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EDITORIAL

LIVING FOR OTHERS

One of our Indian novelists described of three levels of living. He finds at the lowest level the dog-like life fighting for food as the 'end all and be all'. He would identify a large chunk of our population under this category drawn from all classes, castes and religions of people, whether rich or poor, educated or illiterate, in the towns or villages but all animated by basic selfishness. The second category is those who have attained a certain sense of humanity by religion or culture and they are like common crows the robber birds, but as soon as they find food, call out to their kin to share the meal with others. This category of people considers this sharing as a virtue at least for the purpose of attaining 'punya' and 'Moksha'. Then lastly a small tiny minority, who are like the proverbial 'Mother', willing to 'Live for others'. Then the novelist identifies in Jesus Christ Himself this spirit to live for others.

How about us? Our attitude? Our spirit of service? Our dedication and commitment to live for others?

"Break the bar, break it
Let the captive mind free
Let life with its boistrous laughter
Fill the dry river bed. . . . . "

Thus dreampt our great saint Poet Rabindranath Tagore, of life. Life with full of laughter and liberated mind, with overcoming of all kinds of dryness so that life can flow smoothly like a river filled with water, for the teaming millions of our country. Yet what is the reality we see today?

Living for others as far as we are concerned should be living for the poor. Our services should primarily be geared to them, services in the field of health, education or otherwise. And the overriding reason for this is because God is with them. It is in the struggle of the poor that God speaks and reveals Himself. We need to opt for the poor not because they are better than the rich; not because they are holy and the rich are not; much less because they are the majority. We need simply to follow God's lead.

If our option is to live for others, this can meaningfully be realised only by living for the poor. Then of course our involvement, our services and all should be more and more where the poor are.

LIFESTYLE AND HEALTH

—Alcohol Advocacy

Is there increased pressure for health-oriented social 'policy changes that relate to the availability of alcohol? Are people involved in an alcohol debate?

—Marcus Grant

There is a growing awareness today that alcohol causes health problems. Ten years ago, an article here would have devoted most of its space to chronicling the range and severity of alcohol-related problems. It would have been neaessary to demonstrate the link between drinking and disease.

Today, that link is well understood, at least by most of these who are concerned with public health. What remains the challenge for the next ten years, is to ensure that the same awareness is spread through governments, the general population and the scientific community. That is the aim of alcohol advocacy.

Within the WHO programme on alcohol-related problems, advocacy is one of the four priority areas for action. The others are: national alcohol policies, international coordination, and the development of techniques for identification, prevention and management in primary health care settings. All are important, but without effective alcohol advocacy, it would be difficult for the other three to make any headway at all.

So what does alcohol advocacy really mean? Dr. A.R. Al-Awadi, the Minister of Public Health and Planning of Kuwait, who chaired the Technical Discussions on alcohol at the Thirty fifth World Health Assembly in 1982, said that it had to do with "the creation of social awareness" and "the stimulation of the political will of the people".

In developed countries, many of the major causes of death and disease are the direct result of people's lifestyles. This is increasingly becoming true for developing countries as well. Bad diets, lack of exercise, unhealthy habits like smoking and drug-taking, the effects of pollution, stress-these and many other factors contribute to an ever more unhealthy environment in which to live and raise families. The purpose of alcohol advocacy, like health advocacy as a whole, is to help create a situation in which pe ple actively choose health.

The first step in promoting such a concept is to ensure that the relevant people have access to the right information. Of course, this involves gathering data and bringing them together in reports, books and articles, but that is only one part of the process. Advocacy also involves making sure that people are reading all these fine words and that, having read them, they are prepared to do something to make matters better.

A review was undertaken by WHO of all the various documents on alcohol production, consumption and related health problems that had been issued or drafted by the Organization during the past few years. The clear conclusion was that the information available had been insufficiently exploited for advocacy purposes. What, for instance, are the implications for public health of trends in alcohol production and trade?

Whilst alcohol consumption is beginning to fall in some Western developed countries, it is continuing to rise steadily on a global basis, with particularly sharp increases in a number of developing countries in Africa, Asia

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and Latin America. Even though some of these countries were beginning from a comparatively low base figure, the present trends would, if they continued, lead to very high consumption rates before the end of the 1980s. In order to focus the attention of governments on this important issue, WHO has not only prepared a basic report on the current situation, but has ensured that the topic is given prominence in a variety of other journals with wider circulation. (The present article is itself part of that effort!)

The point to note is that if a government wants to take steps to deal with the health consequences of rising alcohol consumption, it will not just involve the ministry of health. Finance, justice, labour, traffic and many other ministries will also have to be involved. Thus, alcohol advocacy takes place within governments, to promote better national health policies.

A more obvious kind of alcohol advocacy achieves its ends through the mass media. Sometimes this takes the form of health promotion campaigns, designed to influence people's drinking habits. It is now rare to try to frighten people into changing. Much more effective is an approach which actually seeks to involve people in making active choices about their own health and about the environment in which they live. In this sense, through community involvement, advocacy is already a two-way process. The expressed needs of the people are fed directly back into the advocacy effort, reinforcing and amplifying its messages.

But there are other ways in which the media carry alcohol advocacy. Just think how much drinking is portrayed in the cinema and on television. Or consider how news reporting and editorial comment in newspapers can communicate messages about drinking. What is required is a real working partnership between health practitioners and media practitioners. The objective is not to limit the media, not to "use" the media, but to work with the media to produce a more health oriented presentation of alcohol issues. Good partnership is good advocacy.

Nor are media practitioners the only group with whom such a partnership can be formed. Advocacy work through the promotion of productive links with a wide range of disciplines. The encouragement of research on alcohol is itself a kind of advocacy within the scientific community. Often, a particular topic, such as alcohol-related problems in adolescene, may have attracted a great deal of public interest but comparatively little scientific study. WHO is well placed to stimulate research efforts, particularly in an area such as biological risk factors for alcohol dependence, which require long-term international collaborative efforts.

One problem of the advocacy approach is how to establish indicators of success. The traditional epidemiological approach to mortality and morbidity data is hard to apply in this area. Whilst it still represents the bottom line for all preventive health measures, it may be that in assessing the effectiveness of advocacy other kinds of intermediate successes are more relevant.

If increased social awareness is the objective, then are more people becoming involved in community activities? Are there more items about the health aspects of alcohol in the popular press and on radio and television? If the political will of the people is to be stimulated, is there increased pressure for health-oriented social policy changes that relate to the availability of alcohol? Are people, in other words, involved in an alcohol debate? For it is through an increasing involvement of people in issues relevant to their own health that the effectiveness of advocacy can best be measured.

For WHO, the challenge is to achieve the right balance between persuasiveness and scientific credibility. If you wait until every last fact is known, you will never be able to say anything. Meanwhile, hundreds of thousands of people will needlessly die of all the diseases and accidents to which alcohol so actively contributes.

On the other hand, there is a responsibility to ensure that the messages which are communicated reflect the best available evidence. The principles of scientific enquiry should not be abandoned in favour of a few catchy mottoes.

An honest citizen, returning home after a hard day's work, and switching on his radio or television set, may maintain that he has a "right" to be entertained. The same citizen, reaching for his beer or wine bottle, may equally forcibly assert his right to drink what pleases him and in what quantity he likes. But as well as a right to choose the lifestyle that suits him best, he may also feel that he has a right to be protected against avoidable risks.

The question is whether all these rights are compatible with health. Alcohol-related problems are health problems and many of them proceed from choices made by individuals and societies about the kind of lifestyles they want to adopt. But choices are not fixed for all time. The promotion of healthy lifestyles in a changing world must remain an important focus of much WHO effort. Alcohol advocacy is just one part of health advocacy, which is what health for all by the year 2000 is all about.

Courtesy — WORLD HEALTH

ORAL REHYDRATION THERAPY

—Denise Ayres

Miss Denise Ayres is the Executive Director of Diarrhoea Dialogue, Appropriate Health Resources and Technologies Action Group (AHRTAG), London.

Few health technologies have as great a potential as oral rehydration therapy (ORT) to make an impact on childhood mortality in developing countries. Simple, inexpensive and effective, ORT can be used not only throughout the health system but at home as well.

Recognising this, international agencies, nongovernmental organizations and ministries of health in many countries are actively promoting this therapy. With the assistance of the WHO programme for the Control of Diarrhoeal Diseases (CDD), some 70 countries are now implementing plans for national diarrhoeal disease control programmes, within which ORT is the main component. UNICEF is playing a leading role in the production of oral rehydration salts (ORS) and in the crucial area of information activities related to ORT.

The use of ORT in treating and preventing diarrhoea is based on the knowledge that glucose stimulates the absorption of salt and water in the small intestine. The first step in turning this knowledge into a more widely available health technology was the development by WHO and UNICEF of a formula for oral rehydration salts. Mixed with drinking water and given in the necessary quantity, ORS solution replaces all the salts and fluids lost during diarrhoea.

An important recent development was the introduction by WHO of a more stable formula containing tri-sodium citrate in place of sodium bicarbonate. Research is still going on to develop mixtures that will replace the glucose in ORS with cereals such as rice powder, which are readily available in some areas and provide valuable nutrients, or that will also contain amino acids and dipeptides. Both types of mixture can increase sodium and water absorption by the intestine and thus reduce the volume and duration of diarrhoea.

The development of the ORS formula, distribution of packets and encouragement of local production of ORS — although a vital undertaking — represent only one part of the strategy to achieve widespread use of this therapy. Actually delivering it remains a crucial issue: what can be achieved at home, what role should the village health worker play and what is the place of ORT in hospitals ?

Strong local beliefs about the best way to treat diarrhoea (if any treatment is given at all) are sometimes incompatible with the ORT approach. The notion that drinking during an attack of diarrhoea is bad is a common one — and not only in developing countries. Before they can accept ORT. mothers need to understand what diarrhoea is; how it leads to malnutrition and often death; why fluid and food given by mouth save lives; and how continued breastfeeding and extra feeding for even a few days can speed a baby's recovery. It is believed that early ORT at home *as soon as diarrhoea starts* may result in fewer children becoming dehydrated and needing treatment with oral rehydration salts at health facilities.

Available foods

Home therapy is based on the use of either fluids and foods already available in the home, such as rice water and carrot soup, or of drinks made up from sugar, salt and drinking water to prevent dehydration from developing. Obviously, almost all home remedies lack the sodium bicarbonate or citrate and potassium chloride contained in the complete ORS formula and are, therefore, not as effective in *treating* dehydration.

In the Gambia, health workers have been taught to administer the therapy, using ORS, and mothers have been taught to mix a safe sugar-salt solution at home. The message has been successfully reinforced by a media campaign. After one year, 67 per cent of mothers could correctly mix a home solution and 47 per cent had used it at least once to treat their children. Not surprisingly, this early preventive treatment at home has meant that the number of mothers taking children with diarrhoea to health centres has dropped from 85 per cent to 50 per cent.

A simple recipe for home-made oral rehydration solution is to mix one level 5 ml teaspoon of salt with eight level 5 ml teaspoonfuls of sugar in a litre of drinking water. In a few places, double-ended plastic measuring spoons are being used which measure out sugar at one end and salt at the other. The advantage of the spoons is that they measure out enough sugar and salt for a relatively small amount of water (200 ml) so that the solution is more likely to be used quickly and not left standing. The major problem with the spoons is that they are not always easily available and, when they are supplied, they frequently come without adequate advice on their use.

One general constraint in the use of sugar and salt solutions, no matter what measuring method is used, may be their lack of availability of the high cost of sugar and salt in many places. In such circumstances, mothers should use drinks and foods that are already available in the home.

Promoting ORT

There has been resistance to the use of the therapy in hospitals in some developing countries. Senior health staff have often been trained to use intravenous infusion for all cases of dehydration, and they remain unconvinced about ORT as available alternative despite scientific evidence proving its efficacy in all but the most serious cases. On-the-spot demonstrations of the use of ORT with dehydrated patients have proved to be the most effective way of convincing doctors. In many hospitals where oral rehydration centres have been introduced, entire wards previously set aside for diarrhoea patients can now be used for other purposes. Large hospitals in Bangladesh, Egypt, Haiti, Jamaica, Nepal and the Philippines have all experienced a substantial drop in the use of expensive intravenous fluids following the introduction of ORT progrrammes. There has also been a substantial reduction of case fatality in some of these hospitals.

Promoting the key health education messages that relate to ORT is important. Differing traditional views on diarrhoea, the wide range of people to be reached, and the availability of different sizes of packets of oral rehydration salts all call for very adaptable approaches to health information programmes. The innovative information techniques used range from television and radio spots to printed materials, puppet shows and theatre. At the international level, aid agencies and other organizations involved in mass communications techniques are collaborating on the development of coordinated public information campaigns to promote ORT.

One major vehicle for information is *Diarrhoea Dialogue*, a quarterly newsletter started five years ago to bring regular news to

all those involved in the prevention and control of diarrhoea. It is distributed free to developing countries, and is available in Arabic, English, French, Portuguese and Spanish. For more information about the newsletter and the work of AHRTAG, write to : AHRTAG, 85 Marylebone High Street, London W1M 3DE, UK.

Since only simple technology is needed for its use, ORT has brought effective mortality reduction within reach of even the most remote dispensary. Its impact at hospital level has also been dramatic; it has enabled expensive in-patient rehydration wards to be closed in many places.

Perhaps the most important achievement is the dissemination of this technology outside the formal health structure. Community health workers (CHWs) can effectively deliver ORT services, bringing about dramatic reduction in diarrhoeas disease mortality rates. In one community in India, a drop of 75 per cent has been achieved. Treatment of children in the home also allows CHW's to discuss with the parents other important topics such as domestic hygiene and better nutrition for sick children. In many settings, ORT has provided a stimulus for the accelerated development of primary health care programmes, and has become a vital element in the overall strategy to improve child health in developing countries.

—*Courtesy* - WORLD HEALTH

PRIMARY HEALTH CARE
The Challenge for Nursing Education

—Amelia Mangay Maglacas

Dr. Amelia Mangay Maglacas is a senior scientist in nursing and heads the nursing unit at WHO Headquarters in Geneva.

Only 15 years to go before the year 2000! For the past seven years-ever since the WHO/UNICEF Conference on Primary Health Care at Alma-Ata-almost everyone concerned with health has been repeating the slogan, "Health for all by the year 2000", imagining the moment when it would become a reality, picturing how the world will be when it actually happens. But, above all, working for it by emphasising health development through primary health care. As Dr. Halfdan Mahler, Director General of WHO, explained, it is people who matter, people who can make or break their own development. And a member of WHO's Executive Board stated last January that health workers too "can make or break a health system in terms of what they do or do not do". This is especially true for nures because, in the majority of countries, they are the most important group of health worker in terms of numbers, closeness to people, and "caring" for people.

WHO has always been aware of this. Back in 1974, the Organization convened an expert committee on community health nursing to identify ways in which nurses could significantly work towards meeting the health needs of all the people. The recommendations issued by this committee indicated that, if nursing services are destined to respond to the real needs of communities, then, nurse education should reflect those needs.

Unfortunately, the time was not ripe for a ready acceptance of the changes proposed. Which is why even today, in too many instances, the education of nurses-like that of other health workers — is still hospital-based and they are given very little or no experience in community health. This is the challenge that faces nurses everywhere today. Throughout their working lives they should be bearing firmly in mind the concept of primary health care. This is why it is essential that the components of primary health care be introduced at all levels of their education, to prepare them to become cooperative partners of the community — which is often more knowledgeable about its own health needs and priorities than are health workers themselves.

When WHO convened another expert committee in October 1983 on education and training for nurse teachers, with special reregard to primary health care, it recognised that more could be done, not only to help nurses to *accept* the new concepts of health and health care delivery, but also to *become* agents of change. If nurses are to realise their potential as agents of change, they must understand the concept of primary health care and know how to practise it. There has to be a fundamental reorientation of thinking and action through responsible nursing leadership in education if nursing is to contribute to the achievement of the goal of health for all through primary health care. The changes required are more than cosmetic-traditional patterns and structures will need to be challenged. As the accent moves from patient-oriented to community-oriented health care, total care undertaken by a health team will be the norm. Furthermore, the fulfilment of primary health care tasks will make greater de-

mands on *cooperation* between nurses and other health-related professionals from different sectors.

Two encouraging examples

Some countries have been reorienting their nurses and nursing education towards the goal of health for all through primary health care, and with considerable effect. Ever-since Senegal signed the Charter for Health Development in the African Region in 1978, and adopted primary health care as the cornerstone of its national health development policy, it has been progressively training its nursing and midwifery personnel in the essential components of primary health care, both in the rural and semi-urban communities and in academic institutions.

Various schools and institutions throughout the country preparing nurses and teachers of nurses have adopted the principles of primary health care as the basis of their curricula and of learning experiences in rural and semi-urban communities. Nurse educators have been undertaking intensive course, including field training, in the components of primary health care to enable them to quickly adap-their teaching to emphasise local health probt lems and needs.

Other health personnel such as community health officers, health post chiefs, and traditional birth attendants are also being given training, and supervision and support are accentuated. Continuing education for everyone in the form of seminars and workshops of two or three weeks is being offered. This process is proceeding slowly but surely. Although it is still premature to give an assessment of its results, the outlook is certainly hopeful.

Thailand is tackling this problem in its own way. Nurses organized a workshop to identify what will be required of them if health care needs are to be met by the year 2000. This gave birth to a series of seminars and workshops to reorient nursing leaders from both the education and service sectors, and a committee was appointed to draft an educational programme that is community-oriented and that focuses on primary health care. Nurses' associatoins promoted the idea of a need for change and mobilised nurses to lend support to this idea. Today, nursing schools are beginning to implement their community-oriented programmes and students are being trained in the communities.

The Challenge

Nurses voicing their commitments, potentials, and good intentions will no longer suffice. Are nurses prepared to challenge the present system of education in order to effectively work towards the goal of health for all, or are they merely going to pursue the *status quo*? The greatest number of health workers are nurses; but what are they doing about primary health care? They, above all other health workers, have been prepared to be closer to people — but are they close to all people?

What can nurses do to really have an impact on achieving health for all? A lot of new things will have to be done:

- new ways of thinking
- new attitudes about health
- new ways cf doing things
- new ways of working
- new relationships formed
- new priorities
- new functions
- new ways of teaching and learning.

Once the nursing community begings to apply the new thinking and becomes actively engrossed in the new way of doing things, partnership with communities will be visibly strengthened and the goal of health for all can be more realistically pursued. Education for nurses based on the concept of primary health care is an essential means of achieving this goal.

Courtesy - WORLD HEALTH

Bishops Set Goals for Justice and Development

(Report of the Indian Phase Bishops Institute for Action VII (Bisa VII) Programme)

—Fr. Yvon Ambroise
National Co-ordinator of BISA VII

1. What is BISA?

As a follow-up of the meeting of Asian Bishops in 1970 the Federation of Asian Bishops' (FABS) was started in 1972.

FABS established an Office for Human Development (OHD) as its Secretariat for Development and Social Action. Through OHD training programmes are organised for Bishops of Asia and these training programmes are called Bishops' Institute for Social Action (BISA).

From 1974 onwards six such programmes have taken place. The first in 1974, the second and the third in 1975. These three programmes dealt with the social dimensions of the Gospel.

BISA, IV, V and VI took place in 1978, 1979 and 1983 respectively. They speculated on Collegiality for Human Development. BISA VII, scheduled to take place at Thailand in January 1986, for which preparations are going on, intends to discover the spirituality based on the religio-cultural dimensions of human development.

2. What's new of BISA VII?

All the six BISA's were conducted in any one of the Asian countries for the Bishops of Asia who wished to participate in the programme. Evaluation of these programmes showed that the programmes ware useful and gave the Bishops social awareness and collegiality but did not pave way for operationalization in one's own country in an effective way. This was due to lack of corresponding programme and the onesided exposure programme because of the selection of one particular Asian country. So BISA VII was planned in such a way that each country would have their programme in their own country with the experience of their social relality and send their delegates to an Asian level meeting to make an Asian synthesis so that each country develops its own operational strategy as well as contributes to the Asian one.

Theme and Purpose : The theme selected for BISA VII is — Asia's Religio-cultural Heritage and Human Development. For decades development work has been avidly taken up by church and church personnel. The very soul of this work is its spirituality. Hence in BISA VII the entire trust is to deliberate and discover a suitable Asian spirituality for social work. To achieve this one has to look to the Gospel values and be imbued in the spirit of our own culture and heritage which are so deep and rich and thus evolve a spirituality of our own, with its own character and dimension suitable to our country and people. So the participants of BISA VII will be given a chance to experience personally the way of living of the poor, downtrodden and oppressed. With this living experience, combined with an analytical synthesis of the situation, the programme intends to lead the participants to arrive at a desired synthesis by synthesizing the lived-in-experience of the poor with a deep contemplative prayer and reflection.

3. Goals

— to deepen the awareness among bishops of the "responsibility of faith for social change" in solidarity with the struggling poor to promote the elabo-

ration of a spirituality of human development and social action in the life and struggles of the poor and in the life and ministry of the pastoral workers.

— to enhance the commitment and dedication of bishop's to pastoral action on behalf of justice and human development for the struggling poor.

4. The Objectives :

— to provide an experience of "being with" the struggling poor.

— to define from the perspective of the poor, the realities of poverty and injustice in the national and the Asian situation.

— to appreciate the aspirations and the "spirit" of the struggling poor as they employ their religio-cultural heritage in their efforts, growth and development.

— to affirm the Kingdom values as seen and lived through the eyes, hearts, and lives of the struggling poor.

— to articulate priorities and develop strategies for action as an Asian Church response to the needs of the poor.

5. Planning

In order to make the experience meaningful; genuine and indigenous one and in order to effect a good follow-up, BISA VII was planned in four phases.

The first phase was the initiation of the national coordinators and the Bishop/Bishops each country sent as their delegates. The initiation session at Hua Hin in Thailand from January 15th to 19th, 1985 was meant for this. Fr. Oshida, a Dominican Priest from Japan, Fr. Aloysius Pieris, s.j. from Sri Lanka, Fr. D.S. Amalorpavadass from India and Fr Bede Griffiths, a Benedictine Priest from India were called to be the resource persons at Asian Level. Of these four, only Fr Bede Griffiths could not come for this session for some unavoidable reasons that kept him in India. Fr Yvon Ambroise, Asst. Executive Director of Caritas India, was appointed by the CBCI as the national co-ordinator for organising the BISA VII in India and he attended this meeting.

The Second Phase of the programme is the actual organization and implementation of the Exposure-immersion programme accompanied with deep reflection in one's own country. Those Bishops who participate in the programme will also elect four Bishops who would share their experience at the Asian Level.

The Third Phase of the Programme is the meeting of the representatives elected and sent by each country after experiencing the exposure-immersion cum reflection at Thailand from January 15 to 23, '86. At the Asian Level there will be a sharing of the different experiences of each country and with the help of resources persons mentioned above there will be an Asian synthesis that will be made.

The Fourth Phase : is the operationalization and implementation in one's own country. The Bishops participate in BISA VII as leaders of their Church in order to exercise their leadership to initiate the spirituality of social work in their Dioceses.

6. BISA VII in India

The Indian phase of BISA VII Programme of exposure and immersion took place from 20th to 30th August at Bangalore and at Anjali Ashram in Mysore. Preparations for this programme has been going on since March. At the invitation of Fr Yvon Ambroise, National Coordinator for BISA VII, the Regional Directors of Social Work of different regions met together for the first time at Satyo dayam in Hyderabad from 19th to 21st March,

to plan out the programme. Fr. Mathew Thoyalil from Kerala Forum, Fr. Victor Maria Soosai from Tamil Nadu Forum, Fr. L. Noronha from West Bengal Forum, Fr. A. Salema from the Karnataka — Goa Forum, Bro. Bernard Singh from Bihar Forum and Fr. Francis Xavier for Andhra Pradesh were present for the meeting. Later on together with Mr. Rudy Lobo from Delhi they had subsequent meetings to choose the sites of projects and prepare the people for exposure. Fr. Remigius — Director of Caritas India joined the above team as one of the facilitators during the ten days of BISA VII programme.

Exposure — Immersion programme

The actual BISA II programme took place from the 20th to 30th August. Bishops Rt. Rev. Benedict Osta — Patna, J.B. Thakur — Muzzafarpur; Gilbert Rego — Simla-Chandigarh; Thomas Thiruthalil — Berhampur; Aruldas James — Uthagamandalam; Fedrick D'Souza — Jhansi; James Toppo — Jalpaiguri; Dominic Kokkat — Gorakhpur; Theophane — Jabalpur; Alex Dias — Port Blair; Linus Gomes — Baruipur; George Anathil — Indore; Joseph Pathalil — Udaipur; Msgr. A. Sharma — Ecclesiastical Superior of Nepal, and Fr. Dias, Deputy General Secretary of CBCI took part in the programme. Due to other commitments, some other Bishops who wished to join the programme could not attend it.

The first three days of the programme took place at Bangalore. After the initiation to the programme, Bishops visited various places and projects to have a first hand living experience of the poor, down trodden and oppressed people by meeting them, having a dialogue and sharing food with the poor people.

On the first day, they visited Ramangaram, a small town about 56 km away from Bangalore and met a group of casual workers who are employed in the silk industries owned by some 100 business people who employ nearly 10,000 people on daily wages. These exploited and oppressed workers shared their difficulties and problems with the Bishops. From there they proceeded to a tribal village inhabited by Lambanis whose forefathers were brought from Rajasthan by Zamindars for cheap labour. Here too Bishops went in groups to visit the people in their houses and listened to them patiently.

In the afternoon, they visited some slums in Bangalore where some slum development schemes are organised by Ms. Santhosh and the fathers of the Holy Cross. After meeting the slum dwellers in their own houses and situation they all gathered together at the Ragpickers' den, a project which has been initiated and sponsored by the Archdiocese of Bangalore. Bishops nearly spent an hour speaking to the ragpickers and trying to gather from them their aspirations hopes and ambitions in life. The meeting was very cordial and homely. The Bishops were touched by the project and the commitment and dedication of the animators who are involved in organizing these ragpickers to whom society is very hostile.

On the second day they visited Kolar Gold Fields. In the morning they were taken down 4800ft. below the ground level to see the working conditions in the mine. From there, two by two they visited some of the families of the miners to see their poor living conditions and had their meals with them. In the afternoon they also met different type of groups consisting of workers, women, elders of the parish and youth and discussed with them their problems. In the evening they visited a rural project 'Sunanda' which is run by the Sisters of St. Joseph of Tarbes.

On the third day the Bishops went to visit the stone quarries. After meeting the stone quarry workers in their working conditions they listened to them carefully the difficulties they

underwent as bonded labourers. The people shared with the Bishops their experience of freedom struggle and what it means to them to be free from the clutches of contractors and quarry owners. After meeting and discussing with the workers both men and women the people took the Bishops to their houses and shared their meals with them.

During these three days of exposure-immerssion and specially on the last day at the quarries, it was inspiring to see the Bishops sitting on the ground under the shade of a tree and discussing with them and listening to them. All through the programme, they spoke to the people, listened to them and shared their ideas and took meals with them on equal footing. This was made possible, since the people were not aware that the persons with whom they were dealing with were Bishops from different parts of India. To facilitate this approach to the people, the Bishops did not put on any insignia pertaining to a Bishop.

The second phase of 7 days were spent in prayer, reflection and synthesis in an atmosphere of peace and tranquility at Anjali Ashram. During the first 5 days of the second phase, Fr. Amalorpavadass initiated the Bishops to Indian spirituality incorporating the Ashram life-experience. It took a day or two to get accustomed to the Ashram life. The Bishops appreciated very much the experience of Indian spirituality. Besides the spiritual discourses during the day, each one seems to have enjoyed the other Ashram curriculum such as getting up at 4.30 a.m. going through yoga exercises, Pratha Samdhya (morning prayer) in the open air, celebration of Eucharist, Madhyan (midday) Samdhya under a tree and Saayan (evening) Samdhya with arati, bhajan, and dhyana. According to Ashram style, they volunteered to serve the food which was taken squatting on the ground. After supper every night they shared their feelings and evaluated the progress of the day. Within five days, they not only learnt a lot about Indian spirituality but also started appreciating the richness and beauty of Indian culture and significance of Indian religious and cultural practices. Above all each one cherished a deep awareness of God emerging out of a God-experience realized in them. The last two days were spent in formulating a synthesis of both the experience of exposure-immersion and Indian spirituality. In that process they spelled out a spirituality for Social Action in India.

The salient features of the experience of the BISA VII programme could be summed up in the following way.

1. The Goal of Social Action is not merely to organize services to people, but to animate them to engage themselves in the process of liberation from injustices, exploitation and oppression present in the society.

2. There are the humanizing and dehumanizing factors in the poor and one can sense the contradictions and tensions they are experiencing in their day to day life. Some of the dehumanizing factors are:

- Exploitation and dominance by the rich and the powerful, leading to total dependence.
- Lack of resources and skills leading to extreme poverty.
- A certain state of hopelesness and helplesness.
- Crude forms of injustice and social discrimination.
- Politically powerless and voiceless.

Some of the humanizing factors are:

- A strong faith in God but not a fatalistic one.
- A desire and aspiration to struggle and come out of the situation.
- Expecting an outside intervention as a liberating force (Messiah)

Hence their life itself is a big struggle to survive and live as human beings.

3. The problems and constraints they face in their day to day life are not merely at the individual level but at the collective and structural levels. And hence, the efforts individually undertaken are frustrated or bear no fruit at all. Therefore it demands change at the collective and structural levels.

4. People have a vague hope of a better future. This hope is kept alive by their faith and inner strength and their unfailing devotion to God which sustains them in their struggle.

5. Our response to such challenges demands that we liberate ourselves from the bondage of our prejudices, over concern for orthodoxy, fear of taking risks, losing comforts, losing our security and status, being identified with the exploited and of denouncing structural evils in the process of liberating the poor.

6. This calls for a deeper and continuous God-experience, leading to total integrity and ability to witness in word and deed.

7. Animators

The role of the Animators (Social Workers) is a vital factor in the process of liberation. The requirements of the Animators as emerged from this experience are:

(i) Real commitment to people and dedication to the cause.

(ii) Ability to inspire and infuse confidence in people and sustain their motivation.

(iii) Capacity to analyse their realities and evaluate with them their growing process.

(iv) A real authenticity in life.

(v) Proper training and on-going formation.

8. It was realized that there is a spirituality operative among the poor people and that one has to discover it.

9. The Bishops also formulated a holistic spirituality of social action.

At the end of BISA VII the Bishops planned a follow-up in three levels: national, regional and diocesan.

(a) At the National level

(i) A Report will be submitted to the Standing Committee for the General Body meeting of the CBCI.

(ii) A request will be made to the General Body of CBCI to promote such programmes at the national and regional levels through Caritas India.

(b) At the Regional level

(i) The Bishops who participated in the programme will serve as catalysts in their respective regions to promote such programmes, for the Bishops, Diocessan Directors and lay leaders.

(ii) Caritas India was requested to facilitate such programmes.

(c) At the Diocesan level

(i) The Bishops will share their experience with their priests, religious, social workers and other core groups of lay people in their dioceses to create a better understanding and right perspectives of spirituality of social action.

Jana Saukhya—A Brief Report

Co-operatives in Public Health

Co-operatives in Public Health was a new concept in Wynad. The Government is all for promoting co-operatives in different sectors: agriculture, industry, credit, consumer goods and services, labour etc. Health is every body's business. Why don't we co-operate to preserve, promote and restore our own health and also to create health awareness in the general public.

This question was seriously asked by Fr. C.M. Thomas who has organized several co-operatives in different areas he had served. There were industrial co-operatives, consumer cooperatives, milk producers co-operatives which now run with greater or lesser degrees of success. His enthusiasm has inspired others too.

As the secretary of Health service co-ordination in the Diocese of Mananthavady, this idea of co-operation among different health service institutions was discussed and certain amount of understanding and co-ordination was realized. During this period he completed a two year certificate course in 'HEALTH CARE AND WELLNESS MANAGEMENT' offered by Voluntary Health Association of India and had opportunity to visit different well known community health programmes serving the base level people. There was also a Rural Health Programme conducted by WSSS under the auspices of the Diocese of Mananthavady.

A fruitful combination of the idea of co-operatives in the promotion of peoples' health was discussed among friends, people working in the field of health. The idea was much appreciated. But it was new without precedence. Many interested people promised co-operation. So a proposal was forwarded to the Assistant Registrar of Co-operatives with the model byelaws and project report of the proposed society. The matter was considered. After several clarifications, permission was accorded to collect shares and a share capital of Rs. 50,000/-. was proposed as the authorised share capital of the society. It is easy to collect promises, but difficult to collect cash! However, the promoting committee collected the initial share amount within the stipulated time and deposited it in the District Co-operative Bank Kalpetta, as directed by the Joint Registrar of Co-operative Societies.

Though permission was granted to collect shares, the idea was still being discussed in the co-operative circles. In other co-operatives the members have economic benefits; there is economic activity in the society. But so far there was no co-operative society for public benefits — people's health and education. The primary aim of the co-operatives is the individual benefits and not the general public. Hence, there was also hesitation regarding the proposed society, since it does not have economic activity as its primary goal.

After a chain of correspondence and several talks from the office of Taluk Co-operative Societies to the Minister's office, the permission was withdrawn and chief promoter was asked to draw the money and return to the members.

An Alternative — Jana Saukhya

The members were keen on the idea and not to get back the share amount they paid. So, after several discussions an organisation was registered under the societies registration act — to achieve the same goal, with necessary changes — JANA SAUKHYA (wellness of the people).

While the organizational work was going on, there was action on the other side. The members discussed several possible programmes and to start with, thought of School Health programme in Wynad. Teachers and parents from different schools were very positive to the suggestions of the society. A formal meeting was convened on 20th August 1984 for a detailed planning. The meeting came out with the following recommendations :

- Intensify contacts with schools.
- Identity interested teachers for animating the programme in each school.
- Conduct a session for the motivation and training of these animators.
- Organize a study tour to MGDM Hospital Kanghazha where the school health programme is successfully being carried out since 1975, and to the well known community health programmes in Kerala.
- Select and train student health guides so that they be in a position to guide others when the programme is launched.
- Contact public health department and the officer incharge of School health and plan a combined programme for the school year 1985-86.
- Prepare resource materials for the students and teachers and also build up a resource team.

According to the recommendations of the meeting the following steps were taken :

- Schools were contacted and interested teachers were identified.
- A training session was arranged for the teachers at St. Catherine's High School, Payyampally from 22nd to 24th March 1985. 26 teachers from 10 schools participated the training session.
- Study tour was conducted from 3rd to 8th December '84 to School Health Programme Kanghazha, Health O' Million Trivandrum and Kottar Social Service Society.
- District Medical Officer was contacted and we found them very co-operative.
- Field Publicity officer was contacted and he promised to arrange film shows in the schools. The themes will be related to health and sanitation.
- A training session was arranged for student health guides at Pastoral Centre, Nalloornadu from 28th May to 1st June 1985. 41 students from 8 schools participated in the training camp.
- A resource team is being organized. The members of Jana Saukhya Managing Board had several meetings and they took part in the training sessions and some also joined the study tour.

The Launching of the Programme

8 schools, out of 10 proposed, sent their students for the orientation seminar. Teachers brought the participants and a few stayed throughout. During the planning exercise the students planned programmes for their respective schools. There was a meeting of the teacher animators, representatives of parent teacher association and Jana Saukhya team to finalise the planning, on 9th June 1985. In this meeting the following decisions were made:

- The programme shall be launched with a formal inaguration in August where the teachers and students participated in the orientation seminar (8 schools).

— The school health committee shall discuss and finalize the programmes for each school.

(Though, the programme has common features, the details need not be the same in every school).

— During the Onam holidays there will be a refresher seminar for teacher animators and student health guides. Only after that we will consider expanding the programme to other schools.

The following programmes are suggested for the schools during the year:

1. *Sanitation Campaign :* A latrine for each house (at least a pitl atrine). Cleanliness in class rooms and school premises.
2. *Herbal Garden :* A garden of medicinal plants for common diseases.
3. *Film shows :* With the collaboration of the field publicity department, film shows on health, sanitation and related subjects will be conducted in the schools.
4. *Health day Celebration :* A day shall be set apart for public functions before 31st January, 1986. The health day celebration is an occasion to "take health" to the community, through various cultural programmes.

Funds

We have been operating so far with the donations from our friends and members and also with the money borrowed. A grant of Rs. 51,698/25 has been given by CEBEMO.

As a rule, each school should find its own resources for their programme. Jana Saukhya will cover only the training and general administration. The programmes planned involves more human effort than money.

Personnel

Apart from the voluntary services of the President, board members and resource team, two persons are working full time as Co-ordinator and field assistant of the programme. So far, we could not get the services of a full time public health nurse — there is a big demand for them. The Co-ordinator and the field assistant had been working in the planning, training, organizing the programmes and contacting different people and government offices for the training mentioned above and for future programmes.

Office

At present, the office of JANA SAUKHYA and School health programme is functioning at the President's residence. There is a disadvantage that it is situated in the interior and 2 kms. away from the bus route, though the parishioners had gladly allowed. We had been looking for a place in Kalpetta, Dt. head quarters for reasons of accessibility and contact, but so far could not find a room for a moderate rent. The search continues.

Future Plans

The Health co-operative had plans to adopt community health programmes and to run a people's pharmacy. But now these have been shelved for the time being. We will concentrate and intensify our work in School Health and will expand the same next year. A few schools are insisting to join this year itself, but we may consider them only after September. Posters, stickers reading materials etc. are being prepared for the current programme.

We continue our contacts with interested people and like-minded organizations which promote health at the base level and emphasise systems which benefit low income and base level people such as Homeopathy, herbal medicine, naturopathy. But, our most important concentration is on building up a strong base for JANA SAUKHYA itself, enrolling and motivating more members.

Secretary, JANA SAUKHYA

Trained Dais in Rural Himachal Pradesh

—Renu Sobti

Thanks to the training they have received, the Dais *in Himachal Pradesh use aseptic methods in delivery cases, advise mothers on immunisation and family planning and help the paramedical staff during family planning camps and field.*

In the context of the bleak socio-economic milieu mothers and children in lower strata and of certain regions are vulnerable to disease, disability and premature death. Our high Infant Mortality Rate i.e. 125 per thousand population (Census 1981), is associated with infection and malnutrition. In India a majority of the deliveries are conducted at home mostly by traditional *dais* who have learnt this art through family tradition.

However, most of these traditional birth attendents (dais) are illiterate and have little knowledge about the antiseptic and other precautions to be taken during and after birth. Keeping this in view, to make the practice aseptic and safe, a short-term scheme for *dais* was launched under the New Health Policy of the Government of India from October, 1977.

The scheme, "One Month *Dais* Training" is expected to provide at least one trained *dai* in every village. The *dais* for training are selected by the village sarpanch and during training they learn safe, aseptic methods of delivery, recognise symptoms of complication, acquire modern knowledge on nutrition and prenatal and postnatal care. The training includes a minimum of two deliveries to be conducted by the *dai* under the guidance of Trainer. After a period of 30 days' training, the *dais* will be given a stipend of Rs. 300/- and a maternity kit each. Every *dai* will be entitled to a payment of Rs. 2/- for registering a postnatal care and Re. 1/- for registering and antenatal case.

Till recently, over 398,792 *dais* have been trained. The 'idea is' to train at least one *dai* from every village with the ultimate objective to train all practising *dais* in the country.

To ascertain the preference of the rural community for trained *dais*, the performance of trained *dais*, a study was conducted in six PHCs, three each in the Districts of Solan and Kangra in Himachal Pradesh. The performance of randomly selected total 72 *Dais*, 36 trained (one month) and 36 untrained *dais* was studied. From each PHC 6 trained *dais* and 6 untrained *dais*, of which 3 trained and 3 untrained *dais* from the villlages within the distance of 5 km from PHC, rest from bebeyond 5 km or remote areas were selected.

1. Personal Characteristics

Sixty per cent of *dais* were in the age group of 40-50 years, while 15 per cent below 40 years and 25 years, and 25 per cent above 60 years of age. Eighty per cent of them had annual income of less than Rs. 4000/-. About 15 per cent of the trained *dais* had less than 2 years of experience as a *dai* while the rest had more than 10 years of experience.

2. Selection of dais for training

According to rules dais for training are selected by village sarpanch, but in the villages of Solan and Kangra the recommendation of *dais* for training was done by sarpanch and interviewed by PHC's doctors, whereas some

of the names were forwarded by sarpanch to medical officers who preferred very young girls and divorced girls to old experienced *dais* for the training. In most of the places it was observed that training was given only to achieve the targets (i) interest of *dais* regarding training was not considered, such dais obviously did not perform their duties properly after training. (ii) Moreover, at some places *dais* with six months training got training once again.

3. Training of Dais

All the trained *dais* had undergone a uniform pattern of one month training. The training programme of *dais* was carried out at PHCs as well as in sub-centres. The trainees had received the stipend, midwifery kit while training certificates were not issued at many places after the completion of course.

4. Performance of Trained Dais

The trained *dais* were found to have gained sufficient knowledge about aseptic measures, anatomy of female reproductive organs, the importance of immunization, prenatal and postnatal care and family planning methods. The performance of trained *dais* in compaigning for immunization, using aseptic methods, helping ANMs and LHUs during family planning camps, was better in the villages around PHCs and in sub-centre villages where the ANM visits were regular and frequent. It was found that about 70 per cent of sub-centres were without any female worker. The reason: no ANM would work in difficult and distant subcentres. On the other hand, in the remote areas, a majority of mothers preferred ANM services to going to centres on the advice of *dais* just because they wanted door-to-door services. Trained *dais* felt no co-operation from PHC staff and villagers, with the result such trained dais stopped advising villagers at all on immunization, family planning and other components of training. Thus, no difference was observed in the work of trained and untrained *dais* in remote villages.

About 20 per cent of trained *dais* who were working properly i.e. using aseptic methods, advising mothers on immunization, family planning etc. were very helpful to ANMs and LHVs during family planning camps and during their field visits.

Only 10 per cent of the trained dais were advising mothers for proper intake of food during the antenatal and postnatal phases. None of the *dais* had any knowledge about colostrum. About 25 per cent of the trained *dais* were found to be very helpful in promoting the camps for immunization for children and 20 per cent had been advising expectant mothers on immunization and on collecting iron with folic acid tablets from the Centres.

Family Planning

Thirty percent of the trained *dais* were helpful in motivating on family planning, according to them some villagers did not observe family planning for the following reasons: (i) They waited for a male child to be born; (ii) Every child is a gift from God; (iii) Fear of operation; (iv) Shyness in approaching the centre; (v) Ignorance of family planning methods.

Since the kit is not regularly replenished, the *dais* could only use scissors for all the deliveries; at some places even scissors were not available. In Himachal, both trained and untrained *dais* were using scissors. About 25 per cent trained dais used to cut the umblical cord with sterilised scissors. At few places sickle was used which was given to the *dai* by the mother herself. Hence kit was not carried at the time of delivery. Honoraria was not paid to any *dai*; a majority of the *dais* were not even informed about the payment of Rs. 2/- for registering the postnatal case and Re. 1/-

(*Contd. P. 40*)

Workers' Rights

(Part II)

— P.D. Mathew

The Employment of Children Act, 1938

What is the purpose of the Act?

This law was enacted to regulate the employment of children in certain industrial occupations.

What are the occupations in which children below 15 are prohibited to work?

Occupations connected with:

— the transport of passengers, goods or mails by railways; or

— cinder picking, clearing of an ash pit, building operations on railway premises; or

— the work in catering establishment at a railway station; or

— work relating to construction of a railway station, or with any other work which is done in close proximity or between the railway lines; or

— the port authority within the limits of any port.

Note

* If children between 15 and 17 are employed in the above occupations, their period of work must be adjusted in such a way that they get at least 12 consecutive hours of rest between work periods.

Which are the processes in which children below 15 cannot be employed or permitted to work?

1. Bidi - making
2. Carpet weaving
3. Cement manufacture including bagging of cement
4. Cloth - printing, dyeing and weaving
5. Manufacture of matches, explosives and fire-works
6. Mica-cutting and splitting
7. Shellac manufacture
8. Soap manufacture
9. Tanning
10. Wool cleaning

Dispute regarding the age of a child

If a dispute arises between the Inspector and the employer regarding the age of a child employed in a workshop, the matter must be referred by the Inspector for decision to the prescribed medical authority (Section 3C).

The duty of the Employer to maintain register

If children below 17 are employed in occupations mentioned in Section 3, then the employer must maintain a register for inspection by an Inspector.

This register must contain:

(a) the name and date of birth of every child under 17 years of age employed or permitted to work;

(b) the periods of work of any such child and the intervals of rest to which he is entitled;

(c) the nature of the work done by child:

(d) other particulars prescribed by the rules.

What are offences under the Act?

(i) Employing a child in occupations prohibited under Section 3.

(ii) Not sending a notice to the Inspector before carrying on work in certain processes mentioned in the Schedule.

(iii) Failure to maintain a register or making false entry in it.

(v) Failure to display a notice containing an abstract of sub-sections (1) and (2) of Section 3 and 4.

What is the punishment prescribed for the above offences?

Simple imprisonment up to one month or fine up to Rs. 500 or with both.

Note

* Prosecution under this Act can be instituted only by or with the previous sanction of an Inspector.

* Certificate of age granted by a qualified medical practitioner will be conclusive evidence regarding the age of a child.

* A Court inferior to a Presidency Magistrate or a Magistrate of the first class cannot try any offence under the Act.

THE EQUAL REMUNERATION ACT, 1976

What is the object of the Act

This labour law was enacted to provide payment of equal remuneration to men and women workers for the same work or work of similar nature and to prevent discrimination on the basis of sex, against women in matter of employment.

This Act was enacted to give effect to Article 39 of the Constitution which envisages to give equal pay for equal work for both men and women.

* "Remuneration" means the basic wage or salary and any additional payment in cash or in kind.

* "Same work or work of similar nature" means responsibility required from a man and woman are the same.

Duty of the employer to pay equal remuneration to men and women workers for same work or work of similar nature

An employer must not discriminate on the basis of sex, whle paying the workers for work of a similar nature that is done (Section 4).

No discrimination may be made in recruitment on the basis of sex

Section 5 of the Act prohibits the employer to discriminate against women, while recruting labourers for the same work or work of a similar nature.

Note

* This Act does not affect those laws which prohibit or restrict the employment of women in certain occupations or establishments of a hazardous natures.

* Provisions of this Section do not affect reservations for Scheduled Castes or Scheduled Tribes, ex-servicemen, retired employees etc. in the matter of recruitment.

AUTHORITIES UNDER THE ACT

(1) Advisory Committees

* The Central or the State Governments may constitute the Committees to advise them.

* The Committee consist of ten nominated persons by the Government of which one-half should be women.

* The Government may make orders regarding the employment of women workers after considering the advice given by the Advisory Committee.

(2) Officers to hear complaints and claims

* The Government may appoint officers, not below the rank of a labour Officer, to hear and decide complaints with regard to the contravention of any provisions of this Act and claims regarding the non-payment of wages at equal rates.

Note

* The officer is given power of a Civil Court for the purpose of taking evidence and for enforcing attendance of witnesses and compelling the production of documents.

* After hearing both parties and making an adequate enquiry regarding the claims and complaints to give adequate directions to the person concerned.

* Any employer or workmen aggrieved by the order may make an appeal within 30 days to a specified authority. The decisions of that authority will be final.

* Complaints and claims must be made in triplicate in Form "A" and Form 'B' respectively.

(3) Inspectors

The Government may appoint competent persons as Inspectors to investigate whether the employers comply with the provisions of the Act and the Rules.

What are the offences and their penalties under the Act ?

(a) Failure of an employer to produce or to maintain a register, muster roll or other documents related to the employment of workers.

(b) Refusal to give evidence or any information to the authorities mentioned in the Act.

Penalty for the above offences is a fine up to Rs. 1000.

(c) Discriminations in recruitment for the same work or work of similar nature on the ground of sex.

(d) Not paying remuneration at equal rates to men and women workers for the same work or work of a similar nature.

(e) Failure to carry out any direction made by the Government under Section 6(5).
Penalty for the above offences is a fine up to Rs. 5000.

Note

* "Company" means any body corporate, and includes a firm or other association of individuals.

* Provisions of this Act regarding offences by companies, cognizance and trial of

offences by courts (i.e. Section 11 and 12) will be same as in the case of the Contract Labour (Regulations and Abolition) Act, 1970.

* Any special treatment accorded to women in connection with the birth of a child is not against the spirit or provisions of the Act.

* Forms mentioned in the Acts are available at a trade union office or with labour welfare officers and Inspectors.

THE INTER - STATE MIGRANT WORKMEN (REGULATION OF EMPLOYMENT AND CONDITIONS OF SERVICE) ACT, 1979

The purpose of the Act

The system of the employment of inter-State migrant labour is an exploitative system prevalent in Orissa (known as Dadan Labour) and in some other States. In Orissa, Dadan Labour is recruited from various parts of the State through contractors or agents called *Sardars/Khatadars* for work outside the State in large construction projects. Inter-State migrant workmen are generally illiterate, unorganised and they are forced to work under extremely adverse conditions. They are exploited in several ways by the contractors and their agents.

In view of their hardships and to secure effective protection against their exploitation the Central Government felt the need of legislative arrangements both in the State from where they are recruited and also in the State where they are engaged. Hence this legislation was enacted in 1979 to regulate the employment of inter-State migrant workmen and to provide for their conditions of service.

Application of the Act

It applies:

— to every establishment and every contractor, who employs or who employed 5 or more inter-State migrant workmen on any day of the preceding twelve months.

Explanation

* "Inter-State migrant workman" means any person who is recruited by or through a contractor in one State under an agreement for employment in an establishment in another State, whether with or without the knowledge of the principal employer.

* "Contractor" includes a sub-contractor, *Khatadar, Sardar,* agent or any other person, by whatever name called, who recruits or employs workmen.

* "Workman" means any person employed in or in connection with the work of an establishment to do any skilled, semi-skilled, or unskilled, manual, supervisory, technical, clerical work for Payment. It does not include a person employed in a managerial or administrative capacity.

Registration of Establishment employing inter-State migrant workmen

Legal provisions, regarding the registration of establishments, stated in the Contract Labour (Regulation and Abolition) Act, 1970 are equally applicable to the registration of establishments under this Act.

Without obtaining a certificate of registration, no principal employer is allowed to employ inter-State migrant workmen in his establishment (Section 6).

A contractor cannot legally recruit workmen in one State for the purpose of employing him in any establishment situated in another state without obtaining a valid licence from a licensing officer.

What are the duties and obligations of a contractor ?

The main duties of a contractor are:

(1) to furnish information within 15 days regarding the recruitment of inter-State migrant workmen to the specified authorities;

(2) to issue to every inter-State migrant workman a pass book affixed with a passport size photograph of the workman indicating in it the following:

- the name and place of the establishment, where he is employed;
- the period of employment;
- the rate and modes of payment of wages;
- the displacement allowance payable;
- the return fare payable to the workman on the expiry of the period of his employment;
- deductions made;
- other particulars as may be prescribed by the rules,

(3) to furnish information in a prescribed manner to the specified authorities regarding workmen who cease to be employed as inter-State migrant labour. He must also send a decleration to the specified authorities that all wages and other dues are payable to the workmen and the fare for the return journey to their State have been paid,

(4) to maintain the pass book of the workman up-to-date.

Wages welfare and other facilities to be provided to Inter-State migrant workmen

Wage rates and other conditions of service

* The wages and holidays, hours of work and other conditions of service will be similar to that of other workmen doing similar work in the same establishment.

* In no case, would he be paid a wage less than the wage fixed under the Minimum Wages Act, 1948.

* His wage must be paid always in cash.

Displacement allowance

At the time of recruitment, the contractor must pay to the workman displacement allowance equal to 50% of the monthly wages payable to him or Rs. 75, whichever is higher. This allowance is not refundable by the worker and it must be in addition to the wages or other amount payable to him (Section 14).

Journey allowance

The Contractor is obliged to pay the workmen expenses of the journey to and from the place of his residence to the place of work in the other State. Besides, the workmen is entitled to payment of wages during the period of his journey as if he was on duty (Section 15).

Other facilities

Every contractor who employs inter-State migrant workers in an establishment has a duty:

- to ensure regular payment of wages;
- to give equal pay for equal work irrespective of sex;
- to ensure suitable conditions of work;
- to provide protective clothing to the workmen;
- to report to the specified authorities and close relatives of the workman (Section 16).

Note

If the contractor fails to provide the above facilities within the prescribed period, the

principal employer will be liable to provide the same. The expenses incurred by the principal employer for providing the facilities may be recovered from the contractor (Section 18).

What is the responsibility of the principal employer and the contractor with regard to the payment of wages?

* Every contractor is responsible for payment of wages to the workman. Wage must be payed before the expiry of the fixed period.

* Every principal employer must nominate a representative to be present at the time of payment of wages by the contractor. It is the duty of the representative to certify the amount paid as wages.

* It is the duty of the contractor to ensure the payment of wages in the presence of the authorised representative.

* In case the contractor fails to make payment of wages within the prescribed period, then the principal employer will be liable to make payment of the wages to the workmen. He is entitled to recover the same amount from the contractor (Section 17).

Is the workman liable to pay the debt after the completion of his employment under the contractor?

* It is the duty of the principal employer and the contractor to ensure that the loan given to the workman does not remain outstanding after the completion of the period of his employment. The obligation of a workman to repay any debt obtained by him during the employment is deemed to be extinguished at the completion of the period of his work and no suit or proceeding will be entertained in any court for the recovery of such debt.

Offences and Penalties

1. Obstructing the Inspector

Obstructing an Inspector from making any inspection, examination, inquiry or investigation in relation to the employment of inter-State migrant labour is an offence punishable with imprisonment up to 2 years or with fine up to Rs. 2000 or with both (Section 24(1).

2. Wilfully refusing to produce documents

Those who wilfully refuse to produce on demand of an inspector or any other authorised person, any register or documents or prevent any person from appearing before them will be punished with imprisonment for a term up to 2 years or with fine up to Rs. 2000 or with both (Section 24(2).

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

Those who act against any of the provisions of the provisions of the Act or the rules may be punished with imprisonment for a term up to one year or with fine up to Rs. 1000 or with both. If the offence is continued an additional amount up to Rs. 100 per day will be fined during the period of contravention (Section 25).

4. Other offences

Offences which are not included in the above categories and for which no other penalty is elsewhere provided, will be punishable with imprisonment for a term up to 2 years or with fine which may extend to Rs 2000 or with both.

Note

Provisions of this Act regarding:

— Offences by companies (Section 27),

— cognizance of offences by court (Section 28),

— limitation of prosecution (Section 29),

— power to exempt in special cases (Section 31),

— protection of action taken under the Act (Section 32),

are similar to those provisions explained under the Contract Labour (Regulation and Abolition) Act, 1970. See pages 16-17.

Does non-observance of the provisions of these Acts violates the Fundamental Rights of a workman?

In the Asiad workers' case (AIR 1982, SC 1473), the supreme Court held that non-observance of the provisions of labour laws really violated the Fundamental rights of the workmen. According to the judgement, employment of children below 14 years in construction work violates Article 24 of the Constitution, as construction work is a hazardous employment.

Non-observance of the provisions of the Equal Renumeration Act, 1976 which demands payment of equal wages to men and women for work of similar nature, according to the judgement, is in effect and substance a breach of the principle of equality before the law enshrined in Article 14 of the Constitution. Similarly, not complying with the demands of the Contract labour (Regulation and Aboliation) Act, 1970 and the inter-State Migrant workmen (Regulation of Employment and Conditions of Service) Act, 1979, which requires a contractor to provide basic amenities to the workmen, was violation of Article 21 of the Constitution.

The Court also held that non-payment of statutory minimum wages to workmen under the Minimum Wages Act, 1948, violated the Fundamental Right contained in Article 23 of the Constitution. This Article is clearly designed to protect the individual not only against the State but also against other citizens who indulge in "traffic" in human beings and "beggar" and other forms of forced labour. The Court held that these labour laws are clearly intended to ensure basic human dignity to the workmen and if they are deprived of any of the rights and benefits to which they are entitled under the provisions of this welfare legislation that would be a violation of the Article 21 of the Constitution.

Can service rendered for a wage less than the statutory minimum wage be considered as "forced labour"?

Article 23 of the Constitution prohibits any form of forced labour. In the judgement on Asiad worker's case the Court held that the word "forced" must be construed to include not only physical or legal force but also force arising from the compulsion of socio-economic circumstances which leave no choice or alternatives to a person in want and compels him to provide labour or service even though the remuneration received for it is less than the minimum wage. Hence, where a person provides labour or service to another for remuneration which is less than the minimum wage, it clearly falls within the concept of "forced labour" under Article 23 of the Constitution.

What are the Constitutional means available to a workman for the enforcement of his Fundamental Rights?

If any of the rights of a workman given under these labour laws are violated by a contractor or principal employer, the workman is entitled to approach the High Court under Article 226 or the Supreme Court under Article 32 for the enforcement of his Fundamental Rights and request the Court to make appropriate orders for the enforcement of the same.

Who are entitled to approach the Court for the enforcement of the Fundamental Rights of workers and members of other weaker sections ?

Because of the prevailing socio-economic conditions in the country, where there is considerable poverty, illiteracy and ignorance, the Supreme Court has expanded the scope of "locous standi" in litigation. Accordingly if a legal right of an individual or class of person is violated and if by reason of poverty or disability they cannot approach the court for judicial redress, any public spirited individual or organisation acting bonafide (in good faith) may move the Court even by addressing a letter to the Court which will consider it as a writ petition and take action on it. Matters regarding the violation of the Fundamental Rights of a class of poor citizens can be brought to the attention of the Supreme Court under Article 32 or to the High Court under Article 226 by way of Public Interested Litigation.

What is a Public Interest Litigation ?

It is a new mode of litigation. It is brought before the Court to promote the interest of the poor and illiterate persons who are in a socially and economically disadvantaged position. It is essentially a co-operative or collaborative effort on the part of the petitioner, the State or public authority and the Court to secure the observance of the Constitution and legal rights and privileges conferred upon the vulnerable sections of community and to administer social justice to them.

Note

Issues like keeping of under-trials for years in jails without trial, blinding of prisoners in Bhagalpur, exploitation of workers employed in Asiad projects, eviction of slum dwellers in Madras, eviction of pavement dwellers in Bombay, children in jails, mismanagement of the State Home for Women in Agra, banning of harmful drugs, release and rehabilitation of bonded labourers etc., were brought to the Supreme Court under Article 32 as Public Interest Litigation by varios voluntary organisations and public spirited persons. At the request of the Court this kind of litigation is exempted from Court fees and petitioner is given free legal aid by the Court to conduct the litigation.

Has the Government any obligation to enforce the labour laws and to safeguard the rights of the weaker sections ?

The Supreme Court judgement in the Asiad workers case placed great responsibility on the Government and its agencies for the enforcement of various labour welfare provisions of labour laws as in many cases they are the principal employers. According to the judgement, the Government and its administrative agencies as principal employers cannot escape their obligations to the workmen to ensure observance of these labour laws by the contractors and if these labour laws are not complied with by the contractors, the workmen would clearly have a cause of action against the Government and its administrative agencies (Ref. to Sections 16, 17, 18 and 19 of the Contract Labour (Regulation and Abolition) Act, 1970, Sections 14, 15, 17 and 18 of the Inter-State Migrant (Regulation of Employment and Conditions of Service) Act, 1979).

The judgement emphasised that whenever any Fundamental Right which is enforceable against a private individual is being violated, it is the Constitutional obligation of the Government to take the necessary steps against such violation and to ensure the observance of the Fundamental Right by the private individual who is transgressing the same. The responsibility of the Government becomes greater especially when the person injured belongs

to the weaker sections of the community and unable to wage a legal battle against the strong and powerful who are exploiting them.

A Landmark Judgement for Social Justice

In connection with the organisation of Asian Games (Asiad 1982) about on lakh labourers from various States were employed by the Union of India, Delhi Administration and Delhi Development Authority for the construction of various Asiad Projects. Most of these labourers were working under contractors. These illiterate and unorganised labourers were exploited by the contractors in several ways.

They were not paid the statutory minimum wages and working facilities were not provided to them in accordance with the labour laws treated above. To enforce their legal rights and to ensure the observance of the provisions of various labour laws, people's Union for Democratic Rights (PUDR) has brought the matter of their exploitation to the attention of the Supreme Court by way of Public Interest Litigation. At first this organisation wrote a letter to Justice Bhagwati regarding the exploitation of construction labourers employed in Asiad Projects. This Court has accepted the letter as a writ petition and appointed 3 social scientists (Dr. Alfred de Souza, Dr. Walter Fernandes of the Indian Social Institute and Prof. Das Gupta of Peoples Institute for Development and Training, Delhi) as Ombudsmen (Commission) for the purpose of investigating and inquiring into the conditions under which the workmen engaged in various Asiad Projects were working. Weekly reports based on the interviews of the workmen and contractors were submitted to the court. The Writ Petition was argued by PUDR (Petitioner) and Union of India, Delhi Administration and Delhi Development Authority (Respondents). The judgement on this case delivered by Justice P.N. Bhagawati and Justice Baharul Islam on 18th Sep. 1982 is considered a milestone in judicial history by making justice available at the highest Court level, to the weak, poor and the illiterate and in expanding the ambit of the Fundamental Rights and in providing unconventional means to the weaker sections to enforce them.

For further information on Legal matters contact:

Director, Legal Aid
Indian Social Institute
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Gram : INSOCIN.

Population Expert Attacks FP Policy Norms

Express News Service : Bangalore, May 24, 1985.

Prof. Ashish Bose, President of the Indian Association for the Study of Publication, told Express News Service in an exclusive interview here that India's policies on Family Planning were slavish to western norms disregarding Indian values.

Earlier in his address to the Tenth annual conference of the Association at Bangalore also he had found fault with the present policy on Family Planning and raised questions whether it was possible to divorce family planning programmes from the broad social milieu of the Indian masses with their values attached to marriage, family and children.

He had told the conference that the western norms had eroded the solidarity of the family and weakened the institution of marriage.

He said that the one child model being advocated in the West and China was "heading for a disaster and bound to fail". According to him this sort of extreme population control gave birth to a new set of social problems. "No one can deny that low fertility will increase the population of the age — a society loses all dynamism if it has a zero population growth because in a few years the nation will be filled with old people with very few young ones to offset the imbalance."

"Yet, in India we have been blindly following the western models and our family planning programmes have been heavily influenced by foreign funding agencies and foreign experts of doubtful calibre", he observed.

"To make matters worse it is our bureaucrats and politicians who are coordinating with these agencies and setting family targets for our masses. All the target setting is done by them in New Delhi — it is like distributing cement and steel quota to industries!"

Prof. Bose who is extremely critical of the bureaucratic stranglehold of what is actually a "people's movement" feels that this one-way communication must stop if family planning is to become innovative in India.

"Women who play the central role in any family planning movement have been totally ignored. The women must take over from the bureaucrats".

Prof. Bose advocated immediate decentralisation of all family planning programmes. "It is ironical that while health is a state subject, family planning is a Central subject. Every district should be allowed to prepare its own plan according to the needs of the area".

Coming down heavily on the area projects launched by foreign agencies in 66 districts, Prof. Bose said that these projects were solely manned by beauraucrats, who more often than not, have vested interest and were extremely data oriented. "Sitting in Washington they demand the baseline reports of the latest demography of India and for feat that the funds may be discontinued. Our Indian officials, spend 40 per cent of their time filling useless proformas.

He wanted separation of the government health programmes and the family planning programmes to be ended.

The government's entire family planning strategy has been dominated by sterilisation programmes to control population growth, he deplored.

"If you ask me why sterilisation — I'll say because it is the easiest way out. But unfortunately the net result is, it has arrested quantity not quality. Most women who have been sterilised are over 40 — even most of the men are well past 60 and widowers — in short, people who have passed the fertility stage".

The expert was also very critical of the incentive policy for sterilisation. He pointed out that there was a move in the present Government to give gold medals to FP workers who motivated the highest number of sterilisation. "I am warning the Government that if it takes such a wrong step it willl be thrown out as unceremoniously as Mrs. Gandhi's Government in 1977", he said.

He concluded : "Basically what I am trying to tell the Government in so many words is keep out of family planning — because it is the job of social reformers, — doctors and primarily of women's organisation".

—*Courtesy* - Indian Express

The three day seminar on health and development was held at Jyothir Vikasa Kalennahalli from 2nd to 4th June 1985 was attended by the fathers, brothers and sisters working in Mandya region. The seminar was conducted by CHAI, New Delhi under the auspices of St. Thomas Mission Society Social Service Department. Fr. Thomas Therakam, Dr. Antony, Dr. Vijay, Sr. Jayaseeli and Sr. Mariamma led the seminar.

The seminar began with the team members and the participants introducing themselves and their work. The participants then expressed their expectations from the seminar. 'How to begin working in a village, what should be the style of involvement to be pursued, and the question of tension within us' are some of the areas where the participants asked for clarifications and wanted discussions. With regard to the procedure of the sessions it was decided that equal importance be given to the theoretical and practical side of various questions. Concepts such as goal of our work, basis of village work, role in braking the existing social structures, relief work etc. are decided to be dealt with during the seminar. On the other hand, health education, nutrition, mother and child health care, facing the felt needs of the village, the working of CHAI are subjects on which practical knowledge was sought.

Then a case study was taken up (Fr Ashok) and the participants spliting into groups analysed the case and found out the reasons for the failure of Fr. Ashok in his undertakings and thought about a right position to be pursued in any social welfare scheme.

The second day began with Sr. Innocent introducing the medicinal value of herbs found everywhere. Taking outside the classroom, she demonstrated various herbs, identified them and explained their medicinal value. Though short, it aroused interest in participants to know further on this matter.

Dr. Antony, then demonstrated a diarrhoea patient, explained the symptoms of dehydration and how a victim of diarrhoea could be treated.

Health should be seen not as health care only but it has to be viewed and studied in a much wider perspective. Health is the total well being of the individuals and families and communities as a whole and not merely the absence of sickness. So its social dimension with all its implications are to be taken into consideration.

WHO's call for health for all by 2000 A.D. envisages a greater involvement of agencies whether Government or non-governmental in

health education programme, especially among the rural population. One of the parameters to gauge the standard of health of a people in the rate of infant mortality. So health care of expectant mothers and infants are of paramount importance. They are the most vlulnerable group in the society and therefore needs extra care and attention. Giving various statistical datas about infant mortality Dr. Antony made it very clear that illiteracy is the root cause for an unhealthy community. So MCH programme should not merely be a CRS food distribution programme but rather it should primarly and basically be an education programme, he said. So, the approach, planning, methodology etc should have these aims in view. Well prepared classes on health, suited to the people, time, context etc. should become the main part of the MCH programme.

Only healthy mothers can be get healthy children. So, better food, immunisation etc. are of great importance for the health of both the mother and the child. Since diarrhoea is one of the main causes for child death, Dr. Antony in the next session elaborately explained various remedies to tackle dehydration.

How to start a village programme? Dis cussing this question Fr. Thomas said that knowing the people and their feelings are very essential. This is possible by constant and regular contacts with the people as well as study and observation. He also emphasized the need for keeping various records to facilitate our work. He also said that any problem of a village has to be viewed in a wider perspective and not in isolation.

The third day was mainly spent for planning the future programmes for the region. The participants, basing on the guidelines given by the directors drew up tentative programmes for the future.

The faith reflections basing the slide shows and prayers during the Holy Mass helped the participants to imbibe more spirit and dynamism in their missionary activities. The interventions and sharing of practical experiences by Dr. Vijay, Sr. Jayaseeli and Sr. Mariamma also enriched the participants very much.

Sd/-

Director of Social Workers
St. Thomas Mission Society,
Mandya, Karnataka.

EMPLOYMENT

1. WANTED an MBBS doctor for immediate appointment. Interested doctors may contact directly :

   Sr. Mary Paschal DM
   Sister Incharge
   Carmel Matha Health Centre
   Eleanganny P O, Vanapuram Via
   N.A. Dist., T.N. 606 753

2. An experienced surgeon presently working in a government hospital would like to work in a Mission Hospital as a Surgeon in General or Orthopaedic section or both. Institutions interested to have his services may contact directly :

   Dr. B Das Gupta
   A-1, Circular Road, Burnpur
   West Bengal 713 325

Mahidol University Honour for WHO Regional Director

The Mahidol University in Bangkok, Thailand, has awarded an honorary degree of Doctor of Public Health (honoris causa) to Dr U Ko Ko, WHO Regional Director for South-East Asia. At an impressive ceremony in Bangkok on 11 July, the degree was conferred by His Majesty the King of Thailand in recognition of Dr Ko Ko's distinguished record of service in the field of public health.

In a citation read at the convocation ceremony, Dr. Natth Bhamrapravti, Rector, Mahidol University, referred to the services rendered by Dr Ko Ko in his country, Burma, and also his contributions to public health internationally after joining the World Health Organization in 1969. Professor Natth specifically mentioned the contributions of Dr Ko Ko towards health development in Thailand, especially with relation to health manpower development in Mahidol University and in the process of the establishment of the ASEAN Training Centre for Primary Health Care Development (ATC/PHC) in Bangkok, as a leading centre of expertise in PHC.

Dr. U Ko Ko, who has been WHO Regional Director for South-East Asia since March 1981, was earlier conferred an Award of Honour by the Mahidol University for his outstanding contributions towards the progress of the University with special reference to the ATC/PHC at Bangkok.

Dr U Ko Ko, having obtained his medical degree from the Unversity of Rangoon, undertook post-graduate training in Public Health at the University of Edinburg and at the London School of Hygiene and Tropical Medicine.

The Regional Director, who is the author of a number of scientific and research publications is also a Member of the Royal Society of Health, London, an Honorary Fellow of the Indian Academy of Medical Sciences and a Fellow of the Royal College of Physicians, Edinburg, U.K.

Dr U Ko Ko served the health services of his country in various capacities including Director of Disease Control, in the Ministry of Health. He was also Professor of Preventive and Social Medicine at the Institute of Medicine II in Rangoon.

As a national officer, Dr U Ko Ko was a member of the WHO Expert Advisory Panel of Cholera. He represented his country at the WHO Regional Committee for South-East Asia and at the World Health Assembly. He was elected Vice-President of the 22nd World Health Assembly in 1968. He was also a member of the WHO Executive Board. Dr. U Ko Ko joined WHO in 1969 and, after serving in positions of increasing responsibilities, was appointed Regional Director for South-East Asia in 1981.

Courtesy - WHO

WCC's Castro Asks for Co-operation on Health

GENEVA (EPS) — In remarks during the 38th World Health Assembly, World Council of Chruches General Secretary Emilio Castro questioned terms under which church and other non-governmental organizations (NGOs) co-operate with governments in international health questions.

Speaking as part of a panel of NGO and government representatives (10 May), Castro observed that "governments are prepared to accept co-operation from NGOs, but on their own terms. Obviously, governments are responsible for national welfare. But, is it right to ask NGOs to collaborate without involving them in decision making?"

The WCC leader said that while "NGOs can't carry out health work counter to government programs, ... they can ask to be heard

in the prior planning process". He said that while many government health ministries were eager to include NGO financial, technical, and personnel resources in their national health programmes, they expected NGOs to fit into their plans without prior consultation on such "major national choices".

On the other hand, he added, "NGOs may..... fear losing their identity when they integrate into government programs".

Castro cited the 1982 WHO adoption of a code on the worldwide marketing of breast-milk substitutes as a notable example of successful NGO/WHO collaboration. He said that as "independent forces", NGOs "can act as mediators". As such, he said, they "should be at the disposal of the international community."

The WCC Christian Medical Commission has an official relationship with the World Health Organization, including semiannual meetings of a CMC/WHO standing committee.

Courtesy - CMC, Geneva

Seminar-Cum-Retreat

CHA organised three short courses with a duration of one week each, for Sister Nurses, Paramedicals and Hospital Administrators during the months of April-May (from 15th of April to 9th May 1985) at Amarjyothi, Capuchin Ashram, Kattappana, Idukki Dist, Kerala. The speciality of these courses compared to others, were that they all were Seminar-cum-Retreats for the promotion of spiritual and personal growth through clinical experience and they were all subsidised with financial assistance received from MISSIO, AACHEN.

As for the first course there were thirty two participants while for the second and the third their numbers dropped to seventeen and fourteen respectively due to the practical difficulty of releasing these personnel from many institutions.

The evaluation sheets of the participants of these three courses give clear indications with regard to the following points:

The courses were highly appreciated by all concerned. The various subjects and the exposition of the same by the eminent professors enlightened them on various issues, cleared many doubts and misconceptions and created in them a sense of increased self awareness. Many of them mentioned that the topics were directly related to the apostolate of the healing ministry and hospital administration and these lectures have helped them to question as to how they relate themselves to the sickly bretheren in times of their suffering and death. They were reminders of committed Christian life and as such helped them in analysing the priorities in the religious life. There were renewed enthusiasm and life among the participants. Throughout the course a very spontaneous, happy and prayerful atmosphere prevailed which many of them have recorded as "rare and wonderful experience" of the seminar. All the participants were deeply touched by the hospitality they received at Amarjyothi Ashram. They were also greatly impressed by the Franciscan simplicity, the great concern for one another and above all by the individual attention they received in the Ashram. The natural beauty of the selected spot, the pleasant climate, the comfortable accommodation, delicious food, trip to Thekkady—all added to the beauty and charm of these courses. All of them expressed their heartfelt gratitude towards the convenor and Organiser: Rev. Fr. John Vattamattom SVD and Director : Rev. Fr. (Dr) Felix Podimattom OFM Cap for providing such beautiful courses and expressed their desire to avail more of such opportunities in the future.

Hospital Sunday Celebrations

1. St. Joseph's Cluny Hospital, Pondicherry

Around 5.30 p.m. on 17th March 1985 the open space in front of the hospital was filled to overflowing with patients, their relatives, doctors and staff of the neighbouring hospitals-about 200 in all for the hospital sunday celebration based on the theme "Towards a People Oriented Drug Policy". Followed by mass and a light refreshment, cultural programme saw on foot. Words of welcome and short talks on the theme followed. There was a short play presented exceptionally well by the staff. It clearly brought home the message of mass exploitation by drug companies, the mistaken belief that more medicines means faster cure; shortage of eseential life saving drugs and the flooding of the markets with tonics and vitamins; over prescription of glamourous and costly medicines by doctors; the drug companies influence to get the medicines pushed up through the doctors; the undue packing costs and the indiscriminate rise in the prices of the medicines. The spectators highly appreciated it and with the National Anthem, the evening function came to an end.

2. St. Joseph's Hospital, Nellore

With an exhibition open for all on the theme "Towards a People Oriented Drug Policy", it celebrated the hospital day on 30th March 1985. Using charts and exhibits the common and communicable diseases, their treatment, the drugs used, its dose, its effects, side effects etc. were explained to the people. The tutors spoke also on banned drugs, drug hazards, preventive measures, preservation of health by nutritious food, hygienic living conditions and the responsibility of the health practitioners in prescribing medicines. The people appreciated it very much.

In the evening there was Eucharistic celebration and homily on the theme by the Bishop of Nellore for which there were large gatherings. After the mass there were sweets distribution and the needy were served with meals. The celebration came to a close by 8 p.m.

3. St. Joseph's Health Centre, Anliady, S.A. Dt.

It celebrated the hospital day with more than 500 people irrespective of their age and education, on 29th March 1985. There was a Eucharistic celebration and homily on the theme "Towards a People Oriented Drug Policy" by the Parish Priest, Fr. Louise. He emphasised the need for bringing drugs within the reach of the poor and urged all the health care personnel to have Christ like commitment in serving the poor. Followed by it there was a short entertainment programme and sweets distribution.

4. Leonard Hospital, Batlagundu, Madurai

A week before the celebration of hospital Sunday, there was a get-together of all the staff to decide as to how it should be conducted. At this time there was a discussion on the theme to point out the use and misuse of drugs and the importance of practicing "naturopathy" as a "way of life". The group decided to have a prayer service and some role plays for the occasion. Accordingly, on 24th March 1985 a prayer service was conducted in the evening, for which there was a great gathering. Then, through a series of role plays — the need for approaching hospitals at an early stage in the case of certain sicknesses; the need for immunisation, the importance of personal and alround cleanliness; necessity of adequate intake of water; need for nutritious food; method of treating the dehydrated; need for the formation of good habits etc. were displayed. The whole function was an eye-opener to many.

5. Holy Cross Hospital, Rajibpur, W. Bengal

The hospital tried to get all the personnel of the catholic dispensaries of the diocese for its celebration of hospital sunday on 17th March 1985. There were doctors, nurses, priests, nuns and lay people. At the Eucharistic celebration Fr. Mario brought out beautifully tne works of the great physician — Jesus; and his unlimted love for man. After this, there was a seminar in which Dr. Edward Jude, Medical Officer, Holy Cross Hospital, spoke on the theme of the use and misuse of drugs and the dangers involved in it. Fr. Chellaswamy, Director, Adult Education, spoke on the healing ministy in the Church. Sr. Monica H.C. shared with the group her experience and views, on Community Health. Following, there was a discussion in which all the nurses and hospital staff of various dispensaries participated. The points of discussion were:

1. To hold regular meetings of all dispensaries of the diocese to share knowledge, experience and solve difficulties.
2. Purchasing of medicines in bulk or from voluntary health associations to ensure cheap and quality medicines.
3. To hold regular immunization programmes for the villages around the dispensaries and to contact the District Headquarters for supplies.

Followed by a sumptous meal and small entertainment programme and with the firm decision of celebrating the hospital sunday every year the function came to an end.

6. Prem Seva Sadan, Cheruvumdaram, Khammam

The 24th March 1985, was a memorable day in the history of this village as it never before had a hospital sunday celebration. There was a grand Eucharistic celebration during which the parish priest spoke on the significance of the hospital day celebration. Followed by mass the dispensary was blessed and the patients were prayed over. There were sweets distribution and a small entertainment programme. Finally, the meaning of the theme "Towards a People Oriented Drug Policy" was explained to the people and they appreciated it.

7. St. Francis Hospital, Beawar Road, Ajmer

The management, staff, students patients and their relatives observed 17th of March 1985 as hospital sunday on the theme "People Oriented Drug Therapy". There were both talks and role plays depicting the dangers involved in the drug misuse and in treating the patients by non-qualified pharmacists. It was appreciated by all.

8. Our Lady of Providence Hospital, Basna, Raipur

It celebrated the hospital day on 17th March 1985 with all the indoor patients. After giving the aim and meaning of the celebration a 'Bhajan Service' was conducted. Followed by it a few of the healing scenes of Jesus Christ were enacted by the Boarders. People took part in it with much devotion.

9. Ursuline Dispensary, Khunti, Ranchi

After having informed the people about the celebrations, 24th March 1985 was observed as the hospital day. Followed by mass a talk was delivered on the theme by one of the sister nurses, and then sweets were distributed to the children.

10. Our Lady of Health Dispensary, Padrekudi, Ponbethi, Pudukkottai

The 17th of March 1985 was observed as the hospital day around the theme "Respect

Life". There was a Eucharistic celebration and then a fancy game to put the people at ease with one another. Followed by it, there were exhibitions, debates and film shows. All these helped the people to realize the importance of respect for life, the need for collective action, importance of cleanliness etc. Everything was planned and executed by the people themselves.

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(*Contd. from P. 23*)

for antenatal case. At a few other places many formalities had to be done to get the money. Many *dais* complained that the distance between the villages and centres was more. As they were not getting any incentive, a majority of trained *dais* did not show more interest in registering the cases. Records of birth and deaths were mainly maintained by chowkidars or ANMs of those areas.

A majority of the dais were interested in getting stipend of Rs. 300/-, maternity kit and a certificate too; furthermore, some of them wanted to be recognised in the area after the training. A few other *dais* admitted that they were richer by the training received than the knowledge and skills they had.

Awareness and Popularity

A majority of the medical officers, health staff and *sarpanchs* were found to be aware of the *dais* Training Programme but due interest was not shown by most of the doctors. As reported by doctors hardly one or two meetings had been arranged by the higher authorities regarding this scheme in three years. They were mainly interested in bigger programmes like malaria, family planning etc. Villagers, however, were aware of the trained dais; at many places only trained *dais*, where they were working properly, were called for deliveries rather than the untrained. People felt that trained dais could do better work, guide them properly for immunizatim, family planning programmes etc. Now about 50 per cent of untrained dais wanted to get trained in the popular training programme.

On the other hand, in the remote areas it was found people had preference for experienced *dais* trained or untrained. It was also observed that people had preference for old and experienced untrained *dais* rather than young trained *dais*. .

It is hoped that trained *dais* are expected to play a vital role in providing better mother and child health care services, thereby reducing the Infant Mortality Rate. Experienced *dais* should be selected for the training as villagers have preference for experienced *dais* rather than young trained *dais*.

Courtesy—SOCIAL WELFARE

Catholic Hospitals in India — Guidelines for the use of drugs and pharmaceuticals

Preamble: The Catholic Hospital Association of India and its member institutions subscribe to the motto "The love of Christ Compels Us". It is an urge to come to the help of all people, wherever they are and whatever their situation, treating them as whole persons, following the example of Jesus Christ. What the people need above all is an understanding care as brothers and sisters in Christ. We have to give love and consolation, removing despair and ingorance.

The large majority of patients who need or seek care or cure from the member-institutions of CHAI suffer from infections, diseases due to undernutrition, lack of safe water supply and sanitation, polluted environment, wrong life styles, and lack of even elementary health care facilities. The requirement is adequate nutrition, safe drinking water, better sanitation, protection of the environment, basic medical care and health education, adopting health-promoting life styles and preventing disease. Our institutions should provide primary health care and health education, to all those who seek care; more importantly, our institutions must get out to where the people are and provide essential health care, as Jesus went about healing and teaching. In this effort to reach the unreached, we should co-operate whole-heartedly with those health workers and volunteers in the field, helping them and, in turn, taking their help (more to help than to be helped). An intimate knowledge of the dynamics of the society in which we live and act is necessary to help our people attain and maintain health.

There will be others who need further treatment and management of specific diseases, requiring more specialised care. Many of our institutions have the necessary facilities and can provide the needed diagnostic, therapeutic; rehabilitative and preventive services. Depending on the available resources our hospitals should provide such services, after ensuring that primary health care needs of the communities in which they function are met.

Many of the problems which bring about illness have social and economic bearings; poverty, unemployment, illiteracy and other similar factors contribute to sickness, and death and a vicious cycle is created. Solutions to these major problems are difficult, take time and require great efforts. They are mostly beyond the scope of the hospitals; yet, health care services have an immediate and effective role to play. This has many facets, one of which (an important one) is the proper and judicious use of drugs and pharmaceuticals, including those for cure, alleviation and prevention.

The whole issue relating to the use of drugs and pharmaceuticals should be received from the perspective of a health policy, which gives the goals, priorities and the directions of our health care services. Advances in Science and Technology have put into our hands the means of preventing disease and alleviating suffering. We must get the wisdom and humility to use them properly for the benefit of humanity.

1. *Policy:* There is today, a welcome movement, both national and international, towards a more rational drug policy. The members of CHAI can be effective partners

in this wider movement. Every health care institution or facility (hospital/dispensary/health centre) should frame its own policy for the proper use of drugs and pharmaceuticals in the context of the purpose for which the facility was established. The policy must be people oriented—for the benefit of the individual, the family and the community. It should prevent the exploitation of the health care facility (and through them, the people) by the drug manufacturing firms, pushing their products by all kinds of gimmicks, gifts and temptations and the "hard sell" by the company representatives. The durg policy should be evolved by the informed participation of all concerned in procuring, prescribing and dispensing drugs. Such informed decision will ensure commitment to the policy and long-term effectiveness.

2. *Pharmacy:* Whether large or small, each health care facility dispensing drugs should have qualified pharmacist(s), who manages the pharmacy efficiently, providing service. The pharmacist

   (*i*) identifies the drugs required for the hospital or health centre considering

   a. efficacy

   b. quality

   c. safety

   d. economy, and

   e. availability; and places proposals before the drug and therapeutic committee for selection;

   (*ii*) Procures the selected drugs

   a. at minimum price,

   b. in the right form and quantity, and

   c. at the right time;

   (*iii*) Stores the drugs under appropriate conditions so as to maintain

   a. potency, and

   b. quality;

   (*iv*) arranges for

   a. pre-packaging,

   b. compounding, and

   c. dispensing,

   adopting scientific, legal and ethical principles;

   (*v*) uses proper inventory control;

   (*vi*) initiates and implements policies for supply within the hospital;

   (*vii*) wherever indicated and feasible, undertakes the manufacture of pharmaceutical formulations, such as intravenous fluids, oral rehydration salts, mixtures and ointments, following all the rules and regulations and quality controls;

   (*viii*) arranges for the routine checking and analysis of drugs; and

   (*ix*) maintains the various registers, as required by law and necessary for information, follow-up and action.

Library: The pharmacy will have a small library of books, monographs, and leaflets, dealing with professional, technical, legal and other matters. The pharmacy will also subscribe for relevant journals.

3. *Drugs and therapeutics Committee:* It is essential to have a drugs and therapeutics committee. In its simplest form, in the small hospital or health centre it would consist of

(*i*) the administrator,

(*ii*) the doctor,

(*iii*) the nurse, and

(*iv*) the pharmacist (secretary)

If there is a medical superintendent, he/she will also be a member. Depending on the size of the hospital, more members can be added, without making it unwieldy. The optimum number may be kept at 7; such a committee will have

(*i*) the hospital administrator

(*ii*) the medical superintendent

(*iii*), (*iv*) doctors, by rotation

(*v*) nursing superintendent

(*vi*) an outside expert (clinical pharmacologist/pharmacist/stores manager)

(*vii*) Pharmacist (secretary)

In the larger hospitals, there can be two committees: (1) therapeutics (2) Purchase. The drugs and therapeutics committee will have the following responsibilities:

(*i*) formulate the drug policy of the hospital

(*ii*) prepare the drug list with details for the hospital (formulary)

(*iii*) review and update the list periodically

(iv) monitor and review drug reactions, using appropriate forms for report

(v) disseminate information regarding

(a) administrative and professional policies,

(b) availability of new products and formulations, together with adequate data regarding indications, adverse reactions, interactions and contra- indications, and

(c) new information about older products already in use, which may help to modify their use.

The drugs and therapeutics committee should meet often in the initial stages and later on less fequently (say, once in 3 months), There will be requests for additions (in the light of newer, more efficient drugs becoming available, experience, changes in personnel and services) and suggestions for deletions. The committee should aim at keeping as small a number of drugs and formulations as possible, without sacrificing efficiency; this will ensure a reduction in stock and money tied-up as also greater efficiency in management. The drugs and therapeutics committee could publish occasional newsletters or bulletins for health personnel and public giving information regarding

(i) developments in drugs and pharmaceuticals,

(ii) medical and nursing implications in the use of certain drugs and in specific situations, and

(iii) side-effects/hazards/contra-indications about new and older drugs.

4. *Choice of drugs:* The choice of drugs depends on

(i) prevalent diseases and national programmes,

(ii) treatment facilities,

(iii) available personnel, and

(iv) financial resources.

The drugs selected should be efficient (effective with good cost-benefit ratio) and safe. It is necessary to ensure *quality*. It ia a fallacy to think that the more reputed firms produce better quality drugs. Many of these larger firms give contracts to small scale firms

(loan licences) and the products will not have any better quality. Quality control can be achieved by

(i) W.H.O. certification scheme regarding the quality of pharmaceutical products on the market

(ii) Good manufacturing technology

(iii) product information, based on the basic studies and clinical trials carried out by and on behalf of the manufacturer, analysed critically and

(iv) samples sent to an independent analytical laboratory.

It is also necessary to ensure stability and bio-availability. The drug must have keeping quality under the environmental (temperature, humidity, etc) conditions. Bio-availability will be determined by, among others, the fraction of the dose of the drug that enters the systemic circulation. There can be differences in the rate of dissolution or of solution of the formulation and also in the rates or completeness of absorption of the drug from the gastro-intestinal tract. Added to this will be factors like differences in peripheral utilization.

5. *Drug list:* The list should include all those drugs required to satisfy the health care needs of the large majority of patients for whom care (out patient or in-patient) is provided by the hospital. It should also include drugs in common use required in emergency. The drugs in the list should be available at all times in adequate amounts in the appropriate dosage forms. All drugs listed will be in *generic* names. The custom of usage of brand names has posed very high barriers to market penetration by equally effective but cheaper drugs. The expensive promotional activity of the manufactures boosts up the cost of medicines. The gretear utilization of generic drug names can lead to lower prices. To start with, the list of essential drugs prepared by WHO may be used as a basis (Technical report series, 685). Many other lists are available, e.g., Christian Medical Council list; formulary of postgraduate Institute of Medical Education and Research, Chandigarh; Bangladesh, Sri Lanka and Tanzania drug lists and so on. A list adapted from the WHO list is given in Appendix, to be modified to suit the requirements of a particular health care facility. The drugs are grouped into broad pharmacological and therapeutic categories. All those who prescribe medicines in the health care facility should stick to the list; ordering medicines outside the list should be done only in exceptional cases. There should be all relevant information (concise, accurate and comprehensive) available;

(i) International generic name

(ii) Pharmacological effect and mechanism of action

(iii) Clinical indications

(iv) Dose; duration of treatment; range for children; dosing interval; special situations such as renal, hepatic and cardiac insuficiencies,

(v) Contra-indications.

(iv) Precautions, especially in situations like pregnancy, lactation, etc.

(vii) Adverse effects and drug interactions.

(viii) Effects of overdosage; therapy-general and specific.

5.1. Depending on the policy, traditional medicines may be included in the list, if the doctors are conversant with their use. Of importance are medicines in Ayurveda, Siddha, Unani and homeopathy. Large scale production of Ayu-

rvedic drugs is now undertaken by many pharmacies in the country. Ayurvedic medicines are prepared in the form of distillates (arka), fermented preparations (asava and arishta), linctus (avaleha), incinerated matter (bhasma), powder (churna), ghee (ghrita), tablets (vatigutika), decoction (kwatha) and others. The siddha medicines use mercury, sulphur, iron, copper, gold, arsenic and other minerals as well as vegetable poisons; care must be exercised in their use, particularly by those not trained in their use. The Unani medicines consist mainly of herbal but also include animal, mineral and marine drugs, used either singly or in the form of decoctions, infusions, tablets, powders, confections, syrups and aquas. In the case of these drugs and pharmaceuticals belonging to the different systems of medicine also, it is important to have all the relevant information as listed in 5(i) to (viii). Simple home and herbal remedies could be useful as also the non-drug therapies.

6. *Procurement:* Drugs may be obtained from differnent sources; it is necessary to have a procurement policy. Considerable savings can be effected by strategic purchase policies. If there is a central purchasing agency on a national, regional or diocesan level, the drugs can be obtained at reduced prices by bulk purchases and repacking in smaller quantities for member institutions, using effective but less costly containers. The technical and legal implications must be looked into. Another method is to order in bulk for the requirements for a whole year but to be supplied in small quantities at stated intervals.

7. *Meeting with representatives:* The drug committee should lay down a policy as to when and how the representatives can meet with the medical and pharmacy personnel. This should be aimed at a three-fold objective:

(1) to get valid and reliable information about new drugs and formulations,

(2) to avoid wastage of time, and

(3) to reduce the high pressure salesmanships with free samples and gifts for the individuals to influence their decisions.

It would be better if the representatives meet the hospital personnel in groups, so that scientific and valid information can be given, questions asked and clarifications obtained. This would ensure that ineffective products are not given to patients who could have been treated better with more effective or safer drugs or with no drugs at all.

8. *Storage:* The drugs must be stored properly. Those which require refrigeration must be stored carefully in refrigerators and the temperature of the refrigerator checked every day. Schedule drugs must be kept as required by law and proper registers maintained. In hot climates, the drugs can be kept cool by simple methods.

Bin cards must be prepared; the cards should give full details of date of order, price, vendor's name, expected date of delivery, quantity ordered, quantity received and expiry date. Drugs with expiry date must be monitored carefully.

9. *Management:* The purchase and distribution of the drug must be managed efficiently with respect to the quantity stocked (minimum and maximum), order quantity, lead time and ensuring continuity of supply; there is need to prevent overstocking, maintaining the stock at the optimum level, reviewing past records of requisitions and utilization and changes in services

and availability of drugs. "First-in, first out" policy may be followed; this would ensure that the drugs, even with short shelf-life, move sufficiently quickly. Training should be given in proper materials management.

10. *Costing:* There may be conflicting interests in costing the drugs-humanitarian and the need to have a 'margin' to meet the expenses. The usual method is to mark up the price above the purchase (wholesale or hospital) price by a certain percentage, keeping the final price (as given to the patient) within the usual retailer's price. This method may be given up and replaced by adding a fee-for-service to the cost; this would prevent the tendency to go for constlier medicines as they would give a higher gross margin. The tendency, if it exists, of making a profit from drugs to meet "other expenses" must be curbed, a possible alternative would be to charge for consultations.

11. *Prescribing:* The following points must be considered while prescribing;

(i) Does the condition require a drug at all ? Or, does the patient need advice? Sir William Osler, father of modern medical practice said: "One of the first duties of the physician is to educate the masses not to take medicine".

(ii) Is the safest and simplest medicine being prescribed for adequate duration and no more? The doctor must balance safety and efficacy against the hazards. It is necessary to prevent iatrogenic diseases; the simplest effective drugs with minimal toxicity must be prescribed. Praticular attention must be paid for the effects on the unborn child, while prescribing for the pregnant woman.

(iii) Has the patient been informed of the possible adverse reactions? This is particularly important in the ambulant patients.

11.1 Poly-pharmacy (prescribing many drugs for one disease) must be avoided. With more rational, selective and discriminating prescribing, combination drugs are on their way out. In Japan, very few of the new products are fixed-dose combinations, whereas in our country, there are more and more of the fixed-dose combinations. Polypharmacy indicates

(i) lack of knowledge of the action of the drugs,

(ii) inability to critically diagnose the condition and evaluate therapy

(iii) lack of confidence on the part of the prescriber,

(iv) exploitation by the drug industry, and

(v) gullibility of the public (especially with respect to tonics, vitamins and other nutritional formulations).

The combinations are often irrational; they lack flexibility; some of the components may be unnecessary; and the drugs may even be incompitable.

12. What can CHAI do? There are a number of measures which CHAI can do to help in the optimal use of drugs and pharmaceuticals in the member institution.

12.1. Procure the drugs at the minimum cost by centralised purchasing in bulk packing and distributing.

12.2. Manufacture a few of the items which are commonly needed by the member hospitals, ensuring good manufacturing procedure and quality control.

12.3. Arrange for the checking of drugs (quality control) at the request of member hospitals.

12.4. Publish a medical letter on rational drug therapy, separately as a monthly letter or in the "Medical Service". This can give all necessary information about drugs, the bioequivalence, the dosage schedules, the indications, adverse reactions and contra-indications. The cost benefit information should give the adverse consequences of therapy (including therapy-ralated morbidity and mortality) apart from the approximate cost per dose and the total treatment. It can have thought provoking information sheets on various aspects of drug policy.

12.5. Keep member institutions informed of all related developments and publications by organisations with similar interests.

12.6. Identify resource persons or groups who can be invited by member hospitals in their re-orientation programmes.

12.7. Organise regional seminars and workshops.

12.8. Generate a list of acceptable and interchangeable drugs for the small, medium and large sized hospitals.

12.9. Arrange for periodical training programmes for the pharmacists and others in procurement and management of drugs and pharmaceuticals.

Appendix

1. Anaesthetics

1.1. General anaesthetics and oxygen

* ether, anaesthetic	inhalation
halothane	inhalation
nitrous oxide	inhalation
* oxygen	inhalation (medicinal gas)
thiopental	powder for injection, 0.5 g, 1.0g. (sodium salt) in ampoule

1.2 Local anaesthetics

* lidocaine	injection, 1% 2% (hydrochloride) in vial
	injection, 1% 2% + epinephrine 1 :100,000 in vial
	topical forms, 2-4% (hydrochloride)

2. Analgesics, Antipyretics, Nonsteroidal Antiinflammatory Drugs

2.1 Non-opioids

* aspirin	tablet, 100-500 mg
ibuprofen	tablet, 200 mg
indometacin	tablet, 25 mg
* paracetamol	tablet 100-500 mg

2.2 Opioid analgesics and antagonists

* morphine	injection, 10mg (sulfate or hydrochloride) in 1-ml ampoule
naloxone	injection, 0.4 mg (hydrochloride) in 1 ml ampoule
* pethidine	injection, 50mg (hydrochloride) in 1 ml ampoule

3. Antiallergics

* chlorphenamine	tablet, 4mg (maleate)
	injection, 10 mg in 1 ml ampoule
* epinephrine	injection, 1 mg (as hydrochloride) in 1 ml ampoule
cromoglicic acid	oral inhalation (cartridge) 20 mg (sodium salt) per dose

4. Antidotes and other Substances used in Poisonings

4.1. General

* charcoal, activated	powder
* ipecacuanha	syrup, containing 0.14% ipecacuanha alkaloids calculated as emetine

4.2 Specific

* atropine	injection, 1 mg (sulfate) in 1 ml ampoule
deferoxamine	injection, 500 mg (mesilate) in vial
dimercaprol	injection in oil, 50 mg/ml in 2 ml ampoule
naloxone	injection, 0.4 mg (hydrochloride) in 1 ml ampoule
protamine sulfate	injection 10 mg/ml in 5 ml ampoule
sodium calcium edetate	injection, 200 mg/ml in 5 ml ampoule
sodium nitrite	injection, 30 mg/ml in 10 ml ampoule
sodium thiosulfate	injection, 250 mg/ml in 50 ml ampoule

5. Antiepileptics

* diazepam	injection 5 mg/ml in 2 ml ampoule
ethosuximide	tablet, 250 mg
* phenobarbital	tablet, 50 mg, 100 mg syrup, 15 mg/5ml

* phenytoin	tablet, 25 mg, 100mg (sodium salt)
	injection, 50 mg (sodium salt)/ml in 5 ml vial
carbamazepine	tablet, 200 mg
valproic acid	tablet, 200 mg (sodium salt)

6. Antiinfective Drugs

6.1. Anthelmintic drugs

* mebendazole	tablet, 100 mg
* piperazine	tablet, 500 mg (citrate or adipate) elixir or syrup (as citrate) equivalent to 500 mg hydrate/5 ml
pyrantel	chewable tablet, 250 mg (as embonate)
	oral suspension, 50 mg (as embonate)/ ml
tiabendazole	chewable tablet, 500 mg

6.2 Antiamoebic drugs

* chloroquine	tablet, 200 mg (as phosphate or sulfate)
diloxanide	tablet, 500 mg (furoate)
* metronidazole	tablet, 200-500 mg
* dehydroemetine	injection, 60 mg (hydrochloride) in 1 ml ampoule

6.3 Antibacterial drugs

6.3.1 Penicillins

* ampicillin	capsule or tablet, 250 mg, 500 mg (anhydrous) powder for oral suspension, 125 mg (anhydrous)/5 ml
	powder for injection, 500 mg (as sodium salt) in vial
* benzathine benzylpenicillin	injection, 1.44 g benzylpenicillin (=2.4 million IU)/5 ml in vial
* benzylpenicillin	powder for injection, 0·6 g
	(=1 million IU), 3.0 g (=5 million IU) (as sodium or potassium salt) in vial

phenoxymethylpenicillin	tablet, 250 mg (as potassium salt)
	powder for oral suspension 250 mg (as potassium salt)/5 ml
* procaine benzylpenicillin	powder for injection, 1g (=1 million IU), 3 g (=3 million IU)

6.3.2 Other antibacterial drugs

* chloramphenicol	capsule, 250 mg
	powder for injection, 1 g (as sodium succinate) in vial
cloxacillin	capsule, 500 mg (as sodium salt)
	powder for injection, 500 mg (as sodium salt) in vial
doxycycline	capsule or tablet, 100 mg (as hydrochloride) injection, 100 mg (as hydrochloride)/5 ml in ampoule
erythromycin	capsule or tablet, 250 mg (as stearate or ethylsuccinate)
	oral suspension, 125 mg (as stearate or ethylsuccinate)/5 ml
	powder for injection, 500 mg (as lactobionate) in vial
gentamicin	injection, 10 mg, 40 mg (as sulfate)/ml in 2 ml vial
* metronidazole	tablet, 200-500 mg
	injection, 500 mg in 100 ml
salazosulfapyridine	tablet, 500 mg
* sulfadimidine	tablet, 500 mg
	oral suspension, 500 mg/5 ml
	injection, 1 g (sodium salt) in 3 ml ampoule
* sulfamethozazole + trimethoprim	tablet, 100 mg+20mg, 400 mg+80 mg
* tetracycline	capsule or tablet, 250 mg (hydrochloride)

6.3.3 Antileprosy drugs

clofazimine	capsule, 100 mg
* dapsone	tablet, 50 mg, 100 mg
* rifampicin	capsule or tablet, 150 mg, 300 mg
ethionamide	tablet, 125 mg, 250 mg

6.3.4 Antituberculosis drugs	
* ethambutol	tablet, 100-500 mg (hydrochloride)
* isoniazid	tablet, 100-300 mg
* pyrazinomide	tablet, 500 mg
* rifampicin	capsule or tablet, 150 mg, 300 mg
* streptomycin	powder for injection, 1 g (as sulfate) in vial
* thioacetazone+isoniazid	tablet, 50 mg+100mg, 150 mg+300 mg
6.4 Antifilarial drugs	
* diethylcarbamazine	tablet, 50 mg (citrate)
6.5 Antifungal drugs	
amphotericin B	powder for injection, 50 mg in vial
* griseofulvin	tablet or capsule, 125 mg, 250 mg
nystatin	tablet, 500 000 IU
6.6 Antileishmaniasis drugs	
* sodium stibogluconate	injection, 33%, equivalent to 10% antimony, in 30 ml vial
6.7 Antimalarial drugs	
* chloroquine	tablet, 150 mg (as phospate or sulfate) syrup, 50 mg (as phosphate or sulfate)/5 ml
* primaquine	tablet, 7.5 mg, 15 mg (as phosphate)
* quinine	tablet, 300 mg, (as bisulfate or sulfate) injection, 300 mg (as dihydrochloride)/ml in 2 ml ampoule
* amodiaquine	suspension, 150 mg (as hydrochloride)/5 ml
sulfadoxine + pyrimethamine	tablet, 500 mg+25 mg
7. Antimigraine Drugs	
* ergotamine	tablet, 2 mg (as tartrate)
8. Antineoplastic and Immunosuppressive Drugs	
azathioprine	tablet, 50 mg
bleomycin	powder for injection, 100 mg (as sodium salt) in vial powder for injection, 15 mg (as sulfate) in vial)

busulfan	tablet, 2 mg
chlorambucil	tablet, 2 mg
cyclophosphamide	tablet, 25 mg
	powder for injection, 500 mg in vial
cytarabine	powder for injection, 100 mg in vial
doxorubicin	powder for injection, 100 mg, 50 mg (hydrochloride) in vial
fluorouracil	injection, 50 mg/ml in 5 ml ampoule
methotrexate	tablet, 2.5 mg (as sodium salt)
	injection, 50 mg (as sodium salt) in vial
procarbazine	capsule, 50 mg (as hydrochloride)
vincristine	powder for injection, 1 mg, 5 mg (sulfate) in vial
	9. Antiparkinsonism Drugs
biperiden	tablet, 2 mg (hydrochloride)
levodopa	tablet or capsule, 250 mg
levodopa + carbidopa	tablet, 100 mg + 10 mg, 250 mg + 25 mg
	10. Blood, Drugs affecting the
	10.1 Antianaemia drugs
* ferrous salt	tablet, equivalent to 60 mg iron (as sulfate or fumarate)
	oral solution, equivalent to 15 mg iron (as sulfate) in 0.6 ml
* folic acid	tablet, 1 mg
	injection, 1 mg (as sodium salt) in 1 ml ampoule
hydroxocobalamin	injection, 1 mg in 1 ml ampoule
* iron dextran	injection, equivalent to 50 mg iron/ml in 2 ml ampoule
	10.2 Anticoagulants and antagonists
heparin	injection, 1000 IU/ml, 5000 IU/ml 20 000 IU/ml in 1 ml ampoule
phytomenadione	injection, 10 mg/ml in 5 ml ampoule
warfarin	tablet, 5 mg (sodium salt)
	11. Blood Products and Blood Substitutes
	11.1 Plasma substitute
* dextran 70	injectable solution, 6%

12. Cardiovascular Drugs

12.1 Antianginal drugs

* glyceryl trinitrate	tablet, (sublingual) 0.5 mg
* isosorbide dinitrate	tablet, (sublingual) 5 mg
* propranolol	tablet, 10 mg, 40 mg (hydrochloride)
	injection, 1 mg (hydrochloride) in 1 ml ampoule
* verapamil	tablet, 40 mg, 80 mg (hydrochloride)
	injection, 2.5 mg/ml (hydrochloride) in 2 ml ampoule

12.2 Antiarrhythmic drugs

* isoprenaline	tablet, 10 mg; 15 mg (hydrochloride or sulfate)
* lidocaine	injection, 20 mg (hydrochloride)/ml in 5 ml ampoule
* procainamide	tablet, 250 mg, 500 mg (hydrochloride)
	injection, 100 mg (hydrochloride)/ml in 10 ml ampoule
propranolol	tablet, 10 mg, 40 mg (hydrochloride)
	injection, 1 mg (hydrochloride) in 1 ml ampoule
* quinidine	tablet, 200 mg (sulfate)

12.3 Antihypertensive drugs

hydralazine	tablet, 50 mg (hydrochloride)
* hydrochlorothiazide	tablet, 50 mg
propranolol	tablet, 40 mg, 80 mg (hydrochloride)
sodium nitroprusside	powder for preparing infusion, 50 g in ampoule
methyldopa	tablet, 250 mg
* reserpine	tablet, 0.1 mg, 0.25 mg
	injection, 1 mg in 1 ml ampoule

12.4 Cardiac glycosides

* digoxin	tablet, 0.0625 mg, 0,25 mg
	oral solution, 0.05 mg/ml
	injection, 0.25 mg/ml in 2 ml ampoule
digitoxin	tablet, 0.05 mg, 0.1 mg
	oral solution, 1 mg/ml
	injection, 0.2. mg in 1 ml ampoule

12.5 Drugs used in shock or anaphylaxis

dopamine	injection, 40 mg (hydrochloride)/ml in 5 ml vial
* epinephrine	injection, 1 mg (as hydrochloride) in 1 ml ampoule

13. Dermatological Drugs

13.1 Antifungal drugs

* benzoic acid + salicylic acid;	ointment or cream, 6% + 3%
miconazole	ointment or cream, 2% (nitrate)
nystatin	ointment or cream, 100,000 IU/g

13.2 Antiinfective drugs

neomycin + bacitracin	ointment, 5 mg neomycin sulfate + 500 IU bacitracin zinc/g

13.3 Antiinflammatory and antipruritic drugs

* betamethasone	ointment or cream, 0.1% (as valerate)
* calamine lotion	lotion
* hydrocortisone	ointment or cream, 1% (acetate)

13.4 Astringent drugs

aluminium acetate	solution, 13% for dilution

13.5 Keratoplastic and keratolytic agents

* salicylic acid	solution, topical 5%

13.6 Scabicides and pediculicides

* benzyl benzoate	lotion, 25%
* lindane	cream or lotion, 1%

14. Diagnostic Agents

tuberculin, purified protein derivative (PPD)	injection

14.1 Ophthalmic drugs

fluorescein	eye drops, 1% (sodium salt)

14.2 Rediocontrast media

adipiodone meglumine	injection, 25% in 20 ml vial
barium sulfate	powder
iopanoic acid	tablet, 500 mg
meglumine amidotrizoate	injection, 60% in 20 ml ampoule
sodium amidotrizoate	injection, 50% in 20 ml ampoule

15. Disinfectants

chlorhexidine	solution, 5% (gluconate) for dilution
* iodine	solution, 2.5%

16. Diuretics

amiloride	tablet, 5 mg (hydrochloride)
* furosemide	tablet, 40 mg
	injection, 10 mg/ml in 2 ml ampoule
* hydrochlorothiazide	tablet, 50 mg
* mannitol	injectable solution, 10%, 20%
spironolactone	tablet, 25 mg

17. Gastrointestinal Drugs

17.1 Antacids and other antiulcer drugs

* aluminium hydroxide	tablet, 500 mg
	oral suspension, 320 mg/5 ml
* cimetidine	tablet, 200 mg
	injection, 200 mg in 2 ml ampoule
* magnesium hydroxide	oral suspension, equivalent to 550 mg magnesium oxide/10 ml

17.2 Antiemetic drugs

* promethazine	tablet, 10 mg, 25 mg (hydrochloride)
	elixir or syrup, 5 mg (hydrochloride)/5ml
	injection, 25 mg (hydrochloride)/ml in 2 ml ampoule
metoclopramide	tablet, 10 mg (as hydrochloride)

17.3 Antihaemorrhoidal drugs

local anaesthetic, astringent and anti-inflammatory drug	ointment or suppository

17.4 Antispasmodic drugs

* atropine	tablet, 1 mg (sulfate)
	injection, 1 mg (sulfate) in 1 ml ampoule

17.5 Cathartic drugs

* senna	tablet, 7.5 mg (sennosides)

17.6 Diarrhoea, drugs used in

17.6.1 Antidiarrhoeal (symtomatic) drugs

* codeine	tablet, 30 mg (phosphate)

17.6.2 Oral rehydration solution

	g/litre
* oral rehydration salts	
sodium chloride	3.5
sodium bicarbonate	2.5
potassium chloride	1.5
glucose	20.0

18. Hormones

18.1 Adrenal hormones and synthetic substitutes

* dexamethasone	tablet, 0.5 mg, 4 mg
	injection, 4 mg (sodium phosphate) in 1 ml ampoule
* hydrocortisone	powder for injection, 100 mg (as sodium succinate) in vial
* prednisolone	tablet, 5 mg

18.2 Androgens

testosterone	injection, 200 mg (enantate) in 1 ml ampoule
	injection, 25 mg (propionate) in 1 ml ampoule

18.3 Estrogens

ethinylestradiol	tablet, 0.05 mg

18.4 Insulins and other antidiabetic agents

* compound insulin zinc suspension	injection, 40 IU/ml in 10 ml vial, 80 IU/ml in 10 ml vial
* insulin injection	injection, 40 IU/ml in 10 ml vial, 80 IU/ml in 10 ml vial
* glibenclamide	tablet, 5 mg

18.5 Thyroid hormones and antithyroid drugs

* levothyroxine	tablet, 0.05 mg, 0.1 mg (sodium salt)
* potassium iodide	tablet, 60 mg
* propylthiouracil	tablet, 50 mg

19. Immunologicals

19.1 Sera and immunoglobulins

anti-D immunoglobulin (human)	injection, 0.25 mg/ml	All plasma fractions should comply with the WHO requirements for the Collection, Pro-
antirabies hyperimmune (serum)	injection, 1000 IU in 5 ml ampoule	
* antivenom sera	injection	

* diphtheria antitoxin	injection, 10,000 IU, 20,000 IU, in vial	cessing ant Quality Control of Human Blood and Blood Products
immunoglobulin, human normal	injection	
* tetanus antitoxin	injection, 50,000 IU in vial	

19.2 Vaccines

BCG vaccine (dried)	injection	
* diptheria- pertussis tetanus vaccine	injection	
* diphtheria-tetanus vaccine	injection	
* measles vaccine	injection	All vaccines should comply with the WHO Requirements for Biological Substances
* poliomyelitis vaccine (live attenuated)	oral solution	
* tetanus vaccine	injection	
rabies vaccine	injection	
* typhoid vaccine	injection	

20. Muscle Relaxants (peripherally acting) and Cholinesterase inhibitors

neostigmine	tablet, 15 mg (bromide)
	injection, 0.5 mg (metilsulfate) in 1 ml ampoule
gallamine	injection, 40 mg (triethiodide)/ml in 2 ml ampoule
suxamethonium	injection, 50 mg (chloride)/ml in 2 ml ampoule

21. Ophthalmological Preparations

21.1 Antiinfective

* silver nitrate	solution (eye drops), 1%
* sulfacetamide	eye ointment, 10% (sodium salt)
	solution (eye drops), 10% (sodium salt)
* tetracycline	eye ointment, 1% (hydrochloride)

21.2 Antiinflammatory

* hydrocortisone	eye ointment, 1% (acetate)

21.3 Local anaesthetics

tetracaine	solutuion (eye drops), 0.5% (hydrochloride)

21.4 Miotics

pilocarpine	solution (eye drops), 2%, 4% (hydrochloride or nitrate)

21.5 Mydriatics

homatropine	solution (eye dorps), 2% (hydrobromide)

21.6 Systemic preparations

acetazolamide	tablet, 250 mg

22. Oxytocics

* ergometrine	tablet, 0.2 mg (maleate)
	injection, 0.2 mg (maleate) in 1 ml ampoule
* oxytocín	injection, 10 IU in 1 ml ampoule

23. Peritoneal Dialysis Solution

intraperitoneal dialysis solution (of appropriate composition)	parenteral solution

24. Psychotherapeutic Drugs

* amitrptyline	tablet, 25 mg (hydrochloride)
* chlorpromazine	tablet, 100mg (hydrochloride)
	syrup, 25 mg (hydrochloride) 5 ml
	injection, 25 mg (hydrochloride/ml in 2 ml ampoule
* diazepam	tablet, 5 mg
fluphenazine	injection, 25 mg (decanoate or enantate) in 1 ml ampoule
* haloperidol	tablet, 2 mg
	injection, 5 mg in 1 ml ampoule
lithium carbonate	capsule or tablet, 300 mg

25. Respiratory Tract, Drugs Action on the

25.1 Antiasthmatic drugs

* aminophylline	tablet, 200 mg
	injection, 25 mg/ml in 10 ml ampoule
* epinephrine	injection, 1 mg (as hydrochloride) in 1 ml ampoule
* salbutamol	tablet, 4 mg (sulfate)
	oral inhalation (aerosol), 0.1 mg per dose
	syrup, 2 mg (sulfate)/5ml
beclometasone	oral inhalation (aerosol), 0.05 mg (dipropionate) per dose
cromoglicic acid	oral inhalation (cartridge), 20 mg (sodium salt) per dose
* ephedrine	tablet, 30 mg (as hydrochloride)
	elixir, 15 mg (as hydrochloride)/5 ml
	injection, 50 mg (sulfate) in 1 ml ampoule

25.2 Antitussives

* codeine	tablet, 10 mg (phosphate)

26. Solutions Correcting Water, Electrolyte and Acid-base Disturbances

26.1 Oral

* oral rehydration salts (for glucose-salt solution) potassium chloride	(for composition, see 17.6.2: Oral rehydration solution) oral solution

26.2 Parenteral

* compound solution of sodium lactate	injectable solution
* glucose	injectable solution, 5% isotonic, 50% hypertonic
* glucose with sodium chloride	injectable solution, 4% glucose, 0.18% sodium chloride (NA^+ ⁻30 mmol/1, $C1^-$30 mmol/1)
Potassium chloride	injectable solution
* sodium bicarbonate	injectable solution, 1.4% isotonic (Na^+ 167 mmol/1, $HC03^-$167 mmol/1)
* sodium chloride	injectable solution, 0.9% isotonic (Na^+ 154 mmol/1, Cl^-154 mmol/1)
* water for injection	in 2 ml, 5 ml, 10 ml ampoules

27. Vitamins and Minerals

* ascorbic acid	tablet, 50 mg
ergocalciferol	capsule or tablet, 1.25 mg (50,000 IU) oral solution, 0.25 mg/ml (10,000 IU)
* nicotinamide	tablet, 50 mg
* pyridoxine	tablet, 25 mg (hydrochloride)
* retinol	capsule or tablet, 7.5 mg (25,000 IU), 60 mg (200,000 IU); oral solution, 15 mg (50,000 IU)
* riboflavin	tablet, 5 mg
* thiamine	tablet, 50 mg (hydrochloride)
* calcium gluconate	injection, 100 mg/ml in 10 ml ampoule

Drugs and pharmaceuticals marked with (*) are suggested for health centres and smaller hospitals. Where there is no doctor, the list will have to be shortened drastically to ensure safety.