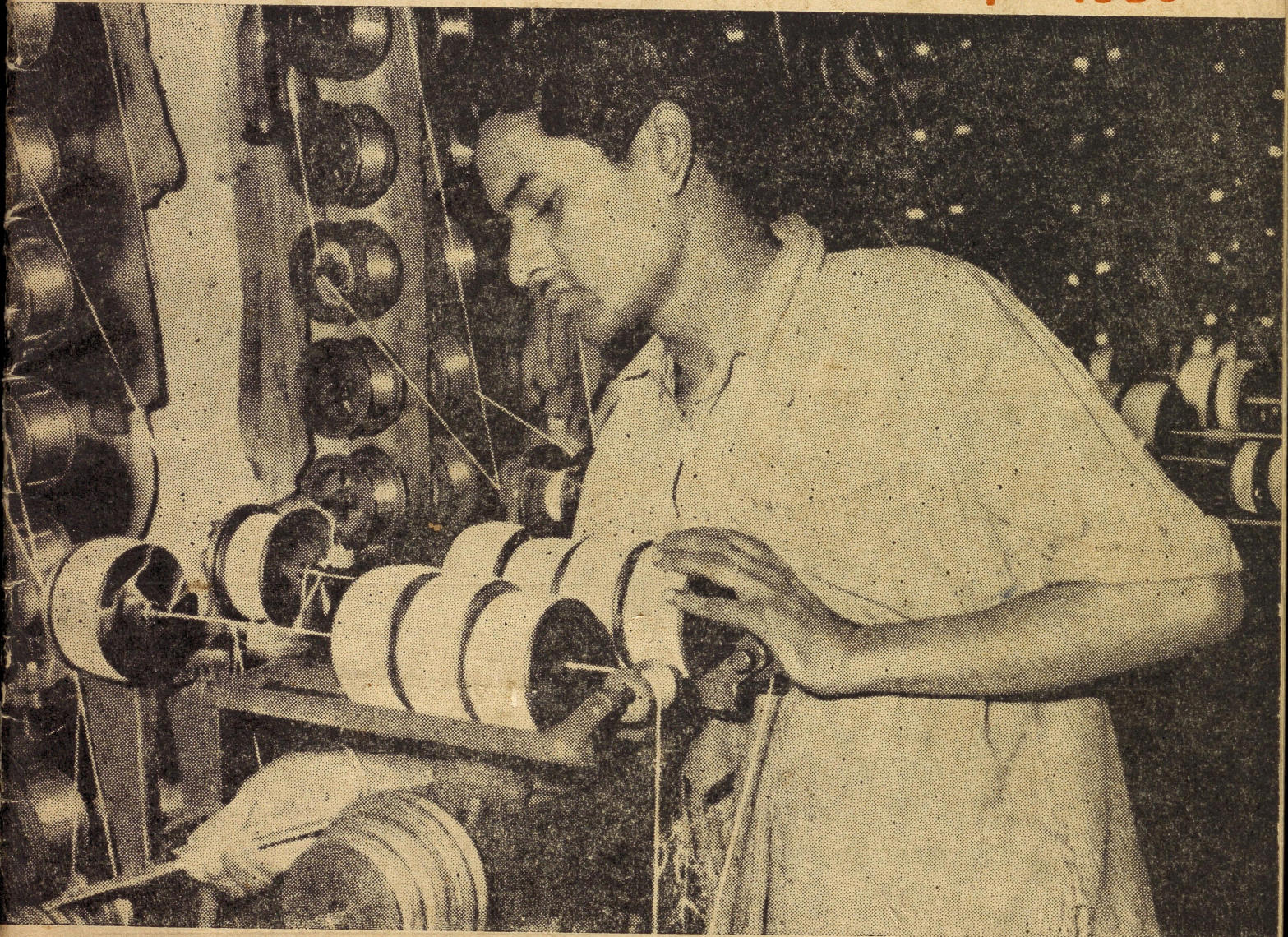


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WORLD HEALTH DAY 1985

**HEALTHY YOUTH
OUR BEST RESOURCE**

swasth hind

Phalguna-Chaitra-Vaisakha March-April 1985
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Readers Write

Swasth Hind is a good journal for health education and I wish it a great success.

Dr S. K. Manchanda
Deptt. of Physiology
School of Medical Science
Universiti Sans Malaysia
Minden, Penang
MALAYSIA

Editorial and Business Offices

Central Health Education Bureau
(Directorate General of Health Services)
Kotla Marg, New Delhi-110 002.

ASSTT. EDITOR

D. N. Issar

Sr. SUB-EDITOR

M. S. Dhillon

SUB-EDITOR

G. B. L. Srivastava

COVER DESIGN

B. S. Nagi

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HEALTHY YOUTH: Our Best Resource

Recognising the importance of youth in the wake of rapid economic development, urbanisation and changing social norms, the United Nations have rightly designated the year 1985 as the International Youth Year (IYY). As a sequel to this, the World Health Organization has decided to devote the World Health Day—7 April, 1985, to Youth. The theme selected for World Health Day is “Healthy Youth, Our Best Resource”. The theme has a special significance. The Day can serve as a powerful impetus for creating universal awareness of the health needs—physical, mental and social—of our young people.

HEALTHY YOUTH is our best resource in the development of our nation and in establishing international understanding and lasting peace. What is required is their active participation in planning, decision making and implementation of programmes which effect their lives and the future of their societies. For the achievement of the above objective, the theme of the World Health Day-1985 "Healthy Youth, Our Best Resource" and the theme of the International Youth Year "Participation, Development and peace" are complementary and supplementary to each other.

The participation of youth as of other sections of the society in matters that relate to the development of personality, health, creative activities, social services and other such developmental and welfare activities which promote peace, international understanding and human rights is of utmost importance.

Keeping in view the special importance of the youth in the present day world, there is a need for a wide spread information, education and communication (IEC) programme not only for the young people but the community as a whole with a view to:

1. Raise the general level of health awareness. Such information should focus not only on the specific health needs of the young people, but also on how they can contribute to bring about improvements in health of the family, community and the nation.

2. Emphasise the importance of health education, sanitation, nutrition, family life education, environmental sanitation, pollution, traffic education, etc., and should involve the young people in such programmes in rural and urban areas.

3. Highlight the special problems of the youth, e.g., accidents which are a major cause of death and disability.

4. Stress the risks associated with marked increase in smoking and drug abuse, consumption of alcohol among young people along with the information about facilities available for counselling, de-addiction and rehabilitation.

5. Identify the specific needs of the disabled youth and emphasise on rehabilitative programmes for physically and mentally disabled young people.

6. Highlight the various components of the National Population Education Programme, especially the family life education, including sex education and marriage counselling, to prepare the young people for responsible parenthood. Young people should be encouraged to participate in the family welfare programmes being implemented at the national, state and local levels.

7. Encourage the development of social services as a useful tool in mobilising young people in creative activities for the benefit of the society. Such services should reflect the local problems and their solutions with emphasis on health and family welfare.

8. Publicise the programmes aimed at prevention of crimes and delinquency and treatment of deviants, and drug abuse.

9. Emphasise the need for initiation of programmes for eradication of illiteracy among youth, especially the disadvantaged, the rural youth and the urban poor.

10. Create awareness of the facts about adolescence and youth among parents, teachers and students through various media and interpersonal communication in schools and universities.

[Contd. on Page 65]



YOUTH AND NATIONAL SERVICE SCHEME

DR (SMT) USHA BANERJEE

National Service Scheme has built up hundreds of students, who are voluntarily dedicated to the cause of social and economic development of the country. This group of youth could be the torch bearer of all constructive activities of the nation for future days to come.

YOUTH is recognised as a stage of life between adolescence and adulthood. It commences approximately at fifteen years and merges into adulthood about ten years later. The definition of the age could not be rigidly applied to all, as our society and the world comprises various people from different social strata. The age boundaries of this stage of life, depends on the nature of the society of a particular country.

In country like India, where we have people from different economic and social background, this period of adulthood sometimes ends before eighteen or twenty; sometimes it extends beyond twenty five. In case of economically weaker section of the society, the individual moves into adulthood at an early period of life and becomes over burdened with responsibility of looking after the family.

It could be, however, indicated very clearly that youth is a period of life, where the individual goes through maximum learning process, so that he or she can face the challenges of life lying ahead. Youth is in a way the best period of life, where one possesses maximum energy, muscle power and ability to assimilate things, needed for learning process. The shape of behaviour and pattern of their work depends on the social institutions, that are supposed to serve the youth, *e.g.*, educational institutions, family environment and political and economic environment. Above all, it is accepted that education is vital for young people to make them the citizens of a nation in true sense. Therefore, education need to be imparted to students in proper manner.

Education and service

National Service Scheme (N.S.S.), which was introduced in 1969 by the Ministry of Education and Youth Services, Government of India, was an attempt to rectify the modern education system of the country, where education is by and large divorced from social reality, by exposing the students and the community at large to social problems. National Service is only meant for student youth, who are mainly in colleges and universities.

The objectives of the scheme are broadly education and service. It is intended that students involvement in the scheme will enable them to participate in development process of the country and thereby their perception about social reality would be enhanced.

It provides student youth group to expand their horizon of knowledge and perception to make them democratic, idealistic and sensitive beings for future days to come.

The scheme which was introduced in 1969 on a pilot-basis in 40 Universities and institutions of higher education with an involvement of about 40,000 students has grown considerably in the last fifteen years. There has been a substantial increase in the numbers and its coverage now extends to all States and Union Territories of the country. About 6.4 lakh students and around 3500 teachers from 137 Universities and Institutions of higher learning are involved in various activities under the programme.

In Delhi University alone about 14,000 volunteers in sixty colleges are covered by National Service Scheme.

Instrument of social change

The educational nature of the NSS is now widely recognized and it is felt that the introduction of NSS is a concrete attempt at making education relevant to the needs of the society and also making it an instrument of social change and development.

The programmes under the NSS can broadly be divided into two major categories:

- (i) Regular Activities Programme
- (ii) Special Camping Programme

Regular programmes

Students are to render services for 120 hours in a calendar year in an institution, either a hospital, or a community in any other welfare institution or in a urban complex adopted by a particular college.

Under Regular Programmes the students are involved in a variety of welfare activities which are distributed throughout the academic year. The activities undertaken as regular programmes are social services in institutions like hospitals, schools, work in institutions for handicapped, etc. This scheme allows a good deal of flexibility. Each NSS Unit has the freedom to choose such programmes as may meet the local needs, suit interests of students and relate to local conditions and provide material for their educational enrichment.

Special Camping Programme

These camps are held for 10—12 days in the communities adopted by the concerned NSS Units. The campers consist of the Programme Officers, student volunteers and local youth. The various projects undertaken involve developmental work, health, sanitation campaigns, survey work, educational projects and other relief work. These projects also create assets like roads, wells, soakage pits, and provide support to local development programmes.

During the various campings the student volunteers did commendable work by taking up many useful community projects such as road laying, providing drinking water facilities, undertaking rural electrification, public health and sanitation, adult education, family welfare, tree plantation, rodent control, weed control, animal health care, pest management, welfare of youth, women and children, educational campaigns to eradicate social evils.

Intangible gains

Besides tangible gains, there are intangible gains also to the village community where students live for 10—12 days. When the students work in different activities especially involving manual labour, the rest of the village community, especially village youth can hardly afford to remain aloof. This helps in

bringing about certain attitudinal changes in the village/slum community and awareness among the people about their own welfare needs which they can meet themselves. When students engage themselves in various projects in rural areas and urban slums they become sensitive towards the life situations prevailing in these areas and it brings tremendous attitudinal change among the students which is the greatest achievement of NSS.

Organisation

The present organisational pattern of NSS provides for one part time teacher incharge for 100 to 200 student volunteers in a college. The teacher incharge shoulders the responsibility of organising NSS work over and above his teaching responsibility. At the university level, the Programme Coordinator under the guidance of the University Advisory Committee coordinates the programme. University level NSS Advisory Committee is comprised of all development functionaries of the State with Coordinator or Professor in University as Secretary. The scheme is financed by the Ministry of Sports, Government of India through the University. The Department of Sports is responsible for all youth programmes in the country. While National Service Scheme is meant for educated student youth in urban and rural areas, the *Nehru Yuvak Kendras* are meant for uneducated rural youth. △

[Contd. from Page 62]

11. Extend support for establishment of youth centres, particularly in rural and slum areas, libraries, recreation and sport centres with a view to expanding the scientific and cultural level of training of young people.

12. Involve youth in self-help projects and programmes like National Service Scheme,

etc., to meet their own health and other needs in both rural and urban areas.

13. Disseminate information on perspective employment opportunities to young people before entering educational and vocational institutions.

14. Provide educational opportunities to disabled youth in both rural and urban areas.△

THE LOVE OF SHARING THE JOY OF GIVING

JITENDRA TULI

Each member of NSS has the burning idealism that only the young can have, coupled with a deep conviction that much of the ills that beset society can be sorted out with some love and understanding and by sharing what we have, even if it is little, with those who have nothing.

FOR as long as he can remember, Padam has considered weekends as something special. As a child, in boarding-school, weekends were happily spent with local guardians. Later, in college, they provided a welcome relief from the long scholastic hours spent in cramped classrooms.

Today, Padam looks forward to weekends even more eagerly. "For the first time, I have learnt what the word satisfaction means", he says. No, he has not joined a rock group, or taken to painting, or for that matter, going for long, fast rides on his motorcycle. What he has started doing is working with and for the physically handicapped.

Over three years ago, as a fresher in college, he joined the National Service Scheme (NSS) under which young collegiates devote a set number of hours to social work every week. "Actually, most students consider this an opportunity to have fun. Usually, it means going to a village or a slum to clean up the place, or help lay a road or a sewage line, or participate in some development project".

What changed the whole scene for Padam was the first NSS camp he attended. It was for the physically handicapped, and the young student was appalled to see the large number of polio-afflicted children. "What was even more tragic was the realization that it took so little to prevent polio", he says with feeling.

Shortly after this camp, he heard, through a friend, of a voluntary group, the Amar Jyoti Charitable Trust, which was engaged in identifying, attending to and rehabilitating the handicapped in and around Delhi. He contacted the Trust, which gladly welcomed him. He has now been associated with them for three years.

"We hold camps every month at which patients identified by young volunteers are examined by a team of orthopaedic surgeons, physiotherapists and others. They are measured for aids like calipers and crutches, which are distributed at a subsequent camp. All the aids—including tricycles, wheel-chairs, artificial limbs and calipers—are given free".

What Padam and his group of friends do is to register the patients, fill out the registration cards with biographical and medical details, and later on follow-up on rehabilitation at the patients' homes.

It was after one such camp, which lasted almost the whole day, that we met Padam and his friends. That day they had catered to over 500 people. There was a look of satisfaction on their bright, though tired faces. Each one, in their own way, felt that they had been able to contribute a little towards making life a bit easier for someone. Amar, another young college graduate said, "we realize that the problem is immense, but we are also confident that, with such efforts, a lot can be achieved".

Poonam, who helps illiterate patients fill out forms and also follows-up on them at home, finds her work with the handicapped the only sensible thing to do. "The choice is either to do this, or watch movies on the video, or idle away time attending coffee parties or doing nothing", she says emphatically. For her, the choice was clear.

What do the families of these young helpers think of their involvement in such work? Are they proud? Do they encourage them to do more? Would they themselves like to help? "Well", says Padam, "one would like to think so, but it isn't quite the case with everyone. Yes, some families are happy that we spend time like this; they know where we are and what we are doing. But there are others who say that this is not going to help us get a job. They feel it would be

better if we were to spend the same amount of time in improving our job prospects. But then, these are personal opinions.

We are here because we want to be here. And we hope that we will continue to find the time for this work even when we settle down in regular jobs.

The same sentiments are echoed by other young people, working in urban slums, or in rural areas, with the underprivileged and underserved. Each one of them has the burning idealism that only the young can have, coupled with a deep conviction that much of the ills that beset society can be sorted out with some love and understanding and by sharing what we have, even if it is little, with those who have nothing.

Interestingly none of these young people had gone into voluntary health work as a substitute for a medical career. It was not a case of opting for the second best.

"This is the way we like it, and this is the way it will be", says Vijay, who is undergoing training in making "calipers and leg braces".

In a few cases, workers come from a family background in medicine, but, by and large, they have no connection with a medical tradition. Some liked to work with and for the handicapped because somebody close to them or someone in their families was afflicted. But most were doing it for the sheer love of sharing and the joy of giving. These are words from a popular melody: would you like to join in? △

"First of all our young men must be strong. Religion will come afterwards. Be strong my young friends, that is my advice to you. You will be nearer to heaven through football than through the study of Gita. You will understand the Gita better with your biceps, your muscles a little stronger".

—Swami Vivekanand

THE PURPOSE OF INTERNATIONAL YOUTH YEAR

"The proclamation of the Year is evidence of the international community's growing concern with the situation of youth and also recognition of the important contribution young people can make in shaping and designing the future of humanity. With this in mind, the main objectives of the year are to:

(a) heighten awareness of the situation of youth, and of their needs and aspirations among decision-makers and the public;

(b) promote policies and programmes relating to youth as an integral part of social and economic development, according to each country's experience, conditions and priorities;

(c) enhance the active participation of youth in society and in particular the promotion and the achievement of development and peace;

(d) promote among youth the ideals of peace, mutual respect and understanding among peoples;

(e) encourage co-operation at all levels in dealing with youth issues.

In accomplishing these objectives, the year will provide an opportunity for increased understanding of global interdependence and of the external factors affecting the social and economic environment of young people, such as those being addressed in the effort to establish a new international economic order.

IYY should also stimulate research, data collection and analysis of the problems facing youth and the widespread dissemination and exchange of information on youth-related issues".

Global situation of youth

Close to 20 per cent of the world's population, or one inhabitant out of five, falls into the 15-24 year

age group, which the United Nations defines as youth without prejudice to national definitions.

The global youth population in 1980 was estimated at 857 million, an increase of 67 per cent over the past 20 years. Current United Nations projections indicate that it will pass the one billion mark in 1991 but both the growth rate and the proportion of the total population comprised by youth are expected to decline slowly throughout the remainder of the century, as a result of the decrease in global fertility levels.

A majority of young people (665 million) live in the developing countries of Africa, Asia and Latin America where more significant increases are expected to occur. Projections for the year 2000 point to an increase by one third, at which time 83.5 per cent of all youth, or 893 million, will live in the developing regions.

A recent study revealed that the key words in the experience of young people in the present decade are probably "scarcity", "unemployment", "underemployment", "ill employment", "anxiety", "defensiveness", "subsistence", and even "survival" itself.

Particular categories of youth, such as women, rural youth, urban youth in marginal groups, disabled youth and young refugees are particularly vulnerable to the current social problems which are compounded by rapid economic and technological change.

The effects of a concrete, structural crisis of chronic economic uncertainty, the destabilising effects of an accelerating arms race and the growing threat to world peace are not confined to any single locality or nation. But, because the situation of youth varies from one country to another as well as from region to region, IYY is focused primarily on the local, national and regional levels."

—YOUTH BULLETIN
November 1984

SWASTH HIND

No one can ignore the importance of youth involvement in community participation or, indeed, children's participation in the process. After all, the very essence of development is about people having a significant share in the decisions that affect their lives, thus forging a genuine future for their children.

CHILDREN, YOUTH AND COMMUNITY PARTICIPATION

MARY RACELIS-HOLLNSTEINER

IN the long-lasting, often acrimonious debate over the merits or demerits of development at least one principle prevails: given the tiniest shred of hope, people everywhere will struggle to provide a better future for their children. Indeed, the self-esteem of parents is closely related to their success in launching their offspring into adult life. The extent to which adults, aided by youth and children themselves, establish an environment conducive to the healthy development of children, an environment to which they participate on their terms in the events affecting their lives, spans the degree to which the next generation can experience fulfilled hopes, and not failed aspirations.

In traditional, fairly isolated, rural communities each adult generation formed its successors through a series of activities which they themselves defined and controlled. Although certain sectors of the population may have been left out of formal decision-making processes—like poorer families, and iso-

lated women—traditional mechanisms of communication normally transmitted important decisions to these groups, enabling them to react. The arena for action, in other words, lay within reach of every member of the community.

As external forces impinged on this relatively self-contained world, whether fostered by trade, colonisation, religious movements, political conquest or "development", decision-making for a shifted to locations outside the community, often in distant national or even world capitals, making it difficult if not impossible for residents to affect those decisions. From those in control, they became those controlled.

This emergent status of passive beneficiary rather than active decision-maker is most obvious in many government-promoted development programmes ostensibly designed to help the poor but all too often falling far short of this. Even if resources and services reach the

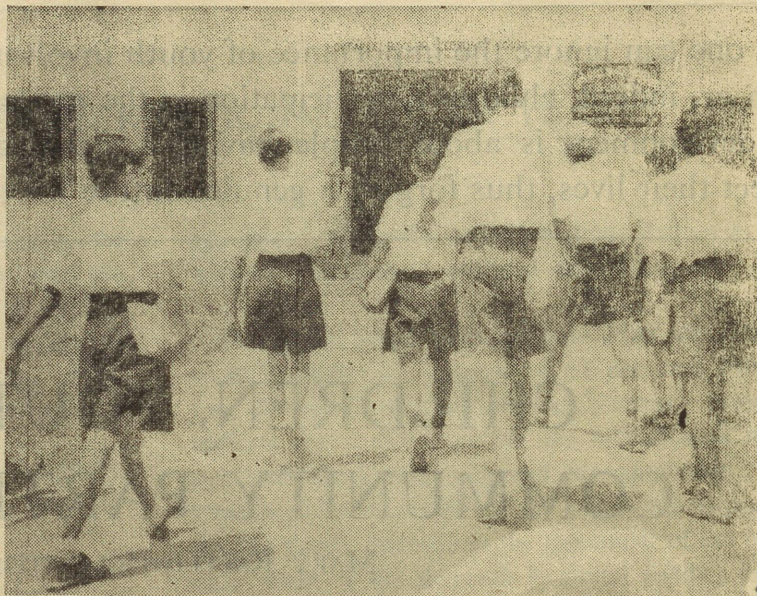
poor, or reach only a privileged few, rarely are community residents allowed a say in the formulation of plans, priorities, implementation and monitoring-evaluation schemes in programmes supposedly designed for their benefit. Nor are they asked whether they even wanted these programmes in the first place!

The examples of this "top-down" style are strewn widely across the development landscape—in village water pumps or taps long since rusted, caved-in latrines, powdered milk supplies hardened into cement-like blocks, dilapidated reading centres with a few ancient, tattered magazines lying about on broken furniture, roofless health posts exposing a few bottles of long-expired medicine, baby-weighing scales safely locked away still sealed in their original wrapping, and other such examples. The tragedy is that poor rural and urban slum residents *do* want water taps that work, safe latrines that do not give off foul odours, child-feeding

programmes, interesting reading material and health facilities that respond to their needs. What they have not been accorded is the time and opportunity to work out for themselves effective management systems that establish, for example, who will be responsible for the goods and services coming in, how they are to be organized, which groups will be the major beneficiaries, how to store, replenish and pay for new stocks, who is to get what kind of training, and more generally who decides what and when.

Decision-making in community issues is not a new task for poor rural or urban slum dwellers. They have planned, prioritized, implemented, and evaluated their actions all their lives. To recognize this, one only has to observe farmers' skill at managing irrigation water distribution schemes, nomad shepherds packing up their pastoral household every few months and moving animals and people to the next grazing-residential site, illiterate literate women organizing savings associations to generate credit, or community groups mounting a complex series of festival activities that draw hundreds or thousands of worshippers and onlookers.

The novelties development programmes bring to the community are specific technologies like oral rehydration to control diarrhoeas, or family planning techniques; scientific knowledge like the germ theory or disease and its relation to sanitary latrines, schistosomiasis control, or weaning food preparation; financial requirements needed for purchasing medicine in contrast to free or cheap local herbs dispensed by traditional healers. Novelties also include bureaucratic proce-



Children are major catalysts for development. Therefore, the education of the children should be our common aim.

dures for gaining access to goods, services and information, like keeping records, or registering a community group to give it a legal personality, or submitting written requests and project proposals complete with budget estimates to government agencies. Establishing effective working relationship with outsiders whose expertise and trustworthiness still have to be proven also can be considered as new challenges.

Government or non-government organizations (NGO) workers also face a new situation but of a different nature. If they are serious about working with small "grass-root" communities in a joint decision-making process, they must have more intensive contact with people, spending more time in communities with scarce physical comfort and engaging in a continuing dialogue with the residents. They need to be sensitive to existing leadership structures and the factions, animosities, friendships, alliances and coalitions that

characterize most communities. The roles of men, women and children, the history of people-government relations, attitudes toward outside-initiated innovations and a host of other considerations are critical concerns in community dynamics. Empathetic community workers can gradually build up a reservoir of trust if they appreciate that poor and illiterate people also possess a vast fund of knowledge, and a rational approach to life that sustains the daily struggle for survival and responds to new challenges. A basic respect for people and a willingness to learn from them characterizes the new breed of community workers committed to promoting development based on the participation of people.

Participation for, with and by children

Children as motivators. Children are major catalysts for development. In virtually every developing country, parents have spontaneously and enthusiastically come together to build school-houses for them. While



The involvement of youth in community activities such as demonstration on good nutrition, not only has a direct effect on children; it also establishes in the youth themselves a satisfying pattern of community service that can well carry over into their adult lives.

men dig the foundations or hammer on the roof, women carry away the soil, mix mortar, serve food and refreshments, and sometimes dig and hammer too. Political enemies will work side by side in a temporary truce to promote a common aim—the education of their children. For some communities, building a school or nursery is virtually the only activity that arouses the active cooperation of all households. So powerful has this drive been that in countries as distant from one another as

Peru, Philippines, and Tanzania, governments have been hard-pressed to supply the teachers needed to staff these schools as fast as they are completed. Sometimes the lack of road or living quarters for teachers has created additional difficulties, as in Pakistan, but people have supplied the missing elements.

Children without families. Another spontaneous response to children's needs appears in community-generated approaches to the problems of

street children. Some 40 million children in Latin America are estimated to come from crisis-ridden families that leave them either to fend for themselves or to be totally abandoned. Generally the offspring of poverty-stricken urban households headed by a woman struggling to make ends meet, these children roam the streets, often in groups for mutual protection and support, begging, stealing and engaging in prostitution to survive in the face of exploitation and abuse. However, a

number of adults everywhere are concerned and care enough to act.

In Nicaragua, following the national war of 1979, many thousands of children without family support found homes within a year through the mobilizing efforts of community residents.

As a councillor in one city put it, "We were determined that not one of our children would have to leave us and that not one of our children would be without a family. All of us in Esteli are each child's family." Similar community-based programmes in Brazil, Colombia, Honduras and Mexico are keeping abandoned children out of orphanages and rejecting institutional arrangements in favour of integration into foster homes or their own rehabilitated families.

Women's efforts

Women in particular show keen interest in organized action for children. All over the world poor women have taken time off from their time consuming everyday chores to engage in group activities directed at enhancing their children's wellbeing.

A group of poor corn farming families in the southern Philippines had successfully mobilized themselves to gain land titles. While both men and women had been heavily involved in the group's activities, the women soon agreed that they as a group would do something to improve the poor health status of their children. Accordingly, they requested and obtained from the government rural doctor an agreement that he would visit their villages every month to dispense medical services. To his great surprise and admira-

tion when he made his first call mothers had already identified the most serious cases of illness and malnutrition and the children concerned were present for examination each with a written medical record.

A donor agency's subsequent allocation of medical supplies then led to a decision to send two villagers for training as community health workers. On their return they started vegetable gardens to supply children with new nourishing food, thus recognizing that medicine is curative and appropriate food can prevent illness. It is interesting to note that their next project sought loan funds to buy a work animal for their husband, not only to include him in the benefits of their

Given the tiniest shred of hope, people will struggle to provide a better future for their children

organization but also to ensure that he would continue to accept late meals and other inconveniences as appropriate trade-offs for the women's ongoing involvement in community activities for children.

Unfortunately, despite women's contributions to family, community and society, the significance of their efforts still goes largely unappreciated. It is taken for granted that what women do is simply in the nature of things and nothing remarkable; working in the fields; taking care of children; preparing and cooking food, cleaning house and surroundings; washing, mending and ironing clothes; fetching wood and water; feeding and caring for animals and

poultry; tending the kitchen garden, weaving, sewing or knitting clothing; manufacturing baskets, rugs, mats, jars; trading produce in the market; taking children to the health clinic or local curer; and attending to the demands of husband, in-laws and her own family. Nor does this list cover the tasks undertaken by women in urban slums and others working for wages who must find time for workplace and home.

In this context, community participation clearly cannot be considered genuine unless women play an active part in the definition of community problems, in setting priorities for action, implementing these prospects and assessing their outcome. Too often have community workers discussed local needs and activities with men only. In part this stems from their consulting with the formal village leaders, who are usually all men. While this procedure cannot be avoided as part of local protocol, it can be criticized for not going far enough. A good community worker should have the capacity to develop a scheme that will enable every group in the community to express its views and be heard specially the most disadvantaged such as women, landless workers and others among the voiceless and powerless. It is neither accurate nor practical to accept the contention of some villagers that men speak for women in matters of community interest.

Youth efforts

While adults play the major role in child maintenance, youth also offer a great potential force. Because they have not yet acquired full adult responsibilities through marriage, their roles remain flexible and they can be steered toward acting in

¹Mary Racelis-Hollnsteiner and Peter Tacon, "Urban migration in developing countries; consequences for families and their children". *Child Development and International Development: Research-Policy Interfaces*, D. A. Wagner, Editor, San Francisco, Washington, London, Jossey-Bass, 1983, pp. 10 and 16.

OBSERVATION OF IYY IN INDIA

For statistical purposes, the United Nations defines persons aged 15 to under 25 as youth, without prejudice to other definitions of member States. In India, it has been agreed to include young people between 15-35 as youth.

The Union Department of Sports is the nodal authority for youth affairs in India, hence it is formulating and considering activities relating to the IYY. In August, 1983 the Department of Sports set up a working group on IYY under the Chairmanship of Secretary (Sports). The group, consists of representatives of the State Governments, Union Ministers, Youth Organisations and voluntary organisations. The working group is further split into 4 sub-groups namely:

- (i) Policy
- (ii) Publicity
- (iii) Programmes and Implementation
- (iv) Finance.

The working group and its sub-groups have held several meetings and have made several recommendations. Basically the Department of Sports vis-a-vis the working group intends to treat the three themes of IYY "Participation, Development and Peace" in an integrated manner. The observation of IYY in India provides an opportunity to reach out to youth and to motivate them. Therefore, there are leading up programmes in 1984, actual programmes in 1985 and follow-up programmes in 1986. The aim is to attract increased attention to the situation of youth and to help to encourage participation by young people in the community. The intention is that their activities continue permanently in future years also. The strategy for IYY is to reach to the maximum number of youth and ensure their active participation in the programme. The IYY is being treated as a National Programme involving several ministries of the Government of India and all State Governments and Union Territories.

— YOUTH BULLETIN,
November 1984

favour of children. Nor is this a new undertaking; older brothers and sisters have long been accustomed in rural societies to caring for their younger siblings; what needs organizing, however, is their doing so systematically in groups to encompass children outside their families.

Young people have been identified as effective pre-school attendants or teachers. With some training they become active partners in the thrust toward more physically and mentally stimulating environments for children. Having more free time and often more education than adults, they have been successfully mobilized as assistants in immunization campaigns and child-weighing sessions, reminding parents to bring their children at the appointed hour, helping with the record-keeping and quietening screaming children. They utilize their creativity and energy to raise funds for favoured causes, often child-related. These take many forms—exhibitions, football games, dances, raffles and the like. Their involvement in child-related community activities not only has a direct effect on children; it also establishes in the youth themselves a satisfying pattern of community service that can well carry over into their adult lives. This period of apprentice-

ship, moreover, gives them practical training about children that will stand them in good stead when they themselves become parents.

Children's efforts

Perhaps the least recognised as a potential force for genuine development are children themselves. Since they are usually cast in the role of beneficiaries, their active contributions go unnoticed. Yet children's participation has value in its own right.

One of the most common sights in developing countries is that of the eight or 10 year-old child carrying a baby around or keeping a watchful eye on a toddler. Given the pattern of sibling care, one can build on it by training primary school children in the elements of early child stimulation and simple health and sanitation practices, like washing hands, brushing teeth, the proper use of latrines, and not bathing in polluted ponds.

Children can also serve as effective teachers at home. Some youngsters for instance have insisted on being given vegetables at meals, following school lessons. The concept of bringing children into the decision-making process in a manner appropriate to their early years

is not so far fetched as it sounds. Since children start working at home or in the fields at fairly early ages—tending the animals, fetching water and fire wood, cooking, cleaning and so on, surely in light of these responsibilities, their conscious participation in family and community matters makes sense. It is also good practice for adult life.

Everything points to the fact that people's participation in decision-making is the *sine qua non* of development. It is also clear that children play a key role in that process. They serve as the motivating force for improving family and community wellbeing. With a brighter future for their children as an incentive, parents strive to improve the environment for growth and taken new technologies and ideas in their stride. Women, especially, seek ways and means for children not only to survive but also to prosper in adulthood. No one can ignore the importance of youth involvement or indeed, children's participation in the process that is, after all, the very essence of development: people having a significant share in the decisions that affect their lives and forging a genuine future for their children.

—W. H. O.

Educating and training all road users, especially the young people, in safe driving behaviour is of utmost importance when we are looking forward to the progressive use of technology. Only a better understanding of factors involved in road accidents will help us in evolving an effective programme of road safety behaviour for the people. This we can do by re-establishing the missing link between accident prevention and primary health care policies.

YOUTH AND ROAD ACCIDENTS —Role of Health Education

DR H. C. AGARWAL

THE increasing industrialisation and urbanisation all over the world has resulted in the rapid growth of transport systems with greater movement of people and goods. The transport systems especially the road systems continue to grow both in the developed and developing countries as key element in economic and social development. In rural areas too, national highways are being built for high speed traffic with little thought given to the needs and problems of road users especially pedestrians and animals. Apparently this creates a chaotic situation which often results in road accidents.

Everywhere accidents are proving to be a major and increasing cause of injury which often result in hospitalization, disability and even death especially among the school going children, the young people and the elderly persons. It is said that for each death there are several hundred non-fatal accidents, and may be ten or so permanent disabilities.

But accidents are not always that accidental. There is something more to the accidents than mere failure of machine or man. Accidents follow the same pattern as any other disease, i.e., the host, the agent and

the environment. In case of road accidents the pattern is the driver, the vehicle and the road. There the most important factor is the perception and the behaviour of the road users—such as the observance of traffic signs, choice of speed and decisions on when to overtake or cross the road, etc. Apart from the children the others who are the prime victims of road accidents are the young people who sometimes take unwarranted risk which is considered to be the normal behaviour of their age. Young people have generally the pre-disposing factors leading to accidents. These factors relate to unawareness of risks, lack of experience, the urge to explore, adventure and thrill and a sense of self-esteem. Recently due to the emergence of youth cult the young people are fascinated by the idea of the motor-cyclist as a hero.

Mobike has become a symbol of sex-energy, ego consciousness and adventure into the unknown terrains.

The youth is gaining importance and is becoming a focal point of modern society, because of its increasing role in the socio-economic development. This phenomenon has gained attention in sixties when the youth

became a focus of society and the media. Healthy youth, today, is our best resource for our future development. Therefore, we are to bear in mind the disproportionate number of young people involved in road accidents and the resultant injuries and disabilities from which they consequently suffer. Of course, we are concerned with the growing burden on the already scarce health services and the economic loss to the nation but more so because the youth are our best assets. In this year of youth we are committed to develop our youth resource not only as a productive manpower but as an end in itself.

The problem of drinking and drug abuse, though universal, is more associated with the young people. It goes without saying that alcohol impairs driving ability and increases the risk of accident as well as the severity of its consequences. Driving under the influence of drugs and alcohol and the heightened emotional tension along with the social pressure to perform in a certain way contribute to the growth of road accidents. Of course, joy ride in stolen vehicles is an additional risk factor.

Prevention—intersectoral approach

How a number of individual and social factors interact and result in the occurrence in road accidents will focus our attention on this particular "Health problem of our age". This necessitates to identify the elements involved in road accidents and the need for educating the people in preventing the possible occurrence of accidents. Road accidents like any other health problem is preventable if proper and adequate information and education is given to the people. It calls for an intersectoral approach to both prevention of accidents and care of the injured. Education should begin with school children by imparting the knowledge about the road safety measures. The drivers need to be trained in proper maintenance of vehicles and safe driving. They are to be oriented to anticipate the behaviour of the road users. Young people need to be educated regarding risk factors, traffic rules and maintenance of their vehicles and safety precautions which they need to keep the death and disability off the road. The use of helmet may not be fashionable with some people but is a must for the drivers especially for the two wheeled vehicle driving. Two wheeled vehicles are increasingly playing an important role in the socio-economic conditions of the developing countries.

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The riders of this category of vehicles are more vulnerable to road accidents. There is evidence that suggests that a positive correlation exists between accident risk level and the severity of injury and the engine capacity of the vehicles.

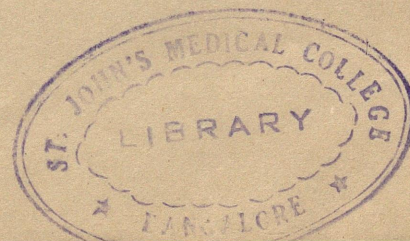
We need to exchange experience and information on the patterns and the magnitude of the road accidents within our country and identify the areas which require the preventive and educational steps. We are also to understand the local cultures and conditions so that training, rehabilitation and education efforts may result in an improved behaviour on the part of the road users.

Role of Youth

Youth have a special role to play in the case of accidents and emergency situations. Many a time a victim suffers because he is not attended to or taken to hospital or even prompt medical care/first aid is not provided on the spot. Youth is endowed with idealism which needs to be further kindled. Rendering help to a victim of road accident is not only a humanitarian act but also a social responsibility. Youth is to be prepared to fulfil its obligations towards the society and thus help in a noble cause. Young people should also be trained in first-aid and other such activities by which the time between the accident and the medical aid made available, is minimised. In this year of youth we are to utilise potential of youth and mobilise their resource for their active participation in creating an environment in which the accidents are prevented to the maximum extent possible.

Youth in India is a big force that contributes to various developmental activities including health. Hence, they assume greater responsibility in spreading the message to prevent/avoid accident. Particularly, in road accidents and emergency medical care, youth can play a significant role in giving a helping hand to injured persons involved in the accident by providing some first-aid, informing the concerned authority, calling ambulance, etc.

Road accident is not only a health problem, but it has its close relevance to socio-economic development. A large number of road accidents means a big loss to our productive manpower, i.e., youth which has its qualitative dimension too. Therefore, it is the respon-



sibility of all of us to help minimize the intensity of this problem. Therefore, a coordinated approach between various agencies such as health, youth welfare, medical, police/road safety, communication and voluntary organizations need to be developed.

Educating and training all road users, especially the young people, in safe driving behaviour is of utmost importance when we are looking forward to the progressive use of technology. Only a better understanding of these factors will help us in evolving an effective

preventive programme of the road safety behaviour for the people. Perhaps this we can do by re-establishing the missing link between accident prevention and primary health care policies looking forward to the Health for All by 2000 A.D.

(Based on the key-note address delivered on the occasion of inauguration of Medical Rescue and Resuscitation Course, on 19 January, 1985, at Vigyan Bhawan, New Delhi.)

SPORTS MEDICINE PROMOTES POSITIVE HEALTH

The family physician looking after sportsmen and athletes has an important role to play in preventive medicine, Dr C. M. Muthiah, Joint Director of the National Institute of Sports at Patiala, said at the annual conference of Indian Association of Sports Medicine held in Bombay recently.

By advising a sportsman on hygiene, diet and physical exercise, the family physician can reform dietary errors, check overweight, and help control smoking and drinking habits. This would enable the individual to reach his peak form of fitness.

Sports medicine, a relatively new branch of medical science, he explained, encompassed not only the clinical aspects but also physiology, biochemistry, orthopaedics, and biology. Sports medicine has evolved with related sports sciences like sports anthropometry, sports pedagogy and sports nutrition.

Dr Muthiah, explained how sports medicine could benefit both sportsmen and non-sportsmen in a number of ways.

The knowledge accrued from research in sports medicine can be applied to design physical exercise and sports for handicapped children which can be made a part of the rehabilitation and social reintegration programme. The programme for physical assessment can also be adopted for rural areas involving minimum expenditure and maximum time. The rural check-up for children could routinely include:

- a classical anthropometric/physiological checkup.
- a properly chosen index of strength.
- lung function tests.

- blood pressure.
- and E.C.G. if possible.

The record of the check-up must be accompanied by the previous case history and life style description.

The medical history of a top athlete should be recorded in a medical data card which would also contain results of periodic check-ups from school level up to the national level of sports competition. This would help in maintaining a proper record of the health and physical fitness of our top athletes, and he urged Indian Association of Sports Medicine (IASM) to take up this task.

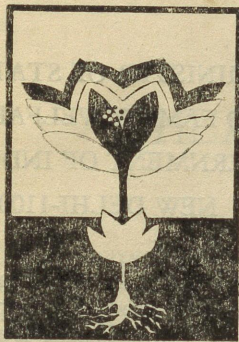
The National Institute of Sports at Patiala was contributing to promotion of sports by identifying some tasks for its field wing. These include:

- National coaching schemes at all levels.
- Development of rural sports.
- Development of sports for women.
- Development of university sports.

Dr Muthiah urged sports medicine doctors to contribute to the coordinated development of sports science which would eventually help to raise the standard of sports in the country.

The conference was inaugurated by Shri M. L. Apte, Sheriff of Bombay, and the papers presented were wide-ranging, covering bio-chemistry, medico legal aspects, psychology, arthroscopy, and nutrition in sports medicine.

— Medical Times
November 1984



Healthy youth: our best resource

THE WORLD IS WASTING ITS HEALTHIEST RESOURCE

1985 is International Youth Year. With one and a half billion people aged between ten and 24 there are more young people alive this year—as a proportion of world population—than there may ever be again.

In rich and poor countries alike, death rates are lowest for 10-24 year-olds. Their bodies are at their strongest to resist diseases that kill their younger brothers and sisters. The mortality rate for children under 10 in Thailand and Sweden, for example, is nearly twice that of 10-24 year-olds. Free of the shadow of childhood disease, healthy youth are, as the World Health Organization (WHO) puts it, “the world’s best resource”.

And their intellectual fitness has never been keener. Over the last two decades secondary school enrolment has nearly doubled in the developing world, while in industrialized countries 84 per cent of 12-17 year-olds are now in school. Progress in some countries has been startling, with 100 per cent of the USSR’s high-school-age youngsters in school by 1979 compared with just 49 per cent in 1960. And in that same period Malaysia, Jordan and

Peru all trebled their high-school enrolment rates.

Health and education: two major advantages that give young people a head start in the race towards a better future. And they need all the help they can get. Because they will probably have to undergo more changes in the next few years than any previous generation of young people. According to WHO, youth stands today at the point of transition. Not only will the young have to move from childhood to adulthood. But—with cities sprawling ever larger, television and radio networks encircling the earth, and roads and machines starting to push their way into every village—today’s young people also stand at the threshold between traditional and modern ways of life. Some will never have to step over that threshold. In many rural areas a young person’s future is already mapped out: for him the ploughing and planting; for her the hoe and the cooking pot—just like their parents before them. Their society will cushion their transition to adulthood, arranging their marriages, helping raise their children, measuring their use of alcohol and other drugs, and

teaching them the skills of parent and farmer.

But change is coming fast. And many young people are being swept along with it. Schools have come to the village; the first light bulb swings above the village store. Factories, offices, shops and cinemas beckon from the growing cities. Today three quarters of the world’s people live in rural areas. But by the year 2000 half the world’s people will live in cities. And many of those migrating to cities—between 20 and 40 per cent in rich and poor countries alike—are aged 15 to 24.

Changes of this magnitude—country to town, field to factory—leave the young very vulnerable. Cut off from the past, they can be blown in any direction. And their landing is unlikely to be a soft one. In the modern world the cushions of tradition and the extended family are gone, leaving young people to face new challenges with little support.

The most important thing is to find a job. Though they have health on their side, young people are

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MESSAGES

MINISTER OF HEALTH
AND FAMILY WELFARE
GOVERNMENT OF INDIA,
NEW DELHI-110011

Within next few years the number of young people will further grow with a visible impact on the social scene. They will be facing many challenges in the throes of the new emerging patterns of economic, social and political life with increasing stress on the individual and the family life.

Thus it is appropriate that the United Nations has declared 1985 as the International Youth Year (IYY). The theme—Participation, Development and Peace—is of special interest to India. We want to give youth the feeling of participation in the developmental activities which is possible only if there is peace on this earth.

The World Health Organisation has also chosen the theme for this year's World Health Day—7th April as 'Healthy Youth, Our Best Resource'. India is committed to achieve the Goal of Health for All by 2000 A.D. Our efforts thus should be directed towards this end with full recognition of the need for augmenting health care services for the young people, so that we can look forward to a healthy and prosperous India.

MOHSINA KIDWAI

MINISTER OF STATE
FOR HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA
NEW DELHI-110011

The year 1985 is the International Youth Year with the three basic themes: Participation, Development and Peace. By devoting the World Health Day—7 April, this year to the Youth, the World Health Organisation has emphasised the need of all round development of young people into a mature and healthy social being so that they are able to make responsible decisions.

They are our real future and offer it a new vision and a new hope. The theme 'Healthy Youth, Our Best Resource' is also appropriate as there is a need to create awareness about the importance of preparing young people not only for responsible parenthood but also for a healthy and responsible citizenship.

Our programmes for youth should strive for the active role of young people in promotion of national health programmes and of small family norm.

YOGENDRA MAKWANA

DIRECTOR GENERAL OF HEALTH SERVICES
NEW DELHI-110 011

The youth is an important and useful resource and wealth of any family, society or nation. Their participation in the development and prosperity is not only significant but vital. The youth is the hope of the future world and they are the pride of any society.

Let us all actively participate and join hands in various activities needed for bettering the life and future of our young people by implementing the programmes set forth during the International Youth Year, 1985, regarding organizing special health and welfare programmes for the youth, mobilizing youth power for national services and development, encouraging specially productive activities for the youth, providing sufficient educational and vocational programmes for the youth, reaching the disadvantaged youth, rehabilitating the disabled youth and preparing youth for responsible parenthood. The Youth Day in our country was observed on 12 January 1985—the birth anniversary of Swami Vivekanand. The International Youth Year is being celebrated by various Departments of the Government of India and States and voluntary agencies working for welfare of youth.

The importance of youth particularly healthy youth has been very well recognized in the theme of the world Healthy Day—7 April, 1985, i.e., Healthy Youth—Our Best Resource. The theme itself brings out the importance of the youth for the development and progress of mankind as being our best resource. But we should not miss the point that it is the healthy youth which can deliver us the goods. All of us have to actively participate in the welfare programmes for the youth.

DR D. B. BISHT

SWASTH HIND

HEALTHY YOUTH FOR STRONG INDIA

—RAJIV GANDHI

"The country needs a continuous push and the youth must give it" said Prime Minister Shri Rajiv Gandhi while launching the "Year of the Youth" by inaugurating the National Youth Forum on "Youth for Unity and National Integration" on 12 January, 1985 at New Delhi.

Incidentally, 12 January this year also happened to be the 122nd birthday of Swami Vivekanand.

The Prime Minister said the country was proud of its youth and their capacity to rise to meet the challenges facing the country and produce positive results. They have proved it in the past, but what is lacking in the youth is that they tend to be very happy to rise to a certain level and then "seem to start relaxing thinking I have done my bit". They must clearly know that "it is the final spurt that really makes the difference". He noted that "we have to rise above parochial, caste, religious differences, regional differences, linguistic differences and then build a united, strong India."

He said the country had in recent weeks seen a new surge in the youth of the country. This must be strengthened and carried forward. The youth "is always impatient—impatient with procedures, wanting results—and we must work hard towards this."

It has now to be seen that new programmes brought in were such that they build the youth, build the character of the youth and in that character they build Indian culture, Indian traditions, Indian values. "We have to see that the physical strength, physical condition of our youth, is improved."

"As Vivekanand said, it is not just the mind, but the mind must be supported by a strong body and that is very essential. We have to concentrate on how we can build our youth physically and make them really winners in whatever field they participate."

The Minister of State for Youth Affairs and Sports, Shri Jaichandra Singh, said January 12, the birthday of Swami Vivekanand, would be celebrated as National Youth Day every year. △

MESSAGE

HEALTHY YOUTH : OUR BEST RESOURCE

DR HALFDAN MAHLER

DIRECTOR GENERAL, WORLD HEALTH ORGANIZATION

KICKING UP dust on a make-shift football pitch in a Brazil village; running races through the Kenya bush; wrestling in a Bangkok tournament; or breaking world records in the Olympic games: young people's sporting achievements testify that theirs is the age of peak physical fitness.

In 1985, International Youth Year, the world will harvest not only its biggest, but also perhaps its best crop of young people in history. Today's young people are the healthiest age group and are better educated than ever before. Having survived the vulnerability of childhood years, they are intrinsically healthy and,

over last two decades, school enrolment has nearly doubled in the developing world, though they are mainly boys on the school benches.

With better access to the world's store of knowledge, young people are able to grasp and use new ideas. In many countries there are young faces that are staring at the flickering green computer screens, young fingers that are moving like lightning over the keyboards, or creating new circuitry that will itself create new computers.

The potential of youth, if it is to be properly tapped, requires understanding and support. Youth is a

very special time with special challenges. This is the period when the body changes from that of a child to that of an adult. It is an age characterized by impatience as well as curiosity, and by a strong desire to leave childhood behind and play an independent role.

More than three-quarters of those between 15 and 24 live in the developing world, and that proportion will probably reach 84 per cent by the year 2000. Thus the challenge is greatest there. A major trend is for youngsters to leave the countryside and migrate to the city in hope of a better life. This erodes the traditional structure of the rural family

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handicapped by their lack of experience. In the queues of people waiting for jobs in many countries it is young hands that are left idle, with 15-24 year-olds accounting for 70 per cent of the unemployed in Syria, 67 per cent in India and 60 per cent in Ghana.

And in many countries the situation is getting worse. In urban Sri Lanka, for example, the two most recent government censuses revealed that unemployment among young men doubled, and among young women it trebled, in the eight years between 1963 and 1971. Little wonder that finding a job becomes an obsession. Anxiety about employment is the subject that most concerned 15 year-olds in the United Kingdom. Their other main worry is exams. And it's not hard to see why. In Latin America, for instance, years of education are directly linked to the chance of a job, with nearly three times as much unemployment among young people without schooling compared to those who completed high school.

Some countries have been making valiant efforts to harness the energy of their young people, realizing that they are, as WHO puts it "the most productive human asset of family and society". China, for example, has found jobs for 29 million people—that's three-quarters of the urban employed—in the last five years. In Shanghai alone, one million new jobs have been created for young people since 1977.

Though many fail to find space within the formal system, the majority of young people in most countries do eventually carve out a niche for themselves; behind a charcoal brazier roasting bananas for sale on the teeming streets of Manila; dodging in and out of the traffic, selling newspapers in Chicago; or bending in oil-stained overalls over the open bonnet of a broken-down car in Lagos.

Most find a way of making a living. But few find an occupation that makes the most of their skills, creativity and potential. In this sense education is a mixed blessing. Often it simply turns young people away from the countryside and gives them aspirations they will never be able to fulfil. Disappointment and frustration, laced with the pressures of modern city life, make a bitter brew to drink.

And, in their search for comfort, self-expression and excitement, many of today's young people risk destroying the good health that is one of their most important assets. The proof is in the statistics. In some countries the healthiest age group—10-24 year-olds—is the only age group in which mortality rates are actually rising. This rise is not due to the infectious and parasitic diseases that help fill the graveyards of the developing world. No, the things that are killing today's youth in increasing numbers are the ills of modern society: traffic accidents, suicide, drug and alcohol abuse.

Accidents are the leading cause of death of young people in the rich world, accounting for half of these deaths in the United States of America. And they're a growing threat in the developing world too, causing one quarter of deaths to 10-24 year-olds in Paraguay, for instance. Suicides are also claiming an alarming number of young people—16 per cent of deaths in Japan and 6 per cent in Thailand for example.

A picture seems to be emerging : of youthful energy thwarted and rejected, of youthful potential wasted. "Adolescents are able to shape their own health patterns as well as those of the next generation", says WHO, but acknowledges that health is not simply a question of doctors and hospitals. Health is about people having control of their lives, being able to explore their full potential. This potential goes beyond the health of the individual to the health of the society in which they live. The idealism and energy of youth can also provide the drive for more social justice, better care for the elderly, more concern for the environment, to quote but a few examples. Young people have shown that they want a better, healthier future. They've studied for it, have often left home for it, have queued up waiting to work for it. They are, as W.H.O. says, "our best resource". And a resource the world cannot afford to waste.

—W. H. O

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and replaces it with the stressful lifestyle of marginal populations living in urban slums. Young migrants are forced to face the challenges of city life without the training or skills that they need. The unemployed in many parts of the world include a very high percentage of young people—many of them illiterate, most of them unskilled and inexperienced. The dice are already heavily loaded against them.

If age is characterized by caution, youth is characterized by a love of risktaking. Such impulses can be guided to take positive

forms—sport, outdoor adventure, social experiments—rather than towards the negative habits of cigarette smoking, abuse of alcohol or dependence on other drugs. Society must also take into account the elements inherent in the spirit of youth, including the urge to seek self-identity and to find an outlet for one's love for others.

The young have a large role to play in health care: they themselves are most aware of their own health problems; they maintain an open mind and represent the group best able to appreciate the basic tenets of primary health care, beginning

with the responsibility of caring for themselves.

Studies have shown that a majority of youngsters went to help others and want to assume responsibility. A good place to start may be with national community programmes that demonstrate how to keep fit and achieve a healthy lifestyle.

On World Health Day 1985, in the drive towards health for all, every community should take stock of its youthful resource and nurture it for all its promise. The joyous and explosive energy of youth and its natural curiosity are there to be exploited to build a better world.

△

Referral system, which necessitates a two-way flow of beneficiaries, staff and equipments between different levels of care will have its major contribution towards achieving the better coverage of services in rural areas.

REFERRAL SERVICES AND PRIMARY HEALTH CARE

DR (SMT) INDIRA MURALI

and

L. B. S. DEY

WITH the advances in technological development in the field of health, coupled with the increasing community awareness towards health care and the scarcity of resources, the health administrators today are faced with many challenges. Increasing accessibility of health services to the majority of population, improving utilisation of services and thereby ensuring the effective use of scarce resources invested in rendering them, meeting basic as well as specialised health needs of all, most of the time, in least costly manner, and correcting the imbalance in distribution of resources in different population groups are but a few challenges among them. Primary health care approach adequately supported by an effectively functioning referral system is probably one of the means to meet these challenges. Significance of referral services in relation to comprehensive health care cannot be over emphasised. Referral service in medical care has been defined as a "system by which patients—while undergoing treatment by a doctor of the patients' choice or at a place of the patients' convenience—are

given facilities from the hospital to avail the specialised consultation, medical care and ancillary services wherever required. The cardinal feature of referral system is that the individual continues to be the patient of the doctor whom he consulted first".¹

In most of the countries, including India, a pyramidal structure is accepted as the model for delivery of health care in which referral service at successive levels is provided. In rural India, primary level health care is rendered by health guides, *dais* and multi-purpose workers at the community level, with support from Primary Health Centres (PHCs) and secondary and tertiary level care by referral hospitals or community health centres, sub-divisional/taluk hospitals, district hospitals and teaching hospitals. It is important that at various levels of care there should be a proper balance between nature of health problems and the corresponding contents of care required and this would be possible only with the appropriate combination of personnel and facilities at each level. In many countries like India, services have been over

concentrated in the urban areas which make it extremely essential to divert attention towards improving coverage of services in the rural areas. Referral system, which necessitates a two-way flow of beneficiaries, staff and equipments between different levels of care will have its major contribution towards achieving this purpose, i.e., better coverage of services in rural areas.

Referral process

In the context of primary health care, ideally, the referral process involves, referral by the primary health care workers of those cases who require more competent medical attention, to health centres or first line hospitals which in turn will send their cases for medical advice to the higher and more specialised health care facilities if needed. Alternatively they will be visited periodically by medical specialists from the higher echelons. In certain situations diagnostic and treatment equipments can be obtained on loan to these lower level institutions in order to provide better care for their patients. After diagnosis or treatment, the specialised referral institutions send back cases with case reports to ensure continuity of follow up at the peripheral level.

Importance of referral system is in its distribution of health care facilities in a manner that beneficiaries can get maximum service promptly and without overcrowding or stress on the health care delivery system at any one point of care. Efficiency of a referral system will depend on the quality and quantity of services rendered, which in turn depends on adequacy of facilities available at different levels of care.

Development of referral system in India

The recognition of the need for a good referral system by the authorities in order to make best use of the scarce resources and to provide competent/specialised services to the most needy, is not very recent in India. Since independence, over the different five year development plan periods health authorities have made efforts to improve the health care delivery system and to establish good referral services as one of its inbuilt components. However, Government's anxiety in this direction has been reflected more by

way of recommendations of different expert committees rather than in actual implementation. While some of the committees examined the problem at micro level, e.g., Gilder committees in 1952 for the State of Delhi,² majority were concerned with the issue at a macro-national level. Among these, recommendations made by Jungalwalla Committee which defined functional and operational levels and their responsibilities in referral, and discouraged excessive specialisation;³ A. P. Jain Committee which recommended regionalisation of specialist services with adequate laboratory and diagnostic facilities; development of district hospitals into fullfledged referral hospitals to overcome the deficiency in number of teaching hospitals, flexibility in referring cases to suit the condition of patients, mobile team of specialists to visit sub-divisional hospitals and PHCs at regular intervals to guide the practitioners at these levels, etc.⁴ and Srivastava Committee which recommended the three tier system of national referral complex⁵ are worth mentioning.

Side by side, in successive five year development plans of India, in the field of health, the programmes were also aimed at development of referral services by removal of deficiencies in district and sub-divisional hospitals and by providing specialists' attention to common diseases in rural areas. However, these efforts attained high priority during the Fifth plan period wherein under rural health programmes it was proposed to have one sub-centre for 10,000 population and to upgrade one out of every 4 PHCs to a 30 bedded rural hospital with selected speciality services like medicine, surgery, obstetrics, and anaesthesia, as first link in the chain of referral services.⁶ According to the Sixth five year plan, as against the earlier policy of setting up upgraded rural hospitals, Community Health Centres were proposed to be established, each covering 1 lakh population with 30 beds and specialised medical care services in surgery, medicine, paediatrics and gynaecology and obstetrics.⁷

More recently, the sub group of the Working group on Health for All by 2000 AD constituted by the Ministry of Health and Family Welfare⁸ also emphasised the need for support of Primary health care by an effective referral system and made recommendations pertaining to operational details for more effective implementation of referral services.



Efficiency of a referral system will depend on the quality and quantity of services rendered, which in turn depends on the adequacy of facilities available at different levels of care.

Selected issues and suggestions

Thus one can find that there is no dearth of knowledge regarding need for referral services or about the essential characteristics of a good referral system. However, there are various issues related to its operational aspects which need to be examined if an effective referral system is to be established. Some such issues are:

1. Need for clear and specific operational guidelines

Even though for the rural health services, the levels of care have been defined, there is lack of clear under-

standing about roles and responsibilities, and limitations of each category of health personnel at each level of care. There is need for standard procedural instructions and guidelines regarding referral of cases for each category of personnel. For instance, in case of referral of an under-nourished child, there is need to define (a) what level of competence is needed for each category of personnel,—i.e., *dai*, Health Guide, Multi-purpose Worker (M&F) and Health Assistant (M&F) for, say, detection and management of malnutrition; (b) at what stage the case needs to be referred and to what source and for what purpose; (c) criteria or circumstances under which referral is to be made; (d) what degree and type of management of the condition is permitted for each category of staff; etc. Similar details are to be worked out for all the common conditions/health problems likely to be encountered in the field.

2. Level of technical competence of personnel

Another area which often gets least attention is the development of required level of competence in health personnel, which is to be attained through training and experience under supervision; broadway of defining roles and responsibilities leave training also insufficient and vague. Details about training, i.e., contents and methods should be worked out after considering the specific job responsibilities and there is need to ensure that corresponding to the level in the referral hierarchy, the technical competence is also strengthened.

3. Adequate resources and their standardisation

In many a situation the hindrance in rendering the desired level of care is not the lack of technical competence alone but also the want of adequate resources of the desired nature, i.e., equipments, drugs, supplies, etc. Just as in case of developing technical competence to meet graded level of care there is a need to develop standards for requirement of resource items, their nature and quantum according to the level of care expected to be rendered.

Further it is essential to ensure their availability at the right time, in right amount and in desired condition.

To illustrate the above aspects consider the case of an Auxiliary Nurse Midwife. If she is expected to refer high risk pregnancy cases, e.g. with high blood

pressure, there is need (i) to specify this while deciding her roles and responsibilities, (ii) to develop her technical competence in checking Blood Pressure by training, and (iii) to ensure that a Blood Pressure apparatus and stethoscope in working condition are made available at the work station, *i.e.*, sub-centre, (iv) to prepare and disseminate standing instructions and operational guidelines to this effect.

4. *Need for coordinated development of services in urban areas*

While in general terms it might be correct to say that development of health services in India has been urban oriented, it is not so in case of referral services. For the rural areas, the personnel at different levels of care and referral institutions at different levels have been identified, even though vaguely, as indicated above and are still not being implemented successfully. However, the urban population particularly in major cities are covered by multiple health care agencies with certain amount of overlapping and duplication of services in certain areas, and with total lack of attention and care in certain other areas, particularly slums. Apart from some sections of population covered under Defence Services, Railways, Central Govt. Health Scheme (CGHS), Employees State Insurance (ESI), etc., who enjoy benefits of varying degrees, in relation to referral services, the vast majority has no such clearly defined services. The time has come to reconsider our false contention regarding urban health services and there is need to achieve coordinated services from different services agencies.

5. *Need for regionalisation*

To have an effectively functioning referral system there is need for regionalisation with certain amount of restriction on the individual's entry point into the health care system. In the absence of this, there is likelihood of the lower-echelons being bypassed resulting in overcrowding and extra work load at higher levels of care. While in some systems like Armed Forces and CGHS there has been an implied restriction on the beneficiary's entry point into the health care system, in other systems of care either in urban or rural areas, people are free to make their own choice of entry point thereby resulting in under/over utilisation of certain service facilities. Whether this should

be restricted is a debatable issue under the current socio-political milieu in India. At least effort should be to minimise chaos resulting from this practice. If good quality service is made available at peripheral levels and if the community is convinced about it, probably this practice might be reduced.

6. *Need for proper documentation*

Issues specifically related to referral process include lack of proper documentation system either by way of issue of proper referral slips (with all needed items of information about the case to enable the specialist/higher competent authority to take necessary decision without delay) or by way of maintaining records regarding volume and nature of referral at different levels of care to enable follow up, etc. It is needless to emphasise the usefulness of proper referral slips in identifying the referred cases at the referral institution; in serving them promptly if purpose of referral is properly recorded in the slip and for proper follow up action if duplicate slip is maintained at the referring institution.

7. *Need for proper explanation to referred patients*

There is generally no mechanism to ensure that a referred case really utilises that service and to find out the reason in case they have not used it. A clear explanation of the purpose and importance of the referral to the patient would go a long way to ensure effective use of service, *e.g.*, explanation regarding importance and urgency of a diagnostic or therapeutic procedure for the benefit of the patient. Further, a clear explanation to the patient regarding time, and place to report and the need for special precaution if any to be taken before reaching there, *e.g.*, empty stomach before some investigations, etc. is extremely important to help the case.

8. *Lack of continuity of care*

Ideally it would be better to have continuity of care from the same source of service including the person who renders service even after referral of a case. Under Indian set up of health care where no specific attachment for individuals to a specific source of primary care exists, (as in UK with general practitioners) this is not feasible particularly in urban areas.

9. *Need for follow up of referred cases*

Follow up of referred cases or even other cases like family planning acceptors, patients suffering from chronic diseases, etc., has been a major issue in health care delivery both in urban and rural areas in India. Eventhough the primary care workers like health guide, *dai* and Multi-purpose Workers are expected to do the follow up of cases as per their job descriptions, the efforts to operationalise this have been meagre. Isolated efforts to arrange for such follow up of referred cases have been reported, e.g., referral at Raipur Rani Block in Haryana¹ and under MMT (Mobile Medical Team) scheme in Tamil Nadu². But in general, once a case is referred by someone the usual tendency has been for them to get lost for long periods. This is also closely linked with the process of 'referral back' of cases from specialised institutions. They should send the case back to the referring institution with needed instructions and advice.

10. *Priority attention to referred cases*

A case referred from one level of care requires the needed attention due to him/her at the referral institution. What generally happens in our current health set up is that once a case is referred from a Primary Health Centre (PHC), to say, a district hospital, he/she is not given any priority attention over the rest of the routine cases attending that institution. Opening separate counters for referred cases only, under different hospital departments/specialities, earmarking a particular competent officer of a senior rank to attend to only referred cases etc., have been tried in isolated situations. The working group for Health for All by 2000 A.D., constituted by Government of India has recommended that some institutions like District hospitals should be earmarked as purely referral institutions where only referred cases (and no primary care cases) are attended to.

11. *Adequate transport facilities for referral*

Transportation of referred cases particularly emergency/serious cases generally poses problems. Non-availability of official transport in working condition, inadequate provision for POL, lack of clear official instruction regarding use of transport for different purposes, etc., are some of the reasons for this. While steps to smoothen such situations should be initiated from the government side, it is worthwhile to consider

active involvement of the community in this regard. The steps like convincing the community about the importance of referral and need for its support through transport facilities, making them aware of their role and responsibility towards their own health care, helping them in organising locally suited transport system—village based or sub centre based, and enabling them in its effective management, etc., need to be initiated by health staff.

12. *Referral—a means of continuing education and supervision*

Apart from the service to the needy, referral service need to be considered as a means for continuing education for health staff too. Rather than confining to one way (upward) movement of cases for availing special care at centralised institutions, efforts to mobilise the specialised care (personnel and selected facilities) towards peripheral areas need to be made. There are various advantages from this; (a) the specialists get opportunity to observe the average service conditions and constraints under which generalists function, (b) they can guide and educate the generalists regarding appropriate management of cases suited to the resources and facilities at that level and even discuss about already referred cases and their management, (c) more opportunities for mutual interaction between specialists and field personnel, (d) extension of feasible diagnostic and therapeutic facilities towards periphery, and (e) above all the referral institution and its staff will be able to perform their supervisory responsibilities—guiding, controlling, etc., more effectively.

The issues mentioned above are only a few among many which need to be considered for implementing a good referral system. Even for these there is a need for coordinated effort from the health administrators (technical advisors and executives), clinical specialists, trainers (educators for medical, nursing and para-medical staff) and the community itself.

Instead of leaving the recommendations made by experts for improving referral services just at conceptual level, a time has come to initiate the translation of these concepts into action. For this the administrators, service givers and trainers should work together in order to decide on the operational details in

terms of guidelines and standing instructions for staff as well as to assess resource requirements and finding out mechanisms for their procurement, etc., for the different levels of care. Incorporation of the details regarding criteria of referral and procedures involved in the training of different categories of personnel is imperative in addition to the added emphasis on developing appropriate technical competence of personnel.

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LIVER TRANSPLANTS IN YOUNG PEOPLE

SURGEONS are rapidly increasing the success rate for liver transplant operations in young people under 21. Until recently they had been reluctant to do such operations on young patients because of the side-effects of drugs used.

Typical figures published for such transplants in 1982 showed that a 57 per cent survival rate was then being achieved among patients less than 18 years old. In this case it represented 16 survivors out of 28 young people given a new liver.

New figures published by hospitals in London and Cambridge carrying out a joint programme show that the predicted one-year survival rate has risen to 75 per cent. Surgeons at King's College Hospital, London, and Addenbrooke's Hospital in Cambridge say: "A most encouraging feature to emerge from this series was the excellent results in the younger age group."

The new review covers operations on 26 patients in the year ended 31, July 1984. Ten of these involved patients aged between two and 20, and at the time of reporting nine were alive. In the older age group, seven of the 16 patients were alive.

In their report to the British Medical Journal, the surgeons reveal that since the two-hospital programme started in May 1968, a total of 167 people suffering from liver disease have been treated with transplants. During that time there had been many changes in operating techniques, methods of choosing patients and drug treatment to stop the body rejecting the new liver.

More donor organs are now being made available and this has made it possible to give some patients a second new liver when the first transplant has failed. The transplant team has also been successful for the first time in transplanting a donor liver in two patients who had suffered severe liver failure. Of the latter development, the team reports, "Our current experience gives considerable hope for a greater use of liver grafting in these very severe types of liver failure."

The problem of side-effects of long-term steroid drugs given to young liver transplant patients is being overcome by wider use of the new drug Cyclosporin A. British scientists have played a major part in developing the application of this anti-rejection drug.

—BIS

HUMAN SETTLEMENTS IN DEVELOPING COUNTRIES

RAMESH CHANDRA

The population explosion in India during the last five decades has generated high density urban settlements and also led to the formation of slums. The Seventh Five Year Plan lays emphasis on the development of human settlements in a balanced manner.

This article analyses problem areas encountered in the planning of balanced urban settlements and suggests coordinated projects for successful implementation.

THE growth of urban human settlements in the world, which has taken place during the last decade and which is projected to take place till the turn of the century, i.e., the year 2000, is phenomenal.

While the world population is estimated to increase by 1500 million, more than three-quarters of the increase, i.e., 1200 million people will be added to urban human settlements in more than 15 years. It has been estimated that in the developing countries, the percentage of the population living in urban settlements will rise from 28 per cent (1975) to 44 per cent.

In numbers this signifies a growth from 830 million to 2150 million. In Africa, the urban settlements are expected to double their size from 160 million to 350 million. In Latin America 75 per cent of the population (455 million) would be living in urban settlements by the year 2000.

In 1950 only two cities in the developing countries had over five million inhabitants. In 1980 there were 26 cities with a population of five million or more

in the world of which 19 were in developing countries. By 2000 A.D., if the present trend continues, 58 cities of the world will have a population of five million or more, 44 of which will be in developing countries. It has been estimated that the population of slum and squatter settlements in urban settlement areas is increasing at twice the rates of growth of population of the cities. This is four times faster than the world population growth.

Spurt in urban population

In our country, total population has grown from 279 million in 1931 to 684 million in 1981. The annual growth rate which was 2.16 per cent in 1951 to 1961 increased to 2.48 per cent in 1961-71, but declined to 2.46 per cent in 1971-81. In terms of growth of urbanised human settlements, India is by no means a highly urbanised country.

According to 1971 census, about 20 per cent of the total population resides in the urban areas and the remaining 80 per cent lives in rural settlements. This proportion has further increased to about 24 per cent according to the 1981 census. However, in absolute numbers, the total urban population living in urban

settlements comes to 156 million which is large enough by any standards. There are 12 cities of million-plus population and more than 200 cities of population between one lakh and 10 lakhs in the country.

The results of lack of attention to the planning of human settlements are becoming obvious day by day. The unplanned and un-regulated growth of human settlements is leading to the springing up of large slums and concentration of squatter settlements. This is creating a rural-urban divide resulting in inter-personal differences and inter-regional imbalances. This is also leading to environmental degradation, depletion of resources, breaking down of services and accentuation of the problem of urban renewal and environmental pollution.

There is a close connection between the unplanned human settlements and the problem of poverty. Poverty is the biggest problem of the Third World. Approximately, two-third of the population of the developing countries, i.e., about 1.2 billion people live below the poverty line and of these 700 million could be put under the category of destitutes. Lack of proper housing is an important dimension of poverty. Approximately, one-fourth of the world's population does not have adequate shelter and live in extremely insanitary and unhygienic conditions. More than 50,000 people die of malnutrition and disease every day. One hundred million people have no shelter and sleep on streets, pavements and open spaces.

From this background emerges the supreme necessity for a basic policy framework of human settlements. The policy may undergo change due to local variations.

A "Settlement Pattern" has to be evolved with accent on proper land use, growth with social justice, employment opportunities and curbing of migration to high density metropolitan areas.

Planning with eco-balance

The planning of human settlements raise certain issues the solution of which requires research and development efforts on continuing basis. Pattern of human settlements has to be such which is comparatively free from natural hazards. A large part of the world faces the risk of one natural hazard or the other. It may be floods, storms or earthquakes.

A satisfactory human settlement policy must take into account these natural hazards and evolve a strategy of building up protection measures against these natural hazards. It may be worthwhile to attempt the formation of a National Plan of Human Settlements mapping the entire land mass of the country in the various regions of optimal growth or density of population. The need for conservation of scarce resources including energy while planning human settlements needs no emphasis.

The problems faced in planning of human settlements particularly in developing countries are lack of cohesion and linkages of the plan, inadequacies of outlays and the lack of effective machinery.

Emphasis in seventh plan

It is a matter of satisfaction that the approach to the Seventh Five Year Plan in India has placed emphasis on the development of human settlements. It has emphasised that the need for shelter or housing has emerged as one of the most important felt needs of the country, perhaps next only to food. With regard to the provision of shelter which is an important dimension of human settlements, the approach of the Seventh Five Year Plan says: "If a further deterioration in housing shortage is to be prevented and shelter is to be provided to the net addition to population, the number of houses required to be built would be at least 17 million during the Seventh Five Year Plan period".

This is a colossal figure and nothing short of a major national programme of housing development can hope to tackle it. The approach of the Seventh Plan also highlights another important dimension of human settlement that of urban growth. It is recognised that provision of shelter cannot be developed significantly without infrastructure primarily consisting of electrification, water supply, local roads, sewerage and garbage collection, etc. In the Seventh Plan it has been envisaged that the process of urban development will be spread out over 12 metropolitan cities of million plus population, more than 200 cities of population between one million and one lakh, towns with population between 1,00,000 and 5,000 and small rural urban centres.

The national and central financial institutions and banking structures should be involved more actively

SWASTH HIND

It is a matter of satisfaction that the approach to the Seventh Five year plan in India has placed emphasis on the development of human settlements. The need for shelter or housing has emerged as one of the most important felt needs of the country, perhaps next only to food.

in the process of lending funds for the growth of human settlements. With a view to ensuring a smooth flow of adequate finances there is a need for a central financing organisation at national level for extending assistance for projects and schemes for settlements, particularly in urban areas.

The year 1987 has been declared as the International Year of Shelter for Homeless by the United Nations Organisation. The task of ensuring proper growth of human settlements in developing countries is a colossal one. This necessitates development of a system of International cooperation and understanding.

The involvement of international organisations with regional and sub-regional units will quicken the pace of implementation of the programme.

The need for international cooperation and exchange of expert experience and research findings will be felt more in the areas of developing low cost sanitation, cheaper and more effective system of sewerage and the use of substitute material and energy saving. This is not a problem of developing a few pockets or islands in selected countries; this is linked with the far wider problem of the growth and sustenance of the civilization itself. Δ

CHANCHAL SINGH MEMORIAL PRIZE 1985

The Tuberculosis Association of India will award in 1985 a cash prize of Rs. 1,000 to a medical graduate, preferably below 45 years of age, for an original article not exceeding 30 double spaced foolscap typed pages (approximately 6000 words), excluding charts and diagrams, on any aspect of Tuberculosis (in which he or she is specialising or has worked) adjudged best by a Special Committee of this Association. The article sent in for this competition should be original and it should be certified that it has not been published elsewhere. **Article or paper already published or based on work of more than one author will not be considered for this Award.**

Those interested may send their article in **quadruplicate** to the Secretary-General, Tuberculosis Association of India, 3, Red Cross Road, New Delhi-110 001, to reach him on or before 31 July, 1985.

YOUTH AND PARTICIPATION

WHO's goal, Health for All by the year 2000, and the aims of the International Year of Youth 1985 are closely linked. Both recognize youth as a resource for health. Young people have special health problems, but they also have the energy and imagination to deal with many of them if they are given the means.

Developing countries today contain 74 per cent of the world's population between the ages of 15 and 20. It is not only fair and sensible that youth be given responsibility for its health; it is absolutely essential. Young people provide insights about their own health in a way most health professionals can't. Young people can provide information about how they act in regard to drinking, smoking and the use of illegal drugs. What they actually think and do is a vital ingredient in any movement to promote health.

The effect of young people's ill health can last far into later life. Accidents are estimated to disable—permanently—three times as many people as they kill. Smoking and alcohol abuse can store up "epidemics" of respiratory disease, liver damage and cancer for middle age and beyond. Teenage pregnancy can kill mother and child and, even if they survive, babies born to teenage mothers may be physically or mentally handicapped.

Spreading the word about health risks is another way young people can make their generation healthier—provided they are given the information. Young people can counsel each other when trained and given support. Risk-taking need not find destructive outlets. Music, painting, writing, all the arts, and physical exercise can encourage fitness and healthy lifestyles. In sports, exploration, even social development and politics, idealism and daring are needed—and youth can provide them.

Young people have shown they want to pitch in and help others. A nationwide poll in England in 1984 showed that 78 per cent of youth favoured a voluntary scheme for community service. The young can help the aged, the chronically ill, the disabled. WHO's Rehabilitation Unit has pioneered a service in some 25 countries where young people act as local supervisors and motivate, instruct and guide the young disabled and their families. With training, the young can take part in screening people for health programmes and also provide paramedical help. They can support health services in the field by delivering messages and supplies where most needed. Providing health care can be an adventure.

Other youth organizations of all kinds are dealing with agriculture and development schemes. And they can tackle tough social problems too. Jamaica, for example, has one of the highest teenage pregnancy

rates in the Western hemisphere. However, it was not the physical dangers of immature child-bearing that the women concerned saw as their main problem. More important for them was the fact that pregnancy leads to expulsion from school—and reduces their chances of employment. So, instead of just providing contraceptive services, the Women's Centre Project has concentrated on vocational training and lobbying the Ministry of Education—resulting in a more lenient attitude, enabling young mothers to complete their education. Up until 1982, some 70 per cent of the 425 women attending the Centre had found places in further education and only 19 had become pregnant again.

"The Door", a social agency for youth in New York, also responds to young people's needs—as the 400 young people who cross its threshold each day readily testify. Martial arts are one of the main attractions: an example of a positive rather than negative attitude to health. The vigorous training that most martial arts entail ensures that participants give up smoking—of their own accord. And young people who would not normally seek out health services specifically are brought into contact with them when they take advantage of the other facilities. Perhaps even more important, many of those who come regularly through "The Door" have stayed to help provide the services themselves, getting involved in workshops and eventually becoming counsellors to new arrivals.

The success of "The Door" stems from its understanding that, as WHO says, "many of the health issues faced by young people are strongly influenced by social, economic and behavioural factors". Encouraging the world to look on its young people positively as a resource instead of as a problem is one of the major aims of International Youth Year. Of its three themes—"Participation, Development, Peace"—participation comes first. And rightly so. If the energy and ideas of the young can be attracted to health programmes, then change will follow. The WHO Study Group on Youth noted: "When young people have an active role to play in a health service there is a ripple effect. The shape of the health service changes. There is a redistribution of power and roles are blurred. Youth consultation allows for the concept of the "expert" to become demystified and professional jargon starts to disappear".

But the effects need not be confined to the health sector. As Mexico's President Miguel de la Madrid said of International Youth Year: "The need of the hour is to give even greater encouragement to the involvement of the young in national affairs, because we are convinced that their presence acts as a kind of oxygen improving the health of the nation".

—W.H.O

KALU GETS INTO TROUBLE

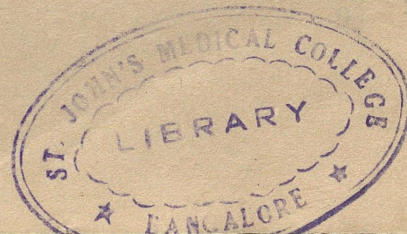
DR R. L. BIJLANI

KAVITA was fond of toys, and she had plenty of them. She kept them neatly arranged on a few shelves in her room. On one shelf were dolls of all types. Kavita called her dolls by the names she had given them. Geetha, a doll in a bright purple saree, had been presented to her by her father's friend who had come from Madras. Another doll, Rani, was dressed up in a drum-shaped skirt, all ready for a Manipuri dance. Then there was the naughty looking Raju who clapped his hands every time you pressed his tummy. Nancy was a fair-skinned, golden-haired doll which Kavita's auntie had sent from America. Nancy had shifty eyes which seemed sleepy when she was lying down, but were bright and alert as soon as she sat up. Kavita's newest doll was Chameli, who was churning some *lassi* in a pot. She brought it from Jaipur during the last winter holidays. On the second shelf in Kavita's nursery were some animals. Kalu was a hairy bear; Monu was a monkey with a long tail. Lamboo was a giraffe who seemed to be very proud of his neck. Softy was the naughty rabbit which Kavita got on her fifth birthday. There were also several other toys in the nursery—an aeroplane, a drum, a bat, and several balls and marbles. Kavita's favourite toys included some dry pods, cold drink caps, toffee wrappers, smooth stones and shiny pieces of coloured glass which she had collected from the roadside.

Kavita looked after her toys very well. She dusted them often, and always kept them at their proper places. But there was one thing Kavita did not know about her toys. Every night, after she had gone to bed, the toys came alive. They talked and played,

and sometimes, they also quarrelled. Raju would sit on Lamboo's back and clap, and Kalu and Rani would dance. Monu was very fond of climbing up and down the shelves, and would even sit on Kavita's chair and pretend to read like her. Nancy liked to stroke Softy to sleep, and sometimes while doing so, she herself fell asleep. There were two things, however, that all the toys loved the most. One was to press Raju's tummy and make him clap. The other was to get a glass of *lassi* from Chameli. Geetha kept a watchful eye on all the toys, and saw to it that they were all back to their proper places before it was time for Kavita to get up.

One night, the toys were playing as usual. Kalu was in a naughty mood. He quietly pulled at Monu's tail and quickly got away. When Monu looked back, Kalu just looked the other way. He did it again, and when Monu looked back, Kalu gave such an innocent look that nobody could suspect him. This continued for some time, but finally Monu caught him. He told Kalu to behave himself. But Kalu was in no mood to listen, and continued his mischief. Geetha also noticed what was going on, and she told Kalu to stop his silly tricks, but Kalu just didn't bother. In the meantime, Monu grew more and more angry as well as alert, and finally, as soon as his tail was touched, he swung around and ran after Kalu. Quick and agile Monu seemed so frightening to fat and clumsy Kalu that he stumbled and fell down the shelf on an outstretched hand with a thud. He felt such a severe pain in his elbow that he howled with pain. Except for Raju, Nancy and Lamboo, who could not climb down, all the toys ran to have a



look at Kalu and to comfort him. Lamboo bent his long neck down to ask him what had happened. Nancy got an idea. She pressed Raju's tummy and made him clap and clap and clap till Kavita woke up. Kavita ran to the nursery and was surprised to see Kalu howling in pain, and all the other toys running here and there trying to be helpful. Kavita loved her toys so much that she couldn't bear to see any of them in misery. Chameli suggested that if only Kavita could take Kalu to the bone setter in the village for a massage, he would be all right. Kavita thought she better wake up her parents. At first, they didn't believe that toys could play and get hurt. But when they saw that Kavita was in the earnest, her father got up to have a look into the nursery. He did not agree to take Kalu to the bone setter. Massage could spoil a fracture, he told Kavita. "We shall take him to the hospital", he said. Kavita carried Kalu in her lap and went with her father to the hospital. Kalu was seen by a doctor in the Casualty. Kalu's arm was bent and he had a swelling at the elbow. Even the slightest movement at the elbow was highly painful. The doctor got an X-ray done. The X-ray showed that Kalu had a fracture in the lower part of the arm. Kalu was taken to the operation theatre where he was first made unconscious so that he would not feel any pain. Then his limb was moved about and stretched to put the broken ends of the bone in their original position. Then a plaster was put around his arm to keep the broken parts of the bone in their proper position. When Kalu came around, he was sorry to see his arm strapped. The doctor told him not to stretch the arm, and not to get any massage done. He just had to move his fingers repeatedly to avoid swelling of the arm and to prevent his arm from getting too lazy. The plaster was to stay there for six weeks. Finally, the doctor said, "Kalu, have plenty of milk and curd they are good for bones. And, don't be naughty—next time, your fracture could be worse".

On his way back from the hospital, Kalu promised that he would never be naughty again. In the nursery, he said sorry to Monu and Geetha for not listening to them. For six weeks he was miserable. He needed help with eating, washing, and everything big and small. All his friends were glad to help, but Kalu did not exactly enjoy being a burden on them. When Kalu didn't want to have milk, he was fussed over quite a lot, and he secretly enjoyed it.

At last, the 6 weeks were over. Kalu was taken to the hospital. An X-ray was taken, and luckily his bone had become whole again. The plaster was removed and he returned home. He has never been naughty since. Even the other toys have learnt a lesson and behave well. They all continue to play every night. Kavita knows about it now, but she doesn't mind it so long as they play decently. △

PRESIDENT'S CALL TO ERADICATE LEPROSY

Shri Zail Singh, the President of India, presided over the annual general meeting of the Hind Kusht Nivaran Sangh on 29 December, 1984, in his capacity as president of the Sangh. He congratulated the organisation and workers which are engaged in leprosy work.

"Leprosy is a disease which requires more dedicated service than many others. The social stigma attached to the disease gives the patients great pain and the removal of this stigma requires an intensive health education", Shri Zail Singh said.

Shri Zail Singh recalled the selfless service rendered by the father of the nation to leprosy patients and also the great interest the late Prime Minister, Smt. Indira Gandhi, had taken in eradicating this disease from the country.

He exhorted the doctors and other leprosy workers to speed up research and supplement the efforts of the government in eradicating the disease.

NEW INITIATIVES TO STRENGTHEN AND STREAMLINE FAMILY WELFARE PROGRAMME

THE number of family planning acceptors during the first eleven months of 1984 was of the order of 12.55 million compared to 11.33 acceptors during the same period of 1983. This represents an increase of 10.8 per cent. Method-wise, the number of IUD insertions went up by 71.7 per cent, oral pill users by 74.9 per cent, and sterilisation 3.9 per cent.

A total of 3.87 million sterilisation operations were performed during the period as against 3.72 million during the corresponding period of the last year.

The number of IUD insertions was 2.23 million compared to 1.30 million in the same period of 1983. The number of women using oral pills increased from 2.5 lakhs to 4.4 lakhs.

Controlling population growth continues to be a national priority and during the year a number of initiatives were taken to improve the effectiveness and outreach of the Family Welfare Programme so as to make it a mass movement. In this effort, full use is being made of the mass and folk media as also of inter-personal communication channels.

Services at the doorstep

Continuous efforts at expansion of the network of primary health care and family welfare with a view to taking them to the doorsteps of the people, are bearing fruit. About four lakh health guides and 4.9 lakh trained 'dais' are working in villages all over the country. Similarly, 70,000 sub-centres, manned by a team of one qualified male and one female health worker, are providing maternal and child health care and immunisation services in addition to family planning education, motivation, and supplies and services in spacing methods to village communities. The current year's (1984-85) target is to set up over 9,000 new sub-centres. Their total number is expected to go up to 1,20,000 by 1990.

Nearly 7,000 primary health centres, each with a team of three medical officers including one lady medical officer, render curative as well as family planning services including sterilisation, MTP, etc. This network of medical services is being strengthened by opening new one-doctor primary health centres, one for a population of every 30,000 (20,000 in hilly, tribal and backward areas). The existing primary health centres are being upgraded as referral, consultative and supervisory centres with the addition of more beds and specialist services.

Post-partum scheme which is one of the more successful components of the Family Welfare Programme, has undergone considerable expansion with the result that at present under the programme, there are 554 approved medical institutions at district level or above and 400 at the sub-district level. Some of the administrative steps and initiatives taken in recent months to build up the momentum of the Family Welfare Programme are:

1. Major States have been asked to conduct detailed exercises taking into account their present couple protection level, conditions in the field and their management capacity so as to fix appropriate targets for themselves in order to realise the overall national target of effective couple protection rate of 60% by 2000 A.D. This is intended to decentralise the process of target-setting and ensure the participation of the programme managers in the planning process.

2. Since 1966, when the staffing pattern at various levels for family welfare was laid, there has been manifold increase in the size and sweep of the programme. A Committee has been set up to suggest appropriate need-based staffing for various levels at the Centre, States and Union Territories.

3. A special fund for innovative publicity projects has been created at the Centre to provide for expenditure on items which may not be covered by the

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SOCIETY IS JUDGED BY WHAT IT DOES FOR CHILDREN

—RAJIV GANDHI

The test of a society is "how far it strives to ensure a bright future for its children," the Prime Minister, Shri Rajiv Gandhi, said, calling for "a sharing of experience between developed and developing countries for the benefit of children everywhere."

In a statement endorsing UNICEF's 1985 Report on the State of the World's Children, the Prime Minister declared: "Children own the future. Mere economic prosperity does not mean that children get their due share of care."

Commending the UNICEF Report for highlighting achievements as well as difficulties faced in child care programmes in many

countries, he said that while "scarce resources and burgeoning populations have been severe constraints to giving children all they need" in India and other developing countries, "programmes of education and health should popularise simple remedies and habits."

Shri Gandhi said UNICEF's publication of the report "should lead to a sharing of experience" between developed and developing nations for the benefit of children world wide.

With this statement in support of the UNICEF Report, the Prime Minister is in the forefront of world leaders who have advocated greater attention to children's needs. The UNICEF Report is

annually presented to heads of government and heads of State and released to the world media to promote recognition of children's rights.

Drawing attention to India's action since independence in eradicating many diseases and curbing others, the Prime Minister recalled UNICEF's cooperation with India "on a wide range of programmes for improving child health." India was now committed to a national programme of "Health for All by 2000 AD." he added.

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approved pattern of assistance under the Family Welfare Programme. This step is expected to remove quite a few bottlenecks experienced in the implementation of the Family Welfare Programme. The scheme is being operated with effect from the current year with an allocation of Rs. 1.5 crores.

4. In view of the importance of spacing between births for ensuring child survival and the mother's health, as well as the contraceptive needs of the younger couples who have not yet achieved the desired family size, a vigorous policy has been adopted to promote spacing methods—IUD devices like Copper T. Oral Pills, condoms etc. A contraceptive Marketing Organisation has been registered under the Societies Act to promote spacing methods and arrange for needed supplies of material. A specific campaign is being planned to popularise spacing methods.

5. The scheme for involvement of private medical practitioners of modern and integrated medicine in performing sterilisation operation and IUD insertions has been extended till 31-3-1987. An evaluation of the scheme is also being undertaken to make it more effective.

6. An innovative scheme has been initiated to ensure that all the eligible couples in a particular village community start practising one or the other family planning method. Mahila mandals and village Health Committees are motivated to implement the campaign. The scheme has already made a very good impact in a few selected districts of Rajasthan, and it is proposed to recommend this scheme of 'Parivar Kalyan Villages' with cent per cent acceptance of family planning to other States after refining and perfecting the strategy.

—PIB

NEWS

W.H.O. REGIONAL MEETING ON MEDICAL RESEARCH

THE development of a relevant programme of medical research to satisfy the needs of the respective countries is recognized as one of the pre-requisites to attain the goal of Health for All by the Year 2000. The effective utilization of the results generated by such research is just as important.

To review these and other aspects of health and health-related research, the WHO Regional Office for South-East Asia had organized the fourth meeting of the Directors of the Medical Research Councils or Analogous Bodies and Concerned Foci in the Relevant Ministries. The meeting was inaugurated on 3 December, 1984, at Jakarta, Indonesia, by the Minister for Health of Indonesia, Dr Suwardjono Surjaningrat.

Attended by policy makers, senior research administrators, health administrators and scientists from the Member Countries, the meeting examined how to further strengthen the national and regional research programmes.

Addressing the inaugural session, the WHO Regional Director for South-East Asia, Dr U Ko Ko, highlighted the importance of such meetings in promoting the sharing of information and cooperation between the Member Countries. Tracing the developments since the first such meeting held in Sri Lanka five years ago, the Regional Director expressed satisfaction at the considerable headway made in the promotion, coordination and management of research activities in the Region.

National health research policies based on national development plans were being developed in the countries, with priority areas having been identified on the basis of information available on the health status of the people. Another important development had been the establishment of both national as well as institutional ethical review bodies in the Member Countries, the Regional Director stated. These ethical review bodies will ensure the safety of human subjects involved in biomedical research.

The present strategy for the development of health research called for the creation and utilization of the necessary manpower resources and management structures for attaining, as early as possible, the goal of Health for All.

Referring to the vital role of health services research, Dr Ko Ko stated that one of the recommendations made at a consultative meeting on "Reorientation of Medical Education for HFA needs" was that training in health services research should form an essential component of medical education. Such a strategy would result in the accumulation of a body of knowledge and expertise related to different aspects of health services research. More importantly, it would stimulate attitudinal changes among the faculty and the students, thereby contributing positively to the reorientation process. Δ

MARCH-APRIL 1985

FILARIA AND MALARIA FIELD OFFICERS CONFERENCE

A three-day Conference of Programme Officers and Entomologists working under the National Malaria Eradication Programme and Filaria Control Programme was held from 29-31 January, 1985 in New Delhi. It reviewed the progress of the programme to combat the disease. The Union Minister of Health and Family Welfare, Smt. Mohsina Kidwai inaugurated the Conference.

The incidence of malaria came down from 64.6 lakh in 1976 to 16.8 lakh in 1984 as a result of several steps taken to eradicate the disease.

The Filaria control programme taken up in 1955 is presently covering 32 million people in 180 towns in 12 States and Union Territories. Anti-larval operations and treatment of Filaria cases are being undertaken under the Filaria Control Programme. 27 Survey Units have so far surveyed 240 districts out of 290 districts endemic to Filaria. One hundred and three clinics set up under the Programme are conducting the examination of cases and giving treatment at the doorsteps of the patients.

STATEMENT ABOUT OWNERSHIP AND OTHER PARTICULARS ABOUT NEWSPAPER Swasth Hind TO BE PUBLISHED IN THE FIRST ISSUE EVERY YEAR AFTER LAST DAY OF FEBRUARY

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Kotla Marg,
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Asstt. Editor
Indian
Central Health Education
Bureau, Directorate General of
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Kotla Marg, New Delhi-110 002 |
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I, Dr H. C. Agarwal, hereby declare that the particulars given above are true to the best of my knowledge and belief.

New Delhi
1 Feb., 1985

Sd/-
Dr H. C. Agarwal
Director

**Keep a gap of
three years
between two children**

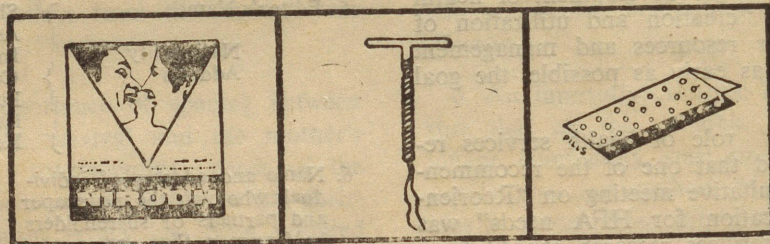


Choose any method

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BOOKS

HEALTH CARE IN CITIES OF THE THIRD WORLD: THE SITUATION AND SOME IDEAS FOR LOW COST SOLUTIONS. Basta, S.S. *World Hospitals* 1984 Feb; 20(1): 34-36.

In spite of the fact that urban emigration is on increase during past four to five years, that by 2000 A.D. 40 per cent of the world's population will be urbanised, and that the fastest growing urban areas are the slum and squatter areas, there is still insufficient movement on the part of municipal and national leaders to implement the recommendations of those many urban experts who advocate low cost and community self-help projects. City health statistics are misleading as the squatter or slum inhabitants do not appear in the statistics and thus indicate false or illusory averages. The solution to the problem lies in developing programmes based on com-

munity participation and self-help, ranging from typical "sites and services" component in which families are encouraged to build their own homes using simple credit mechanisms to purchase their land and materials, to upgrading slums where families pay for the recurrent costs involved in maintaining and building infrastructure for community health workers and nutrition programmes. The government must provide security of tenure, and basic credit institutions.

An example of such a programme relating to development of better delivery of Health Care in Juba, a large city in Southern Sudan, is described. A Health Education Demonstration Project for the already established Expanded Programme of Immunization was proposed to serve as an entry point for future development. Various phases of the programme started in October, 1982 and the progress achieved so far are examined.

—National Medical Library
Ansari Nagar, Ring Road,
New Delhi-110029.

Authors of the month

Dr (Smt) Usha Banerjee
Programme Coordinator
National Service Scheme
Delhi University
DELHI-110007

Shri Jitendra Tuli
Information Officer
South East Asia Regional Office
World Health Organization
Indraprastha Estate
NEW DELHI-110002

Mary Racelis-Hollnsteiner
Director
UNICEF Eastern-African Regional Office
C/O World Health Organization
NEW DELHI-110002

Dr H. C. Agarwal
Director
Central Health Education Bureau
Kotla Marg
NEW DELHI-110002

Dr (Smt) Indira Murali

and

Shri L.B.S. Dey
Department of Community Health
National Institute of Health & Family Welfare
New Mehrauli Road, Munrika
NEW DELHI-110067

Shri Ramesh Chandra
Secretary
Ministry of Works & Housing
Nirman Bhawan
NEW DELHI-110011

Dr. R. L. Bijlani
Department of Physiology
All India Institute of Medical Sciences
Ansari Nagar
NEW DELHI-110029

“If there is one section above all others who should be of our concern—it must be our youth. They are the inheritors of our future. In all things the torch must pass to the next generation.”

— SMT. INDIRA GANDHI