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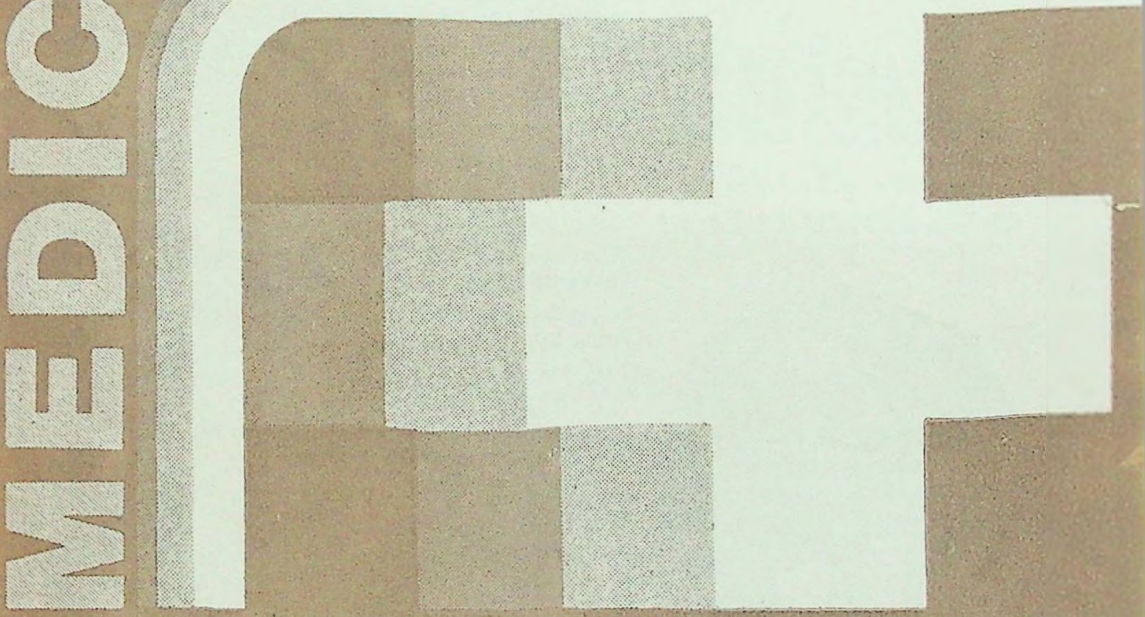

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vol 42 no 4 april 1985

medical service

"the love of christ urges us" 2 cor 5 : 14

official house journal of the catholic hospital association of India

vol 42 no 4 april 1985

published by the catholic hospital association of india c b c i centre, goldakkhana new delhi-110001

printed at kalpana printing house new delhi-110016

contents

EDITORIAL

Healthy Youth: A Hope for Tomorrow

Young people getting together and indulging in arson, looking, burning of buses, blocking roads and traffic etc. are daily occurences in our country. Our news papers have to devote a considerable portion of their space everyday in reporting of such incidents. If we take any riots (like what unfortunately happened following the brutal assasination of Mrs Indira Gandhi), disturbances, strikes in schools and colleges etc. We see it is the youth that are being used for the purpose. This is one side of the picture. On the other hand we also see how actively our youth are involved in works of relief and rehabilitation after a calamity whether natural or man made. Or how they are engaged in work camps, in sports and games, and many adventures which bring honour and name to the country and achieve positive results. This shows that there is a sign of hope for the future provided the elders direct our youth and above all give examples.

If we critically analyse and if we are honest enough to admit we will be able to find very easily that the society is very often responsible for the destructive tendencies and activities of youth. Making use of the youth, particularly of school and college students by political parties to achieve their own interests is a common practice in our country with painful consequences of the society paying a heavy price and the education system getting deteriorated day by day. This will tell upon the future of the developing countries, particularly our country. It is estimated that by the close of this century, developing countries including ours will have more than 80 per cent of those between the age group of 15 and 25 years. This calls for a more serious consideration towards this all powerful reservoir of human potential by all concerned. These power resources should be used to the maximum to build up a healthy human society where there will be more sense of true freedom—freedom of the children of God, justice, care and concern and respect for one another.

"The young have a large role to play in health care": says Dr. Mahlet, the Director General of WHO, "they themselves are most aware of their own health problems; they maintain an open mind and represent the group best able to appreciate the basic tenets of primary health care, beginning with the responsibility of caring for themselves. Studies have shown that a majority of youngsters want to help others and want to assume responsibility. A good place to start may be with national community programmes that demonstrate how to keep fit and achieve a healthy lifestyle".

As we are almost in the middle of the International Year of the Youth, let us all realise the tremendous potential in our youth and direct them, with all honest efforts, to build up health communities and a healthy nation at large for, a healthy youth of today is our hope for a better tomorrow.

A Clinical Approach to Headache in General Practice

—Belinda Viegas

(*Text of the Departmental Seminar compiled by Thomas M.J., Dept. of Psychiatry, St. John's Medical College, Bangalore*).

The initial problem in the management of headache is to decide whether any special investigation is warranted. In the majority of patients a carefully elicited history will establish the pattern so clearly that any special tests are superfluous. When there is diagnostic difficulty or when the history suggests a serious disorder, investigations become necessary and good judgement is required to determine the sequence of tests which is safest for the patient and most likely to produce a definite answer.

The initial approach will depend on the duration of headache, i.e.

1. The acute severe headache.
2. Acute recurrent episodes of headache.
3. The headache of subacute onset.
4. The chronic headache.

When a headache suddenly develops in a patient for the first time, the presence or absence of fever and neck rigidity are of great importance. Patients with acute headache, photophobia, elevation of body temperature and neck stiffness obviously have an intracranial disturbance and the question of lumbar puncture arises. The C.S.F. commonly shows a lymphocytic pleocytosis if headache is present at the height of a viral invasion. When a confident diagnosis of a specific infection cannot be made after examination of a patient, L.P. may be necessary to distinguish between meningitis, encephalitis, and subarachnoid hemmorhage. The normal C.S.F. should not contain more than 5 lymphocytes/cm and should never contain polymorphonuclear cells. A high polymorph count is almost always caused by bacterial meningitis and a purely lymphocytic reaction indicates a viral meningoencephalitis, but mixed cellular reaction may be found in both viral and bacterial infections, particularly in tuberculous meningitis. The glucose content of C.S.F. assume a particular significance in these doubtful cases. The C.S.F. level of glucose depends upon the blood level. But, providing that the patient is not hypoglycemic and that the fluid has not been allowed to stand for some hours before examination, a C.S.F. glucose of 30mg/100 ml or less suggests a bacterial or cryptococcal meningitis or the rare carcinomatosa meningitis.

Apart from the diagnosis of infectious disease, L.P. may be required to confirm subarachnoid hemorrhage. If this diagnosis is self evident and the patient conscious, it is often better to proceed immediately to a ECT scan and cerebral angiography in a centre suitably equipped for it, since L.P. gives no additional information and may precipitate further bleeding.

After head injury there may be difficulty in distinguishing post-concussional headache from that of an expanding intracranial haematoma. A persistent headache and insidious drowsiness are always signals to be on the alert. Dilatation of one pupil or a minimal hemiparesis are late signs which should prompt immediate CT scanning or carotid angiography and neurological intervention. Neck stiffness

arising in this context is a particular source of concern as it suggests midbrain compression from "coning" of one of the temporal lobes through the tentorial opening. When radiography of the skull demonstrates a fracture of the lateral aspect, the possibility of an extradural haematoma from a torn middle meningial artery should be borne in mind, and justifies close observation of the patient. A CT scan is particularly helpful in following the course of patients with a post-traumatic headache of doubtful origin. Unilateral or bilateral subdural haematomas can be missed by CT scanning in their iso-dence phase so that there is still a place for cerebral angiography in doubtful cases.

Acute headaches without neck stiffness may also be of intracranial origin. Blood pressure may suddenly increase in acute nephritis, toxaemia of pregnancy, malignant hypertension and the crisis caused by phaeochromocytoma or in a patient on monoamine oxidase inhibitors taking sympathomimetic drugs or tyramine containing foods. The finding of hypertension on examination does not of course exclude an intracranial lesion as the source of headache. The blood pressure is usually secondarily elevated in patients with subarachnoid and intracerebral haemorrhage.

Acute headaches of extracranial origion such as sinusitis, retro-bulbar neuritis, acute angle glaucoma and abcesses around the roots of the upper teeth can usually be diagnosed clinically.

Some of the entities mentioned above such as sinusitis or pressor reaction of phaeochromocytoma may recur periodically. Repeated episodes of meningitis suggest either defective immunological mechanisms or more commonly, that the nasopharynx communicates with the sub-arachnoid space through a fracture in the floor of the anterior fossa. This leads to CSF rhinorrhoea with clear fluid dripping from the nostril when the head is best forwards. Unlike nasal secretions CSF contains glucose so that it can easily be confirmed if the fluid is of intracranial origin.

Repitition of a subarachnoid haemorrhage from an intracranial aneurysm carries a mortality in the vicinity of 50% like that of the original episode. Cerebral, cerelellar or spinal angiomas on the other hand may bleed, little often with little or no residual deficit.

Attacks of cerebrovascular insufficiency are clearly demarcated by symptoms and signs of the territory which is rendered ischaemic. The classic story of internal carotid insufficiency usually seen only in part is that of blurring of vision is one eye resulting from retinal ischaemia, accompanied by fleeting paraesthesia or paresis of the opposite side. If the dominant hemisphere (the left in right handed subjects) is involved, dysphasia is an additional symptom. Transient ischaemic attacks may be accompanied by headache on the side supplied by the defective carotid artery. Insufficiency of the vertebro-basilar artery is characterized by momentary vertigo, dysarthria and ataxia, or by a combination of brainstem symptoms and signs including diplopia, tinnitis, deafness, paraesthesia over the face and body and hemiparesis or quadriparesis. Because of the posterior cerebral arteries which supply the occipital cortex arise from the basilar artery, the patient may experience a temporary homonymous hemianopia, visual hallucinations like those of migraine or a complete bilateral suppression of vision. Since the medical part of the temporal lobe, the entry portal of the brain for memory, is also within the distribution of the posterior cerebral artery, amnesia may be a feature of vertebrobasilar attacks. The occipital headache which may be present for the duration of the attak is insignificant compared with the dramatic nature of the focal neurological symptoms. Paroxysmal cardiac dysrhythmias may produce the attacks through hypotension,

sudden neck movements may obliterate the lumen of the vertebral artery in the neck of spondylitic patients, and arm movements may induce a shunting of blood from the vertebral artery into the subclavian artery if its intraluminal pressure is lowered. Inequality of the radial pulses and a bruit over the clavicles or in the neck may indicate the site of stenosis. Embolism from subacute bacterial endocraditis must be considered if a cardiac murmur is detected.

Intermittent hydrocephalous is a rare cause of recurrent headache, but should be considered if the history is relatively short, if the headaches are severe, if they are precipitated by a quick forward movement of the head or are associated with obscuration of vision, impairment of consciousness, myoclonic jerks or weakness of the legs. The final diagnosis will depend on CT scanning and other neurological investigations.

The pattern of pain and headache in tic douloureux, cluster headache and migraine are usually sufficiently distinctive for a diagnosis to be easily made. Where doubt exists other conditions may be excluded by investigations. But a positive diagnosis depends upon the clinical history. The frequency and duration of headache establish the temporal pattern which is so important in the diagnosis.

Migraine may recur irregularly at intervals of months and years but commonly a pattern has become established by the time a patient seeks medical advice. The headache may be linked to the menstrual cycle or may appear one to ten times each month without any obvious cause, disappearing only during pregnancy, holidays, admission to hospital or other periods of prolonged rest. It may last from a few hours to several days, but is usually followed by a period of freedom from headache before the next attack starts.

Cluster headache on the other hand has an intriguing periodicity. It usually recures in bouts lasting from 2 weeks to 3 months and then vanishes completely for 3 months to as long a 4 years. During a bout, the headache returns once, twice, or more in 24 hours and lasts from 10 minutes to 2 hours on each occasion. The fact that the pain persists for this length of time clearly distinguishes it from trigeminal neuralgia, which recurs as trasient jabs of pain, each lasting a fraction of a second, although the jabs may be repetitive. The two disorders are mentioned together because they are commonly confused in general practice. One point that the conditions have in common is the tendency to remit spontaneously for months or years. The distinction between the two is most important because the mechanism and treatment of each are entirely different.

Tension headache is set apart from those just considered by the absence of any paroxysmal quality or periodicity about it's course. While acute forms of tension headache may appear at the end of a stressful day in a busy office or a house of screaming children the usual story of the sufferer is that there is always a headache lurking in the background. Such patients have some sort of headache all day and every day. They are never really free except for an hour or two after ingestion of their favourite caffeine containing analgesic. There is a form of headache intermedicate between this undulating pattern and the parosysms of migraine. This is termed tension—vascular headache, because surges of more severe throbbing headache become superimposed every few days or weeks on an otherwise monotonous background of constant discomfort.

Headache is commonly bilateral except in migraine attacks (of which about 2/3rds are one sided). Cluster headache and tic douloureux are almost always strictly unilateral. Tension headache is usually bilateral but sometimes may be one sided owing to asym-

metrical muscle contraction, found particularly if there is associated imbalance of bite.

The most important distinction here is between pulsating or throbbing headache indicating a vascular origin and a constant ache. Migraine commonly starts as a dull headache, but may develop a throbbing quality and later become a constant severe pain. Tension headache is usually dull constant, tight, pressing or band like.

The only form of headache with a recognisable prodromal phase is migraine. Before the headache starts there may be visual hallucinations or a complex succession of neurological symptoms which adhere to much the same sequence on each occasion. Visual hallucinations may take the form of simple flashes of light or a coloured display of zig-zag scintillations moving slowly across the field leaving a scotoma behind. There may be patch or generalized blurring of vision at the height of the disturbance or a clearly defined homonymous heminopia.

There are a wide variety of symptoms linked with migraine headache including photophobia, gastro-intestinal disturbance, fluid retention and focal neurological changes.

The reddened forehead, injected conjunctiva, lacrimating eye and occasional Horner's syndrome of cluster headache are distinctive vascular phenomena. The nostril on the affected side may block or run with fluid.

The explosive pains of tic doulourex may be detonated by stimulation of any area served by the trigeminal nerve. Talking, chewing, swallowing, shaving or even a puff of wind blowing on the face are trigger factors commonly mentioned.

Alcohol usually triggers cluster headache during a bout but not at other times. It may also bring on migraine when the patient is in a susceptible phase and not in the refractory period after an attack has recently ended.

Certain foods are said to induce migraine but doubt has been cast on whether in the traditional migraine, precipitants act specifically or by a psychological conditioning process. Vascular reactivity appears to be altered by hormonal changes, thus accounting for the association between migraine and menstruation and its relief in some women during pregnancy.

The migrainous patient usually prefers to lie in a darkened room whereas the sufferer from cluster headache prefers to sit up or pace the floor, holding his hand over the affected eye. Rebreathing into a paper bag or the inhalation of air with 10% CO_2 is said to shorten the vasoconstrictive phase of migraine and the inhalation of CO_2 relieves most patients with cluster headache.

Voluntary relaxation of forehead and jaw muscles will reduce the severeity of tension headache.

Headache of subacute onset is of interest to the doctor and of potential danger to the patient. Someone who has never experienced more than "ordinary headaches" which most of us get at times, starts to complain of a different sort of headache which may affect one or both sides and becomes progressively more severe. If the patient has been complaining of ear-ache or of nasal obstruction with pain over the forehead or maxillae before the onset of headache, thoughts turn to the complications of otitis media and sinusitis.

If the patient has signs of raised intracranial pressure, a CT scan is the investigation of choice and will pick out most cases of cerebral abscess, tumor, infarction or haemorrhage. If the ventricles are not enlarged or displaced, "Benign intracranial hypertension" is suspected but it must be borne in mind that bilaterally symmetrical subdural haematomas may escape detection by CT scan.

The rare cases of Addison's disease or hypocalcemia presenting with increased intracranial pressure must be remembered and excluded. In patients over the age of 55 years, the blood picture and ESR should always be examined to pick up the odd patients with temporal arteritis.

In the patient who has suffered from headaches for a year or more, the prospect of a tumor or other serious intracranial disorder being the cause is more remote. If the patient's headaches have been consistent in character for 5 years or more one may feel fairly confident that they are not caused by an intracranial tumor, although the occasional patient may be found to have a tumor which is quite unrelated to the headache with which he presented.

As a general rule any headache which has been present for more than 5 years is a tension headache or migraine and diagnosis depends on the history. The greater the time spent in taking the history of a patient with headache, the more likely are the correct diagnosis and solution to emerge, and the more interesting will the patients's problem be to the doctor.

Leprosy Eradication

Myth or Reality ?

The anti-leprosy work offers many challenges—and if we can respond to these adequately, eradication of leprosy will become a reality. The myth that the disease is divine dispensation and cannot be eradicated can be broken. How fast this can be achieved depends on how seriously we take up the challenge.

—T.K. Parthasarathy

The war on leprosy has been mounted again, now in a big way. The goal is eradication of this scourge by 2000 A.D. Appropriately, the National Leprosy Control Programme has been redesignated as the National Leprosy Eradication of Leprosy under the chairmanship of Dr. M.S. Swaminathan, then member, Planning Commission.

The emphasis will be on the traditional method of disease control the twin front of case detection and treatment but on a more vigorous and sustained scale. The treatment strategy will shift from the single drug regimen to multi-drug therapy.

Health education will be the sheetanchor of the programme; make the people realise that leprosy is like as any other communicable disease, encourage those with symptoms of the disease to seek medical advice promptly and persuade patients to take regular and complete treatment.

A policy guidance and surveillance body called the National Leprosy Eradication Commission, headed by the Union Minister for Health and Family Welfare has been set up at the National level. A National Leprosy Eradication Board—another body suggested by the Swaminathan Committee—has been set up under the chairmanship of the Secretary, Ministry of Health and Family Welfare, as the executive body of the Leprosy Eradication Commission. The States with a high incidence of the disease will similarly set up such policy guidance and implementing agencies under the chairmanship of the Health Minister and Health Secretary respectively. The Programme has also been included in the new 20-point programme.

Preliminary estimates based on the 1981 census indicate that the total number of cases in India will be about 3.95 million. Out of this 20 per cent cases will be of infectious type and 25 per cent have one or other form of disability. Twenty per cent of cases are children under 14 years of age. Nearly 400 million of the 680 million population (1981 census) live in areas endemic to the disease—areas where the disease prevalence rate is 5 and more per 1000 population. According to the Working Group, 12 States and Union Territories are highly endemic. Tamil Nadu, Andhra Pradesh, Pondicherry and Andaman and Nicobar islands have a prevalence rate of 13 and above per 1000 population; Orissa, West Bengal and Nagaland have a rate between 9 and 12/1000. There are seven States with a prevalence rate between 5 and 8/1000. Besides, there are considerable variations in the prevalence within the same State. In Tamil Nadu the rate ranges between 15/1000 in Coimbatore District to 28/1000 in Salem District while in West Bengal the prevalence is between 4/1000 in Darjeeling and 25/1000 in Purulia.

The Government of India in Leprosy Control Programme as early as 1954 with the main objective of detecting cases and treating them with modern anti-leprotic drugs free of cost so as to effectively control the spread of the disease in the community. Upto March 1983, 3.16 million cases have been registered. During this period, 0.26 million cases have been discharged from the control as disease-arrested or deleted otherwise thus leaving a balance of active cases registered till the end of March 1983 at 2.90 million. In this process, the National Programme has so far established 6960 Survey, Education and Treatment (SET) Centres, 389 Leprosy Control Units and 607 Urban Leprosy Centres. During the current plan (VI Plan) the Programme is completely aided by the Central Government. Under this the entire maintenance and operational cost of the units set up by the States since 1978 will be borne by the Central Government. The Programme expects to cover the entire population in the endemic areas by the next Plan Period.

Encouraging results have been reported from selected areas. The Indian Council of Medical Research had assessed the working of a few centres in Maharashtra and Tamil Nadu which had been functioning for over 15 years. According to published reports, the problem in the units evaluated "have shown definite decline in new cases detection, infectivity rate and deformity rate. "An assessment of the total work in Tamil Nadu indicated that the prevalence rate has come down from 20.4/1000 population in 1970 to about 15/1000 in 1980." It is stated that the results could have been much better, if along with case detection, multi-drug regimen had been introduced.

The anti-leprosy armamentarium today has powerful curative and prophylactic drugs. The disease is completely curable, without any deformity, if detected early and treatment instituted promptly. The treatment has to be taken regularly for a long period as prescribed by the doctor. The only lacuna is the absence of a vaccine against the disease to achieve primary prevention. So far not much success has been achieved in developing an immunizing vaccine to protect healthy persons. A large number of research workers around the world are vigorously engaged in developing a vaccine.

Systematic case detection

The working Group, besides recommending systematic case detection and treatment in highly endemic districts, has urged that the existing single drug therapy by dapsone (DDS) should be supplemented by one or more bactericidal drugs like rifampicin and clofazimin at least in the treatment of smear positive or infectious type of disease. The Working Group had recommended that the multi-drug therapy should be launched in the form of a campaign ultimately leading to the eradication of the disease.

The Government had accepted the recommendations of the Working Group and decided to introduce multi-drug regimen project (MDRP) in all the 92 highly endemic districts in the country in a phased manner. The ultimate objective is to convert all infectious cases into non-infectious within a short period and thus reduce the quantum of infection with a view to interrupting the chain of transmission in the community.

The multidrug regimen campaign was introduced initially on a trial basis in 1981 in Wardha district of Maharashtra. It was decided later to introduce the MDRP in eleven endemic districts namely Wardha and Amaravati (Maharashtra), Purulia (West Bengal), Santhal Parganas (Bihar), Ganjam (Orissa), North Arcot (Tamil Nadu), Srikakulam and Vizianagarm (Andhra Pradesh) and Vadodara (Gujarat). The other districts will be covered during 1983-84 and 1984-85. The project has already been introduced in Purulia

in February 1982, and in Ganjam, North Arcot, Srikakulam and Vizianagarm in February and March 1983.

Health Education

The availability of powerful drugs alone cannot lead to the eradication of the disease. Cases have to be detected in a sustained manner and drugs provided to the patients regularly. It should also be ensured that the patients take the drugs regularly and for the period advised. The greatest barrier to the successful case detection are ignorance, prejudice and wrong notions. Even today leprosy is feared and it is very widely believed that the disease is the direct result of sin committed in the past life, and it is a divine punishment and hence cannot be cured. The moment one is told that he/she is a victim of leprosy, despondency sets in. The ugly deformities in the hands and feet and face leads to social boycott of the patient and the family. Because of the attitude, some patients leave their homes and take to begging and live far away from the home to avoid identity.

In fact leprosy is a less infectious and less contagious disease than tuberculosis. Only 20 percent of the estimated cases are lepromatous (infectious)—those disseminate leprosy becillus through nasal secretions. Although many are infected, only a very small number develop the disease. Even among the people who live in close contact as spouses of lepromatous patients only 3 to 5 per cent get the infection, according to experts.

In spite of such findings, leprosy patients are despised and looked down upon. Such an attitude makes the victims and those with signs and symptoms avoid diagnosis. In the light of such social implications, the Working Group has recommended, rightly too, "that a nationwide mass education campaign needs to be launched and pursued vigorously and remove superstitions and wrong beliefs and social stigma attached with leprosy".

Most of the leprosy patients belong to the poorer sections of the community and these usually crowd in the slums where the parents and children huddle together in the small shanty dwellings. This gives rise to the problem of leprosy in children. As stated earlier, 20 per cent of the leprosy cases in the country are children. Dr. R. Ganapathy, Director of the Bombay Leprosy Project, in an article in *Swasth Hind* (January 1983) has said that "while surveys of 10 per cent of child population attending randomly selected municipal schools revealed a general prevalence rate of 3 per 1000, there existed pockets of endemicity of the order of 10.8 per 1000 in some schools in the northern suburbs of the city".

Dr. F.M. Noussitou, WHO consultant, has said that in countries or areas where the prevalence rate of leprosy is 5/1000 or more convenience of the examination of school children has to be considered. "This method of case detection is recommended when the estimated prevalence among the students is in the range of 4-5 per 1000 or more". (Leprosy in Children, WHO, 1976). The Working Group has also recommended that "screening of pre-school children and youth for possible infection through skin camps should become a regular activity".

Public Participation

A programme of this magnitude with the complexity of social and economic problems cannot go on full steam under the governments efforts alone. Official activities should be supported and supplemented by people's participation. The public should feel that they ate partners in the programme. What are the ways in which the public could provide the needed support?

Health education of the people on the correct information about the disease and edu-

cation of the patients that the disease is curable and that the patients should continue to take the long treatment regularly could be one such public education activity. The Working Group has said the objectives of a health education campaign could be "to create an awareness and interest among the people about the programme and develop positive attitudes and pratices towards effective action to control of leprosy depends on health education, early diagnosis using active methods of case finding and early treatment of all forms of the disease.

Another aim could be to motivate voluntary agencies to sustain and promote the objectives of the National Eradication Programme by undertaking specific responsibilities such as community self surveys, in the endemic areas, holding of skin camps, initiate activities for case detection, case holding, drug distribution and rehabilitation. There are 56 voluntary organizations today engaged in leprosy control activities. The Working Group has also suggested that "voluntary communicators" should be placed at the grassroot level. Such a communicator "will be one of the community selected for his positive attitude towards leprosy and his ability to work with the people". He will not be paid any salary "but his work will be recognised either by small awards or by public recognition".

All channels of mass communications, both governmental and private could take up the challenge the programme presents and put out suitable message in a sustained manner. If such an education programme could be planned and implemented in which the newspapers and magazines, radio, television, film and other media units could participate in a planned way, the Eradication Programme would be able to remove the fears in the people's mind and make case detection work easy. The health worker on his part should pick up the message put out on the mass media channels and build an educational programme in the community, in the clinics and during home visits. They can involve the teachers, and educational authorities in the health education work.

The anti-leprosy work offers many challenges—and if we can respond to these adequately, eradication of leprosy will become a reality. The myth that the disease is divine dispensation and cannot be eradicated can be broken. How fast this can be achieved depends on how seriously we take up the challenge. We include the government and the public.

Courtesy : *SOCIAL WELFARE*

Role of Natural Family Planning Programme and Voluntary Health Programme Services

—Sr. (Dr.) Catherine Bernard

Contextualizing Primary Health and Family Planning :

Health and Family Planning in our present time is very much a service distributed by a group of health professionals to a group or community whose role is often expected to be passive recepients. It can be said that very much of the existing health and Family Planning facilities in India cover only a small part of the population, while the vast majority of the people cannot afford the cost of institutional health care and hence have very little or no access to basic health care or fertility awareness facilities.

It can be said therefore that Primary Health Care and F.P. is planning, promoting and maintaining health. It is understanding that health is a component of the overall socio-economic development with emphasis on 'starting from people rather than programme'. This understanding therefore requires an approach entirely different as contrasted to curative health services.

The WHO Executive Council in its 1975 meeting at Geneva stated that Primary Health Care must ensure :—

1. That it is shaped around the lifestyle of the people itself.
2. Local people should be active in planning, so that their needs and priorities are met.
3. Health Care offered should make maximum use of Community resources.

Therefore, Primary Health approach starts from people rather than programme and consequently it is liikely to have a profound influence on fertility regulation measures as well.

Health Services and Family Planning in India—a brief overview

Health and F.P. are closely linked even though F.P. is not essentially a health component. Health Care services and facilities in India are very much oriented to conditions of technology and industrialization with emphasis on highly sophisticated curative practices.

This approach is very much present even in the medical education in our country. Unfortunately a similar system pervades many of the medical institutions started by Religious Congregations and Missionaries. Even though established for and in rural areas they are caught up in the political attitude of the existing medical system and carry health services in total submission to the dictates of the drug industry.

One can take this system into the Sphere of Family Planning. India opened its first F.P. clinic in 1925 and 5 years later the Government of Mysore opened the first state sponsored birth control clinic. This was the first state sponsored clinic in the world. In 1935 Margaret Sanger—founder of Planned Parenthood came to India and the F.P. Association of India was founded in Bombay. In 1959 India became the first country to adopt F.P. as a national policy. Since then in each of the 5 year plans millions of Rupees have been allocated for F.P./population control programmes.

It is interesting to note that inspite of efforts being made both in public and private sectors, we still remain caught up in the attitude that F.P. is a medical problem and fertility is a pathology to be treated or arrested and pregnancy a problem to be dealt with. On close look at this system, it is not surprising to note that the medical profession continues to benefit the drug industry rather than the people.

We therefore need to take a look at F.P. and its impact on the Family :- (*contemporary F.P. approach*).

For F.P. to be acceptable to the Indian people, it must be recognised that F.P. does not belong to the realm of medicine and medical care. Fertility and/or pregnancy is not a disease to be arrested or eradicated, but rather an integral component/process of the individual to be integrated, and respected. It must also be recognised that fertility and fertility regulation must remain within the power and capability of the couple to use and choose within the frame work of responsibility and human dignity.

It is when fertility and F.P. services proliferate, remaining confined and controlled by specialists and health workers, such services and programmes will not have the desired effect and impact on the given population.

This leads us to the topic of NFP and NFP programmes, wherein approach and emphasis is on:

1. People/Persons and not on problem,
2. Respect,
3. Responsibility.

NATURAL FAMILY PLANNING—THE BILLINGS OVULATION METHOD

What is Natural Family Planning

Natural Family Planning is planning for achieving or avoiding a pregnancy by planning the time for intercourse. By becoming aware (observing and recording) certain naturally occuring symptoms and bodily change that occur in a woman's menstrual cycle and using the knowledge as a guide, a couple can learn to identify times of fertility and infertility in each menstrual cycle. If the decision is to achieve pregnancy, they will know when pregnancy can occur, if they wish to avoid pregnancy then they should abstain from intercourse on those days when conception can take place.

Methodology of Natural Family Planning

The Calendar Rhythm— is an isolated method not advocated by contemporary natural family planners. The Calendar method leads to many unplanned pregnancies because of variations that can occur in the women's menstrual cycle. Because of these variations the calculations that seem to apply to regular menstrual cycles will not hold good and therefore accounts for 'failures' of the method.

Basal Body Temperature and Sympto Thermal Methods

Ovulation is indicated by the thermal shift that occurs in the thermometer as a result of hormonal changes that occur in the woman's body.

Other symptoms like breast tenderness, abdominal pain, backache, cervical mucus are other symptoms of ovulation, and may assist in interpreting the thermal shift which occurs as a result of Ovulation.

Ovulation Method—Billings

Drs. Billings of Australia pioneered the use of the cervical mucus as a single parameter for the prediction of ovulation and its application to Natural Family Planning. Women are taught to observe their mucus patterns at the vulva, relying primarily on the sensa-

tion of wetness and lubrication. The mucus can usually be felt and/or seen when the woman washes or after going to the toilet.

According to the world's famous scientist—Brown, Berger and Odeblad, whenever total oestregen exceed the threshold of 15 mg per 100 ml per 24 hours the cervical mucus is sufficiently liquefied to leave the cervix and appear at the vulua. If a cycle is ovulatory, the mucus will become increasingly lubricative, elastic and clear until it reaches its peak. The changing behaviour of the mucus is called the build up 'Peak' is therefore defined as the last day of lubricative mucus, not necessarily the day of maximum stretch (elasticity).

The Billing method persumes that once the fertile type mucus has begun, sperms can be maintained in a viable state in the cervical cryts and other uterine sites until ovulation. Experiences have shown that couples must abstain from the onset of fertile—type mucus until of 72 hours beyond 'peak'. Women are taught to distinguish between mucus related to ovulation and other vaginal discharges, also the fertile type mucus by its elasticity and lubricative quality.

When couples wish to avoid pregnancy they must abstain from the onset of mucus until the fourth day after peak. In case of short menstrual cycles they are asked to abstain during menstration, which may mask the onset of mucus in a woman with a short menstrual cycle.

After the learning stage many women can distinguish menses from mucus and also their baseline discharge as distinct from cervical mucus.

After the Ovulation, progesterone abruptly suppresses the peak mucus, the pattern continues with sticky mucus for a day or two and then returns to dryness. After a few cycles the physiological changes are so easily recognised by most clients. The use of marking a chart has facilitated deserving fertility patterns and overcomes the barrier of illiteracy.

Special Circumstances :

The Ovulation Method Billings can be used in times of breast feeding, pre menopause, irregular menstrual cycles. Using the method can also help detect pathological situations like vaginitis or cervicities etc. and the necessary medical assistance is given.

Effectiveness of Natural Family Planning

Unlike contraception, NFP can be used to achieve or avoid pregnancy. The underlying assumption in contraception is that the couple use a device, technique or medication in order to prevent conception resulting from coitus. Natural Family Planning on the other hand is based on the timing of coitus and calls for abstinence during the fertile phase if pregnancy is not desired.

Some of the major use effectiveness continuation rate studies carried out show the results achieved in different countries—USA—92% Continuation rate—of 329 users for 12 months (Dolack) USA (Klaus) 95% continuation rate for 1090 Users—with 24 months.

NFP and Health Care Systems

If one refers to the understanding of Primary Health Care and the role of NFP—one must recognise and admit that NFP is not only *a form* it is Primary Health Care—for NFP is planning—to achieve or avoid pregnancy and in doing so maintains health. It is by integrating fertility that health is maintained. Furthermore it is shaped around the lifestyle of the people to be served for it integrates culture, physical integrity and procreative choice. In this process the person/couple become actively involved, become aware of their needs and strive to meet their priorities.

(*Contd. on Page 28*)

Healthy Youth—Our Best Resource

Fr. Thomas Joseph, CHD, CHAI

(Address Presented for the symposium on 'Healthy Youth—Our Best Resource' organized by the Indian Federation of the United Nations Association, at New Delhi on 9th April, '85, the world health day).

Healthy Youth, as the best resource for the development of the nation, is a theme worth reflected upon in the International Year of the Youth. My reflections are based on the experience I gained from four years of my involvement among the rural youth of one of the backward and tribal districts of Kerala, and from my present experience in the promotion of community based health programmes launched by CHAI.

The World Health Organization has defined health as, 'a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity'. This definition has widened the horizon of health to a much broader concept than what we all conceived ten years ago. In the past we concentrated our effort on the promotion of physical health with an aim of alleviating the suffering of the humanity from physical ailments. But today, ever since the new definition of WHO, our perspectives have broadened and accordingly we aim our efforts towards the 'well being' of the total person in his existential milieu, through an integrated and comprehensive approach. The new thrust on the mental and social dimensions assumes paramount importance, when we think of health in relation to the youth of today.

However, an overall understanding of the youth in general may not, I am afraid, fall in the correct perspective unless we make an effort to differenciate them existentially, based on the difference in the socio-political environment to which they belong. Because, when we think about the well being of the youth we have to be very clear about which youth we are talking about. Is it the rural ones who constitute the majority of the youth population of India? or is it the urban or the slum youth? I feel it is crucial, because their health problems vary from region to region and from place to place, depending on the different socio-political milieu.

Youth is a unique period in the human life span, wherein a person experiences a 'belonging' and not so belonging' state in his/her existence as an individual. The drastic biological and psychological changes experienced within himself/herself, the sociological experience of the transition from childhood dependency to the adult autonomy, the intolerance, misunderstanding and the neglect experienced from parents, teachers and the 'grown ups' in general, the disturbing conflict and tension arising out of the idealistic enthusiasm and the uncompromising impatience with hypocricy, the frustrating disillusionment on the affairs of the society around-all these and many other personal experience make the people of this age groups, phenomenaly different and substantially unique from any other groups. The above characteristics of the youth clearly prove the fact that their health understood as total well being involves many factors, not so thought about till recently as normally related to health.

Contrary to the experiences of social scientists, the medical profession contents that youth is a healthy group. It may be partly

because of their limited understanding of the concept of health in the broader sense, and partly because of the inadequate training they received during the course of study, to understand the teenage problems deeply.

A sizable bulk of the population in India today is constituted of the youth, between the age group of 15-25. According to reliable sources, it amounts to 135 million, out of the 700 million population of our country. At the global level, the total number of 15-24 age group was 850 million in 1980, far exceeding the entire population of India.

The youth of a particular period of history is the authentic reflection of the society of that time. If our youth is not in a state of total well being, it is because the society is not well. Only a healthy society can give birth and sustain a generation of healthy youth. The health of the society ultimately depends on healthy economic, social, political, religious and cultural aspects of that society. These factors are important, because they are the determining forces of the total well being of individuals families and communities.

If we dare to take a quick look at the Indian society as a whole, can we objectively say that the overall environment is condusive to the emergence of a generation of healthy youth? The prevailing object poverty of the majority of our people, concentration of wealth in the hands of a few, widespread unemployment, the existing low wages especially in the rural areas, rampant corruption and dishonesty prevailing in all spheres of life, sharp decline of the human and sublime moral values in personal and social life, the growth of the capitalistic values and the cut-throat competitions, unrealistic and mythifying role of the media, etc., etc., are some of the glaring maladies of the society we are living in. These are reflected in the life of the youth in general in the forms of frustration, drug and alcoholic addiction, involvement and participation in the anti-social activities etc., They are all but symptoms of certain deep rooted illness of the society, to which the youth are 'condemned' to cope with.

In the communal violences and the riots that our country witnessed in the recent past, the urban and slum youth, played a very significant role. The incidence of teenage pregnancies, 'accidents' as the youth nickname it, the mushrooming of illegal centres of abortion in our cities, eve teasing, bride burning and other assaults on women, child marriage and early parenthood—all these according to me are real symptoms and reflections of an unhealthy society, rather than unhealthy youth. It is important that a proper social diagnosis is done and an overhauling of the society is initiated, so that we may have a healthy generation of youth in mind, body, and spirit—growing towards adulthood, in whose hands the future of the nation will be safe and secure.

Youth is our resource, that too, healthy youth; none of us will dispute over it. As we have seen above, the health of the youth is conditioned by the health of the society. A radical transformation of the society is inevitable, for our nation to become healthy. Now the question I want to raise here is: can we positively try to harness the enormous potentialities of the youth in India to transform the very society they belong to, which in turn can ensure a healthy generation of youth in the long run? I am highly optimistic about this possibility, provided we win their confidence, through sincere involvement and humble search, walking along with them side by side.

It is hightime that we thought of ways and means for positively channelising the energy of the youth for creative purposes. The unorganized sections of youth should be

organized at local and regional levels,and a value based awarness building process should be initiated among them through nonformal education, functional literacy and continuing education for the school dropouts. There are hundreds of thousands of nominally existing youth organizations especially in the rural areas of our country, which should be reactivated, through well thought out plans for nation building. I am confident that if they are properly motivated and adequately trained they can make immense contribution towards the national goals of 'Health for all by 2000 A.D.' 'eradication of illiteracy; and integrated rural development etc. Different opportunities should be generously provided to them for effective utilization of their youthful and powerful resources, and thus inclucating in them the feeling that they are important of all, that we are hopeful of them.

To ensure their participation and collaboration, our very outlook of the youth and their problems need to be changed. We must start looking at them as individuals with unique personalities of their own and not merely as 'little adults' or 'overgrown children'. Any amount of sympathy will only put them down,but real empathy can build them up. Efforts should be made along with them to develop their own inherent resources to cope with emerging needs of this particular age and to develop their own potential to become craftsmen of their own lives and life of the entire nation. Special attention has to be directed towards vulnerable sections of youth, such as those belonging to broken homes, victims of physical, emotional and sexual assaults, members of SC and ST groups, homeless, unemployed, extremly poor etc., care should also be taken for the chronically ill and physically disabled youth, so that they may not be pushed out of the main stream of social life.

At this juncture, I would like to quote an incident from the Life of Jesus Christ, as narrated in the Holy Bible (Lk. 7 : 11-15) A young man, the only son of a widow died, and at the time of the funeral procession, Jesus Christ happened to pass that way, learning from the people assembled that this young man was the only son of the widow, Jesus Christ was moved with compassion, and reaching out his hands to the coffin, he touched the young man; and giving him new life, enabled him to stand up, and then gave him back to the widow, for whom this young man—her son was the only resource in life.

The youth of today needs a life giving touch from all those for whom the youth and the entire human society is still a matter of concern.

Yes the healthy youth is our best resource. We can make our youth healthy, if we can make our society healthy. And the youth is our best resource to build a healthy, humane and Just Society.

Towards A Low-Cost Rational Therapeutics

Reflections of an intern in a rural health centre

—Navin Machado

In this paper I attempt to elaborate on the following 3 areas in the light of my experience as an intern in a small rural health centre. Firstly rational therapeutics in a rural setting. Secondly, the genesis and propogation of the tonic culture. Thirdly, the mystique of injections.

Background

My study encompassed 750 clinical cases, over a period of two months. It was done in Huskur, which is a village 22 kms from Bangalore, 6 km off the Bangalore — Hosur Road. Huskur has a population of 1500, there are 15 villages in a radius of 5 kms. The centre thus caters to a population of about 7500.

There are two general practitioners in the village. One comes daily, the other bi-weekly. There is a government PHC 5-6 kms away and a clinic run by religious sisters 6 kms away from the main road.

The people are predominently Telugu speaking immigrant population. Most are small scale and marginal farmers.

In my study, all diagnosis were clinical. Skin diseases constituted about 35% of cases (of these, half come under the category of wounds and wound infection and about a third had either impetigo or furuncles). The remaining had ABCD deficiencies, scabies, fungal, and other skin diseases. About 30% had respiratory diseases (of which URTI constituted half, asthma, about a quarter and the rest had lower respiratory tract infection and a few pulmonary TB).

Of the remaining one third the following was the break up in decreasing order or importance—amebiasis, arthralgias and arthritis, helminthiasis, other diarrhoeas, anemia, eye and ear infections, malnutrition, gynaecological disorders, vitamin deficiencies, dental disorders, acid-peptic disease, malaria, leprosy and other.

Rational therapeutics for Primary Health Care

The drugs used in treatment were 27 in all, yes 27 in all, against 60,000 drugs and chemicals in our national formulary. These included those used for symptomatic treatment: aspirin, paracetamol, CPM, and antacid, an antispasmodic, diazepham, cough mixture and turpentine linament. Antihelmintics, piperazine citrate and Bephenium hydroxynaphthoate vitamins and minerals, Vitamin A and B complex, ferrous sulfate, chemotherapeutic agents and antibiotics, (sulfaphenazole, penicillin, chloramphenical and nitrofurazone ointments, chloroquine and metronidazole). Tropical preparations: iteol, gentian violet, benzyl benzoate. Others such as aminophylline, local anaesthetic and oral rehydration mixture.

The question that now arises is, how effective was the treatment—effective in medical terms. Only 5% of our patients were referred to a hospital which means 95% of diseases were managed with less than one-two-thousandth of the drugs and chemicals in our national formulary. Follow up was possible in only about 1/3rd of cases, almost all of

which showed a satisfactory response to treatment. The incidence of side-effects were few, minimal and far between, effective in economic terms. On an average it cost the patient one rupee. I must mention here that this included treatment for upto 5 days in many cases. Cost effectiveness was maintained on the following basis.

(a) Preventive aspects were stressed,

(b) drugs were used along the following principles. firstly, symptomatic treatment alone was used, unless definitive treatment was indicated by the nature of the disease, after all "about 4 out of 5 illnesses are self-limiting" (Helping health workers learn, David Werner and Bill Bower) Secondly definitive treatment was used as far as possible as single drugs, in as few doses as pharmacologically justified and only when a definite diagnosis was made.

Low cost, rational management

I shall illustrate, with a few examples. *Airborne contact dermatitis* :—a skin allergy to Parthenium was treated as follows: avoidance of the addergen, minimising the exposed area of the body, application of any available oil to the exposed area, keeping finger nails short, daily evening bath and change of clothes. Only in more severe cases were antipruritics or salicyclic acid, ointment give. Topical steroids were reserved for more resistant cases and a short course of systemic steriods only for the most severe cases. The reluctance to use drugs unnecessarily is obvious.

Upper respiratory tract infections : similarly symptomatic treatment and simple measures such as steam inhalation and saltwater gargles were advocated for all those of viral aetiology. A differentiation between those of viral and bacterial aetiology is emminently possible on clinical grounds. Sulfonamides were used for those of a bacterial nature. And compare the costs Rs. 3/- for a course, against Rs. 30/- for a course of erythromycion, the so called drug of choice. (The treatment equally effective, the cost 1/10th, the consequences for reaching). Drugs relegated to history in Western text books are used effectively in an Indian setting. More expensive and often life-saving antibiotics are used only when absolutely indicated, such that the ever worrying problem of drug resistance is kept in abeyance.

Lower respiratory tract infections : were treated with injectable pencillin for 7 days, when there were problems regarding compliance, treatment was switched to oral pencillin, 20 out of 21 cases were managed on these lines. And compare the costs, for a child of 4 years Rs. 15/- against Rs. 50/- for a course of oral Ampicillin or Rs. 300/- for a course of intervenous Ampicillin and, gentamycin, admission to a hospital, a chest X-ray and an intravenous line. *And in a country such as ours cost must be an important consideration.* The question that then arises, is, would any more drugs be desired? The answer to which is, if we are to maintain the same cost effectiveness, no more drugs are called for, unless ofcourse, more drugs are made available to the common man's pocket.

The implications of this study are obvious and I am sure my discerning reader has perceived the depth of the problem. It is only when every mother accompanying a child, that is brought to a sub centre, is given dietary and immunisation advice irrespective of nature of the illness; when diarrhoea is treated with dietary and oral rehydration advice alone, unless definitely indicated, when anemia is treated with dietary advice and ferrous sulphate tablets costing 1.4 *paise/day; when helminthiasis is diagnosed with certainity on clinical grounds and treated effectively within Rs.* 2/-, *then and only then*

can the hope for 'Health for all by 2000 AD' be realised.

Tonic Culture

This was a study of the people who came to the subcentre asking for tonics. The victims of this tonic culture, fell into 4 groups, (a) firstly *children under 3 years of age* often of mothers who had inadequate breast milk, or stopped breast feeding early due to various socio-economic considerations. The children were then put on artificial feeds, which were hopelessly inadequate, resulting inthe vicious cycle of malnutrition and infection.

These mothers believed that tonics were appetizers, when the loss of appetite was invariably related to chronic under-nutrition and infections; that tonics were meant to put on weight (Mothers who didn't have money to buy pulses, vegetables, eggs and milk had money to buy tonics); that tonics were builders of immunity as the child had frequent colds and diarrhoeas.

Secondly young girls in the latter half of the second decade. Girls who had not attained menarche, probably as a normal variant, girls who had white discharge often physiological; girls who had scanty periods, which are the rule, rather than the exception in the early years of womanhood. Here mothers believed that their daughters hady 'less blood' and scanty periods and hence required a tonic.

Thirdly newly—married men, who had problems coping with the stresses of providing for a family or disappointments in their sexual lives.

Fourthly the elderly, especially women, many of whom had degenerative diseases for which the treatment is not always effective and often time—consuming. The patient was told she had 'weakness', which was taken as an indication for a tonic. The diagnosis excluded them from household work they were no longer capable of and the bottle of 'tonic' in the corner served as a passport to a more sedentary life.

We all know that the only indication for vitamins and minerals are specific deficiency states. Tonics are not appetizers, body builders, builders of immunity, menstrual regulators, aphrodisiacs or cures for weakness.

If the myth of tonics has lived, we who are involved in health, must be responsible for both acts of commision by not discouraging such beliefs and acts of commission by prescribing it for all types of problems.

Mystique of Injections

The third area is the mystique of injections. most people were nebulous about the difference between the same drug been given orally and parenterally but they considered injections superior to oral preparations because of the following factors :—

A. factors for which doctors were responsible :-

(1) Firstly when an illness was of a more serious nature, irrespective of the necessity, the need for an injection was specified to make some quick money.

(2) Secondly even if the injection didn't cost much, a much higher charge was levied eg. in our sub-centre the list of charges reads, any injections Rs. 3/- though aminophylline costs Rs. 1/- and Benzathine Pencillin 12 lakh units costs Rs. 4.50.

(*Contd. on Page 32*)

If the patient can not come to the Dispensary the Dispensary should go to him

By community health we mean not only the health needs of a community but also other aspects which go to make up the general well being of the community. The concept of community health is based on the principle that the health of person does not always depend upon the condition of his physique alone but also, to some extent, on his mental and moral states which are again influenced by his social and economic conditions. Therefore our health programme are not exclusively limited to looking after purely health needs of the community but also to economic, cultural and social needs of the community. Socio Educational Centre has been working on two sectors:

1. Youth Activities,
2. Mother and Child Health Programme.

Under the youth activities we have

- Social Leadership Training Programme
- Vocational Training Centre,
- Poor Children's Fducational Assistance.

Under Mother and Child Health Programme we have

- Health and Adult Education Programme
- Clinic
- Mobile clinic
- Individual health care
- Small savings scheme
- Pre-matrimonial course
- Balawady for pre-school children
- Functional literacy.

Our Purely health programme in the community are concerned with curative as well as preventive health services to the community. We have a dispensary in the Centre at Gundala. The people around have been making use of its services ever since it was opened in 1975. The doctor and the nurses working in the dispensary after attending to the medical needs of the patients, take the opportunity to give them health education on the prevention of diseases. This dispensary is also in charge of the Mother and Child Health Programmes. It runs a mobile clinic also. Twice in a week our doctor and nurses, visit one of the eight villages adopted by the Centre for the present, to attend to the health needs of the people. They attend to the curative as well as preventive health needs of the people. All the small and the simple health needs of the people are attended to while big and serious cases are referred to the hospitals, both government and private, with which the Socio Educational Centre is in contact with. While and after attending to the health needs of the people the doctor and the nurses educate the people on how to prevent all kinds of diseases for "prevention is better than cure".

Under individual health care the Socio Educational Centre takes care of lepers, T.B. patients, people disabled by accidents and chronic diseases and the aged. Besides supplying and buying medicines for these people we also supply food to all the deserving cases.

The community health rendered by Socio Educational Centre are not only curative health services confined to dispensary alone, but they also form part of the other service activities pursued by it. But in this case the Health services are of preventive nature. This is based on the service motto "that if the patient

can-not come to the dispensary the dispensary should go to him" In the case of the rest of activities under this section the preventive side of health care is dealt with. The Social worker-incharge of the Small Savings Scheme on her routine visits to the beneficiaries impresses upon them, as well as their friends and neighbours, how their small savings can help them to meet their sudden health needs caused by any contingency or accident with out going to the money lenders to borrow money. They also take the opportunity to give them health education on personal hygeine and sanitation of their home and surroundings to prevent the incidence of diseases so that they could save the money which they will have to spend when any member of the family falls ill.

For the *pre-marital education* to the youth we have a mobile team visiting various villages in the diocese according to need. The youth are taught the duties and the responsibilities of the wife and husband towards each other, the responsibility of parents towards their children, family planning and the necessity to keep home clean and tidy and free from disease and want.

In the *Balawady* the children are taught the need of putting on clean clothes and keeping themselves clean. The teachers impress upon the parents the necessity of keeping their children neat, clean and healthy, so that they may be protected from all kinds of infantile ailments.

Functional literacy is used in Adult Education. As we work among women personal hygeine and health sanitation of home and surroundings, food and nutrition are the important subjects through which they are taught the three Rs. In all the activities under the first sector, the subject of community health is given its due importance.

In the curriculam of both the leadership training and the vocational training we conduct every year, the educators or the catalysts are taught to teach the people the importance of health and sanitation both personal and public and how to apply and practise principles of health and sanitation in their daily life. The trainees in the vocational training are taught the principles of personal hygiene, health sanitation to be practised in their life at home and elsewhere. In the activity of *poor children's* educational assistance, the Socio Educational Centre, in addition to the financial assistance also provides the children with a free medical check up and free medicines.

—Sr. Damiana Elamthuruthil

C.H.A.I. Annual Meet-1984

A Comment on the Exhibition

Now that CHAI conference 1984 is quite far away, and all the noise has died down, I'd like to make a critical comment or two on one specific part of it, the exhibition. I lay great faith in education, and hence I believe that the exhibition was very important. I spent much of my free time at the exhibition—discussing and also observing.

The exhibition was a mixed success. There was a section on herbal medicine which evoked a lot of interest and enthusiasm, even among doctors. This must have given a boost to the participants opinion of the value of Herbal medicines. Hopefully, the plan to publish the information on Herbal Medicine will go through in English and in Malayalam if possible.

Another section tried to analyse the Socio-Economic—Political factors underlying the whole problem. This section was ignored, by and large, because none really understood what it was trying to say. One occasion where a single picture is NOT worth a thousand words!

The first section on Rational Drug Therapy, was the most energetic. It created so much of excitement! Much more than anyone would have dreamed of. But also, there was more heat than light—confusion prevailed.

The most intriguing poster was entitled "Banned and Bannable Drugs". Everyone wanted to know—what does "bannable" mean? Are these drugs banned? If so, how are they available in the market? Why are they banned? What do we use in inflammation, if Analgin and Phenylbutazone are banned?. . . . Too many questions, few or no answers. They all went away with guilty feelings, discussing this poster. They continued to discuss it a month after the conference—in a hospital in Andhra Pradesh, in many hospitals in Kerala, wherever I went, I was asked about the poster. But their pharmacies already contained a few thousand rupees worth of such drugs and their doctors continued to use such drugs, so they said that those Bangalore doctors were talking nonsense. Guilt has to be rationalized!

Another poster sarcastically said "Ayurvedic Drugs" and showed Garlic Pearls and what not. Many of the visitors decided that garlic pearls etc were good. Humour is useful, but not if it distracts understanding.

The language used was generally of an unnecessarily high scale. Most of the participants are Malayalis and Tamilians working in Kerala or North India, and hardly speak English. (The exceptions were the minority Bangaloreans and Mangaloreans) Most exhibitions fail due to complex vocabulary or complex grammatical constructions.

The posters criticised; they did not offer solutions. This created a "negative" atmosphere—I can't describe it better.

There was no one around to guide, discuss or stimulate the visitors; hence the confusion and anxiety created by the Drug Policy section; hence the apathy towards the S-E-P section. I tried to play this role, whenever I had free time-but that was only for short periods of time.

The solution is obvious from the problems. The exhibition must be planned beforehand, so that it will be systematic—presentation of problems,discussion of etiology, suggested solutions (or whatever). It must be aimed

their role in immuno-suppression, pregnancy outcome, reduced productivity and even school performance. These potentially important issues should not be overlooked and deserve further investigation. The public health significance of any relationship between humans and their intestinal parasites will not be assessed satisfactorily until thorough longitudinal studies are carried out. Human parasitology has left the zoological arena and has become an interdisciplinary subject now requiring contributions from anthropologists clinicians, epidemiologists, immunologists and sociologists, among others. The same may be said of nutritional science as it attempts to unravel the complex causes of human malnutrition. In our opinion the case for longitudinal studies, conducted by interdisciplinary teams of scientists in communities where malnutrition and intestinal parasitism prevail, needs to be made to those agencies with the financial capacity to support such research. It is only when the results of such studies are available that the actual rather than suspected impact of intestinal parasites will be identified and appreciated.

In the past, health planners, no doubt through lack of information because of the insidious nature of the parasitic disease, perhaps tended to discount the public health significance of parasites lie giardia, ascaris and hookworms. However, on the basis of current knowledge we would urge public health planners wherever possible to review priorities for public health measures that could begin to relieve the burden of human intestinal parasitic infection. Depending upon local conditions, this approach may also bring some relief from the ravages of malnutrition.

Courtesy: *Herald of Health*

(*Contd. from Page 23*)

B. factors which influenced a patient in such a judgement :-

(1) Firstly dramatic relief of symptoms e.g. breathlessness in an acute attack of asthma, of inflammation in infection, of fever, of intractable vomiting. This has lead to the myth of one—injection cures, even in conditions such as bronchopnumonia.

(2) Secondly cost, isn't it natural for some one to assume that anything that costs more should be better.

(3) Thirdly the air of mystery for a patient related to the administration of an injection. Here it must be pointed out that, for the patient, allopathy differs from other traditional systems of medicine only in this respect.

My plea is 3 *fold, that injections are not given unnecessarily to raise finances, that all injections are not included under a higher charge and that when there is a choice between the route of administration of a drug and the difference is only in the time taken for the onset of action, this should be explained to the patients with the relative costs and he/she be given the choice of the route of administration of the drug.*

News from the Diocese

Beginning with this issue we are starting a new column in Medical Service "News from the Diocese. This would give details of the development in the Dioceses with regard to the work initiated to promote the involvement of CHAI. The relevance of this could be viewed against the background of the attempts being made to reorganize and revitalize CHAI in each Diocese. The "Diocesan Co-ordinators of CHAI", wherever appointed are requested and welcomed to prepare a report of the attempts made in this regard in their respective Dioceses and send it to the office for publication—Editor.

Diocese of Mysore

A meeting of the key personnel related with health and development was convened on 7th February, 1985. There were 22 participants. Sr. Beatrice, Diocesan Co-ordinator of CHAI, welcomed everybody. Tne meeting was all about seeking collectively ways and means to make the health care system of the Diocese relevant and responsive to the needs of the poor. The meeting got started with the opening prayer and the inaugural address was given by Rt. Rev. Dr. M. Fernandez, the Bishop of Mysore. Quoting relevant passages from the 'Cor unum' document he stressed the need for christian solidarity with the poor and the need for health services of the church reaching the real needs of the poor, and urged us to strive for the development of the people in all respects.

Following this, the Diocesan Social Service Director Fr. Becket D'Souza spoke about the importance of wholistic approach in our healing ministry. He based his talk on the gospel message of the paralytic man at the pond of Bethsaida (John 6 : 1-9). Jesus took note of this uncared and helpless person, reached out to him and healed him.

Some analysis on the existing health care delivery system of the Diocese was also attempted. Dr. Pius started with sharing some of the draw backs in the health activities of the Diocese and stressed the need for preventive aspects. The participants reflected upon the drawbacks in the system at three levels—at the private practice level, at the institutional level and at the level of government health centres and hospitals. Further they raised these questions for their discussion—What all diseases one comes across, what percentage requires a doctor and medicines and what percentage does not require, how much health education is given, how much the people are involved in health care and what could be done in future.

To initiate action for the future, a three member committee was set up for the CHAI unit. The following resolutions were taken:

Improve the cooperation and coordination among the institutions. CHAI members should meet thrice a year, tentatively February, June and November.

We will not use banned and expired drugs and will not collect money for free services.

We will not isolate patient from the family, family from the community and community from the society.

We will try to stick to wholistic approach.

With all these deliberations and resolutions, the meeting came to a close by the evening with a colourful dance which presented the idea of leadership development to reform the Indian Society.

—*Sr. Beatrice.*

SOLAI MOBILE RESOURCE CELL

(SMRC)

—a regional Training team—

The SMRC is one of the units of SOLAI (Trust). It is a mobile style training team consists of our full time trainers and ten part time honorary resource persons. It is available to support the training needs of the Rural Development and community based Health programmes in the voluntary sector.

Areas of Training

- ⊛ SOCIAL LIFE ANIMATION
- ● COMMUNITY BASED HEALTH ACTION

* Building groups for collective action
* Health Education — Political prespective
* Organising Women for liberation
* Youth power planning and action
* Consumer education and action
* Environmental education and action
* Herbal medicine
* Development education (General course)
* Media for Development

Priority groups for training (For sensitizing and skill development programmes.)

* People's organisations (youth groups. Women groups/village leaders)
* Action groups/small organisations
* Teacher Training Colleges/Institutes
* Seminarians (Preferably Deacons)
* Diocesan programmes for rural areas
* Traditional drama groups
* Writers

Areas of operation

Tamilnadu, Pondichery, Chittoor Dist. of Andhra Pradesh & KGF (Karnataka)

Languages : Tamil/English Telugu Kannada.

Cost : A reasonable contribution to SOLAI (Trust) will be fixed on the basis of the financial position of the inviting organisations and the duration, nature and the number of participants of each course.

For further details please write:

The Chief Resource person
Solai Mobile Resource Cell
Solai (Trust) Christianpet
Katpadi-632 007. N.A.

"Surveillance of Essential Drugs"

Surveillance is a word that has been used in the past to mean 'watching carefully over a person having an infectious disease, to see both predictable and unpredictable behaviour of both, patient, and disease (and sometimes the environment also). In recent times however, Surveillance has been used to mean—" the exercise of continuous scrutiny of, and watchfullness over the distribution and spread of infections and factors related thereto, for effective control". (Ref. I). It is not just passive reporting of disease, but prompt investigating, confirming in the lab., detecting the source of infection, route of transmission, identifying both primary (index) and, secondary cases, systematic collection of morbidity and mortality data, consolidation and evaluation of data, special field investigations and rapid dissemination of information for control and prevention. (Ref. 2, 3). Surveillance could be an important component of Health Information Systems and thus provide health agencies with overall intelligence and disease accounting capability. Thus, early warning of unexpected occurrence of diseases and changes in prevalence, and its potential effect on the community could be suggested. (Ref. I). Surveillance can be seen as an essential aspect of rational design and evaluation of any control programme. (Ref. I). It is now being used in many other areas viz. Nutritional Surveillance, Epidemiological Surv., Environmental and Demographic Surv, etc.

Applying this concept of Surveillance to Essential Drugs, we can see that it is very basic to any rational drug policy we could think of. By substituting the word "essential drug(s)" in place of "infectious disease", the concept of disease surveillance becomes "essential drugs surveillance."

Components of an essential drug surveillance system would include an essential drugs committee, a quality control laboratory, field officers, data collection and analysis wing, an epidemiological wing, educational wing and an evaluation and follow-up wing.

Essential drugs Committee should include a physician, a Maternal and Child Health specialist, a Pharmacologist, a Pharmacist, Health Ministry representative, representatives from Directorate General of Health Services (DGHS), State Health Directorate and District Level (DHO, DMO, etc.), a few representatives of both Consumers and noted Drug companies (i.e. manufacturers of essential drugs), Field Officers (to be discussed below) and a Legal adviser. The membership of this Committee should be temporary and, excluding the representatives from the Govt. side, all others could be on a three or five yearly basis (or whichever interval is found to be convenient, operationally). This Committee should meet at suitable intervals and decide on the list of essential drugs to be accepted, and also what are the policies based on the experiences of both the consumers and providers of drugs, especially in relation to side effects, cost, availability, acceptability, stability during storage, etc.

Field Officers would be members of the Committee who, in allotted areas, could inspect hospitals, health centres and dispensaries at stipulated intervals and report back to the Committee. They could even conduct surprise checks on prescription, dispensing, drugs storage practices, etc.

Quality control laboratories could be set up as regional essential drugs centrol contres. These could be the present day drug control

WANTED

Training Officers

QUALIFICATION

Post graduate in Rural Development and Diploma in Health Education or Dip. in Sanitation.

or

Graduate in Nursing or statistics and Post graduate in Sociology or Anthropology.

or

Post graduate in Economics or Social work and Diploma in Marxian Thought.

or

Post graduate in Nutrition and Diploma in communication.

EXPERIENCE

* atleast 3 years grass root level experience in Rural Development/Community Health programmes.
* experience in conducting participatory training programmes at different levels.
* Good knowledge in Tamil is essential/Knowledge in Telugu or Kannada is preferable.
* ability and interest in conducting short training programmes on Social Life ANIMATION in rural areas of Tamilnadu, Pondichery and in certain pockets of Andhra and Karnataka.

Programme Asst. (Technical)

QUALIFICATION : Dip. in Arts/drama/communication.

EXPERIENCE

* Conducting training programmes for Animators/Community organisers.
* Producing simple educational aids and experience in Popular theatre/Journalism is preferable.

Office Secretary

QUALIFICATION : Type writing Higher in English and Tamil

* Experience in office administration
* Short hand in Tamil is preferable.

Pay commensurate with qualification and experience.

Apply with Bio-data on or before 30-4-85

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labs, adequately integrated with both consumers and private hospital representatives. These labs. could be linked with international labs. to achieve national and internatjonal standards.

An epidemiological wing would be necessary in any drug surveillance system to recognise drug problems (overuse, misuse and emergence of toxicity among essential drugs, etc.), to verify the problems (based on past data), to confirm and study the ecology of the problems, to collect, analyse and tabulate data in addition to conducting field trials and of course to give recommendations to the essential drugs committee.

The educational wing should inform the consumers, pharmacists, medical practitioners and institutions about the drug policies, toxicities, banned drugs etc., and conduct seminars, audiovisual presentations, quizzes, competitions, and even bring out publications such as bulletins or journals.

Finally, the evaluation and followup wings would conduct continuous and terminal evaluation of the drug surveillance system. This could be in the form of questionnairs (KAP) *Knowledge Attitude Practices*, or in terms of specified time or population-bound objectives. Terminal evaluation could be at the end of a specified period of time, when some specific objectives are achieved. Follow up would consist of action taken, based on recommendations, (set by the epidemiological wing in consultation with the essential drugs committee), and findings of evaluation.

This essential drug surveillance system discussed above could be implemented at any level right from national to voluntary (mission hospital or health centre) level with suitable modification. If time and money permits, help from management sector could be utilized, to scientifically implement this system at all levels viz. through the use of Operations Research etc.

In conclusion, all that has been written may sound highly theoretical and complicated, but in a matter as important as essential drugs, no stone should be left unturned if we are to deliver an efficient system to the people. Any pitfalls of a system are likely to increase and proliferate like a cancer, and spoil whatever good that has been done, especially in countries like India. So it is the duty of all of us to see that everything that is earthly possible (within the resources available) is done to tackle this problem of drugs used in the health sector.

References : (I) WHO 1968, Report of the Technical Discussions at the 21st. World Health Assembly On National and Global Surveillance of Communicable Diseases; (Unpublished document, A21/Tech. Discussion/5, WHO Geneva. (2) Benenson, A.S. ed (1980). Control of Communicable Diseases in man, 13th, edition, American Public Health Association, New York. (3) Kerr L. White *et al* (1976) Epidemiology as a fundamental science, Oxford University Press, New York.

An article by :-

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15 Months Training in Community Health and Development Concluded

On completion of the 15 months training in Community Health and Development organized by CHAI (CHD), 14 sisters of 'Mission Sisters of Ajmer' were awarded with certificates at a function hosted in this connection on 20th of April, 1985. Bishop Ignatius of Ajmer Diocese distributed the certificates at the function presided over by Fr. John Vattamattom SVD, the Executive Director CHAI, and attended by the training team of Community Health Department. Sister Yvone, the mother general of the congregation, governing body members and a good number of the sisters were present at the function.

Appreciating the training programme, Bishop expressed the hope that the trained sisters would fulfill the charism of the congregation better. This would be a magnificent work for the Diocese and the country. Earlier, while giving the welcome speech Mother Yvone said that the trained sisters are taking the congregation back to the original purpose for which it was founded. In his presidential address, Fr. John mentioned that through village work they are giving the love of Christ and thus themselves to the people. This demands rededication and recommitment Two of the trainees shared their experiences. The training and village work instilled in them newer insights and reinforced their commitment to their own religious life. Fr. Thomas Joseph, programme director of CHD of CHAI expressed the team's appreciation over the performance of the sisters both at the theoretical and practical levels. He appreciated the congregation for the process of rediscovering its real purpose through organizing the training programme and motivating sisters for village work. Sr. Nicolette, one of the trainees proposed the vote of thanks.

Employment

Mr. J.R. Livingston Rose
T.C. 14/1309
Observatory Lane
Palayam, Trivandrum 33
Kerala, is a General and Psychiatric Nurse. Seeks suitable employment. Those institutions interest may contact directly.

Indian Hospital Association

C-11/72, Shahjahan Road, New Delhi - 110011

Sl. No.	Name of the Institute	Type of the Course	Duration	Remarks
1	All India Institute of Medical Sciences, New Delhi - 110029	Masters in Hospital Administration (M.H.A.)	2 years for medical graduate and 3 years for non medical graduates.	Admission twice a year.
2	Y.M.C.A. Institute of Management Studies New Delhi-110001	Diploma in Hospital Administration (D.H.A.)	1 Academic year	Open to medical graduates.
3	Faculty of Business Management Delhi University, Delhi - 110007	Master of Business Administration (M.B.A.) in Health Care Administration (H.C.A.)	3 years	Open to medical graduates only
4	Armed Forces Medical College Pune, Pune University.	Diploma in Hospital Administration (D.H.A.) and Degree in Hospital Administration (M.H.A.)	1 year for Diploma, 2 years for Degree.	Open to medical graduates of the Armed Forces.
5	Post Graduate Institute of Medical Education and Research, Chandigarh.	Diploma in Hospital Administration	1 year.	Open to medical and non-medical graduates.
6	National Institute of Health and Family Welfare, New Delhi, Delhi University.	M.D. (Health Administration)	2 years	Open to medical graduates.
7	National Institute of Health and Family Welfare, New Delhi	Short Course in Hospital Administration.	2 weeks	Open to medical and non-medical graduates

8	Indian Hospital Association, C-II/72, Shahjahan Road, New Delhi - 110011	Short Course in Hospital Administration.	2 weeks	Open to medical nursing and non medical graduates
9	Institute of Medical Science, Sri Nagar, Jammu and Kashmir.	Degree in Hospital/Health Administration.	2 years	Open to medical graduates (Likely to start)
10	C.M.C. Hospital, Velloore Tamil Nadu.	Certificate Course in Hospital Administration.	1 year	Open to non-medical graduates only
11	National Institute of Health and Family Welfare, New Delhi	Diploma Course in Hospital Administration.	1 year	Open to medical graduates (likely to start)
12	Tata Institute of Social Sciences, Sion-Trombay Road, Deonar, Bombay - 400088 (Extra Mural Studies)	Certificate Course in Hospital Administration	1 year	Open to medical and non-medical graduates
13	Hospital Services Committee Bombay Management Association, Bombay.	Diploma Course in Hospital Administration.	½ year	Open to medical and non-medical graduates
14	Pune University Pune at Sancheti Hospital and Ruby Hall Clinic-Pune.	Certificate Course in Hospital Administration.	1 year	Open to non-medical graduates.

Note : For details write to the respective Institutions.

Compiled by : Dr. P.N. Ghei
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Indian Hospital Association