our hospitals ? The Government has already banned 34 combinations. We need to join movements to ban many more for the sake of our people.

All these issues will be discussed in this column.

Community Health Development of CHAI Review its Plan of Action

After nearly an year, the Community Health Department of CHAI again met together at St. John's Medical College, Bangalore, from 19th - 27th May, 1984 to review the plan of action based on the philosophy and vision of Community health which was formulated last year. The following persons were facilitators during the Session : Prof. George Joseph, Fr. Stan Lourduswamy, Fr. Claude D'Souza, Mr. Rudy Lobo, Drs. Ravi and Thelma Narayan, Mr. Augustin Veliyeth and Mr. R.T. Rajan. The main thrust of the discussion was the role of CHAI's CHD as a national organisation. It was the common consensus that CHAI's CHD should strive to make Community Health a national movement rather than limitting its scope to train some groups. Hence it was felt that CHAI (CHD), being a national organisation has to share the CHD vision with the nation to make Community Health a movement, instead of concentrating on activities which could be carried out by other individuals and organization at various levels who could be the future partners of CHAI (CHD).

The sharing of the vision consists in exchanging discovering, appreciating and promoting the same vision in the health and development activities and movements going on in various parts of India. It also means learning from each other as friends and equals assuring solidarity for one another. This kind of sharing can be achieved only by working with and through as many individuals, groups and organizations as possible. Only through this way CHAI (CHD) can facilitate a national health movement.

With this understanding, we envisaged the following objectives and strategies :-

General objective : Sharing the vision to make 'Community Health' a national movement.

Specific objectives

(i) To get the vision across national bodies as Catholic Bishop's Conference of India (CBCI), Conference of Religious of India (CRI), Caritas India, Catholic Relief Services (CRS), Indo German Social Service Society (IGSSS), Indian Social Institute (ISI) Voluntary Health Association of India (VHAI), Central Health Education Bureau (CHEB), Indian Medical Council, Ministry of Health (Govt. of India), Central Social Welfare Board (CSWB), Indian Federation of Medical Guilds, Catholic Nurse's Guild of India (CNGI), Medico Friends Circle (MFC), Participatory Research in Asia (PRIA), People's Institute for Development and Training (PIDT) etc.; media like AIR & TV, News agencies like PTI, UNI, etc., CHAI member institutions, State Ministries of Health and education, health directorates, Diocesan Directors, Heads of religious formation houses, various action groups. In short all those who are interested in People's development.

(ii) Identify partners who share similar vision—individuals, voluntary agencies and action groups.

Strategies : The following strategies are to be worked out by the Central (CHD) team or with the partners or through the partners.

(a) By the Central (CHD) team :

(i) Identifying partners either through correspondence or personal contacts.

(ii) Research, Documentation, Dissemination through publications and other media.

(b) With partners :

(i) Seminars, Workshops

(ii) Consultation, Evaluation, Planning

(c) Through partners :

(i) Training Programmes

(ii) Demonstration — etc., bringing on a common platform organisations, groups and individuals sharing a similar vision on health and development and promoting joint action in selected areas.

These are proposed to be carried out through a time bound three year plan.

Specific Plan for 1984-85

1. Identifying member institutions with Community Health Programmes. This will be done through sending communication to individual institutions by means of a questionnaire.

2. Identifying groups and individuals who could be the partner of CHAI (CHD) from already existing informations collected by agencies as Caritas India, ISI, IGSSS, CRS, Solay, NFC, etc. Besides these concentrate on at least two regions in the coming year for collecting detailed and comprehensive informations.

3. Organise regional workshops, atleast four, for member institutions and possible partners, where they can meet, exchange views and develop links for effective collaboration in future.

4. Organise two Zonal Workshops for diocesan health co-ordinators who were appointed at the request of CHAI.

5. Getting across the vision through regional languages:

— Translation of the vision, important Church documents the National Health Policy, etc. into at least 6 languages as Hindi, Oria, Telugu, Kannada, Tamil and Malayalam.

— Visual presentation of the vision through mobile exhibition and through printed materials that can be sent by post.

— Audio-visual exhibition on drug-issues.

6. Staff Development Programme :

— The existing annual evaluation and study session, which normally falls around the month of May.

— Three other meetings at the team level for sharing, study, evaluation and planning. Tentatively they were fixed to be in the months August, October/November, and February.

— Weekly meeting of the team for half day at least, during which each one can share their work and the information received from books, journals and different persons or groups. This session could also form as part of an ongoing study, evaluation and planning programme.

— Attending useful short term courses seminars etc. depending on the interest and needs of each team member.

7. Existing programmes : Though in the light of the present understanding and in tune with the general long term action plan, the type of involvement of the team will be different, the existing programmes will have

to be continued. Even afterwards, the possibility of taking up similar Training Programmes in the future is not completely ruled out.

As we are aware that any movement can be only at the people's level, we plan to join hands with any one who is interested in people's growth and development.

Fr. John Vattamattom, SVD
Executive Director, CHAI &
Secretary, Health Section of
the CBCI Commission for
Justice Development and
Peace.

President of World Health Assembly Stresses Importance of Political will

Speaking of the goal of Health for All by the Year 2000 Professor Guillermo Soberon Acevedo, President of the 37th World Health Assembly, declared that "there has never been in the history of humanity a concerted effort on such a scale to achieve higher levels of well-being. It may be added nevertheless that the importance of this initiative by the World Health Organisation has been paralleled by the effort made in the field to achieve this goal." In this year of 1984 we are coming ever closer to the year 2000 which the countries of the world, joined together in the World Health Organization, have chosen to make a substantial step forward for the benefit of all peoples of the world : namely, to ensure that they enjoy a state of health compatible with an agreeable life and adequate social and economic development. This goal, although possible, is not one that will be easy to achieve. Nevertheless, the difficulties which are being encountered can only spur on the determination of those who are participating in this task."

"Political will on the part of governments is indispensable." Professor Soberon Acevedo added. "They must realize, "he said, "that in order to meet popular demand in regard to health, must be conceived as a social objective of deep significance and political importance."

WHO Director-General Calls for Imaginative Management

Introducing his biennial report of the work of WHO in 1982-83, the Director-General, Dr. Halfdan Mahler, called for imaginative management : "In reality, what is required is imaginative management to orchestrate the never ending arduous tasks that have to be performed—by Ministries of Health and related social and economic sectors; by social security organizations; by Universities and research and development institutes; by people in all walks of life as facilities, health centres, hospitals and laboratories; and by storehouses, factories and the like. In this gigantic human beehive each and every individual and institution has a specific role to play—planning and identifying priorities in such a way as to bring epidemiological needs and social preferences into line with each other; in allocating resources; in deciding on the most appropriate technology; in taking preventive action; in providing care. Yes, even keeping health centres and hospitals clean and shining; without that nobody will have any faith in them."

"Permeating all that is the information and education of people and the everlasting training, training and training again of health workers for the specific jobs they have to perform; and ensuring that they are provided with conditions that will be sufficiently attractive to recruit them to the service and keep them there and yet be commensurate with the social and economic realities of the country and the community in which they live and, hopefully, serve. I realize fully well that all of this is easier to preach from this platform than to practice in real life. But that practice is the real challenge : more repetitions of the sermon in countries and in WHO will get us absolutely nowhere."

Editorial Board of our Journal Medical Service meets at Bangalore

The meeting of the Editorial Board of our journal met at St. John's Medical College, Bangalore, on May 18, 1984. The meeting reviewed the situation and it was felt that our journal should be made still more attractive and informative. It was decided to start a new column on drug issues moving towards a rational drug policy.

Another point discussed was the population issue. This being the population year, where, under the auspices of our journal the various moral and ethical issues of population problem could be studied for the benefit of all. Fr. John Vattamattom SVD, the Editor was commissioned to do the needful in this regards.

Doctors Commit to Rural Work

Under the auspices of CHAI and St. John's 2 days sharing session by the doctors who have done or still doing the rural placement, after their studies in St. John's Medical College, was done on 19th and 20th May 1984. Twenty doctors coming from various parts of the country and some of the alumni staff of St. John's participated in the discussion. Dr. Ravi and Thelma Narayan and Fr. Claude D'Souza were the facilitaters. The discussions ended on a very positive note and with number of very valuable suggestions. A more detailed report on this will be published later on.

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Continuing Medical Education

What is it ? —Medical Education is continuous and life-long; CME is that part of medical education which follows formal undergraduate and postgraduate medical education. Unfortunately, there has been a tendency to divide life into an area of "learning"—the first 20-25 years, and "doing"—the following 30-35 years. This compartmentalisation is wrong. Learning has to be "by doing" and "while doing".

Why CME ? —CME is a must for all those who want to be practising good medicine. So, whether you are a general practitioner, out in the village or in a posh locality in the city, or a specialist in small hospital or Faculty member in a prestigious institution (clinical or non-clinical) all need CME. CME prevents our slipping down, re-inforcing what we had learnt and learning what is new, updating our knowledge, skills and attitude. The need is so great that CME has been made mandatory in may States in U.S.A.

Has there been CME ? Yes; bits and pieces of CME have been taking place all the time. When you attend conferences or the programmes prefixed or suffixed to them. You do have some CME. Recently there have been programmes arranged in posh hotels in New Delhi, Bombay and Srinagar. But these have been haphazard and the impact has been little. We need systematic CME, within the reach of all health professionals.

Present Plans now : There are two areas which C.M.C., Vellore will be taking up now :

(i) General Practice

(ii) Specialties
These programmes will be aimed priority wise at

(i) Alumni of CMC

(ii) Mission Hospitals

(iii) Others

The urgent area is that of general practice. The practitioner finds it almost impossible to get away from his practice. Yet, the need for updating knowledge, skills and attitude is greatest here.

Correspondence Course —The answer to the problem is correspondence course (Distance Learning). The material, prepared by the Faculty of C.M.C., Vellore is brought to you by post, in 12 instalments. They will give 'What is New 'and' What is Relevant' to the Practictioner. The first booklet will be sent in the first week of August, 1984.

How to join —Write to the Co-ordinator, CME, CMC Vellore-632 002 for details, enclosing a long, self-addressed and stamped envelope.

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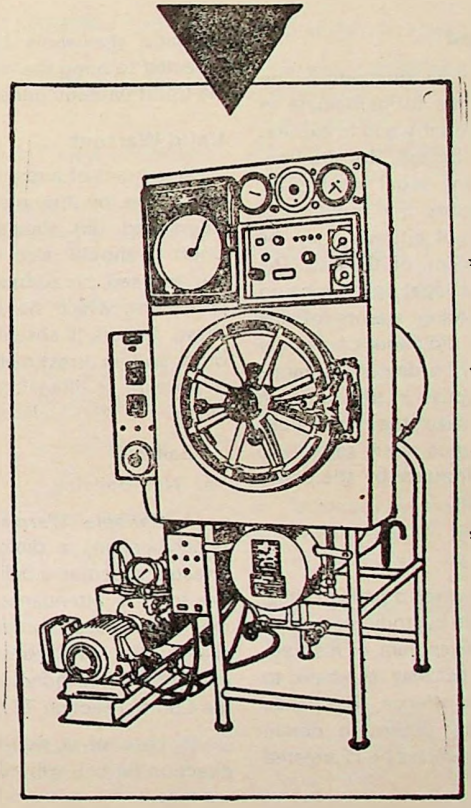

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LEGAL EDUCATION—8

On Your Rights if Arrested

P.D. Mathew

Your Rights if Arrested

The Constitution of India guarantees the citizens' fundamental rights to participate in the political life of the country and to express themselves as political beings. But the freedom is hedged in by many legal restrictions by the police, bureaucrats and politicians. Even legitimate activities of citizens may be considered as infringement of the law. The general ignorance of our legal rights is being exploited by law enforcing agents of the State and consequently violation of human rights is increasing day by day at an alarming proportion. The objective of this note on *Arrest and Bail* is to raise the legal consciousness of the citizens with regard to their rights when confronted by the police and agents of the judiciary.

Arrest of a Person

A person is arrested when a police officer or a citizen takes him into custody or otherwise substantially deprives him of his freedom of action so that he may be held to answer for a crime or an offence. The police in India do not have any power to detain anybody for questioning unless he is arrested with or without warrant.

Warrant of Arrest

It is a written order issued by a Court to a police officer to arrest and produce an offender or to search his premises for a particular thing. A police officer who executes the warrant shall notify the substance thereof to the person to be arrested and if he demands, shall show him the warrant. He is expected to bring the required person before the Court without unnecessary delay.

Valid Warrant

A warrant of arrest should be(i) in writing (ii) signed by the presiding officer of the Court and (iii) should bear the seal of the Court. It should also contain the name of the accused, his address and indicate the offence with which he is charged. If any of these factors is absent, the warrant is not in order and an arrest made in execution of such a warrant is illegal. Warrants are of two kinds:

i. Bailable
ii. Non-Bailable

A *Bailable Warrant* is a Court's order which contains a direction that if the person arrested executes a bail with sufficient sureties for his attendance before the Court, he may be released from custody. In that case it shall further state the number of sureties, the amount of the bond, and time for attending the Court. (Section 71 Cr. P.C.)

In case of a non-bailable warrant the direction for bail will not be endorsed on the warrant.

Arrest without Warrant

A police officer has power to arrest a person without warrant if he is suspected of having committed a cognizable offence. Normally in non-cognizable offences a police officer cannot arrest a person without a warrant from a Magistrate.

In the first Schedule of the Criminal Procedure Code (Cr. P.C.) offences have been classified and enumerated as cognizable and non-cognizable. The more serious offences such as murder, rape, robbery, theft, wagin war against the State etc. are cognizable.

When can a person be arrested without a warrant ?

A person can be arrested without a warrant

1. If he is concerned in a cognizable offence or if there is a reasonable suspicion, complaint or information that he has committed a cognizable offence ;
2. If he possesses implements of house breaking;
3. If he possesses stolen property;
4. If he is a proclaimed offender;
5. If he obstructs a police officer on duty;
6. If he escapes from legal custody;
7. If he is a deserter from the army, navy or air force;
8. When he is out of India, commits an offence punishable under any extradition law or under the Fugitive Offenders Act;
9. If he is a released convict who breaks the restrictions imposed by the Court on his movements;
10. If he is suspected of preparing to commit a cognizable offence;
11. If he is a habitual criminal;
12. If he, after commiting a non-cognizable offence in the presence of a police officer, refuses to give the police officer his name and address or has given him a false name and address;
13. If he is required by a police officer of another police station who suspects that he has committed a cognizable offence;

How is Arrest made ?

Arrest is complete when there is submission to custody by word of action and in such a case touching or confining of the body of the person arrested is not necessary, but mere surrounding of a person by the police does not amount to arrest (Sec. 46).

What happens if you resist arrest?

If you forcibly resist arrest, the police officer can use all means necessary to effect the arrest (Sec. 46). He can even cause your death provided you are charged with an offence punishable with death or life imprisonment. However, he is not justified in using force more than necessary to obtain the arrest [Sec. 46). Therefore, unnecessary restraint or causing physical inconvenience; tying of hands and feet are not permissible if there is no necessity for doing so.

What are your rights when you are arrested?

If you are arrested :

1. You must be informed of the reasons for your arrest (Fundamental Rights : Article 22 and Sec. 50 Cr P.C.);
2. You have a right to see the warrant if you are arrested under warrant (See 75 Cr. P.C.);
3. You have a right to consult a lawyer of your choice. (Fundamental Rights : Article 22 of the Constitution);
4. You must be produced before the nearest Magistrate within 23 hours

(Fundamental Rights : Article 22 of the Constitution);

5. You must be told whether you are entitled to be released on bail, (Se. 50 Cr. P.C.).

Can you be handcuffed ?

According to the latest ruling of the Supreme Court, normally an arrested person should not be handcuffed unless he is violent or he is a desperate character or he is likely to attempt to escape or to commit suicide. Arrest is not a punishment. Hence unnecessary restraints are not permissible, if there is no necessity for doing so.

Search of a place entered by a person sought to be arrested

Sec. 47 of Cr. P.C. Compels all persons to afford to the police facilities for search in a place for a person sought to be arrested. Police officers have power to break open any door or window to carry out a search and to liberate himself or any person who is detained inside a premises.

Search of an arrested person

A police officer has the right to search a person only after he is arrested. After the search the police officer must keep in safe custody all the articles taken from the person and give him a receipt for the same.

A search of an arrested female should be done with strict regard to decency. A woman can be searched only by another woman. (Sec. 51).

Examination of arrested person by medical practioner

A police officer not below the rank of a Sub-Inspector may require an arrested person to be medically examined if he feels that this may provide evidence to prove the offence (Sec. 53).

* He may use reasonably necessary force to have the medical examination performed;
* The accused person can make a request to the Magistrate that he had not committed the offence (Sec. 54);
* A woman has a right to demand that she be examined by a woman doctor (Sec. 53 (2), 54);
* In cases of torture in police custody, this provision of law must be taken advantage of and the victim should demand in the Court that he be medically examined to prove torture by the police.

Detention of an arrested person

Article 22 (2) of the Constitution lays down that every person who is arrested and detained in custody should be produced before the nearest Magistrate within a period of 24 hours of such arrest exclusive of the time necessary for the journey from the place of arrest to the Magistrate's Court. However, Sec. 167 of the Cr. P.C. vests the power in the Magistrate to authorise the detention of the arrested person for more than 24 hours, if the investigation cannot be completed within that period. In no circumstances can the accused be detained in custody for a moment more than twenty four hours without a special order of a Magistrate who can order his detention for a term not exceeding 15 days on the whole. At the end of 15 days he must be produced before the Magistrate. If there are adequate grounds for further detention in judicial custody (jail) he can pass an order to that effect, for a period not exceeding 15 days. But the total period of detention cannot exceed 60 days, whether the investigation of offence against him has been completed or not. The order of a Magistrate sanctioning the detention for an indefinite period is illegal. If the accused is

not able to furnish bail during the stage of investigation he may be detained in judicial custody beyond 60 days. In case of a non-bailable offence the arrested person may be kept in jail until the trial is over.

Search Warrant

Search Warrant is issued by the Magistrate for the following purposes :

* For the recovery of a document or thing which may not be produced in the court otherwise;
* For search of a house suspected to contain stolen property, forged documents, etc;
* Seizing any publication banned by the government;
* For discovery of a person wrongfully confined.

A search warrant gives the power to the police officer to search the required place and to seize the objectionable article known as 'Mudammal'. Police may use force to effect a legal entry provided that they announce who they are, and why they have come, demand entry and are unreasonably refused.

* The Police officer executing the warrant may search any person in or about such place if that person is reasonably suspected of concealing on his person any article for which search is made. If the person to be searched is a female then the search shall be made by another woman with the strictest possible decency.

Procedure to be followed

The officer making a search shall :

* Call upon two or more respectable residents of the locality (called *'panches'*) to attend and witness the search. Failure to attend is an offence under Sec. 187 I.P.C.
* Make the search in their presence. So, the search would be illegal if the *'panches'* are kept outside while the search takes place inside the building;
* Make a list of all things seized and of all places in which they were found. (The list is called the 'panchnama';)
* Get the list signed by the witnesses— *'Panches';*
* Permit the occupant of the place to attend the search and give him a copy of the list of things signed at his request;
* 'Panches' are not required to attend the court as witnesses unless specially summoned by the Court.

Rights of the occupant of the premises searched

* The accused himself cannot be compelled to produced any document or property which is likely to involve him in any criminal charge. Hance police have to get a warrant issued by a Court of Law;
* The police have no general power to enter or search your premises without your consent;
* The court may specify in the warrant a particular place only to which the search will extend;
* It is important that the warrant is read and the directions are taken note of before the police are allowed to make inspection;
* If the police have no legal authority to enter your premises you can refuse the entry;

* If they have no legal authority to remain you have a right to insist on them leaving;

* If they refuse you have the legal right to use reosonable force to remove them (Sec. 97, of I.P.C.).

BAIL

Bail means releasing an arrested person from legal custody until his trial. Bail gives the freedom to seek advice from friends, consult a lawyer, to trace witnesses and to collect evidence for one's defence and to continue his job.

When bail is not granted, the arrested person will be on *remand* and will be kept in custody to facilitate the investigation and to obtain evidence.

Provisions regarding bail can be classified into 2 categories : i.e. (1) Bailable cases; and (2) Non-Bailable cases.

Bailable Cases

In the case of bailable offences, granting of bail is a matter of legal right. This means that bail cannot be refused and shall be granted by a police officer in charge of a police station having the accused in his custody. The release may be ordered on the accused executing a bond, even without sureties.

Non-Bailable Cases

In non-bailable cases, only the Court can order release of the accused person on bail. However, if the police officer or the Magistrate is of the opinion that there is no sufficient material against the accused and that the complaint needs further investigation he may also release the accused on bail (Sec. 437 (2) Cr. P.C.).

Normally bail is not granted when the accused person appears, on reasonable grounds, to be guilty of an offence punishable with death or imprisonment for life. But women, children under 16, and sick people can be released on bail by a Magistrate even if charged with offences punishable with death or life-imprisonment.

An accused person is entitled to be released on bail as soon as reasonable grounds for guilt cease to appear, between the close of the case and delivery of judgement. A person released on bail may be taken into custody by an order of the Court, if his conduct subsequent to release is found to be prejudical to a fair trial (Sec. 48 Cr. P.C.)or if he does not observe the conditions of the bail.

Power of the Court to grant bail

The discretionary power of the Court to grant bail is a judicial power and is given by established principles. Before granting bail the Court must consider the seriousness of the charge, the nature of the evidence, the severity of the punishment prescribed for the offences and in some cases the charactrer, means and the status of the accused.

If you are arrested, how to get released immediately from police custody ?

In warrant cases, find out the directions endorsed in the warrant and execute a bond with sureties (Sec. 71) :

* If the offence charged is bailable and the arrest is made without warrant, ask the police officer in charge of the police station to grant you bail after executing a bond;

* The police officer has the discretion to to release a person on his executing a bond without sureties (Sec. 436 of Cr. P·C.);

* If you are not granted bail immediately you have the right to telephone your

advocate, a friend or a relative. Give your advocate the names and addresses of the possible sureties. If you don't have an advocate inform your friend or relative;

* The name of the Magistrate Court where you will appear;
* The time the Court starts;
* To take to the Court anyone else who is prepared to stand surety;
* To contact an advocate if possible.

If you can deal with these matters before you go to the Court you may be saved an unnecessary remand in custody.

Granting of Bail by the Magistrate

If a person is arrested for a non-bailable offence, and there exists a reasonable ground to believe the guilt of the person, he may not be granted bail by the police officer. In such cases the accused person must give a written application to the court to grant bail. The court must grant bail unless he is charged with a crime punishable with death or life-imprisonment. In such cases only the sessions or the High Court can grant bail.

Common police objections to bail

* The accused will not appear at his trial;
* He will interfere with witnesses or material evidence;
* He will commit further offences while on bail;
* Police enquiries are not complete;
* Further charges might follow;
* Stolen properties have not been recovered;
* The co-accused are absconding;
* The weapon with which the crime was committed has not been recovered.

Normally the police makes an application for the remand of the accused. In such an application they give their reasons for further detention of the accused in custody. The reasons given by the police must be refuted to the extent possible.

Application for Bail

* If the accused can afford an advocate he can make an application and represent the accused before the judge;
* If the accused cannot afford an advocate he may make a written application to the judge. For this he must get an application form from the prison staff and complete it as fully as possible giving sufficient reasons to convince the judge of the need of granting bail.

The following special grounds for release must be mentioned in the application :

* Condition and state of accommodation; whether there is a possibility of eviction in case bail is not granted;
* Whether he is likely to loose his job;
* How refusal of bail would create hardship to the dependent members of the family;
* How keeping in custody would affect the poor state of health and treatment.

Refusal of Bail by the Magistrate

If bail is refused, the Magisfrate must record the reasons for the same. Such a record is necessary to make a proper appeal for bail in higher Courts.

Appeal

If application for bail is rejected by the Magistrate the accused person can appeal to a Sessions Court or High Court.

Disagreement with the objections raised by the police in granting bail or the fact of no objection raised in the Court must be incorporated in the application for bail. If one's application is rejected one may try again in one's next Court appearance.

Conditions for Bail

The Magistrate may grant a bail :

* Without any condition;
* Subject to special conditions;
* Subject to bond with or without sureties.

Special conditions usually state that the accused person must report to the police station at specified times or surrender his passport. One can challenge in a Court any unreasonable condition imposed by the Magistrate. If the Court refuses to change the conditions, the accused person can reject them. But in that case he will not be released until his appeal is heard and disposed of in his favour.

Bond and Sureties

* An accused person may be released on personal bond with or without sureties;
* Sureties are people who guarantee a sum of money for appearance of the accused in the Court on the appointed day and time.
* Those who stand as sureties must be present in the Court and if asked must guarantee the Court under oath that they are prepared to act and have sufficient funds;
* They can file affidavits before the Court stating the fact to show that they have sufficient funds to pay the surety and that they are even otherwise fit to be sureties;
* The Magistrate has the power to reject the surety without giving any reason. If the sureties are not in the Court, the arrested person will be kept in custody until the police have interviewed them and found them to be satisfactory;
* Sureties must be over 18, have a permanent address and have sufficient money to cover the amount of surety after payment of all their debts. The sureties may carry to the Court documents such as ration cards, rent receipts, provident fund slips, salary slips and income tax challans;
* The police and the Magistrate have no right to reject sureties on grounds of their personal character, political opinions, criminal records or sex, unless they are professional sureties.

Bail after Conviction

If an accused person is found guilty, the Magistrate will pass the sentence after considering his past record. If the convicted person wants to appeal against his sentence in a higher court, the Court which passed the sentence must release him on bail.

* When the sentence is for imprisonment for a term not exceeding 3 years, or;
* When the offence for which the person is convicted is a bailable one and the person is already on bail.

The release will be for a period that will enable the convict to present the appeal and get the orders of the appellate Court.

Once a person files an appeal against his conviction, the appellate Court may suspend the sentence and release him on bail or on personal bond.

Anticipatory Bail

When a person has reason to believe that he may be arrested for a non-bailable offence

he may apply to the High Court or to the Court of Session for a direction that in the event of such an arrest he may be released on bail.

If such a person is arrested without a warrant by a police officer and if he is prepared to give bail, he must be released on bail. In case a warrant is issued against the accused by a Magistrate, it must be a bailable warrant in conformity with the direction of the High Court or the Court of Session.

The purpose of the provision is to releive a person from disgrace by being detained in jail for some days before he can apply for bail when he is implicated in a false case by a rival.

Recent Observations and Recommendations of the Supreme Court on Bail

* The Bail system prevalent in our country is oppressive and discriminatory against the poor, since the poor would not be able to furnish bail on account of their poverty. The court, by ignoring the differential capacity of the rich and the poor to furnish bail and treating them equally, produces inequality between the rich and the poor.
* The bail system should be thoroughly reformed so that it should be possible for the poor to obtain pre-trial release as easily as the rich without jeopardising the interests of justice.
* The Court and the police must abandon the antiquated practice of release only against bond with sureties, and if the accused has ties in the community and there is no substantial risk of non-appearance, he may be released on his personal bond without monetary obligation, subject to penalty in case of breach.
* The amount of bond the Court fixes to release the accused on personal bond should not be based merely on the nature of the charge but on the financial capacity of the accused and the probability of his absconding.
* When the accused is released on personal bond, the Court or the police should not insist upon inquiring into his solvency as a condition of acceptance of his personal bond.

For further information in Legal matters contact :

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

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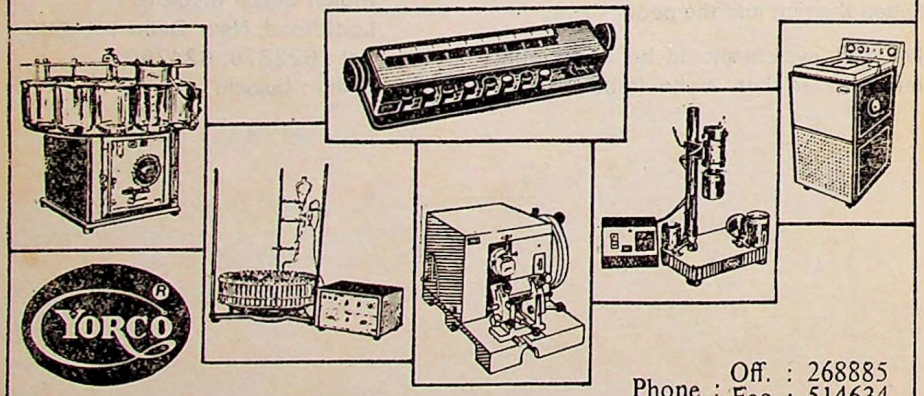

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