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MEDICAL SERVICE

emotions health and behaviour ● the right of wife, children and parents for maintenance ● blood transfusion reactions : role of nursing staff

vol 40 no 7 august 1983

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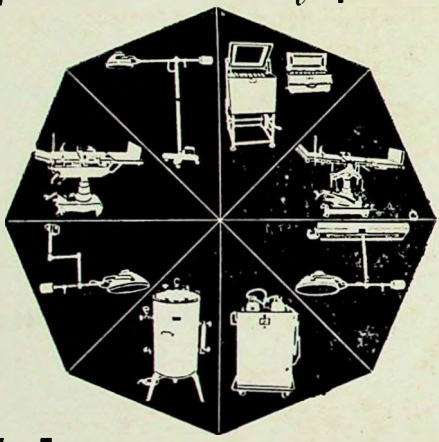

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contents

EDITORIAL

Self-reliance and dependence

Our beloved Father of the Nation, Mahatma Gandhiji, wrote : "Inter-dependence is and ought to be as much ideal of man as self-sufficiency. Man is a social being. Without interrelation with society he cannot realise his oneness with the universe or suppress his egotism. His social inter-dependence enables him to test his faith and to prove himself on the touchstone of reality. If man were so placed or could so place himself as to be absolutely above all dependence on his fellow-being, he would become so proud and arrogant, as to be a veritable burden and nuisance to the world. Dependence on society teaches him the lesson of humility. That a man ought to be able to satisfy most of his essential needs himself is obvious, but it is no less obvious to me that when self-sufficiency is carried to the length of isolating one-self from society, it almost amounts to sin. A man cannot become self-sufficient even in respect of all the various operations from the growing of cotton to spinning of the yarn. He has at some stage or other to take the aid of the members of his family. And if one may take help from one's own family, why not from one's neighbours ? Or otherwise, what is the significance of the great saying "The World is my Family"? (Young India).

Situation in the world we face today is quite different from what was visualised by Mahatma Gandhiji. What we need today is developing of a healthy inter-dependence at all levels. This is not against self-reliance. But on the other hand, it leads to self-reliance, if properly understood and genuinely practised. Man as a social being needs others and the society. But this dependance of man on his fellow beings should be in accordance with a healthy growth process and by maintaining one's own self-respect and self-determination.

Only a selfless inter-dependence can bring about genuine growth. Man's selfishness can hamper this growth and that is what actually happens. If we analyse the situation in the world today, we can easily find that selfishness may be the root cause of all evils. Under such situation, a real inter-dependence at various levels leading to self-reliance becomes difficult. Hence, at various levels powerful groups try to keep the less powerful ones depending on them at the cost of the genuine growth and self-reliance of

the less powerful ones. It is obvious that when Gandhiji spoke of inter-dependence, this is not the type of dependence he visualised. In the type of inter-dependence he spoke of, he upholds humility, mutual respect, mutual assistance, etc., which will lead to the integrated growth of man as individual and in his community, nation and in the world community at large.

In the fields of various services too, this genuine inter-dependence should be maintained whereby, when receiving the services, people can grow in to self-reliance. If we are not careful, our services can lead to paternalism, which hampers genuine growth. Self-reliance, therefore, should lead to inter-dependence and inter-dependence should lead to true self-reliance and genuine growth whereby the world becomes one family !

Announcement

Workshop on "scientific advances of ovulation method" for government/ corporation employed doctors. October 21st to 23rd in bangalore. Free, including subsidised travel. For application form and details, apply to :-

"crest"—centre for research
14 High Street
Bangalore 560 005.

Emotions, Health and Behaviour

G.R. Subbaraman

Feelings and emotions are natural. We enjoy pleasant feelings. Distress feelings upset us. When we are feeling upset our brains don't work as well as they do, when we are feeling good. This is true whether we have just been hurt or whether we have just been reminded of a time before, when we felt bad. Because of this we often do things that don't make sense, that doesn't make things better for us or anyone else. The stored up distress feelings affect our health, lower our ability for coping with the environment and develop rigid patterns of behaviour. This process of damage and loss caused by the distress experiences can be reversed and the lost ability can be recovered. Developing a system for discharging the distress and regaining the natural zest is discussed in this paper.

From the moment of birth we experience feelings and emotions. Some of them are pleasant and wonderful and some are intense and frightening. We enjoy the pleasant ones. They also make others feel good. Grief, fear and anger make people uncomfortable. We are told 'don't be sad', 'be happy,' 'don't get angry,' 'anger will raise your B.P.,' 'it is not nice to be angry,' 'be bold,' 'there is no reason to be afraid' and so on. We learned that while good and pleasant feelings were accepted, approved and sought after, distressing feelings were disapproved and should therefore be avoided. The feelings, however, continued, but with fewer and fewer ways of expressing them. Scientists found out that holding the feelings inside makes people sick and develops rigid patterns of behaviours.

Some such emotions produce damaging tension. They are grief, fear, anger, embarrassment, boredom and physical distress. They are universal. Regina Sara Ryan and John W Travis in their "Wellness Work Book," state, "Hurts, anger, fear, deep sadness-these create an energy which will look for an outlet somewhere in the body, if it doesn't get conscious recognition or expression. Some of those outlets might be :

—a nervous habit such as smoking or over eating

—driving recklessly

—gritting teeth

—'getting' a sore throat or an asthmatic attack, a headache

—an extra rush of adrenalin into the blood stream that makes us feel 'wired

—a stress-related condition such as constipation, skin disorder, eye fatigue or ulcer, or

—building defences, by withdrawl and depression, to keep us from being hurt again."

According to Harvey Jackins undischarged emotional distress is a kind of glue that holds together an inappropriate and repetitive pattern of behaviour like drinking, drugging, gambling, etc., which the individual seems unable to control. The individual holds most of the time chronic feelings such as lonely and not being loved, helpless and timid, hopeless and pessimistic, powerless and dependency and ultimately loses all the initiative.

It is seen that often people with no physical symptoms feel bored, depressed, tense, anxious and generally unhappy. They wonder why their lives are not richer and more satisfying. This emotional state often sets the stage for physical diseases through the lowering of the body's resistance. Harvey Jackins estimates the present day adult man or woman, who everybody thinks doing 'Just fine' is operating on only about ten percent of his or her original resources of intelligence, ability to enjoy other people. The other ninety percent of his/her vast potential is covered by feelings of distress and rigid patterns of behaviour.

90% Inhibited
By Distress Feelings
And Rigid Thinking &
Behaviour

Only 10%
Functioning.

Psychologists realise that emotions by themselves are neither good nor bad, they simply are. It is important to understand that they are not amoral. Without them life will be dull and boring. Any human being is capable of feeling emotions. Becoming aware of the feelings, accepting them as normal and developing healthy ways of expressing them is essential. "Feelings are not to be felt. If they are good feelings, enjoy them, but not be guided by them. If they are bad feelings, feel them and discharge them, but do not be guided by them. Logic should always be the guide. Regardless of how one feels, it should always be possible to determine the right thing to do and do it" suggests Harvey in his book "The Human Situation". The release of emotions calls for reassessment of values and raises questions that might otherwise have gone unasked.

Inherent Characteristics of Human Beings

Now the question arises : What are the natural qualities of human beings ? How do emotions affect them ? Harvey Jackins in his theory of human behaviour postulates that man's essential nature comprises qualities of intelligence, zestful enjoyment of life, loving, cooperative relationships with others, curiosity and communicativeness. Specifically our basic tendency is, to love ourselves and one another, to act rationally, to enjoy what we do, cooperate with one another, explore and discover more above each other and the environment and communicate with one another. All other human behaviour and feelings except this innate characteristics are acquired and not inherent.

What is Intelligence ?

He defines intelligence as the ability to create and use new, suitable, responses to each situation. The intelligence operates by comparing and contrasting new information with that already on 'file' from past experiences and constructing a response based on similarities to a past situation but modified to allow for the differences. Only human beings have this ability to create and use brand new, tailored to fit, response that exactly match and successfully handle each new situation. The behaviour of other forms of life is based on pre-set (instinctive) patterns of response. These patterns are fixed in the heredity of the individual creatures and are very similar to the patterns of other creatures of the same species and the number of available patterns of responses are few and finite. This preset, rigid, pattern of behaviour does not carry high survival value for the individual. It permits the species to survive only in association with massive reproduction rates. The human behaviour is qualitatively different from the behaviour of other forms of life.

The essence of rational human behaviour consists of responding to each instant of living with a response created afresh at that moment to precisely fit and handle the situation of that moment as that situation is defined by the information received through the senses of the person. During a good and ordinary experience we continuously receive great volume of information and this information is continuously and quickly checked against the information already on file. Similarities are noted, differences are noted. A response is put together and handed out in a fraction of a second and the new information has already been cross-referenced and understood.

What Went Wrong

If this description (intelligence, zest, loving and co-operative relationship with others) of what inherent human is like is true and valid, then something has gone wrong. The failures to handle the environmental situation, the terrible feelings which enclose adults most of the time, the miserable relationship that are commonly seen between adults, are all the results of something gone wrong. What went wrong ? How is our inherent nature often fully or partially obscured ?

How Emotions Affect

We get hurt physically and emotionally, from very early in life and repeatedly after – we meet distresses, indifference, frightening events, scoldings, disappointments, obstacles, punishment, ridicule boredom and physical hurts like pain, illness, discomfort, hunger, etc. These are experienced as disturbing emotions such as fear, pain, anger, grief, humiliation, embarrassment, shame, etc. While being hurt our rational intelligence stops functioning. The critical faculty suspends under stress. This in turn slows down the ability to see things as they are and to find new responses. We often hear statements like 'when I am angry, I cease to be man', 'I am so upset, I cannot think' and so on. These are very accurate observations of human behaviour in distress because we cannot think intelligently or clearly, and this is only the beginning of the loss of intelligence. The information input through the senses during distress is recorded unevaluated and un-understood in fact it is a recording of what went on during the distress experience.

During good and ordinary experience the information input is very rapidly checked against intormation on file. Similarities and differences are noted and a fresh appropriate response is put together. The information from a good and ordinary experience is 'filed' discretely what computor people might call discrete bit storage. One can remember one item of information from a distress experience. Besides the sight, sound, etc., re-stimulate the old distress recording. A person in distress or when re-stimulated says things that are not pertinent, does things that are not pertinent, does things that are not sensible, fails to cope with the situation, talks foolishly, endures terrible feelings that has nothing to do with the present.

This irrational behaviour is quite uhlike the creative capable behaviour of a clear thinking person. The brain mis-stores the information recorded during distress along with the negative emotion itself. What is wrong with a particular person is a unique thing, the unique result of the unique distress experience. As a result of repeated experience of distresses most people function on a very small percentage of their inherent capacity.

We have seen how undischarged emotions affect the health and behaviour. What are the natural ways of expressing them ? Is it possible to express them without offending others ? Yes.

The Natural Ways of Expressing Emotions

We are gifted with a natural process of expressing emotions. This process undoes the effects of hurts past as well as present ones. The outward manifestations are very familiar to all of us and every one of us has experienced and observed them. A child after being hurt will cry loudly if permitted to do so and thereby recover from the hurt very quickly. After being frightened a child will scream, and shake and perspire. After being angered, a yelling, vigorous tantrum will result. A child given friendly attention after an embarrassing situation will talk and laugh about the experience spontaneously until the embarrassment is dissipated. The expression of emotions takes place by one or more sets of physical processes, such as crying or sobbing, trembling with cold perspiration, laughter, angry, shouting and violent movements (tantrum), with warm perspiration, interested non—repetitive talking and yawning often with scratching and stretching. These are the ways by which human beings release tensions. Harvey Jackins termed them 'discharge'.

During discharge the residue of distress experiences is being recalled and reviewed (not necessarily with awareness). Rational evaluation and understanding of the information received during the distress experience occurs spontaneously following discharge. It occurs only to the degree that discharge is completed. On completion, the negative anti-rational effects of the distress experiences are totally eliminated.

What Keeps The Discharge Process Operating?

There is a fundamental mistake in our interpretation of these discharges. Tears are mistaken for grief, trembling for terror, angry shouting for anger, etc. Crying never occurs unless a person needs to cry because tears free oneself from grief. Similarly, trembling and cold perspiration releases oneself from terror, angry shouting from anger; laughter from irritations. In early childhood all of us were discharging in the spontaneous ways. Immediately after the distress experience or at the first opportunity thereafter a distressed person would normally seek the attention of another human. If he is successful, the process of discharge occurs. Unfortunately the sound of crying stimulates the distress of the other and this interrupts the discharge. In early life children are told 'shut up', 'be a good boy', 'are you a girl', 'don't be a coward' etc. Thereby unawarely interrupted the natural healing process. Cultural and social organisations also play a part. In many cultures the expression of grief and fear by males is strongly discouraged, but there is a tolerance of expression of anger and laughter. The customs for females are quite different. The expression of anger is severely punished, laughter is suppressed, but expression of fear and grief are appreciated.

As we experience frequent external interruptions of discharge, we learn to interrupt them ourselves to avoid the unpleasant reactions from others. Repeated attempts of controlling discharge virtually become automatic. We become conditioned to limit or extinguish discharge entirely so that this self-induced interruption of expressions of emotion becomes a pattern.

Now we have learned that suppressing emotions, judging or repressing them, or running away can only be harmful to a person. So we look for suitable and acceptable means to discharge them. For discharge to occur one needs attention of another human being. It is our nature to release our tension, to turn to another person so to release hurts from our system. Every day,

everyone of us, in some way or other, tries to reach out to find a listener to be listened to. We are seldom listened to because of the international pressure of the other to talk himself or our distressing events re-stimulate the other and is likely to break in.

Co-Counselling

Remarkable changes can take place in a person who is being listened to. It is preferable that two people agree to take turns to listen to each other. 'Yes, I will listen to you and really pay attention to you for a while, if you in turn, will do the same thing for me'. This taking turns is called co-counselling. Here the word counselling does not mean giving advice but means basically listening and paying attention. Two people take turns counselling and being counselled sharing equal time. The one acting as a counsellor listens, pays attention, draws the other out, permits, encourages and assists emotional discharge. The other acting as a client discharges without fear of being judged, without worrying of what is being said is taken for granted and becomes free of the rigid patterns of tension and behaviour.

Balance of Attention

Discharge takes place only when the client's attention is balanced between the past distress and the present time. If the client is engulfed in the past distress, he will become so involved that he is unable to discharge it. To ensure this balance the counsellor gives his total attention and encourages the client to give him at least a part of his attention too.

Creating Safety

A feeling of safety is promoted by the correct attitude of the counsellor. He should always hold positive attitude about the loving, zestful, intelligent, co-operative nature of people. A counsellor with this attitude takes very different course of action than one with negative attitude. He draws a clear distinction between the person as being basically good and wholesome and the distress pattern, which shows him in a bad light but which is actually a foreign element like a parasite in his personality. By making this distinction one avoids the common mistake of being critical and negative. The counsellor must consistently and openly appreciate the positive traits of the client and helps the client to maintain a similar attitude towards himself. Such an attitude gives self-confidence and encourages the client to move in a positive direction and contradicts self-disparaging statements. The counsellors should avoid interpretation, advice, comparison or suggestion regarding the problems of the client. Solutions are no good, unless the client has worked them out himself. The counsellor maintains a warm accepting attitude towards the client, a genuine interest and relaxed concern. Whatever is shared by the client is absolitely confidential and should never be talked out.

Overcoming Control Patterns

Sometimes the lack of discharge may be due to control patterns. From our earliest years, we are admonished to stop crying, screaming, shaking, raging, etc. As a result we have learned to control the discharge. A client may hook his feet tightly, grip the arm of the chair, bite the nails, etc. The counsellor should insist on that person to uncross his feet, swing the arm in a relaxed manner or contradict the distress with proud posture; discharge will begin as rigid controls are interrupted.

Goals of the counsellor

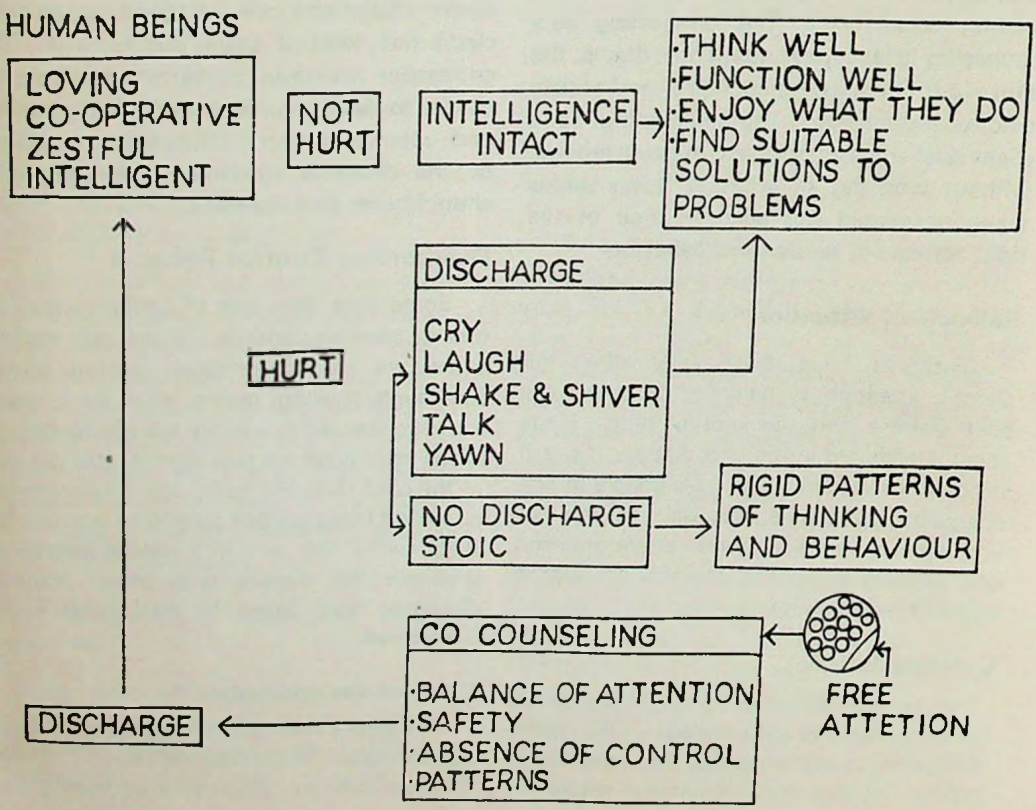
The goal of the counsellor is that of freeing the client from his distress. The only effective means of doing so is by helping the

client to discharge the painful emotions or tensions.

The first and the most important thing for the counsellor to do is to listen. Listen with full attention and interest. This will encourage and enable the client to talk about himself, about his patterns of distress. He may relate them in terms of difficulties or experiences that occurred to him. The counsellor may at times direct the client's attention to the distress when the discharge slows down or stops. The counsellor can give his full attention to the client only when he himself gets counselling and discharging. Otherwise the counsellor will often be re-stimulated by the client's distress and his attention is interrupted.

Re-evaluation

With the discharge of emotional feelings, information and cognitive process associated with the distressing event return to awareness. The distressing feelings and the information contained therein are reassessed and re-evaluated. Therefore it is called re-evaluating co-counselling. The discharge results in increased rationality, freer attention, alertness, openness to new experiences, insight and behaviour change. The individual exercises greater dominance over feelings and behaviour. With frequent discharges on different distresses, he enjoys the freedom to experience a rich variety of alternatives and makes the most rational choice among them. Each gain in rationality is a gain in



the enjoyment of living. Relationship with other people becomes enjoyable and reproductive.

Any two persons can team up together to help each other in freeing from the distress feeling and rigid patterns of behaviour left by hurt experiences of the past. We c an also integrate this Re-evaluation Counselling process in our personal, family and work situations and exchange effective assistance.

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Question Box

When problems are mounting every day, it is not possible to deal with all of them in a magazine like ours. However, there may be cases in which one would like to get some help and guidance quicker and even personally. With this in view, we have introduced a Question Box in our magazine. Your questions and doubts on health matters can be sent to this question box and you will get an answer directly or through the column of Medical Service as early as possible. A panel of doctors will deal with the questions, and answer will be given accordingly. Please clear your doubts through this question box.

Please write to :

Question Box, Medical Service
c/o Dr. Paul Neelamkavil
Dept. of Dermatology
St. John's Medical College
Bangalore 560 034.

LEGAL EDUCATION—2

THE RIGHT OF WIFE, CHILDREN AND PARENTS FOR MAINTENANCE

P.D. Mathew

The Right of Maintenance

Chapter IX of the Code of Criminal Procedure 1973 (i.e. Sections 125 to 128) deals with the order of a Judicial Magistrate for maintenance of wife, children and parents, who are wilfully neglected by the husband, father or sons. Section 125 confers a statutory right of maintenance to wife, children and parents and imposes a legal obligation on husband, father or sons. This right was formerly enforced through a civil suit in a Civil Court. Now it can be enforced through an application for maintenance in a Criminal Court. The rights conferred by these Sections are statutory rights independent of and uncontrolled by the personal law of the party. These Sections provide a quick remedy for neglecting and refusing to maintain dependent wife, children and parents, who do not have sufficient means to maintain themselves.

Provisions of Section 125

1. Any person having sufficient means has a legal obligation to maintain :

   a. his wife, unable to maintain herself, or

   b. his legitimate or illegitimate minor child, whether married or not, unable to maintain itself, or

   c. his legitimate or illegitimate child (not being a married daughter) who has attained majority, where such child is, by reason of any physical or mental abnormality or injury unable to maintain itself, or

   d. his father or mother unable to maintain himself or herself.

2. The Magistrate of the first class can order such a person to maintain his wife, children or parents and to make a monthly allowance for their maintenance.

3. The monthly rate of maintenance allowance ordered by the Magistrate must not exceed Rs. 500 on the whole.

4. The Magistrate must satisfy himself of such neglect or refusal by collecting adequate proof through court proceedings.

5. The Magistrate may order the father of a minor child referred to in clause 1 (b), to make such an allowance until she attains her majority, if he is satisfied that the husband of such a female child does not have sufficient means to support her.

From what date such allowance to be paid ?

Maintenance allowance may be payable from the date of the order, or if so ordered, from the date of the application for maintenance.

Explanation

1. *Sufficient Means* : The term means sufficient property or definite employment, and includes a capacity to earn money. An unemployed able bodied man who is suffering from no infirmity is presumed to have sufficient means to support his family.

2. *Neglect or refuse to maintain* : It may be expressed or implied. The court may infer neglect from the conduct of the person. The neglect or refusal must be present. A mere

offer to maintain in the future is not sufficient.

3. *Maintenance* : It means food, clothing and lodging and expenditure for the education of the child.
4. *Wife :* To justify an order under this action the applicant must be the legal wife. A concubine or a mistress is not entitled to maintenance.
5. *Child* : The word 'Child' in Section 125 is used with reference to the father. There is no qualification or age; the only qualification is that the child must be unable to maintain itself.
6. *Unable to maintain itself :* It means unable to earn complete livelihood for itself without depending on any other person.

What is the nature of the Order ?

* The order must be for a monthly payment in money only.
* It can be against the husband, father and sons only.
* The order can be issued to the husband or father or sons only if they have sufficient means to pay the amount.
* The rate of the sums awarded must be a fixed amount, but it can be altered from time to time by the Magistrate.
* The maximum maintenance allowance that can be awarded is Rs. 500/- only.

Justifying grounds of wife's refusal to live with her husband.

Adultery, cruelty, apostacy, a second marriage of a Christian or a Hindu husband with another wife and irremediable breach between the husband and the wife are good grounds for the wife's refusal to live with her husband. If she leaves her husband's house without a justifying cause, she is not entitled to the relief.

Order when not made or cancelled

A wife shall not be entitled to maintenance in 3 cases, viz :

1. If she is living in adultery, or
2. If she refuses to live with her husband without sufficient cause, or
3. If they are living separately by mutual consent

* On proof of any of the above three grounds, the order will be cancelled by the Magistrate.
* The above cases serve as a defence for the husband, if his wife proceeds against him for maintenance.
* Section 127 also provides for the cancellation of the order where it appears to the Magistrate that, in consequence of any decision of a Civil Court, his own order should be cancelled.

When can the order be altered ?

The Magistrate may alter the allowance if circumstances of either party change, provided the monthly rate of Rs. 500/- is not exceeded (Section 127).

What is the durability of the Order ?

The order remains in force until it is either modified or cancelled. The mere fact that the wife has returned to live with her husband does not nullify the order automatically, and on her separation she can again enforce the order.

In which court should such proceedings be instituted ?

Proceedings under this Section may be instituted against any person in any district—

a. where he is, or
b. where he or his wife resides, or
c. where he last resided with his wife or mother of the illegitimate child.

* If he has a permanent residence, the Magistrate of that place has jurisdiction.
* If the parties have no fixed place of residence. the Magistrate within whose jurisdiction they last resided (even though temporarily) has jurisdiction.

Evidence and procedure (Section 126)

* All evidence in maintenance proceedings shall be taken in the presence of the husband of the woman or the father of the child and his pleader and recorded as in a summons case.
* If the respondent (the husband or the father) wilfully avoids service or wilfully neglects to attend the Court, the Magistrate may hear and determine the case *ex parte* (in the absence of the opposite party). Any order made *ex parte* may be set aside, for good cause shown on application within 3 months from the date of the order.
* The Court may also make an order as to the costs.
* An application for maintenance is not a 'complaint' but a 'petition.'
* Since refusal to maintain is not a criminal offence, maintenance proceedings are not a trial of offences. So the husband or the father is not considered an accused but a respondent.
* The respondent may offer himself as a witness and give evidence on his behalf.
* The proceedings resemble very much a civil suit in nature.

Is there any appeal against the Order ?

There is no right of appeal from an order passed under Section 125. The aggrieved party may move the higher court in revision. The higher court has jurisdiction to set aside or modify the Magistrate's order in revision.

How is the order enforced ?

The Magistrate may (if the person so ordered fails without sufficient cause to comply with the order) for every breach :

a. issue a warrant for levying the amount due (in the same way as in levying fines) and
b. sentence the offender to imprisonment for not more than one month for the whole or any of each month's allowance remaining unpaid after the execution of the warrant.

* A Warrant will not be issued for recovery of an amount due for maintenance unless application is made to the Court within one year from date when it became due.
* A copy of the order of maintenance must be given free to the applicant and it may be enforced by any Magistrate in any place where the respondent resides.

Civil Suit

The wife or a child or parents have another remedy to secure maintenance. It is a suit in a Civil Court, in which a decree may be obtained for an amount commensurate with the status and means of the party liable. Even the arrears of past maintenance can be recovered in the suit.

An order passed under Section 125 is no bar to a suit for maintenance in a Civil Court. A decree for maintenance passed by a Civil Court which cannot be enforced on account of insolvency of the husband, is no bar to proceedings under this Section.

For Further Information in Legal Matters Contact :

Director, Legal Aid
Indian Social Institute
Lodi Road, New Delhi 110003
Tel. 622379, 624760
Gram : INSOCIN

Blood Transfusion Reactions
Role of Nursing Staff

— Miss Amrit Varsha, Dr. R.S. Dahiya

With the advance in the management of various medical problems, either surgically or medically, the transfusion of blood has acquired a greater importance in our country and the world as a whole.

According to various surveys conducted, two per cent of all blood transfusions are accompanied by unfavourable reactions. Recently, we have observed haemolytic jaundice in many patients after blood transfusions in postoperative period. In two patients, it proved to be a fatal outcome in the surgical ward. This has prompted to study the various blood transfusion reactions in detail and give a comprehensive account of each.

The main complications from blood transfusions are: A. Haemolytic reaction. B. Allergic reactions C. Bacterial reactions. D. Febrile reaction. E. Circulatory overload F. Embolism. G. Transfusion of infectious agents, hepatitis, malaria and syphilis.

A. Haemolytic Transfusion Reaction:

It is one of the most severe complications of blood transfusion therapy, cause being donor-recipient ABO incompatibility. The cause may also be Rh incompatility, but it is not so severe. Factors which may contribute for this are: 1. Improper storage of blood. 2. Faulty blood transfusion procedures.

When a haemolytic reaction occurs, the agglutinated cells, after the reaction of antigen and antibodies in recipient plasma and donor cells, block the capillaries, thus resulting in obstruction to blood flow to the vital organs. It may ultimately lead to renal failure.

Prevention

1. Evaluation of the potential donor should be done properly. He should be free of colds, allergies, hepatitis and syphilis. 2. There should be proper check on the patient and the blood product. 3. There should be a double check of all the blood products with another nurse or health personnel. 4. The intravenous tubing must be flushed with isotonic solution before and after the blood is administered. 5. After starting blood transfusion, remain there with the patient for 15 mts. The severe reactions due to blood transfusion tend to begin soon after initiation of blood transfusion. 6. The infusion should be started at a slow rate to begin with. 7. The patient should be encouraged to call in case even unusual feelings or symptoms occur.

Signs and Symptoms

1. The onset will be immediate. 2. Patient will have facial flushing. 3. Will report burning sensation along the vein. 4. Patient will have fever with rigours and chills. Temperature may be 105 degree or more. 5. Rapid and laboured respiration will be complained of by the patient. 6. Patient will complain of chest pain. 7. Low back pain. 8. Headache may also ensue. 9. Ultimately the patient will go in shock.

Intervention by a Staff Nurse: The transfusion should be immediately stopped. 2. Recheck blood slip with unit of blood and patient to determine if there is any error

made. 3. Inform the doctor on duty. 4. Treat shock if present by giving nasal oxygen, fluids and epinephrine as ordered by the doctor. 5. Obtain two blood samples from a vein which is at a distance from the site of infusion. One samble is sent to the blood bank along with the bottle of the blood transfused and other may be centrifused (Pink plasma indicates haemolysis). 6. Obtain first voided urine to test for haemoglobinuria. If it is present, the specimen may be red or black. 7. When renal involvement is suspected, then prompt treatment with mannitol is initiated so that diuresis is there to avoid renal tubular damage. 8. The fluid balance should be monitored.

B. Allergic Reactions: Allergic reactions are thought to be related to the presence of substance that are capable of interacting with antibodies present in the donor or recipient blood plasma.

Prevention

1. Health history is important to be asked before the blood is transfused. It is important to elicit information about any previous transfusions and more specifically about any allergic reaction to transferred blood. 2. Administer antihistamine, e.g., Inj. Avil 15-20 minutes before starting the infusion.

Signs and Symptoms: 1. Dyspnoea, 2. Urticaria, 8. Facial and or glottal edema, 4. Asthma, 5. Pulmonary edema 6. Anaphylaxis.

Nursing Intervention: 1. Stop transfusion immediately. 2. Inform the doctor on duty. 3. Treat the life threatening reactions (edema and anaphylaxis). 4. Administer antihistaminics parentrally. 5. Administer corticosteroids parentrally.

C. Febrile Reactions: These reactions occur more frequently when equipment is reused, e.g. glass collection bottles, tubings, etc. The toxic substances in blood tubings and bacterial proteins are among the offending agents. Now with the invention of disposable equipment, this possibility is rare. However, febrile reactions do occur. The explanation for this seems to be the presence of antibodies directed against leucocytes. Another explanation in developing countries may be ill-equipped hospitals and ignorant paramedical staff.

Prevention: *1*. The patient should be informed during transfusion about this. 2. Administer antipyretics to persons who are known to have this reaction. 3. Transfusion with frozen washed packed cells may prevent this reaction. 4. See that the disposable, properly sterilised equipment is being used for transfusion.

Signs and Symptoms: Febrile reactions are characterized by : 1. Chills and fever that occurs an hour or more after the transfusion. 2. Headache, tachycardia and general discomfort may be present. 3. These symptoms may persist for 8-10 hours.

Nursing Intervention: 1. Discontinue the infusion of blood and notify tne physician immediately. 2. The blood should be senk back to laboratory for re-examination for type and cross match as well as culture and sensitivity. 3. Treat the febrile reaction manifestations symptomatically.

D. Bacterial Reactions: These are caused by the transfusion of contaminated blood products and may prove fatal if not treated at once. The organisms which are commonly responsible for such type of reactions are: Pseudomonas, Coliform, Achromobacteria.

These bacteria liberate endotoxins. These reactions are very rare otherwise.

Prevention: 1. Asceptic collection technique should pe used. 2. Change transfusian equipment frequently. 3. Do not keep the blood at room temperature unnecessarily. 4. Do not use blood that has been heated to above room temperature. 5. Do not prewarm infusions. 6. See for any haemolysis in the blood to be transfused.

Sign and Symptoms: There will be fever. 2. Hypertension which is very severe. 3. Pain in abdomen and peripheral parts of body. 4. Dry, flushed skin, 5. Vomitting. Bloody diarrhoea may be there.

Intervention by Staff Nurse: Stop transfusion immediately and inform the doctor concerned if available. 2. Start broad spectrum antibiotics as directed immediately by the most rapid mode of administration. 3. Treat the bacteraemic shock. 4. Maintain the vital signs, fluid and electrolyte balance.

E. Circulatory Overload: Circulatory overload occurs when the blood or packed cells are administered too rapidly for the individual's cardiovascular system to respond to the additional volume.

Prevention: 1. The packed cells should be given to persons susceptible to circulatory over load, e.g. infants, elderly patients with cardiac or respiratory diseases. 2. There should be slow infusion with the patients in a sitting position. 3. J.V.P. and C.V.P. must be monitored.

Signs & symptoms: 1. Tightness in chest. 2. Laboured breathing. 3. Dry cough. 4. Crepts at the base of lungs. 5. Pulmonary oedema. 6. Tachycardia.

Intervention by a Staff Nurse: 1. Stop or slow transfusion, depending on severity of symptos. 2. Prop up the patient. 3. Vital signs are to be monitored. 4. Administer diuretics as ordered.

F. Air Embolism: The incidence of air embolism has been reduced by the use of plastic bags, but air may be introduced if the tubing is changed during the transfusion. Shock and cardiac arrest may ensue.

Prevention: 1. Avoid air into the infusion system; 2. If air is introduced, stop the infusion.

Signs and Symptoms: 1. Dyspnoea. 2. Cyanosis. 3. Shock. 4. Cardiac arrest.

Intervention of Nursing Staff: 1. Lower the head of the patient and turn the patient on left side. The air will collect in the righht atrium where it can be gradually released to the lungs. 2. Treat shock. 3. Treat cardiac arrest if it occurs.

Follow-up of the Cases

1. The nurse should advise the patient who has experienced a transfusion reaction to relate this information to other nurses and physicians. 2. Measures to maintain a positive state of health should be taught to the patient who has a chronic disorder which requires periodic transfusion. 3. The patient should be advised to keep a neutral or written record of this and any other transfusion reaction. 4. It is also important to teach patients their blood groups and Rh types so that they too can be observant and knowledgeable during any future transfusions.

—courtesy The Nursing Journal of India

Kerala Social Service Forum and CHA-Kerala Unit

Inauguration of the Office
May 9, 1983

The long cherished idea of having a permanent Centre for the Kerala Social Service Forum was realized on May 9, 1983, when Rev. Fr. P. Remigius, Executive Director, Caritas, India, lighted the traditional Oil Lamp to inaugurate the office of the Forum at Sivarama Menon Road, Pachalam, in Cochin City, Kerala. Rt. Rev. Msgr. Peter Chenaparambil, Diocesan Director for Social Action and Bishop-elect of Alleppey, blessed the building. The Most Rev. Benedict Mar Gregorios is the Chairman of the Forum. Fr. Remigius in his Inaugural address explained the real meaning of "Development". He stressed the need for joint planning and action in the field of development.

The Office of the Catholic Hospital Association of India—Kerala Unit also will function in this new building.

A business meeting was presided over by Rt. Rev. Msgr. Peter Chenaparambil. The members of the Forum discussed ways and means to co-operate with the subsidised and aided self-help rural housing scheme for the economically weaker sections in the rural areas, Sponsored jointly by the Govt. of Kerala, the HUDCO, New Delhi, the Kerala State Housing Board and Voluntary Agencies. The proposed housing project envisages the construction of one lakh houses, each costing about Rs. 6000/—by the beneficiaries themselves, in sites owned by them, using low-cost methods with locally available building materials. Technical guidance and assistance will be given by the Kerala State Housing Board.

The group decided to study the project further. At the same time it was proposed to take up the construction of 15000 houses all over Kerala for the economically weaker sections in collaboration with the Govt. The group authorised the Executive Secretary to prepare a project to Caritas India, with the hope of getting a subsidy of Rs. 1000/—per house. Rev. Fr P. Remigius, the Executive Director, Caritas, India, who was present at the meeting, promised all possible help for this joint venture of the Forum.

Hospital Sunday Celebration 1983- more reports

Catholic Mission Hospital, Kalunga, Orissa : The celebration commenced with solemn Holy Mass by His Lordship Bishop Alphonse Bilung, SVD. There was a large gathering of people from the villages and also patients present on the occasion. In his Homily, His Lordship mentioned a few words about the celebration of Hospital Day and the theme 'Respect Life. After the Holy Mass, refreshments and sweets were distributed to the patients. The last item was a good film show which all people enjoyed.

St. Xavier's Hospital Vinokonda, Nirmalanagar, Guntur Dist., A.P. : The day was initiated with a High Mass. The celebrant based His Homily on the healing mission of

Christ the Eternal Physician. Fr. Sathyanandam gave an inspiring speech, elucidating the value of the gift of life and how an agent of destruction of this precious gift, causes havoc in human life. Dr. Devaiah spoke on how to protect life through proper health care. Sr. Ignatius brought out the value of human life and the role of the mother in the protection and growth of life. It was a day of inspiring, instructive and enriching experience for one and all.

St. Joseph's Hospital, Nellore, A.P : The celebrations commenced with a special prayer service in which all the hospital staff and patients participated and offered prayers of praise and thanksgiving and invoked God's blessings on the suffering and the sick. This impressed the people very much. The importance of the day was made known to all the patients and the hospital staff were instructed on the necessity of re-dedicating themselves to the cause of the healing ministry which takes its origin from Jesus Christ, our Divine Physician. The whole staff was imbued with renewed vigour, enthusiasm and energy for serving the suffering to the best of their ability. In the evening, a Holy Mass was celebrated in the hospital premises with selected reading for the occasion. All the patients, staff and guests participated in the Holy Mass and were privilleged to be filled with the spirit of the Lord. An apt homily was preached by the celebrant and many people present were fortunate to hear the word of God for the first time in their life.

March 27 was set apart as a day of free service to all the deserved patients who came to OPD. Medicines were also given free of cost. About 200 deserved old persons were given free meals which was very much appreciated.

St. Joseph's Health Centre, Lourdepuram, Trivandrum : All the inpatients and MCH mothers were also invited for the celebrations. The Indian Lamp was lit to inaugurate the function with a small liturgical service. There was a drama depicting the importance of the hospital day celebrations. The main message was 'Respect for Life'. The importance of not making any difference between male children and female children as well as the evils of abortion was impressed on all who were present.

Good Shepherd Health Education Centre. Coimbatore : As it was a small dispensary, the Hospital Sunday was celebrated in a humble way. People from the village and the parishioners were invited. After the Mass, all assembled in front of the Good Sheperd Statue. There was a prayer song followed by selected readings from the Bible. Then a passage on the evils of abortion was read which appealed to and enlightened the people who were present. Sweets were distributed at the end of prayer meeting.

St. Mary's Dispensary, Manavanallur, Thanjavur, Tamil Nadu: There was a good response for the celebration of the Hospital Sunday. Sr. Mary gave a talk about the moral, spiritual, physical and psychological evils of abortion. With forceful examples of harm, evil and death suffered by people in surrounding areas who resorted to abortion. The people in this area live close to nature.and nature's way and do not go in for abortions despite inducements. Euthanasia is not heard of at all and no one has recourse to this.

Our Lady of Health Dispensary, Pudukkottai Dist. : The celebrations started in the morning with the Holy Mass and all the prayers and Hymns were concentrated and prepared around the theme "Respect Life". In addition to fancy games which were enjoyed by all the people, an exhibition was arranged on the topic "DO YOU KNOW" explaining to the people the various stages

of human growth from conception by means of posters and drawings. To many of those who were ignorant it was a revelation and they were astonished by the new knowledge they got.

In the evening there was a public meeting which started with a beautiful prayer song. There were some special items which were exclusive for Tamil culture such as Kummiyadi and Villuppattu. A small skit on 'ABORTION IS A MURDER' was also staged; it was a bit jovial but at the same time it made the people to think a little.

Mr. Chandrasekar who presided over the function then delivered his speech. He explained how we in India give less importance to human life and give more importance to things unlike in other countries. After the speech, prizes were distributed and the celebrations concluded with a film show.

Community health worker's training, a new vision of the Diocese of Dumka

Introduction

This report is about a simple and significant event that has recently taken place in our diocese. The first session of the Community Health Worker's Training Programme was held at St. Joseph's Convent, Cilimpur, from 13th to 26th March.

This training course is, in many ways, a point of arrival, the result of a long process of evaluation, rethinking and reorientation of the diocesan health apostolate.

The present situation

The medical field has always been given priority among the various forms of charitable works, and much time, energy, finance and sacrifice have gone into the effort of looking after the sick and bringing relief to the suffering. Most of this work was done on an individual basis, each congregation running its own dispensary with often just one Sister-Nurse as suming total responsibility. But returns have been too poor for the resources invested. True enough, many persons have been treated, and individuals—heads of families and mothers—are alive and looking after children who otherwise would have been left orphaned. Most of us cherish touching incidents of lives saved by our timely intervention and God's grace. All this is good and we are thankful for it.

But the impact made so far on the health level of the people in general is negligible. We have no precise data or statistics to help us in our evaluation. But we know that infant mortality rate and maternal mortality rate are still far too high and the incidence of communicable diseases like TB and leprosy have hardly been affected. A supply of safe drinking water is still a dream for many, and the idea of using latrines to improve environmental sanitation and prevent disease has still to dawn.

Our people are ignorant of the real causes of disease, and seek help from traditional healers whose main concern is that of making money. They put up with sicknesses that could be relieved with simple inexpensive remedies, and go for professional treatment only 'in extremis' and often when it is too late. In short they have still to be awakened to the fact that health for all is a right which can be achieved if we all work for it together.

Preparatory activities

In August, 1979, at the invitation of our Bishop, Telesphore Toppo, a team of two consultants from VHAI spent a few days in the diocese to assess the health facilities of the area, analyse the actual situation and help

the diocese in further plans of health programmes. This study, made by Dr. K. Cherian and Ms. Simone Liegeois, was followed by a seminar for the Health Personnel of the Diocese, held at Cilimpur, where the report was discussed.

In September, 1981, another meeting of the Health Personnel was held at Bishop's House, to find ways of involving village people in preventive and promotive health care. The subject of Community Health Care was brought up again at the Development Orientation and Motivation Seminar held at Jisu Jaher in April 1982. And in September, 1982, a team from CHAI, Sr. Marina and Miss Lovely, conducted a seminar for Health Personnel at the Social Development Centre, Dudhani.

During this seminar, the diocesan approach to health care, and the Community Health Programme were presented to the participants and a Diocesan Health Animation Team was formed. The decision was taken to divide the Diocese into five Health ones with Centres at Guhiajori, Cilimpur, Sohorgati, Jamtara and Mariampahar, and to train village women as Community Health Workers to be placed under the supervision and co-ordination of their respective Health Care Centres.

The Trainees

The selection of women for training was entrusted to the parish priests and Sisters who had most contact with the villagers. The number of participants was to be limited to 30; so each parish was asked to send 3 women. It was thought preferable to choose them from those villages where conscientisation, primary education and other programmes for development were already in progress, so that health could take its proper place in the plan for integrated development. Other criteria given for selection were that the women should be married, with children over the toddler stage, of good reputation and acceptable to the village community.

And so, on Sunday 13th March we found ourselves welcoming a miscellaneous group of women, 25 in all (4 of them from a neighbouring diocese), ranging in age from 20 to 50, all married except one. Two of them had brought their youngest child with them as they could not leave them alone at home, and they proved to be very useful especially during the food preparation demonstrations.

The women varied in their abilities, background, etc., but they had several things in common. They were all full of enthusiasm and goodwill, eager to learn as much as possible so as to be of service to their fellow villagers, and ready to sacrifice themselves to achieve this aim. This was shown by the fact that they left their families for a fortnight and faced the difficulties of a journey to a place they did not know, many of them walking many kilometres to reach Cilimpur. During the course itself they made great efforts, studying during their free time, asking us for notes and more classes : "We have so little time and so many things to learn". And all this with no prospect of reward or remuneration because their service is to be on a voluntary basis and they were aware of this.

All this was a great encouragement to us, so that we too made an effort to give them of our best.

The Training

This was a matter of learning with them, getting to know them and the village situation from them, and selecting the material most suited to their needs and the teaching methods that fitted their abilities.

The training itself was conducted by a team consisting of Sr. Grace, S. Crescenzia

and Sr. Catherine from Cilimpur, Sr. Bernard from Guhiajori; Sr. Marina from CHAI and Ms. Marcette from SDC were Resource Persons. There was a basic syllabus to follow, but the programming was done on a day-to-day basis, taking into account what had been achieved during that day, and our growing understanding of their abilities and needs. Sr. Marina's role was that of giving the right orientation, advise about the content and help with the ongoing evaluation. The classes, demonstrations, etc., were given by the Sisters from Cilimpur, who already had considerable experience in training village women for MCH programme.

The classes were prepared on the preceding evening. The teaching medium being Santali, which Sr. Marina and Ms. Marcette do not follow, it was necessary to ensure in advance that the instructors, only one of whom is a qualified nurse, understood clearly the content to be delivered to the trainees.

In this way, the team itself grew in knowledge and experience through the contribution of each of its members, and the hesitation and apprehension with which we had approached the task have been replaced by confidence, and an eagerness to repeat the training for new Health Workers.

A point worthy of mention was the presence of two observers to the course, Sr. Sheela and Sr. Alyamma. Both of them had trainees for their Health Centre at the course, and both found that attending the course had given them a good insight not only into the training itself but also into what they could expect of their Health Workers and what they could do to support them.

It is hoped that during future training programmes. Other sisters will come as observers at least for a few days. This helps to start the relationship between the Sister and her collaborators. Moreover it is planned that eventually these training sessions will be conducted in the respective Health Centres, and so it is good for the Sisters to acquire experience of how the training is carried out.

As will be seen from the report, various methods were used to convey information to the trainees and to show them how to transmit it, in turn, to the villagers. Teaching was done with the use of flash cards and flannel graph, demonstrations, practice sessions and slide shows. The women were made to take an active part through role plays, cooking demonstrations, discussions, etc. We found that while they are good at reproducing what had just been taught to them, their memory power is limited and a lot of repetition is needed to fix the knowledge in their mind. So, various ways of having them repeat the same information were exercised, such as making them give class with the use of flash-cards, role plays and other methods mentioned above.

This variety, together with song, an occasional dance, and chatting with the women, helped to maintain a cheerful, relaxed atmosphere which is congenial to learning. The participants were all satisfied and happy with the training, and eager to start applying their newly-acquired knowledge.

And this is where the Training Course can be considered as a departure point.

Looking forward

Health care in our Diocese is taking a new turn. These women are being prepared to promote health and prevent sickness in their villages, and alleviate illness by simple means, where possible. But their training being an ongoing process, their knowledge has to be reinforced and their mistakes corrected. They also need support, encouragement and an occasional push.

It is the Sister-in-Charge of the Health Centre Dispensary who is in a position to fulfil this role, through regular meetings with her Health Workers and visits to the villages.

These matters were discussed during the meeting of Sister-Nurses held at Cilimpur during the last three days of the Training Course. The diocesan plan was outlined and a programme drawn up for the next year. The Central Health Team will do its best to give the necessary help and support to the Sisters so that the plan can be put into effect.

This report is itself an effort in this direction. It is written mainly for those Sisters who could not be present during the training course so that they can have a written account of what the Health Workers have learnt and what is expected of them. The narrative form of the day-to-day report has been adopted to give the readers an insight into the dynamic process of the training : the growth in mutual understanding, leading to a better appreciation of these women's abilities and limitations, and a greater respect and love for them. It is hoped that the Sisters will enter into the same spirit, and continue to reinforce the teaching that was given to the Health Workers.

There may be other remedies useful in the treatment of common ailments, and other methods of dealing with particular situations, but we trust that the Sisters will use only what is written here. Moreover, what they practise in the dispensary will be in keeping with the basic principles of our new approach. This will avoid confusion and accelerate the reorientation proeess. The Health Workers have asked for some notes on the diseases and the remedies for them. This is being prepared in Santali, and the English version of it will be published later.

The last part of the report contains an account of the decisions reached at the Sisters 'meeting and the diocesan plan of action, and also the words spoken to us by the Bishop when he came to visit us at Cilimpur.

Word of Thanks

It is natural that at this point our hearts are filled with gratitude for all that has been achieved so far. In this spirit I would like to express a word of thanks to Bishop Telesphore for the vision he has presented us with; to Fr. Richard for his faith and determination which conceived the plan for health apostolate and brought it to light, and for his encouraging presence during the course; to the Superior, Sr. Guglielmina, and the Community of St. Joseph's Convent, Cilimpur, for their hospitality and indispensable help; to all the Sister-Nurses in the Diocese, to the Health Workers, and to all the people with whom we are working and will work to build a better, healthier community worthy of human dignity.

A blossom is opening out, and is entrusted to us to nurture that it may flower and bear fruit.

To the Lord from whom all good things come we raise our prayer of thanksgiving. May He bring to completion the work He has started with us and among us.

Marcette
Diocesan Health Care
Coordinator

M &R.F. Hospital, Naganahalli, Mysore, launches out a programme in Community Health

Naganahalli, a remote village, is considered to be a backward Taluk in the whole of Mysore Dist. A decade ago, Naganahalli, was known for its wild life. It is in this village that M & R F Hospital has been functioning since 1975. In 1978 it extended its service taking up outreach programme of M.C.H. for

50 beneficiaries of surrounding villages. Since then these villages have much improved in health conditions. Now the hospital focuses its attention on community health and school programme.

A week 's training programme from 5th to 11th June, 1983, for 10 *dais* from 4 villages was organised with the help of CHAI Health Promoter Sr. Marina and the staff of M & R F Hospital, Sr. Concepta, PHN, Dr. V.N.K. Prasad, MBBS, and Sr. Irene, the staff nurse. These *dais* and 3 men as supervisors were exposed to the needs of the common disease cure like diarrhoea, scabies, sore eyes by indigenous medicine, much more to the cause and prevention, by means of flash cards, discussions and role play etc., some problems of the village like child marriage, joint family system, normal and abnormal pregnancies.

It looked as if these women were well versed in indigenous medicine, yet upgrading is needed in cleanliness and conducting deliveries. These women will work now as community health workers in their respective village and the supervisors will get a report of their work. A follow-up of all the work will be done from the Centre.

Inauguration of holy redeemer health centre.

The 15-bed Holy Redeemer Health Centre is the first of its kind in the Diocese of Kohima, Nagaland. This Centre is situated at the foothill of Nagaland, about 16 Km. from Dimapur.

On the 31st January, 1983, the In-patient Department of this Centre was officially inaugurated by His Excellency Mr. S.C. Jamir, Chief Minister of Nagaland, in the presence of a very large gathering of priests, sisters, friends, officers, well-wishers and the people of the locality.

Mr. Pralie Peseye, the Chairman of the Town Council, welcomed the guests and expressed his gratitude to the Bishop and the Catholic Church for starting an Institution of this type in Nagaland, and particularly at Chumukedima.

Rt. Rev. Abraham Alanjimattathil, D.D, Bishop of Kohima, Nagaland, blessed the new building constructed by the aid from German Misereor. The Out-Patient Department was inaugurated by him earlier on the 19th July, 1982, when Dr. Sr. Adele Thaliyan, M.D., joined the staff. The day-to-day management of the Health Centre is entrusted to the Sisters of Charity of Sts. Bartholomia Capitanio and Vincenza Gerosa whose headquarters are at Calcutta.

In his inaugural address the Chief Minister expressed his great appreciation for the work done by the Catholic Church in Nagaland, particularly in the field of health and education. He donated a sum of Rs. 10,000 for the initial expenses of the Health Centre and promised further help.

In his homily Bishop Abraham stressed and exhorted the congregation present to be the 'Good Samaritans' to the sick. He invited the sisters to bear witness to the love of the Crucified Lord to all who come under their care.

After a light refreshment the function came to an end.

The work of the healing ministry is flourishing from this Centre, and thousands of sick are benefited every month. The love of Christ is shared with all who come to this Centre named after The Most Holy Redeemer of us all.

Medical Uses of Iodising Radiation—Radiation Hazards—Prevention for—

In its Notification No. T. 20014/1/83-NMC dated 19.1.1983 the Directorate General of Health Services (Nuclear-Medicine Cell), University College of Medical Sciences Campus, Ring Road, New Delhi-110029, has informed that a Radiation Medicine Division has been established in the Directorate to plan radiation protection measures at the national level. All health authorities/institutions are requested by the Directorate to ensure that their radiation installations, i.e. X-ray, Radio-Therapy and Nuclear Medicine Departments are surveyed by the Bhabha Atomic Research Centre, Bombay, and their recommendations implemented as early as possible. Personal monitoring of all Radiation Workers must also be taken up if it has not been done so far. The survey of the installations and personal monitoring is done by the BARC, Trombay-Bombay-400 085, free of cost. This survey should be repeated every five years.

If any case of Radiation Hazards has been reported in any institution, details thereof are required to be communicated to the Directorate as early as possible and also ensured for future too.

Under the Atomic Energy Act, it is the responsibility of the employer to ensure that all radiation workers properly observe Radiation, Protection Norms and personal monitoring of the radiation dose received is recorded fortnightly with the help of the Film Badge Service of Department of Radiation Protection, BARC, Bombay.

The present position in respect of the information called for vide paragraphs 1 & 2 above is required to be communicated to the Directorate immediately in the following prescribed proforma:

Sl. No.	Name and address of the authority/ Agency	Cases of Radiation Hazards with facts		Type of Hazards	Period of working with Ionising Radiation	Remarks if any
		Jan. '82 to Dec. 1982	Jan., '83 to date			
1	2	3	4	5	6	7

The Directorate has stressed that this may please be treated as 'MOST IMMEDIATE' and the required information be sent to them on priority basis.

Impart Study of Community Health Programmes

1. Jammuon: (Varanasi Diocese)

In 1982, the Community Health Department of CHAI had assisted Fr. Ivon Joseph of Varanasi Social Service Society to integrate Community Health Programme with the existing development programmes at Jammuon Mission.

Two members of the team visited the area this month and had personal discussions with the Community Health Workers and project personnel, including visit to all the villages covered by the programme. Health education and environmental sanitation is looked after well, and by this alone, the Community Health workers claimed that they could control cholera in two villages. We found that husbands and other family members also joining the community health workers in organizing the villagers and solving community problems and some time family problems. The health workers and supervisors work so much hand in hand that a good rapport is established between the people and the centre. They have formed Mahila Mandals, Balasabhas etc., and credit unions are functioning well.

The team felt the need for refresher courses for the community health workers from time to time and also a little more creative supervision on the part of the supervisors of the programme.

We wish the programme every success.

2. Community health programme in the Diocese of Rourkela:

Two members of the Community Health Department team visited Rourkela to plan out follow up for the Community Health Workers trained by Community Health Department in January, 1983. A thorough study of the programme and detailed discussions with the personnel concerned revealed to us the need for more orientation and systematic planning of the whole programme. At the moment the programme is carried out in five parishes of the Rourkela Zone. We proposed to take up a three days Orientation Programme for Priests of those Parishes and 2 Sisters from each health centre. After this programme, second phase of the training for Community Health Workers will be carried out—it was mutually agreed.

3. At Balasore Diocese:

The team visited two health centres in Balasore, at Jaleswar and Rangiam. The Diocese is planning to launch a Community Health Programme in 40 villages in the circumference of these two health centres, run by visitation Sisters. Training of 30 village health workers is planned, and the construction of the training centre is nearing completion. We offered our service for a one week team training session for the priests and sisters in the project area.

With the present enthusiasm of the energetic and young sisters and the untiring support of Monsignor Jacob Vadakkevettil, the Programme - we are sure - will bear much fruit and good luck.

4. Orientation and Planning Programme at Berhampur Diocese:

From 1978 onwards, Community Health Programme is effectively carried out in the Diocese of Berhampur. But for the past few months the Bishop and the people concerned have been thinking for a re-orientation and new planning of the programme.

Three members from the Community Health Department of CHAI attended a one day meeting of Sisters working in the Health

Centres, convened by the Bishop. 17 Sisters participated in the meeting. The bulk of the time was spared for reflecting on the social reality around us, the call of the Church and the State for Community Health approach in the Health Care system and also the urgent and important need of the hour for a relevant and meaningful Christian response to this situation.

After discussions in groups, for practical conclusions, the group assembled in the general session and made the following decisions.

a) To convene a meeting of all the Sisters engaged in Community Health once a year. This will be done by the Bishop.

b) Two co-ordinating committees were constituted for the two zones of the Diocese with three Sisters engaged in Community Health and Bishop will appoint one priest from each zone for these committees.

c) These zonal committees will meet once in 4 months to encourage, evaluate and plan for the zone.

d) To have a 5 days orientation programme for all the Sisters in the field of Community Health, at the earliest.

e) To take up regular follow up and refresher courses for Community Health workers.

We hope this get-together and planning will initiate a new process in the Community Health Programme of the Diocese of Berhampur, and we are also looking forward to a healthy competition between the two zonal committees .....!

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An Integrated Approach to Health and Development : HOSKOTE—Bangalore

— CHAI Team

CSI Hospital, Bangalore, can be really proud of the Community Health Programme it started in Hoskote, which is situated at the outskirts of Bangalore.

Dr. Ravi Raj who is the pioneer of this programme, had started his work 8 years back covering about 50 villages in and around HOSKOTE. The Community Health Department of CHAI studied the process and the evolution of this programme and found it worth sharing with all those who are engaged in building healthy communities.

This programme is functioning in a '3 tier system' — i.e.

i) Micro Centre — situated at the heart of every village

ii) Mini Centre — each catering to 11 villages around and

iii) Macro Centre — situated at HOSKOTE.

A local woman, selected by the people and trained by the Doctor and his team, is placed at the Micro Centre as the Health worker. Her role is vital in the whole programme and she is given the freedom to use the traditional medicine as well as a few simple and selected drugs. Through her, early detection and treatment of diseases is made possible.

Two ANMs who are placed in charge of a Mini Centre are given a special one-year training by the Doctor at the Macro Centre. During this time they are taught to look after the patients, with a few selected and simple drugs. In this way they gain self-confidence to be in charge of the Mini Centre which looks after the health needs of 11 villages.

The Macro Centre is situated at HOSKOTE and 2 doctors are in charge of it. Dr. Ravi visits the Mini Centres at least once a week and Micro Centres occasionally. His encouragement sustains his health team to render efficient services by being vigilant and available all time.

Some of the other salient features of the programme are:

a) Promotion of local leadership: The social worker attached to each Mini Centre helps the villagers to identify the local leader in the village. And these leaders are assisted by the social worker to form youth clubs and other organizations and also to take up concrete actions like medical camps, construction of roads, deepening of ponds, etc.

b) Skill survey is taken in all the villages, and accordingly training facilities are provided in their own places to improve their skills.

c) Agricultural programmes are taken up for farmers, and incentives like loans, pumpsets, cattles, seedlings, fertilizers, etc., are given. The repayment of the loan is upto 85%.

d) The project has ensured the involvement of women in the health education programme and running of Balwadis. The mothers contribute in kind towards the feeding of the

children in the Balwadis and also they serve the Balwady by turn.

The people are cooperating with the programmes to their level best. They have contributed land for putting up Mini Centres. Dr. Ravi and his team love and respect the people they serve. Through this health programme they have started the process of awareness building and people are encouraged to make organised efforts for their rights.

40TH NATIONAL HOSPITAL CONVENTION AND EXHIBITION

Theme : "Respect life"

Venue : St. Pius X College, Aarey Road
Goregaon East, Bombay 400 063.

Date : 6th—10th November, 1983

(Special programme on NFP and Family Welfare on Nov 10th)

Registration Fee : Rs. 250.00 per head

(Rs. 30/- extra for the NFP programme on 10th)

Payable by cheque/draft drawn in favour of 'National Hospital Convention and Exhibition'.

Stall Booking for Exhibition and Booking of Advertisement space in the convention Souvenir is on.

Last date of :

Registration/Booking of Stall/Advertisement 15th October, 1983

For further details and Registration Forms, etc., please contact :

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