MEDICAL SERVICE

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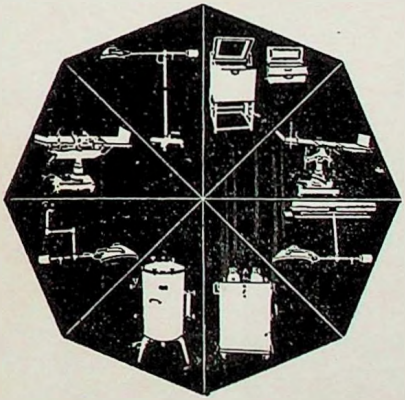

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contents

Guest EDITORIAL

A new philosophy, a new name

It is indeed gratifying that the recently held readership survey has helped to reveal the useful role that the journal plays, particularly for those directly or indirectly involved in the ministry of healing. To us, more than anything else, it serves the unique purpose of unification of goals, ideals and values among our institutions. This assumes greater significance in today's context as there is a marked shift in values seen all round us. There is an increasing tendency for commercialisation of the health institution and the health profession itself to a large extent.

In the context of changing concepts of health care and the norms pertaining to it, the relevance of a rethinking on the role of our existing institutions assumes special significance. The emphasis today is on 'health for all'. This should no more remain a sublime goal or a pious wish, but has to be translated into a reality as expeditiously as possible. The health profession and the agencies that are concerned with the welfare, dignity and development of man face no greater challenge than this, today. The net work of our institutions bound by traditions of yester-years are called upon to play a new role and act as agents of change realigning their own priorities. They should have a more meaningful role in the context of our pledge to make primary health care a reality, in an all our effort to see that the message of health reaches every home.

Our journal should subserve this interest and should serve as a powerful instrument to assist in this process of transformation. It is in this context that the suggestion made by some of our esteemed readers that the title of the journal require a change needs consideration. It is indeed heartening that a good majority of the alternatives in the title suggested goes in conformity with the emerging philosophy on health which have been referred to. To cite a few examples :

'Our Healing Ministry'

'Health Care'

'Help to Health'

'The Healing Touch'

'Health and Development'

While we fully appreciate their views and share their concern, we do feel that it is more important that the contents of the journal should be in tune with this new orientation, to justify and change in name. We have to guard against serving old wine in a new bottle.

Earnest attempts are being made to bring about qualitative changes in the contents befitting our overall goals. Although rarely resorted to, change of title certainly is permissible within journalistic traditions. It either ushers in a policy change or portends one. We would certainly give due weightage to the candid suggestions made by our learned readers when the question of a change of title of the journal is taken up.

Letter from a patient

Dated today

To

Doctor/Nurse
Your hospital
Your town

Dear Doctor/Nurse,

This is the most critical stage of my life, and I am at your mercy. My whole body is paining. I need care. I need affection. I need personal attention. Will you deprive me of these and consider me a specimen for your practice ?

My family is starving at home. My purse is empty. I am embarrassed and frightented to step in to your nursing home and subject myself for tests by your imported equipments. Also I am afraid how far I can afford the medicines you prescribe. Last time I was told by you to take nutritious food. I listened to you carefully and I decided to follow your instructions strictly. Would you pardon me ?; I could not take any of them at least once.

Dear doctor/nurse, how can I find solution to the illness I have been suffering from all through the years ?

I remain, disturbed and totally confused,

Sincerely,
Your Patient

Role of the Ministry of Healing—A Perspective

—Dr. George Joseph

During the past few decades, nations of the world particularly those that have won political freedom and are free to guide the destinies of their people are engaged in an all out effort to improve the quality of life of people by pursuing strategies of development akin to their ideologies. The socio-political upheavel, meant to liberate man from all that 'cabins, cribes and confines him' has led to increase his longing and aspiration for a better life. Technological break-throughs and speedy advances in the Communication media have had their inevitable contribution to make.

In India, during the post-independence era major efforts were made to provide basic health care to its people particularly those spread over the 6,00,000 villages. The entire rural India was divided into Community Development Blocks accommodating, approximately, 100 villages per Block for integrated development and a primary health centre allocated to each of them for providing integrated health services. We have today over 5,400 PHCs engaged in this effort. In spite of the substantial investments made, the health status of our people today is far from satisfactory. No doubt, we have made impressive achievements in many crucial areas particularly in the areas of control of communicable and pestilential diseases and Family Welfare Planning. The sheer magnitude of the task that still remain is so great that one almost despairs of meeting our health needs or realising our aspirations on the basis of the broad models of health care, we seemed to have accepted. *An alternate strategy of development of health care services was therefore evolved which marked a major departure, based on the following principles.

— A universal and egalitarian programme of efficient and effective health services cannot be developed against the background of a socio-economic structure in which largest masses of people still live below the poverty line. Therefore there should be sustained and vigorous attack on the problem of mass poverty and for creation of a more egalitarian society.

— Development essentially means the development of man and not of things: Emphasis should be on the development of human rather than the material resources. The most significant tools for the purpose are education and health. Taken together they form the most powerful instruments for the development of man and human resources.

— Adoption of the model of health services from the industrially advanced and consumption oriented societies of the west has inherent fallacies. Health gets wrongly defined in terms of consumption of specific goods and services, basic values in life which essentially determine its quality gets distorted; over-professionalisation increases costs and ultimately has an adverse effect even on the health and happiness of people. We have to take a conscious and deliberate decision to abandon this model and strive to

* Report of the Group on Medical education and support man power—Government of India, April 1975.

create instead, a viable and economic alternative suited to our conditions—the new model will have to place greater emphasis on human effort rather than on monetary inputs.

— Health is essentially an individual responsibility in the sense that, if the individual cannot be trained to take proper care of his health, no Community or State programme of health services can keep him healthy. The issue is basically one of education.

— The community has the great responsibility in the sense that, if the individual cannot be trained to take proper care of his health, no Community or State programme of health services can keep him healthy. The issue is basically one of education.

— The community has the great responsibility to provide a proper environment for helping each individual to be health—supply of safe water—adequate measures for disposal of human excreta and the like. These social aspects of health need strengthening and the highest emphasis.

— The over emphasis on the provision of health services through professional staff under state control has been counter productive. It devalues and destroys the old tradition of part-time semi-professional workers which the community used to train and throw up and which with certain modification will have to continue to provide the foundation for the development of a national programme of development in our country. We have to have large bands of semi-professional workers from among the community who would be close to the people live with them and provide medical services.

This bold Indian experiment roused the attention of planners and administrators all over the world. In fact, there was great concern expressed by the International Community of experts who came forward to assist the third world countries in evolving a health care strategy to match the health needs of communities particularly, those who have long been denied the benefits of even elementary health care. The Alma-ata declaration (1978) by the WHO has emerged out of this concern. The concept of Primary Health Care* gives a positive direction to planners and administrators in this regard and even provides operational guidelines.

Government of India came out with the National Health Policy in 1982, which by and large is dictated by the emerging world opinion about the need to evolve a health care strategy to match the needs. The task that we are addressing ourselves today is the building up of a multi-tier health establishment that has its very roots in the rural homes. Administratively, the peripheral most unit is the village level family health and welfare centre and whence the services trickle down further through the agency of the village volunteers who help carry the message of health to the rural homes. The peripheral units are backed by a referral system that provides for the upward and

* Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them and at a cost that the community and country, can afford. World Health Organisation, Primary Health Care, WHO, Geneva, 1978.

downward flow of services. The PHC's the Taluk and District hospitals and the institutions that make provision for specially and super speciality services at the apex, are all linked together in a bid to provide regionalised health care services, each link in the chain, meant to provide clinical care at a given level of expertise.

Admittedly, the building up of a health care hierarchy of such magnitude need stupendous efforts and resources. The growing importance of the voluntary sector in supplementing the national efforts is at once obvious. It is against this background that one has to look at the present day activities of our institutions under the Ministry of Healing How do they conform to the goals as laid down by the national health policy ? The foremost task ahead of the Ministry today is to assist in this effort to bring primary health care within the effective reach of people. The present day health care institutions under the church namely our hospitals—are required to provide the leadership in operationalising the programme of extending primary health care to communities. With the courage of conviction, let me state that the church and its Healing Ministry has hitherto faced no greater challenge at any time.

It may be recalled that our hospitals, represent pioneering efforts on the part of dedicated medical missionaries mostly from abroad to provide the much needed medical relief and succour to large segments of humanity at a time when health efforts by governmental agencies in the various states were barely rudimentary. Suffice to say that our institutions had a decisive and historic role to play as forerunners of the present day health establishments in the different states, particularly in terms of quality, content and coverage of health care.

We have today as per information available from the Synod Secretarial, 69 hospitals and 111 out-reach clinics in the 4 regions of the Synod. Now let us come to the crucial question about the role of our institutions under the Healing Ministry as an extended activity of the church. Time has come when one has to critically look at their present day activities and style of functioning and their relevance in today's national context—more than that, their role as an extended activity of the church. Do we need to sustain and perpetuate them purely for historical reasons or do we envisage a new role for them as powerful 'agents of change' in the context of development?

I have attempted in the presentation so far to highlight the scope and relevance of not only continuing the activities of our hospitals but also the great role they are expect ed to play in the context of the present-day national efforts to implement primary health care. What is needed today is to bring about a different orientation in our thinking to enable us in our future planning. Can we not offer leadership at this crucial phase? This calls for, among other things, a realignment of our priorities.

Representatives of 21 dioceses have met and discussed the futuristic role of the existing institutions and have reached a consensus that the greatest challenge that faces us today is to assist in the national endeavour of extending primary health care to the rural population. Plans have been drawn to develop models of health delivery systems suitable in the various social and cultural contexts. The general pattern that has emerged is to bring under the purview of the existing rural hospitals the responsibilities of extending basic health services to communities in their catchment areas. The operational mechanism suggested is the development of satellite centres manned by basic health

workers. The activities of the satellite centres will be supplemented by the activities of the village level workers selected and trained by the local health team. With this the role and style ot functioning of the hospitals will be greatly altered. They will no longer wait for patients to come to them but reach out to the periphery, identify the needs and assume responsibility of supervising the health of people in the rural homes.

Adoption of this new role to foster the development of health of communities marks a major departure from the traditional one. The success of such an attempt will depend on the dedicated endeavour of the health team. Development of health man power, therefore, is almost a pre-requisite to the success of such programmes. Our dioceses are concerned about this need for developing appropriate health man power. The existing training institutions which hitherto were responsible for turning out personnel for institutionalised services have now to employ their training resources for preparing the required man power representing competence at different levels. Dioceses where such facilities do not exist will have to develop training capabilities or utilise available facilities of sister dioceses preferably of the same socio-cultural background. This pooling and sharing of resources should become an accepted norm between institutions within the dioceses or between dioceses not only confined to this area of training but even to the service programmes.

Responsibility of evolving/developing 'models'

I for one, an convinced and I am sure there are many here who share the same conviction that the task ahead of us today is to evolve and develop 'models' be it in relation to health, education or development. Can we help evolve models of health care suitable to the needs of people, relevant and feasible in the social context, under the aegis of the existing institutions namely, the rural hospital. In the 21 dioceses the needs vary vastly. There are dioceses where even sembolance of a health system does not exist. We are called upon to extend care to those who are denied these all their lives, imbued with a spirit of dedication and upholding Christian ideals.

The concept of primary health care, is in essence inspired by the loftiest Christian ideals which our Lord Himself demonstrated during his earthly life and mission, namely 'reaching out' for the lowliest and lost. Let me refer to one such instance, the healing of the impotent man at the pool of Bethesda who bore his infirmity for 38 years, most of which probably he spent at the pool of Bethesda next to the sheep gate. He passes before us nameless and seen as one among the crowd, John's description of that crowd is graphic. He says that in the porches lay a multitude of sick, blind, halt, withered. Here, we see a company of the unfit, the derelict, the outcaste, all probably waiting, desiring a cure. Christ that day chose to go that way to meet the impotent man. It is said, that it is not his usual way to go to Jerusalem. Going out to meet the people in need is therefore our Christian goal, carrying the message of love and hope. Our job then is to develop a model of health care in a given context so that others can emulate that example. It is the job of lighting a lamp and keeping it on a pedestal.

Apart from the prime task of assisting in the process of extending primary health care especially among the socio-economically disadvantaged groups, there are some other vital issues that deserve consideration of the Healing Ministry as a matter of policy.

— identification of newly emerging community health problems brought about

by rapid changes that are occuring both in the demographic and socio economic seenes and evolving models of care feasible within the frame of reference of the church and the healing ministry.

For example the care of the aging and the aged. The problem is vast and complex with serious social implications. However the gravity of the problem has not been appreciated even today. It is timely and opportune for the ministry of healing to evolve feasible models of care relevant in the given social context.

— evolving patterns of care for vulnerable groups in our society as part of health related social welfare programmes.

For example day care centres creches, nurseries for children of working women. This is visualised as part of comprehensive family welfare scheme especially among labour populations such as plantation workers, fishermen in the coastal areas, agricultural labourers, tribal population etc., where women go for work ordinarily or can seek gainful employment at least during seasons.

— Health and welfare programme for the disabled.

This should be viewed as a very challenging task ahead of the church and the ministry of healing. A comprehensive programme should include not only assessment of the nature and the extent of the problem in a given area. Say, under the jurisdiction of the local churches and the comunities directly under its influence, put also the identification of local 'resources. training of local leadership as well as local volunteers who could help in a comprehensive rehabilitation programme. The ministry should visualise service for the disabled including their rehabilitation as part of the total health responsibility to the community. Planning of such a programme would, inter alia, include the training of the required personnel for undertaking comprehensive rehabilitation programme at the regional centres.

— Comprehensive health programmes for the control of diseases like leprosy, tuberculosis.

Activities of the ministry of healing should lay continued emphasis on programmes for the control of diseases like, leprosy, tuberculosis especially those which have a social dimension. However, one has to strike a note of caution in that such efforts should fit into the national strategies for the control or eradication of such diseases. Any such programme should make adequate provision for the rehabilitation of the individual as well as the family.

Quality of care-challenge before the church

I shall confine myself to two aspects of this question which are of immediate relevance to our ministry.

Here, quality, refers to 'acceptable' standards of care—and even so, is very difficult to define, as it is highly variable according to the context in which it is used. There is a growing tendency among the lay public as well as the profession to always equate equa lity with enhanced cost of services. Services given at a low cost are branded as 'second quality' and substandard. This has serious implications in the field of health services. It even helps to demoralise the personnel who provides such services. Let us accept that 'quality of care' refers to what is best for the person, and is feasible to be administered in a given context and which is scientifically sound. A family health worker who advises a village mother, to compound a home

remedy to rehydrate her child ailing from vomiting and diarrhoea, from the commonest of household provisions readily available to her (salt and sugar) is practising high quality scientific medicine. In fact she is practising better scientific medicine than the private practitioner who prescribes a combination of antibiotics and other drugs with brand names, —the bane of over-professionalisation and high technology.

The second aspect is of equal if not greater relevance to our ministry.

It is a common experience that in our quest to provide quality of care of our patients, to make our institutional services acceptable to public at large, we often tend to lose sight of our Christian calling and ideals. Let me illustrate : for e.g.—the service we extend to our patients in the general ward and the non-paying ones—the apparent discrimination shown in the quality of care. Often resource contraints are blamed. It is a common experience that we deny even basic amenities to these persons. We try to save on ceiling fans and even mattresses and pillows on the plea that these are luxuries to which these people are not accustomed to. In such matters there can be only one standard to be set as a guide before us—namely, what would Christ want us to do? Thus as a matter of very great concern. I often feel that if Jesus Christ were to seek admission in one of our hospitals, of necessity, will have to be a general ward patient and that too, a non-paying one. If he happens to walk in alone into a casualty department, exhausted after a long day's toil, with bruises on his feet due to the long walk through the rugged country side, what would be the type of welcome we extend to him? Of course, he wouldn't have enough to pay the caution deposit or even to buy the O.P. card. We know the instance when he didn't have enough to pay the temple tax. I am afraid, as per rules of the establishment he will be sent to a dingy ward.

Now, let us look at the resource—implications. If we consider the general ward patients especially the non-paying ones as our guests of honour, guests of the church and of the diocese, these problems can easily be resolved. Then it becomes incumbent on the church and the parishioners to welcome them, to treat them, to feed them and take care of them demonstrating the tender loving care of Christ and meet the cost thereof.

Mother Teresa has said that she tries to see the face of infant Jesus in every child picked from the street, from under the garbage or from the gutters. We in the ministry have to be guided by nothing less than this standard of Christian service. The responsibility should be basically that of the whole church as it should serve as a living example to demonstrate Christian love in action. This, then is the present day challenge before our institutional ministry and let us look forward to an era of dedicated endeavour on the part of our institutions to reach out to even the remotest needy villages in our dioceses with the message of 'health' inspired by the Love of Christ and to be qualified to receive his commendation on the final day of judgement 'Come and posses the kingdom which has been prepared for you ever since the creation of the world. I was hungry and you fed me, thirsty and you gave me a drink, I was a stranger and you received me in your homes, naked and you clothed me; I was sick and you took care of me, in prison and you visited me. Whenever you did this for one of the least important of these brothers of mine, you did it for me.'

Respiratory Tract Infection in Children

—K.N. Shah

General Considerations

Respiratory tract infections are extremely common in paediatric practice. They may occur at any age but are more common in infacy carrying high mortality and morbidity. This is because of poor resistance in younger age group and anatomical and physiological variations of infancy. It can involve any part of the respiratory tract but upper respiratory infections are more common than lower respiratory tract. Many different organisms can infect respiratory tract but viruses are the commonest invaders. They may be acute or chronic. Chronic infections are commonly due to resistant bacteria, fungus, parasites etc. They are more common in lower socio-economic group carrying high mortality and morbidity because of poor nutrition, poor hygiene, over-crowding, lack of medical facilities etc. In this article, only non-tuberculous infections will be considered.

Classifications

Two classifications are in common use :

Anatomical

Respiratory tract is divided into upper and lower respiratory tract. Upper respiratory tract includes nose (rhinitis), ears (otitis), sinuses (sinusitis) and pharynx (pharyngitis). Lower respiratory tract includes epiglottis (epiglottits), larynx (laryngitis), trachea (tracheitis), bronchi (bronchitis), alveoli (alveolitis) and pleura (empyema). This classification is not ideal because it is common for any organism to involve more than one anatomical part or even the whole respiratory tract and the diagnosis is made from the part that is macimally involved e.g. pneumonia although there is associated pharyngitis, rhinitis etc.

Aetiological

Many agents e.g. bacterial, viral, fungal, spirochetal, mycoplasma, parasitic etc. can affect the respiratory tract in the same way. Since it is difficult to identify the exact pathogen in majority of cases because of poor laboratory facilities and inaccessibility of the anatomical part involved, this classification is obviously not ideal.

Although none of the classifications is satisfactory but because of lack of better one, combination of both is commonly used e.g. acute viral bronchiolitis, chronic staphylococcal pneumonia etc.

Aetiological Classification

Most acute respiratory tract infections are caused by viruses and mycoplasma. Influenza type A and B cause upper rather than lower respiratory tract infections. Adenoviruses type 1, 2, 3, 5, and 7 account for 10% of respiratory tract infections. Rhinoviruses and coronarviruses mainly involve the nose causing "common cold" syndromes. Coxsackie A and B commonly cause nasopharyngeal infections. Parafluenza viruses types 1, 2, 3 and 4 account for the majority of cases of the croup syndrome but may also produce bronchitis, bronchiolitis and upper respiratory tract infections. Respiratory syncytial virus is the principal cause of bronchiolitis and may also be a cause of pneumonia, croup and bronchitis. Other viruses e.g. measles, german measles, chicken pox etc. may be associated with varying amounts

of upper and lower respiratory tract infections as part of a general clinical picture invilving other organ systems.

Bacterial infections primarily involving respiratory tract are not as common as viral infection. Acute epiglottitis is commonly due to H. influenzas. Pneumonias are commonly due to gram positive and gram negative organisms. Pharyngitis and tonsillitis may be caused by streptococci or diphtheria organisms. Whooping cough bacilli involve upper as well as lower respiratory tract.

Upper Respiratory Tract Infections

Rhinitis

Acute rhinitis is always viral in aetiology. It is characterized by fever, sneezing, running of nose etc. and may involve other parts of respiratory tract. After couple of days, secondary bacterial infections may occur giving rise to thick purulent discharge. Allergic rhinitis also presents with sneezing, running of nose, courgh etc. and is difficult to differentiate from viral rhinitis on clinical examinations. Since acute rhinitis is of viral origin and a self limiting condition, only symptomatic treatment with antipyretics is necessary. Antibiotics are indicated when there is secondary bacterial infection.

Pharyngotonsillitis

Acute pharyngotonsillitis is one of the most common illnesses of childhood. Because of infections of mass of lymphoid tissue encircling the nasal and oral pharynx known as Waldeyer's ring, 80% of infections are viral e g. coxsackie, influenza, parainfluenza and respiratory syncytial adenoviruses and Epstein-Barr virus of infectious mononucleosis. The commonest bacterial infection is due to group A beta haemolytic streptococci while H. Influenza, pneumococci and staphylococci are secondary invaders. Diphtheria organisms are also primary invaders but less common because of immunization.

Clinically actue pharyngotonsillitis is characterized by fever, malaise, headache, loss of appetite, sore throat, mild to severe redness and exudation, nodular or ulcerative lesions of the soft palate, tonsils and pharyngeal wall. Cervical lymphadenopathy may be present. Illness last from one to seven days. Differentiation between viral and bacterial pharyngitis is extremely difficult on clinical grounds.

W.B.C. count, throat swabs for microscopy and culture for diphtheria and streptococcal organisms and blood for rising antibody titre for various viruses, are some of the useful investigations. Other conditions e.g. infectious mononucleosis, herpangina, leukaemia, agranulocytosis may give similar clinical picture.

Complications due to viral pharygitis are rare. In case of streptococcal pharyngitis, local abscess or spread to retropharyngeal space, sinuses, middle ear, mastoid, meninges and mesentric glands can occur. Rhenumatic fever and acute glomerulonephritis are late complications.

Treatment is symptomatic for viral pharyngitis e.g. bed rest, extra fludis, antipyretics and analgesics, warm saline gargles, etc. For streptococcal infections, penicillin either oral or parenteral, or erythromycim, if penicillin is contraindicated, for 10 days is adequate and will prevent rheumatic fever and acute glomerulonephritis.

Chronic Pharyngitis and Tonsillitis

These are characterized by recurrent cough, sore throat, fever, cervical adenitis, middle ear infections, mouth breathing and adenoid facies as a result of adnoid enlarge-

ment and foul breath may be present. Retropharyngeal and peritonsillar abscess may develop. Fatigue, loss of appetite, less of weight, arthralgia, postnasal drip etc. are other symptoms. Allergic pharyngitis is difficult to differentiate from infective pharyngitis. A careful history and follow up of the cases are useful in such cases.

Treatment is adenotonsillectomy after considering carefully its indications and contra-indications.

Retropharyngeal Abscess

Potential space between the posterior pharyngeal wall and prevertebral fascia contains several small lymph glands which may be infected secondarily to upper respiratory tract infection and suppurate. It may occur from vetebral osteomyelitis. Staphylococcus aureus and group A haemolytic streptococci are common pathogens.

Clinically acute nasopharyngitis is followed by high fever, difficulty in swallowing, refusal to feed, severed distress with throat pain, hyper extension of head, torticollis, laboured respiration and accumulation of secretions in the mouth. A bulge in the pharyngeal wall is usually seen. A digital examination may reveal fluctuation. Lateral view of nasopharynx will reveal retropharyngeal mass on X-ray. In differential diagnosis meningitis because of neck retraction, various causes of torticollis, T.B. spine etc. should be considered.

Treatment

Treatment is surgical with extensive course of proper antibiotics against staph, aureus or streptococci e.g. injection penicillin in doses of 1,00,000 units/kg./day in 3-4 doses or erythromycin 50 mg./kg./day in 3-4 divided doses for 7-10 days. infections, of sinuses and ears are beyond the scope of this article.

Lower Respiratory Tract Infections

Group (Epiglottitis, Laryngitis; Laryngotracheitis, Laryngotracheobronchitis)

Croup is a syndrome characterized by inspiratory stridor, peculiar brassy cough, hoarseness and respiratory distress due to varying degree of laryngeal obstruction. The obstruction in infectious croup is due to inflammatory oedema and spasm. It includes acute epiglottitis, acute laryngitis, acute laryngotracheitis, and acute laryngotracheobronchitis and spasmodic laryngitis.

Acute Epiglottitis

It is a severe life threatening, rapidly progressive infection of the epiglottitis and surrounding areas. Commonest aetiological organism is type B, H. influenza. Onset is abrupt, preceded by upper respiratory tract infection in some cases. Child is usually between 2 and 12 years of age. Child is normal when he goes to bed but awakens in the middle of the night with high fever, hoarseness, cough, stridor and respiratory distress. Course is very rapid leading to shock-like state characterized by pallor, cyanosis and impaired consciousness, coma and death. On examination there is marked respiratory distress with inspiratory stridor' flaring of alae nasi, and retraction of suprasternal notch, supraclavicular and intercostal spaces. The pharynx is inflamed. Cherry red, swollen epiglottis can be seen when the tongue is depressed. Swollen epiglottis can also be seen on lateral X-ray of upper airway. Acute epiglottitis is a real paediatric emergency and death can occur within few hours on onset. There is striking polymorphonuclear leucocytosis and throat and blood cultures are positive for H. influenza type B.

Acute Laryngitis, Acute Laryngotracheitis and Acute Laryngotracheobronchitis

They will be discussed together as they have common viral aetiology e.g. parainfluenza viruses, adenoviruses, influenza viruses, enteroviruses, respiratory syncytial viruses and measle viruses.

Viral croup usually occurs between 6 months and 3 years. There is preceding upper respiratory infection, consisting of rhinorrhoea, coryza, fever etc. After few hours to 3 days child develops typical croup syndrome. Children are anxious and restless but never so toxic as in acute epiglottitis. Signs of bronchitis and bronchiolitis like rales and rhonchi with marked respiratory distress and expiratory stridor and diminished breath sounds are common in acute laryngotracheobronchitis. Temperature may be normal or very high, chest X-ray may be normal or emphysematous. Illness may last for few days.

Spasmodic Croup

Children between one and three years are often affected. Clinically it resembles acute laryngotracheobronchitis but there is no evidence of viral infection in family members. It occurs commonly in anxious and excitable children and hence allergic and psychologic factors should also be considered. Onset is sudden at night with brassy cough and respiratory distress with minimal coryza on the previous day. There is usually no fever. Illness lasts for few hours and the child is normal the next day. Similar attacks are repeated with less severity for another night or two with eventual complete recovery.

Differential Diagnosis of Croup Syndrome

Diphtheritic laryngitis should be ruled out by smear and culture of the throat and laryngeal swab. Croup of measles is ruled out by other signs and symptoms of measles. Foreign body, retropharyngeal abscess, extrinsic compression by masses angioneurotic oedema, endotracheal intubation, tetany, trauma to the lower respiratory tract etc. can give rise to croup and should be kept in mind while analysing a case of croup syndrome.

Prognosis

It depends upon the type, severity of croup, age of the child, duration of illness and extent of respiratory tract involvement. Mortality of epiglottitis is 10 to 15% while prognosis is excellent in other types of croup.

Treatment

Mild cases of croup may not need admission but those in respiratory distress should be admitted. As children are anxious and restless, minimum handling should be done. High humidity and O_2 are most important. Humidity is maintained by giving steam inhalation and moist O_2 should be administered in high concentration preferably in a tent. Mild sedative if carefully given helps the anxious children. I.V. fluids are very useful because it prevents dehydration and liquefies the respiratory secretions. Syrup ipecacuanha has been recommended by some authorities to treat the laryngeal spasms. Corticosterioids reduce the inflammation and improve airway obstruction but has no effect on the duration of illness.

In acute epiglottitis due to H. influenza, amplicillin in doses of 200 mg./kg./day i.v. in 4 divided doses with chloramphenicol in doses of 50 to 100 mg./kg./day i.v. in divided doses are very useful. In proved or suspected cases of diphtheria ADS plus erythromycin should be administered.

If there is no improvement, then intubation and tracheostomy may be necessary.

Acute Bronchitis

Acute bronchitis may not exist as a separate entity in children. It is usually

associated with tracheitis and infection of other parts of respiratory tract. Aetiological agents are mainly viral as mentioned previously with other conditions but tracheitis may be commonly seen with such specific infections like influenza, whooping cough, salmonella, diphtheria, scarlet fever, measles etc. Allergy, poor health, climate, air pollution and chronic infection of upper respiratory tract may be predisposing factors for repeated attacks of bronchitis.

Clinically acute bronchitis follows upper respiratory tract infection. It starts with hacking dry cough after 3-4 days of acute nasopharyngitis. Anterior chest pain is frequently present and may be aggravated by coughing. Within several days the cough becomes productive and sputum becomes purulent. After a week or two, sputum becomes thin and child is alright. On clinical examination throat is congested and there are rales and rhonchi with mild respiratory distress. In healthy children no complications occur but in malnourished children, child may get otitis, pneumonitis etc.

Differential Diagnosis

Acute bronchitis should be differentiated from asthmatic bronchitis which is a form of asthma. Such children show exaggerated response of bronchi to various respiratory tract infections, with exudates and spasms, as in bronchial asthma.

Treatment

There is no specific treatment for bronchitis as it is of viral aetiology. Symptomatic line of treatment for cough e.g. atmosphere with high humidity may help, antihistaminies, expectorants and antibiotics are not useful, unless secondary bacterial infection is present.

Chronic Bronchitis

Chronic bronchitis as an isolated entity is doubtfull. With repeated attacks of acute bronchitis, anomalies of respiratory tract, foreign body, bronchiectasis; immune deficiency, T.B., allergy, sinusitis, tonsillitis and cysticfibrosis should be ruled out.

Acute Bronchiolitis

It is a common disease of lower respiratory tract in infacy. It occurs during the first two years of life with a peak incidence at 6 months of age. The incidence is highest during the monsoon and may occur sporadically or in epidemics. Aetiologic agents are always virus and in majority of cases, respiratory syncytial virus is the cause. Parainfluenza type 3 virus, mycoplasma and adenoviruses are other causative agents. Usually minor respiratory tract infection is present in other family members.

Clinically, it starts with mild upper respiratory tract infection followed within few days by respiratory distress, paroxysmal wheezy cough, irritability, continuous crying, extension of neck and difficulty in taking feeds. Usually fever is mild or absent. Infant is very apprehensive and restless. On examination, there are rales, rhonchi, diminished air entry, expiratory wheeze, marked tachypnoea, other signs of respiratory distress and severe air hunger. Liver and spleen are pushed down due to severe emphysema.

Chest X-ray shows emphysema with scattered small patches due to small atelectasis secondary to obstruction of bronchioles. W.B.C. count is within normal limits. Nasopharyngeal culture will grow the causative virus. Frequent serum levels of rising antibody titres are also useful.

Differential Diagnosis

Bronchial asthma is usually considered but it is uncommon below the age of one

year. Family history of asthma, repeated attacks in the same patient, eosinophilia and dramatic response to bronchodilators may suggest asthma. Excessive crying and extension of neck may mimick meningitis.

Course and Prognosis

Infant is very ill for 3-4 days and then slowly improves over a period of few days. Mortality is less than one per cent and occurs due to respiratory failure, associated congenital heart disease, respiratory acidosis, profound dehydration due to tachypnoea etc.

Treatment

All cases of acute bronchiolitis with respiratory distress should be hospitalized. As it is of viral aetiology, treatment is symptomatic. Humid atmosphere and moist O_2 are very useful to relieve hypoxaemia, allay anxiety, restlessness and relieves dyspnoea and cyanosis. Sedatives should be avoided. I.V. fluids are useful in preventing dehydration due to tachypnoea and liquefy the secretions in respiratory tract. Soda-bi-carb is useful in respiratory acidosis. Antibiotics are not useful because of viral aetiology of the disease. Corticosteroids have also not been found to be useful. Bronchodilators are, in fact, contra-indicated since they increase restlessness, O_2 requirement and cardia output. Tracheostomy is also of doubtful value since obstruction is at the level of bronchioles.

Pneumonia

Pneumonias are classified into two types:

Anatomical

a. Lobar pneumonia

b. Lobulan pneumonia

c. Bronchopneumonia

d. Interstitial pneumonia

Aetiological

a. Bacterial—gram positive and gram negative such as pneumococcal, streptococcal, Staphylococcal, H. influenza, klebsiella, pseudomonas.

b. Viral or probable viral infections, e.g. respiratory syncytial virus, parainfluenza, ademo, entero, rhino influenza, herpes simplex.

c. Other infections—e.g. pneumocystis carinii, Q fever, mycoplasma pneumoniae, actinomycosis.

d. Mycotic infections—e.g. candidiasis, cryptococcosis.

Clinical Signs and Symptoms

Clinical pattern varies in infants and older children. In infants after an initial period mild upper respiratory infection, there is abrupt onset of high fever, restlessness and respiratory distress. Patient appears ill with air hunger, cyanosis, grunting, signs of respiratory distress; cough may be mild. Clinically there may not be any sings of pneumonia but for few rales. Gastric distension is common and may develop into paralytic ileus. Meningism may be present. Apnoic spells are common in young infants.

In older children, signs and symptoms are those found in adults. After a brief mild upper respiratory infection there is high fever with rigors, respiratory distress, restlessness, a dry hacking cough and sometimes delirium. Pain in chest may be severe. Initially there is dullness with diminished air entry followed by bronchial breathing and increased vocal fremitus. As resolution occurs, moist rales appear with the disappearance of signs of consolidation.

In bronchopneumonia, apart from scattered rales all over, no other findings are present on auscultation.

It is very difficult to diagnose the aetiology of pneumonia from clinical examination. Polymorphonuclear leucocytosis may suggest bacterial aetiology. Leucopenia may suggest viral aetiology or fulminating bacterial pneumonia. Blood cultures are sometimes positive in bacterial pneumonias. Positive throat cultures cannot be considered a proof of bacterial pneumonia.

Chest X-ray only helps in anatomical classification of pneumonias. Pleural fluid smear and culture or lung aspiration through needle may help in finding the aetiological diagnosis.

Some Important Differentiating Points

1. Pneumococcal and streptococcal pneumonias occur in older as group.

2. Staphylococcal pneumonia occurs commonly below one year of age, is rapidly progressive and carries high mortality and morbidity. It has a tendency to progress to empyema, multiple cysts, lung abscess, pneumothorax etc.

3. Pneumonia due to gram negative bacteria are common in immunodeficiency syndrome or in those who receive antibiotics, prednisolone etc. for a long time.

4. Bronchopneumonia is common in infant while lobar pneumonia is common in older age group.

5. Viral pneumonias on chest X-ray show diffuse infiltration especially in perihilar regions. Effusion is rare.

6. Tuberculous pneumonias have insidious onset. Other evidence of Koch's e.g. positive mantoux test and gastric lavage may be there.

Prognosis

It depends on the age, nutrition of the child, type of pneumonia and the aetiological organism. It is poor in infancy, in malnourished children, in bronchopneumonia and in staphylococcal and gram negative bacterial pneumonias.

Treatment

General line of treatment includes good nursing care, i.v. fluids, O_2, antipyretics and sedatives.

Special treatment depends on the aetiological organism. There are no specific drugs for viral infection. For pneumococcal pneumonias penicillin in doses of 50,000 units/kg./24 hrs. either orally or i.v. or cephalosporin in cases allergic to penicillin in doses of 50 mg./kg./24 hours, either i.v. or orally for 7 to 10 days. In mild cases oral and in severe cases parenteral administration is preferred. For streptococcal pneumonia penicillin in the drug of choice. For staphylococcal pneumonia penicillin G in doses of 100,000 units/kg./24 hours is used if organisms are not resistant. Otherwise, semisynthetic penicillinase resistant penicillin like methicillin in doses of 200 mg./kg./24 hours or cloxacillin doses of 150 mg./kg./24 hours or cephalosporin in doses of 50 mg./kg./24 hours parenterally is very useful. Sometimes trimethoprim sulpha in doses of 6-10 mg./kg./day in two doses and erythromycin 50 mg./kg./day in three to four doses have been found to be useful. For empyema and pneumothorax, drainage with a thick tube is very useful. For H. influenza, chloramphenicol in doses of 100 mg./kg./24 hours or ampicillin doses of 200 mg./kg./day i.v. should be tried. For klebsiela, kanamycim in doses of 15 to 20 mg./kg./day i.m. or gentamicin in doses of 6 to 8 mg./kg./day i.m. should be administered. For pseudomonas carbenicillin in doses of

400 mg./kg./day or gentamicin or amikacin should be tried.

Suppurative Diseases of Lung

Empyema

Empyema means collection of pus in pleural cavity. Infection of pleura occurs from adjacent pulmonary and subdiaphragmatic foci by contagious spread or via bronchopleural fistula or from a distant focus by haematogenous spread. Common organisms are staph, aureus, H. influenza, streptococci, pneumococci while E. coli, klebsiella and pseudomonas are rare organisms.

Clinically patient is very toxic with high swinging fever with rigors and on examination there is stony dullness, diminished air entry and mediastinal shift on the opposite side. There is marked polymorphonuclear leucocytosis. Chest X-ray shows effusion on the effected side. T.B. pleural effusion is difficult to differentiate clinically in empyema and diagnostic tapping should be done which shows plenty of polymorphs, and culture shows the causative organism unless the antibiotics are administered previously.

Specific treatment depends on the aetiological agent and should be continued for 4 to 6 weeks. Intercostal tube drainage is a must.

Bronchiectasis

Bronchiectasis refers to dilatation of bronchi due to inflmmatory destruction of bronchial and peribronchail tissue. It is usually the result of chronic pulmonary infection. It may be congenital either due to an arrest of bronchial development or associated with dextrocardia and sinusitis (Kartagener syndrome). In majority of cases it is acquired after birth. Measles, pertussis, pneumonia, tuberculosis foreign body, lymph nodes pressing on the bronchus, chronic lung infections, lung abscess, cysts, bronchial asthma, immune deficiency syndromes with recurrent chest infections and chronic sinusitis are well known precursors.

Clinically cough is always present and produces copious mucopurulent discharge during acute infections. It is severe in the morning. Coarse, buddly rales are present. Fever is present in the acute stage. Clubbing of nails is present in chronic cases. Recurrent respiratory tract infections are very common. Haemoptysis may be mild or severe. It follows intermittently improving and relapsing course. Blood count may show anaemia with polymorphonuclear leucocytosis, sputum for smear and culture may show infective organisms, plain chest X-ray may show honeycombing or collapse, consolidation and bronchoscopy and bronchograpy are diagnostic.

Treatment

Treatment is to administer antibiotics for 7 to 10 days during acute stage depending upon the causative agent, and prophylactic antibiotics for few weeks. Ampicillin and tetracyclines can be given for a long time in older children. Postural drainage is very helpful. Surgery is only advised when medical treatment fails.

Lung Abscess

Lung abscess is a suppurative process resulting in destruction of pulmonary parenchyma with formation of a cavity containing purulent material. It commonly results from aspiration of infected material and occurs commonly in the most dependent parts of the lung e.g. posterior segments of the upper lobes and the apical segments of the lower lobes. Common organisms are bacteroids,

fusobacterium, anaerobic streptococci, staph, aureus, klebsiella. Amoebic abscess is rare in children.

Clinically the onset is insidious with fever, malaise, anorexia and weight loss. Foul smelling sputum is characteristic in untreated cases. Haemoptysis is not uncommon, onset may be acute in staph, aureus and klebsiella. Spiking fever, toxic look, respiratory distress, chest pain etc. are common. On examination dullness and diminished air entry are present. Polymorphonuclear leucocytosis common and chest X-ray typically shows thick walled cavity with or without fluid level with surrounding infiltration sputum may be positive on smear and culture examination.

Treatment

For anaerobic bacteria penicillins in doses of 1,00,000 units/kg./24 hours for 4 to 6 weeks is the drug of choice. In penicillin resistant strains chloramphenicol is useful. Metronidazole i.v. has been found to be quite useful. *Abscess takes several weeks to disappear on chest X-ray.* Surgical drainage is rarely necessary.

—(Courtesy : *The Bombay Hospital Journal*)

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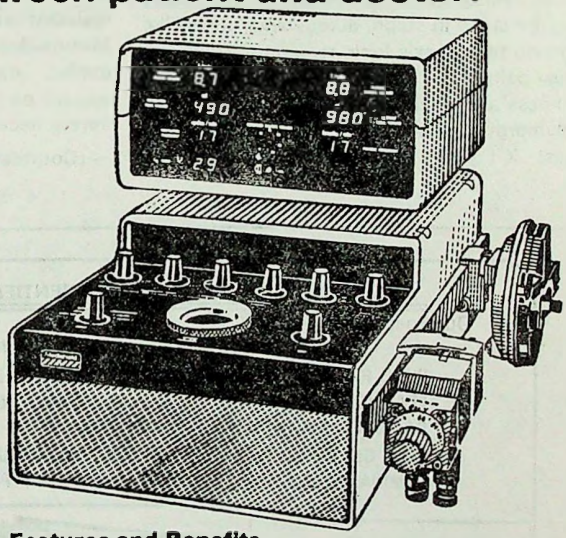

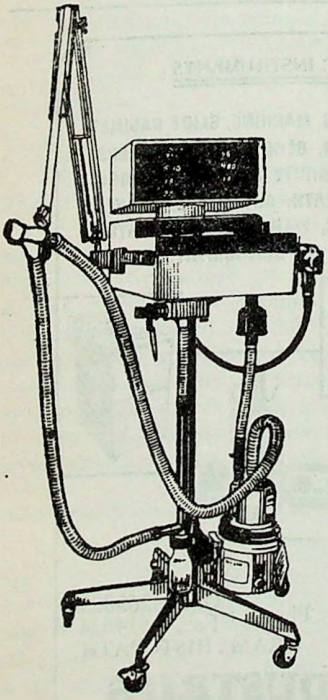

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Prescriptions As They Should Be

—Mira Shiva

[*Principles of Rational Drug Therapy* is based on *"Rational prescribing—the right drug for the right patient at the right time at the right amounts and with due consideration to relative costs"* (*Department of Health Education Welfare, 1969*).]

Rational Therapeutics is based on :

(a) *As accurate a diagnosis as possible* under the constraints of diagnostic facilities and supportive staff and costs. (Relative contributions of history taking, physical examination and lab investigation to diagnosis and management of medical outpatients, B.M.J. 2, 486-89).

(In 83% new hospital outpatients the final diagnosis was reached on history and referring doctor's note. Only 5% diagnosis was reached after investigations).

Hamptom, J.R., Harrison, MJG., Mitchell, JRA, Pritchard, J.S. and Seymore C. (1975).

(b) *Appropriate use of Drugs*

Drugs available should be :

(1) Effective

(2) Safe

(3) Economical

(4) Essential

(5) Easily available

(6) Acceptable (culturally and socially to the patients)

(7) With little scope for misuse

(8) Easily administered

(See article on Rational Drug Therapy-Drug Issue-April-June 1982-HfM). Therapeutic Guidelines, Upanda, J. Yudkin, G Brown, AMREF.)

(c) *Effective Communication to the patient about usage of drugs*

Various studies have shown that between to 10% 9% patients with an average of 50% do not take prescribed treatment, they forget or reject their doctor's advice. (Ref. Psychological studies of doctor-patient communication in contributions to medical psychology Ed Rachmann, Oxford Pergamon Press, Page 9-42). Dr. George J Caranasos et al in the Journal of the American Medical Assooiation (JAMA) talking about lack of communication between Doctor and patient says :

"Patients also cannot identify correctly 60% of their medicines. Forty percent of patients receive drugs prescribed by 2 or more physicians, increasing the possibility of drug interactions. Twelve percent of patients take drugs prescribed for someone else and 60% of the patients consider their drugs completely safe".

Coranasons, George J et al, Drug Induced Illness Reading to Hospitalization, JAMA, 228—713-717, 1974.

Dr. Hulka an epidemiologist at the University of North Carolina and others revealed that 58% of the total number of patients

studied made mistakes in the way they took their medication—they took *either too much, not enough* or *at the wrong time*.

In our Indian context, effective communication with illiterate, often ignorant patients, for whom what we consider superstitions is a reality, requires special skill and on this depends whether the drug will be taken

— at the times suggested

— in correct amounts

— in a correct way

— for the correct duration and that the patient would be above to report back any serious adverse reaction and not consider it worsening of the disease or consider the diagnosis to be wrong.

Most of our rural patients who are used to home remedies, traditional systems of medicine—western medicine is *alien* even though it is often associated with the "awe" and "mystery" accorded to white man's medicine. The dangers of these medicines and the importance of taking it properly is often underestimated. In this social context our responsibility as effective communicators and educators obviously increases. The need to shoulder and appropriately delegate some of these responsibilities to other trained staff is very pivotal in rational drug therapy.

What Encourages Drug Misuse ?

1. *Drug Policies* which allow; *hazardous and irrational* drugs to flood the market; which allow their heavy promotion and creation of false needs are very much to blame. Even concerned Health Personnel have so far never felt the need to express their opinion in all this. The power of the drug industry is obvious from some of the following examples :

Eg. Lifting of price restriction category III drugs by the Govt. in return of dissolving of the foreign equity shares by certain multinational from 70% to 40% and having their demand met. Finding more and more unessential but profitable drugs flooding the market is but a natural outcome. (For categorise of Drugs and Drug Price Control Order see Drug Situation in India).

Another example is the enability of the Govt. to ban the 23 irrational combination drugs which the Drug Consultative Committee recommended for withdrawal, because of vested interest (list available with VHAI).

The drug companies getting a stay order :

— on Govt. decision to allow sales of 5 single ingredient drugs *only* under generic names

— on Govt.'s decision to ban high dose estrogen-progesterone combinations involved in the hormonal pregnancy test scandal (the tests are officially banned since (1976).

The fact that Bangladesh heavily dependent on foreign drug imports but could manage to ban 1707 hazardous and irrational drugs, maker our indifference and apathy all the more pathetic.

2. *Number of Drugs*

There are 30,000 drugs in the market. Hath Commission recommends 116 essential drugs while WHO recommends about 200 essential drugs to deal with 90% of the problems in most hospitals. Studies based on information recall showed that it was *not possible to remember important information of more than 100 drugs*—this being the *highest estimate*. Most of us can remember much less.

A survey of 92 hospitals conducted by a Church Agency indicated that 25 drugs were

3 Questions

? What good does this drug do

? What harm can this drug do

? Can this patient afford it

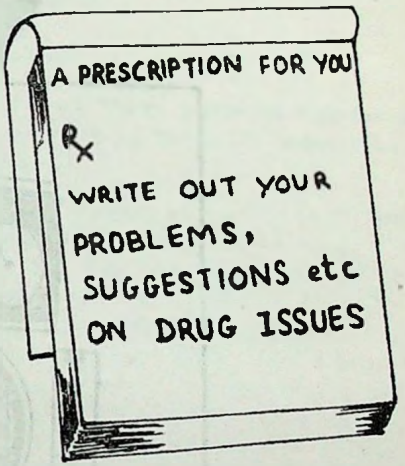
adequate to take care of most of the problems according to WHO working group on Rational Drug Therapy.

What are the Deciding Factors Guiding the Choice of the Drugs that we Prescribe ?

Many times it's not the principles of *rational drug therapy*, but the subtle influence of the drug representatives and their *biased medical literature*. When confronted with too many diverse unfamiliar drugs, with each drug being sold under 50 to 200 different names—confusion and misuse is the expected end result.

3. *Combination Drugs*

Kinds of drugs with expected misuse potential are *Combination Drugs*. 60-70% of the brand products in the market are not single ingredient drugs but combinations of or more. Less than 5% of drugs in the WHO's Essential Drugs List are combination drugs. In combination drugs many of the most important ingredients are in sub-therapeutic doses or the combinations are *totally irrational and non-sensical*.



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— the cost of combination drugs is any day more than *cost* of single ingredient drugs.

— what is probably worst is the potential for *adverse reactions* it is known that changes of drug interactions increase with the increase in number of drugs prescribed. The chances of drug interaction increases by 40% when 6 or more drugs are prescribed. The fact that 2 or 3 combination drugs may easily contain 6 or more known or unknown ingredients is often over looked.

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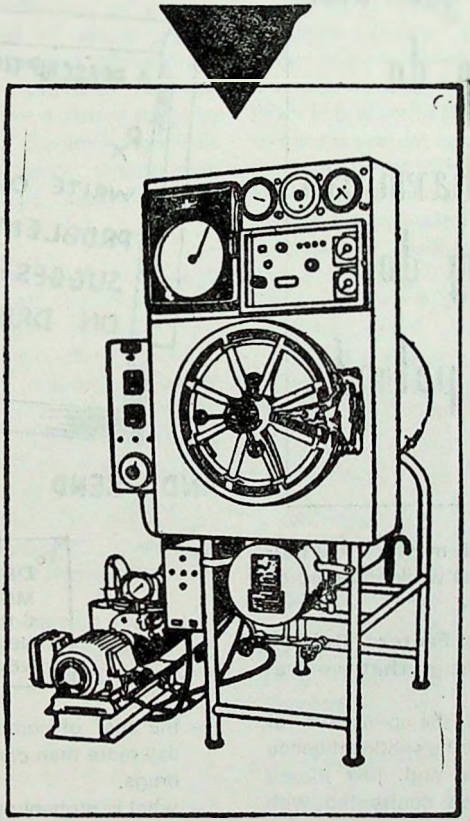

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LEGAL EDUCATION—10

Do You Know Your Fundamental Rights

(Part I)

— P.D. Mathew

Your Fundamental Rights

The Constitution of India, Part III, guarantees Fundamental Rights to the citizens. These rights represent the basic values cherished by the people of this country since Vedic times and they are meant to protect the dignity of the individual and create conditions in which human beings can develop their personality to the fullest extent. Without these rights the citizens, moral and spiritual life will remain stunted and they will not be able to develop their potentialities.

These rights are wide ranging and comprehensive and they fall under six heads, namely, right to equality, right to freedom, right against exploitation, right to freedom of raligion, cultural and educational rights and right to Constitutional remedies.

These are not privileges or favours but basic rights to which every citizen is entitled. However, since they are not absolute or unlimited, their exercise can be reasonably restricted by the State on various grounds.

The purpose of this leaflet on Fundamental Rights is to raise the legal consciousness of citizens with regard to their rights so that they may exercise them responsibly and prevent government authorities and others from encroaching on them, and in case of their violation, find redress through legal remedies provided in the Constitution.

Which are Your Fundamental Rights

1. Right to Equality (Articles 14-18)
2. Right to Freedom (Articles 19&358)
3. Protection Aganist Conviction (Article 20)
4. Protection of Life and Personal Liberty (Article 21)
5. Protection Against Arrest and Detention (Article 22)
6. Right Against Exploitation (Articles 23-24)
7. Right to Freedom of Religius (Articles 25-28)
8. Cultural and Educational Rights (Articles 29-30)
9. Right to Constitutional Remedies (Articles 32-33 and 359)

I. Right to equality

(Articles 14-18)

Under these Articles the Constitution guarantees the following rights.

1. *Equality before the law*

This means the absence of any special privilege in favour of any individual and the equal subjection of all classes of citizens to

the ordinary law. In other words it means, that there shall not be any discrimination before the law on the basis of rank, office etc.

2. *Equal Protection of the Law*

It implies equal treatment in similar circumstances both in the privileges conferred and in the liabilities imposed between one person and another if, as regards the subject matter of legislation, their position is the same.

This principle does not take away from the State the power of classifying persons on the basis of their legitimate needs. Thus the State can make special law for the benefits or protection of Scheduled Castes, Scheduled Tribes etc. Differential treatment to this class of citizens does not violate Article 14 which guarantees equal protection only when there is no resonable basis for such differentiation.

3. *Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth (Art. 15)*

The State cannot discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them. Under this right the State has guaranteed to all citizens adult suffrage(Art. 326) equality in employment, equal eligibility for the office of President, membership of Parliament etc. It also gives every citizen right of access to and use of institutions, places, roads, wells, restaurants, hotels, etc., maintained by State funds intended for the use of general public.

The Article does not authorise any citizen to use somebody else's private property like wells or roads or swimming pools etc. At the same time Article 15 (3) and (4) gives power to the State to make any special laws for the benefits of women and children, Scheduled Castes, Scheduled Tribes etc. Thus the provisions of maternity relief for women workers (Art. 42) free education for children (Art. 45) or measures for prevention of their exploitation, [Art.39(f)] reservation of seats for Backwaid Classes of citizens and special provisions for their advancement, do not violate Article 15.

4. *Equality of opportunity in matters of public employment (Art. 16)*

* This Article guarantees :

  Equal opportunities for all citizens in matters of employment and appointment to any government office [Art. 16 (1)].

* No discrimination be made on grounds only of religion, race, caste, sex, descent, place of birth, residece or any of them in respect of any employment or office under the State [Art. 16(2)].

Exceptions

* The State has power to reserve posts in favour of Backward Classes of citizens if they are not adequately represented in Government services. [Art. 16 (4)].

* Offices connected with religious or denominational institutions, are to be reserved for members of any particular religious or denomination [Art. 16(5)]

* Parliament has right to prescribe any requirement regarding resdience in a State in respect of any particular class or classes of employment in that State [Art. 16(3)].

5. *Abolition of Untouchability (Art. 17)*

This Article declares :

i. Untouchability is abolished and its practice in any form is forbidden and

ii. if a person tries to enforce' Untouchability' in any form, he will be guilty of an offence, punishable in accordance with Law.

Note

The word' untouchability' is not defined in the Constitution but it is meant to denote different practices in different parts of India, as developed through the ages.

The Parliament passed the 'Untouchability' (Offences) Act in 1955 which was amended in 1976. It is now known as the Protection of Civil Rights Act 1955. This Act prescribes punishments for various types of 'Untouchability' offences.

6. Abolition of Titles (Article 18)

This article prohibits : (i) the State from conferring titles on citizens except military or academic distinctions, (ii) citizens from accepting titles from foreign States, (iii) non-citizens who hold any office of profit or trust under the State from accepting any title from any foreign State without the consent of the President.

Note

Titles are abolished as they tend to create unnecessary distinctions among the people, and such distinctions would not be in line with the ideal of social, economic and political justice. What Article 18 prohibits is the conferment of titles and not of awards. Hence we have such awards as Bharat Ratna, Padma Shri etc.

II. Right to Freedom

The right to freedom guaranteed under Article 19 can be classified the following six heads :

1. Freedom of Speech and Expression
2. Freedom of Assembly
3. Freedom to Form Associations or Unions
4. Freedom to move Freely Throughout India
5. Freedom to Reside and Settle in any part of India.
6. Freedom to Practise any Profession

Note

There are the liberties of every citizen. They are not absolute as they are qualified and may be limited by the State, e.g., my right to move anywhere does not enable me to enter any premises I like. The restrictions imposed on these liberties are supposed to be for the public good. Let us now look at the restrictions that the State can impose on these rights.

1. Freedom of Speech and Expression

The right to freedom of speech and expression of citizens is subject to the power of the State to make any laws impossing reasonable restrictions in the interest of :

i. Security of the State,

II. Soverignty and integrity of India,

ili. Friendly relations with foreign States,

vi. Public order,

v. Decency, and

vi. Morality.

The State can also make reasonable restrictions on 'freedom of speech and expression' in relation to contempt of Court, defamation and incitement of offence.

* Two conditions have to be satisfied if a restriction is to be held Constitutional :

a. it must be reasonable,

b. the restrictions must relate to one of the matters mentioned above.

* Whether a restriction is reasonable or not can be decided only by the Courts.

* restrictions could include prohibition also,

* freedom of the press falls within 'Freedom of speech and expression' and is therefore available to the same extent.

2. *Freedom of Assembly* [Art. 19(1) & (3)]

* It includes :

a. right to assemble peacefully and without arms,

b right to hold meetings, and

c. right to take out processions.

* These rights are guaranteed subject to three limitations, namely :

a. the assembly must be peaceful,

b. its members must be unarmed, and

c. the State may impose reasonable restrictions in the interest of pubic order, or the sovereignty or integrity of India.

* The State can declare an assembly of 5 or more persons unlawful when it intends to achieve any of the following by means of criminal force;

a. to overpower the government.

b. to overpower any public servant in the exercise of his lawful powers.

c. to take possession of any property.

d. to deprive any person of the enjoyment of his incorporal rights.

3. *Freedom to form Associations* [Art. 19 (1) (c) & 19 (4)]

Our Constitution gives all citizens the right to form associations or unions. But the State has power to make resonable restrictions on this right in the interst of

i. Sovereignty and integrity of India,

ii. Public order, and

iii. Morality.

4. *Freedom to move freely throughuot India* [Art. 19 (1) (d) & (5)]

Every citizen has a right to move freely in any part of the Indian territory. But the State can impose restrictions on this right for the following reasons :

i. In the interst of the general pubic, and

ii. For the protection of the interest of any Sheduled Tribes.

5. *Freedom to reside and settle in any part of India* [Art. 19 (5) & (1)]

on this right also the State can put reasonable restrictions on the basis of the interest of the general public and the protection of the interest of any Scheduled Tribes.

6. *Freedom to practise any profession* [Art. 19 (1) (g) & (6)]

Under this, every citizen has the freedom to practise any profession or to carry on any occupation, trade or business of his choice.

Note

* In the interest of the public welfare, the State can place restrictions on this right.

* The Article does not guarantee a monopoly to any individual or association to carry on any occupation,

* Carrying on of any trade, business, industry or service by the State would not be questionable on the ground that it is an infringement of the rights guaranteed by Art. 19 (1) (g)

* The State may (a) impose reasonable restrictions of profession in the interest of the general public : (b) prescribe the professional or technical qualifications necessary for carrying on any occupation, trade, bussiness : (c) carry on any trade, bussiness or industry or service, by itself or through a corporation, owned or controlled by the State to the exclusion of private citizens. [Art.19 (6)]

Can freedom guaranteed under Art. 19 be suspended ?

Article 358 provides that during the Proclamation of Emergency, the State including legislative and executive authorities, will be free from the restrictions imposed by Art. 19. In other words during the period of Emergency the provisions of Art. 19 are liable to be suspended.

III. Protection in respect of conviction for offences (Art. 20)

This Article guarantees that :

i. A person must not be convicted of any offence except for the violation of law in force at the time of the commission of the act;

ii. A person must not be subjected to a penalty greater than that which might have been inflicted under the law in force at the time of the commission of the offence [Art. 20 (1)]

iii. A person cannot be prosecuted and punished for the same offence more than once [Art. 20 (2)]

iv. A person accused of any offence cannot be compelled to be a witness against himself [Art. 20 (3)]

Note

* There is no punishment within the meaning of Art. 20 (2) unless it is preceded by prosecution of a criminal nature.

* Art. 20 (3) grants the privilege against self-incrimination.

* The expression "to be a witness ' is not limited to the evidence given in court, but also covers testimony previously obtained by force from the accused.

* The protection of Art. 20 (3) also extends to the documentary evidence obtained by force from the accused.

IV. Protection of life and personal liberty (Art. 21)

The Article states :

* No person shall be deprived of his life or personal liberty, except according to procedure established by law.

* This Article restraints the Executive from proceeding against the life of personal liberty of the individual except under the authority of law made by the State.

* When a person is deprived of his life or personal liberty in accordance with a law prescribing a procedure for the same, Art. 21 is not violated. It is for this reason that the confinement of an under—trial prisoner or the arrest and detention of a person by the police under the code of Criminal Procedure is considered legal.

Note

* This Article confers on the citizen the Fundamental Right to life and liberty, the most cherished and prized possession in a civilised society.

* It requires that no one shall be deprived of his life or personal liberty, except by procedure established by law and this procedure must be reasonable, fair and just and not arbitrary.

* It is for the Court to decide by the exercise of its power of judicial review, whether the deprivation of life or personal liberty in a given case is by procedure which is reasonable, fair and just or otherwise.

V. Protection against arrest and detention in certain cases (Art. 22)

Under Ordinary Law

1. When a person is arrested, under the ordinary law of the land he must be informed soon after arrested of the grounds of his arrest, and

2. An arrested person must be given the opportunity to consult a lawyer of his choice and to be defended by him [(Art. 22) (1)]

3. An arrested person must be produced before a Magistrate within 24 hours of his arrest (excluding the time required for bringing him to the Magistrate).

4. No person can be detained in custody beyond 24 hours without the authority of the Magistrate. [Art, 22 (2)]

Preventive detention [Act. 22 (4) to (7)]

Its main object is to prevent a person from committing an illegal act which is likely to be injurious to the security and safety of State or the interest of the public.

* Clauses (4) to (7) of Art. 22 impose certain limitations upon the power of the Union and the State Legislatures to make any law providing for detention without trial.

* Ordinarily a person cannot be detained for more than 2 months unless the detention is approved by an Advisory Board.

* A state law cannot authorise detention beyoned the maximum period prescribed by Parliament under the powers given to it under Art. 22.

* Parliament may by law prescribe the circumstances or type of cases in which a person can be detained beyond 2 months without the consent of the Advisory Board.

* A person detained under a preventive detention law has right to obtain information about the reasons of the detention and to make a representation protesting against the order of detention.

Powers of the Courts

i. The Court can examine the Constitutional validity of the law on preventive detention

ii. It may also examine the grounds of detention to see whether they are relevant to the order.

iii. It can interfere with the order if it is *mala fide*.

iv. The Court may inquire about the grounds conveyed to the detainee to see if they are sufficient to enable

him to make an effective representation.

VI. Rights Against Exploitation (Art. 25-28)

These Articles prohibit

a. Any form of forced labour, and

b. Children below 14 working in factories or mines or in any other hazardous employment.

But the State can impose compulsory service for public purposes without making discrimination on anyone on grounds only of religion, race, or caste or class etc.

VII. Right to freedom of religion (Art. 25-28)

1. Freedom of conscience and free profession of religion

India is a Secular State. Equal rights are therefore given to all citizens in respect of freedom of conscience and religion. Art. 25 (1) provides that

i. all persons are equally entitled to freedom of conscience and,

ii. all have the right to freely profess, practise and propagate religion subject to public order, morality and health.

* But the State has power to make laws: (1) to regulate or restrict any economic, financial, political or other secular activity which may be associated with religious practice; (2) to provide for social welfare and reform; or (3) to permit all classes and sections of Hindus to enter into Hindu religious institutions of a public character.

* The wearing and carrying of kirpans is included in the profession of Sikh religion.

* References to Hindus, includes persons professing the Sikh, Jain or Buddhist religion.

2. Freedom to manage religious affairs (Art. 26)

Subject to public order, morality and health, every religious demoination or any section has the right :

a. to establish and maintain institutions for religious and charitable purposes;

b. to manage its own affairs in matters of religion;

c. to own and acquire movable and immovable property, and to administer the property in accordance with law.

3. Freedom as to payment of taxes for promotion of any particular religion (Art. 26)

This Article secures that the public funds raised by taxes shall not be utilised for the benefit of any particular religion or religious denomination Suppose the State imposes tax for the promotion of say Hindu religion, it would be quite lawful for a person to refuse to pay such tax.

4. Freedom as to attendance at religious instructions (Art. 28)

* Religious instruction is forbidden in educational institutions wholly maintained by State funds.

* Institutions which are maintained or aided by the State cannot compel anyone to attend religious worship conducted in these institutions.

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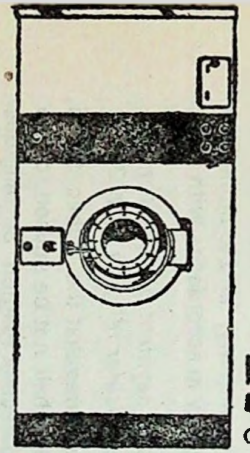

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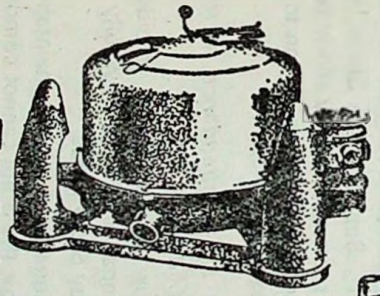

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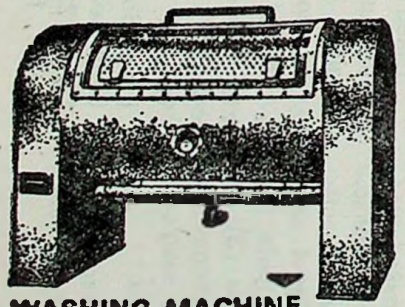

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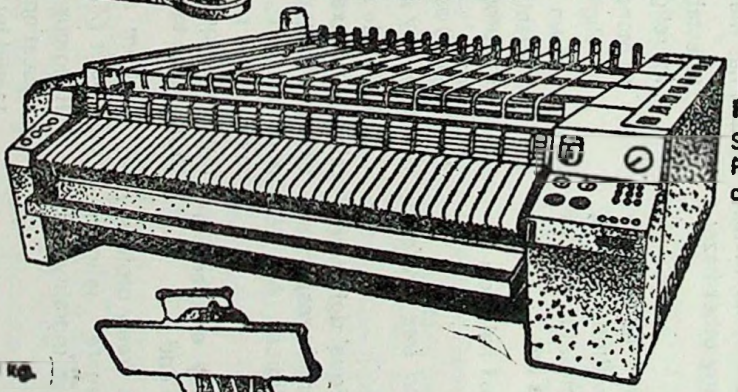

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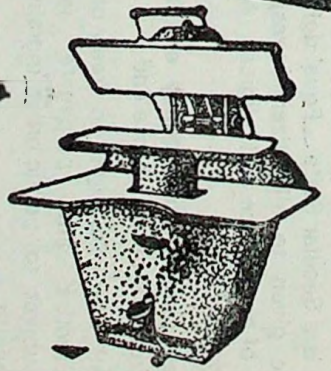

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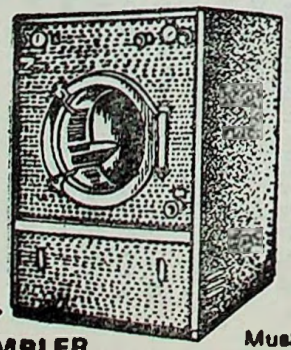

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Thirty-Seventh World Health Assembly

Over 1,000 delegates, including 114 Ministers of Health and 26 Directors-General of Health attended the Thirty-seventh World Health Assembly which completed its session in Geneva on 17 May.

Meeting under the Presidency of Professor Guillermo Soberon Acevedo, Secretary of Health and Social Welfare of Mexico, the Assembly heard the Director-General of the World Health Organisation, Dr. Halfdan Mahler, appeal to all industrialized countries to demonstrate absolute solidarity with the developing countries.

By far the most substantial debate was devoted by the Assembly to the global strategy of Health for All and country reports on monitoring progress in its implementation. It was the first evaluation exercise since the strategy was launched, in 1981.

"If there were any doubts about the wisdom of starting such an open monitoring and evaluation process, I think there should be none now. You have called your own bluff without fear, and have clarified the extent of the dramatic gap between the health situation to which we all aspire and the situation which actually exists in most countries", said Dr. Mahler. But he warned that "the prospects for the less developed countries are not at all bright, unless they are able to take dramatic action and unless the international community is able and willing to take equally dramatic action".

The World Health Assembly urged all Member States to speed the reorientation and the modifications of health systmes towards primary health care and to give the highest priority and assure full responsibility for the continuing monitoring and evaluation of their strategies.

The following are some of the highlights of the Assembly :

Action Programme on Essential Drugs

The Assembly urged Member States to intensify action to implement national drug policies and strategies with WHO support. Many delegations reported activities which reflect the commitment of Member States to the lines of action recommended at previous Assemblies and indicate that the WHO Action programme on Essential Drugs and Vaccines is rapidly accelerating and unstoppable.

The Assembly also called for the dissemination of unbiased and complete information on drugs and an exchange of information between Member States on drug use and marketing practices.

It requested the Director-General to arrange a meeting in 1985 of experts representing the parties concerned—including governments, the pharmaceutical industry, and patients and consumers, organizations-" to discuss the means and methods to ensure rational use of drugs . . . and the role of marketing practices in this respect, especially in developing countries.".

Prevention of Blindness due to Vitamin A Deficiency

Some 10 million children are affected by vitamin A deficiency and xerophthalmia in

Asia alone and more than a million become blind every year. The disease is also prevalent in Africa, the Western Pacific and limited areas of the Americas. Safe effective and cheap techniques exist to control Vitamin A deficiency. The Assembly therefore urged all Member States to give high priority to the prevention and control of Vitamin A deficiency and xerophthalmia wherever these problems exist, through appropriate nutritional programmes, as part of primary health care.

Importance of Technical Cooperation

The Assembly reaffirmed the importance of technical cooperation among developing countries and called upon developed countries to continue to provide technical cooperation and financial resources, particularly to the least development countries.

Abuse of Narcotics and Psychotrophic Substances

The Assembly, recognizing the dramatic increase in drug addiction, all the more alarming in that the young are the chief victims of narcotics dependence, noted with satisfaction the development of the WHO programme on drug dependence, and requested the Director-General to strengthen epidemiological surveillance systems.

Infant and Young Child Nutrition

Recogning that the implementation of the International Code of Marketing of Breastmilk Substitutes is an important action to protect healthy infant and young child feeding, the Assembly requested WHO to intensify collaboration with Member States in their efforts to implement and monitor the Code.

'An Appeal'

All over the World a lot of misconceived sympathy is extended to the blind but a very few persons are prepared to do anything about it in the matter of rehabilitation and giving the blind an equal opportunity to do any kind of work. The worst calamity to befall a person to have eyes and fail to see.

The National Association for the blind (Haryana state Branch) functioning in Faridabad since 1980, gives education, training, shelter, employment, services to the blind by organising sheltered Recanning workshop, Telephone Operators Training, Cassettes recorded Library & Placement etc.

Unemployment problem among blind community is one of the human courages. There are about 150 blind persons registered with us for Peons, Musicians, Teachers, Packres, Press operators, Chippers, Duplcator operators and Waterman etc.

In this respective we appeal to your goodself lend your support in this humanitarian endeavour.

—Francis Xavier
Placement Officer.
National Association for the Blind
1C/99, N.I.T Faridabad (HS)

During our convention held at Ranchi in 1981 we had resolved that our institutions should give employment opportunities to the disabled. Here is an opportunity to do something. Please do the needful and help.

—Executive Director

Hospital Sunday Celebration and Inaguration of Community Health Development Programme-Ooty

The Diocesan Unit of Catholic Hospital Association of India celebrated the Hospital Sunday on 1st July at 10 a.m. in Udhagamandalam Social Service Society, Ootacamund. About 40 participants who are

in-charge of Hospitals, dispensaries in Ootacamund Diocese, and Centres in charge of the Targetted Mother and Child Health Education Programme participated. The function started with a Mass.

Then Rev. Fr. Joseph Antony Samy, Treasurer, Catholic Hospital Association of India spoke on "RESPECT LIFE". He said "Man is created in the image of God and has been redeemaed by the death and resurrection of Jesus Christ. This is the ultimate source of human dignity. Everybody has to respect each one's life."

He stressed the statement made at the time of our convention in Bombay in November 1983 "We have to respect life at conception, life in the unborn child, life at birth, life in the growing and developing child, life in pain and suffering, life in the physically and mentally retarded, life in the socially rejected, life in the terminally ill patients, life in the addicted, life in the Poor or the economically disadvantaged, life in the exploited, life in the aged, life in the dying". A discussion was then followed.

Community Health Development Programme

The inaugural function of the Community Health Development Programme started at 4 p.m. with Prayer Song. Rt. Rev. Dr. Arul Das James, Bishop of Ootacamund presided over the function. Mr. Jagadeesh Ramasamy, District Health Officer was the Chief Guest. Rev. Fr. Joseph Antony Samy, Director, Udhagamandalam Social Service Society gave the welcome speech. Mr. Jagadeesh in his speech said that we must give importance to prevention and promotion of health and assured his assistance when ever needed and inaugurated the Community Health Development Programme.

Rt. Rev. Dr. Arul Das James lighted the Kuthu Villaku and in his talk appreciated the work of U.S.S.S. and also he wished best future so that programme would play a prominent role in the midst of the poor and the downtrodden especially for the women folk irrespective of caste, class and creed. Mr. Fernandes also appreciated the service rendered by U.S.S.S. and also he assured his help and wished good success. Plans are made to train the necessary health workers to realise the following objectives :

To give new thrusts to the existing health institutions with a stress of shifting from the Medical work to preventive and promotive health work community organization and community action for development. Health is seen in the total perspective of development.

To give reorientation to the personnel involved in Medical and Health Education work (including TMCHEP—Targetted Mother and Child Health Education Programme) in the diocese on the need and significance of community health development programme.

To co-ordinate the health care services being rendered by various religious congregations in the diocese

To create awareness among the urban and rural poor and to organise them for concrete and specific social action by bringing out the latent/potentialities of the people through this Community Health Development Programme.

Community Health Department (CHD) Of CHAI with Training Programme

Short term training Programmes in Kerala

After a week's study and evaluation session that concluded by the end of May 1984

the training team of the Community Health Department moved onward to South for two training programmes in Kerala—one in Northern Kerala and the other in Southern Kerala. The programmes, organized by Kerala Social Service Forum, were attended by health and development workers representing all the dioceses in Kerala. During the entire training programme, it was a search to find out as to how the existing infrastructure could be used most fruitfully to work for an integrated approach in health and development work. Health and development are related integrally. In the undeveloped Indian situations, development essentially means facilitating a process of bringing about human living situations for the vast majority for whom they are rejected. Hence, against this background, it means that the health and development workers who participated in the training programmes should take up a greater responsibility and a deeper involvement in people based programmes and movements. The participants and the CHAI (CHD) team thought together on the wider implications of health and sought ways and means to incorporate activities based on the new vision.

The participants were grass root level workers. The programmes were of 10 days each. Regarding such programmes, it was proposed that in future, it could be thought to organize Orientation/training programmes for diocesan policy level people who plan and organize different programmes for the dioceses and they would be able to develop a core team of trainess to train the grass root level bodies. Training programmes at this level would help CHAI better to share the ideas on Community Health with a wider area. By the first week of July the CHD team started the way back of Delhi.

Fifteen months training programme

Currently CHAI (CHD) is conducting two training programmes of 15 months each. The course schedule and contents were worked out in December 1983. The programme is titled "Community Health Team Training (CHTT) Programme" and as the name itself suggests, the course builds up teams to work in village communities with a comprehensive view on health and activities oriented towards making "Healthy Communities". The parameters of a healthy community are related to the Social, economic, political and cultural realities of the population with which one is working. The course starts with a critical understanding of Indian reality at the macro level with special reference to their local situations. The 'unhealthy' individual is situated in these millieu and modalities and strategies are worked out to improve his total life, thus enabling him to be a healthy individual, a person in a state of complete well-being.

The course has seven phases. It starts with an introductory 3 weeks residential session, after which the participants are sent to respective Centres where they were already working. Then, after evety third month they are either visited at their respective centres or brought together in general sessions. The former one is called follow up meeting and the latter one regional meeting. CHTT programme has 2 follow up meetings and 5 regional meetings. At each phase some input sessions are given alongwith certain specific assignments.

At each phase, the participants share their experiences and their assignments apart from the input sessions they are offered. Participatory method of education, a joint search made by the trainees and trainers together effected through discussions, role plays, case studies, games, etc., are used in the programme. This method serves for them a purpose as they are to involve in a dialogical education in all their activities in the field.

At present we have two groups for CHTT programme started almost at the same time,

one by the middle of January '84 and the other by the middle of February '84. The first one was at the request of Mission Sisters of Ajmer while the second one was organized by the Bishop of Varanasi for Sisters of different congregations working in his diocese. The first follow up visit to both the Centres were carried out in the months of April and May.

Of late, we undertook the second follow-up programme with the regional meetings held at Ajmer and Varanasi, one week session each, in the last week of July and the first week of August. Now, both the programmes have completed six months each and all the participants are actively involved in field level activities in their respective Centres. In the month of October we will be contacting them again, when they will be called together for a regional meeting as part of the third follow up programme.

Report of Review and Planning Session of the Community Health Department of CHAI held at Bangalore from May 19th to 26th '84

CHAI had drawn up a new vision and philosophy on health during the months of April and June '83 in its annual review, planning and orientation session held at St. John's Medical College, Bangalore. To promote this vision across the country the Community Health Department of CHAI took up specific tasks and activities for the year 1983-84. After an year, the department with its extended team members and together with some resource persons gathered again in the same venue to review the plan of action and the conduct of activities against the background of the objective of reaching the new vision on health to as many individuals, groups and organisations as possible.

Apart from the staff of the Community Health Department the session was attended by the following resource persons: Prof. George Joseph, Fr. Stan Lourde Swamy, Fr. Claude D' Souza, Mr. Rudy Lobo, Drs. Ravi and Thelma Narayan, Mr. Augustine Veliyath and Mr. R.T. Rajan.

The discussions and deliberations of the first half of the one week session were an attempt to deepen our insights regarding the current approach worked out by CHAI-Social, economic, cultural and political dimensions of health and on the importance of using the church infrastructure and the membership for the promotion of this vision. Efforts should also be made to involve other organizations and action groups. The role of CHAI as a national organisation was viewed against this background. CHAI's role would be an effort to facilitate a process by which health could be a right and responsibility of all the citizens. Here emerges the concept of making Community Health a national movement. Health, conceptually a state of total well-being, could be attained only through total liberation. With this in view, modalities and strategies were worked out for a three year period and specifically for the coming year. This constituted the theme of the second half of the session.

On 19th May the session started with a brief self introduction. Then a brief of the current approach of CHAI was given. This vision is very much in line with the spirit and content of 'Alma-ata' and the various church documents issued from time to time. It is a philosophy of health envisaging the total well-being of the individual which is directly linked with the Social, economic, cultural and political realities that condition the individual. Hence the real and comprehensive definition of health uses different terminologies and parameters which call all for the necessity of an integrated approach. The

task is to promote this idea through the member institutions and the Church institutions and also through various groups and agencies involved in development work. Then a brief view of the evaluation of the health care system in India starting right from the British period was made. The Bhor comittee of 1944 rightly identified health as a facet of development and hence advocated a multi-faceted approach with regard to improving the health condition of the people. Since then various review committees were instituted and recently Government of India has published the Revised National Health Policy in which due emphasis is laid on the concept of Social justice and it is stated that priority should go to the poor. The Policy statement recognises the role of the village "dai" and local personnel. It is a question of empowering the people which might pose a challenge to the so called professionals who alienate and deprofessionalize others. In line with this specific task, CHAI could think whether it could develop model projects in community health through its member institutions and the Church structure. Being in the structure let us work towards using it creatively and meaningfully so that church could be made relevant to the times and to the people, thus making it really based on values. This would also make a shift in Church's power base from structures and institutions to the people.

In promoting the new vision on health, rather than working alone, CHAI could develop linkages with various individuals and groups who hold a similar view. Then the concept of making Community Health a movement of the people in association with various groups and agencies was introduced.

On the second day the Community Health team spent the time with the doctors of the rural placement scheme of SMJC. The report on that is made separately. On the following day CHD resumed its meeting with the resource persons. The day started with a brief description of the annual report of the CHD and the CHTT (Community Health Team Training) Programme. In the past and to a great extent even to-day the approach is curative implement through hospitals equipped with professionals and vested with immense power by virtue of their control over the resources. Some hospitals do have CH Programmes, but that too are in a way "colonial" in character in the sense that they are not a process of empowering the people but ultimately resulting in increasing the flow of people to the Hospitals CHAI (CHD) is trying to promote a concept and practice of Community Health based on a social analysis which recognises the existence of dehumanizing situations and institutional forces that limit and alienate the life of the majority. In this approach people are themselves made "professionals" of their own health i.e., a situation in which each one is responsible for his health and each one can claim that as his right. The diagnosis and treatment are not a non-participatory process, but a political will is generated in which people see and reflect upon their problems and take decisions collectively. Here power goes to the people and hence resources are not controlled by institutional structures Health means life which means existence in its entirity which is related to the economic, social, political and cultural forces which in the present contexts subjugate and limit the life of the people. Hence health inevitably means total liberation.

Our approach is a process of moving and working with people and disseminating and promoting such activities throughout the country. In essence this becomes making community health a living movement. For the realization of this CHAI could start working with its 2000 member institutions, especially 1500 of them which are either small hospitals or dispensaries. CHAI can contact the 110

dioceses and different congregations. It could also contact different lay organisations and groups. All these are the efforts to share the vision with the whole nation. Here emerges the relevence of developing regional groups, resource pool or key trainees in difference parts of the country. Few member institutions and few groups and individuals in different regions may share this view. We will have to being with them. Development means "second coming of Christ" and hence definitely priests and sisters have got a creative role in making the Church relevent to the current society since church essentially means the people of God. With these deliberations third day's meeting concluded.

On the next day discussions were oriented towards making Community Health a movement. There is cut-throat competition between hospitals within the existing system and in that process they are equipped with the most sophisticated technological implements and highly qualified specialists. Economic viability is a basic condition for his and funding agencies are approached for this. The poor are left in the society uncared and not looked after. The Community Health approach envisaged by CHAI tries to reduce the number of the poor and their unmet needs. Funding agencies are also becoming increasingly interested in this. This approach is realized through the participation of the people and this requires more commitment and creativity.

The political dimensions of health could be understood by considering the ill-health of the poor who are prone to diseases that affect them due to variety of reasons as lack of food, safe drinking water, hygenic and adequate living conditions etc., all of which could be changed only by a favourable political will. It should be clearly understood that when we speak of political dimensions, it has nothing to do with the often understood party politics. Hence at times it may even lead to confrontation with the powerful community that enjoys the fruits of the economic, social and political power at the cost of the poor.

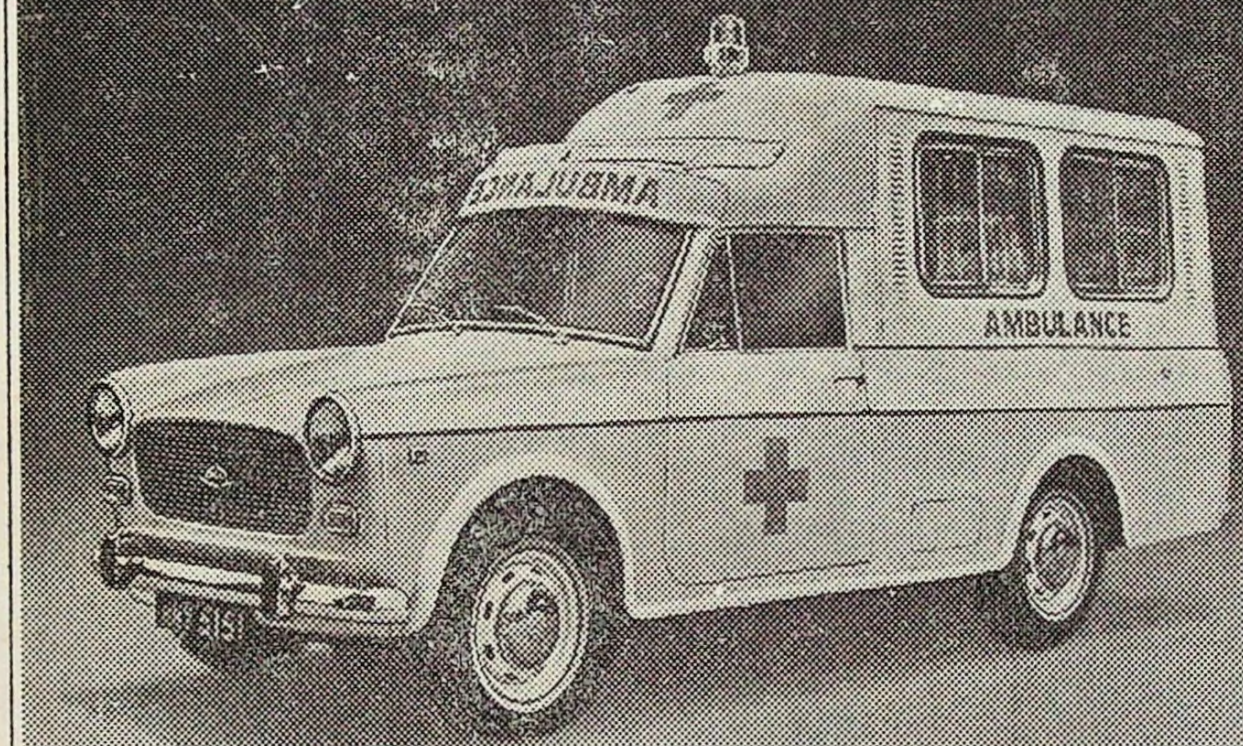
The following day also was spent on the same topics. The proposed movement is a movement of the whole membership. At present, money and personnel are invested in starting sophisticated hospitals. Many people engaged in hospital work started thinking of the new vision on Community oriented approach and this has created tension for them with regard to their present activities and what they consider more desirable. And on the other side, there are small rural dispensaries on the verge of expansion, those that have started thinking of expanding to highly institutionalized health centres. This has created tension for them. Here CHAI has a precise role of managing these tensions creatively so that eventually these tensions could be channelled to developing some Community Health projects.

It is important that CHAI share these ideas with policy makers as Bishops, heads of religious congregations, heads of voluntary groups, Government bodies etc. Organisations as Caritas, IGSSS, CRS, ISI etc, Medical educators at different levels and Mass media.

The role of CHAI (CHD) as a national organization was discussed in detail against the background of the points mentioned in the previous pages. CHAI has to identify regional partners to work out different strategies that may be found suitable for the realization of the vision and the objectives.

In the following days of the session, specific strategies and action plans were formulated. They are proposed to be worked out at three levels, i.e., by the Central team, with the partners and through the partners. A note on this was already published in the June issue of Medical Service.

The Premier Ambulance



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What makes it a good buy is the cost.

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- easily manoeuverable — so congested areas and narrow streets are no problem.
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In fact, the Premier Ambulance has all those features you can invest in... and make a good buy!

The Premier Ambulance is a "deemed export" item. So you can even purchase it with donations received from international organisations. And get it at 25% less than the local price!

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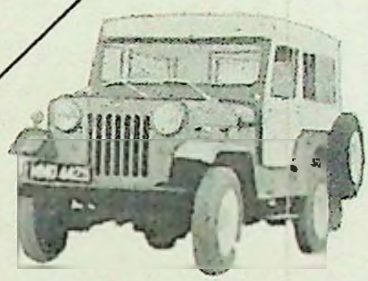

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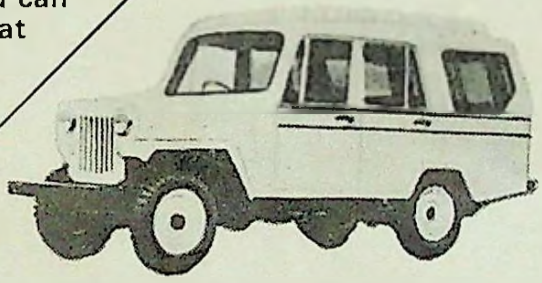
C.J. 500 DP-101- METAL BODY WAGONETTE



C.J. 500 DP-101- DELUXE STATION WAGON

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