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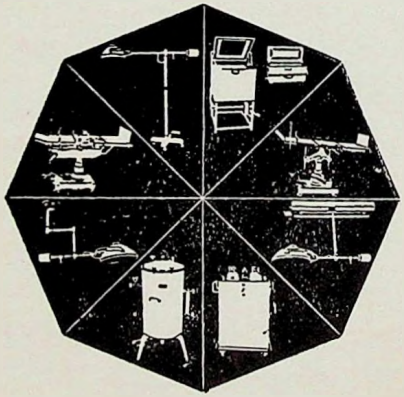

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contents

EDITORIAL

Convention with a difference

We are coming closer to our 41st Annual Convention of the Catholic Hospital Association of India. The members of the association gathering together annu ally to discuss various matters of common interest particularly for the interest of the common man was a regular feature from its inception in 1943. Hence we are here now preparing for our 41st Convention, to be held at St. John's Medical College, Bangalore f rom 23-26th November 1984. Over the years a new element of exhibition (of hospital equipment, furnitures, vehicle etc) was added to this event. But organisationally this became increasingly difficult to have it every year.

However, there is going to be a difference in this year's convention. The usual 'glamour' of exhibition will not be there. There will be a serious workshop for two days and the topic selected for this convention is the "Drug Issues". During these two days we will try to understand the issues relevant to drug prescribing and drug distribution and pharmacy policy in our institutions in the context of the ICMR/ICSSR warning in the "Health for All" report that *"Enternal vigilance is required to ensure that the health care system does not get medicalised, that the doctor-drug producer axis does not exploit the people and that the abundancc of drugs does not become a vested interest in ill-health"*.

In order to arrive at a certain policy decisions and to decide upon some definite follow up action, we have already requested that persons with decision making power on these issues to attend this years convention. Accordingly it is hoped that the workshop will be able to pay attention to the health situation in India, role of drugs in health care, pattern of drug production vis-a-vis the people's health needs, the dynamics of the drug industry, the patterns of drug distribution/availability in the health care system, the national drug policies and laws etc. It is also hoped that the workshop will create an awareness of the growing irrational use, over use, misuse of drugs by health personnel etc. The workshop will also look at these issues in the context of the CHURCH HEALTH SERVICES and from the common man's point of view. The workshop will discuss on the practical and possible solutions to these problems.

In order to do this, serious preparations are undertaken by the local committee. Already in our journal 'Medical Service' we have started the column- "Peoples, Pills and Prescriptions". The next issue of our journal will be completely dedicated to the various aspects of drug issues. It is also hoped that the participants of this year's convention will come with certain amount of preparation to be shared in the workshop so that based on this and their vast experience more meaningful conclusions and decisions can be arrived at.

However the main difference of this years conve ntion should be seen and measured, not by the programmes of the convention days only but by what happens afterwards. i.e. the follow up action taken by our member institutions. Let us hope that after this convention we will be a bit more closer to our aim of making our health care services *accessible to all our people* in a more *acceptable* and *affordable* way and with their *involvement*.

41st Annual Convention of CHAI and Workshop on 'Drug Issues'

Venue	:	St. John's Medical College Bangalore 560034	
Dates	:	23rd—26th November 1984	
Last date to receive registration for	:	October 30, 1984	
Accommodation	:	will be arranged as per request	
Fees	:	Registration (non-returnable)	Rs. 50.00
		Food	110.00
		Accommodation	70.00
		Local Transport	20.00
		Total	Rs. 250.00

(Payable by crossed cheque/draft/MO in favour of Catholic Hospital Association of India)

Return travel arrangements : as per request. The request with details together with approximate amount should reach us latest by 20th October. No guarentee for requests received after 20th October.

Executive Director
CHAI CBCI Centre
Goldakkhana
New Delhi 110001.

Please register immediately

Convention local office :

Sr. Anna Maria
Secretary, CHAI Annual Convention
Committee 1984
St. Marth's Hospital
Bangalore 560 009.

Life in Unity: Work and Bread

Political Conditions for an Economic Translation of an Ecumenical Mandate

Jan P. Pronk

"Life in Unity" means work and bread for all. That requires a fair distribution of scarce resources and this, in turn, a fair distribution of political power. Life in unity is an ecumenical mandate of major economic significance, to be realized in political terms.

In the past, until some centuries ago, a just distribution of the earth's resources was neither an economic nor a political prerequisite to manage the world. There was one earth, but it contained many worlds which were hardly dependent on each other. Life or death in one of them did not affect the others. If one part of the earth suffered a decay, others could still flourish. The distribution of the world's resources was not subjects to global political decision-making.

Two factors changed this pattern: colonialism and the technological revolution in communications. Both originated in the West as the result of political decisions in western economic interests. The earth became one world : technically a small one, economically a managed one, politically dominated by a centre in the West. It became a global feudal society, controlled by an industrial elite which did not share resources, work and bread with the numerous have-nots.

Then came World War II : death and destruction in a divided world. After that, new era started with, for the first time in the history of humankind, a world-wide effort to rationally manage international relations by creating a new international economic order on the ruins left by the Great Depression and the War. It was a deliberate effort to create more work and more bread for more people; more life and more unity, not for ethical reasons but because of the enlightened self-interest of the then elite, who could only flourish under conditions of economic and political stability.

And so the Bretton Woods system was created: a World Bank and an International Monetary Fund together with an international organization dealing with world trade. The United Nations was established, with its Security Council and Specialized Agencies, enabling the nation states to negotiate stability and growth. The Marshall Plan injected new life into Western Europe. Development aid was provided to poor countries to help them build an infrastructure. New institutions were created to foster economic cooperation : OECD and the European Communities. The development of the Third World was stimulated by the adoption of the Strategies for the First and the Second Development Decades. It was also the era of decolonisation of the South and, after the Cold War, detente between East and West.

Of course, we should not glorify the past. Life in unity remained far from reality. But there was some progress towards more work and more bread for more people, due to concrete action—even if insufficient—for about 25 years.

The situation is different now—it changed about 10 years ago. The new international economic order which had been created in the 1940s crumbled, and the call for another new one was not heard. Instead, there was a North-South dialogue, which resembled a dialogue between deaf and dumb, or even worse because deaf and dumb indeed do communicate with each other. The United Nations lost credibility as a forum where economic and political problems could be negotiated and solved. Negotiations produced only words, not policies. Tension between East and West increased. The arms race got out of control. Economically the world is in a crisis, with double digit unemployment figures in the North and negative economic growth in the South. The beginning of the 1980s is characterised by less work and less bread for more people. Economic forecasts for the turn of the century are gloomy: even under the least pessimistic assumptions, the number of people living below any decent level of existence will be higher than one billion in the year 2000. Concrete action is necessary to fight the crisis, to build a new order—as we did after the Great Depression and after the War. But now we shy away from action. Even meetings organized for that very purpose, like the Cancun Summit or UNCTAD VI, fail.

How did this come about ? What are the basic reasons for the collapse of progress towards more life and more unity, more work and more bread ? We have to know the answer to this question if we really want to work in the right direction.

In my view the reasons are twofold. Firstly, the structural economic crisis in which the world finds itself today is rooted in the international economic system itself, which was created after World War II. For more than two decades that system served its purpose for those who created and controlled it: stability and growth. But at the same time the system had a number of basic structural deficiencies which eroded it. The absence of the socialist countries of Eastern Europe and of the Third World countries from the negotiations of the basic elements of the system was such a deficiency. The international economic order was basically a Western one, with Western-values—such as free markets and private enterprise—and was controlled by Western countries. If these countries tried to accommodate themselves by shifting domestic instability onto other countries, by exporting inflation, by manipulating exchange rates or by protecting weak and declining industries, they could easily do so because there were no sanctions on bad behaviour.

That is the first reason: the deficiencies of the system made it highly unstable and weak. The second reason is that governments, instead of trying jointly to rectify these basic deficiencies, produced more chaos by short-sighted, inward-looking, unilateral "beggar-thy-neighbour" policies.

For the last 10 years we have been paralysed. To quote Mr. Ramphal, Secretary General of the Commonwealth: "The form of the North-South dialogue has been about what should be done, but the real argument, the often unspoken question, has been about why we should do anything". And at the same time the rich have helped themselves. To quote Ramphal again: "There was no inertia or lack of innovation when the North felt its immediate interests endangered. The (Western) International Energy Agency was established within months of a perceived 'energy crisis'. Those elements of the debt crisis which most threatened major Western banks or Western strategic interests produced urgent intervention and impressive coordinated response. Meanwhile, facilities, denigrated when urged in support of Southern

economies, were at hand to serve Northern interest". No substantial additional financial resources were committed to the least developed countries at the United Nations Conference on the Least Developed Countries in Paris (September 1981) but, shortly before that, new money (Special Drawing Rights) was made available to support European currencies or to prop up a weak dollar.. And at present, due to an artificially high interest rate in the United States, to very low commodity prices and to protectionist measures hampering access to markets of industrialized countries, the flow of resources from the poor to the rich is bigger than the other way round. There is no unity and there is even no effort to hide this fact. "Why should we do anything at all ?" is the present answer of the North to the demands of the South.

Well, there is one reason : that is interdependence beween countries or, in the words of the Brandt Commission, a "common interest" of all countries in the survival of the world economy and of the world itself. It may seem doomsday language, but indeed survival is at stake. The present international economic crisis, for a number of reasons which I will not elaborate now, is more fundamental and more complex than any previous one. The economic problems ahead are enormous. The transition from traditional energy to new and renewable sources of energy, from negative to neutral environmental effects of economic growth and, above all, from a world population of at present for billion people to eight billion one generation later (all of whom have to be fed) —all these transitions are necessary but will not take place automatically.

The world food problem in particular has not yet been solved. Sub-Saharan Africa is hungry; it does not receive adequate support. If no major investments in food production and no changes in food policies are made, there will be substantial food shortage in other parts also of the world in a decade or two from now. Further more, work has to be created for all these people—an additional four billion in four decades—which means that nine out of ten new jobs globally have to be created in the Third World itself. These are challenges which demand joint global action in an interdependent, united world. If that action does not take place, then survival will certainly be at stake.

Of course, this has already often been said by scientists, by United Nations expert groups, by the Brandt Commission, at our previous Assembly and on many other occasions. Interdependence has by now become official jargon. All the Ministers addressing UNCTAD VI in Belgrade, in June this year, expressed their belief in interdependence and common interests. Nearly all the Western politicians at the Conference explicitly agreed with Mr. Clausen, President of the World Bank, that world economic recovery, including economic recovery in the Western industrialized countries, would be unthinkable without a major economic upheaval in the Third World. But all this talk turned out be just lip service. During the UNCTAD VI negotiations themselves, the rich countries refused, after the beautiful speeches in plenary, to make the resources for such an upheaval available—they even advocated conditions and economic policies, such as for instance within the framework of the International Monetary Fund, which would strangle developing countries and force them to cut expenditures intended to benefit their poorest population strata. Countries such as Brazil are on the verge of bankruptcy, and for poor people in these countries bankruptcy means death. The tragic aspect of this situation is that these developing countries, which are highly indebted and at the mercy of their rich creditors, hardly dare to demand fundamental structural

change, as, for example, in international financial and monetary relations, let alone a new international economic order. Many delegates of rich countries told us in the corridors at UNCTAD VI that they were very much at ease because pressure from the South had never been so weak as at present.

And again it became crystal clear that life in unity is still far away. More work and more bread is not being simply given by the rich to the poor. It has to be fought for, it has to be negotiated, just as the labour unions had to after the industrial revolution in the West. But negotiations only make sense if three conditions are met.

There should be a common or mutual interest befween the parties; there should be some degree of equality in power between them; and there should be political will. The common interest between rich and poor in survival is still being overlooked by the rich or only being paid lip service to. The poor are weak: they lack negotiating power more than ever. The political will of the forties and the sixties has faded away. The tragedy is that the international economic crisis is parallelled by a crisis in political decision-making and political institutions, due to the paramount import of short-term horizons in decision-making; to the almost exclusively inward-looking orientation of policy makers; to the inclination towards shifting each one's burden on to the shoulders of weaker groups, to alienation of elites from the grassroots; due also to prisoner dilemma situations and to the fact that in politics greater weight is given to aims conceptualized in terms of power—which by definition is a zero sum game—than in terms of welfare.

If these trends are not reversed, there will be increasing economic and political insecurity not only for the weaker countries or for the poorer population strata, but also for the international community as a whole. Then the international community will be united—united in insecurity—owing to scarcities as the result of inadequate economic policies; to increasing economic inequalities resulting in violence caused by the arms race; to increasing political tensions between superpowers which give higher priority to strengthening and enlarging spheres of influence than to solving globa roblems; and owing also to the aggressive policies of individual countries which answer all these threats by creating more "Lebensraum" for themselves—territorially and economically—guaranteeing themselves access to already scarce resources, to the sea bed, to the Arctics and to space—which will undoubtedly lead them into confrontations with other countries.

So the trend should be reversed, away from crisis and confrontation towards survival and unity. What option do we have ?

We could return to the choices made in the 1940s, when we created a new international economic order as an answer to the then prevailing crisis. This option-I call it "international democratic capitalism"-would be a step out of the present chaos by strengthening the policy principles and institutions which were established at that time. However, this option would not be in the interest of the poorest countries and of that part of the world's population which presently has only marginal relations with the market.

We could return to the choices made in the 1950s, when political decolonisation started ("international literalism") and an international community of nation states was shaped, by drawing the economic consequences: the creation of an international social welfare state with the help of international income transfers in the form of development aid. This, however, would not be adequate because it would not deal with the causes of inequality.

We could implement the pleas made in the 1960s, combining international aid with a strategy for international development which should also contain policy changes in the fields of trade in manufactures and commodities. This option ("international economic democracy") would be a major improvement, but still would only imply changes within the framework of the prevailing international economic order.

We could return to the model of the early 1970s by seriously striving, on the basis of economic cooperation between developing countries, towards more collective self-reliance for the South, possibly even some degree of delinking from the North. However, this would imply some confrontation between North and South and would not contribute to a solution of world-wide global crises, threats and insecurity.

So the only promising option is one which would enable us to cope with the problems of the 1980s. You may call it a new international economic order, or internationally democratic socialism, or life in unity, or a just, participatory and sustainable society.

Can the Church play a role in this ? Yes indeed. To negotiate and build a system which guarantees work and bread for all should not be left to bureaucrats, technocrats and diplomats. Neither can it be left to politicians, not only because of the political crisis phenomena which I mentioned, but also because such a system needs an additional dimension. In the words of Thomas Beckt, in T.S. Eliot's "Murder in the Cathedral" :

> Temporal power, to build a good world,
> To keep order, as the world knows order.
> Those who put their faith in worldly
> Not controlled by the order of God,
> In confident ignorance, but arrest disorder,
> Make it fast, breed fatal disease,
> Degrade what they exalt.

That is indeed what happened in the seventies: after twenty-five years, worldly order with fatal disease. That is what should be avoided in the remaining years of this century.

The Church can help; the Church is a value guardian. Values such as survival, social justice and equitable sharing of resources are easily forgotten during negotiations. Churches can constantly highlight their crucial significance.

Churches are people's movements which can challenge power, act as vanguards and as advocates for change. That is essential because people, and in particular the poor, are easily forgotten during negotiations Did we not speak about a church of the poor ?

That is the cynical lesson of the last ten years. We talked and negotiated about work and bread, about welfare and development, but the basic values and the fate of poor people were not on the agenda.

One could argue that this always will be the case and that any effort to negotiate more work and more bread for more people would be a waste of time. I agree that people's participation at the grassroot level is a *conditio sine qua non*. It is an essential but not a sufficient condition, because the unequal distribution of power, together with the rapid technological revolution of the last couple of decades, has given the elites at the top a nearly insurmountable advantage over the people at the grassroots. Action at the grassroot level may help to challenge power, but should go hand in hand with action to influence that power. Life in unity requires meticulous and dedicated action at all levels as a united movement by all peoples. Moreover, life in unity should not only be seen as the aim of a process, as its final outcome. It should also characterize the process itself.

Sharing work and bread with each other, and with the yet unborn generation, is an ethical ecumenical mandate. It always has been. But whether the mandate was implemented or not, did not, in the past, have consequences in terms of survival. Now it does.

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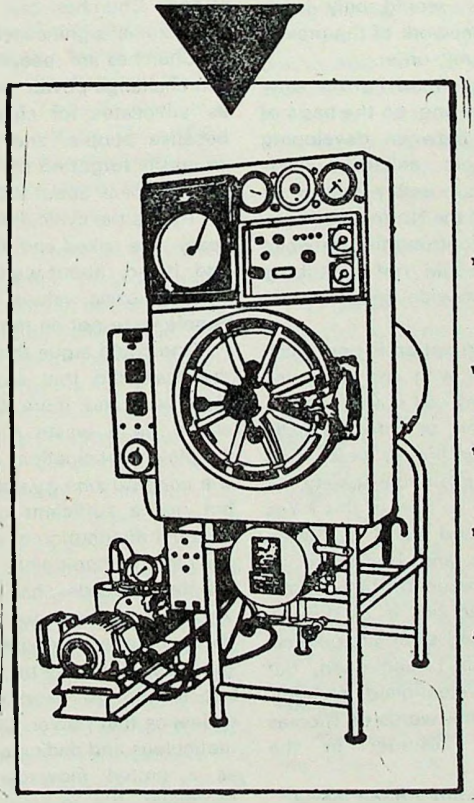

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The Two Halves of Rural Health

Provision and Participation—Studies in Social Dynamics of Primary Health Care

— Meera Chatterjee

Time is short for the journey towards 'health for all', not because the year 2000 is sacrosanct, but because the vicious relationship of disease and poverty will make the task increasingly difficult. The travellers are a motely crowd—politicians and planners, health professionals, development specialists, social scientists, "the people"—all in search of the goal but presently out ot step with one another. Studies in Social Dynamics of Primary Health Care maps the terrain, describes the obstacles and the alternative paths for India. We are left to believe the road is not impassible, provided visibility improves.

The past is succinctly summarised in a chapter on the evolution of health policy in India. Over the years, the country has accumulated infrastructure, personnel and programmes. The emphasis has been on centralised facilities rather than on far-reaching services, on hardware and not on software, on quantity and not quality. The orientation of the health system towards the urban rich, its curative, clinical, pharmaceutic and technologic bias, its Western derivation at the expense of indigenous methods, its isolation from related sectors and its distance from social and economic realities are now acknowledged candidly by government health documents. The recent (1982) Statement on National Health Policy calls this health system "inappropriate and irrelevent" to the country's needs.

There have been efforts at providing health care to the poor. Foremost among them is the Community Health Workers Scheme, initiated in 1977, in which the authors have been intimately involved. Here they present their observations, gleaned during several years of field work, from the perspective of both providers and beneficiaries. To this they ass an analysis of the rural health system which is expected to provide back-up services for the primary care imparted by village level workers. When, during the course of their field-work, the state government of Punjab substituted, the CHW scheme with a pilot "mobile health team" project, that too become a subject for study. The authors also focus attention on two important national programmes, the National Malaria Eradication Programme and the National Family planning Programme, which have been in operation for over two decades.

The book delves into the workings—and non workings—of the CHW scheme. Although the effort is generally welcomed by village people, including the poor, who have felt helpless in dealing with their health problems, the demand is for curative medical care of the allopathic variety, and there is little enthusiasm for the preventive or promotive tasks which are the crux primary health care. Consequently, there is meagre evidence of basic improvements even in, say, sanitation, both providers and beneficiaries are responsible. It is linked to other well-known weaknesses of the scheme—the inadequacy of CHW training, the quandary about supervision of the workers, and the passivity, as opposed to participation, of the community. Clearly, the scheme has not brought about a change in the medical-

professional bureaucratic approach to rural health care. In fact, the authors contend, the CHW is "another rung added at the bottom of the existing health service hierarcy". And, given this situation, the failure of the delivery system to meet the functional requirements of the village-level worker (training, information, guidance, supplies, salaries) renders the scheme practically important.

Another critical defect, noted but not emphasized by the authors, is the scheme's failure to induct women—the vast majority of CHWs are men; even the authors use the pronoun "he" throughout to refer to the CHW, despite their avowed concern for women. This naturally means that the pressing tasks of primary health care which are focused on women and children remain largely undone.

To overcome some of these inadequacies, it has been proposed to set up village health committees as part of the revised Health Guides Scheme in the Sixth Plan period (1980-85). It is hoped that this will elicit greater community involvement, including that of women, and clarify the relationship between health worker and community. Whether this will change the CHW's role from paramedic to social worker engaged in generating social awareness, organisation and action, which the authors see as most important, remains an open question.

The trend to the "professionalization of barefoot medicine" was also manifest when the Punjab Government opted to replace the CHW with a mobile health team. Led by a doctor, the health team was charged with delivering "total health care" at the village level. The authors evaluated the first fifteen months of this pilot project. They concluded that, as an extension of the "provider approach", this 'alternative' too remains largely clinical-curactive in nature, inaccessible to many, and isolated from the community despite its intention to involve the people. They suggest that a combination of this effort and a well-run CHW programme would be efficacious.

Raising their sights from the primary to the secondary level of health services, the authors present their onservations in three blocks in Haryana. They find the rural health delivery system rife with problems. It is hierarchical. Decision-making for health is dispersed, making coordination difficult. Programmes are introduced in an *ad hoc* fashion and consequently management of logistics and personnel is grossly deficient. Certain basic concepts such as a uniform service-to-population ratie, are deemed impracticable and, hence, inequality of access to services remains a major drawback. These problems also affect the vertical programmes concerned with malaria and family planning, on which much effort has been expended nationally, but which have failed to make adequate impact.

By this time, the authors have marshalled considerable evidence regarding provision of and participation in health care. The overall picture is one of inadequacy on the part of providers, which spells poor programme implementation; and of insufficient information to and organisation of communities, which prevents their participation in health care. In sum, although the present perspective on health envisions greater participation among the people for improved health, the attendent schemes have largely been extensions of the "provider approach" of the past.

The future begins with the philosophy of Alma Ata, and the "Alternative Strategy" of the ICSSR-ICMR Study Group on Health For All, (See FUTURE 1,p 53-55 for a review). Both are concerned with the relationship of health to development outside the health sector. On the other hand, primary health care also seen as a point of entry

in the effort to remove poverty and inequality as the "vanguard of the development process". The authors too perceive primary health care more as a "social rather than a medical problem" which calls for the "transformation of social organisation" and the "integration of health care into the overall social-economic development of the community".

The sum of evidence and philosophy in a series of prescriptions by the authors for rural health. These are the directions with which we are armed; until we come to the next intellectual turnstile.

First, the existing rural health service system must be "reorganised, reoriented, rationalised and restructured". This is a priority emanating from the precedence given to primary health care. The purpose of such change in the health infrastructure is to decentralise decision-making, shifting responsibility to beneficiaries, thereby making them participants. The authors support the alternative model proposed by the ICSSR-ICMR group which called for a "radical change" in the health service system. This model is commnnity-based, linked to referral services, synthesizes traditional and Western medicine, integrates preventive and promotive aspects of health with curative care. However, the structure proposed differs only marginally from the present pattern of health services. The strength of the alternative model thus lies more in the principles it espouses. These are that the majority of health complaints should be dealt with at the village level; that a system of referral to specialist centres should give those in need adequate access to medical care, ensured by proper location of facilites; that the responsibility for the functionning of this system be vested in the people and their representative institutions.

Second, the authors propose that a change in the attitudes and motivations of health personnel is more important than "mere" restructuring of health services. The urban, bureaucratic, professional-clinical bias must be replaced by the rural, decentralised, participatory and preventive orientation of primary health care. Discussing how the national health care delivery system can be democratised, the authors are certain that the elites—administrators, planners, intellectuals, and especially doctors—must overcome their alienation from the masses, identify with the cause of the people, and establish their *bona fides.*

This prescription encompassed the *third* proposal, to reform medical education so that community health and epidemiology preside over sohpisticated speciality medicine.

Fourth, the authors are in favour of integrating indigenous medicine with the modern allopathic system because of the "holistic" and "culturally-relevant" approach of traditional practitioners. Left to themselves, the traditional system have clearly not been able to deal effectively with the most pressing rural health problems. They have also been subject to the strains of modernization. The legacy of the national health effort is the rising, if misguided, expectation, even in the remotest rural area or among the poorest, for sophisticated, professional medical treatment—paraphernalia of 'scientific' medicine. Thus, a return to traditional medicine which has been concurrently devalued is unrealistic. While its "revitalisation and integration" may be desirable, it is difficult to see who can be charged with responsibility for dispensing this prescription.

Fifth, the authors Propose the regulation of private medical practice and controls on the drug industry. "In the long run" they say, "the objective should be to absorb all private professionals in the public provision of health and medical services". This bitter

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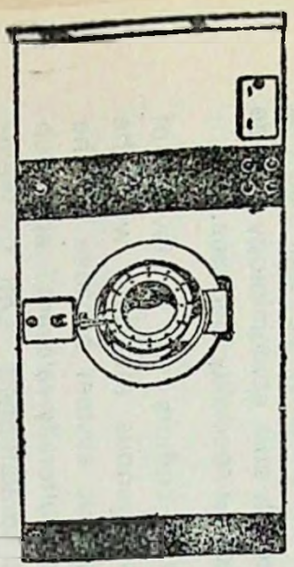

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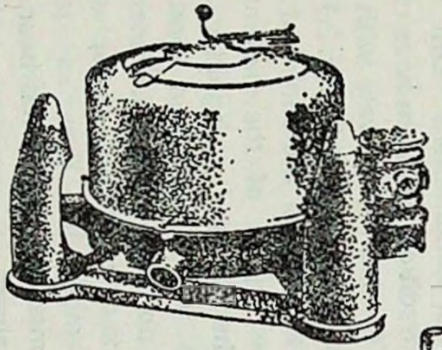

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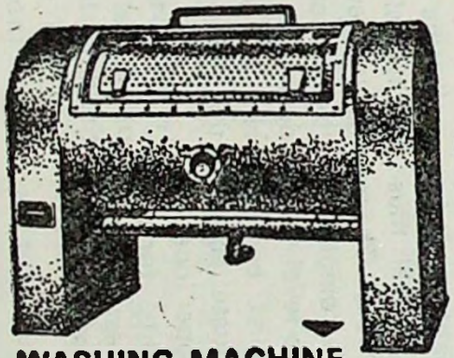

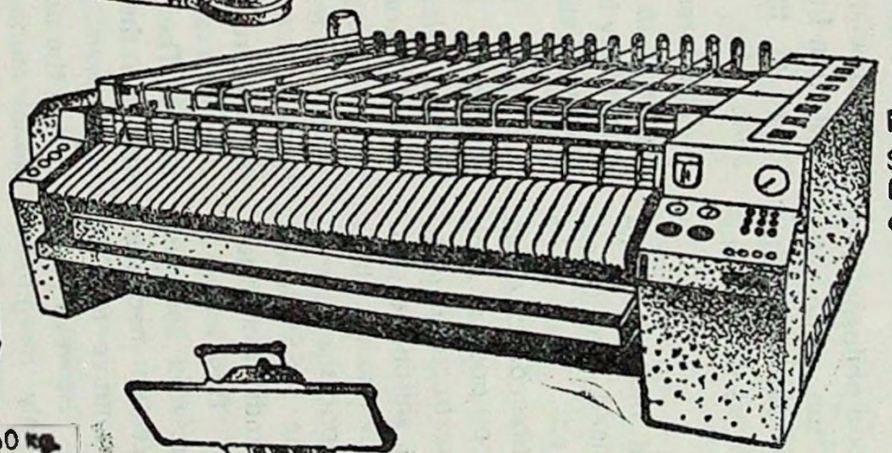

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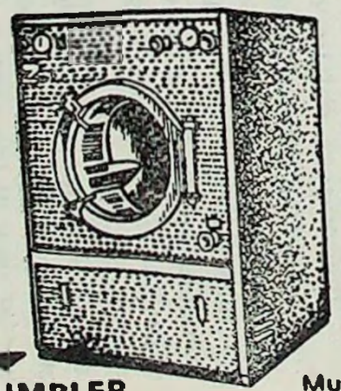

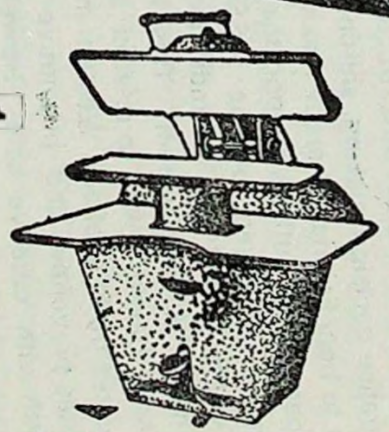

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pill is unlikely to be swallowed by many concerned with their individual health rather than with health for all.

These five prescriptions are related to the infrastructural modifications and improvement of performance with which the authors suggest the "formidable task" set forth by the ICSSR-ICMR group should begin. They are, it must be noted, contained in some form in the new National Health Policy which the authors have appended but not analysed as their book was already in press when the policy was announced. They comprise only one part of the authors' overall strategy to bring about change in health care and health status, the half concerued with *provision*. The other half of the strategy has to do with *participation*, and must also commence without delay. This entails enhancing the capacities of rural communities to take responsibility for their health and includes generating "health consciousness" through health education, and improving community organisation so that people can participate in the assessment of their health needs, in planning, organising and monitoring health services, and even conttibuting financially to them.

This last hope brings up a question of vital importance, on which the authors as well as the Policy Statement, are largely silent.

How is Health for All to be financed? Although primary care services are "low-cost" relative to the price of sophisticated medicine, a sizeable increase is called for in the health budget. The ICSSR-ICMR Group proposed that the two to four per cent of past plan budgets be increased to eight per cent in subsequent plan periods. The authors reiterate this plea. It will be necessary ensure that within the health budget, primary health care for the poor receives a large share, that this is not absorbed by the specialist centres for the urban rich. This is a matter of political, professional and popular commitment.

Dr. Meera Chatterjee is Senior Fellow, Centre for Policy Research, New Delhi 110021. *Health For All-An Alternative Strategy*, reffered to in the review, is the Report of a Study Group set up by the Indian Council of Social Science Research and the Indian Council of Medical Research. It was published in 1980

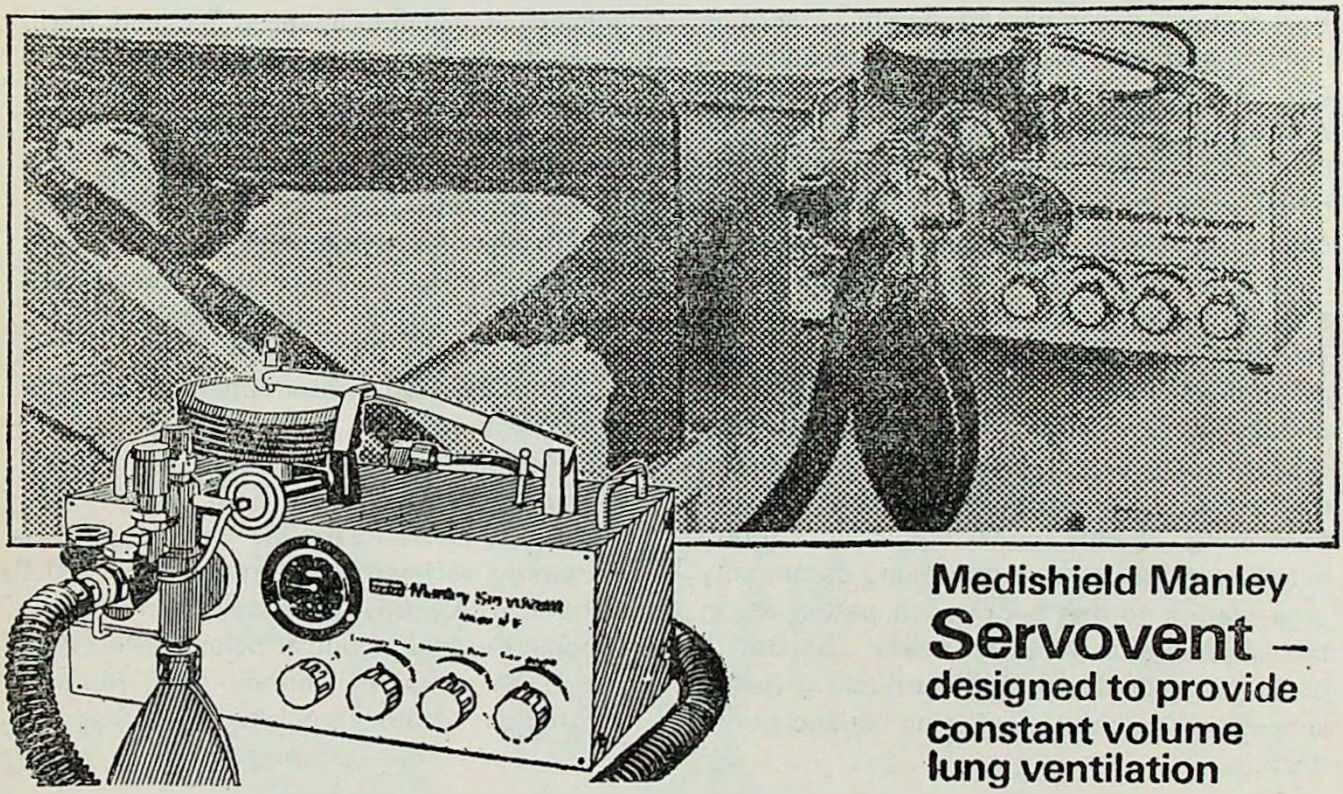
Country future, *UNICEF*

The Indian market is flooded with at least 25,000 formulations which are produced by 5156 drug manufacturing units. By the end of this year the drug production is expected to touch an all time high of Rs. 1800 crores, yet only 20% of our bretheren have get a tablet of Paracetamol from cradle to coffin. Can we afford to have the luxury of 25,000 formulations ? More so when it is well-known that if 98% of these are thrown in the sea it would be better for mankind and worse for the fishes.

Prof. V.S. Mathur
M.D., D. Phil (Oxon) M.A.M.S.

Courtesy : Drugs Bulletin Vol. 6

Some day, your patient's life might depend upon this equipment



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OBM 8584 A

A Hospital Chooses

(Kurji Holy Family Hospital—Formulary and Therapeutic Guide)

By Sr. Joan Matheikal, Dr. V.R. Sinha, Dr. R.G. Ramaiya

(The following is from the introductory part of the detailed 'Formulary and Therapeutic Guide' by the staff of the Kurji Holy Family Hospital. We thought it would be of some use and also would serve as an inspiration to those who would like to take similar steps as this praise worthy one by the Kurji Holy Family Hospital—Editor)

Forward

The laudeble achievement of Kurji Holy Family Hospital in preparing the 'Formulary and Therapeutic Guide' is the result of the unstinted cooperation and hard work that went into the making of this document. It is heart-warming to see a united effort bear fruit and to know that the full backing of all the medical staff is behind this Formulary.

Kurji Holy Family Hospital will continue its efforts to transform itself into a more community-centered Hospital. We see this happening through building the image of the Hospital as a centre for health education, leadership-training, conscientization and social reform rather than that of merely being a Centre for curing diseases. A wholistic approach to health which emphasises the participation of the community/individual for taking responsibility for his own wellness will be the basis for examining to create a dependence of drugs for the continued health and wellbeing of the people.

We will encourage our doctors, nurses, paramedical and all co-workers to rise to this challenge. We recognize that with the publication and implementation of fhis Formulary at KHFH, we take one step in that direction. By taking this one small step, we can be sure that we are strengthening those forces working for social justice and peace in the world today.

Introduction

This Formulary is the result of the accumulated experience of our Senior Medical Staff over the last 10 years. We know that 96-98% of conditions admitted to our hospital can be treated by drugs included in this updated Formulary. It is being presented in a new format giving the generic name, dosage, indications, contraindications, main side-effects all in the same page. Information about comparative cost of treatment is also provided.

We present below certain considerations which should be kept in mind by Doctors while prescribing drugs.

1. *Is the drug really necessary?*

   (a) Does the patient need any drug at all?

   (b) Is the drug being given to relieve symptoms, to treat the underlying conditions, or to make the patient feel that something is being done?

Bill *Cash/Credil Memo*

Ph. 322064

Date 22.1.1983

No.

Name_____

Address _____

Qty	Particulars	Rate	Amount Rs.	P.
100	Calmpose (Made by Ranbaxy		20	00
		Total	20	00

Goods once sold are not returnable

Bill *Cash/Credit Memo*

Ph. 322364

Dated 22.1.1983

No.

Name _____

Address _____

Qty	Particulars	Rate	Amount Rs.	P.
100	Diazepam (Made by Ranbaxy)		5	15
		Total	5	15

Good once sold are not returnable

(c) Is the drug the most suitable for that patient and that conditions?

(d) Is the drug the cheapest drug of that type? If it is not, could a cheaper drug do the job as well?

(e) What side effects may the patient suffer?

(f) Do the possible benefits to the patient out weigh the possible risks of the drug?

(g) How may the drug interact with other drugs, the patient is receiving?

2. *Cost consideration*

Many patients who visit our hospital are very poor. They simply can not afford the exorbitant cost of treatment. It is the duty of every Doctor to keep this awareness in mind, while prescribing. Diagram given above gives you an idea of how some very similar preparations may vary in cost by a factor upto 25%. Surely, a cost conscious Doctor can help considerably to lighten the burden of treatment cost to the patient.

3. Generic names

It is the policy of the hospital to use generic names for prescribing. Most drugs

cost very much less in its generic form, for example, Calmpose (Ranbaxy) costs 0.13 paise per tablet whereas the same drug in its generic form Diazepam (Ranbaxy), cost only 0.05 paise per tablet. Lyraymcin (Lyka cost Rs.10/-per vial which in its generic form Gentamycin (Hindustan Antibiotics) cost only Rs.7.50/-

We request all Doctors to abide by the Hospital Policy of prescribing drugs in its generic name. Further, it may kindly be noted that even if a drug is prescribed in its brand name, the pharmacist is authorised to dispense the same drug in its generic form.

Introduction and deletion of drugs

The procedure for introduction or deletion of a drug from its Formulary is :

(a) Any Senior Doctor may recommend a new drug in writing to the Pharmacy and Therapeutic Committee giving its indications, contra-indications, main side-effecfs and advantages over existing drug in the formulary.

(b) Pharmacy and Therapeutic Committee will carefully consider the suggestion from the point of view of Pharmacological efficiency, cost and other relevant criteria and decide to include or not to include the recommended drug in the Formulary

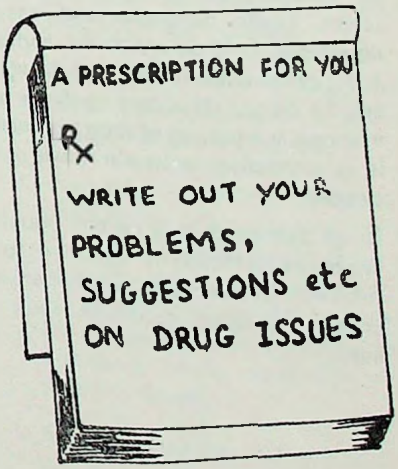
Rationale and objectives

It has been stated that rational drug therapy is the art and science of prescribing the best suited drugs to individual who need them, not to those who merely want them. The drugs used will be :

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

For practitioners of rational drug therapy, the drug industry in India presents a bewilderingly chaotic picture :

* The drug market in India is flooded with more than 30,000 formulations, majority of which are cxotic formulations boosing up the cost to the patient.
* Drug advertisements and contacts with drug representatives are the source of information on drugs for most Doctors. However, such information has been found to be very reliable. According to WHO "such information is always influenced by commercial interests.



AND SEND

To
DRUG COLUMN
MEDICAL SERVICE
C.H.A.I., C.B.C.I. CENTRE
NEAR GOLDAKKHANA
NEW DELHI-110001

The basic theme of promotional material is that drug will provide the answer to a distressing clinical problem. Little attention is given in aiding physician to use his clinical judgement. Unfavou rable aspects and complications of such treatment rarely receive sufficient attention".

* There is reportedly one drug representative for every 4 doctors in India as compared with one drug representative for 30 doctors in developed countries.
* Diseases that affect the people in India are mainly nutritional, infectious or communicable, gastro-intestinal, diarrhoea, malaria, filaria, measles, leprosy and T.B. However, in 1976 out of total production of Rs. 700 crores, 25 percent was spent on vitamines, tonics, health restorative and enzyme digestants, 20% on antibiotic and only 1.3% on sulphonamides and 1.4% on anti TB drugs. This data confirms how irrational the pattern of drug production is in comparison to health needs of our people.
* Drugs banned in their parent countries or proved inefficacious continue to be marketed by multinational companies in under developed countries such as India.

Given above confused situation, a hospital interested in promoting and supporting rational drug therapy among its doctors is compelled to do the following :

— Restrict the drug made available through its pharmacy to a short list of basic and essential drugs
— Provide realiable clinical, pharmacological and therapeutic information about these drugs.
— Encourage doctors to prescribe through generic names.
— Educate doctors on the cost of drugs.

Objectives

KHFH Formulary and Therapeutic Guide is an an attempt in that direction. It has been brought out after considerable amount of discussion among senior medical staff of KHFH. Its objectives are :

— To provide a list of drug that will be st ocked in KHFH Pharmacy
— To provide reliable pharmacological and therapeutic information about these drugs.
— To name the above listed drugs in its generic names whenever possible
— To provide information about comprarative costs of drugs wherever possible.

Do You Know Your Fundamental Rights

(Part II)

P.D. Mathew

VIII. CULTURAL AND EDUCATIONAL RIGHTS (Art. 29-30)

1. Protection of interests of minorities (Art. 29)

   a. Any section of citizens residing in India and having its distinct language, script or cultures has the right to conserve the same.

   b. Educational institutions maintained or aided by the State cannot deny admission to any citizen on grounds only of religion, race, caste and language.

2. **Right to minorities to establish and administer educational institiutons (Art. 30)**

   This Article guarantees :

   a. All minorities based on religion or language have a right to establish and administer educational institutions of their choice,

   b. In granting aid, the state cannot discriminate against educational institutions managed by minorities based on religion or language.

Rights of Minorities Based on Religion and Language

* Religious and Linguistic minorities have the same rights under Art 30 (1)

* Admission of students from other communities to educational institutions conducted by minority communities does not affect the minority rights of that institution

* Right to establish educational institutions of their choice includes the right to establish and conduct educational institutions for general secular education and shools and colleges

* Freedom of choice of the medium of instruction in education institutions is also guaranteed by Art. 30 (1)

* The right given to minorities is a positive one giving special privileges. Any unreasonable abridgement of it is unconstitutional. The minority rights are subject to reasonable restrictions in the interest of efficiency of instruction, discipline, health, sanitation, morality, public order etc.

* Affiliation though not provided for in Art. 30 cannot be denied to a minority institution without sufficient reason.

* This right cannot be lost by its non-use. It cannot be effectively waived either.

* Only if a minority community has established an institution does it have the right of administering it under Art. 30 (1)

* The right to administer means the effective administration of the affairs of the educational institution and it does not include the right to mal-administer

* The minority communities have the right to form their own Governing Bodies to manage their educational institutions without interference from the State

* Although the State has no power to interfere in the internal management of the minority institution. It has power to make regulatory measures to ensure the excellence of the institution and to issue guidelines to guarantee security of service to teachers

Is Right to property a Fundamental Right?

Till 1977, right to property was held to be one of the Fundamental Rights in the Constitution. The 44th Constitutional Amendment removed the right to property from Part III (the chapter on Fundamental Rights) by deleting Articles 19 (1) (f) and 31 and by inserting in Part XII a new chapter IV on right to property under Art. 300 A. Art. 300 A. states : "No person shall be deprived of his property save by authority of law."

Note

The right to property is no longer a Fundamental Right but only a leagal right. This change would not affect the right of minorities to establish and administer educational institutions of their choice

Saving of laws providing for acquisition of states (Art. 31A)

A law made by the State regarding :

1. acquisition of any estate, extinguishment or modification or any rights related to the estate, or
2. taking over the management of any property by the State for a limited period either in the public interest or in order to secure the proper management of the property, or
3. amalgamation of two or more corporations for proper management or public interest
4. removal or modification of any rights of managing agents, secretaries, managing director, director and managers of corporations or of any voluntary rights of shareholders, or
5. extinguishment or modification of any rights arising from any agreement lease of licence for the purpose of searching for, or winning, any mineral or mineral oil or the premature termination or cancellation of any such agreement, lease or licence, cannot be declared void on the ground that it takes away or abridges any of the rights conferred by Arts. 14&19.

Note

* If a law regarding the above matters is enacted by a State Legislature it cannot be enforced without the President.

* The State through legal provision cannot acquire an estate in which a person, holds land within the ceiling limit for personal cultivation, and has building or structures, unless he is paid adequate compensation for the land or building at a rate not less than the market value.

Validation of certain Acts and Regulations (Art. 31B)

Art. 31 B provides that certain Acts and Regulations specified in the nineth Schedule

to the Constitution relating to the acquisition of estates and modification of rights therein cannot be made void on the ground that it infringes any of the Fundamental Rights guaranteed by the Constitution.

This article was incorporated in the Constitution to remove the Zamindari system and to remove all Constitutional obstacles to land reforms

Saving Laws giving effect to certain Directive Principles (Art. 31 C)

According to this new Article introduced in the Constitution through the 25th Amendment any law made for the promotion of all or any of the Directive Principles cannot be considered invalid on the ground that it infringes any of the rights conferred by Arts. 14 and 19.

Note on Directive Principles of State Policy

* They form part IV of the Constitution
* They are considered fundamental principles in the governance of the country and it is the duty of the State to apply these principles in making laws for socio-economic and cultural reforms.
* They indicate the policy which the Union and States ought to follow but they cannot be enforced through legal action in the Courts,

Conflict between Directive Principles and Fundamental Rights

The Supreme Court has held that in case of irreconcilable conflict between the two, the Fundamental Right shall prevail

The Court proposed that an attempt must be made always to harmonise the two and the State, while implementing these principles, should take care to see that the Fundatmental Rights are also protected at the same time.

IX. Right to Constitutional Remedies (Arts. 32-35 and 359)

The Constitution of India guarantees not only Fundamental Rights but also adequate provisions to enforce them. Accordingly, the right to entorce all the Fundamental Rights is itself made a fundamental Right in the Constitution, under Art. 32.

Note

a. every citizen has the right to move the Supreme Court for the enforcement of the Fundamental Rights (Art. 32 (1).

b. The Supreme Court has the power to issue directions or orders or writs including writs in the nature of

habeas corpus,
mandamus,
prohibition,
quo warranto, and
certiorari,

Whichever is appropriate, for the enforcement of any of the Fundamental Rights under Art. 32 (1)

c. Parliament has the right to appoint any other. Courts to exercise power and function mentioned in Art. 32 (2) and Art. 32 (3)

Constitutional Remedies

1. **Writ of Habeas Corpus (to have the body)**

* The writ is one of the most important safeguards of the liberty of a person. This remedy is always available in case

of deprivation of personal liberty or an illegal detention. On an application, the court is empowered {to direct that the detained person be produced before it and is entitled to enquire into the grounds of his detention is illegal, it can order the immediate release of that person.

* his writ is meant only to determine the legality or illegality of a detention

* Normally, it is for the arrested person to make an application for "*Habeas corpus*" Bu t if for any reason he is unable to do so, a relative or a friend can also make an application for his release.

* Under Art. 226 High Courts, too, have power to issue writs for the enforcement of Fundamenta l Rights and for any other purpose

* Reasons which can prompt the court to issue writs of "*Habeas corpus*" are

i. the law under which the detention is made is invalid (ultra vires)

ii. the law under which the order of detention has been made violates Arts, 14, 19, 22 (1), 22 (2), 22 (5) etc of the Constitution;

iii. the authority who issued the order of detention has on jurisdiction;

iv. the intention of the authority is mala fide;

v. the detention is without any legal justification,

2. Writ o f mandamus (we command)

A writ to *mandamus* is a command directed by the supreme Court of High Court to any person, corporation, inferrior court or tribunal' compelling them to do something specific pertaining to their office and duty. It commands the person, to whom it is addressed to perform some public or judicial duty which he has refused to perform and the performance of which cannot be enforced by any other adequate legal remedy

When are writs of mandamus issued?

A writ of *mandamus* may be issued under the following circumstances :

1. the petitioner must have the legal right to compel the performance of some legal duty owing to him by the respondent
2. The legal right of the applicant must be existing on the date of his application,
3. The duty imposed on the opposite party must be one emerging from a statue. It cannot be issued to enforce departmental instructions or orders not having any statutory foce.
4. The Petitioner must satisfy that he has already demanded the performance of his duty but the authority has refused to act.
5. He must also satisfy that there is no effective alternative remedy.

3. Writ of Prohibition

* It is also known as 'judical writ'.
* It is issued by a superior Court to an inferior Court to prevent it from exercising jurisdiction with which it is not legally vested. In other words it comples the courts entrusted with judical duties to keep within the limits of jurisdiction.
* It is issued in respect of pending proceedings forbidding the tribunal or the Court from continuing the proceedings

* A writ of prohibition may be issued on an application supported by an affidavit.

* If a judge or any party proceeds with the case in spite of writ of prohibition, contempt of Court proceedings can be started against the person concerned.

4. Writ of "Quo Warranoo" (by what order)

* It is issued to prevent illegal assumption or use of public office by anybody.

* It is issued against a person who claims or usurps any office, franchise or liberty.

* The writ requires the person to show on what authority he supports his claim. It can oust him from the office if the claim is not well founded.

* It is in the nature of an injuction.

Conditions requisite for the issue of Quo Warranto

1. The office must be public.
2. The office must have been created by a statue or by the Constitution itself.
3. The respondent must have assumed the office on his own.
4. The respondent is not appointed to the office in accordance with the law, or he is not legally qualified to hold the office.
5. The respondent continues to exercise the office till data of the application.

5. Writ of Certiorari (to be more fully informed of)

This writ is issued by a Court and is directed to the judge or other officers of its subordinate court. It enquires the subordinate Court to transfer the record of a proceeding pending before it to the Superior Court to be tried there, in order to ensure the applicant sure and speedy justice. In India the writ of "certiorari" is mostly used for quashing the decision of the inferior Courts or Tribunal.

When can the Fundamental Right be suspended?

* While the proclamation of Emergency is an operation the Fundamental rights conferred on citizens by Art, 19 will remain suspended. Besides, under Art. 359, when the proclamation is in operation the president may declare the suspension of the right to move any Court for the enforcement of the president must be laid before each House of parliament for their approval.

* At normal times, the Constitution allows the State to impose reasonable restrictions of the Fundamental Rights on grounds of the soverignity and intergrity of India, the Security of the State, public order, decency, morality etc.

* To maintain discipline and to ensure the proper discharge of their duties, the Parliament is empowered to restrict or abrogate the Fundamental Rights of Armed Forces and Forces charged with the maintenance of public order.

* Parliament has power to suspended Fundamental Rights of citizens residing in areas under martial laws. This gives right to soldiers and other forces to violate Fundamental Rights in the course of the discharge of their duties (Art. 34)

Power of judical Review

In India, the power of judical review is vested in the Supreme Court and High Courts,

under Arts. 32 and 226. By the exercise of this power the Supreme Court can examine the Constitutional validity of a legislation and declare it invalid if it violated Constitutional safeguards.

Art. 13 of the Constitution provides that if any law, rule or order, which is inconsistant with part III of the Constitution, is void. Under Art. 32 the Superme Court and under Art. 226 High Courts can give relief in the nature of writs to any individual whose Fundamental rights are infringed.

These Courts can also examine whether restrictions imposed on Fundamental Rights are reasonable and whether they are imposed in the interest of certain subject like public morality, order etc.

Power under Arts 32 and 226

The Supreme Court, under Art. 32 has power to issue all directions, or orders. or writs for the enforcement of fundamental Rights only, but under Art. 226 the High Courts have the power to issue order, or writs for the enforcement of Fundamental Rights and for any other purpose.

For the purpose of enforcement of Fundamental Rights a citizen may either more the High Court or Supreme Court as their jurisdiction is concurrent in this matter. A person, whose petition is dismissed by the High Court, cannot move the Supreme Court under Art. 32 on the basis of the same facts.

Has the Parliament power to abridge the Fundamental Rights?

In Swami Kesavananda Bharati's case, in 1973 the Supreme Court held that the Parliament has power to amend the Fundamental Rights including property rights.

However it has emphatically ruled that Art. 368 does not empower Parliament to alter 'the basic structure' or framework of the Constitution.

For futrher information in Legal matters contact :

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Lodi Road, New Delhi-110003.
Tel : 622379 : 624760
Gram INSOCIN

Bacterial contamination of oral rehydration solution

The value of Oral Rehydration Therapy in the treatment of acute diarrhoea and dehydration is now well recognised. WHO has recommended that the rehydration solution should be prepared with potable water. However, most people in rural areas have no access to clean water and the only available well water is often contaminated with fecal material. A study was undertaken to determine the degree of bacterial contamination of Oral Rehydration Solution prepared from untreated well water and the same water used after boiling. Children consuming the solutions were observed to see if there was any difference in diarrhoeal morbidity.

This study was conducted in a village near Hyderabad, where a project on feasibility and acceptability of oral rehydration therapy is in progress. ORS packets with a standard composition of glucose and electrolytes were given freely for all children with acute diarrhoea, and the mothers were advised to dissolve the mixture in one litre of drinking water, preferably in boiled water. Samples of ORS were collected from 23 subjects in the field, immediately after constitution and transported to the laboratory for bacteriological examination. In 12 cases, untreated well water was used for preparing the solution, while in the rest well water was boiled and cooled before use. The samples were tested for total viable counts, presumptive coliform and E. Coli counts by standard procedures. The counts were reported at 6 an d 24 hours after storage in the laboratory, at ambient temperature. Statistical analysis was done using 't' test after square root transformation.

The results are presented in the Table 40 and can be summarised as follows .

1. Samples of well water showed high coliform counts indicating fecal contamination. This finding confirms our earlier observations and shows that untreated well water is not fit for drinking purpose.

2. During storage, the well water showed further multiplication of bacteria but the increase in coliform and E. Coli counts was much greater in Oral Rehydration solution prepared from it. This indicates that addition of glucose and electolytes promote rapid bacterial growth.

3. Oral Rehydration Solution prepared from boiled well water also showed an increase in bacterial counts during storage, but the E. Coli counts were significantly lower compared to the solution prepared from untreated well water at all time points.

These results indicate that it is safer to use boiled water for preparing ORS. Practical feasibility of this adproach however, needs to be evaluated in field.

4. In children consuming ORS prepared from contaminated well water, severity and duration of diarrhoea was not different from that observed in the other group consuming clean ORS. However, this is a short study and a longer trial in larger number of children in needs to establish the inoccuousness of such solution.

by National Institute of Nutrition
Indian Council of Medical
Research, Hyderabad 500007.

Table 40

Bacterial counts in oral rehydration solutions

	Total viable counts X 10^3/ml			X 10^6/ml		Presumptive coliforms X 10^3/ml			E. Coil Counts/ml		
Time of storage (hr)	0	6	24	0	6	24	0	6	24		
Untreated well water	14± 10	54± 32	1.3± 1.0	0.4± 0.34	0.4± 0.38	5.5± 4.1	7.9±a 3.86	81.3±a 60.3	136± 84		
ORS in well water	95±a 60	230± 117	119± 102	0.3± 0.18	2.8± 0.18	331±a 187	7.±a 3.3	58± 36	2292±b 778		
ORS in boiled water	1.3±b 0.56	482± 332	60±a 15.2			7.5±b 2.36			100± 53		

Calues are mean ± S.E.

* counts <0.1/ml

a P <.01
b P <.001
] Compared to ORS in boiled water

Medical Ethics Forum-35

By Fr. George Lobo, S.J.

Selling Organs for Transplantation

Case : An unemployed man with several children offers to donate one of his kidneys for a fairly big some of money. He also donates his corneas to be taken after his death for a recompense. Is such sale licit?

With the discovery of a new anti-rejection drug, cyclosporine, the incidence of organ transplants and the corresponding demand for organs is likely to rise. The *donor* system in vogue till now does not seem to provide the needed supply. To meet the shortage. Dr. Barry Jacobs of the U.S.A. has set up an International Kidney Exchange Ltd., which would pay individuals or families for organs.

There is no ethical objection to transplant of corneas or other organs taken from cadavars provided the respect due to the dead human body is maintained and due premission is obtained from next of kin unless the person himself or herself had donated the organ while still living. When organ transplantation from living donors was first introduced, there was reluctance on the part of many ethicists to find this procedure morally acceptable because it involved mutilation or the loss of an organ, e.g., kidney which is an integral part of the body. After some time, most ethicians conceded its acceptability provided the *functional integrity* of the individual was not compromised. The donation of one of a pair of healthy organs, such as the kidney would be licit, as it did not in itself imply the loss of functional integrity since the remaining healthy organ could readily carry out the required kidney function for the individual. The risk to which the donor was placed by the loss of one kidney if the remaining one were later to become damaged by disease or accident was considered acceptable in the light of the tremendous benefit to the receiver who was joined to the donor by charity or human solidarity. But would the giving up of an organ be ever justified by the motive of monetary compensation?

Those who oppose the payment system hold on practical grounds that, as the experience with blood transfusion shows, the quality of organs with a price tag would go down because the givier would be inclined to hide a disease which if known would make the organ unaccepatable for transplantation. A volunteer donor would not likely be seriously tempted to hide such relevant information. Besides, as some fear, this would tend to make the poor a source of spare parts for the rich which would be against social justice.

But would it be intrinsically evil to accept financial recompense for an organ donated for transplantation? Can one donate an organ out of human solidarity and at the same time accept money in exchange? Many persons perform a work of charity or minister to the sick and yet will accept a salary. They would generally be willing to work gratis if all the necessities of life were otherwise provided. The salary need not be the prime consideration.

The main point is that organ donation with the implied risk must be motivated by suitably virtuous reasons which must be proportionately serious. An organ donation for the sake of money destined to be used

(*Contd. Page 37*)

Indian Academy of Pediatrics Policy Statement Based on Report of Special Committee (1983) Recommendations on Breast-Feeding

1. Breast-feeding remains the best feeding for all Indian children. Mother's milk supplies all nutrients needed for the first four to six months of life, including water. Even inadequately nourished mothers provide milk of sufficient quantity and quality during this period. In the second year of life, breast-milk continues to provide atmost half of the child's total nutritional requirements. Breast-feeding also helps in spacing children.

2. Pediatricians should actively co-operate with their obstetric colleagues in spreading correct information on breast-feeding to all mothers during the antenatal and postmatal period. They should assist the mother prepare for breast-feeding during pregnancy. Pregnant and lactating mothers should be provided with extra calories in form of locally available food preferences, dietary habits and meal patterns.

3. Obstetric practices that may interfere with proper loctation should be discouraged.

4. Baby should be put to breast preferably in the labour room itself but definitely within four hours after delivery. This is true for all babies whether delivered normally or after Caesarean section.

5. To promote proper lactation, rooming-in of babies and 'on demand' breast-feeding schedule is strengly recommended. Practice of isolating normal babies for fear of infection from visitors and for other reasons in a separate nursery and feeding babies by clock should be discouraged.

6. Prelacteal and supplemental feeding particularly when given through a feeding bottle, should be strongly discouraged as such practices interfere with successful lactation.

7. Normal newborns do not need any type of prelacteal feed with glucose or artificial milk as clostrum is enough to meet the limited needs of the newborn baby in the first few days of life. However, if found essential, the same could be given with a spoon rather than through a feeding bottle.

8. Most infections in the mother and commonly used drugs taken by her need not always come in the way of breast feeding. Thus in case of maternal tuberculosis also, breast-feeding can often be continued. However, treatment of the mother and close observation of the infant is essential.

9. Restriction of breast-feeding for any length of time before and after the administration of oral polio vaccine is not required.

10. Normal exclusively breast-fed babies may pass several loose motions each day. This is not diarrhoea and does not necessitate the use of any medication. In the early weeks of life, the stools may even be green in colour. Similarly, some normal

breast-fed infants have very infrequent motions. The stools are loose. This need not be treated as constipation.

11. Infectious diarrhoea can occur in children who are on a mixed diet or those given contaminated water. However, breast-feedihg should be continued in such cases.

12. In an exclusively breast-fed child who is gaining weight adequately, routine administration of water and vitamins, and addition of outside milk, weaning foods, juices and soups is not needed until the age of six months as early addition of such items interfere with proper lactation and increase the risk of diarrhoea and allergic disorders like eczema and bronchial asthma.

13. A baby demands feeds frequently especially in the first few days after delivery. This is physiological and should not be taken as a sign of inadequate breast-milk. Crying in a baby is mostly due to colic and not necessiarly due to inadequate milk.

14. A continuous effort should be made by all pediatricians to encourage freshly made, locally available family foods to be used as weaning foods as they work out to be far better, cheaper and beneficial than the marketed weaning foods (e.g. porridge made with locally available cereals). These foods should be started between 4-6 months, preferably at 6 months in infants, who are thriving well at the breast. Breast-milk is continued along with solids.

15. Pediatricians should follow in entirety the 'Indian National Code for Protection Promotion of Breast-feeding' in its letter and spirit. Thus (a) hospitals, nursing homes and doctor's place of work should not be allowed to be used for the display of infant foods, feeding bottles and teats, (b) pediatricians should refus a l types of inducements from the manufacturers and distributors of these products and (c) employees of such manufacturers and distributors should not allowed direct or indirect contact of any kind pregnant women or with mothers of infants and young children.

WHO Director-General Calls 1984 Year of Opportunities for Health for All

WHO Regional Committee for South-East Asia, Thirty-seventh Session, New Delhi, India, 18-24 September 1984

New Delhi : The WHO Director-General, Dr H Mahler, has called 1984 a year of opportunities for health for all. Addressing the 37th session of the WHO Regional Committee for South-East Asia here today. Dr Mahler said that for WHO, four major events were noteworthy. These were the start of the evaluation of the strategies for health for all, the gathering momentum of the Organization's Seventh General Programme of Work, preparation for the programme budget for the biennium 1986-87, and the progressive introduction of the new managerial arrangements for the optimal use of WHO's resources by Member States.

Regarding the evaluation of strategies for health for all, Dr Mahler referred to several basic questions that needed to be asked fearlessly. For example, "Are you expanding the coverage of your population with primary health care ? Are your people learning more about health so that they can assume growing responsibility for their own health and for that of their family and the community in which they live ? Do women have access to care before, during and after pregnancy ? Do all your people have access to the vaccines and essential drugs they require at a cost that they and the country can afford ?" Dr Mahler stressed that this way obstacles could be identified and remedial action taken.

Referring to the principles underlying the Seventh General Programme of Work, Dr Mahler said that these principles for building up national health systems had emerged as a consensus at Alma-Ata six years ago. They involved planning and carrying out primary health care systematically until all the population had access to motivated health workers, who were adequately trained, equipped and supplied to carry out their duties.

Turning to the programme budget proposals for 1986-1987, the Director-General said that one of the most disturbing facts that had come to light recently was that most countries did not know how their resources for health were financed and how much people were able and ready to pay to protect and restore their health. Unless this was known, how could programme budget decisions be made, he wondered. This was another obstacle that could become an opportunity to make serious efforts to clarify "just how and where and when and why and by whom we are spending on health as a first step to putting right what is wrong." This was an area where WHO's resources in each country could become a "key to many doors", including enlightened external support based on equally enlightened identification of priorities. The universality of WHO offered the opportunity for fruitful cooperation at the country, intercountry and regional levels as well as the inter-regional and global levels, he added.

Referring to the new managerial arrangements for technical cooperation between countries and WHO, the Director-General said that these arrangements were aimed at making optimal use of WHO's Seventh General Programme of Work in support of national strategies for health for all. He paid tribute to countries that had experimented with these new ways of working with the Organization, and invited them to experiment with them further. He urged all the countries of the Region to carry out as speedily as possible the regional plan of action for making the WHO's resources optimally useful for all of them.

Dr. Mahler called for a worldwide solidarity for health for all. "There exists a terrible danger that our strategy for health for all will join the ranks of other initiatives that started with bright hopes for better social justice, only to lead to those who had much having more, and those who had little having less". This could be prevented if the countries display solidarity and ensured that the weaker were supported by the stronger.

Thirty-Seventh Session of the WHO Regional Committee for South-East Asia Opens

New Delhi: The thirty-seventh session of the WHO Regional Committee for South-East Asia was officially declared open by the outgoing Chairman, Mrs Chandra Kala Kiran, Secretary, and was inaugurated at World Health House today by the Chief Guest, H.E. Mr. B Shankaranand, Minister of Health and Family Welfare, Government of India.

In his inaugural address, the Health Minister stressed the need for a clear vision of social goals with regard not only to the quantiattive aspect of the population, but also the qualitative aspects of life and human development.

Referring to the country's national health policy, Mr Shankaranand said that it laid stress on the preventive, promotive and rehabilitative aspects of health care through the primary health care approach. "It also views health and human development as a vital component of overall socio-economic development with active community participation", he added.

The Health Minister reiterated India's commitment to attaining the goal of health for all through universal primary health care. Notwithstanding the economic constraints, the current National Development Plan provided a much higher allocation for health and related sectors.

Referring to collaboration with WHO and cooperation with developing countries, Mr Shankarannad said that India, with its vast reservoir of trained medical man-power, was in a position to meet the immediate requirements of friendly developing countries and in organizing training programmes for their medical personnel.

In his address, the Regional Director of the WHO South-East Asia Region, Dr U Ko Ko, referred to India's contribution to medical sciences and said that the Indian systems of traditional·medicine continued to serve large populations in the country.

India's determined efforts in health development were reflected in the formulation of its national health policy and in its emphasis on maternal and child health, planning, control of tuberculosis and leprosy as well as the provision of drinking water supply and sanitation in the context of the goal of health for all through primary health care.

Regarding the health situation in the Region, the Regional Director pointed out that perceptible progress had been made in all the countries. Tremendous efforts continued to be made to improve and expand the national health tnfrastructure and raise the health status of the people through intersectoral collaboration for socio-economic development, of which health was an integral part.

Recognizing that positive health was essential to the development of the human potential, the countries had been individually and jointly formulating strategies for health for all, developing plans of action based on these strategies and taking concerted steps to implement them. "It is heartening that many innovative approaches towards initiating and assimilating desired changes at the grassroots have already been evolved and absorbed within the framework of primary health care in many counties of the Region", the Regional Director added.

In his address to the Regional Committee, the WHO Director-General Dr H Mahler called 1984 a year of opportunities for health for all. The Director-General mentioned that one of the main obstacles to attaining the goal of health for all was the weakness of the health infrastructure in most countries. The recognition of these obstacles had given rise to the opportunity to overcome them by setting forth in the global strategy for health for all the principles on which to build up sound health systems based on primary health care.

To ensure that the goal of health for all by the year 2000 was achieved, the Director-General called for a worldwide solidarity. Unless this was done, the present disparities in health care would continue. This could be prevented if the countries displayed solidarity and ensured that the weaker were supported by the stronger.

WHO Regional Committee Office-Bearers

New Delhi: The 37th session of the WHO Regional Committee for South-East Asia elected the following as office-bearers :

Chairman : Mr. C R Vaidyanathan
Secretary
Ministry of Health and Family Welfare, Government of India.

Vice-Chairman : Dr S D M Fernando
Director-General of Health Services Ministry of Health, Sri Lanka

Dr H Mohammad Isa, Director-General of Medical Care, Ministry of Health, Indonesia, was elected Chairman of the Technical Discussions which will deliberate on, "Innovations in primary health care within the community".

The sub-Committee on Programme Budget of the Regional Committee elected as its Chairman, Dr Uthai Sudsukh, Deputy Permanent Secretary, Ministry of Public Health, Thailand.

Option for Life in Mexico city

Following the heels of the UN International population Conference held in Mexico City from August 6th-15th, 1984, PLAN (Protect Life in All Nations—an International Pro-Life group) organised its third International Pro-Life conference in Mexico City from 11th-15th August 1984. A well above 20,000 strong Pro-Life strong rally by the Mexicans and some of the participants of the conference to the world famous shrine of our Lady of Guadalupe, originating from the Square of the Three Cultures, which flanks the building (Foreign Affairs) where the major UN sessions were held, marked the beginning of the 5 day conference on 11th August. While the over all tone in the UN meeting was an anti-life one delegate from various countries arguing for abortion, sterilisation etc, this march and the conference that followed was one of Pro-Life. The marchers walked along 10 km route in prayer and chanting of hymns by the band concluding that day's programme with the concelebrated Holy Mass at the New Basilica of Our Lady of Guadalupe.

The conference began on August 12, with a concelebrated Holy Mass at the Cathedral of Mexico City. There after the meeting was called to order by Paul A. Brown PLAN's Secretary. The time that followed till the evening of 15th August was spent in sharing the concerns and situations in different parts of the world. More than 200 people from more than 20 countries participated in the 4 days deliberations a good number of them being mexicans. From India Fr. John Vattmattom SVD attended the meeting representing the Catholic Hospital Association of India (CHAI). Fr. Paul Marx OSB, Vice-President of PLAN, giving an account of the situation in various countries in the world in promoting abortion remarked that "the West has lost its will to live". He mentioned that two third of the world is pro abortion. He asked the Mexicans to continue their love for children as he found Mexico, with a 5.4 birth rate, "rich in children," as against US (1.8), Canada (1.7) and West Germany (1.2). (It should be noted that a birth rate of 2.2. is required just to reproduce a country's population.

Others who presented papers and spoke during the conference include : Dr. Carlos Fernandez of Mexico, Sara Brown of Scotland, Fr. Rene Bel of France, Alfonso Bravo Mier, Manuel Zepeda, Gabriel Vera, Ma. Aurora Guzmen of Mexico, Valerie Riches of England, Fr. Antony Zimmerman SVD of Japan, Martin Humer of Austria, Marijo Zivkovic of Yugoslavia, Fr. Otto Maier of Germany, Paul and Judie Brown and Dr. Herbert Ratner of USA and Fr. Pedro Richards of Urugaay. The delegates shared the situations in their respective countries. Dr. Herbert Ratner, advisor to the Pontifical Council for the Familly, warned the audience that "the Social engineers are out to get you. If you haven't been aborted, euthanasia will get you yet". He continued his warning reminding the audience that "the

World Bank, the Population Council IPPF, US AID etc. don't like children. Neither do drug firms. The pill is chemical warfare against the women of the world".

Every morning the meeting started with concelebrated Holy Mass and praying for the needs of the various countries. On 15th August, the day of India's Independence, Fr. John Vattamattom SVD of CHAI was the main celebrant for the concelebrated Holy Mass in the morning. Fr. John in his message requested the participants to pray for India especially at this juncture when respect for life is declining rapidly in spite of the ancient rich religious heritage of the country and the Principle of Ahimsa upheld by its great leader Mahatma Gandhiji.

The final ceremony of the Third International PLAN Conference was a paraliturgy wherein everyone in attendance held a lighted candle as each of the eight priests present expressed, in succesion, some thoughts and prayers concerning right to life. After each utterance, the group sang the conference's "theme song," "The Light of God," first in Spanish and then alternately in English, French, and German.

The concluding message can be expressed as follows : "You must light your own candle. Overwhelming problems become opportunities when you trust in God. The real heroes of pro-life are the people in the trenches. Take time to read and learn. Spread the message. All organizations exist to serve people. Say *'viva la vida'* once a day. With Mary, let us always say 'Yes' to the Lord", and therefore "Yes to Life".

—FR JOHN VATTAMATTOM SVD

(*Contd. from Page 31*)
for obtaining luxury items would not constitute an adequate reason. But if the money were to be used for basic necessities and other funds were simply not available, then the donation need not be viewed as morally unacceptable. Of course, it is lamentable that some people are in such straights that they have to resort to such extreme measures to survive.

Years ago Pope Pius XII did not find donation of corneas altogether illicit : "Moreover, must one, as is often done refuse in principle all compensation? This question remains unanswered. It cannot be doubted that grave abuses could occur if a payment is demanded. But it would be going too far to declare immoral every acceptance or every demand of payment. The case is similar to blood transfusions. It is commendable for the donor to refuse recompense: it is not necessarily a fault to accept it." (Allocution to Eye Specialists, May 14, 1956.)

Because of the current climate of dehumanizing attitudes towards the individual person, it would be wiser to avoid the outright selling of human organs. Of course, suitable compensation for the cost of the donor's surgery and possibly for the loss of wages could always be demanded. The diminishing or risking one's physical integrity for financial profit is to be avoided as far as possible. But we could not outright condemn a person who has recourse to it as a last resort when he has to other way of maintaining himself or his family. It is for society to see that people are not driven to such straights.

B.C.G.

By Dr. Rajaratnam Abel, MBBS : MPH

B.C.G. is the vaccination that gives protection against tuberculosis. It stands for Bacilles-Calmette-Guerine, names after the two scientists who discovered the vaccine. In the past there have been many questions and doubts expressed about the value of B C.G. Many recent studies have now clearly defined the role of B.C.G. in the prevention of tuberculosis.

This vaccine is produced by a strain of cattle tuberculosis bacteria. These bacteria are repeatedly grown outside the body in laboratones. This process of growth makes these bacteria to lose their virulence or capacity to produce disease. However, because these are foreign to the human body, when introduced by injection into the skin the body responds by developing immunity or specific resistance.

What happens is very much similar to primary tuberculosis, only the site varies from the lung to the skin. The injected tuberculosis bacteria invade the lymph nodes of the armpit. Actually a controlled disease is allowed to develop. As the disease develops the body also responds by producing immunity. So what is done is the creation of artificial immunity against tuberculosis.

The dose of the vaccine is 0.1 ml. This is injected into the most superficial layers of the skin. The usual site is just below the shoulder. Successful vaccination is indicated by a nodule that develops at the site of injection, 10 days to 4 weeks after the injection. Sometimes a small pustule of an abcess may form at the site. If accidentally the injection is given deeper under the skin or into the muscle it may produce an unlcer or wound. At such times the lymph node in the armpit is enlarged significantly.

How much Protection?

B.C.G. vaccination does not give 100% immunity. Also the results vary from the time the injection is given. The protection afforded is 80% over a period of 5 years coming down to 60% over a period of 5 years. This means 60%—80% of the population will be protected against tuberculosis. The protection is equal in both sexes. It gives protection from all forms of tuberculosis. Should infection occur in spite of B.C.G. vaccination, then the disease is of a very mild nature. B.C.G. therefore gives a definite though a partial protection.

It was thought that B.C.G. might give protection against leprosy also in addition to tuberculosis. But this is not proved yet. Now attempts are being made to give B.C.G. and small pox vaccination at the same time. One injection may cover both tuberculosis and small pox.

Who should receive B.C.G.?

The ideal person is a new born child. This child has no contact with tuberculosis and it is safe to give the child B.C.G. immediately after birth. The only precatuion is when the mother has tuberculosis. In such situations B.C.G. can be delayed or a difrent type of B.C.G. can be given. This is the INH resistant B.C.G. This means the bacteria will not be killed by INH. This child, after receiving the vaccination can also be treated with INH without affecting the development of immunity.

In a country like India where the risk infection is high it has been found usefu l to give B.C.G. Vaccination to all below the age of tuberculosis by doing tuberculin testing. But the process was cumbersome and many children were missed. Further it was found that even if the child had primary tuberculosis B.C.G. was not harmful. So all below the age of 15 years can saf ely receive B C.G. vaccinatio n even without tuberculin testing. This is what is called mass B.C.G. vaccination.

In the western countries, where the risk of infection is low, the above does not apply. Here B.C.G. is given only to those in whom the risk of infection is high. This includes close contacts of a person suffering from 'open' tuberculosis, or when a person goes to a country where the risk of infection is h igh.

B.C.G. should not be given in the fol owing situation. When the child is prematurelyborn, when he is of low birth weight, andwhen the children are suffering with skin diseases.

The best example to show the value of B.C.G. is an incident that took place in Denmark during World War II. B.C.G. vaccination programme was being carried out in a school of 300 girls. Initial tuberculin testing showed 100 girls to be positive and 200 negative. Of the 200 girls who were negative 100 received B.C.G. vaccination. The war suddenly intensified, and so the school was closed. Hundred girls missed B.C.G. vaccination.

The next school year the B.C.G. work was restarted. The 100 tuberculin negative girls were again tested. The health authorities were surprised to see that 40 of the 100 girls showed a positive reaction indicating these girls developed infection since the last vaccination programme.

The contacts of these 40 girls were checked. Their teacher had been changed that year. This new teacher had cough during the winter months. She reported this to her doctor,who treated it lightly because he too had a winter cough. The teacher was checked again and the preliminary tests showed her to be all right. But one special test indicated that she was suffering from tuberculosis. She was the cause of infection among the 40 girls who did not receive B.C.G. vaccination.

Unfortunately, in India and other developing countries due to poverty, ignorance and technical and personnel difficulties B.C.G. vaccination has not made much headway. B.C.G. definitely gives protection against tuberculosis and all children below 15 years must be vaccinated.

Courtesy: *HERALD OF HEALTH*

Emphysema: The Facts About Your Lungs

Emphysema is on the increase. In eleven recent years deaths from this disease almost tripled. Over 20,000 die of it every year.

Who Gets Emphysema?

Persons with emphysema are, for the most part, males between 50 to 70 years old. Women get empysema, too, but not as often as men. A very high percentage of the people who have emphysema smoke cigaretees and have been heavy smokers for many years.

How it Attacks?

The thing that usually brings the patient to his doctor is that he has begun to feel short of breath on exertion in the morning or evening or both. He may think he has asthma or heart disease.

Effects of Emphysema

Emphysema may begin with only a slight morning or evening inconvenience in breathing. Next, a short walk may be enough to bring on an attack of breathlessness. It may reach a point where ever breath requires a major effort.

Treatment

Doctors can help emphysema patients live more comfortably with their disease. Different treatments, including antibiotics, help different patients at different times. Under a doctor's care, most patients can get relief from their attacks of breathlessness.

If a man's job does not require heavy physical labour, his doctor will usually say that he can continue to work. It is very important for the patient to stop smoking to help avoid further irritation and lung damage.

People with emphysema, with the help of breathing retraining, carefully selected exercises, and aid in keeping their lungs clear of excess fluids, can learn to make the best use of the breathing capacity they have.

Prevention

Continuing research is being conducted to find answers to many questions about this disease, but doctors do know that cigarettes smoking is a definite cause, and that cutting out smoking can avoid damage for many who would otherwise develop the disease. Controlling air pollution can also help.

Modern medicine can usually slow down the progress of emphysema if patients are treated early. It is always the doctor's immediate concern to clear up any infection or irritation of a patient's respiratory system, because these things set up possible starting place for emphysema.

Courtesy: *HERALD OF HEALTH*

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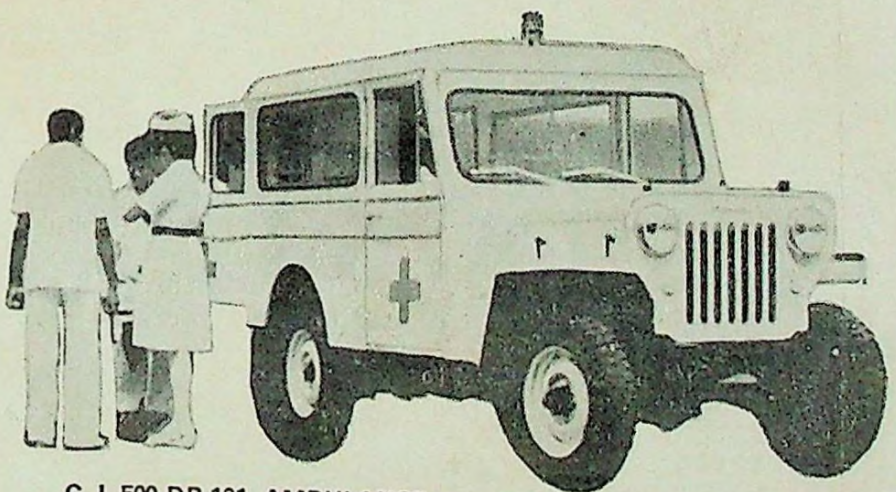

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