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In this issue.....

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Homoeopathy was born in Germany, nurtured in the USA and has now grown big in India. Let us hope that one day India will have modern versions of Nalanda and Taxila Universities in homoeopathic education and draw disciples from the East and West. For details read the article, "**Homoeopathic Education—A World View**" by *Dr M. P. Arya* (p. 3).

It is an irony that despite tremendous potential of homoeopathy in curing common ailments, homoeopaths are approached for the treatment of uncommon ailments. It is considered good only when common ailments become uncommonly troublesome or chronic or when there is a difficult condition which defies current allopathic treatment or there is a proposed surgical treatment which is dreaded. For details, read the article, "**Homoeopathy in Common Ailments**" by *Dr Sarabhai Kapadia* (p. 6).

Homoeopathic research on medicines is always of permanent, constant, and enduring value. A homoeopathic medicine once tested is never discarded. These are its fixed traits till eternity. For details read the article, "**Recent Research in Homoeopathy**" by *Dr H. L. Chitkara* (p. 8).

In 1974, a joint UNICEF/WHO study on alternative approaches to meeting basic health needs in developing countries recommended the mobilization and training of practitioners of traditional birth attendants for primary health care services. This idea was supported by the World Health Assembly. For details, see the article "**Traditional Medicine—W.H.O.'s Programme**" by *Dr R. H. Bannermann* (p. 12).

The discovery of insulin 50 years ago gave new hope and life to many thousands of diabetics who otherwise would have died young. Diabetics began to live longer. But researchers still face many problems. What causes diabetes? Can it be prevented? How are diabetics best treated to prevent them developing long-term catastrophes? If they do develop complications of the disease, how can these be best treated? For details, read the article, "**Diabetes Researchers Look Beyond Insulin**" by Professor *K. G. M. M. Alberti* (p. 14).

Slums adjacent to military areas in most cantonments are responsible for communicable diseases and are a threat to the troops and their families. How far a health education campaign is an answer to this problem. For details, read "**Providing Health Care in a Slum in Cantonment**" by *Col. R. N. Varma* (p. 19).

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Unless steps are taken now to ensure that right staff is trained and will be available in five or ten years' time, the demand for health manpower will not be met by the supply and the health services will not be able to achieve its goals. What is planning and development framework and future trends in health manpower? For details, read "**Trends in Planning for Health Manpower**" by *P. Hornby, A. Mejia, D. Ray and L.A. Simeonov*, (p. 23).

SWASTH HIND WISHES ITS READERS

A HAPPY NEW YEAR

PLACE OF HOMOEOPATHY IN MEDICINE

DR JUGAL KISHORE

Homoeopathy, based on a fundamental law of therapeutics, will always have an important place in the world of scientific medicine. But it has a special relevance today, because in certain types of sickness, practically no curative treatment is available in allopathy although very powerful drugs for suppression and palliation have been discovered.

HOMOEOPATHY is a system of medicine of comparatively recent origin. It was in 1805 and later in 1810 that Dr Samuel Hahnemann enunciated the Law of Similia, which is the basis of Homoeopathic treatment. If a drug or a medicine can produce a particular disease or disturbance in the human body, it can also cure a similar condition provided it is prescribed in suitable small doses. This principle of treatment was known to the physicians of ancient India but its application was properly established only by Hahnemann. Homoeopathy came to India during Hahnemann's time in 1839, when Honigberger treated Maharaja Ranjit Singh of Punjab.

But, in modern times, developments in medicine in general have taken place so fast that many people are under the impression that Homoeopathy is already an outmoded system and that it has no place in the modern scientific world. The common man is often misled that there are no new developments in Homoeopathy, whereas in allopathy every few weeks or months one hears of new discoveries and new drugs.

Law of Similars

To understand this anomaly and to remove the misunderstanding from the minds of the people, I want to mention that the Homoeopathic treatment is based on an eternal law of similars. A drug, discovered 100 years ago, still works as efficiently and cures diseases as effectively as it did at the time of its discovery. There is no need to discard it provided the stipulated conditions of its indications are present. In Hahnemann's times, there were about 100 drugs but today we are using over 2,000 drugs for various conditions

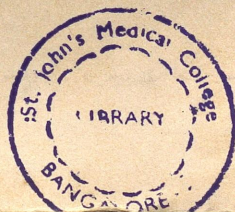
according to the individual needs of a patient. And tremendous amount of literature on Homoeopathy has accumulated during this short period.

In this system of medicine, new drugs are being added and should be added so as to make the armamentarium complete. But whatever has been discovered continues to be of eternal value. On the other hand, in the modern system of medicine, drugs are discovered and discarded at about the same rate. Another phenomenon of today's medicine is the emergence of Iatrogenic disease, i.e., diseases caused by drugs. With increasing introduction of newer drugs in modern medicine, there is growing prevalence of drug-diseases.

Homoeopathy, based on a fundamental law of therapeutics, will always have an important place in the world of scientific medicine. But it has a special relevance today, because, in certain types of sickness, practically no curative treatment is available in allopathy although very powerful drugs for suppression and palliation have been discovered.

Let us, for example, examine the phenomenon of allergic diseases like allergic rhinitis (hay fever); bronchial asthma; urticaria, allergic dermatitis and also allergic disturbances of gastro-intestinal tract. Here, Homoeotherapy plays an important part for curative reactions.

This is conceded by the exponents of the allopathic school. Today, man is exposed to a large number of irritants or allergens and ingests a large variety of chemically synthesized drugs. With the result, that



he is witnessing allergic manifestation to an extent not known before.

There is an increase in the incidence of degenerative and collagen type of diseases like nephritis, arteriosclerosis, rheumatoid arthritis, scleroderma, lupus erythematosus etc., Homoeopathic medicine can play a very effective role in this area.

In paediatrics, Homoeopathy has a great application despite the advances made in modern medicine. In children, apart from the case of administration and their welcome acceptance, these medicines are able to elicit quick curative responses; they tend to strengthen their defence mechanisms.

In chronic, intractable diseases affecting different systems in man, where labelling of diseases is impossible, homoeopathic drugs alleviate and may often cure such cases. Diseases like irritable colon, chronic diarrhoea of unknown origin, chronic amoebiasis, piles, fissure—recurrent mouth ulcer—and lots of other clinical conditions are not only relieved but cured by the small doses of the homoeopathic medicine.

Surgical conditions

Many conditions like enlarged tonsils, renal and gall-bladder stones, uncomplicated appendicitis, tumours, warts, fistula, fissure, piles etc., are considered as surgical requiring operations in allopathy. But in homoeopathy these are regarded as medical conditions are cured by internal medicine.

In psychosomatic diseases, where psychological conditions, stresses and anxieties are expressed in terms of physical signs and symptoms, simple homoeopathic medicines go a long way in helping the patients.

Medical scientists have come to the conclusion that no system of treatment is complete. There will always be lacunae because of either faulty approach or lack of capacity to apply the basic principles or side-effects of drugs. The spectrum of medical therapeutics is very large wherein these medical systems occupy varying areas in this spectrum. It is for the discriminating therapist to choose the weapon and his particular field of activity according to the requirements of the patient. Homoeopathy forms a very important part in this spectrum. If we are able to give sufficient inputs for its development and its practice is made more scientific, results will be astounding and the area of its application will become much wider. It may be possible to tackle more effectively diseases like cancer, where

Conditions for Practising Homoeopathy

Persons with postal training in Homoeopathy, will not be allowed registration on the basis of such training. Therefore they cannot practise Homoeopathy with postal training.

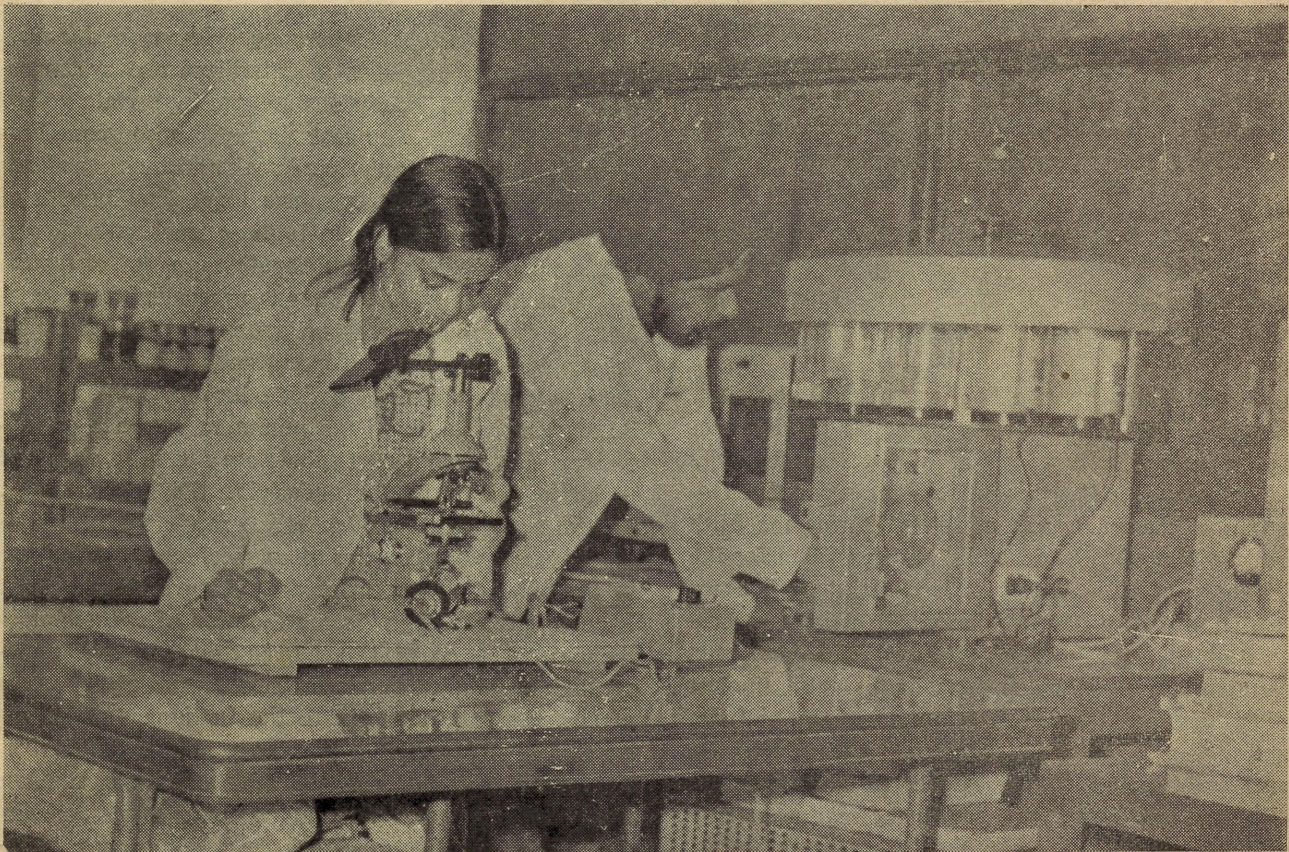
It has come to the notice of the Government of India that a number of private agencies in the country are issuing advertisements offering postal tuition and correspondence courses in Homoeopathy with the false assurance of registration to practise Homoeopathy. It is notified for the information of the general public that in accordance with the provisions of the Homoeopathy Central Council Act, 1973, no person can legally practise Homoeopathy in any State unless he possesses a recognized medical qualification in Homoeopathy and/is enrolled on the State or Central Register of Homoeopathy.

human system seems to break down and the vital principles present in the body are unable to maintain harmony.

No side-effects

One of the basic differences of homoeopathy from other systems is that it gives small stimuli which the body requires for mobilizing its defensive as well as curative forces inherent in it to fight the disease. The disease may be of any kind and from any source; whether it is an infection, or a process of degeneration or proliferation of malignant cells in the tissues or a psychic disturbance, the homoeopathic drug tends to bring back the internal balance by mobilizing the naturally existing forces or processes. It is possible that it stimulates certain vital areas (silent areas) of the brain which are responsible for mobilizing the defensive mechanisms. The human body has got its own powers of fighting diseases and it has at times to be stimulated into action. That is why we do not have any side-effects.

Homoeopathy has a greater relevance today because of increase in iatrogenic diseases and also because man is tampering with body's capacity to develop its fighting mechanisms. Indiscriminate use of antibiotics and steroids is responsible for this phenomenon. Recurrence of common infections in children has tended to increase in recent years. Homoeopathy is a safe alternative, a very natural way of helping the body to restore internal balance—mental and physical—and without any side-effects.



A view of the Homoeopathic Pharmacopoeia Laboratory

HOMOEOPATHIC EDUCATION —A World View

DR M. P. ARYA

Homoeopathic teaching in foreign countries is not vastly institutionalized as it is in India. With the exception of Mexico, Brazil and France, training outside India is limited to brief courses of not more than a few weeks, or months or at the most a year. These courses though well drawn out are introductory in nature with a view to introduce homoeopathy to practitioners of modern medicine. Thus, the Indian graduates who go abroad for advance training in homoeopathy get disillusioned.

INDIA perhaps has the world's largest number of homoeopaths. Today, it can boast of having 1,25,000 recognized practitioners of Homoeopathy—70,000 registered and 55,000 enlisted with various State Registers. (There are also practitioners with no valid licence and their number may well run into lakhs). There are 96 teaching institutes, 44 homoeopathic hospitals,

about 450 Government dispensaries, including 11 dispensaries under the Central Government Health Scheme (CGHS).

A Central Council of Homoeopathy has been established by an Act of Parliament for regulating Homoeopathic education and practice. A national Institute

has been set up for advanced training and research in Homoeopathy. The country has a chain of institutes and centres for organized research in Homoeopathy under the Central Council for Research in Indian Medicine and Homoeopathy. Universities at Kanpur and Calcutta have created faculties in Homoeopathy.

Every State Act provides for a body to affiliate Homoeopathic institutions in the region. The States have directorates and the Centre has an Honorary Adviser to advise on matters relating to Homoeopathy.

A Central Homoeopathic Pharmacopoeia Laboratory has been set up for formulating standards in Homoeopathic medicines. India is one of the few countries which has its own Homoeopathic Pharmacopoeia Homoeopathic Pharmacopoeia of India. During the Fifth Five Year Plan, Rs. 161.55 lakhs were provided for the development of Homoeopathy. In short, there is every thing that a system of medicine could claim and possess. And all these developmental activities have been accelerated in the post-independent India within the last couple of decades. Though homoeopathy came to India around the beginning of the nineteenth century when Dr Samuel Hahnemann, the discoverer of homoeopathy; was alive, it got institutionalized in the real sense only after Independence.

The mode of invent and its spread in the beginning had set the future pattern of homoeopathic education in the country. The credit of fostering the homoeopathic knowledge goes, and rightly so, to the lay public who at one time or the other experienced the "magic of minimum dose" and had personally benefited from its healing power. These people not only opted for it but seriously adopted its practice. More zealous amongst them started training others. Inevitably, the science fell into the hands of those for whom probably it was not originally intended. Thus the beginning of the twentieth century saw the coming in of several homoeopathic institutions in the south-eastern parts of the subcontinent; many of these now do not exist any more.

The sudden popularity of homoeopathy and dearth of trained persons gave an opportunity to the undesirable elements to enter the profession. Fake institutions came up. Sale of unauthorized degrees had started. With the result, the science of homoeopathy was looked down upon as spurious and quackery—the position from which it has still not completely recovered. Thanks to legislative enactments there is now some control on teaching and practice of homoeopathy. It is hoped that sooner or later it will regain its credibility.

Standardization

Much more remains to be done. Homoeopathic education in India is still not standardized and systematized. Majority of institutions are run by private voluntary organizations who lack financial resources. Teaching facilities, particularly clinical, and their standards of education are far from satisfactory. Emoluments of teachers are meagre; hence fulltime teachers with real academic aptitude in homoeopathy are not attracted. Teachers are untrained. They are recruited from amongst the practitioners who are more interested in building up their practice. Hence teaching is relegated to secondary place. Homoeopathic educationists have fixed S.L.C./Matriculation as the minimum entrance qualification. But these young minds are not fully equipped to grasp the intricacies underlying the homoeopathic philosophy of treating diseases and mechanics of origins of illnesses. Various types of courses, ranging from two to five-and-a-half years are now being pursued. There is no uniformity either in the duration of courses or in their contents. Syllabii have been drawn up and implemented without any consideration to the actual needs of students and relevance to the fundamentals of science. Lack of profitable avenues to homoeopathic doctors discourage the talented and ambitious students from seeking admission in homoeopathic colleges. The most serious drawback in the existing education is the blind alley in higher studies. This has adversely affected getting personnel for teaching and research jobs.

Advanced homoeopathic education

Notwithstanding the shortcomings enumerated above, India can hope to be in the forefront in the not too distant a future, in homoeopathic education. With the Central Government's aid given to promising institutions, they are getting themselves better equipped and are fulfilling their basic requirements. There are visible signs of greater inclination on the part of State Governments towards running model homoeopathic institutions of their own Centrally sponsored "orientation training" for training teachers will help them in doing their jobs better. Newer and advanced experimental methods are being introduced in teaching. Attempts are afoot to introduce a uniform course of training all over the country. Plans are being drawn up to start degree course in homoeopathy. And need for post-graduation is being felt.

Teaching not institutionalized abroad

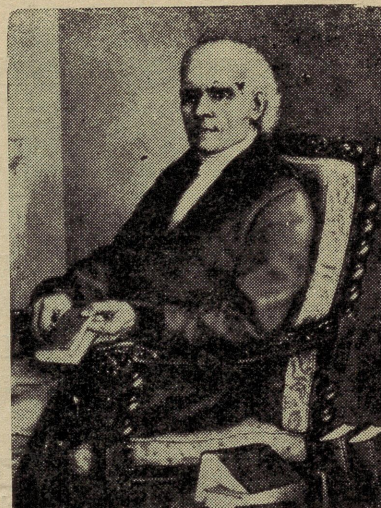
Homoeopathic teaching in foreign countries is not vastly institutionalized as it is in India. with the excep-

tion of Mexico, Brazil, and France, training outside India is limited to brief courses of not more than a few weeks, or months or at the most a year. These courses, no doubt are well drawn up and include both theory and practical training. But they are introductory in nature and are intended to introduce homoeopathy to practitioners of modern medicine. These training courses are designed in this manner because the legislation insists on having a modern qualification at the first instance before they are permitted to practise homoeopathy. Thus the Indian graduates who go abroad for advanced training and knowledge in homoeopathy get disillusioned and a little disappointed after experiencing this.

Great Britain has a two-tier system of training—an introductory course leading to Diploma of the Faculty of Homoeopathy and an advanced training course leading to the Membership of the Faculty. Membership course is open only to graduates of modern medicine. The M.B.B.S. qualified doctors from India are eligible. Till recently, homoeopathic graduates from India were admitted in the Diploma Course.

The United States of America has lost its past glory of possessing some of the prestigious homoeopathic institutions of the world. These institutions are now extinct under the onslaught of the influence of modern medicine. Training centres in this country have now been reduced to a limited number.

The story is no better in the continent. Only West Germany and Switzerland offer a few weeks' training at some centres. Pakistan has a undergraduate college very much on the Indian pattern. Sri Lanka has two undergraduate training centres. In rest of the third



Dr Samuel Hahnemann (1755-1843), the father of Homoeopathy, was born in Germany. It was in 1805 and later in 1810 that Dr Hahnemann enunciated the Law of Similia, which is the basis of Homoeopathic treatment. If a drug or medicine can produce a particular disease or disturbance in the human body, it can also cure a similar condition provided it is prescribed in suitable small dosage. This principle of treatment was known to the physicians of ancient India; but its application was properly established by Dr Hahnemann. Homoeopathy came to India during Hahnemann's life-time in 1839, when Honigberger treated Maharaja Ranjit Singh of the Punjab.

world countries, teaching in homoeopathy is still at planning stage.

Someone has rightly said that homoeopathy that was born in Germany, nurtured in the USA has now grown big in India. Let us hope that one day India will have modern versions of Nalanda and Taxila Universities in homoeopathic education and draw disciples from the East and the West.

The problem of conflicting human rights

There are many examples of conflict between the rights of an individual and those of others in the community in which he lives. In the early days of strains of organisms becoming resistant to penicillin, I, like many others, have had to withhold penicillin from one newborn baby for whom it would have been beneficial in the interests of other babies in the nursery. The argument of the Common Good versus individual human rights is ever with us. The allocation of resources, financial and manpower, for different types of health care calls for the judgement of Solomon. Should a resuscitation unit of four beds be staffed by nine nurses and supplied with sophisticated equipment while geriatric and mental deficiency patients are grossly deprived? Article 29 of the Universal Declaration calls attention to the duties to the community and states that "in the exercise of his rights and freedoms everyone shall be subject only to such limitations as are determined by law. . .". Surely there are limitations for which there is as yet no legislation but which would be within the spirit of the Declaration.

DUNCAN, A. S. Scientific and technological development in biology and medicine which may lead to the infringement of human rights. In: BTESH, S. ed. *Protection of human rights in the light of scientific and technological progress in biology and medicine*. Geneva, Council for International Organizations of Medical Sciences, 1974, p. 31.

Homoeopathy In Common Ailments

DR SARABHAI KAPADIA

Homoeopathy has a great potential in providing medical relief to the smallest in the simplest way. By and large homoeopathic drugs do not have any harmful effects. They can be handed over in the hands of intelligent and comparatively lay people.

COMMON ailments can mean those simple ailments not involving serious effects or those which are widely prevalent. In homoeopathy, a patient is treated as an individual case of a 'remedy symptoms syndrome' and not in terms of names of diseases. This means that every case is studied in its certain peculiarities of manifestation in terms of symptoms and constitutional aspects. These are studied for comparison with similar phenomenon observed in 'provers' as effects of drugs on healthy human beings. This is not a symptomatic treatment but it is a device to obtain radical cure through study of all observable manifestations of sickness. There are 30 to 40 acute syndromes which cover most of the common acute ailments. And 80 to 100 constitutional syndromes which cover most of the commonly occurring constitutional diseases. With these, homoeopaths can cure most of the cases when the patient is in a curable stage and palliate suffering in those who have reached an incurable stage. To meet cases of uncommon type, homoeopathy has in its armamentarium more than 800 remedies which can be pressed into service, by judicious use of various repertoires.

There are several common ailments, if we take that sense of the term 'common' like common cold, constipation and headache. There are one or two simplest examples, which are often not cured by various medicines but need perpetual palliation by drugs which cause some harm. Good homoeopathy can cure, in the real sense, these ailments.

Treating mechanical injuries

Treatment of mechanical injuries in homoeopathy provides for medication which not only takes care of pain and sepsis but also provides real stimulus to the vital healing powers of the affected person. The healing value of homoeopathic medicines in burn injury can be appreciated only by witnessing its magical action in

suitable cases. All standard first-aid procedures should be properly applied. Whatever mechanical damage involves displacement of tissues must be surgically corrected. Setting of fractured bones, sutures to wounds, etc., are no doubt required.

Success of modern preventive medicine in epidemic diseases is a demonstration of the validity of the homoeopathic law. All vaccinations are based on the law of homoeopathy, i.e., "*Vishah Vishasya Aushadhah*" Preparations of vaccines could be replaced by homoeopathic 'nosodes' which would be far more economical and can be more conveniently handled to meet our large requirements.

Most of these diseases can be treated by harmless and economical homoeopathic medicines. Homoeopathy simplifies the course of these diseases. But most important difference is that it recognises these diseases as "Toxins elimination crisis", which process, it can assist. After acute sickness is treated under homoeopathy there is improvement in general health.

Surgical operations can be prevented

Many surgical operations can be prevented by timely application of homoeopathy. Suitable cases of appendicitis, renal and gall stones, polyps, fissures, piles, wart, etc., are common examples of this type. Most of the cases of recurrent septic tonsils, for example, will get cured and tendency to re-infection eradicated. Tonsillectomy leaves the patient with inferior resistance to the infecting organisms. Its beneficial value is considered doubtful even by some eminent thinkers in modern school of medicine. This simple, common condition which defies modern medicine, yields easily and permanently under homoeopathy.

Timely application of homoeopathy to counteract several 'CAUSATIONS', well known to lower vital resistance, will prevent and even cure countless number



The Union Minister of State for Health and Family Welfare, Shri Jagdambi Prasad Yadav, visiting the museum of the Homoeopathic Pharmacopoeia Laboratory, Ghaziabad. It is a Standard cum Drug Testing Laboratory at the national level.

of individual cases of various diseases by raising the vitality of the patient. For example, remote effects of mechanical injury, exposure to excessive heat, cold, draft, indulgence in unsuitable food, animal and other poisonings, undue emotional strains of fear, anger, vexations, jealousy, grief and such other factors lower vitality and nurture various diseases. This involves consideration of common causes of ailments in various sick individuals and not the names of the diseases. Homoeopathy has developed solid knowledge in this direction. An understanding of human situations in a person having sympathetic heart for suffering of the sick provides a nucleus to enable him to study homoeopathic books to find very valuable remedial measures.

Despite tremendous potential of homoeopathy in curing common ailments, homoeopaths are approached only for the treatment of uncommon ailments. It is considered good only when common ailments become uncommonly troublesome and chronic, or when there is a difficult condition which defies current allopathic treatment or there is a proposed surgical treatment which is despised. Even then by its effectiveness, and

remote success, it has earned its present good reputation and patronage.

Homoeopathy has least harmful effects

Homoeopathic dosage of drugs is such that by and large their use involves least danger of harmful effects and they are capable of tremendous healing powers. They can be handed over in the hands of intelligent and comparatively lay people, with great safety. For this reason we should take a pragmatic view of the country's health problems in the existing social and economic situations. There is a great potential in homoeopathy to provide medical relief to the smallest in the simplest way. Why not propose a short training course, suitable to the genius of homoeopathy and at the same time helpful in solving country's immediate problems?

Most literature of homoeopathy is in the English language. Hence, a good knowledge of English is essential to practice homoeopathy. All important books need to be translated into various Indian languages. Homoeopathy has all the resources for providing 'curative remedies'. These very remedies act as palliatives in incurable cases. Thus homoeopathy effectively treats wide variety of human ailments. ○

RECENT RESEARCH IN HOMOEOPATHY

DR H. L. CHITKARA

The existing Homoeopathic *Materia Medica* is almost entirely made up of plants indigenous to Europe and America, where this science was originally developed. . . . The procurement of these plants is becoming more and more costly which in course of time may become impossible. Hence, the urgent need is to exploit the rich resources of our own plants and herbs and discover their homoeopathic properties without much delay.

REPORT of researches on cancer and other incurable diseases being carried on in the world appear in the Press practically every day. The common man, who is now getting more familiar with homoeopathy, naturally asks, "Is anything similar being done in homoeopathy? Are newer homoeopathic medicines being tested for these diseases? What is being done in this field, especially in India?"

The use of homoeopathic medicines is governed by a fixed law, *i.e.*, a medicine, given in a very minute dose, is bound to cure all the symptoms completely, only if or because it can produce all those symptoms on healthy human beings.

In fact, the object of research on a homoeopathic medicine is not to test them on diseased persons but on healthy persons first.

New medicines

The late Dr Sarat Chandra Ghose, an eminent homoeopathic physician and Editor of the Hahnemannian Gleanings, Calcutta, was probably the pace-setter of Homoeopathic Research in India. The incident which led him to this pursuit is very interesting. In 1887, his sister's husband vomited blood all of a sudden. His condition became grave. In those days, in the absence of present-day powerful drugs, no treatment seemed to help him. One day a Sanyasi came, and under his instructions, the patient was administered teaspoonfulls of expressed juice of the leaves of *peepal* tree. The effect was marvellous, the bleeding stopped and the patient was completely cured. Dr Ghose was a student at that time. In

1899, he tried to test this medicine homoeopathically. He took 40 drops of the tincture in one dose. The result was that he had a frequent desire to micturate. The urine contained blood in an abundant quantity. He also had an inclination to cough which caused him to spit blood. Other symptoms were, a slight, dull headache, giddiness, and nausea, dimness of sight, weakness and restlessness. He then took three drops of the tincture after every hour. After the third dose the symptoms vanished. His wife took the tincture in 20-drop doses repeatedly for two days. On the third day, blood dysentery and menstrual bleeding started. In addition, she had slight headache, weakness and restlessness, dimness of eyesight, burning on the top of the head, difficulty in breathing, a feeling of sadness and melancholy. She was given minute doses of the tincture which arrested the effects of the drug. The third experiment was done on a dog in a similar way. The dog vomited blood of bright red colour. Three small doses of the same medicine stopped the vomiting.

Dr Ghose read in the Ayurvedic literature that *Peepal* (medical name *Ficus Religiosa*) leaves were recommended for stopping bleeding from bowels, lungs, stomach, bladder and other parts of the body. He was convinced that this medicine was truly homoeopathic for all kinds of bleeding, and he used it successfully in curing many such cases subsequently.

Later, Dr Ghose started testing other plants in common use in indigenous practice for the purpose of finding out or verifying their therapeutic value in homoeopathic form. He tested about 50 such plants in common use including *olat kambal*, *Kalmegh*,

Neem, Bilwa fruit, Punarnava, Papayya, Durba grass, Gurmar, Basaka, Tulsi, Ashoka, Arjuna, Jaamun, Gilo, Kurchi, Babchi and Serpaganda.

He published his experiments in the leading homoeopathic journals of the world. These were later compiled into a book, "*Drugs of Hindoosthan, with their Homoeopathic uses, provings and clinical verifications*", Ca'cutta (1949). Four or five of his discoveries were incorporated into the British and American Homoeopathic *Materia Medica* in his life time. It will perhaps be interesting to recall here that the use of *Serpagandha (Rauwolfia serpentina)* was also hinted at by Dr Ghose, because the drug was very popular in the indigenous system for the treatment of insanity and high blood pressure. It was subsequently thoroughly tested in the modern system of medicine, and its active principle was isolated and found useful for bringing down blood pressure. Ultimately, it proved to be the pivotal therapy for reducing blood pressure, and the forerunner of the only approach for a new class of hypotensive drugs which have come to be used in modern medicine.

Durba (lawn grass): Taking a cue from Dr. Ghose, the tincture of Durba, a common lawn grass, (*Cyanodon Dactylon*) was taken up for clinical trial under the Central Council of Research in Indian Medicine and Homoeopathy (CCRIMH). Dr Ghose had stated, "If a systematic proving (testing) of this drug be made by us, it will open up a vista of therapeutic sunshine before the homoeopathic fraternity of universe". This prophecy has proved correct through the various investigations conducted by Dr Jugal Kishore and CCRIMH and its therapeutic potentialities in the cases of amoebiasis has been found positive.

Homoeopathic testing of medicines often bring out unexpected and very valuable therapeutic properties, as illustrated below:

Haldi: Dr D. P. Das of Rourkela had an occasion to experiment with *haldi* or turmeric. It is an ingredient of food, as it is commonly used in preparing *curries* in the Indian homes. Women make a paste from it and apply it externally over the skin for keeping it healthy, smooth and shining. It is generally considered to be a vermifuge by the practitioners of Ayurveda. Dr Das took a cupful of turmeric decoction in order to get rid of worms. Instead of decoction being made from dried turmeric, the people at home made it from raw fresh turmeric from the courtyard. After taking it, he felt the following symptoms:

- (i) Severe itching with eruptions like urticaria,
- (ii) Swelling of eyes with redness and itching and
- (iii) Restlessness.

Once the eyes of his buffalo were watering, and he asked his servant to wash them with turmeric water. Within a short time, the condition of the buffalo became serious. She started scratching the eyes with her forelegs. The eyes became swollen reddish, and the eyeballs turned upwards. This, he thought to be the effect of turmeric. On the basis of these, Dr Das prepared a low trituration of *haldi* (it is a special process of making medicine out of dry substance by grinding it with sugar or milk, and reducing the medicine in the powder in successive steps). He used it successfully in a number of cases of urticaria and thread-worms. Subsequently, CCRIMH experimented with this remedy (medical name *Curcuma longa*) on a more scientific and in a more elaborate manner. It has been found that this medicine not only produces burning, pricking, and itching all over the body, but also increases the blood-sugar. On Homoeopathic principles this remedy can therefore prove very useful for increase in blood sugar and *glycosuria* with symptoms like inflammation of surface nerves (called *developing diabetic neuritis*).

Antmul: Till three to four years ago, a philanthropic couple in New Delhi used to distribute leaves of a plant to asthma patients. One leaf each was to be chewed very early in the morning, beginning from full-moon day for three successive days. Relief was reported in many cases. On investigations, Dr Shivpuri of the Patel Chest Institute, Delhi, found that the leaves were of an Indian Plant *Antmul* (Botanical name: *Tylophora Indica*). The relief after taking this plant was definite, ranging from two to six months in many cases. On the basis of this, the CCRIMH has taken up the testing of this medicine, and a preliminary proving (testing) has been made. Although symptoms obtained did include difficulty in breathing, heaviness in chest, and tickling in throat, other unexpected symptoms were found, such as, aching in big joints ameliorated by rest, sleep, and by rubbing both the legs together. On this last indication, Dr Jugal Kishore treated three cases, one of rheumatism of joints (Arthritis) and two of rheumatism of bones of the joints (Osteoarthritis) with this remedy. Cases of osteoarthritis, in which bone changes are present, are very difficult to treat, and any remedy which helps in such cases is, indeed, very precious.

Significance of the experiments

These cases illustrate, though briefly and in a simplified way, how the idea of testing the remedies

crops up, how these medicines are tested on healthy individuals, and how the homoeopathic testing reveals their unsuspected, hidden, and very valuable therapeutic properties.

CCRIMH

Till only five to six years ago, homoeopathic research in India was being done sporadically by individuals here and there. In December 1969, the Central Council for Research in Indian Medicine and Homoeopathy (CCRIMH) was set up by the Government of India, and research work has been taken up on a planned and systematic manner under the Council. Besides the above medicines, experiments for laying down the standard preparation of medicines and testing (called provings) of a number of homoeopathic medicines have been made. These include a few of Dr S. C. Ghose's experiments given above, and others.

Clinical research

Research is also being done on specific diseases not with a view to find specific remedies (which is basically contrary to the homoeopathic approach), but to demonstrate the efficacy of homoeopathic treatment for assessment of degree of cure, and in relation to time taken, and to narrow down, if possible, the number of remedies required to a small group in different diseases. Of course, this is being done partly to make homoeopathy more acceptable to practitioners of modern medicine. Wherever possible, practitioners of modern medicine can associate themselves with this research as consultants and assessors. Some of the conditions on which researches are being done are: 1. bronchial asthma, 2. diabetes mellitus, 3. schizophrenia and other behavioural disorders, 4. infective hepatitis, 5. acute infections like allergic rhinitis, sinusitis, allergic dermatitis, tonsillitis, eruptive fevers, 6. rheumatic diseases, 7. filiarisis, 8. viral conjunctivitis, 9. helminthiasis.

No specifics

It has to be constantly borne in mind that the homoeopathic way is to strictly individualize each patient. Evidently, the medicines recently tested and reported above are not specifics. They are only an addition to the existing stock of remedies, which already include a large number suitable for similar conditions.

Other medicines

Meanwhile, non-official research is also going on. Like the late Dr Ghose, Dr R. P. Patel of Kottayam,

Kerala in our time has devoted his life-time to research in two fields specially.

1. The advocacy and supply for use of a new series of homoeopathic dosage, called the *Fifty Mille-simal*. Though it was discovered by the founder of Homoeopathy himself, it remained unknown till only about 40 years ago.

2. *Development of Tautopathic Drugs*—These medicines are the dilutions of the commonly used powerful allopathic drugs. It is well-known that almost all powerful allopathic medicines may have side-effects, sometimes of a serious nature. These side-effects, carefully recorded, are included in the leaflets enclosed in the packing of the drugs. According to homoeopathic principles, whatever symptoms a drug can produce it can cure (in a smaller dose). Dr Patel has prepared smaller doses of all the commonly used allopathic drugs, like Aspirine, ACTH, BCG, Insulin, Pethedine, Penicillin, Streptomycin etc, so that these can be used by the homoeopathic physicians in two ways:

(1) to counter the side-effects resulting from use of the same allopathic medicines in patients coming from allopathic hands, and (2) to use them in symptoms similar to the side-effects, in patients, who have not used these allopathic medicines.

Though this is not the correct way to add new homoeopathic medicines to the official Homoeopathic *Materia Medica*, yet their value to some extent, cannot be under-estimated.

Urgency of research

The existing Homoeopathic *Materia Medica* is almost entirely made up of plants indigenous to Europe and America, where this science was originally developed. In homoeopathy, we must use the exact plants which were actually experimented with. A slightly different variety will not do. Hence for all of our medicinal requirements we depend on imports. As the homoeopathic medicines become more potent on progressive dilution, the quantities required are not substantial (hence of no great financial burden). But this indirectly poses another threat. Some of the plants have now no other economic or commercial value in the countries of their origin. The procurement of these plants is becoming more and more costly which in course of time may become impossible. Hence there is the urgent and dire necessity to exploit the rich resources of our own plants and herbs, and discover their homoeopathic properties without much delay.

Other areas of research

In homoeopathy, other kinds of researches are also being carried on, such as, basic research meant to explain the law of homoeopathy in terms of the parameters of the known basic sciences, and to devise experiments for testing the potency of prepared medicines. Then there is literary research for revising our classical books, the records of provings, by replacing old terms with the more modern ones, and by making additions of new remedies and their symptom-pictures to make them up-to-date. No significant work has been done in India by way of basic research. But

a good beginning has been made for literary research, which in due course, will be of great help to homoeopaths in their work.

Permanent acquisition

Homoeopathic research on medicines is always of permanent, constant, and enduring value. A homoeopathic medicine once tested is never discarded. It is used for all those ailments for which it has been tested in all climes and countries. These are its fixed traits till eternity. ○

Drug Production Should be With Health Ministry Parliamentary Consultative Committee Recommends

The Consultative Committee of Parliament attached to the Union Ministry of Health and Family Welfare has suggested that the production of drugs should be looked after by the Ministry of Health. The Committee which met in New Delhi on 24 December, 1977 under the Chairmanship of the Union Minister for Health and Family Welfare, Shri Raj Narain, felt that since the Ministry of Health is concerned with the various health programmes and medical care of the people in the country, it is only logical that the production of drugs should also be under the charge of the same Ministry.

The Committee also recommended that a standing mechanism should be evolved for monitoring the production, supply, and pricing of essential drugs. The Members of the Committee highlighted the need of ensuring the supply of essential and life-saving drugs at reasonable prices. And essential drugs should be

identified and produced on large-scale and priced preferably on no-loss no-profit basis.

Shri Raj Narain stressed that while fixing the prices of drugs, the cost of production should include only the price of raw material, expenditure involved in converting the raw material into finished product and the minimum packaging cost. It should not include items like expenditure on advertising. Shri Raj Narain said that nobody including the drug manufacturers should be allowed to exploit the common people of whom the majority belongs to the villages.

The Minister of State for Health and Family Welfare, Shri Jagdambi Prasad Yadav, emphasized that not only the prices of essential and life-saving drugs but also the prices of medicines required in the second line of treatment for diseases like tuberculosis, should also be kept at reasonable levels. ○

TRADITIONAL MEDICINE

W.H.O.'s PROGRAMME

The approach will focus on the psycho-social and anthropological aspects of traditional medicine, on acupunctuure and other healing methods, and on the claims made for herbs and medicinal plants.

DR R. H. BANNERMAN

TRADITIONAL and indigenous systems of medicine have persisted for many centuries, even in parts of the world where modern health care is readily available. The idea of mobilizing the manpower component of traditional medicine for purposes of primary health care, particularly in rural areas, has been gaining ground in many countries in recent years. An initial beginning was made with traditional birth attendants, because of the acute shortage of trained midwives.

A meeting on the training and utilization of traditional birth attendants was held in 1972 at WHO headquarters in order to develop the kind of training programmes, research and studies that could improve the services of these workers in their respective communities.

In 1974, a joint UNICEF/WHO study on alternative approaches to meeting basic health-needs in developing countries recommended the mobilization and training of practitioners of traditional medicine, including traditional birth attendants, for primary health care services. This was endorsed the following year by Executive Board resolution and the idea was given support at the World Health Assembly in 1977, when a resolution sponsored by several Third

World Member States was passed by acclamation for the promotion and development of training and research in traditional medicine.

Several Member States have already initiated training programmes for the traditional birth attendants, and orientation courses and seminars for other health professionals.

In 1976, WHO's Regional Committee for Africa had "Traditional Medicine and its Role in the Development of Health Services in Africa" as the topic for technical discussion. The Regional Committee for South-East Asia also adopted a resolution in the same year calling for the promotion of traditional and indigenous systems of medicine in the Region. This was followed by a seminar in Colombo, Sri Lanka, that made pragmatic recommendations about how to implement training, service and research programmes.

June 1976 saw the foundation at WHO headquarters of a working group for the promotion and development of traditional medicine. Its aim was to coordinate the various activities relating to the subject, and it prepared a programme with the following objectives:

● to foster a realistic approach to traditional medicine so as to promote and further contribute to health care;

● to explore the merits of traditional medicine in the light of modern science so as to maximize useful and effective practices and discourage harmful ones;

● to promote the integration of proven valuable knowledge and skills in traditional and modern medicine.

High priorities will be given to the developing countries particularly with regard to primary health care within the context of the country's political structure, economic resources and development plans.

Execution of the programme will be effected in close collaboration with the regional offices and, primarily, at the country level and with active community participation.

The suggested approaches include the formulation of national health policies so as to contain provisions concerning traditional medicine and mechanisms of coordination, and better utilization of the useful elements of traditional medicine in the country's health care system. The administrative machinery needed to ensure effective planning, utilization and supervision of practitioners of traditional medicine will be reviewed within the context of the national health care delivery system.

A questionnaire has already been designed for the collection of all available information concerning practitioners of traditional medicine, their training and services to the community. The analysis of information collected, together with the results of surveys and research findings, will no doubt assist us all in the development of meaningful training programmes for the various categories of practitioners of traditional medicine. Doctors, nurse/midwives, other health

workers and students of health sciences will all be encouraged to undergo orientation in traditional medicine where appropriate.

Multidisciplinary investigations into systems of traditional medicine will be encouraged, and special attention will be given to laboratory and clinical investigations for identifying effective remedies, comprising medicinal plants, animal products and mineral substances. Investigations will also be conducted into the psycho-social and anthropological aspects of traditional medicine, as well as the mechanisms of acupuncture and other healing methods.

Wherever possible, priority will be given to the promotion and development of useful local resources such as herbs for the production of medicinal substances; such action should effectively reduce the drug bills of many developing countries.

Traditional healers and some modern physicians depend to a large extent on herbs and medicinal plants for treatment. The story of herbal medicines is a fascinating one—quinine, until recently, was the only cure for malaria; morphia remains a most effective pain-reliever; rauwolfia is still widely used for the control of hypertension and certain forms of psychiatric disorder, and herbal preparations have been used for many decades to treat rheumatoid arthritis. Recently, we have received serious claims that herbs are being used in China, tropical Africa and Central America for the control of diabetes melitus. All these claims have to be investigated scientifically and authenticated.

There are clear indications of a major break through in therapeutics and health care delivery, and those of us involved in the traditional medicine programme share fully the goal, that we should achieve total health care coverage for all people by the year 2000. *Courtesy : World Health.*○

RAJ NARAIN MEETS CARTER — FAMILY WELFARE EFFORTS EXPLAINED

The Union Minister for Health and Family Welfare, Shri Raj Narain met the President of the United States of America, Mr Jimmy Carter, on 3 January, 1978 in New Delhi to acquaint him with the efforts being made by the Government of India to propagate family welfare.

Shri Raj Narain said that he informed President Carter that the Government did not wish to implement this programme through compulsion and would do so only through persuasion, education and motivation.

He said Mr Carter agreed with him that no force should be used in the implementation of this programme.



RESEARCH

DIABETES RESEARCHERS LOOK BEYOND INSULIN

Discovery of insulin 50 years ago gave new hope to the diabetics who otherwise would have died young. Diabetics began to live longer. But researchers still face many problems. What causes diabetics? Can it be prevented? How are diabetics best treated to prevent them developing long-term suffering? Over the past ten years a great deal of progress has been made toward answering these questions.

PROFESSOR K.G.M.M. ALBERTI

THE discovery of insulin more than 50 years ago gave new hope and life to many thousands of diabetics who otherwise would have died at an early age. However it gradually was recognized that simple insulin replacement was not a total solution.

As diabetics began to live longer, they developed long-term complications of the disease. These include disease of small blood vessels that especially affects the eye and kidneys and can lead to blindness. Indeed, diabetes now is the commonest cause of blindness in Britain.

Large blood vessels are also affected, so that diabetics have more heart attacks, and at an earlier age, than the average man or woman. The complications involve the nerves, too, so that many diabetics have grossly diminished sensation in their feet and legs.

Range of problems

Thus researchers still face many problems. What causes diabetes? Can it be prevented? How are diabetics best treated to prevent them developing long-term complications or suffering short-term catastrophes? And if the diabetic develops the long-term complications of the disease, how can these best be treated?

Over the past ten years a great deal of progress has been made toward answering these questions.

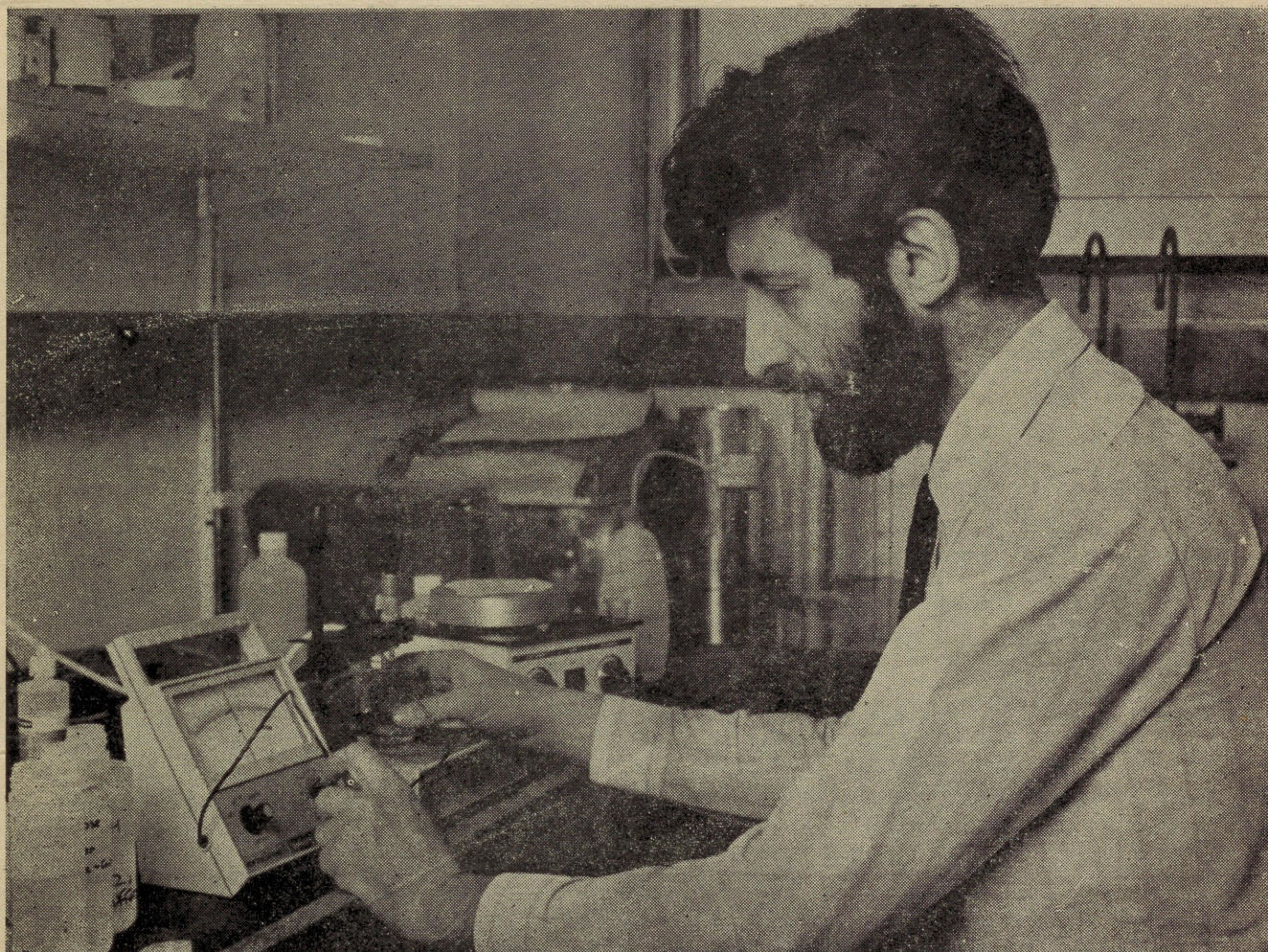
Much of the work has been done in Britain, sponsored primarily by the British Diabetic Association, by the National Health Service, and by individual companies.

Several groups have concentrated on the cause of diabetes and its inheritance. Dr D. R. Camble and Dr K. W. Taylor were among the first researchers to show that many juvenile diabetics had in their blood a high content of antibodies to a particular virus. This led to the suggestion that the virus may be important in precipitating diabetes.

There have also been notable epidemiological studies in which it has been shown that there is a higher than usual incidence of diabetes in children at the ages of five and 11 and at the time of year when they are starting at their first school or at a new school. It is possible that at this time they become infected with the appropriate virus.

Genetic element

However, it is obvious that the virus alone will not provide a solution because many children are infected without developing diabetes. It has long been known that there is a genetic element in diabetes, but this has been delineated much more clearly through the classical studies with identical twins of Dr D. Pyke and his colleagues at King's College Hospital in London.



Professor K.G.M.M. Alberti, of the University of Southampton's Department of Chemical Pathology and Human Metabolism, at work in a Laboratory

Their studies have shown clearly that if one twin has diabetes, there is a very high chance of the second twin developing the disease. This risk becomes a certainty when the twins are over the age of 40. Dr Pyke and his team, with the co-operation of doctors throughout Britain, have studied more than 100 pairs of twins and their studies are unique.

Further exciting work on the inheritance of diabetes has been undertaken by Dr A. G. Cudworth, now of St Bartholomew's Hospital in London. He has studied the histocompatibility antigens in many hundreds of diabetics. He has shown clearly that in younger diabetics there is a markedly increased prevalence of two particular antigens, and possibly a third, while one of the histocompatibility antigens is present with a decreased frequency. This is quite different from the patterns observed in those who became diabetics

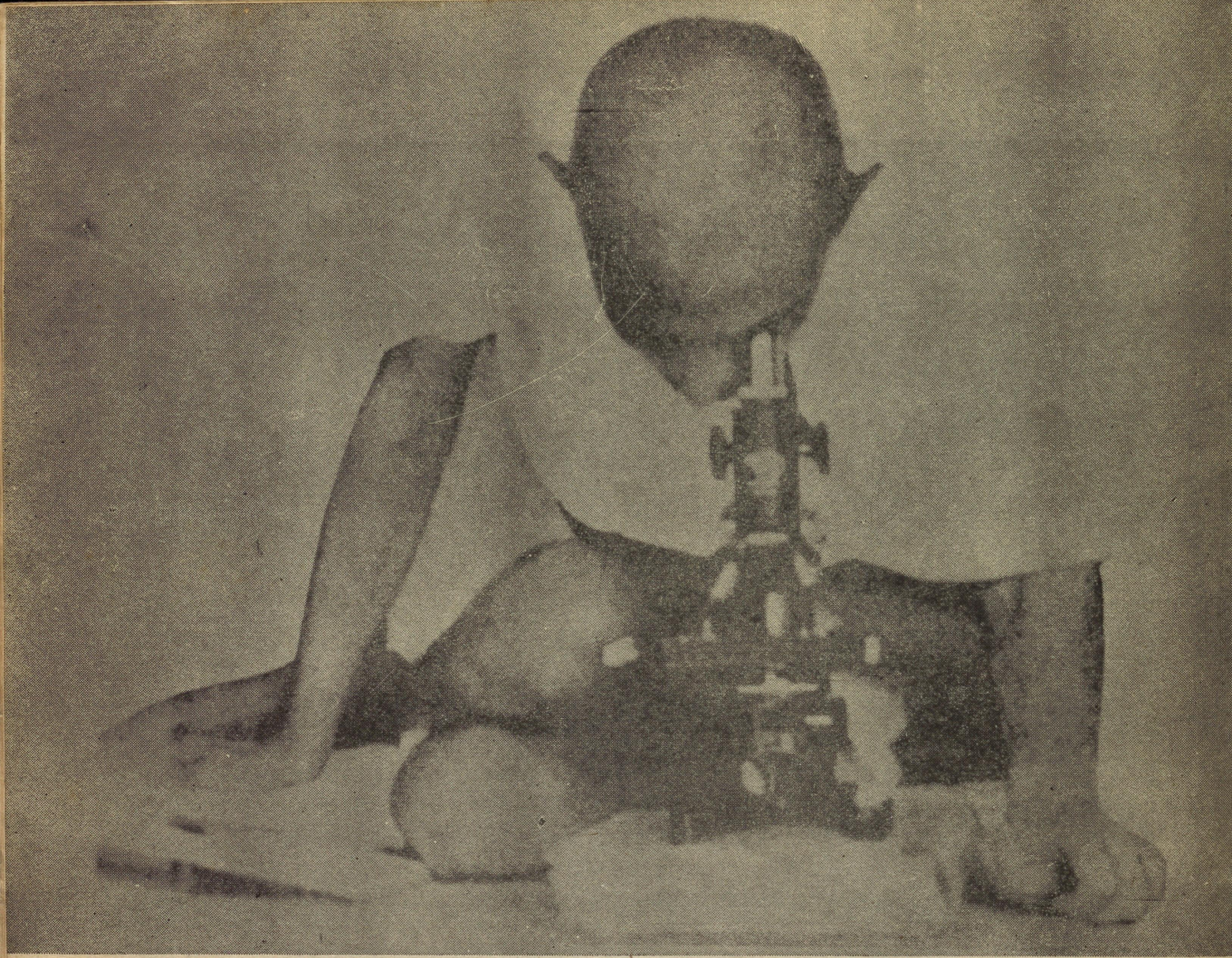
as adults, which has led Dr Cudworth to redefine diabetes as type one or type two, depending on the presence of these antigens.

From these studies is emerging the concept that the development of diabetes is a two-stage process. In the first place there is a requirement for an inherited element, and then a further provocation is required actually to precipitate the clinical disease.

Aetiological studies

Other valuable work on the aetiology of the disease has been done by two groups in London and Edinburgh, who were the first to show that antibodies to the pancreatic isles could be detected in the serum of certain diabetics. In fact, more than 80 per cent of juvenile diabetics have these antibodies in their serum in the first few weeks after the disease is diagnosed.

(Contd. on page 18)



Gandhiji looking through the microscope.



Gandhiji attending on Parchure Shastri, a scholar, who suffered from leprosy.

ANTI-LEPROSY DAY—1978

Every year, India observes 30 January—the martyrdom day of Mahatma Gandhi—as the Anti-leprosy Day. The nation remembers a man who saw in the leprosy patients' lot the root of human sufferings—the selfishness of man, the acceptance of long existing evil as a normal feature of life, and a lack of sense of values which ignore the 'little man' and the 'little thing' which are often the really significant things.

While introducing leprosy work in the constructive programme, Mahatma Gandhi said: "Leper is a word of bad odour. India is perhaps a home of lepers next only to Central Africa. Yet they are as much a part of society as the tallest among us. But the tall absorb our attention though they are least in need of it. The lot of the lepers who are much in need of attention is studied neglect. I am tempted to call it heartless, which certainly it is in terms of non-violence. If India was pulsating with new life, if we were all in earnest about winning Independence in the quickest manner possible by truthful and non-violent means, there would not be a leper or beggar in India uncared for and unaccounted for."

(Contd. from page 15)

It is possible that this is an epiphenomenon in that damage to the islets could release an antigen which then stimulates antibody production secondary to development of the disease.

However, certain patients have been detected where the antibodies to the pancreas are present before clinical onset of the disease. It thus is possible that the disease in certain patients is due to an autoimmune phenomenon, which is not uncommon in other endocrine states such as Addison's disease.

One of the earliest large epidemiological surveys was done in the town of Bedford, north of London, by Professor W. J. H. Butterfield and Professor H. Keen. The study was started more than ten years ago and gave very good figures for the incidence of diabetes in an average community. Many of these patients have been followed up, and exciting results are now emerging to define which patients do or do not develop long-term complications of the disease. It is apparent that many of the patients who would be labelled as diabetics by present-day criteria do not go on to develop eye or blood vessel changes.

It is probable that these long-term studies will result in a redefinition of the diagnostic criteria for diabetes, which obviously will be of major importance to patients with results in the border line area.

Treatment for coma

Another major advance made in Britain in recent years is in the treatment of acute ketoacidosis. For many years treatment of this condition was dictated by dogma and tradition. Dr Peter Sonksen, working in several British Hospitals, challenged these tenets and introduced a much safer, simpler and more logical method of treatment for diabetic coma.

Quite simply this consists of small doses of insulin given either as intermittent, intramuscular injections, or as continuous intravenous infusion. This has greatly simplified the treatment of diabetic coma and has markedly reduced the complications of treatment. Both the intramuscular and the intravenous systems now are used in most parts of the world.

A further development in treatment concerns the use of non-absorbable carbohydrates in dietary therapy of diabetes. These are natural constituents of fibre and it has been shown by Dr David Jenkins and his colleagues in London that the introduction of non-absorbable carbohydrates into the diet can lead to a marked improvement in the control of blood glucose, as well as a fall in blood cholesterol levels. This has

obvious important implications in the treatment of insulin-dependent diabetics and is being actively pursued by several groups.

Again the principle is simple, in that the non-absorbable carbohydrates merely slow down the rate of absorption of sugars from the gut. This is logical as a treatment, because the method by which insulin is given at present—that is subcutaneous injection—results in a slow accumulation of insulin in the blood. This contrasts with the natural physiological state, in which the pancreas release insulin rapidly into the circulation.

If the means to give insulin rapidly cannot be found, then it is sensible to evolve a method to slow down the absorption of food.

Long-term difficulties

The final clinical areas where major advances are being made in Britain concerns the treatment of the long-term complications of the disease. For many years a group at London's Hammersmith Hospital has been examining different methods for treating diabetic eye disease. It was one of the first two groups to show by means of a controlled clinical trial the beneficial effects of removing the pituitary on the further development of diabetic retinopathy.

This proved to have several long-term-problems, and team has gone on to show in a series of carefully controlled clinical studies the value of photo-coagulation—the burning of small new blood vessels that obscure the retina—on the progression of diabetic retinopathy. The group was among the first to prove the beneficial effects of this therapy for severe diabetic eye disease and more recently has shown that early changes in the sensitive part of the eye, the macula, can be prevented from becoming worse by appropriate treatment.

Many other British groups are conducting original basic studies. These include teams working on the mechanism of insulin secretion, on the basic biochemistry of the action of insulin, and on the various metabolic disturbances that may accompany diabetes. Exciting work also is being done on the transplantation of islet cells, on the development of new types of insulin which could be of major benefit in treatment.

It is fair to say that although there are relatively few research workers in the field of diabetes in Britain, their contributions over the past few years have been as important as those from any other country.○

CASE STUDY

PROVIDING HEALTH CARE IN A SLUM IN CANTONMENT

Slums adjacent to military areas are potential breeding grounds for a number of communicable diseases and social evils, thus endangering health and welfare of troops and their families. But a comprehensive health education campaign helps in improving the conditions of slum dwellers.

COL. R. N. VARMA

SLUMS with well-known names like Bari Lal Kurti, B. C. Bazar, Bi Bazar, Ra Bazar exist adjacent to military areas, in most of cantonments. With unsatisfactory sanitary conditions and with slum dwellers ignorant of personal hygiene, the slums are potential breeding grounds for a number of communicable diseases and social evils, thus endangering health and welfare of troops and their families.

Lt.-Gen. P. V. Ramachandran, during his visit to Lucknow (Uttar Pradesh) in early 1976 suggested that Bari Lal Kurti slum in Lucknow Cantonment situated on the outskirts of Army Medical Corps (AMC) Centre and School should be adopted by the AMC for provision of comprehensive health and medical care. The idea was to make

it a model civil locality in the midst of the Cantonment. The measures taken to improve the slum conditions could be adopted in other cantonments.

The project was planned and taken up under the overall supervision of Deputy Director Medical Services Headquarters (DDMS HQ) Central Command. The AMC Centre and School, Army Central Health Education Bureau (ACHEB), Command Hospital (Central Command) [CH (CC)], Base Hospital (BH), Station Health Organization (SHO), Family Welfare Planning Centre (FWPC) and Cantonment Board (CB), Lucknow actively participated in its work.

As the first requirement, a population *cum* sanitation survey was

carried out by the Station Health Organization to collect demographic data and vital health statistics and assess the general state of existing health and sanitary facilities. Concurrently, the ACHEB carried out a "knowledge, attitude and practice" survey to collect information on the prevailing attitudes of the community towards health and disease in general and their immediate felt needs.

Vital statistics

The population of the locality as in March 1976 was 1,136 comprising 582 males and 554 females, with infants (45) pre-school children (140), children of school-going age (334), adolescents and adults (617). Females in the reproductive age group were 278. Of the total





Hazards of waterlogging in the slum of Bari Lal Kurti in a cantonment being explained to the residents of the locality and para-medical trainees

population, 721 were literate (excluding children below five years). On an average there were six members in a family. Of the 156 married couples, 122 were eligible for planned parenthood. The crude birth rate was 42 per 1,000 population, crude death rate was 4.9 per 1,000 population and infant mortality rate was 25.4 per 1,000 live births. There were 189 houses. Ninety per cent of these were one-room hutments with *kutchha* floor. Most of the rooms were small, dark and dingy because of poor ventilation.

Sanitary facilities were very poor with inadequate water supply and poor drainage. Nearly 50 per cent

of the houses had no latrine seats. Being an outlying locality, health and welfare services provided by the local Cantonment Board are meagre.

Health education

Willing and active public co-operation is a *sine-qua-non* for the success of any programme. An intensive health education drive was, therefore, planned and implemented to gain people's confidence to make our services acceptable to them. A house-to-house campaign was done as part of health education drive. An exhibition on health was set up. An almost 100 per cent response from the community augured well

for our future activities. The local community leaders were taken into confidence. The type and manner of delivery of the proposed health care services were tailored to meet their immediate requirements. The people, when approached, clamoured for basic services like enough drinking water, more latrines, general cleaning of the area—in a nutshell an immediate face-lift of the locality within the local resources. An appropriate action with the help of concerned authorities was taken to provide these basic amenities to the extent possible with complete cleaning and white-washing of the local primary school—a "prestige" institution in the locality.



MCH services being provided at the Child Welfare (under five) clinic

Immunization

Immunization services including BCG, polio, TAB, and smallpox vaccination were provided during the drive. School children were thoroughly examined. Those requiring further investigation and treatment were recorded for follow up.

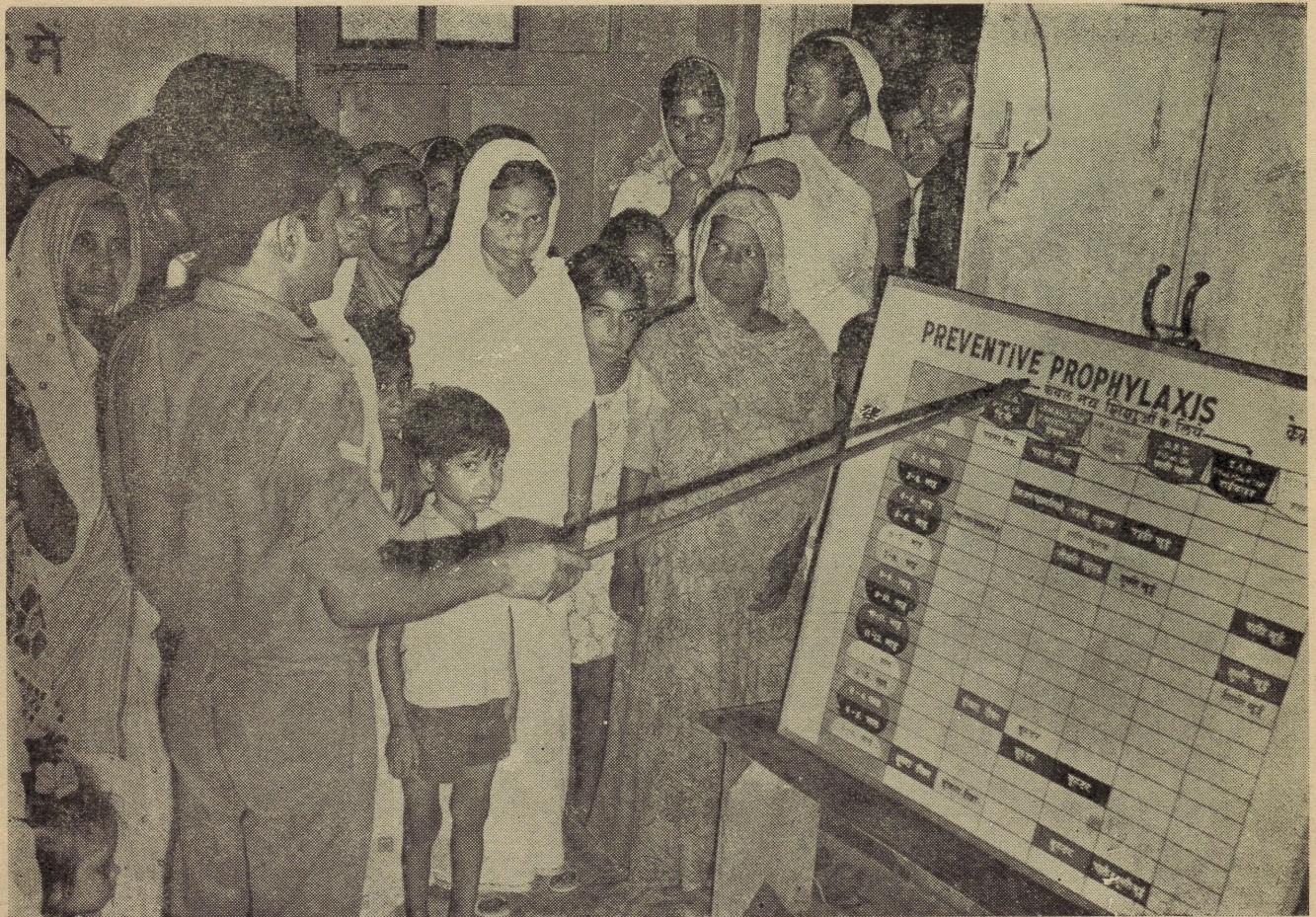
Dental check-up of school-going children was done; and children with minor dental problems were treated. Of the 334 school-going children, 88 suffered from varying degree and type of malnutrition, 12 had defective eyesight, 10 had ear, nose and throat trouble and 56 had dental abnormalities. They have been adequately attended to.

Family welfare

Till this stage, we had deliberately kept quiet about the family planning programme. When the beneficial effects of the health services provided became visible we proceeded to our next programme of covering the expectant and nursing mothers and provided first-aid, diagnostic and treatment facilities on the spot.

An ante-natal team was constituted with a lady medical officer, two nursing officers, one laboratory assistant and one *Ayah* from the Command Hospital, (Central Command), a mobile dispensary with one medical officer, a nursing assist-

ant and an ambulance car equipped with essential drugs from Base Hospital with working elements of the FWPC and ACHEB. The team visited once-a-week at the school building at a time convenient to the people. Adult literacy classes were also organized by the local Cantonment Board which proved popular. The response of the community to the services gradually improved. Taking advantage of this favourable climate, we gradually introduced the family welfare programme. The family planning extension educator/lady health visitor from the family welfare planning centre started visiting the locality to spread the message of 'small family norm'.



An exhibition was set up as a part of the health education drive launched in a slum in a Lucknow cantonment. Photo shows visitors are being explained the preventive prophylaxis

The AMC centre and school, ACHEB and the probationer nursing school are located at Lucknow, where recruits and other ranks undergo basic and specialized training in various para-medical subjects. Trainees from these institutions were given practical field training in this locality. Medical interns and probationer nurses from the CH (CC), sanitary assistant trainees from the ACHEB, recruits/nursing assistants from AMC centre and school were also involved in the delivery of various services, thus giving them the practical community experience.

Fourteen couples had accepted one or the other method of family limitation with 12 sterilizations (males—four, females—eight). A total of 2,000 cases were treated at the mobile dispensary; 40 children and 115 female/male patients were referred to various specialists at CH (CC). The current immunization status of the community is nearly 100 per cent with 250 children up to the age of six years protected against polio; 900 persons of varying age groups given BCG vaccination; 33 children/infants given

smallpox primary vaccination and 393 persons revaccinated.

The teething troubles, common to any such project, having been overcome, the community has now accepted the various services provided, and there is a visible change in their outlook towards health and disease. A comprehensive integrated approach was adopted to provide various community services. There was also the built-in element of training programme. The experiment has shown promising results. And the work will continue. ○

Trends in Planning for Health Manpower

P. HORNBY,¹ A. MEJIA,² D. RAY,³ and L. A. SIMEONOV⁴

THE management of human activities in organized groups has become an increasingly significant issue. Organizations have grown into large entities and the various activities they undertake are increasing in complexity. At the same time, societies as a whole are becoming more concerned with the need to satisfy and protect the individual in his working environment.

Earlier in this century, personnel management was based on a rather simplistic "carrot or stick" approach. It is only in the last two or three decades that the complex and important problems of management have been recognized as requiring skills and techniques that can be taught. One such technique is that of manpower planning, i.e., ensuring that the right number of staff with appropriate skills is available at the right time.

In the development of health services, manpower planning is especially important for various reasons. One of them is that health services are labour-intensive, with the cost of personnel as the largest component in the total cost. Moreover, health services employ people who often need years of specialized training. Thus, unless steps are taken now to ensure that the right staff is trained and will be available in five or ten years' time, the demand for health manpower will not be met by the supply and the health service will not be able to achieve its goals. Manpower planning ensures that such imbalances do not arise, or at the very least are minimized.

Manpower planning must not only ensure that the right training institutions are developed in time but also that the personnel are offered sufficient incentives and career opportunities to attract them, retain them in service, and ensure a high level of individual performance. Such planning takes into account staffing requirements, recruitment, utilization patterns, training, wastage, and retirement, as well as the continuing education of new and existing staff in all the necessary skills.

In many countries, owing to the identification of only some of these aspects as problems of staff mana-

gement and the prevailing piecemeal approach to a solution, it is unlikely that the basic problem of manpower development will be solved, since all the components mentioned above are interrelated. For instance, the rate of retirement and the degree of wastage (rate of pre-retirement leaving) influence staffing requirements and thus recruitment policies and training, which in turn affect career development schemes and the degree of wastage. The methodology of manpower planning aims at integrating all these components so that their interrelationships are explicitly taken into account in meeting future manpower needs.

The manpower planning framework

Manpower planning is concerned with organizing, in systematic fashion, the goals, objectives, priorities, and activities of manpower development in order to ensure that the right number of staff with the appropriate skills are provided at the right time to meet the requirements of the work to be done. The first step is to establish a planning framework that provides an overview of the whole area of decision-making on manpower. In his work the manpower planner has not only to make assessments of the likely manpower demand for certain programmes or schemes but also to compare this demand with the likely supply of manpower from the currently available staff and the new staff being produced by training institutions and/or in-service training programmes.

Fig. 1 shows a simplified framework in which a systematic analytical approach is used to balance the demand for manpower with the supply. The starting point for calculating demand is an inventory of current

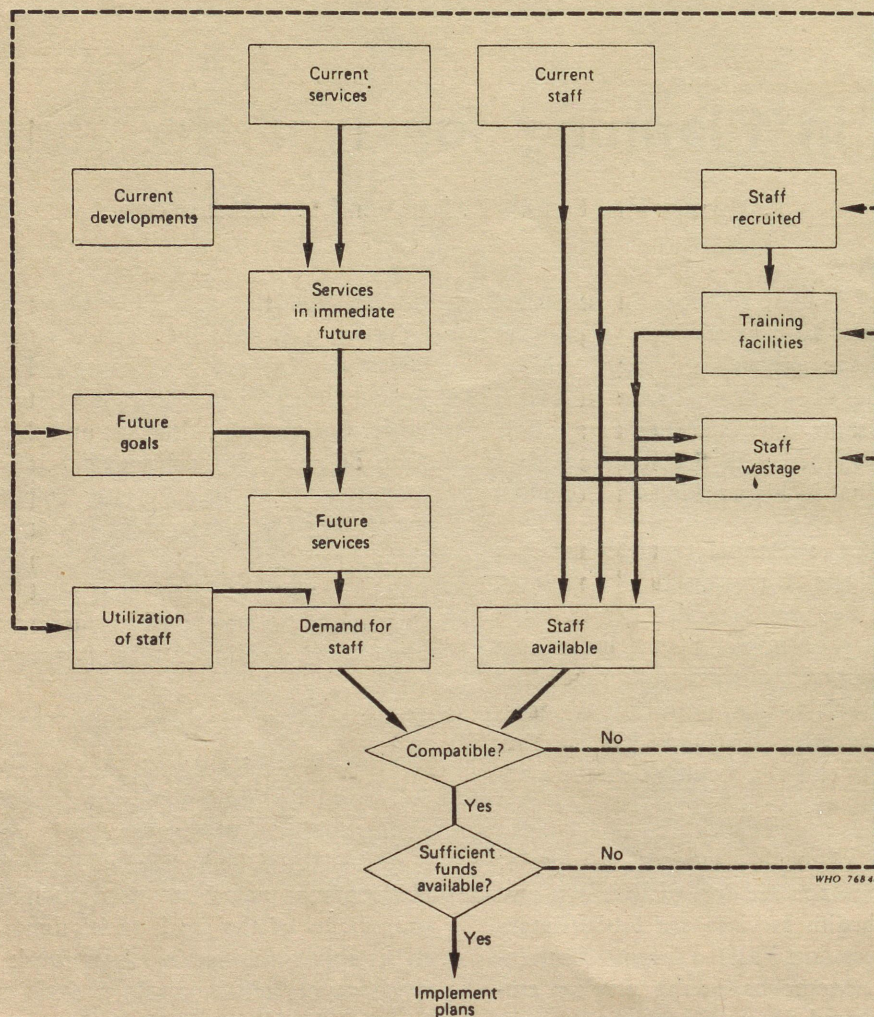
¹Operational Research Specialist, WHO Regional Office for South-East Asia, New Delhi.

²Chief Medical Officer, Health Manpower Systems, Division of Health Manpower Development, World Health Organization, Geneva.

³Scientist, Health Manpower Planning, Division of Health Manpower Development, World Health Organization, Geneva.

⁴Regional Public Health Adviser, WHO Regional Office for the Eastern Mediterranean, Alexandria, Egypt.

Fig. 1. Manpower planning process: a framework



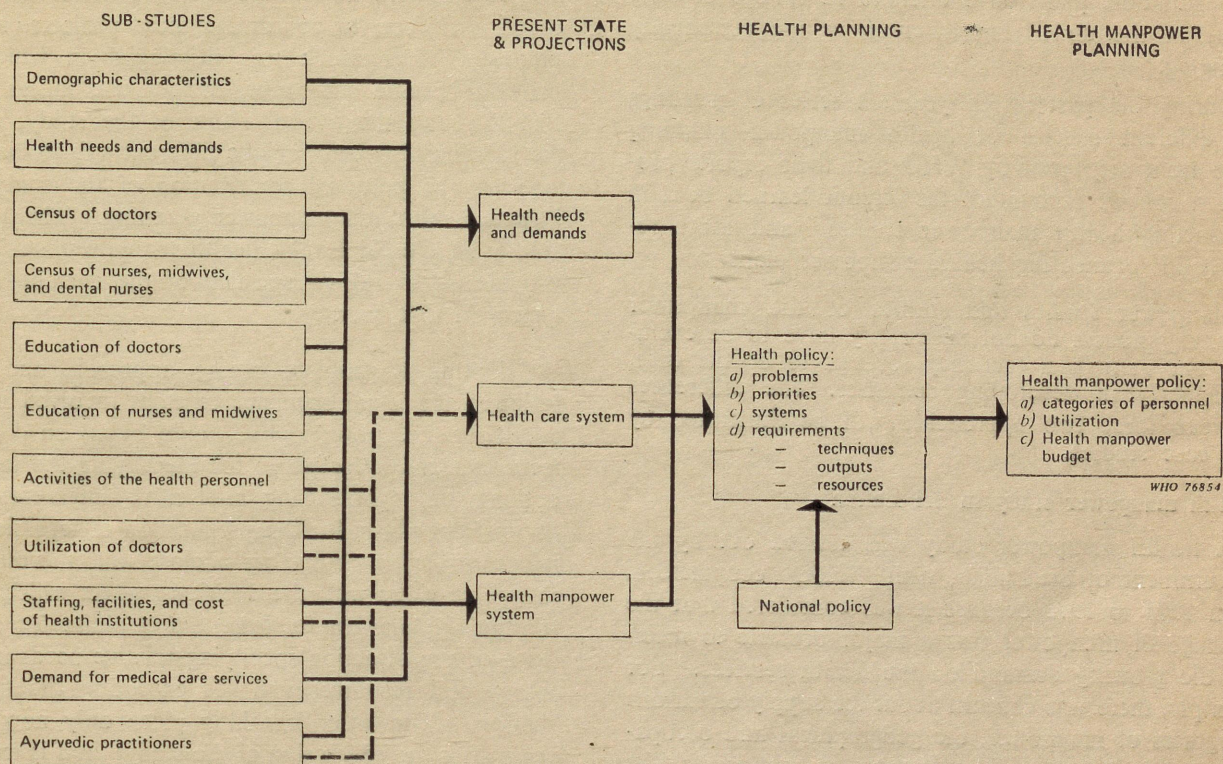
services. However, the inventory will not include current plans for new developments (denoted as current developments) and these must be added to arrive at the overall demand for services in the near future. To this baseline of information on the demand for health services may be added plans for future goals, thus obtaining the requirements of the future health service. These proposals for future services and facilities are converted into manpower requirements with the aid of estimates of staff utilization derived from current patterns of health technology and administration. Taken together, future services and staff utilization provide a picture of total demand in the future.

On the supply side it is necessary to know in the first place the characteristics of current staff (e.g., numbers, age, skill, sex, distribution, etc.), and in particular to assess how many of the present staff of whatever type will remain within the service for each year in the future. To this number should be added the

number of new staff expected to enter or re-enter the service.

Armed with this information, the planner is now in a position to make a year-by-year comparison between the demand for staff and the likely supply. Almost inevitably that first comparison between demand and supply shows them to be unequal, and it then becomes necessary to consider what interventions can be made in the demand/supply process to bring demand and supply into balance. As shown by the dotted line in Fig. 1, interventions can be made to reduce staff loss, change training facilities, change the number and type of staff recruited, or indeed change the utilization of staff or the originally specified future goals. All these possible interventions are interrelated (see Fig. 1) and need to be considered systematically. This last point is of particular importance, and much of the technology of manpower planning has been developed in order that the impact of a

Fig. 2. Interrelationship of sub-studies in the health manpower study in Sri Lanka (1971-73)



particular intervention can be seen as it affects the whole process of producing, deploying, and utilizing manpower.

The development of manpower planning

Manpower planning has since the beginning of the century been based on intuition or impressions, the explicit application of comprehensive planning technology to health manpower problems being a recent development. It is therefore only in the last decade or so that countries have started to link their training plans to the requirements of the health service system. On the whole, past planning efforts have usually been spasmodic, crisis-oriented, sometimes very sophisticated, and often ineffective.

Two types of major studies of health manpower problems have been undertaken in different countries. The first type, which we shall call manpower studies, seeks to improve the quality of information about manpower and is usually carried out on a large scale. The second type, studies of the manpower planning process, makes use of the available information and seeks to improve the quality of the analytical and decision-making process in health service management.

Aided by the rapid development of sampling theory and survey technology, the first type (manpower

studies) became very popular in the 1960s. A number of health manpower studies varying in scope, methodology, and sophistication have been carried out by Member States, some of them with WHO cooperation. Most of these studies adopted a research approach and tended to focus more on the final report than on the processes involved. On many occasions a great effort was made to gather and analyse information without necessarily relating the results to the capacity of the country to absorb and use such information for decision-making and the formulation of plans. Furthermore, it often took too long to complete the study, and this added to its cost. National authorities frequently lost interest because of the delay in obtaining the findings, which in any case were often of limited use for drawing up and implementing plans.

Recently more emphasis has been placed on treating health manpower planning as a continuous process, because it is now realized that it cannot be an *ad hoc* and time-limited activity. A health manpower planning system needs to do three things: (1) plan for health manpower development; (2) take steps to facilitate the implementation of the plan; and (3) organize the complex planning process itself. So far, studies of the health manpower planning process have concentrated on the first stage without paying adequate attention to the other two, so that many plans have not

been implemented. Moreover, in a dynamic and changing situation, plans have often to be revised because many of the underlying assumptions are continually changing.

During the past fifteen years, a series of meetings on different aspects of health manpower planning have been organized by WHO and their reports provide a concise account of the lessons learned both in conducting health manpower studies and more recently in formulating health manpower plans.

Manpower studies and studies of the manpower planning process do not necessarily have to be exclusive but there is a tendency for this to be the case, particularly in developing countries. The differences between these two approaches will be illustrated by two case studies.

Health manpower study in Sri Lanka

A health manpower study was carried out by the Government of Sri Lanka, with WHO cooperation, from 1971 to 1973 because it was considered that the shortage of manpower was a major obstacle to meeting the growing demand on the health services. For example, there was concern about the supply of various categories of manpower, the geographical and occupational distribution and utilization of manpower, the relevance of present systems of medical education, and problems arising from the emigration of health personnel.

It was explicitly stated that the study should be carried out in a context of national socioeconomic development plans and that it should be a model for the health planning process in the country. In particular, guidance was needed on such matters as improvements in health policy formulation, integration of service activities, and coordination between the producers and users of health manpower.

To work towards the attainment of the above goals, the following objectives were outlined:

- (1) To determine the pattern of health manpower utilization within the current health care system in order to: (a) identify the points of intervention for the improvement of productivity, and (b) redefine the roles of the basic health occupations.
- (2) To determine the present needs and demands for health services in order to predict future health manpower requirements.
- (3) To initiate the process of redefining the educational goals for the health professions.

Methodology

The original proposal of a number of projects, each concentrating on a health occupation or a set of health

activities in isolation, tended to retain the old fragmented structure of health manpower in Sri Lanka. In order, therefore, to coordinate these projects, a comprehensive framework was developed in which the projects became sub-studies within one major study. Fig. 2 shows the overall scope of the study, depicts the relationships between the different sub-studies, and suggests the potential contribution of the study findings to health and manpower planning. The 11 sub-studies in the Sri Lanka health manpower study thus provide an overall perspective of the current health system in that country.

Adopting a problem-solving approach, the study followed the usual sequence of steps involved in such a process, i.e., a *descriptive* phase based on data collection; a *predictive* phase for identifying the range of options and synthesizing alternative interventions; a *prescriptive* phase for the preparation of feasible alternative strategies (involving a close and thorough exchange of views with the decision-makers which is still continuing); and an *implementation* phase for designing a course of action specifying relative needs in technology and resources and for executing the planned changes. The latter is taking place only now (three years after the conclusion of the study) and is expected to continue for some considerable time.

The decision-making process

In the early 1970s in Sri Lanka, the programme of the newly elected government included a long list of changes in the political, economic, and social sectors. A new constitution proclaimed the country a republic, abolished the Senate or Upper House of Parliament, and established a National Assembly instead. Land reform and a programme to control increasing unemployment were two major points in the Government's economic programme. The Government introduced a Five-Year Plan (1972-76), in which the objectives and strategies of development were stated. This was the first real effort to formulate a structured medium-term development strategy and represented a step forward, in comparison with the Ten-Year Plan (1959-68), which was never taken as a specific programme for implementation. Innovations were also introduced in the educational system of the country. The participation of the public at the consumer level in controlling the activities of some Government sectors was encouraged and special Janatha Committees (People's Committees) were established for this purpose. A search for new ideas could also be perceived in the Ministry of Health and certain changes were made (e.g., discontinuing the training of "assistant medical practitioners" and filling their posts with medical officers).

A significant feature of the Sri Lanka Health Manpower Study was the special effort to organize an appropriate decision-making body. To this effect a National Advisory Committee for Health Manpower Planning was appointed, with 22 members representing a broad spectrum of disciplines among the most important interested groups and including decision-makers both in health services administration and in the field of education for the health occupations. The Committee included representatives of the Ayurvedic (indigenous) system of medicine which in Sri Lanka has three times more practitioners than the system of western medicine.

The Advisory Committee was meant, *inter alia*, to represent the interests and viewpoints of different groups; to promote inter-institutional coordination; to enlist community, professional, and public cooperation; and to promote a climate favourable to the utilization of findings for policy formulation and decision-making. The Committee identified potential points of intervention where decisions were needed. In addition, the implementation of the different sub-studies involved the active participation of more than 50 individuals from various institutions concerned with health manpower.

On the basis of the study's findings the Health Planning and Programming Section, Ministry of Health, put forward five options for the delivery of health services in Sri Lanka. Some of these were field tested and submitted in 1975 to the competent authorities for a decision. A Committee was recently appointed to prepare a plan of operations for implementing the option chosen. The study has brought together a wealth of information, which previously had been used in a fragmented manner, about both manpower and health services in Sri Lanka. Before 1975, the largest users of some of the information were medical educators, and it is only recently that the Ministry of Health has started using some of the major findings for planning health services for the future. The full potential of the study's findings has not yet been realized and unless a deliberate effort is soon made in this direction, the information may become obsolete before it is used.

A study of the health manpower planning process

The health manpower planning study for rural water supply and sanitation represents a different approach to the problem of planning for manpower development and utilization. In this approach, greater emphasis is laid on improving the analytical and decision-making processes than on improving the quality of the information available to the planners and decision-makers.

Although the case study was concerned with only certain types of environmental health personnel, the concepts and techniques used are of wider applicability. The study was undertaken in a developing country whose government is making a strenuous attempt to improve the present low standard of rural water supply and sanitation as rapidly as possible. The study is relevant since the major obstacle to the development of water supply and sanitation facilities is the shortage of trained manpower. The decision-makers therefore wish to assess the future supply of manpower in order to ensure a balanced commitment of other resources.

Methodology

Some small manpower surveys undertaken prior to the planning study on rural water supply and sanitation were only partially relevant to the personnel to be considered. Thus, without data from a planned manpower study, it was necessary to rely on routine data from many different sources (Ministry of Health, Ministry of Education, Bureau of Personnel, Ministry of Finance, etc.), the opinions of managers at different levels in the service, and the results of some small research projects on manpower. In fact, the data available to the service managers themselves were used, but an attempt was made to bring the information together into a coherent whole and analyse it in a systematic way.

Although there were no definite long-term targets for the expansion of rural water supply and sanitation facilities, the commitment to large-scale expansion was abundantly clear. However, the need for a more precise basis for assessing future manpower demand was met by analysing the current activities for expansion and then making three sets of projections based respectively on a high, medium, and low rate of development (with the current rate of development as a median). These projections thus provided a way of identifying the range of feasible future goals.

The conversion of these goals, expressed as populations to be covered by water supply and sanitation services, into requirements for developing different types of water supply and sanitation facilities was achieved by using the results of earlier small-scale studies and modifying them in the light of informed service opinion. This calculation turned out to be a particularly sensitive factor in the manpower estimates and pointed to the need for more accurate studies on populations served by different water supply schemes.

Determining the manpower required to develop and maintain these different schemes also gave rise to some

uncertainty and indeed conflicts of opinion. However, the different views had enough in common to suggest that the present manpower predictions may be reasonably accurate. By multiplying the number of schemes required for each year by the staff required to develop and maintain each type of scheme, a year-by-year statement of the manpower required was obtained for each of the projections.

To determine which of the schemes would be feasible it was necessary to assess the likely availability of trained manpower in the years to come. The number of staff currently in service was fairly well known although it is possible that quite a few were miscounted through being listed under titles masking their actual background and function. This turned out not to be a particularly significant problem because of the small number of staff in this situation and the magnitude of the proposed expansion. Once the number of current staff had been established it was necessary to determine the losses likely through retirement and sickness and through transfer to other occupations. This information was not available but it was possible to obtain from the age distribution of the staff an idea of the loss due to retirement. The pre-retirement losses were found to be small enough to be disregarded.

The real issue was the capacity of the training institutions to increase their output of trained manpower. There was absolutely no experience to show how quickly this capacity could be changed, and it was necessary to rely almost entirely on informed opinion to ascertain the rate of expansion of the institutions. Once it was determined how the stock of manpower might change, it was possible to compare the demand with the likely supply of staff for each of the years ahead.

It was immediately apparent that the projection based on a high rate of development was not feasible in any circumstances. The other two—the intermediate- and low-rate alternatives—did seem possible, but it was still uncertain how the salaries of the staff would be met in future years. The financial policies of the central government aimed at increasing the financial self-sufficiency of the lower administrative units, and doubts were expressed whether these units could bear the expanding operational costs of the projected development schemes. It was not possible to resolve this issue at the time.

After this preliminary feasibility test, the possibilities for diminishing the effective demand and increasing the effective supply were reviewed. On the supply side, staff wastage was already so low that any further

reduction hardly seemed possible except in the period of transition between completion of training and employment in the service. There were significant problems of incoordination between training and recruitment, with the result that trained staff drifted away from the service. Some recommendations for strengthening this coordination were therefore made in order to reduce the losses.

On the demand side, the numbers of staff required could be reduced by improving their utilization and some suggestions were made on how this might be done. However, the actual level of utilization and the actual population coverage provided by a given service needed to be established much more clearly before any serious attempt could be made to improve staff utilization.

The decision-making process

The health manpower planning study for rural water supply and sanitation furnished the decision-makers with data on the implications and out-comes of adopting different growth and training policies and provided a mechanism for assessing how these outcomes would change if the policies and the future goals and targets were changed. It also highlighted the most sensitive factors and hence the aspects of the planning process that needed further and more detailed examination. The study did not produce a decision on recruitment, deployment, and utilization of staff but rather provided decision-makers with information on which to base their judgements and make a choice.

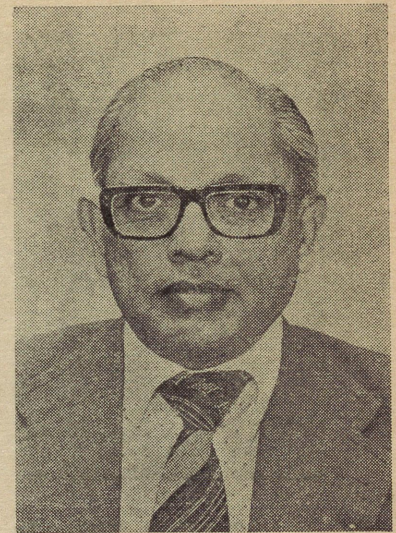
Comparative analysis

The basic difference between a manpower study and a study of the manpower planning process is that the former concentrates on improving the data base for planning while the latter aims at strengthening the analytical and decision-making structure of planning with the help of the available data. However, they have a considerable degree of overlap both in intent and methodology. The long-term aim of both types of study is to strengthen the planning and decision-making process. Both analyse similar areas of information. Both aim at improving identical aspects of health manpower (including utilization), strengthening training institutions, and establishing a firmer basis for predicting manpower requirements.

The proliferation of manpower studies has arisen from the demand of planners for comprehensive basic data. The collection of such data and their analysis

(Contd. on page 37)

OUR NEW DIRECTOR-GENERAL OF HEALTH SERVICES



Dr B. Sankaran

DR BALU SANKARAN has taken over as Director-General of Health Services, New Delhi from 4 January, 1978. He succeeds Dr. P.P. Goel. Prior to this he was Director-Professor of the Central Institute of Orthopaedics, Safdarjang Hospital, New Delhi (Delhi University), from March 1970.

Born on 4 September, 1926 at Madras in Tamil Nadu, Dr Sankaran has had a distinguished career before taking over the present position. He was Assistant Professor of Orthopaedic Surgery (1956-61) and Associate Professor of Orthopaedic Surgery (1963-67) in the All India Institute of Medical Sciences, New Delhi. He was Professor of Orthopaedic Surgery, Maulana Azad Medical College, New Delhi from 1967.

Dr Sankaran was Medical Superintendent of the Safdarjang Hospital, New Delhi from May 1971 to July 1972. He has been the Chairman, Artificial Limbs Manufacturing Corporation of India (A Government of India Undertaking) from December 1972.

Dr Sankaran is Fellow of the Royal College of Surgeons, Canada; Fellow of Academy of Medical Sciences; Overseas Fellow, British Orthopaedic Association.

Dr Sankaran was awarded Rockefeller Foundation Fellowship (1961-63) when he was working as Associate Professor and Research Associate, University of Illinois (Department of Orthopaedic Surgery).

He has been a Fulbright Travel Grantee in 1951 for Postgraduate training at Columbia Presbyterian Medical Centre.

Dr Sankaran is a Member of a number of national and international organizations such as the Board of Editors of the International Reviews of Orthopaedic Surgery; Orthopaedic Synopsis Foundation (International); Journal of Applied Medicine (Indian); International Orthopaedic Correspondence Club (limited to 100 members) throughout the world; Expert Committee on Bio Engineering of the Indian Council of Medical Research; AP Tech. (Application of Techniques for developing countries); and Indian Standards Institution, Government of India.

Dr Sankaran has contributed a number of scientific articles on orthopaedic surgery to the national and international journals which include the *Journal of Bone and Surgery*, the *AMA Archives of Surgery*, the *Indian Journal of Medical Association*.

He has also contributed chapters on various aspects of orthopaedics in the "Textbook of Orthopaedic Surgery" being published by the National Book Trust of India.

Dr Sankaran has been a Visiting Professor of Orthopaedic Surgery to the Universities of Karnataka, Kerala, Banaras, Agra. He has been guest lecturer, University of Chicago, American Academy of Orthopaedic Surgeons, etc.

He has also been Chairman of many national and international seminars and workshops. ○

Jan.-Feb. 1978



The Union Minister for Health and Family Welfare, Shri Raj Narain, inaugurated the XV International Congress of Paediatrics on 23 October, 1977 in New Delhi. Also seen from right to left are: Mr N.S. Tibrewala, President of the Congress; Shri Raj Narain; Dr I. Dogramaci, President of the International Paediatric Association and Dr V.T.H. Gunaratne, WHO Regional Director, South-East Asia Region

XV INTERNATIONAL CONGRESS OF PAEDIATRICS

SHRI RAJ NARAIN, Union Minister for Health and Family Welfare, said in New Delhi on 23 October that India would welcome international cooperation in providing health care for the children.

He added that the child welfare was an integral part of the social justice to which the Government of India was committed. He believed that if children's health was improved and infant mortality reduced, people would be keen to reduce the size of the families.

Shri Raj Narain was inaugurating the XV International Congress of Paediatrics in New Delhi. Over 3,500 delegates from India and various parts of the world attended the week-long Congress.

Shri Raj Narain said that 12 per cent of the children in India who died of various diseases might have been saved if they had been immunized. Another 30 per cent died of pneumonia, diarrhoeal and other conditions. Malnutrition accounted for other 30 per cent of the deaths. Thus there was a great challenge to the public health system. But, he said, the doctors alone could not solve the problem. Overall social development was the answer, Shri Raj Narain added.

That was the reason why the Government of India was giving much attention to the rural development and to increasing the earnings of the people who lived in villages. Only when the people's economic con-

ditions improved they would be able to give themselves and their children proper medical and health care.

The Minister said that he was proud of the traditional Indian systems of medicine and paediatrics has long been mentioned as a special branch of medicine.

Earlier, Prof. N. S. Tibrewala, President, XV International Congress of Paediatrics, called for concentration of efforts on the eradication of malnutrition, infectious diseases, respiratory and other infections and diarrhoeas which accounted for a significant percentage of child morbidity and mortality in the developing countries. The main stress in these countries should be on preventive measures and on improving nutrition and personal hygiene and environmental and public health so as to reduce the load on curative services.

Prof. Tibrewala said that paediatrics had made tremendous progress in India and other developing countries. He added: "Even as paediatrics continues to develop at a fast pace in these countries, I would like to sound a note of warning at the introduction of large scale sophistication of paediatrics being attempted at each and every centre. We must lay down priorities".

Prof. Tibrewala said that the emblem and the theme of the Congress took note of the current status of breast feeding the world over. The theme was "Breast

feeding with love leads to better child health". This was most appropriate for a country (India) where breast-feeding had been advocated and practised to date from time immemorial.

Prof. Ihsan Dogramaci, President of the International Paediatric Association, said that large international congresses also had their usefulness and should be continued. In addition to their scientific value, such congresses brought a large number of paediatricians closer to each other and gave many a colleague a chance to visit countries far from their own homes to gain an idea of conditions in other places.

Invest in child health

Dr V.T.H. Gunaratne, WHO Regional Director, South-East Asia, said: "Despite the major advances that have taken place in science and technology in the last decade, including those in the field of paediatrics and child health, it is a sad fact that the majority of children in the world at present have no access to, and do not benefit from, such advances." The most urgent and challenging task facing us today, he said, was to apply the existing knowledge and provide basic health and health-related care to the millions of under-served children in the urban *ghettoes* and rural areas of the world.

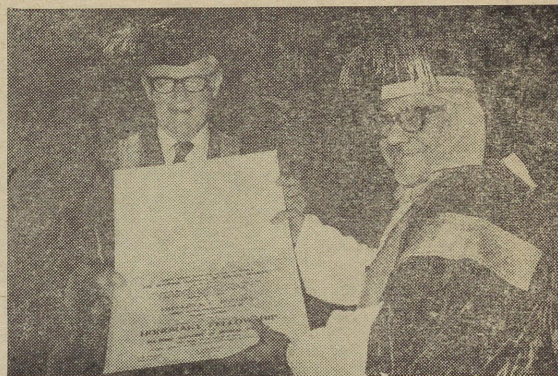
The investment in childhood was not only desirable for humanitarian reasons, but crucial for the overall goals of development, he said.

Dr Gunaratne said on a global basis, priorities in child health must be considered in the light of these facts that more than 80 per cent of the annual 125 million births took place in developing countries, where malnutrition, infection and the consequences of unregulated fertility contributed the highest number of perinatal, infant, childhood and maternal mortality and morbidity. These causes in turn were the result of poor environmental conditions, inadequate education, health and other related social services, he said.

In South-East Asia, and in most developing countries, acute diarrhoeal diseases in children and the six common infectious diseases—tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis and measles—are of social importance as they take a heavy toll of infants and small children," he said.

Only through primary health care which integrated at the community level all the elements necessary to make an impact upon the state of health of the people the basic health needs of the under-served population and their children could be met and the goal of "Health for all by the year 2000" reached, he said.

Jan.-Feb. 1978



AIIMS Honours Two Foreign Doctors

Two of the eminent child specialists attending the XV International Congress of Paediatrics held in New Delhi were made Honorary Fellows of the All India Institute of Medical Sciences at a special convocation of the Institute held in New Delhi on 25 October, 1977. Shri Raj Narain, Union Minister for Health and Family Welfare conferred the Honorary Fellowships on Dr Frederic C. Robbins of the U.S.A. (seen in the photograph above) and Dr I. Dogramaci of Turkey.

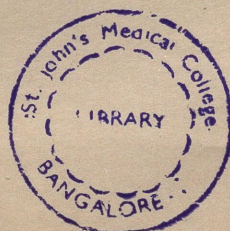
Prof. Robbins, who is a Nobel-Laureate, was honoured in recognition of his work on virus diseases with Dr John Fenders at the Children's Hospital, Boston. He and his colleagues pioneered techniques which made possible the development of polio vaccine.

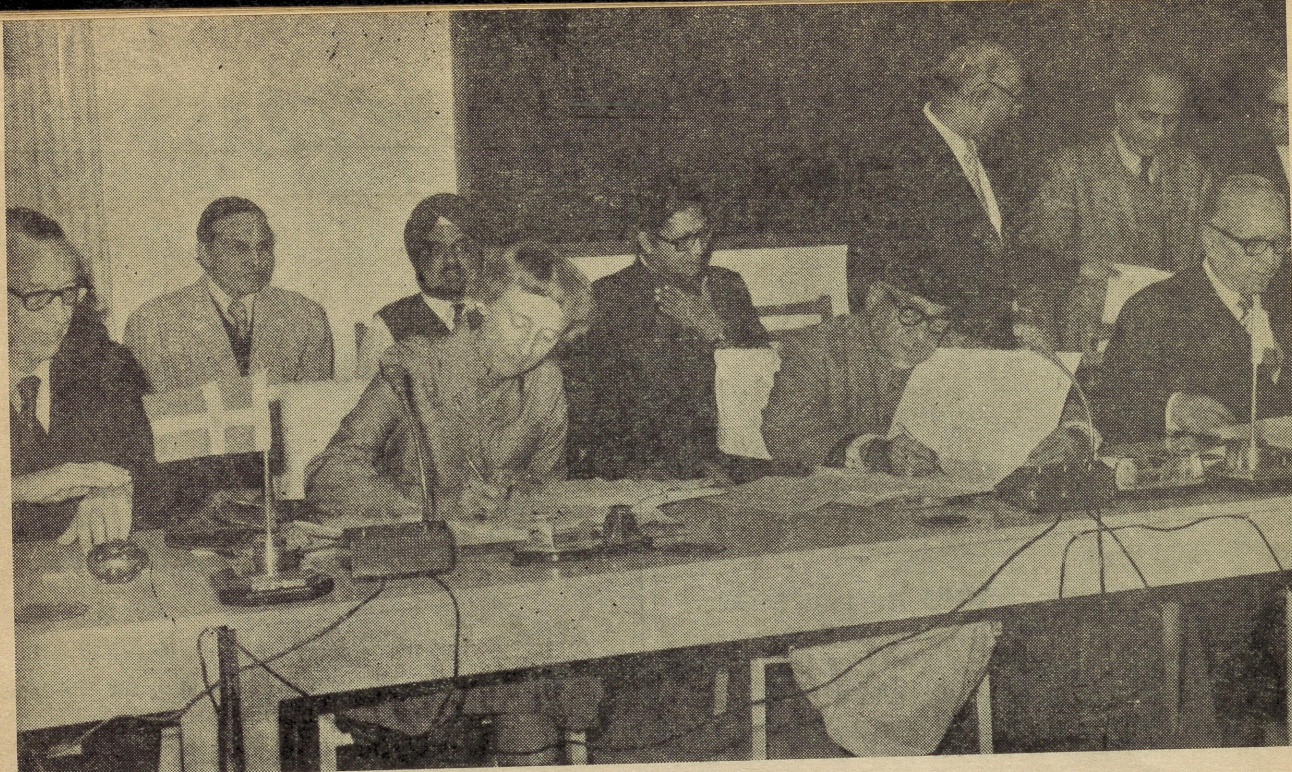
Dr Dogramaci is Professor of Paediatrics, Director of Child Health and President of Hacettepe University Children's Medical Centre at Ankara, Turkey. The citation read out on the occasion said Dr Dogramaci had provided dynamic leadership to the international movement for the improvement of child health, and had done original work on metabolic disorders.

Addressing them as "Acharya", Shri Raj Narain said, the work of both paediatricians had had significance far beyond the boundaries of the countries to which they belonged, and had contributed to the promotion of child health throughout the world.

There had never been so much awareness at the local, national and international level of the need to mobilize all sources to improve the health of children. To help meet this challenge the United Nations had designated 1979 as the International Year of the Child.

A commemorative stamp and first-day cover to mark the occasion was released by the Union Minister of Communications, Shri Brij Lal Varma. The two-rupee, light blue and brown stamp shows "mother and child", a sculpture from *Khajuraho*, now in the Indian Museum, Calcutta. —T.K.T.





Shri Raj Narain, Union Minister for Health and Family Welfare, India (right), and Mrs Lise Ostergaard, Minister without Portfolio in the Royal Danish Ministry of Foreign Affairs, Denmark, signed an agreement on behalf of their respective Governments in New Delhi on 15 January, 1978 under which the Danish International Development Agency will give assistance to India's National Programme of Prevention of Impairment and Control of Blindness.

DANISH AID TO BLINDNESS CONTROL PROGRAMME

INDIA and Denmark signed an Agreement in New Delhi on 15 January, 1978, under which the Danish International Development Agency (DANIDA) will give assistance to India's National Programme for the Prevention of Visual Impairment and Control of Blindness. The Agreement provides assistance to the tune of 60 million Danish Koror (Rs. 8.5 crores) for the Mobile Ophthalmic Units and equipment for the Primary Health Centres, Taluka and District hospitals. A part of the recurring cost of the Mobile Units will also be covered by the Danish Government. The total programme will cost about Rs. 20 crores up to 1983-84, and the balance will be incurred by the Government of India.

Shri Raj Narain, Union Minister for Health and Family Welfare, signed the Agreement on behalf of the Government of India and Mrs. Lise Ostergaard, Minister without Portfolio in the Royal Danish Ministry of Foreign Affairs, signed it on behalf of the Government of Denmark.

Shri Raj Narain said that India had always valued the "very sincere and valuable assistance" rendered to the national programmes for health and family welfare by the Government of Denmark starting with pro-

jects such as the Indo-Danish Oral Cancer Control Project at Trivandrum. The Danish Government had aided many other projects such as the establishment of Speech and Hearing Units at four places, upgrading of the Speech and Hearing Institute in Mysore, supply of equipment for the Central Drug Research Institute, Lucknow, and the large assistance provided for the construction of the building complex of the National Institute of Health and Family Welfare at New Delhi.

Shri Raj Narain said that the Government of India was 'firmly committed' to the task of providing primary health care to the millions of the people living in remote areas. The government was promoting schemes which directly concerned and benefited the common man.

The scheme for the Prevention of Visual Impairment and Control of Blindness is also a step in the same direction. Extensive eye health education programme through mobile units and strengthening of the permanent infrastructure for community-oriented eye health care at the field, intermediate and the Central levels were important components of this programme.

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Swasth Hind

HEALTH AND FAMILY WELFARE PAVILION AT

AGRI-EXPO '77

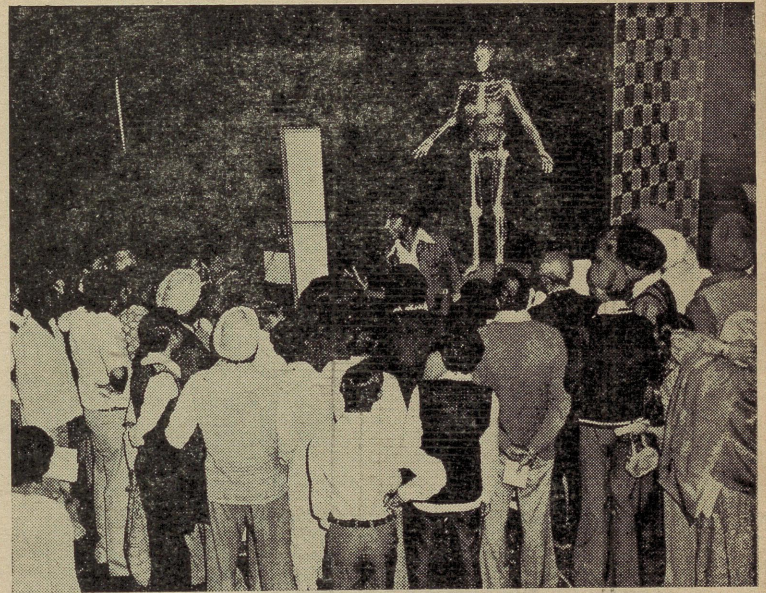
How does your liver function? How goes your heart? What are the muscles, veins, etc? and what do they do? These and scores of other questions were answered by a "Glass-Woman" at the Health and Family Welfare Pavilion, of the Agri-Expo 1977, organized in New Delhi by the Trade Fair Authority, Government of India, from 13 November to 14 December, 1977.

Another attraction in the pavilion, for a layman, was demonstration of yoga exercises, three evenings a week by trained male and female instructors. These exercises taught the viewers on how to keep diseases away and stay healthy the yoga way. Still another popular feature in the pavilion was screening of educational filmshows on a variety of health subjects. These drew huge crowds daily.

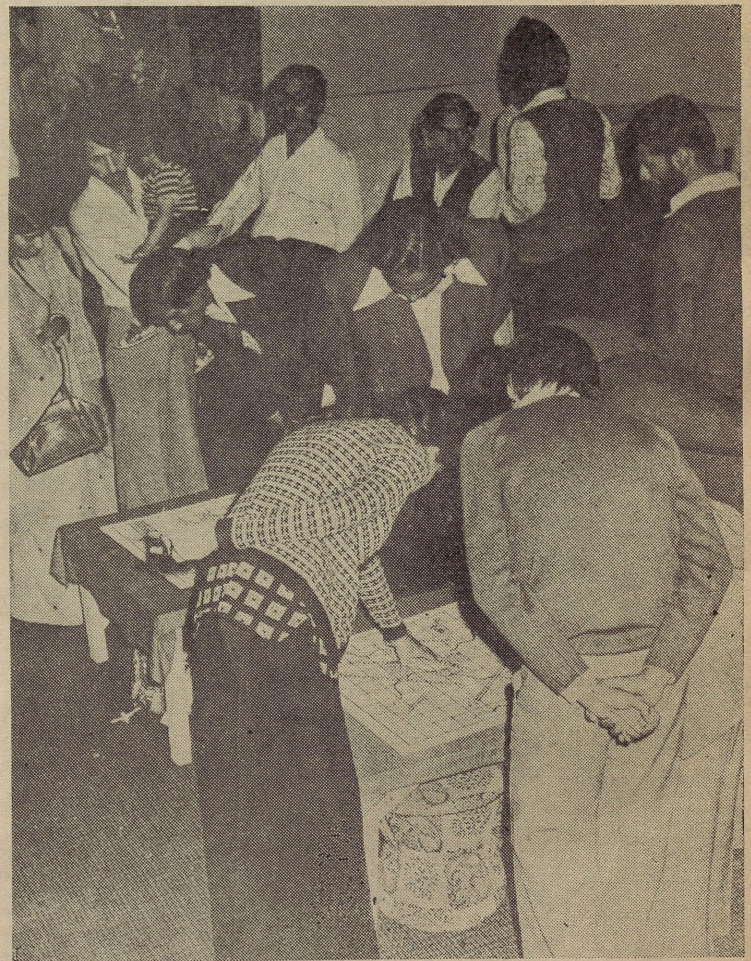
The pavilion was designed, assembled and put up by the Central Health Education Bureau on behalf of the Ministry of Health and Family Welfare. It depicted the present strategy of the Government of India for raising the health status of our people, particularly the vast multitude residing in nearly 600,000 villages. The new Rural Health Scheme got a prominent display. The objective was to reach the message of good health to as wide a group as feasible through the medium of words, visuals, models and charts.

Three sections

The health pavilion had three sections. The first section explained the Rural Health Services, the second covered the Maternal and Child Health (MCH)



"Glasswoman"—a star attraction of the exhibition.



Indoor games for health education of the children proved popular.



and Family Welfare Programmes while the third gave a gist of the major health problems presently confronting the nation and programmes in operation to control them.

The visitor was greeted at the pavilion by a big-sized photograph of the Prime Minister, Shri Morarji Desai, addressing a huge rural audience. Shri Desai's words were "India has 80 per cent of her population residing in villages. Obviously, the country's prosperity depends on their prosperity."

Successive visuals depicted that our villagers lead an active and yet simple life, they have pride in their rich cultural heritage.

How is their health taken care of? Presently, 5,373 primary health centres (PHCs) and 37,931 sub-centres offer services for their preventive and curative needs. Details of the services provided by PHC were given. A PHC scene was created to lend appeal.

Community health worker

A model of a Community Health Worker (CHW) with folded hands was depicted. This worker is an important element under our new Rural Health Scheme, launched on 2 October, 1977. The succeeding panels offered a fund of information on the various aspects of the Rural Health Scheme for one and all, be it a medical or a nursing student, a school boy or an office goer.

The exhibits showed that every village with a population of 1,000 will have a CHW. This worker, selected from the community and for the community, will take care of people's essential health needs. A series of photographs depicted the training strategy of the CHW.

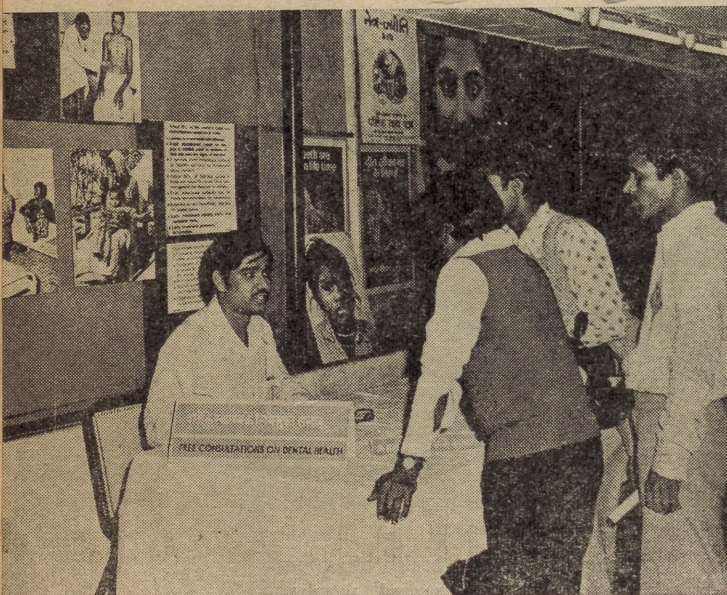
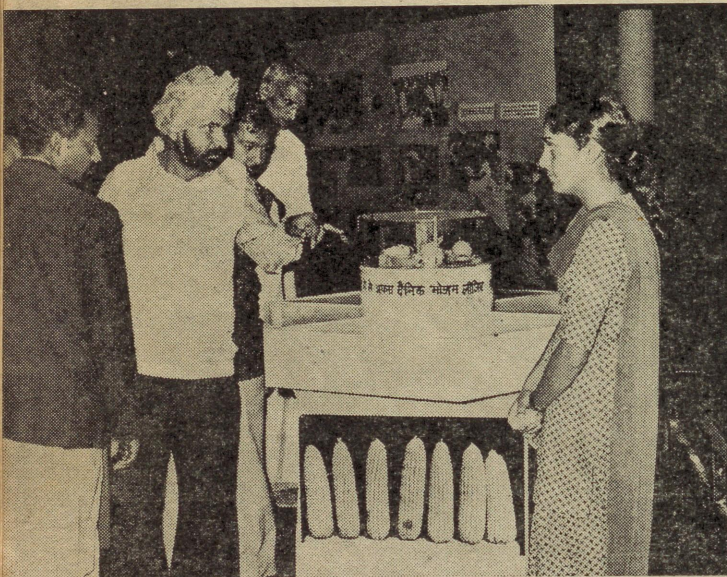
An attraction in this Section, which was of particular interest to farmers and other visitors from villages, were models of sanitary well, soakage pit, compost pit, sanitary latrine and smokeless *chulha*, all designed to improve the health of every individual and family in Rural India.

The second section of the pavilion gave details on family welfare and MCH programme. Among its attractions were a working model on children's growth step by step, a questionnaire on various health aspects, such as, why balanced diet, nutritional requirements of different age groups and segments of population. A rotating model described the six basic food groups on which our daily meals should be based.

Top: Services provided by primary health centres.

Middle: Helpful hints on balanced diet.

Bottom: Free consultation on eye care and dental health.



The exhibits also stressed the importance now being given to the training of *dais*, traditional midwives to take care of child birth in the rural area. The various aspects of baby care, immunization and nutrition for mother and child were also explained through photographs, models and charts.

Population explosion

A few steps ahead, a tell-tale clock depicted the grim reality of population explosion in the country—how speedily we are adding to the country's population in 1½ seconds, one minute, one hour and one day.

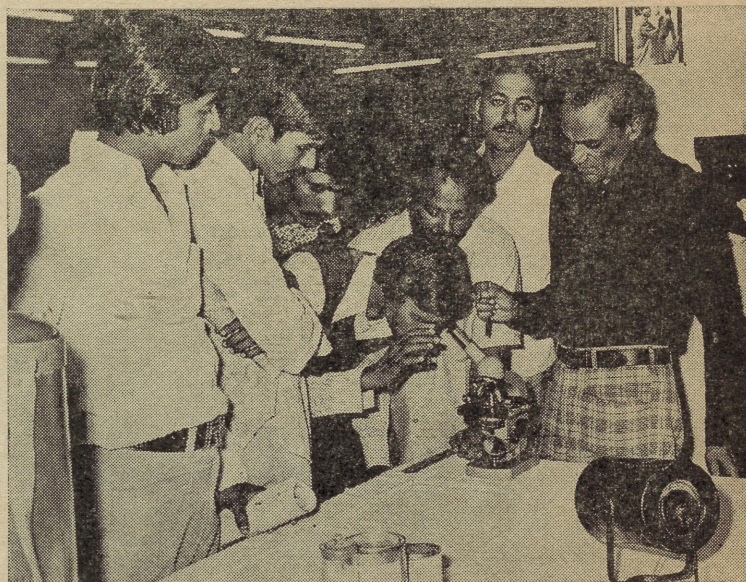
Next, it was impressed upon the viewers that there would be no coercion to make people accept family planning. "Family planning is a purely voluntary programme. There is no compulsion. It is in the interest of the family, the community, and nation to keep the family small" the message read. Other aspects of family welfare covered included details on the easy availability of Niroth through various convenient outlets. The emphasis being given to ancient concepts of *brahmacharya* and *indrinigreha* also came for special mention.

Child health

Today's children are tomorrow's citizens. Their good health and its maintenance is of vital importance for the country's development. A colourful section in the pavilion was devoted to explaining how of children's health. Murals depicted various diagnostic procedures of illness, charts detailed out the immunization schedule and a daylight projector screened some choice recreational slides for kids. Indoor games, such as ludo, and snake and ladder were utilized to get children acquainted with unsafe toys, and arrangements were made to get the tiny-tots measured (height) and weighed. Models and translites on vitamins and their use and weight chart for children were also displayed.

Communicable diseases

In the third section, the viewers were reminded that the Indian health scene, though far improved today, was still faced with communicable diseases like malaria, tuberculosis, leprosy and trachoma. A host of disease-causing organisms were put on view. Under the microscope, a live micro filariae was shown wriggling. This micro-organism carries the dreaded disease of filariasis. On display also was a jet injector for mass vaccination, with a vaccinator ready to perform it. This section had been put up by the National Institute of Communicable Diseases. Then followed a



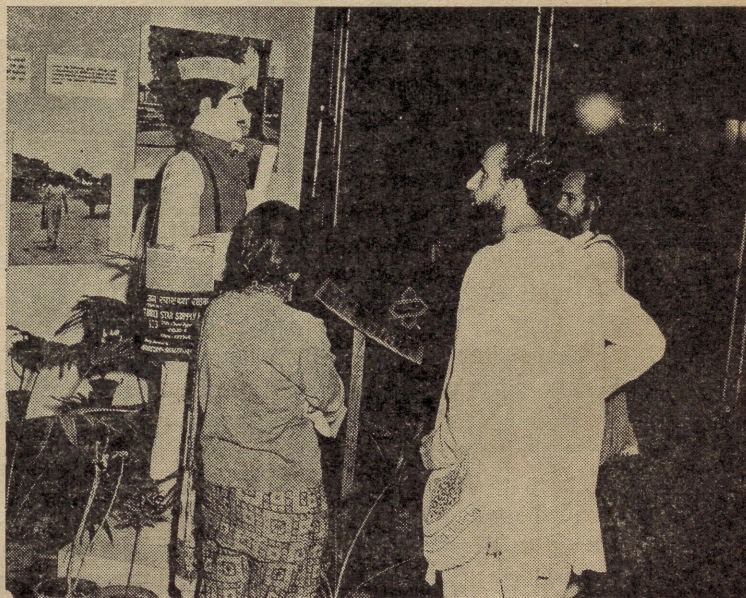
Visitors seeing live microfilariae through the microscope.

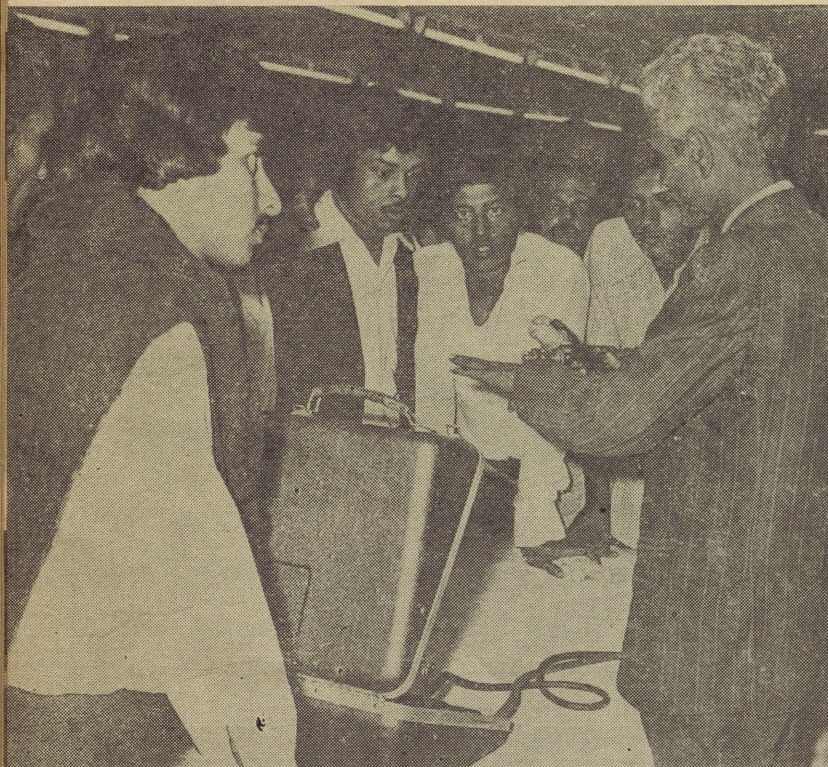
detailed display on malaria—one of the major problems confronting India today. Among the items displayed were larvicides, insecticides and specimens of space spray. A microscope showing malaria parasites was an attraction for the general public.

Eye care

A popular section in the pavilion was the 'Eye Corner' set up by the Ophthalmology Section of the

A model of community health worker.





Visitors being explained the working of jet injector for mass smallpox vaccination.

Directorate General of Health Services and the National Society for the Prevention of Blindness. Here, the display provided basic facts about various eye

diseases, simple eye care rules, eye donation appeals, and demonstration of contact lenses and blind rehabilitation activities. Facility was provided for free eye check-up for vision. This proved to be extremely popular, and at the suggestion of the Union Minister of State of Health and Family Welfare, Shri Jagdambi Prasad Yadav, following his visit to the pavilion, free service was provided daily for three hours in the evening.

The appeal for eye donations yielded encouraging response. More than a hundred persons opted and filled up eye donation cards on-the-spot. Many more took the cards for sending them by post later. Among the queries raised by potential donors were on whom the donated eyes would be used, could one eye be donated during life, and could any type of blindness be rectified through donation.

The following words of the Father of the Nation, Mahatma Gandhi, gave a fitting summing up to the thoughts and ideas conveyed by the exhibition.

“Prevention is better than cure. It is far easier and safer to prevent illness by the observance of the laws of health”.

**—D. Lakshminarayanan
and
H. T. Kansara**

(Contd. from page 32)

Mrs. Lise Ostergaard said that the Indo-Danish co-operation in the field of economic and social development started in 1963. One of the first agreements to be signed by the two governments concerned a project in the field of prevention of leprosy. Since then the cooperation in this sector had developed steadily and today formed an important part of the Indo-Danish technical cooperation programme. She said that with an estimated nine million blind people and about 45 million with visual impairment of varying degree in the country it “is immensely important” that the government had given priority to this project. She commended the government’s programme of strengthening the rural health services by developing the primary health centres both in terms of better qualified staff and better equipment enabling these centres to diagnose early symptoms of eye diseases. She said that “in view of the fact that malnutrition is the cause of visual impairment in more than 200,000

children and that early detection of a number of eye infections or cataracts render these diseases curable, the importance of this development cannot be exaggerated”.

Dr B. Sankaran, Director General of Health Services, expressed the gratitude of the Government of India for the assistance. He hoped that Mrs. Lise Ostergaard would come back in 1985 and see for herself the progress made.

Dr L. P. Agarwal, Ophthalmic Adviser to the Government of India, said that the National Programme for the Prevention of Visual Impairment and Control of Blindness had received international acclaim. The World Health Assembly considered this as a model plan, he said and added that it was a “problem oriented programme equally applicable both to the developing and the developed countries.”

—T.K.P.

(Contd. from page 28)

is often expensive and time-consuming. For example, the health manpower study in Sri Lanka is estimated to have cost US \$ 364 000 and took four years to complete. Often, by the time the results of the study are available, the decision-makers have lost interest and this limits the use of the findings for planning purposes. The findings themselves may also become obsolete with the passage of time.

Studies of the health manpower planning process, on the other hand, aim at supporting the schedule and time scheme of the decision-makers. Irrespective of the poor quality or even lack of hard data, the decision-making process must go on and these studies aim at improving the assimilation and utilization of whatever kind of objective and subjective information is available. Thus they are considerably less expensive and less time-consuming. For example, the manpower planning study for rural water supply and sanitation probably cost US \$ 30 000 and was completed within a period of 18 months, some useful results being obtained in an even shorter time. An analysis of the available data also shows the critical areas to which further efforts at data collection should be directed.

Cost and duration are not the only important aspects of manpower studies. For instance, the Sri Lanka study covered a wide and comprehensive field and promoted the development of national expertise in surveys and analysis which can have a boosting effect on planning. Owing to the time-limited nature of the manpower planning study for rural water supply and sanitation, the transference of skills was necessarily narrower in terms of both the number of national officers involved and the depth of their commitment. Also, this study was restricted to only two occupational groups, which rather limits the comparison of the costs and duration of the two studies. It may be noted that although the manpower planning study was originally meant to include the whole range of environmental health activities, this was not possible owing to organizational difficulties.

Future trends

What are the lessons to be learned from experience with manpower planning? Such planning is now more concerned with the actual decision-making process and implementation of decisions than with the manipulation of numbers in forecasting demand and supply. Without under-estimating the need for the latter, we believe that it is equally important for planners to be continuously involved in all phases of planning, implementation, and evaluation. The lessons of the past decade are that:

(a) Although the basic concepts of manpower planning are generally applicable, health manpower problems are not only complex but also country-specific i.e., each country must develop its own organizational structure for planning.

(b) Because health is affected more by socio-economic development than by health services alone, health manpower planning calls for a multidisciplinary approach and a multisectoral effort. The implementation of planning requires a political decision based on the prevailing policies and legislations, including those formulated in such sectors as education, employment, labour, science and technology, etc.

(c) Health workers alone do not necessarily have the best understanding of community health needs, and the elucidation of the potential demand for health services requires active involvement of all levels of decision-makers including the community itself.

(d) Planning efforts are unlikely to be effective if due account is not taken of the social, economic, and—most important—the political milieu in which they take place. Health manpower planning should be an integral part of comprehensive health planning and should not become an independent activity. In addition, the three components of the health manpower process (manpower planning, production, and management) must be brought into a closer and more functional relationship if manpower plans are to be implemented.

(e) The information collected should be simple, relevant to the problem, and of value in analysing the situation. Efforts should be made to ensure that essential information is not omitted and that data irrelevant to the decisions needed are not collected.

(f) Manpower studies, when needed, should be kept short. Countries with limited planning and research facilities can hardly afford prolonged studies; often, when the decision-makers change, the continuity of the process is jeopardized.

(g) Manpower studies or commission reports, no matter how sophisticated, do not necessarily lead to the development of a plan, much less to plan implementation or to an integrated process of health manpower development.

Health manpower planning should therefore be considered as an endless process producing successive approximations and not simply as an event ending up with a report.—*Courtesy: WHO Chronicle, November 1976.* ○

Need for Encouraging Homoeopathy

THE Vice-President, Shri B. D. Jatti, has said that the rising cost of modern medical treatment necessitated the developing countries like India paid more attention to development of the homoeopathic system.

Shri Jatti said that allopathic drugs were not only very expensive and had unpleasant side-effects on many occasions. Homoeopathy offered an alternative. It was, therefore, logical to encourage the system.

Shri Jatti was inaugurating the 32nd International Homoeopathic Congress in New Delhi on 6 October, 1977. The six-day Conference organized by the International Homoeopathic League was attended by over 1,500 delegates from 28 countries.

Shri Jatti earlier unveiled a bronze shield bearing the insignia of the International Homoeopathic Medical League and the portrait of Dr Samuel Hahnemann, the German founder of Homoeopathy. A commemorative stamp to mark the occasion was also released on the inaugural day by Shri Raj Narain, Union Minister of Health and Family Welfare.

Shri Jatti said that he was glad to note that recently there has been a welcome change in the attitude of allopaths towards practitioners of other systems of medicine and referred to a project of research in which both allopaths and homoeopaths were participating.

Shri Jatti suggested that the homoeopathic system could be adopted in an international health programme, specially in the case of developing countries. "There is a vast scope for utilizing the homoeopathic system in areas where it is considered to be particularly effective, namely, virus diseases, allergies and children's diseases," he said.

Shri Jatti said India accorded homoeopathy a status equal to that of any other system of medicine. The Central Council of Research in the Indian System of Medicine and Homoeopathy had started a small experiment unit in clinical medicine to demonstrate the efficacy of homoeopathy in common conditions like uncomplicated bronchial asthma and skin diseases. The aim was to evolve simpler and inexpensive non-toxic substitutes.

In his address, delivered in Hindi, Shri Raj Narain said that while there was no doubt that the achievements of the modern medicine had been "fantastic", the West too had started showing an interest in oriental traditional systems of medicine. "We do not want

Small Family Norm is Voluntary

—Raj Narain

"Doctors need not have any misgivings about their role in the implementation of the family welfare programme. If people come forward for voluntary sterilization, it is unfair not to help them," said Shri Raj Narain, Union Minister for Health and Family Welfare, while inaugurating the National Family Welfare Fortnight at Town Hall in Delhi on 19 December, 1977. The programme was organized by the Delhi Administration.

The Minister said that the responsibility of people and the workers of the programme now becomes more challenging because compulsion and coercion are removed for all times. "It is my appeal to them to join hands and to show to the rest of the world that willing and voluntary participation in the family welfare programme can bring better results than what were obtained under compulsion," said Shri Raj Narain.

to move on to an over-drug-oriented and surgery-oriented system", he added.

Shri Raj Narain said that homoeopathy although born in Germany had made great progress in the country. Presently, India had 94 homoeopathic colleges imparting training to 5,000 students a year. The Government had established homoeopathic dispensaries throughout the country and it was proposed to start a 100-bed hospital to be attached to the Nehru Homoeopathic Medical College in Delhi. The Government spending on homoeopathy had gone up from Rs. 11 crores in the Second Plan to Rs. 200 crores in the Fifth Plan. There were over 1.5 lakh registered practitioners of Homoeopathy.

In his presidential address, Diwan Harish Chand, Chairman, Executive Board (Homoeopathy), Central Council of Research in Indian Systems of Medicine and Homoeopathy, said that Homoeopathy suited the Indian genius better. By tradition, instinct and training, the Indians were essentially spiritual-minded and could easily appreciate homoeopathic treatment which took care of the body, mind and spirit by administering micro as against macro doses of medicine.

Dr C. Eenhoorn, President of the International Homoeopathic Medical League, said in his address that the League wanted to develop homoeopathy in the whole world, and perhaps in India "you are in a more favourable position."

—D.L.N.

Swasth Hind

Demographic Research Network Expansion

SHRI Jagdambi Prasad Yadav, Union Minister of State for Health and Family Welfare, has said that the demographers have a great role to play in the implementation and evaluation of the Family Welfare Programme. He called on the demographers to function not merely as the eyes and ears of the Government but also as its pathfinders to indicate the lines of action. "I have no doubt that the demographic community in this country will fulfil its role diligently and effectively," he said.

Shri Yadav was inaugurating a three-day Meeting of Demographers, under the aegis of Union Ministry of Health and Family Welfare in New Delhi on 17 November, 1977. The Meeting was attended by the representatives of the State Demographic and Evaluation Cells, the Demographic and Communication Action Research Centres, the Population Centres, the National Institute of Health and Family Welfare, the International Institution of Population Studies, and other Departments of the Government of India connected with the demographic work.

Shri Yadav said the Government of India would expand the demographic research network. Besides the existing 12 Demographic and Communication Action Centres, the Government would set up six more centres to cater to the research needs of the States and Union Territories which were not covered by demographic research facilities.

The establishment of new demographic research centres at Bhopal, Visakhapatnam, Bhubaneswar, and Gauhati has been sanctioned. A proposal to set up a demographic re-

search centre at Udaipur has already reached an advanced stage. The location of another centre in North-West to cover Punjab, Haryana, Himachal Pradesh, and Jammu & Kashmir is being finalized. Demographic and evaluation machinery in the States was likely to be strengthened further during the next five-year Plan.

Shri Yadav referred to the Statement of Policy on the Family Welfare Programme under which the performance of family welfare in the States would be intensively monitored and the Union Cabinet would review the situation in depth at least once a year.

Shri Yadav said the feasibility of providing current information also on the qualitative aspect of the performance besides the quantitative performance, should be considered. A continuous analysis of the characteristics of the programme acceptors coupled with sample checks on the nature of the reported performance would help in improving the correct evaluation of the programme.

Shri Yadav emphasized the need of supplementing the evaluation undertaken through the official operating agencies also by external evaluation through independent agencies. Demographic Research Centres should extend their research activities to cover the health programmes as well because the health and family welfare are inseparable aspects of a total health deal offered to the people.

Shri Yadav reiterated the Government's commitment to the Family Welfare Programme and said that

it would spare no efforts to motivate the people to accept the small family norm voluntarily in their own interest and that of their children and the nation. The Family Welfare Programme embraced all aspects of family welfare and particularly those which were designed to protect and promote the health of the mothers and the children. ○

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RELEVANT TRAINING TO RURAL WORKERS

RELEVANT training and government commitment were listed among the major recommendations of an Expert Committee convened in Geneva in December 1977 by the World Health Organization (WHO) on the "Training and Utilization of Auxiliary Personnel for Rural Health Teams in Developing Countries".

The Committee's tasks were:

- to review the present state of knowledge concerning the training and use of auxiliary personnel in rural health teams.

- to identify the main problem areas in the planning and management of such teams, and to make recommendations to the Director-General of WHO.

The Committee felt that rural communities should participate fully in the training and use of community health workers working in the framework of teams dealing with development in general. The Committee felt that village committees for health and development, selection of staff, and collective sanitation activities, should make such community participation possible and worthwhile.

No derogatory titles

Titles including the words "auxiliary" and "ancillary" should be

avoided, the Committee felt. National or even local names should be sought for a category of personnel commonly known as "medical assistants". Certain specific examples were cited at the meeting, including those of *Feldsher* in the USSR, *Officier de sante* in France, *Medex* in the USA, and *Bedhar* in Iran.

New tasks delegated to front-line personnel

Another recommendation of the Committee concerned the tasks to be undertaken by front-line health workers. Duties which up to very recently were within the terms of reference of doctors, nurses or health technicians, could be delegated, it was felt by the Committee. These include elementary diagnosis of diseases such as malaria, malnutrition and common communicable diseases. Front-line health staff could also deal with certain therapeutic acts, the Committee felt, including injections, distribution of chloroquine against malaria and administration of certain antiseptics. Their main tasks, however, should be prevention of disease and promotion of health, including vaccination, potable water supply, excreta disposal, family planning, community development, etc. It was made clear, however, that such front-line personnel should not work alone or in a vacuum, but be part of a whole sys-

tem and should know where supervision comes from, and to whom to refer cases which are beyond their competence

Pertinent training and continuing education

The Committee recommended that all health personnel, and rural health personnel in particular, should receive *pertinent* training to enable them to respond to the specific needs of the populations they will be called upon to serve. Such training should be given as close as possible to the echelon at which staff will work and it should be borne in mind that all personnel, including front-line health workers, must benefit from systematic continuing education.

Co-operation, acceptability and support

The Committee underlined the importance of information and co-operation at all levels of the community to enable all concerned to draw full benefits from a well managed health system. The need and usefulness of auxiliary personnel are more and more recognized. However, their training and utilization should be carried out with the consent and support of medical and allied health personnel rather than in opposition to them. As members of a health team, their activities should be complementary and not contradictory. ○

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SPECIAL NUMBERS — 1977	
January	Anti-Leprosy Day Health Education in States
February	Habitat and Health
March	Sexually Transmitted Diseases
April	Year of the Child World Health Day—Immunize and protect your child.
June	Rural Health Services
August	Hospital Health Education
September	Ayurveda
October	Rural Health Services
November	Children's Day—Water for the Children of the World
December	Mentally Retarded Children

COMMISSION ON COMMUNICATION PROBLEMS MEETS

THE UNESCO-sponsored International Commission for the Study of Communication Problems held its first meeting from December 14 to December 16 at UNESCO headquarters in Paris.

The 16-member Commission, headed by Mr. Sean MacBride (Ireland), winner of the Nobel Peace Prize and the Lenin Peace Prize and former United Nations Commissioner for Namibia, is expected to study the whole field of communication in contemporary society and to single out those problems calling for urgent action at national or international levels.

In particular, it will examine the obstacles to the free and balanced flow of information in the world and the specific needs of developing countries.

It will also explore how communication can arouse public opinion on such major world problems as hunger, underdevelopment, the energy crisis, environmental pollution and the denial of human rights.

Within this broad mandate, however, the Commission itself will decide on its own work plan and research priorities. Mr. Amadou Mahtar M'Bow, Director-General of UNESCO, who appointed the members of the Commission, emphasized that it is an independent and autonomous body.

Although an attempt has been made to strike a balance among various cultural and ideological points of view, the members have been named in their individual capacities and represent no one but themselves.

The 16-member Commission, which includes Mr. B. G. Verghese, former Editor of the *Hindustan Times* is to make a preliminary report to the UNESCO General Conference in November 1978, and a final report in mid-1979.

In its work, the Commission will receive advice and assistance from a large number of communication specialists, researchers, media representatives and members of professional groups.—*U. N. Weekly Newsletter*

BOOK REVIEW

INTERNATIONAL CLASSIFICATION OF DISEASES—Manual of the International Statistical classification of diseases, injuries and causes of death—1975 Revision Volume I, World Health Organization, Geneva, 1977 pp. 773, price not stated.

THERE have been rapid strides in the use of International Classification of Diseases (ICD) for indexing and retrieval of records and for presentation of statistics for planning, monitoring and evaluation of health services during recent years. The Ninth Revision, which is to come into effect from January 1979 is radical and presents more details than were available in the Eighth Revision and attempts have been made to satisfy clinical requirements and demands from specialists.

The mode of diagnosis in tuberculosis, modes of delivery and provision for anatomical site in musculo-skeletal disorders are provided in optional fifth digit. Similarly, in Neoplasms, fourth digit is provided to indicate histological varieties. The new revision also provides dual classification of certain diagnostic statements based on etiology as well as manifestation of diseases.

Special lists are also provided and are different from those in the Eighth Revision. A Basic Tabulation List is recommended along with minimum lists for mortality and morbidity consisting of 50 causes. The structure of the Basic List is such that totals for specific disease can also be obtained. For example, T.B., Venereal Diseases, Mental Disorders, etc. There is provision to expand short lists for mortality and morbidity according to the Basic List.

Although in the Eighth Revision 'E' code and 'N' code were separately listed out, in the Ninth Revision, 'N' code has been incorporated into the main structure of ICD and 'E' code is recommended as a supplementary list to be used conjointly.

For the first time in the history of the ICD, coding rules for selection of a single cause for morbidity tabulations are spelled out and these would improve international comparability of morbidity statistics.

It would be useful if the WHO undertakes to publish lists comparing detailing list categories between Ninth and Eighth Revisions. It is presumed that extensive training would be undertaken to train personnel in the usage of the new ICD.

—Dr S. K. Sengupta

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