# MEDICAL SERVICE

human resources development as important as economic development ● nursing the crisis in medicine ● patterns of medical use of drugs — a preliminary survey ● legal education — worker's rights ● book review : the state of the worlds' children-1985

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## contents

# EDITORIAL

## LOOKING BACK — LOOKING AHEAD

Taking stock of things to plan ahead is a prudent step in every day life. The Catholic Hospital Association of India needs to look far ahead and recognise its all important role and increasing challenges in the field of health care in this country. It is all the more important when the governments all over the world and also that of our own country is recognising the role the voluntary organisations will have to play in the field of health care. There is an ever growing awareness from all concerned to come to the service of the poor and the oppressed, the voiceless, the most needy, the least cared for, the ones in the periphery. It is here the quality of our service lies.

Service to the poor and needy should come, not from a feeling of pity but from a feeling of duty and dedication. What the poor need is not our pity and charity but the recognition of their rights and dignity and the type of help that will safeguard this dignity. Our health services should be directed to the least ones and the last ones and should not be restricted to matter of convenience and profit. It is here we will have to examine ourselves and see where we stand.

Already as far back as 1975, the National Advisory Council of the CBCI had said the following in its meeting held at Bangalore; "Our health apostolate should be planned within the context of the all-round development of the rural people, especially of the poorer sections, whose needs cannot be effectively answered by our medical institutions with a focus on curative and specialized medical care. Rural -based health programmes, like cottage hospitals and community health centres in rural areas, should receive top priority in our planning as also the orientation training and experience of nurses, medical students and religious towards rural work. Policies of funding agencies should be directed towards implementing these objectives.

It was generally agreed that in the future our funds should be directed to health schemes in rural based projects.

— Catholic Hospitals should be committed to giving basic health service rather than expensive specialised care.

— Every Catholic hospital should endeavour to give at least an additional 10 per cent free medical service to the poor.

— Catholic hospitals should give more care to the training of health nurses for rural areas.

Training of personnel should be:

— rural oriented

— committed to the needs of the people rather than the completion of a programme,

— concerned with the training of health workers.

Efforts should be made to study and use the Indian systems of medicine and health care. Hitherto this has been negligible. Such attempts will be useful becuase this system is :

— cheap

— accepted in rural areas

— effective

and can be integrated in health care service.

The Catholic Hospital Association of India during its this year's convention and workshop to be held at Lucknow from 10-14th November will focus attention on the future involvement of this mighty and powerful organisation in the field of health care in the country. Let us be open to the Spirit and His inspirations to know what is ahead of us in the field of health care ministry in this country.

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## ANNOUNCEMENT

CHAI Annual General Body Meeting 1985.

**Credential Committee**

Chairman : Fr. J Antony samy (Ex-officio)

Member : Sr (Dr) M Fernanda ( ,, ,, )

Member : Fr. George Pereira (nominated)

**Nomination Committee**

Sr. Cassia, Fatima Hospital, Lucknow

Sr. Marcellina, Mariampur Hospital, Kanpur

Sr. Tresa, Benziger Hospital, Quilon

Executive Director

# Human Resources Development as Important as Economic Development

—Rajiv Gandhi
*Prime Minister of India*

Women may be the largest disadvantaged class in our country today, although much is said about backward classes and scheduled castes and tribals but if we put everything together, ultimately, it is women who need help most. At the same time, this help must come in a manner that it does not compromise the self-respect and the dignity of women. Government can do a lot of things, have tried to do a lost of things, and have made a lot of laws. Our Constitution has given equal rights to women but much of it has not flowed down to women themselves. And the fact is that a social problem cannot be tackled at its own level and it is really tackled best by Voluntary Agencies and by highly motivated people working in society.

While dealing with social problems, often we are not really getting down to the root cause; we are just grappling with the symptoms only.

### Do not compartmentalise

We might ask ourselves: why are we giving a high priority to women? It doesn't really need an answer, but let me give a quotation from Gandhiji. Gandhiji said that 'woman is the companion of man gifted with equal mental capacities. She has the right to participate in the very minutest detail in the activities of man. And she has an equal right to freedom and liberty with him'. Unfortunately, Gandhiji had also related it to man. This is what we have got to get out of. The idea is absolutely right but we men tend to really put women in a separate category. The fact is they are not. We are all human beings, we are all the same. And everything must be based on that thinking.

Our Constitution gives some fundamental rights. Discrimination against women is prohibited. Women are the key indicators of economic growth and also a key part of it. Women's education is again a key indicator of our economic growth. But, really, why we want to help women came out and participate more is that in many ways they are the conscience-keepers of the nation. I feel India's greater strength is its spirituality, its inner strength and this comes out much more in Indian women than it does in Indian men. And if in this race for progress and modernisation, we have to maintain our sanity and not get carried away into another stream of civilisation, then we must give this strength to our women so that they are able to come out and see that this is not swept away in what we call or what we tend to call progress and development today.

How exactly do we view the problem of the status of women in our society? This is very difficult to answer because it is not just a question of how we view it, it is a question of what we want to achieve, the problems we face today and finding methods of solving them. The discrimination against women and all the problems related to dowry, their basic rights, are all related to this. And we have to see that women are able to become truly equal in every sense.

### Family Planning and Women's Education

One of the biggest problems facing us today is population, and here the only thing that

is really going to make a dent in family planning is women's education. One of the key factors is as to how to keep girls in schools. There are too many dropouts. We have to see how we can do better in this area. And, of course, we have to look deeper to see why they don't stay in school and get to the root of that. Again it brings us back to our basic social problems. Vocational training can be very helpful, for the family, as well for the standing of the woman herself in the family and for her independence. Teaching is something that women are good at and we are very short of women teachers. Of course, unless they are educated, we will never get enough teachers. And this is an area where we must concentrate on specially for primary schools and middle schools education. The more women can we get involved, the better it will be for education.

There are certain occupations or trades which women can do at home without leaving their families and, may be, we need to develop a marketing system which can help women who don't want to get out of their homes to be productive and selfreliant.

Dowry is one of our most serious social problems and it is an area where voluntary agencies can come in a big way. We have made laws and set up family courts. If there are certain flaws, we are willing to change the provisions. But ultimately it is what the people living in an area actually feel, believe or react that matters. And there is no law which can cut across that . It is an awareness which social workers have to build into our society. We are willing to help voluntary workers in whatever way we can, but this requires a lot of leg work and really only voluntary agencies can do this.

I feel that women must be more active in politics and at all levels and more especially at the very grass root, i.e., Panchayat level. In my own constituency I find that they are very active and they do very good work. Again it is only social awareness which will allow this to happen and voluntary agencies must play a big role in this.

### Human Resources Development

We have got a very large number of departments dealing with helping women. And here we do need some coordination. We are forming a Cabinet Committee for human resources development and this could be a point from which we could start working. We have been working furiously at economic development. Unfortunately, we have not paid enough attention to human development and I feel this is very much an important part.

Another area where I think we have not been active enough but I think it is time that we really got involved is the drug scene. And this is the time when it is not very big in India and we can try and do something from the Government. We are taking action to see that proper steps are taken, but they will be more sort of hard steps — legal identify it, but what is must systems to stop it, catch it, more important is to see that the need for drug does not arise amongst the youngsters and that can happen only with the proper environment in the family, with proper advice and instruction and training. Again the voluntary agencies really are the key in bringing this about. They should see how they can be more involved in trying to stop the drug business before it really gets down to our system.

A problem which women really face and which is very serious is old age. And again it is less of a problem as long as our old family system continues, but more and more in the urban areas we find that this is not happening and women are finding it a tremendous problem. We have to see what schemes we can devise and how we can help these women in their predicament.

Child labour is another very serious area for us to consider and it is not something that we can just pretend it doesn't exist or legislate away. We should see what we can do to make it easier for children to see that they get education and proper care and they are not exploited, not used in areas which spoils their eye sight, limbs or make them handicapped in any way.

All these are not problems that the Government on its own can tackle. These will only be tackled if Government action is helped by the voluntary agencies and by social change. And this is where women social workers and voluntary agencies can work in concert with Government agencies to get to grips with most of the problems.

*— Courtesy : Social Welfare*

# Nursing the Crisis in Medicine

—Dr. Ravi Narayan

## Background

The World Health Organisation has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." In the four decades since this definition, there has been a rapid expansion of efforts which have aimed at the improvement of health of people. In keeping with the historical evolution of medicine, these health efforts have been primarily associated with the increase in numbers of hospitals and dispensaries, medical colleges, nursing colleges, other professional training institutions, pharmacies and a massive growth in the drug and equipment industry. This has resulted in an increase in the technological quality of care, in the specialization of professional training and in the costs of medical care. However, the most disturbing trend in the last decade is the increasing accumulation of evidence that this growth of the medical institutions, technology and industry, supposedly in the quest of health, may actually be proving to be anti-HEALTH. The following quotations taken from the better known sources, including a recent National Health Report, echo this growing truth:

* Increasing and irreparable damage accompanies present industrial expansion in all sectors. In medicine, the damage appears as "iatrogenesis", Iatrogenesis is clinical, when pain, sickness and death result from medical care; it is social when health policies reinforce industrial organizations which generate ill-health; it is structural, when medically sponsored behaviour and delusions restrict the vital autonomy of people by undermining their competence in growing up, caring for each other, and aging——

*—Ivan Illich in 'Medical Nemesis'*

* I believe that more than ninety percent of modern medicine could disappear from the face of the earth — doctors, hospitals, drugs and equipment — and the effect on our health would be immediate and beneficial.

*—Robert Mendelsohn, MD in "Confessions of a Medical Heretic"*

* Eternal vigilance is required to ensure that the health care system does not get medicalised, that the doctor-drug producer axis does not exploit the people, and that the 'abundance of drugs' does not become a vested interest in ill-health.

*—ICMR/ICSSR Reports on "Health for All—an alternative strategy (India)".*

If medicine, doctors and hospitals who were thought to be necessary pre-requisites for health and health care are increasingly becoming the causes of ill-health, then surely Medicine today is in deep crisis.

## Dimensions of crisis

Any sensitive person today visiting one of our hospitals, both government or private, would very clearly pick up evidence of this crisis. A special of hospitalization would put the stamp of personal experience on this situation. The crisis in our hospitals has at least six dimensions if not more.

(a) Technical crisis

Overdrugging or irrational prescribing, unnecessary hospitalization and surgery, unreliable investigations, incompetent use of poorly maintained equipment, the use of treatments designed for critical conditions in everyday situations, and the decreasing quality of care, are well-known every day experiences. They contribute greatly to hospital infections, drug allergies, iatrogenesis of all sorts, and increasing diagnosis of 'non-diseases'.

(b) Attitudinal crisis

Within professional circles — both medical and nursing — treatment is becoming more important than care, drug-pushing more important than healing, technological intervention more important than patient examination. The patient is no longer seen as a whole person suffering but as a dehumanised machine in need of repair and his needs are becoming subservient to the needs of the medical industry.

(c) Cultural crisis

The hospital culture is becoming more anti-family, anti-death and anti-faith. It is insensitive to feelings of people and to local culture and traditions. Births and deaths which in the past were meaningful family events are today alienated hospital events cut off from their family roots.

(d) Social crisis

Doctors, nurses and hospitals are increasingly cut off from the masses of people. The private hospitals including mission hospitals are catering mainly to the rich and privileged few. Free service, if given at all, in these hospitals, is given grudgingly, and with lack of sensitivity. The government hospitals which are forced to cater to the poor, treat them like animals, fully exploiting their pain and needs. Doctors and nurses continue to migrate westwards in large numbers to places where the money is.

(e) Economic crisis

Medicines and the hospital system are fast pricing themselves out of the market. Hospitalization or even a visit to a doctor is often the cause of an economic crisis for the family, further contributing to ill-health.

(f) Transcendental crisis

Both medicine and nursing had in their past, roots in a service-based spirituality and a missionary sense of vocation. Today, as frontliners of the drug and technology industry, these professions are losing their transcendental roots ond are becoming mere business ventures. Capitation fees, life-styles of professionals, and the growing 5-star hospital culture testify to this trend.

## Challenge to the Nursing Profession

The nursing profession has evolved from its early roots, in service and care to a highly scientific and professionalised service aiming at quality care based on latest technology. More than the doctors, nurses have today become a very important and essential part of the hospital system, and for a very long time to come, will identify strongly with it in their work. Hence, as hospital medicine grows in technical, attitudinal, cultural, social, economic and transcendental crisis, the nursing profession will be called increasingly in the years to come to respond and tackle this crisis.

## What can the Nurses do to Alleviate the Crisis ?

The nursing profession will be increasingly challenged in the years to come to move from its medically biased, task-oriented, technology dependent approach in nursing to a health-biased, care-oriented and human relationship-oriented approach in nursing. Some aspects of this approach will be :

(a) Care of the Total Patient

Nurses are best suited to begin this process of humanising our hospitals because of their own historical traditions. They can help a great deal in the practice of 'medicine of the whole person' i.e., responding not only to the physical needs of the patient but also to his mental, social, spiritual, cultural and economic needs.

(b) Unbiased Quality of Service

By personal commitment, nurses could ensure that the quality of service which they provide will not be related to the paying ability of the patient but to his actual need. In fact, this would mean that rather than pampering the rich or private ward patient (the hall-mark of the present system!) they will have to be more sensitive to the poor non-paying general ward patient whose needs are often greater because of his social circumstances.

(c) Supportive of Family Culture

The respect for family and local culture must be re-emphasised in our hospital practice. These include a family approach in ante-natal care; an enhancing of mother-child relationships in post-natal and paediatric wards; involving family in matters of care; informing and allaying tension of relatives; respecting family roles and cultural traditions, and re-orienting hospital practice and communication to local culture, language and situation.

(d) Health Education

An increasing educational effort in all situations of the hospital, involving all members of the hospital team including the nurses, should become an important part of hospital service. Apart from improving patient compliance and hospital experience, this awareness-building process aimed at both patients and their relatives will be a good investment in the future health of the family.

(e) Team Work

Hospital practice is increasingly requiring good team work in patient care. If relationships between team members are healthy and mutually supportive, then there will not only be a raising of ward morale but definite effects on patient care and well-being. Only a healthy team built up on the principles of participative management, group decision making, supportive supervision, and sensitivity to staff welfare, will be able to make hospital practice more healthy. Staff Nurse and Ward Sisters being leaders of a team of nurses, aids, helpers and auxiliaries, will be challenged to play this role in the future.

(f) Cost-consciousness

The constant search for low cost regimes, therapies and techniques should be an important preoccupation for nurses. In addition, a great concern for reduction and increased caution in the use of medicines: and decreasing unnecessary investigations and procedures will go a long way in reducing hospital costs. This will need a greater commitment at the individual, group and administrative levels, since it is the most neglected dimension of the crisis.

(g) Community Extension

Finally, realising that hospital practice tackles or intervenes in less than 25% of existing ill-health in the community, hospital administrations need to reach out more and more to specific communities, especially villages and slums, through extension of hospital services. These could include mobile clinics, extension clinics, leprosy, tuberculosis, and maternal and child health programmes, specialist camps (diagnostic and surgical), health education programmes, and home visiting programmes. This community care process will expose hospital staff to the hard realities of

our socio-political and economic environment, and the inadequacies updirrelevancies of our hospital system. It will sensitise them to reorient hospital practice towards people's health needs, and will stimulate them to organize health programmes in and outside the hospital, to tackle the mental, social, cultural, environmental and economic aspects of health in the community. The nurses of the hospital and the nursing profession at large have an important role to play in this reorientation.

Are the nurses trained in our nursing schools and colleges, today being prepared for these challenges of tomorrow?

—*Courtesy: Golden Jubilee Souvenir* 1933-1983 *St. Martha's School of Nursing, Bangalore.*

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## 42nd Annual Convention of The Catholic Hospital Association of India and workshop on "Towards a People Oriented Drug Policy"

| | | |
|---|---|---|
| Dates : | November 10-11, 1985 | Drug Workshop / |
| | November 11-14, 1985 | Convention Proper |
| Venue : | St. Fidelis School/Ashram<br>Aliganj Extension P O<br>Near Vishnupuri Colony<br>Lucknow 225 020 (UP) | |
| Fees : | Workshop and Convention | Rs. 350.00 |
| | Convention alone | Rs. 250.00 |

(Payable by crossed cheque/draft or M O in favour of The Catholic Hospital Association of India)

Last date to receive
Registration form & fees : 20th October 1985

For Registration form and further details please write to :

Executive Director
The Catholic Hospital Association of India
C.B.C.I. Centre, Goldakkhana
New Delhi 110001
Tel : 310694, 344470

# Patterns of Medical Use of Drugs—A Preliminary Survey

—Perumpanani A.J.

## Introduction

The prescribers and dispensers of drugs have a professional obligation to consider more efficient systems that will enhance the quality of care when prescriptions are indicated. Nevertheless the data regarding this area is scanty in our country.

This history of camphor can be cited as an example to highlight these developments (1). Traditional use of camphor dates back to Chinese medicine. It has been used as an abortifacient, contraceptive, cold remedy, aphrodasiac, anti-aphrodasiac, suppresser of lactation and antiseptic. Albeit no longer used for these ends, camphor continue to be an ingredient of a number of over-the-counter remedies. It has been estimated that 1,00,000 gallons of camphorated oil and 137,000 gallons of spirits of camphor were produced in the United States in 1975 and marketed in packages without safety caps. It is now largely marketed in multi-ingredient liniments for symptomatic relief of 'chest congestion' and 'muscle aches' which contain about 1-20% camphor.

The committee on accidents and poison prevention in the United States has endorsed the following conclusions on the use of camphor. Firstly, it has no established therapeutic role in scientific medicine. Secondly, it has potent toxicologic actions. The ingestion of relatively small amounts has been proved to be fatal. Although accidental oral ingestion is the most common routs of intoxication, significant quantities can be absorbed percutaneously and via inhalation. The transplacental transfer may be toxic to be foetus. Thirdly, camphorated oil in particular is the worst offender in accidental ingestions because it is mistaken for over-the-counter products and is also accidently ingested by toddlers. Lastly, the committee has suggested that pediatricians warn parents of the danger of camphor containing products as long as they are marketed.

It this paper, we present the preliminary report of a student project, which analyses the cost differences between therapeutically useful and useless drugs prescribed by professionals to patients attending the hospital with psychiatric illnesses.

## Materials and Method

The study was conducted on 10 patients who attended the psychiatric out-patient service of St. John's Medical College, Bangalore, during the months of September, October and November, 1984. Only those patients who could furnish the previous prescriptions of treatment for the present illness were included in the study. It was also ascertained that these patients were treated for the same presenting complaints for a period of 3 months prior to the present consultation and that they had no non-psychiatric disorder. Both male and female patients between the ages of 20 and 50 were studied.

All prescriptions were collected from the patient after the final diagnosis was made by the consultant psychiatrist and their use by the patient for his present complaints were ascertained. Those prescriptions not relating to his present complaints were discarded. The remaining prescriptions were divided into two groups based on the present knowledge of the pathology of the illness in question. The first

## RESULTS

TABLE 1

Analysis of Drugs Used

(N = 10)

| Sl. No. | Total No. of drugs | Total Cost | | Cost/Patient/Day | |
|---|---|---|---|---|---|
| | | Group 1* | Group II* | Group I* | Group II* |
| 1. | 16 | 731.50 | 163.30 | 0.63 | 0.14 |
| 2. | 25 | 29.70 | 114.30 | 0.06 | 0.22 |
| 3. | 19 | 28.40 | 608.85 | 0.01 | 2.00 |
| 4. | 17 | 19.35 | 214.85 | 0.02 | 0.20 |
| 5. | 16 | 00.00 | 470.40 | 0.00 | 1.00 |
| 6. | 25 | 00.00 | 458.40 | 0.00 | 0.14 |
| 7. | 36 | 96.60 | 494.80 | 2.60 | 13.70 |
| 8. | 14 | 10.10 | 107.25 | 0.18 | 1.95 |
| 9. | 8 | 22.70 | 135.90 | 0.43 | 2.61 |
| 10. | 18 | 7.20 | 363.30 | 0.04 | 2.06 |
| Total/N | 19.4 | 94.55 | 314.14 | 0.397 | 1.202 |
| | % | 23.3 | 76.7 | 24.9 | 75.1 |

*Group I — Possibly and/or definitely effective drugs.

*Group II — Definitely not effective drugs.

group consisted of 'Drugs that are possibly and/or definitely effective for the present illness' and the second group was 'Drugs that are definitely non-effective other than through placebo response'. Following this the total number of different drugs per patient, total price of drugs per patient and the average price of drugs per patient per day of his treatment were computed.

### Discussion

Surveys of drug consumption in United States during the decade ending in 1973 showed a doubling effect. The total economic value of all ordered pharmaceutical services in 1973 amounted to about 11 billion dollars, after being adjusted for an increase in population by 10% and an increase in wholesale drug prices by 3% (2). There is some basis for believing that the population using medication has not changed significantly during this interval. Surveys of Spitzer et al (3) confirmed that 60% of the people in the community take at least one medicine at any given time and that 30% are taking at least one drug prescribed or suggested by a doctor. Approximately 90% of these figures were represented by the private sector of the health care

system and 70% of these prescriptions reflected drugs used by ambulant patients. It appears that there is a more or less static quantum of population which consumes prescribed drugs in increasing quantities for minor ailments as more drugs are being produced. This section seems to be serviced by the private sector of the health care system.

The annual drug production in terms of cost in India has increased from Rs. 380 crores in 1973-74 to Rs. 2,450 crores in 1984 with an increase of annual per capita consumption of drugs from Rs. 6.56 to Rs. 32.97 in the same period. According to a survey done in a North Indian district, 16.6% of the population sought the services of the allopathic system of medical care (4).

Vitamins and tonics are the most commonly used drugs in the North American population (3). They are used by 25 to 28% of the population, 40% of whom use them as a result of physicians' prescriptions. Various estimates of pattern of drug use show that females and the white population receive 50 to 60% more prescriptions than counterparts. Variations in per capita drug use is also associated with difference in factors like income, education and geographic location (2). A survey conducted on the South Indian urban population showed that the maximum number of prescriptions were for nutritional products and that 16% of these prescriptions had more than one product having the same ingredient in various dosage forms. It was also found that though iron deficiency, anaemia and $B_{12}$ deficiency were the more common deficiencies in the population, sales of B-complex preparations and other vitamins were the highest (5).

Use of multi-drug prescriptions by a large proportion of the population has turned istrogenic morbidity and mortality into a significant public health issues. The annual direct and indirect cost to the population from combined effects of morbidity and mortality attributable to predictable, hence preventable, reactions to drugs has been estimated at nearly 4 billion dollars out of the 11 billion doller drug production in the United States, in 1973 (2). In a 3 year survey of medical services, 2.9% of the admissions were found to be due to drug induced illnesses excluding suicide attempts and drug abuse. More than 6— of these patients died. In 82— of the cases no over-the-counter drugs were implicated. Studies from our country show that 27% of the doctors' prescriptions were for 3 to 4 drugs and 4.3% were for more than 4 drugs at a time (5).

The findings of this preliminary report of 10 cases show that on an average the patients had taken 19.4 different kinds of drugs for the present complaint before they came for psychiatric consultation. Similarly, the average expenditure on noneffective drugs was 76.7% of the total, as compared to 23.3% of expenditure of the possibly effective drugs. The average cost of non-effective drugs per day per patient was Rs. 1.20 and of possibly effective drugs was Rs. 0.40. These results indicate the possibility of an excessive use of drugs of questionable value in the cases studied, and may reflect the magnitude of wastage in our health care system.

However, the trends shown in this study cannot be generalised to the whole of medical care, primarily because the cases selection for this study were of chronic psychiatric illness secondly due to the limitation of the sample size and thirdly because the consultant psychiatrist's diagnosis could have been erroneous. The selection of the chronically psychiatrically ill has been specifically incorporated into this study because it has been reported that the prevalance rates of these cases are as high as 20% among the masses attending general hospital services; and that as primary health services are developed, an increasing number of these patients are expected to seek

help (6). In this study an attempt has been made to reduce the errors due to diagnosis by a brief follow up after the first visit to the out-patient services, though this stage had not been included in the primary methodology.

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# Workers' Rights

## (Part I)

— P.D. Mathew

### Labour Laws

A Majority of the Labour force in India lives in rural areas. Members of the weaker sections of society, especially women, children, landless labourers, tribals and Scheduled Castes, constitute the bulk of this labour force. They are not adequately organised to demand their rights. Their poverty, illiteracy, ignorance and lack of employment opportunities are exploited by landlords, big porjects recruit workmen from rural areas through their agents and employ them in construction works in cities and towns. Being unskilled and unorganised they are forced to work for long hours in unhygienic conditions for less than minimum wages.

There are many labour laws enacted for the protection and the welfare of workers. But this progressive legislation is not adequately implemented due to the lack of political will, effective Government machinery and lack of awareness of their rights among the workers. Many of the provisions of labour and minimum wages are scrupulously violated by contractors. Today, most of the legal rights of workmen in the unorganised sector exist only on paper and not in reality.

The solution to the problem of the exploitation of contract and migrant labourers lies first and foremost in organising them as a consequence of their social awareness. This is possible only through a continuous process of critical reflection on their exploitative situation and through greater awareness of their legal rights.

This brochure is prepared to educate the labouring classes regarding their legal rights under the Contract Labour (Regulation and Abolitions) Act, 1970, the Employment of Children Act, 1938, the Equal Remuneration Act, 1976 and the Inter — State Migrant Workmen (Regulation of Employment and conditions of Service) Act, 1979. In what follows the salient features of the Acts are explained as also the Constitutional remedies available to workers for the enforcement of their rights.

### The Contract Labour (Regulation and Abolition) Act, 1970 with Central Rules 1971

#### What is the purpose of this Act?

This labour law was enacted to regulate the employment of contract labourers in certain types of establisment and to prohibit its practice under certain circumstances.

#### To which establishment does this Act apply?

It applies:

(a) to every establishment in which twenty or more workmen are employed or were employed on any day of the preceding twelve months as contract labour.

(b) to every contractor who employs or who employed on any day of the preceding

twelve months twenty or more workmen.

**Note**

* The Act is not applicable to those establishments which carry on work of a casual nature occasionally.

* Dispute whether work performed in an establishment is continuous or of casual nature will be decided by the Government after consultation with the Board. Its decision will be final.

**Explanation for terms used in the Act**

* "Workmen" means a contract labourer who is hired to work in an establishment or in connection with the work of the establishment by or through the contractor with or without the knowledge of the principal employer (Section 2 (1) (b).

* "Contractor" means a person who undertakes to produce a given result for the establishment through contract labour or who supplies contract labour for any work of the establishment (Section 2 (1) (c).

Contractor includes a sub-contractor.

The above definition also covers contractors engaged in construction of buildings.

* "Establishment" means:

(i) any office or department of the Government or a local authority, or

(ii) any place where any industry, trade, business, manufacture or occupation is carried on (Section 2(1)(c).

* "Principal Employer" means:

(i) in relation to any office or department of the Government or a local authority, the head of that office or department or the officer specified.

(ii) in relation to a factory, it is the owner or occupier (one who has ultimate control over the affairs of the factory) or the manager appointed.

(iii) in a mine it is the owner or agent or the appointed manager.

(iv) in any other establishment, any person responsible for the supervision and control of the establishment (Section 2 (1) (g).

*Authorities*

**(I) Central Advisory Board**

The Central Government has established a Board called the Central Advisory Contract Labour Board to advise it on matters related to the provisions of this Act (Section 3.3).

It consists of:

— a Chairman appointed by the Central Government;

— the Chief Labour Comissioner (Central), ex-officio,

— 11 to 17 members nominated by the Central Government to represent Government, Railways, Coal Industry, Mining industry, contractors and workmen.

**Note**

On the above pattern, State Governments are authorised to constitute the State Advisory Contract Labour Boards. In both the Boards the number of members nominated to represent workmen should not be less than the number of members nominated to represent the principal employers and the contractors.

**(2) Committees**

The Central and State Boards are given power to constitute Committees to supervise

the effective execution of the provision of the Act (Section 5).

### (3) Registering and Licensing officers

The appropriate Governments may appoint gazetted officers of the Government to be registering and licensing officers and define the limits within which they can exercise their powers.

### (4) Inspecting staff

The appropriate Governments may appoint inspectors and define local limits within which they can exercise their powers (Section 28).

The Inspector has the power:

* to enter at reasonable hours any place where contract labour is employed for the purpose of examining any register, record or notices or documents related to contract labour.
* to examine any contract labourer.
* to seek information from persons supervising the work regarding the address of employer and the rate of wage paid, etc.
* to seize copies and registers, records of wages and other relevant, documents in respect of an offence committed by the principal employer or the Contractor (Section 28).

## REGISTRATION AND LICENCE

### Is there any obligation on the part of the principal employer to register his establishment ?

Every principal employer of an establishment is bound to register his establishment within a period fixed by the Government (Section 7).

### What is the effect of non-registration of the establishment ?

A principal employer who does not register his establishment or whose registration is revoked by the registering authority is not entitled to employ any contract labour in that establishment.

### Are Contractors bound to get licences?

The contractors are not allowed to undertake or execute any work through contract labour without obtaining a valid licence from the licensing officer. The licence may contain conditions imposed by the Government regarding the hours of work, fixation of wages and other amenities in respect of contact labour (Section 7).

### Note

For a contractor to undertake or execute any work through contract labour without a licence is a continuous offence and he is liable to be punished until he obtains a licence.

### Can a licence given to a contractor be revoked, suspended or amended?

If the licence has been obtained by misrepresentation of facts or if the contractor fails to comply with the conditions on which the licence has been granted, his licence may be revoked, suspended or amended or the money deposited as security may be forfeited (Section 14).

## WELFARE AND HEALTH OF CONTRACT LABOURERS

Every contractor is expected to provide for contract labourers employed by him the following facilities in accordance with the rules made by the Government (Sections 16-19).

### 1. Canteens

* In every establishment, where work regarding the employment of contract labour is likely to continue for six months and where one hundred or more contract

labourers are ordinarily employed, one or more canteens are to be provided by the contractor for the use of the contract labourers employed by him. A canteen must be provided within 60 days of the date of coming into force of the rules in the case of existing establishments and within 60 days from the date of commencement of employment of contract labour in case of a new establishment (Rule 42).

* If the contractor fails to provide the canteen within the prescribed 60 days then the same shall be provided by the principal employer.

* The Canteen must be maintained by the contractor or the principal employer in an efficient manner.

* The canteen should have:

  — a dining hall, kitchen, store-room, pantry and washing places for workers

  — sufficient light

  — smooth and clean floors and lime-washed kitchen walls

  — provision for removing waste water and collection and disposal of garbage (Rule 43).

**Dining Hall**

— It must accommodate 30% of the labourers at a time.

— A portion of the dining hall must be partitioned off and reserved for women workers.

— It must have sufficient tables, chairs or benches, furniture, utensils and crockery.

— Furniture, utensils and the floor must be kept clean.

— The food stuff served must be according to the normal customs of the labourers.

— The charges for food served should be on a 'no profit no loss' basis and it must be displayed in the canteen.

— The books of accounts pertaining to the canteen must be produced on demand to an Inspector (Rules 45-49).

### II. Rest rooms

Within 15 days of the commencement of the employment of the contract labourer., contractors are obliged to provide rest rooms or other suitable alternate accommodation at every place, where contract labour is required to halt at night in connection with the work of an establishment and in which employment of contract labour is likely to continue for 3 months or more (Section 17).

**Note**

* Separate rooms must be provided for women employees.

* Rest rooms must have a adequate ventilation and light, adequate protection against heat, wind, rain and smooth, hard and impervious floor surface and have adequate supply of clean drinking water.

* If these facilities are not provided by the contractor within 15 days of the commencement of the employment of the labourers, they are supposed to be provided by principal employer.

* The expenses incurred by principal employer in providing the amenity may be recovered from the contractor concerned.

### III. Drinking water facilities

The contractor must provide sufficient supply of clean drinking water at convenient

places and must maintain separately clean washing places for men and women workers at accessible places (Section 18).

### IV. Latrines and urinals

* Where females are employed, there must be at least one latrine for every 25 females;
* Where males are employed, there must be at least one latrine for every 25 males.
* Every latrine must have proper door and fastenings to provide privacy.
* Latrines and urinals provided for men and women workers must have sign boards with the figure of a man or a woman and must have a notice in the language of the majority of the workers indicating "for men only" or "for women only".
* There should be at least one urinal for every 50 workers.
* The latrines and urinals should be situated at convenient places and must be kept clean at all times. Their type and maintenance must meet the requirements of public health authorities.
* Water shall be provided by means of tap or otherwise near the latrines and urinals (Rules 51-56).

### V. First - Aid facilities

* There should be First - Aid Boxes placed at easily accessible places at the rate of not less than one box for 150 contract labourers (Section 19).
* It must contain:
  - small, medium and large size sterilised dressings;
  - one bottle of iodine;
  - one bottle of salvolatile;
  - one snake-bite lancet;
  - one bottle of potasium permanganate crystals;
  - one pair of scissors;
  - one bottle containing 100 tablets of aspirin;
  - ointment for burns;
  - a bottle of suitable surgical antiseptic solution; and
  - sterilized cotton wool (Rule 59).
* The First-Aid Box must be kept in the care of a trained person, who is readily available during the working hours of the establishment (Rules 61-62).

### VI. Creches

In an establisment, where 20 or more women are ordinarily employed as contract labourers, their children below 6 years must be provided with 2 rooms for sleeping and playing (Rule 25(iv)(a).

The contractor must supply them with an adequate number of toys and cots and beddings (Rules 25(iv)(b).

Rules issued in 1972 by the Chief Labour Commissioner (Central) regarding the construction and maintenance of a creche:

* It must be located within 50 metres of every establishment.
* It must be constructed of heat resistant materials and should be rain-proof.
* It must have necessary doors and windows and adequate light and ventilation.
* Accommodation in the creche per child should be at least 20 sq. ft. of floor area.
* It must have a shady playground suitably fenced for elder children.

* It must provide clean drinking water for the children and the staff, milk for children below 2 and refreshments for children above 2.

* A kitchen with utensils for boiling milk and preparing refreshments must be attached to the creche.

* Children and the staff must be provided with suitable uniforms.

* A bathroom adjoining the creche must contain washing facilities, soap and clean towels.

* Every child in the creche must be provided with a cot, mattress, bedsheets blankets, and pillow with a cover.

* The person in charge of a creche should be a woman with midwifery qualification. She must be assisted by female Ayas.

* Working hours of the creche should correspond to the working hours of the mothers.

* It must have first-aid equipment kept in good condition.

* Every child must be medically examined before admission. The weight of each child must be recorded after the monthly medical check-up.

* Creche may be inspected at any time by any of the authorities mentioned in the Act.

*Wages*

**What are the rules to be followed regaridng the payment of wages?**

1. The Contractor must pay wages to the workers every month on a fixed date.
2. When the employment of any worker is terminated by a contractor, his wages must be paid before the expiry of the second working day from the day on which his employment is terminated.
3. Wages must be paid to the workers on working days at the work site on a fixed date and time. If the work is completed before the expiry of the wage period final payment shall be made within 48 hours of the last working day.
4. Wages must be given directly to the worker or to a person authorized by him.
5. No deduction in the wages of a worker is permissible except that which is specified by the order of the Government.
6. The principal employer must ensure the presence of his authorised representative to supervise the payment of wages by the contractor to the workmen and it is the duty of the contractor to ensure the payment of wages in the presence of the authorised representative.
7. The authorised representative of the principal employer must certify at the end of the entries in the Register of wages in the following form: "Certified that the amount shown in column No. . . has been paid to the workmen concerned in my presence on . . . . . at. . . . . "
8. In case the contractor fails to pay the wages to the workmen within the prescribed period, or makes short payment, then it is the responsibility of the principal employer to give the unpaid amount of wages to the worker. The amount paid by the principal employer can be recovered from the contractor.

**Note**

Rule 25(ix) prohibits employment of female contract labourer before 6.00 a.m. or after 7.00 p.m. This rule does not apply to women employed in pithead baths, creches, canteens and nurses and midwives in hospitals and dispensaries.

## OFFENCES AND PENALTIES

### 1. Obstructing the Inspector

Those who obstruct an Inspector in the discharge of his duties, or those who refuse to give reasonable facility for making any inspection, examination, inquiry or investigation in relation to an establishment are liable to be punished with imprisonment for a term up to 3 months or with fine up to Rs. 500, or with both (Section 22).

### 2. Wilfully refusing to produce documents

Those who wilfully refuse to produce on the demand of an Inspector any register or any other documents, or prevent any person from appearing before an inspector, shall be punishable with imprisonment for a term up to 3 months, or with fine up to Rs 500, or with both (Section "22").

### 3. Contravention of the provisions of the Act and the Rules

Those who act against any of the provisions of the Act or the Rules, or the conditions of licence granted are liable to be punished with imprisonment for a term up to 3 months or fine up to Rs 1000, or with both and if the offence is continued an additional amount up to Rs. 100 per day will be fined, during the period of the contravention (Section 23).

### Offences by companies

If the person who commits an offence is a company, the company and every person in charge of the conduct of its business at the time of committing the offence or any other responsible person of the company whose negligence or consent or connivance has caused the offence will be considered guilty of the offence and liable to the punished (Section 25).

### Cognizance of offences by tht Court

No Court inferior to a Presidency Magistrate or a Magistrate of the first class can try cases arising out of the offences committed under this Act.

The Court can take cognizance of any offence only when a complaint is made by the Inspector or with his previous sanction in writing only (Section 26).

### What is the time limit for initiating prosecution?

The Court cannot take cognizance of an offence under this Act, unless the complaint is made within 3 months from the date on which the alleged commission of the offence came to the knowledge of an Inspector.

If the offence consists of disobeying a written order of an Inspector, complaint may be made within 6 months of the date on which the offence is alleged to have been committed (Section 27).

### Power of the Government to exempt in special cases

The Government in the case of an emergency, may exempt an establishment or a class of contractors from the perview of the Act and the Rules.

### Protection of action taken under the Act

No one has a legal right to file a suit or initiate a prosecution against the Government or any of the officers appointed under this Act for anything done in good faith in pursuance of the Act or the Rules (Section 32).

### Duty of the principal employers and the contractors to maintain Registers

* Every principal employer is expected to maintain a register of contractors of his establishment in a specified form (Form XII).
* Every contractor must maintain a register of contract labourers employed by him in form No XIII.
* Every contractor must issue an employment card in Form XIV to each worker within 3 days of the employment and the same must be maintained up-to-date.

### Duty to maintain Muster Roll, Wages Register, Deduction Register and Overtime Register

Every contractor who employs contract labourers in connection with the work of an establishment must maintain:

— a Muster Roll in Form XVII
— a Register of Wages, in Form XVII
— a Register of Deduction for damages or loss in form XX
— a Register of Fines in Form XXI
— a Register of Advance in Form XXII
— a Register of Overtime in Form XXIII

### Duty of the contractor to obtain the signature of the workmen against his entries in the Registers

The contractors must obtain the signature or thumb — impression of worker against the entries relating to him in the Registers. These entries must be authenticated by the initials of the contractors or his representative. It must be duly certified by the authorised representative of the principal employer as specified by Rule No. 73.

### Duty to exhibit notices

The principal employer or the contractor is expected to display notices, in English, Hindi, and in the local language understood by the majority of the workers at a suitable place in the establishment and in the worksite regarding rates of wages, hours of work, wages periods, dates of payment of wages, names and addresses of the Inspectors etc.

A copy of the notice must be sent to the Inspector and he must be informed of the changes as and when made.

Within 15 days of the commencement or the completion of each contract work under each contractor, the principal employer must inform the Inspector regarding the actual date of the commencement or completion of such contract work in Form XI-B (Rule 81).

### Duty of the Contractor to issue Service Certificate

When the work of a contract labourer is terminated for any reason, the contractor must issue him a Service Certificate in Form XV.

### Power of authorities to call for information

The members of the Board, Committee, The Chief Labour Commissioner (Central) and the Inspector have the powers to call for any information or account in relation to contract labour from any contractor or principal employer at any time by an order in writing and a person called upon to furnish the information is legally bound to do so (Rule 83).

### Note

The provisions of the Act and the Rules explained above are based on the Central Act and Rules. The State Governments are given power to make rules for carrying out the purposes of the Act. Persons working for the welfare of contract labourers must also be aware of the State rules so that their legal rights can be enforced effectively and the violations of their rights can be prevented in time.

READERS WRITE :

**William A.M. Cutting, FRCP, DCH**
**Senior Lecturer in Child Health**
**Department of Child Life and Health**
**University of Edinburgh**

6 May, 1985

To,
The Editor
Medical Service
Catholic Hospital Association of India
C.B.C.I. Centre
Goldakkhana
New Delhi 110 001.

Dear Sir,

Recently a friend of mine who knows my interest in both India and therapeutics sent me a copy of "Medical Service" **42**, 1, January 1985. This issue appears to contain a number of contradictions which could confuse your readers who are genuinely wanting to provide a better service. On the one hand you seek to promote a "rational drug therapy" (pages 3-7), and on the other, recommend the "role of traditional medicine in primary health care" (pages 22-24). Of course these are not mutually exclusive, and used correctly, should complement each other. However, there is some discrepency when your authors urge the adoption of the limited drug list proposed by the World Health Organisation, but at the same time recommend the use of indigenous medicines and point out "Ayurvedic Pharmacopieas contain 8000 recipes". On one side polypharmacy is condemned, and it is pointed out that only 7 out of 250 essential drugs recommended by WHO are combinations of more than one compound, while most ayurvedic medicines are mixtures, for example a "combination of Thulasi leaves juice, pepper powder and honey".

Quality control of pharmaceuticals is an important matter for all countries concerned to provide effective and economic drug treatment for its citizens. I was interested to note that every state in India has "its own drug standardisation centre which supervises and maintains standards of Ayurvedic drugs". How can it be possible to undertake such a task is beyond my comprehension, because despite the giant ayurvedic pharmaceutical companies, most products are produced on a small scale or even at a domestic level.

All scientific health workers are agreed that authenticating existing and new remedies, and developing new ones, requires careful and objective research. The only pharmaceutical advertisement in your magazine is from a company which claims to be "pioneers of ayurvedic research". I have written to this company and look forward to receiving their promised set of "latest research data". Regarding the three ayurvedic preparations which they promote, there is no information about the pharmalogical constituents of the products, but the claims of effectivenss are quite dramatic. One product is claimed to be effective for conditions from "masticating trouble" . . . to. . . "constipation", producing "relief within 5-15 minutes even in severe cases". Confidence in their products is not increased by nothing that the allopathic medicine they

advertise, "R. compound", is a combination of oxyphenbutazone and aspirin which is claimed will bring "Quicker relief without side effects. Complete relief within 5-7 days". In Britain paracetamol has largely replaced aspirin because of the latters irritative effect on the stomach, and oxyphenbutazone has been withdrawn from the market on account of unacceptable side effects. The author of your article on traditional medicine recommends as "effective remedies,. . . . pomegrannate skin dry powder. . . in dysentry,. . . and papaya seeds for intestinal worms". While these things may be effective, I would prefer to treat my patients with drugs whose efficacy has been proven for these conditions by controlled studies. On the one hand your journal is appealing to "socially conscious medicos to ask for the withdrawal of all preparations" which contain combinations of drugs of unproven efficacy (page 33), but on the other you seem to be encouraging the use of ayurvedic polypharmacy with preparations, many of which have not been standardised nor subjected to clinical trials. I continue to believe that some ayurvedic medicines are effective for some diseases against which there are no satisfactory allopathic drugs. However, "rational drug therapy" must apply the same standards to all the medicines which it promotes?

*Yours sincerely,*

Sd/-
**Willam A.M. Cutting, FRCP, DCH**
Senior Lecturer in Child Health

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**CONTINUING MEDICAL EDUCATION**

Ref : 12/06/1897/85

Fr. John Vattamattom
Executive Director
CHAI, CBCI Building
Near Goldakkhana
Ashok Place
New Delhi 110 001.

**Christian Medical College**
**Vellore — 2**
6-7-85

Dear Fr. John,

I was happy to receive the comments of Dr. William A.M. Cutting, conveyed in his letter dated May 6, 1985. These comments are very valuable.

I agree wholeheartedly with the observation that in promoting "rational drug therapy", we must employ acceptable standards (same? similar?), whatever be the system of medicine. It is essential to ensure that the drugs are efficient (effective and economical), safe and of good quality.

It is true that there is an apparent contradiction between the stand against polypharmacy and advocating the use of ayurvedic preparations, which contain a large number of active (?) ingredients. One of the main differences is that the ayurvedic preparations are mainly in the crude form of the herbs and their extracts and cannot be compared directly to the pure chemicals or formulations. When the alkaloids and other active principles are extracted and used, it is a different story altogether.

I agree fully that quality control is very important, while there are some attempts at standardization, these are as yet, far from being satisfactory. We expect improvements with the greater awareness of the need for quality at every stage.

Clinical trials (in their own way) are being carried out in a number of places (e.g., the W.H.O. supported trials in Coimbatore), us-

ing the traditional ayurvedic preparations in the traditional way and also through certain institutes of modern medicine. While many of the tall claims may not stand scrutiny (and such preparations ought to be removed from the drug lists), it is hoped that out of these research studies and clinical trials, a few useful and cost-effective drugs will emerge.

The failure to carry out studies in the usual form acceptable to practitioners of modern medicine is practically due to our own fault because ayurvedic physicians are not knowledgeable about our methodology; they follow their own methods, we will have to synthesize them.

It has been the policy of Medical Service to remove or at least reduce the drug advertisements. 'Alarsin' is the only one remaining. There seems to be a misunderstanding. According to the advertisement, the 'R. compound' is not a combination of oxyphenbutazone and aspirin. The firm seems to have compared their 'R. compound' with oxyphenbutazone and aspirin in its effectiveness' in all inflammatory and painful conditions of oral cavity." We do not have data regarding the effectivenss, safety and other parameters of this drug.

As elsewhere in the world, paracetamol has been replacing more and more the use of aspirin, though in India, aspirin continues to be used (in spite of the side-effects) in a big way. Ciba Gigy has withdrawn oxyphenbutazone but restricted use (for conditions like ankylosing spondylitis) is allowed by the Government of India. There are moves to make the Government ban the use of oxyphenbutazone and especially its combination with analgin.

Some of the substances like papaya seeds for worms have been used traditionally as home remedies. We will have to study them under controlled conditions, though not always necessarily under the usual "double-blind studies".

With regards,

*Yours sincerely*
Sd/-
**Dr. C.M. Francis**
**Co-Ordinator, CME**

---

[The above correspondence shows the need to be careful about the choice of drugs. Whatever be the system of medicine (ayurveda, unani, siddha or other) or home remedies, we have to be careful to use only drugs which are effective, safe, economical and of good quality. The practitioner must use only drugs of which they are knowledgeable, bringing the same critical thinking with respect to their indications, contra-indications, side effects, cost and other criteria. We must not swing in our opinion from one end of being against all other remedies to accepting blindly any drug (home remedies, traditional medicine or other systems of medicine), but take a balanced, informed view, using drugs only where essential.

**—Editor]**

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**EMPLOYMENT**

A young and energetic doctor seeks suitable employment preferably in a Kerala hospital. Interested Institutions may contact directly :

Dr. Vijayan Nair
30A3, Juhu Tara Road
Juhu, Bombay 400 049

Book Review

# "The State of the World's Children - 1985"

UNICEF

— Newton Luiz

The situation is ripe for a revolution in child health. Poverty need no longer be so severe a hindrance to health — four low cost techniques are now available to the poorest peoples of Asia and Africa, four techniques that can dramatically reduce Infant Mortality Rates (IMR) by upto 50% within just 5-10 years. This is the sum and substance of the booklet, "State of the World's Children, 1985". It is an astounding claim, considering that IMR has decreased by only 25% in the last 20 years, in these least-developed and developing countries.

And what are these four magical methods? GOBI is the answer — Growth monitoring, Oral Rehydration Therapy, Breastfeeding and Immunization. Four simple techniques that will place the responsibility for a child's health in the hands of its mother, largely displacing the modern doctor as casually and as contemptously as he has displaced the magician, the witchdoctor and the traditional healer.

And even as one turns away in intention and disbelief — what utter nonsense, GOBI indeed :- the evidence is mobilized:

In Cheraga district, Algeria, IMR has been reduced from 103 to 43 between 1976-81, by these techniques alone.

In India a study of 200 Integrated Child Development Services (ICDS) Blocks shows that the IMR has fallen to 89 within 10 years, at the start, the IMR in these areas must have been very much above the national average of 124, considering that in some of them the prevalance of Severe malnutrition was as high as 21.9%.

In Matlab, Bangladesh, the IMR of a study-population of 90,000 was brought down by 11% in just 3 years.

Less than 15% of the world's families are now using ORT, yet it has already saved half a million children in the last one year.

But how does it work? Author James Grant, Executive Director of UNICEF, realily explains: *Growth* monitoring will show the mother that her child is malnourished and unhealthy. "Most malnutrition is invisible and most parents of malnourished children do not know that there is anything wrong".

"Most malnourished children live in houses where there is no absolute shortage of sufficient food to provide an adequate diet for a small child".

"Most malnutrition is caused not so much by lack of food as by repeated infections which burn up calories, depress the appetite, drain away nutrients in vomiting or diarrhoea, and often induce mothers to stop feeding while the illness lasts."

If mild malnutrition is detected early and treated at once, it permits the child to resist infections.

*Oral Rehydration Therapy* (ORT) can cure most episodes of diarrhoea, and mitigate its ravages in all but the most severe cases, thereby causing a dramatic reduction in morbidity and mortality of the poor man's No. 1 killer disease. The duration of diarrhoea is decreased, and malnutrition is less severe. In 1971, faced with a deficiency of IV fluids while cho-

lera raged among refugees from E. Pakistan in Calcutta, a medical team treated 3700 patients with ORT alone; only 3.6% died.

*Breast feeding* ". . . takes the infant out of poverty for these first few vital months in order to give the child a fairer start in life and compensates for the injustice of the world into which he was born". This is because there is no difference in the quality of breast milk of rich or poor, healthy or unhealthy mothers, except in women with extremely poor nutrition. Bottle feeding, on the other hand, means diluted milk and hence malnutrition, unclean water and unsterile bottles leading to diarrhoea, and a loss of the immunological protection afforded by breast milk.

*Immunization* against TB, Diptheria, Polio, Pertussis, Tetanus and Measles would prevent 50 lakh deaths and save another 50 lakhs from disability annually; it would also prevent the malnutrition that follows mealses and TB, and leaves them prone to infection.

Further, a bottled fed child is pushed onto the infection — malnutrition—infection cycle of illness very early in life, and this vicious and often spiralling cycle can kill him easily. But breast feeding would probably protect him for 6 months or so; immunization would reduce the possibility of dangerous illness; ORT would mitigate the diarrhoeas that strike so frequently; malnutrition would be handled promptly. The result would be a child who falls ill less often and less seriously, and thus have time to regain his health in between illnesses. The longterm damage to his health will then be minimal. . . . In this context, the Gambian study may be quoted 5% of children who developed measles died of it, within 9 months, another 10% of them died of other illness; only 1% of those who did not get measles died in the same period.

And finally, a bonus. In the afore mentioned Matlab area of Bangladesh as the IMR fell there was a fall in the birth rate too, for the average mother had decided spontaneously to have 2 children less than usual. Thus GOBI would probably help to stabilize world population at a lower level than previously estimated.

The book goes on to discuss how these techniques can be made known and put into practice. Innovative ideas will be necessary, no doubt, but there is no logical reason why ORT salts cannot be as cheaply and as freely available in every small shop as condoms, and be used freely and confidently by families in the treatment of diarrhoea. With the wide availability of radio and TV, it will be much easier to communicate with the people. What is now needed is professional and powerful advertising backed by indepth study of the target groups.

The claims made by the author — a 50" reduction in IMR within years — are very impressive. Too impressive, in fact, they sound like an elaborate fairy tale, an intoxicated reverie, an optimist building airy castles. Yet, the nature of the claimants is such that they must needs be taken seriously.

The socialist would say, this is highly unreasonable. Little or nothing can be achieved by such simple and direct attacks on illhealth, which is but one facet of a very complex social, economic and political tragedy. You must fight the problem at its root; you can't destroy a tree by snapping a few twigs, nor can you plug a volcano. . . . And grant coolly answers, you can — to some extent. 60% of Bhutanese suffer from goitre, and more than 5% are born with retarded mental development. The use of iodated salt on a national scale, and a ban on the use of plain salt, has meant that this disease will be cured within a few years, by a minimum of effort. A lot can be done within the system.

The author is not unaware of the deeper aspects of the problem. He states categorically that, "The cause of diarrhoea is poverty — poor water supply, poor sanitation, poor health education, poor housing, ORT will not change that poverty." And now he expresses his view point. "The front line in the long war or poverty and underdevelopment is and remains the struggle for economic justice and growth. And the fundamental issues of women's rights, land reform, disarmament, income distribution, job creation, fairer aid and trade policies, and a more equitable international order remain fundamental determinants of children's survival, health and well being. But while that struggle is being waged, an extraordinary opportunity has now arisen to strengthen the 'second front'. Most parents in poor communities could now be given the knowledge and the support to enable them to protect their children from the worst effects of that poverty in their children from the worst effects of that poverty in their most valuable, vital years of growth. And in so doing, a long awaited blow could be struck against development's 'enemy within' — the self-perpetuating cycle of ill-health, poor growth, and lowered potential by which the poverty of one generation casts its shadow on the next."

Grant is a humanist — "Many times it has been agreed and demonstrated that it is a nation's human resources which are the key to its social and economic progress and that investment in people makes economic sense. In its 1980 *World Development Report* for example, the World Bank concluded that the right kind of social investment in such things as primary education and health care can yield an average economic return of up to 25% a year — far higher than can be expected from most investments in physical goods. "An attitude which probably would make some Marxists see Red. They might also consider as empty rhetoric his repeated suggestion that the child's health would now be in the hands of its mother (rather than the doctor), which is needed since only she can take an integrated and long term approach to it.

Finally, Grant points out that a change in health priorities is very much needed. We must spend less money producing doctors and supporting specialist institutions — the money is needed to train dais, to supply our PHCs. We must not imitate Tanzania and give 14% of an health budget to the main hospital in the country, and 15% to all the village dispensaries together. A change in attitudes is due: we must stop thinking that it is acceptable if children continue to be blinded by xeropthalmic and deformed by rickets. We must stop thinking that it is "normal" for women to be anaemic, tired and chronically ill — so common an attitude even among doctors! We must stop overworking, underfeeding and exploiting our women.

This, then, is the author's thesis. The main criticism of his theme would be that, in order to emphasize GOBI, he has deliberately deemphasized the importance of an integrated approach to development, and treated child health as an isolated event. However, if the claims made are in future proved to be valid, then it would be very difficult to overemphasize GOBI. The author has unequivocally asserted that these techniques, all by themselves, can produce magnificient results. Such "isolated" attacks have been quite successful in the past. Smallpox was eradicated. The NMEP may have failed to eradicate malaria, but it reduced malarial mortality from 8 lakhs in 1953 to a few hundreds annually since 1964; it helped to suppress kala-azar and plague; it permitted development work like roads and railways to be carried out in what had previously been highly malarious areas. It is a sensible approach, after all: if the cellar is infested with rats, one must employ a few cats at once, and need not starve till the new raproof cellar is made.

The book makes challenging reading, since such a bold approach needs to be studied, if only to repudiate its thesis. It has an efective and lucid presentation, and makes for easy and interesting reading. (It is supplied as a free booklet, on request from UNICEF, 73 LODI ESTATE, NEW DELHI :- 110 003).

# Fr. Muller's Opens Homoeopathic Medical College

—S.C. Frank

The Management of Fr. Muller's Charitable Institutions has decided to start an Institution of Homoeopathic Medical Education, Training and Research from the academic year commencing June 1985. The Institution is named "Fr. Muller's Homoeopathic Medical College" after the late Fr. Augustus Muller, sj, the founder of the Institutions.

The College has already been affiliated to Mangalore University and offers a 5½ year comprehensive graduate course leading to the Degree of Bachelor of Homoeopathic Medicine and Surgery (BHMS) as recognised by the Central Council of Homoeopathy, New Delhi.

With the existing facilities at their disposal in the way of buildings, laboratories and staff, preparations are being made for admitting a batch of fifty students from all over India for the 1985 term. The College is open to all irrespective of religion, casts or community.

In 1980, when Fr. Muller's celebrated its centenary, a bold plan was outlined for the establishment of a College of Homoeopathy. To many it looked over-ambitious—a mere dream.

But the Governing Board of Fr. Muller's, with the Bishop of Mangalore as its President, took up the challenge and spared no pains to give Fr. Muller's a College of Homoeopathy.

The team of experts entrusted with the study of the need, relevance, feasibility and viability of a Homoeopathic Medical College in Mangalore have been more than satisfied with their findings.

Realising that no haphazard, slap-dash methods can yield results, a Degree Course of intensive study and training extending over 5½ years, with the necessary clinical experience has been clearly outlined for the aspirants. At end of the 5½ years of BHMS Course, a postgraduate course of 3 years is on the cards.

Fr. Augustus Muller brought homoeopathy to India, and set up a Homoeopathic Dispensary at Kankanady, Mangalore, 105 years ago (1880), and by rendering commendable service to the poor and the rich alike, made the homoeopathic system of medicine popuar not only in Dakshina Kannada but all over India and outside.

The people of Karnataka and elsewhere have all along evinced the keenest interest in homoeopathy and developed great faith in the system. The demand for homoeopathic medicines and specifics is on the increase.

From its inception in 1880 Fr. Muller's Homoeopathic Dispensary has been manufacturing and importing from Germany and other foreign countries homoeopathic medicines and specifics.

Today Fr. Muller's has its own manufactory and pharmacy for the preparation of many of these drugs and specifics. The remarkable curative effect of Homoeotherapy on many chronic complaints is very well appreciated.

The promotion of education in the field of health care envisaged in the Memorandum of the Association (1960) of Fr. Muller's Charitable Institutions is the aim of the College and its existing School of Nursing started 25 years ago.

Fr. Muller's has all along held firmly to the highest principles of service to suffering humanity in the spirit of Christ.

Fr. Augustus Muller, himself a great Homoeopath, was a staunch advocate of Homoeopathy. He pursued the science and made a deeper study of the system for the purpose of serving the poor through homoeopathic remedies.

Following in the footsteps of the founder, Fr. Muller's through its college of Homoeopathy, will devote itself to the progress of this science by getting dedicated young men and women genuinely interested in the system and training them for service in the villages as well as in numerous hospitals and dispensaries all over India.

Moreover, with well-trained Homoepaths, Fr. Muller's can depend more and more on itself for the bulk of the homoeopathic medicines it has been importing all these 105 years of its existence.

The assets on the human side are an excellent team of doctors — both allopathic and homoeopathic — dedicated nurses trained for the last 25 years in its own School of Nursing, para-medical and service personnel of proven loyalty and integrity and trained, efficient pharmacists.

On the facilities and equipment side, Fr. Muller's has provision for 750 beds (250 of them are free), an outpatient department, an Emergency ward, a leprosy hospital with a rehabilitation unit attached to it, a maternity hospital, a psychiatric hospital, well-equipped modern operation theatres, a physio-theraphy centre, a chest clinic, a pharmacy (both allopathic and homoeopathic), quarters for senior doctors and land for the future expansion of the college and hostels. The hospital has its own ambulances and other transport.

The Institutions are professionally designed to assure all who seek them, of the utmost loving and sensitive care to the relief of suffering and preservation of life.

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# Sr. Elizabeth Edattukaran Receives National Award

## SR. ELIZABETH EDATTUKARAN RECEIVES NATIONAL AWARD

The North-East in general and the Rapsbun School of Nursing of the Nazareth Hospital in particular have all the reason to be proud of when on August 8th, 1985, Sr. Elizabeth Edattukaran of the Salesian Sisters (Daughters of May Help of Christians) and the Principal of Rapsbun School of Nursing received the National Award for Nursing personnel for the Year 1984. In the following lines, this unassuming little sister explains about her life and life ambitions. We also join with Sr. Elizabeth to share her joy and extend our hearty congratulations. — *Executive Director*

*Sr. Elizabeth Edattukaran*

"I have left my home town in Kerala in 1956 as a young girl to give my life long service among the poor and needy. Under the direction of Salesian Missionary Sisters, I completed my General Nursing Course from Ganesh Das Hospital, Shillong from 1956 — 1959. The Midwifery Course later in 1963 from the same hospital, passed in honours in both General Nursing and Midwifery.

After General Nursing Course, I took up 2 years of formation course for Salasian Religious life and took religious profession in 1961. In 1961 - 1963, I worked in School Health Programme in Shillong and Tangla, Assam, in Voluntary Institutions for 1½ years.

From 1963, I took up the call of Assam Govt. to work as Staff Nurse in Ganesh Das Hospital, Shillong. From 1963 — 1976, I worked in the above hospital, as Staff Nurse, Ward Sister, Sister Tutor, Home Sister's substitute, and filled the gap whenever needed. I worked with enthusiasm in Surgical, Medical, Paediatric, Nursery, obstetrical as well as teaching and gained a lot of experience. From 1969 onward I was appointed as full time Tutor for both G.N.M. and A.N.M. Course. My alround practical experience now contributes to a successful service as a Principal of this Programme Rapsbun School of Nursing with an independent Administration.

During the Pakistan trouble as well as Assam fight I had gone out of my way, along with my Staff and Students to meet the needs of Refugees in their Camps and I consider it as the best services I had ever given to humanity.

Nursing Education is my first choice in the Nursing field, and I am grateful to God and all who co-operated with me till today to enable me to contribute my mite in this field.

1971 - 1972. Section of P.C. Course for General Tutor in College of Nursing, New Delhi, I have been deputed by the Assam Govt. and took the course under the leadership of Mrs. Chaboak one of our well-known leader of Nursing profession and came out successfully standing in 2nd position. On my return, I was posted as Sister Tutor in G.D.H. till 1976.

1976 - 78, I did the post certificate B.Sc. Nursing at Christian Medical College Hospital, Vellore came out successfully with 2nd position in Madras University Examination.

1979, I worked whole heartily for starting New School of Nursing "RAPSBUN" and my Superiors appointed me as the Principal of this Voluntary and independent School of Nursing.

Rapsbun Nursing School was one of my dream since 1963 onward. It came to a reality in an improvised hostel with improvised school facilities in 1979 Sept and now I am in my 6th year as Principal. On 4th June, the hostel and school facilities are shifted to a new and one of the beautiful building in this area. I am happily spending my life with 44 enthausiastic G.N.M. Nursing Students.

**First Fruits of Rapsbun School of Nursing**

(The following is a short description by Sr. Elizabeth herself about the School of Nursing she started. It is encouraging to see how the nurses passed out from this school are doing commendable services in the remote rural areas. This institution deserves help and encouragement from all.

— *Executive Director*)

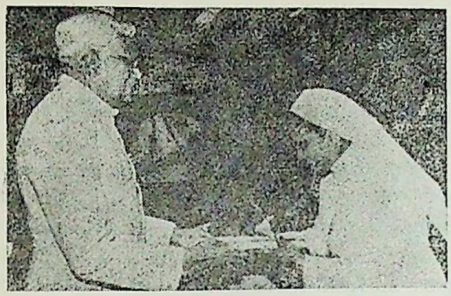
From 1979 we have taken up a project of Nursing training programme to prepare Nursing Personnel for the North East zone mainly for the Rural areas where other prepared categories of nurses are unable to reach. I have been appointed as Principal of this particular school which is Voluntary and independent in regards to administration. It is attached to Nazareth Hospital Shillong for its practical experience. Bishops and Religious congregations and hospital and other benefactors sponsor the candidates for training and the Salesian Sisters give Voluntary Service to teach and form these candidates to dedicated nurses. We have already sent out 3 batches of nurses total 31 of them. Among these 31 nurses, 15 of them are working in different parts of North East zone in the Rural areas giving voluntary services in their own dispensaries and villages visiting programme doing much good to bring about health for all by 2000 A.D. Hope we will be able to continually prepare nurses for the rural areas. The sent 16 nurses are young girls to nursing profession. I am still looking forward for help to furnish the new building and to get a full time staff from outside as I don't have enough prepared people from our own.

Later on, we are also planning to begin with the Female Health Workers Course which will be much needed in rural areas to work along with the senior nurses. May the Lord inspire good people to help us so that we will be able to continue the good work we have started.

— **Sr. Elizabeth Edattukaran**

**PARTICULARS OF THE INSTITUTION FOR PREPARATION OF CITATION**

The SACRED HEART LEPROSY CENTRE is a voluntary organisation started during the year 1916 with five patients as an asylum. In those days the patients who had been abandoned by their families were taken care of by this institution. Gradually the number of patients increased with the discovery



*Sr. Ancilla receiving the Award**

of modern drugs. The institution could transform itself into a modern hospital from 1969 onwards.

The institution has all the required facilities for the treatment of Hansen's Disease. There are about 700 inpatients in the hospital and the out-patients clinic is attended by around 100 patients daily. Various services provided by the institution are in-patients and out-patients services, fully equipped modern laboratory, reconstructive surgery, physiotherapy and occupational therapy, shoe and splint workshop, special school upto 8th standard for the children affected by Hansen's Disease, social welfare and rehabilitation.

There are 91 employees in the institution. The institution started the rehabilitation department during the year 1972 and since then special efforts have been taken for the welfare of the leprosy cured persons. The number of persons rehabilitated rose gradually every year, with the implementation of many new schemes. The institution provides financial assistance for self-employment of cured leprosy persons. Vocational training programmes are arranged for leprosy cured persons inside the institution as well as in other training centres. During the year 1983, the institution launched rehabilitation programmes under the Government Schemes — Integrated Rural Development Programme (IRDP).

In collaboration with the local panchayat union, we could undertake 8 training programmes under the IRDP scheme for persons cured from Hansen's Disease. It was for the first time a voluntary organisation engaged in the treatment of Hasen's disease was selected to take training programmes under the IRDP scheme in this district. We consider this as a recognition and appreciation by the Government. Impressed by our training programmes we could secure more training programmes from the Government during the year 1984. The training programmes were one of the best way for the rehabilitation of leprosy cured persons. We could also secure bank loans for the rehabilitation of the cured leprosy patients.

During the year 1984, in addition to the medical assistance provided for 10,902 cases vocational training for 108 disabled persons were given. Two persons have been employed for the regular salary, 212 patients have been assisted for self-employment under our rehabilitation scheme. The institution has necessary infrastructure to undertake training and other rehabilitation programmes for the leprosy cured persons.

(Sr. Ancilla)

## WHO WORKSHOP ON CONTROL OF TOBACCO-RELATED DISEASES

New Delhi, 22 July : With growing evidence of the direct relationship between smoking and lung cancer, many countries are considering measures to curb the habit, particularly among the young. Similarly, it is recognized that the use of tobacco also has adverse effects on health and that tobacco smoke is carcinogenic to humans. Yet, the

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* Sr. Ancilla, Superintendent, on behalf of the Sacred Heart Leprosy Centre, Sakkottai, Kumbakonam (T.N.) received the National Award from the Vice President of India on 13th May 1985. The award consists of a certificate and cash of Rs. 50,000./-

manufacture of cigarettes and other tobacco products and their consumption are increasing in the South-East Asia Region.

To review ongoing national activities, policies and strategies in relation to smoking and health in the WHO South-East Asia Region, a five-day regional workshop on control of tobacco-related diseases opened at World Health House today. The workshop is expected to formulate national plans of action with specific reference to enhancing inter-ministerial cooperation and coordination for effective implementation of the programme.

Addressing the participants, which include senior health administrators and officials from related Ministries, the WHO Regional Director for South-East Asia, Dr. U Ko Ko, cautioned that there was evidence of an increase in the number of cases of cancer of the lung, chronic pulmonary diseases including emphysema and ischaemic heart diseases. "The global figures for the mortality from lung cancer alone have already risen to 1 million annually. It has been estimated that this figure will increase to 2 million by the year 2000 and continue to rise unless effective action is taken now to halt the smoking epidemic", he added.

Besides, lung cancer, smoking and chewing of tobacco are responsible for the vast majority of cases of oropharyngeal and laryngeal cancers. Other cancers related to smoking are those of the pancreas, urinary bladder and oesophagus. The cure rates of lung cancer are extremely low, even when treatment is early. The only effective method presently available for the control of lung cancer is prevention of smoking.

The risk of lung cancer is particularly dependent on the duration of smoking; the earlier the age of onset of the habit, the greater is the risk to the individual. Furthermore, the longer the duration during which a major proportion of the adult population has been smoking, the higher the incidence and mortality from lung cancer in that population.

The habit of chewing tobacco which is associated with an increased risk of oral and oropharyngeal cancers is also an area of concern in the South-East Asia Region. These risks are enhanced by the intake of large quantities of alcohol. The other cardiovascular and respiratory diseases related to tobacco consumption are also of a chronic nature, leading to absenteeism from work, reduced industrial production and huge costs incurred on the hospitalization of these patients.

There is yet another disturbing dimension to smoking — ecological. The curing of tobacco requires large amounts of firewood. Naturally, this has contributed to deforestation bringing in its wake soil erosion and desertification.

The Regional Director pointed out that several countries in the Region had initiated activities to control tobacco consumption. National advisory committees had been set up in some countries to define the most feasible strategies, approaches and action plans. Some countries had already introduced anti-smoking legislation. "Obviously, a multi-disciplinary approach is required and activities which are in conformity with the socio-cultural milieu are called for", the Regional Director said.

In the final analysis, the success of any tobacco control programme has to be measured by the level of reduction in the prevalence of tobacco-related diseases, such as lung cancer, cardiovascular diseases, chronic bronchitis and emphysema. In countries where such control programmes have been initiated, the results have been encouraging. Observations made in the USA by the American Heart Association showed that mortality rates from heart diseases had decreased significantly with a reduction in the smoking habit.

In North Karelia in Finland, measures taken over a 10 year period to prevent smoking led to a decrease in the levels of hypertension and deaths from cardiovascular diseases. A reduction in the rate of smoking amongst male doctors in Great Britain from 43 per cent in 1954 to 20 per cent in 1971 was associated with a lowering by 25 per cent in deaths from lung cancer during this period.

The outcome and recommendations of the workshop are expected to provide an impetus and added momentum to the activities for the control of tobacco-related diseases in the Region.

Courtesy : WHO

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## ANNOUNCEMENT

Dear Doctor..... !

Of the drugs that are being marketed in our country, approximately 60% are either unscientific, harmful, substandard or banned, Doctors have to depend mainly on the drug companies for information about drugs. Tall claims (often false) are made by drug companies about these drugs while all the harmful side effects and contraindications are not placed before the doctors.

Drugs Action Forum, West Bengal is going to publish a quarterly journal on Drugs and Rational Therapy which will also contain information on harmful, banned and unscientific drugs. The journal will function under the guidance of an advisory body comprising of some members of All India Drug Action Network (AIDAN) and other noted doctors of the country. Doctors and health personnel are likely to be benefited.

Annual Subscription Rs. 12.00 (Four issues).

Bank drafts in favour of Drug Action Forum, West Bengal or Money Orders for subscription may kindly be send to the following address: (Please do not forget to mention your name and address in the M.O. coupon).

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