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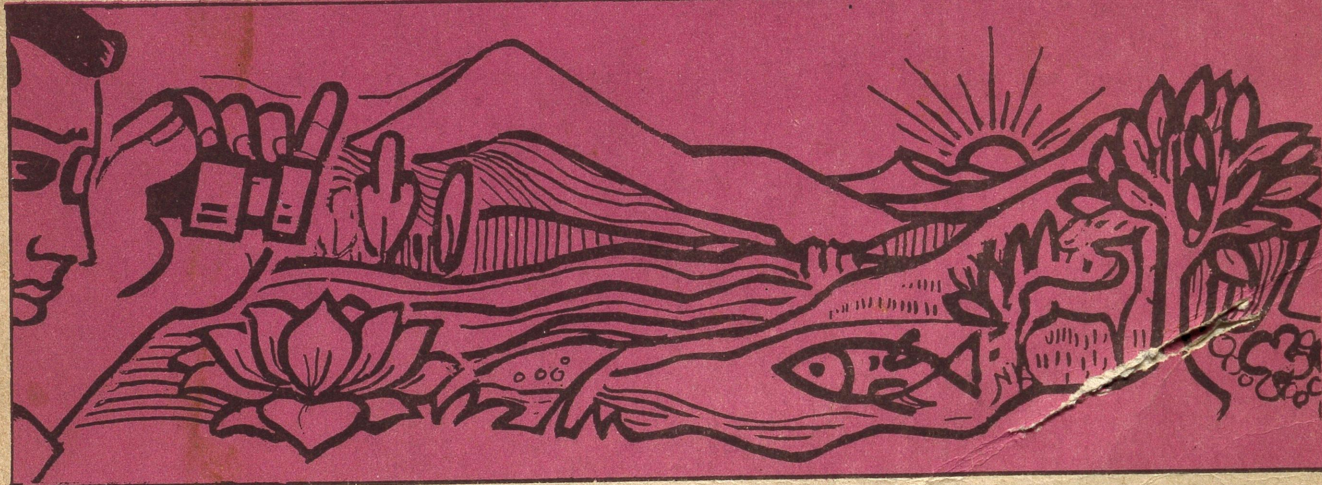

PRIMARY HEALTH CARE

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OBJECTIVES

Swasth Hind (Healthy India) is a monthly journal published by the Central Health Education Bureau, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, New Delhi. Some of its important objectives and aims are to:

REPORT and interpret the policies, plans, programmes and achievements of the Union Ministry of Health and Family Welfare.

ACT as a medium of exchange of information on health activities of the Central and State Health Organisations.

FOCUS attention on the major public health problems in India and to report on the latest trends in public health.

KEEP in touch with health and welfare workers and agencies in India and abroad.

REPORT on important seminars, conferences, discussions, etc. on health topics.

Editorial and Business Offices

Central Health Education Bureau
Kotla Marg, New Delhi-110 002

Edited by M. L. Mehta
M. S. Dhillon

Cover Design Madan Mohan

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Articles on health topics are invited for publication in this Journal.

State Health Directorates are requested to send in reports of their activities for publication.

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HEALTH EDUCATION AND PRIMARY HEALTH CARE

DR GAJANAN D. VELHAL

Universalizing health education through mass spread of the relevant knowledge and information by communication media and means has to become a high priority area of action both by the government and the people themselves. Moreover, ways must be found out to make health education sufficiently specific so that implementation of educational activities can be monitored and their effectiveness evaluated. This would enable decision-makers to judge, whether or not, their allocations to health education were yielding adequate health benefits, says the author.

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HEALTH education is defined as a process that informs, motivates and helps people to adopt and maintain healthy practices and lifestyles, advocates environmental changes that may facilitate the achievement of this goal and conducts professional training and research to the same end. Health education is concerned with establishing or inducing changes in the attitudes and behaviour of individuals and groups that promote healthier living.

Primary health care has been defined as essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford. In fact if primary health care is to be made accessible to all, the inhabitants of every community must learn to rely as far as possible on their own resources. To achieve such self reliance the people should be involved in the planning, implementation and evaluation of health services based on primary health care. In fact the International Conference on Primary Health Care organised jointly by UNICEF and W.H.O. at Alma Ata, U.S.S.R. in 1978 declared that people have the right and duty to participate individually and collectively in the planning and implementation of their health care and that education concerning prevailing health problems and the methods of preventing and controlling them was the first of eight essential elements in primary health care.

Originally health education developed along the lines of the biomedical views of health and disease that were prevalent, at that time, according to which social, cultural and psychological factors were thought to be of little or of no importance. Relatively few efforts were made to understand peoples traditional health beliefs and practices. The assumption under health education activities was that people would enjoy better health if they would act in the manner recommended by the health workers. More often individuals were the passive receivers of a service. Hence the emphasis was on the transmission of correct health information to the general public.

The concept of primary health care has drastically changed this view. The modern concept is that the role of health education is one in which the health care providers and the people both teach each other and learn from each other, changing their roles constantly. The objective of health education is to foster activities that encourage people to be healthy, to know how to stay healthy and to do what they can individually and collectively to maintain health and to seek help when needed. Health Education is a potent approach that can influence people to the extent that unfelt needs become felt needs and felt needs become demands. Far from merely seeking the cooperation of communities in carrying out plans already made, health education should aim at encouraging people to be actively involved in the planning and maintenance of their health care system and to act in partnership with health care providers.

Objectives of Health Education

The three major objectives of health education are:

1. To make the people understand the value of health not only as a personal asset but also as a community asset and the individuals own responsibility in maintaining it;
2. To help people to develop knowledge and skills to undertake the activities which will enable them to help themselves in achieving optimal health; and
3. To help people to understand the nature and purpose of health services and facilities provided for their benefit so that they may be able to make the best use of such services and facilities.

Health cannot be imposed, it has to be attained and without the fullest cooperation of an informed and educated public willing to become involved and self-reliant in matters of health, this will be impossible. Rather than health services filtering down through a number of layers to reach the underserved, a movement starting from the people has to be initiated which reflects the will of individuals and communities to take a full part in the affairs of their country and to share with the government the responsibility for health care and health promotion. Health for all by the year 2000 A.D. is not likely to be achieved by using the available professional services alone. Lay self care has an essential role to play in improving the health status of the people and decreasing health costs. In the absence of health education component being integrated properly, the National and State health programmes will not be able to achieve the objectives laid down and the investment made will be nothing but a drain on the state resources.

The health of an individual, a family, a community and a nation depends on factors within the purview of the individuals and the community. Personal responsibility covers a wide area in the promotion of healthy life style. Individually one can improve his/her health by taking balanced food, using safe drinking water and protecting it from contamination, regular exercise, practising personal hygiene and keeping the house and its surroundings and place of work clean. Community on its part can create facilities for better upbringing of children and youth; take steps to prevent and control communicable diseases, arrange for facilities for holding

sports events and regular exercise, encourage the use of locally available inexpensive nutritious foods, change of social norms of smoking and alcoholism and thus promote healthy living. Community can also organise health services and can ensure full utilization of the available health services.

The scope of health education is widespread and there is enough awareness about its importance at all levels of administration and policy making. It requires further development mainly in the following three areas:

1. Community participation.
2. Research.
3. Monitoring and evaluation.

Only by participating in building their own future, can people grow, hence peoples participation must become a reality. In deciding the nature of health care, attention should be paid not only to peoples health needs but also to the possibility of utilising the peoples ability and creative talent in the processes of planning and implementation. If people are treated with honesty and dignity and are allowed to participate actively at all its stages, they respond with commitment. Participation at community level increases peoples sense of control over issues that affect their lives. Active community participation by villagers has contributed a lot to the success of comprehensive Rural Health Project in Jamkhed, Maharashtra.

Research in the production and use of health education and training material and the impact of health education programmes have received very little attention. Health behaviour research has been limited to KAP studies. While K.A.P. studies convey what people know and do, they rarely tell why people do what they do. Research will reveal why people participate or do not participate in health programmes, what are the real factors responsible for unhealthy practices and what can bring about a change in the lifestyles of the people.

Ways must be found out of making health education sufficiently specific so that implementation of educational activities can be monitored and their effectiveness evaluated. This will enable decision makers to judge, whether or not their allocations to health education are yielding adequate health benefits.

If health education has to have positive impact on overall health status of the community and nation, due consideration should be given to the following things:

1. Ensure that health education activities are based on the peoples perception of their health needs, priority being given to goals that reflect both the felt needs of the people and the needs defined by health professionals.
2. In strengthening lay resources, attention should be paid towards the three roles of women, *i.e.,* those of health protectors, health consumers and agents of social change.
3. Every educated person should consider it as his duty to impart the knowledge to his less fortunate neighbours.
4. Schools and colleges dealing with health education and schools of social work should conduct research into the health behaviour and assess the efficacy of the various ongoing programmes.
5. The students in the higher secondary schools and colleges should receive basic information on health matters.
6. It is important that the messages on health education are clear and that there are no inconsistencies or double standards.
7. Primary health care should not be looked upon as entirely poor man's health system.
8. The political leadership must be convinced that investment in health is sound economics, with popular appeal and social imperative.
9. Hospital being a service institution deals directly with the public and therefore health education activities if carried out by these institutions are more effective to educate a large population.

Universalizing health education through mass spread of the relevant knowledge and information by communication media and means has to become a high priority area of action both by the government and the people themselves. Δ

EDUCATION—HEALTH LINKAGES :

Considerations for Integrated Planning

B. B. L. SHARMA

Education is an important factor responsible for individual as well as family's health. For example, in India mothers are usually responsible for bringing up the children. So, the level of literacy and education of mothers assumes more significance in determining the health status of our children. This is more so where health care promotion is not always institutionalised.

According to Alma-Ata declaration Primary Health Care is essential health care made universally acceptable for Individuals and families in the community by means acceptable to them through their full participation and at a cost community can afford. It forms an integral part both of the community health system of which it is the nucleus and of the overall social and economic development of the community. Alma-Ata declaration further spelt out the minimum essential components of Primary Health Care. These components are not merely independent but are '*Linked Components*'. Since Primary Health Care is an integrated development approach to health; these components have an ongoing interface with education, health and development. These components are:

(i) Educating People about Health and Family Welfare Matters.

(ii) Promotion of food supply and proper nutrition.

(iii) Safe Drinking Water and basic sanitation measures.

(iv) Maternal infant care and family planning.

(v) Immunization.

(vi) Prevention and control of locally endemic diseases.

(vii) Appropriate treatment of common diseases and injuries.

(viii) Provision of essential drugs.

This paper attempts to present that the dual goals of India's health policy (1983) which encompasses Health for All (HFA) and Population Stabilization (Net Reproduction Rate of Unity)—by 2000 AD, have intimate links with education and—its development. The health policy goals in the statement (1983) are levels of health and Family Welfare status. But these suggested achievements '*pre-suppose*' the creation of educational conditions for desired moderation of mortality and fertility. These '*implicit pre-suppositions*' with respect to education are the ones which could help achieving these HFA goals.

Broad Conceptual Frame

In the light of this backdrop of primary health care, it is further reflected here that the nature of both of these two sub-sectors of social sector *i.e.* Education and Health is also responsible primarily to create 'Merit Goods and Merit Services' in the sense of social economics. So, not only this commonality of conceptual welfare-frame is noticed between education and health; but these are inter-linked and inter-locked situations which may be used for effective integrated planning. Besides, Health Care and Care for Education being Merit and Public Goods; both sectors and services emanating from these sectors may be seen governed by 'Externalities', External Benefits or External Losses and Costs on Promotion and Non-promotion of these possibilities.

Again, the premises between Health and education, particularly with reference to achieving Health for All and also education for all stem from the same roots of *Accessibility, Availability, Affordability, Acceptability, Accountability* (in terms of creating conditions for equity and efficiency).

Operation Base

Support mechanism for both—Health Care and Care for education for all and its sustainability depends on community participation and inter-sectoral coordination. This has been vividly reflected in case of HFA commitments.

Education—Health Linkages

We know education is an important factor responsible for individual as well as family's health. For example, in India, mothers are usually responsible for bringing up the children. So, the level of literacy and education of mothers assumes more significance in determining the health status of our children. This is more so where health care promotion is not always 'institutionalised'.

World Bank study of Kerala (1981) has shown that the high level of literacy and education among the females in Kerala is the 'one single' factor which has significantly contributed to the improvements of health status of infants and children. Lot of studies and statistics can be quoted to show the association, and differentials for high infant mortality, non-utilisation of health care, extent of low birth babies, 'non-coverage of immunisation' etc. with the educational status of females in India.

Not only literacy and education gives the chance and access to information and services but also it has inherent strength supported by '*knowledge for decision making*' towards conditions of Health Promotion. Education—Health linkages bring out a simple fact in this context for integrated planning is that 'An educated mother can ensure the optimal utilisation' of available resources for nutrition as also for better hygiene and health of the family. Educated mother can better utilise the available health and medical services and bring accountability into them by demanding what she knows is her right. (Antia, 1992 Science Population Development : The Inevitable Plus).

Moninag (1981 Economic Political Weekly) of course has tried to see literacy and education as factors which determine political awareness and this in turn gives the indicative right to demand and use health and other welfare facilities. This itself is a function of awareness created by education. To indicate this Education—Health Linkage; the examples given by studies are from rural Kerala and rural West Bengal. Possibility of mobilisation for integrated planning at present is not only an issue

of economic development but also an agenda for social issues in health and education. Literature in India and other developing countries have brought out that among households (*for any given income level*), families were better fed where the Mother's education was higher. These differentials are known also for child survival.

In this context, the basic contention emerges from the available personal and professional experiences that health needs (particularly of women, children and other under-privileged groups in terms of illiteracy and uneducated) will hardly be met if health programming continues to focus narrowly on health sector alone and ignoring the education health promotion linkages. All the eight components of Primary Health Care Approach (as listed above) can be pushed through the lever of education and literacy promotion. However, the Primary Health Care Components or some of its Sub-Components can be supported more directly are :

— Educating People about the Health and Family Welfare Matters.

— Promotion of proper nutrition.

— Basic sanitation measures.

— Maternal, infant care and Family Planning.

— Immunisation.

Integrated Child Development Services : An Example

Of many programmes and services, example may be given for one programme where linkage between Health Care Services and Educational efforts may be seen subtly forged'.

Of many programmes, this country wide programme of child development is known for its 'holistic approach' to improve health and educational environment of child. It has twin goals (i) to encourage school enrolment *via* early pre-school stimulation programme for children 3-6 years old (ii) to improve the health and nutrition status of children 0-6 years *via* supplementary feeding to selected beneficiaries. But, it also brings mother's in picture and attempts to promote •mother's education *via* 'health and nutrition education exposures'. A broad package of six integrated services are delivered through ICDS which could be further strengthened as an area for Integrated Planning :

— health checkup

— immunisation

— referral services

— supplementary nutrition

— non-formal education

— nutrition and health education to mothers.

Accessibility for Health Care Services and Educational Facilities

Physical accessibility to health services and also towards educational facilities have been enhancing over the period of time. However, there remain gaps for these 'social inputs' among some states, districts, rural-urban areas, terrains, within socio-economic strata organized *vs.* unorganized groups, etc. These accessibility gaps are there not just in terms of general basic (elementary) services and facilities but also for type, frequency, qualitative aspects, etc. Besides these, observed 'locational biases' are also there.

World Bank Paper (August 1990 WPS 491) on 'How Well do India's Social Service Programme serve the poor', have culled out data from fourth All India Educational Survey and other studies in Health Care to bring out the strange contentions in this paper. The accessibility situation about health is found more striking in terms of rural-urban differences—for an access to health facilities. There are nearly 87 per cent of hospital beds in urban areas of the country but the majority of population lives in rural areas. Also there are studies to show that the population served by a Primary Health Centre varied between 10 to 17 per cent of what it was expected to serve because of its unsuitable location (Bose etc. 1983). Again, in terms of accessibility, health services are also not found readily accessible for tribals; although there is special 'tribal sub-plans'. Studies are there to show—Gare (1983) found that one hospital and 167 sub-centres were covering a population of 2.8 million in three districts of Maharashtra. That was one fourth of the infrastructure required. Another study of a tribal district in Madhya Pradesh showed that a Sub-Centre served about 7000 population, covering an average of 76 sq. kms. against the norm of 3000 population (AFC 1980). Even for nutrition there are some studies to show (Hargopal G. *et al* 1985) that poor people have been denied, at times, the access to nutrition programme by local leaders. These may be small studies in number, micro in nature but speak for the gaps to be filled out through systematic integrated planning.

Another work entitled 'School Education in India: The Regional Dimensions' (Moonis Raza, Aijazuddin Ahmad and Sheel C. Nuna, 1990, NIEPA) has brought out both applied as well as methodological issues with respect to accessibility, availability, quantity, quality,

Linkages between health care services and educational efforts must strive to bring mothers in limelight and attempt to promote mothers' education through health and nutrition education exposures.

equity inter-connectivity and utility. Such crystilized work is grossly unavailable as yet for Health Care Sector. Besides, the fourth All India Educational Survey showed that nearly one fifth of all inhabitants including 16.4 per cent of inhabitants with a population of less than 300 do not have even a primary school. Forty per cent of primary schools have no permanent buildings, 39.7 per cent have no blackboards and 49.5 per cent have no drinking water facilities. Thirty five per cent of schools have only a single teacher to teach 3-4 different classes. The economic base of a region exerts a strong influence on the spread of education (Moonis Raza and Aggarwal 1983).

Broad Conclusion

Since early 1980's Government is reflecting its meaningful awareness and taking new initiatives: whether it is in terms of National Health Policy (1983), National Policy on Education (NPE) 1986, Revised Family Welfare Strategy (1986) which has strengthened the mother and child health and earlier Integrated Child Development Services (1975) which deliver a package of basic health, nutrition and preschool education services to children under six and to pregnant and lactating women. However, intersectoral effort for 'Integrated and Composite Planning' has not been operationalised seriously and meaningfully—within the framework of Education and Health Linkages.

Before, it is concluded it has to be emphasised that not only there is need to integrate both Health and Education Sectors and its services; but also required is the integration of social sector services with 'poverty alleviation programme'. As such, vocational education, adult-health, particularly Reproductive Health, and adult nutrition need to be included and stressed with primary education, child health and child nutrition.

Recently 90 districts in the country have been identified by the Government of India for taking up special efforts to promote family welfare and health performance. These districts have been identified on the basis of their backwardness in terms of literacy,

infant mortality, sex ratio, etc. A beginning for *'decentralised integrated planning'* may be made keeping in view the strong linkages between education and Family Welfare and health care in these identified districts. For this purpose the efforts may have to be taken at Block Level and further at village level planning for health and family welfare. At the village level also the care has to be taken for all the 'social groups' at the grass root levels and to be tagged with socio-economic processes having direct and indirect linkages with education and health.

This integrated planning is not to be a static one and a one time attempt; but it has to be a 'flexible' and 'ongoing one'. The 'entry points' may not always be the same. Sometimes, it may be education creating demand generation for health care services and their utilisation. At times, it may be 'health promotion' creating demand generation for higher school enrolment, etc. Besides, the *'demand generation planning efforts'*; the *'supply creation planning efforts'* have to take due account of the linkages between education and health. Lastly, this will also require new administrative structures which would be more 'responsible' to these areas of commonality of social transformation. Involvement of NGOs and people has been advocated afresh, and more vigorously in various deliberations in developmental forums. Lastly, in the light of observations made by Dr Amartya Sen and others, the role of market economies or role of 'market forces' for promotion of social sector may be taken with little caution. It is a matter of concern whether Social Sector is *'market friendly'* when we know Education and Health; both are Merit and Public Goods. This is also a point while deliberating for Integrating Planning beyond public sector interventions.

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PRINCIPLE FOR ALL PEOPLE TO HAVE PEACE

All people have to make use of their peaceful condition to work for their collective welfare and in turn to maintain Peace. They must bear the principle that peace results from the harmony of mind, body and environment and operation of an effective system for maintaining conditions of peace by eliminating antagonistic forces such as tension, war, pollution, pain and conflicting discrimination, etc.

—M. B. S. CHAR

PRIVATE VOLUNTARY ORGANISATIONS AND PRIMARY HEALTH CARE

DR B. K. PATTANAIK

Improving the health of all citizens is an endeavour in which every section of the society must feel involved. Medical personnel are the leaders of this campaign, but ultimately, it is the people's cooperation which counts. At this juncture, role of voluntary organisations in the promotion of primary health care in rural areas cannot be overemphasised. They are important resource to adopt innovative approaches and provide services to support sustainability and effective implementation of the health and family welfare programmes.

THE Alma-Ata Declaration of 1978 identified Primary Health Care (PHC) as the key instrument to attain the twin goals of Health For All (HFA) and Net Reproduction Rate (NRR-1) unity by 2000 A.D. India being a signatory of the historic declaration reiterated in its National Health Policy (1989), her commitment to attain Health For All by the year 2000. But ironically, the SLOGAN OF HEALTH FOR ALL by the year 2000 remains as distant a dream as ever though this century draws to a close. Similarly, the goal of achieving Net Reproduction Rate equal to one by the year 2000 also looks incredible as the Eighth Five Year Plan document envisages that it would not be attainable even before 2011-2016 A.D.

Primary Health Care Approach seeks to provide universal comprehensive health care services relevant to the actual needs and priorities of the communities at a cost which people can afford. To provide Primary Health Care relevant to the actual needs of the community in the rural areas, health infrastructure, *i.e.* Sub-centres, Primary Health Centres, Community Health Centres, etc. are being established and rural health services are replenished through these centres. Notwithstanding, a collossal improvement in health infrastructure since independence, the quality of life of the rural masses has not been adequately ameliorated. It is rather appropriate to emphasise that improving the health of all citizens is an endeavour in which every section of the community must feel involved. Medical personnel are the leaders of this campaign, but ultimately, it is the people's cooperation which counts. At this juncture, the role of voluntary organisations in the promotion of Primary Health Care in rural areas cannot be overemphasised. The Seventh Five Year Plan has rightly highlighted the involvement of Non-Governmental Organisation (NGO) alongwith community participation in health and family planning programmes on priority.

There are over 30,000 private voluntary organisation (PVOs) in India of different sizes and orientation. Some of the previous studies depict that activities of PVOs are primarily related to income generation and in some cases feeding supplements for children, thus, include health and family welfare within its premises. Therefore, mobilising the active participation of PVOs in health and family welfare programme will yield a salutary benefit for the successful implementation of the programme in rural areas.

Need and Utility of PVOs

The pertinence of PVOs has been greatly acknowledged by the Government for the successful launching of the health and family

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planning programme in the rural areas. Sometimes, governmental personnel are viewed with suspicion by the rural community. They even do not have the necessary rapport between them and the community. Moreover, the Government cannot face the challenge of carrying out the community centered social development programmes. At this juncture, PVOs are important resource to adopt innovative approaches and provide services to support sustainability and effective implementation of the health and family welfare programme. PVOs with trained workers and volunteers can better communicate with the people by ensuring full public participation for providing sustainable benefits to the people than are possible in government set-ups. Considering its importance, the India Population Project VII running in the States of Bihar, Gujarat, Punjab, Haryana and Jammu and Kashmir has emphasised the need of PVOs for increasing demand of MCH and family planning services in these States. The project envisages that the priority would be given particularly to those PVOs with strengths in community involvement and participation, those which provide services or efforts that would stimulate greater development of activities to involve women in the delivery of services as well as their demand for services, and those PVOs which meet the needs of the poorest groups in both urban and rural settings.

The PVOs work as a link between the people and the government. They motivate, persuade and popularise programmes and projects by bringing about attitudinal changes and involving people in the community projects. They encourage people to consider their responsibilities in relation to their development. Once community interest has been mobilized, it is quickly crystallised into a formal mechanism capable of taking action. The active participation of the people ensures greater chances of success and cost-effectiveness than the total dependence on the government when people tend to become passive. The PVOs work to make the government supported programmes more responsive to the needs of the people and also make it aware of the felt needs of the community and their inter se priority with considerations oi resources and local constraints.

It is true that government has larger pool of skilled persons, more intelligent and better informed, but they are bound by rules, regulation and set procedures which sometimes restrict their decision making process. On the contrary, PVOs have greater flexibility in respect of taking quick decision on price, location shift, chosing right alternatives and so on. They have greater scope to choose areas of work and taking spot decision. Their methods of mobilisation, evaluation, monitoring, leadership and supervision are far more effective than those of official agencies. Communication, motivation, awareness, implementation and follow up action in the case of PVOs are faster than that of the official agencies. Therefore, the rich experience of the PVOs should be exploited and utilised for achieving greater effectiveness in the delivery of primary health care in rural areas. It is needed to establish rapport and strengthen the small PVOs which are doing goodwork to achieve result in a time-bound manner.

Activities of PVOs

The Eighth Five Year Plan of the Government of India has emphasised on the involvement of voluntary agencies in various development programmes, particularly in planning and implementation of programmes of rural development. As population control and health and family welfare are important areas of rural development the involvement of voluntary organisations in these activities are very important. Some of the activities, the private voluntary organisations are needed to carry out for the health and family welfare programmes are:

1. To conduct awareness-building camps for motivating community participation linked with the health and family welfare programme such as by organising (a) Dental hygiene camps, (b) eye camps, (c) diagnostic camps, (d) blood donation camps, (e) TB and cancer detection camps, (f) MCH services, (g) FP services particularly sterilisation camps and (h) Sanitation Camps; motivating people for immunisation of infant and pregnant women; imparting health education and population education in the community; helping the health personnel in controlling epidemic/communicable diseases.

2. To visit individual families, organise group meetings and conduct shows and exhibitions on primary health care and family planning themes. Also to encourage school teachers for immunisation of school children and conduct essay, debate, painting and drawing competitions primary health care themes.

3. To undertake their activities within a flexible time frame which allows the community, the time to understand, accept

or even reject, make modifications and mould the community to give positive response towards their programme.

4. Develop appropriate Information, Education and Communication (IEC) support through visual aids such as posters, models flip charts, flash cards, slides, etc., which are particularly appropriate and appealing to women, children, and the community as a whole, using local languages. In this regard they should conduct Communication Need Assessment (CNA) studies and develop appropriate communication materials and methods suitable to particular community.

5. To monitor their programme in order to assess the intensity and frequency of inter-action between field level motivators and the community, the level of usage of facilities, the extent of adoption of MCH and family planning services provided and to check the quality of these facilities.

6. To conduct some evaluative studies in order to assess the impact of their efforts.

7. To maintain co-ordination in their activities and also keeping linkages with different sectors in operation for rural development besides health sector as well as with panchayat institutions, youth clubs and *Mahila Mandals*.

Dominant Issues

I. The effective functioning of PVOs are based on certain guiding principles, these are:

(i) The personnel of PVOs must be involved in the basic aspects of programme formulation, decision making, implementation, monitoring and evaluation.

(ii) The volunteers of PVOs should be drawn from divergent fields, *ie.,* social sciences, medical, nursing, etc., both male and female so that they can effectively deal with the different issues of primary health care and family planning.

(iii) Every effort must be made to minimise the dependence of the activity conducted by PVOs either on material or on human terms from outside, otherwise group autonomy of PVOs will be lost;

(iv) They must see that the programme or activity taken up by them must be able to sustain in the context of locally available resources;

(v) Should always think of what technologically is the next step for the group;

(vi) They should see that the activities being taken up by them are effective, if not efficient for the time being. The programmes are effective :

(a) When participants develop skills that they can utilise these in future programmes;

(b) When learning spreads from person to person in the community;

(c) When they are responsive to needs expressed by the community; and

(d) When they are designed to reach a large number of community members.

(vii) Finally, the volunteers should be guided by the principle and should convince the community that a developmental or preventive approach is more efficient than a remedial approach.

Pre-requisites of Volunteers in PVOs

While considering the role of volunteers in terms of pedagogy of empowering them there are number of areas that merit attention:

(i) *Criteria for selection:* Selection of volunteers is crucial for effective functioning of a PVO. They should possess humility, commitment, sensitivity and self-confidence for working in the rural areas.

(ii) *Skill:* The volunteers should possess adequate ability to communicate both verbally and non-verbally and also to analyse and diagnose the context of his work to the rural people.

(iii) *Training:* In order to develop the above characteristics and skills with the volunteers, pertinence of training cannot be overemphasised. Many experiences suggest that agents are best prepared for work by learning through experience, formal institutional training in primary health care and family planning concepts and methods and in extension techniques, including inter-personal communication and the use of audio-visual aids will go a long way in better equipping the volunteers for their work.

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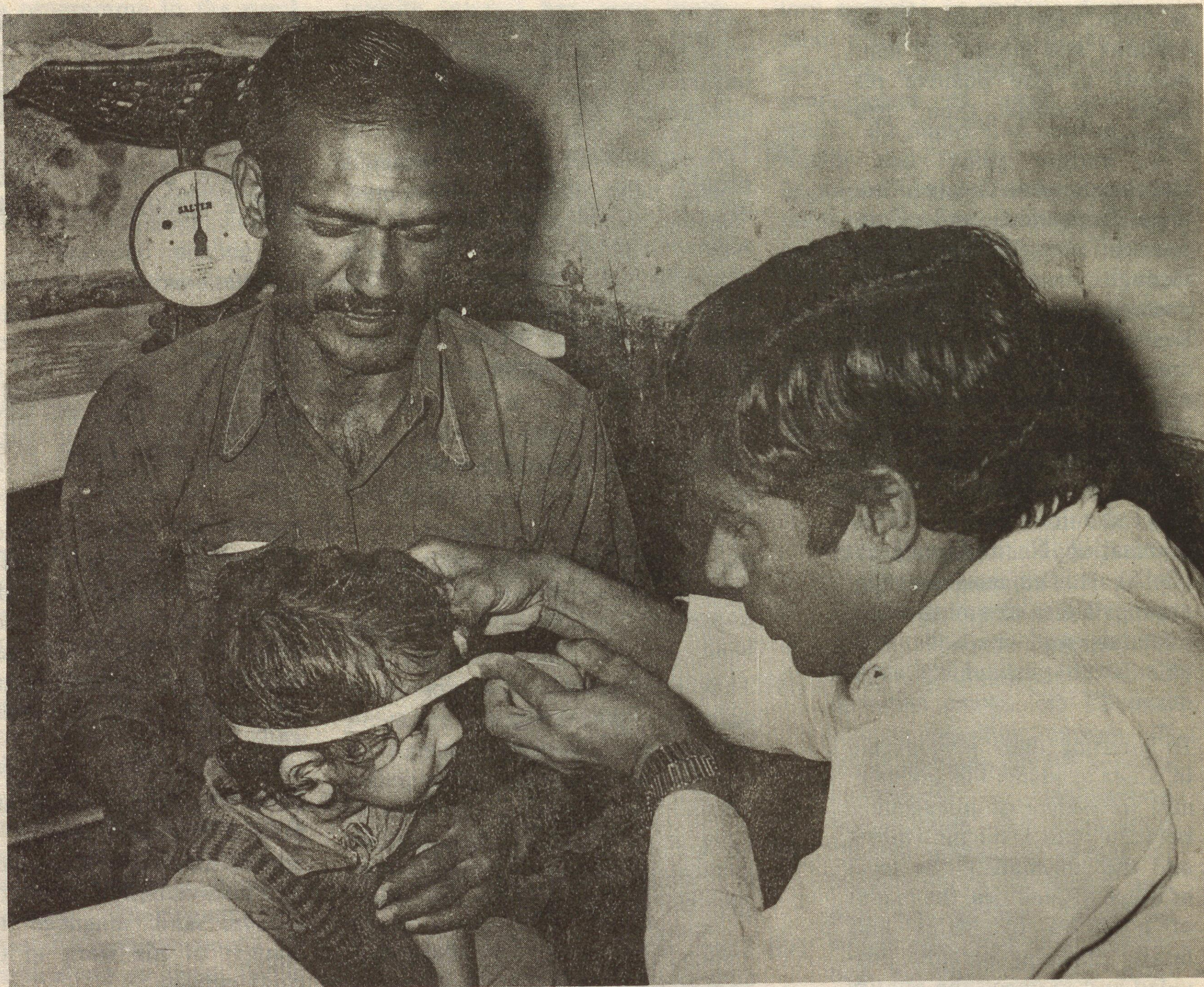


HEALTH CARE DELIVERY

—Need of Comprehensive Health Care

DR DEVI SARAN SHARMA
DR S. B. DABRAL

DESPITE tremendous advancements in the field of medicine, medicare and health, health status of most of the communities in India is far from being satisfactory. The socio-economic and demographic profile is not taking very favourable trend At the present population growth rate, the population of India is expected to cross 1000 million mark by the end of the year 2000. The literacy rate is 36 per cent. More than 50 per cent of the population is below poverty line. According to Centre Calling Reports, 60 per cent of the hospital beds in India are occupied by the sufferers of infective and parasitic disorders. Measles, polio, viral hepatitis and Japanese encephalitis are viral diseases. Malaria,

TB, Leprosy and blindness still remain major public health problems as great barriers to 'Health for All'. Malnutrition is very severe among women and children of lower socio-economic group. Iron deficiency xerophthalmia and endemic goitre are our important nutritional problems. The main reasons of all these problems are social in nature namely, poverty and ignorance. Non-communicable diseases like heart-disease, cancer and Hypertension are the problems of affluent groups. Occupational diseases are increasing with rapid industrialization. Health hazards due to environmental pollution, alcoholism, smoking, drugs, accidents, AIDS, etc. are increasing particularly in urban areas.

If the efforts so far made are critically examined, Sharma (1988) opined that "they have purely been curative; and social, preventive and rehabilitative approaches have totally been neglected".

Present health situation in India proposes that a major magnitude of the problem can be contained if our health delivery system is totally reoriented to provide comprehensive health care to the masses.

Comprehensive health care

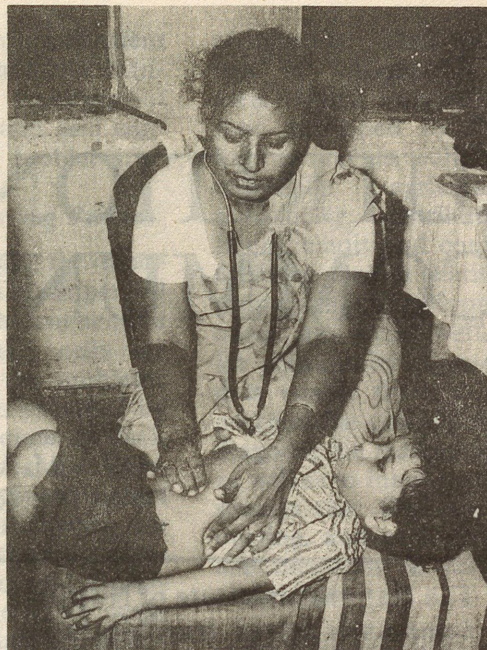
Comprehensive health care combines preventive, promotive, curative and rehabilitative care to all. The elements of comprehensive health care are :

Prevention

Prevention is better than cure is a well known dictum for one and all. Immunization for example can change the incidence and prevalence of many vaccine preventable diseases. The provision of safe water supply can avert waterborne diseases. The care of pregnant mothers can help to reduce the maternal and infant mortality and morbidity. Similarly the use of specific nutrients, protection against occupational hazards, accidents and environmental delepidation and pollution can prevent much of the physical human sufferings. Modification in human health behaviour through health and general education, motivation for cleanliness and adoption of healthy practices only can check the disease process effectively.

Promotion

Adequate nutrition and provision of basic sanitation, personal hygiene, health education, marriage counselling, sex education, periodical health check-up, regulation of lifestyle, improvement in the standard of living and population control are some essential measures for promoting health of the common man.



Early diagnosis and treatment are important to make the cure easier and economical.

Cure

Cure is the felt need which a patient requires in illness situation. Early diagnosis and treatment are important to make the cure easier and economical. For this purpose the health services are required to be easily and conveniently approachable to needy persons. In the contemporary context there is an urgent need that curative care reaches the needy in tribal and rural areas, to the people of lower strata to the weak and ailing children and women, taking into consideration the existing socio-economic, geo-political and psycho-cultural realities of most developing societies.

Rehabilitation

Rehabilitation is an integral part of medical care. W.H.O. (T.R.S. 1969, 81) define it as "the combined and coordinated use of medical, social, educational and vocational measures for training or retraining the individual to the highest possible level of functional ability", and "at enabling the disabled and handicapped to achieve social integration".

Rehabilitation requires multidisciplinary team approach through physicians, various therapists, psychologists, social workers and experts in vocational guidance.

(Contd. on page 44)

NUTRITION TRAINING IN COMMUNITY SETTINGS
—NIN Experience

M. Mohanram
V. Ramadasmurthy

The National Institute of Nutrition (NIN), Hyderabad, has introduced the element of community based learning in its international nutrition training programmes for health professionals. Assessment of the quality and applicability of the learning experience including field placement in work situation was made and it has proved the applicability and utility of community based education approach in the basic and inservice training of health professionals in the Indian situation.

Importance of need-based education of health professionals to meet national goals is now recognised all over the world. India and other developing countries have chosen primary health care as the tool for delivery of health services. Primary health care approach implies a reorientation of health services so that secondary and tertiary care reinforce the health care at primary level and an even distribution of health resources is facilitated with accent on support to primary care.

In a country like India, majority of the population lives in villages and preventive, promotive and curative health care should be made accessible to these people. The health team headed by the medical officer, supported by paramedical health professionals and other grassroot level workers, has to provide these services. It is imperative that the basic education as well as inservice training of all the members of this team should be such that they are fully equipped for their respective job responsibilities.

In most educational institutions, including those preparing the health professionals in the country, the commonest method adopted is a teacher-centred, subject-based approach. In this approach, it is assumed that the learners' experience in learning is of lesser value than that of the teacher. If the learning is problem-based and student centred, the learner will acquire skills in using that knowledge. Miller (Journ. Med. Edn., 37, 185-191, 1962) has observed that even before they graduate, medical students forget most of the traditionally learnt subjects taught during first year, since only knowledge used is better remembered.

Our studies (Mohapatra, et al., World Health Forum, 9, 612-614, 1988) on PHC Medical Officers brought to light several shortcomings in their understanding and functioning in the area of primary health care, particularly regarding nutrition. Gaps in knowledge were apparent with respect to growth monitoring, nutrient contents of various foods, nutrient requirements of certain important physiological groups like children, women during pregnancy and lactation, their own involvement in national nutrition intervention programmes. Very few of them were aware of their responsibility for referral services, an important component of primary health care.

Rationale for Community Based Education (CBE)

Achieving educational relevance to community needs is particularly essential in the case of health professionals. Their education has to be not only community oriented, but should be aslo **community based.** Several international organizations such as WHO (WHO Tech. Rep. 746, 1987) have recognised the merits of CBE. CBE consists of learning activities which use the community extensively as a

learning environment. The learning activity takes place predominantly in community health service settings. The curriculum has to reflect a judicious blend of activities covering a range of health services at different levels.

CBE Approach in 'Nutrition Training

The national Institute of Nutrition (NIN), Hyderabad, has introduced the element of community based learning in its international nutrition training programmes for health professionals. Participants of the NIN Postgraduate Nutrition Courses are either medical college teachers in specified disciplines or health professionals holding responsible positions as State Nutrition Officer or connected with health care delivery. Middle level paramedical personnel from primary health care sector such as trainers and supervisors—health Supervisors, Health Extension Educators—are also trained under one training programme.

The methodology of the Institute's training courses has recently been modified. Participants visit and stay in a rural set-up-PHC-area—about 100 kms. from the Institute for a field based training for two weeks. The PHC base selected has a permanent infrastructure for training, established by Osmania Medical College, Hyderabad. Spacious classrooms and hostel facilities with boarding are provided. Participants camp in this place along with training faculty from the disciplines of community nutrition, sociology, anthropology, statistics and dietetics along with supporting staff. Equipment and other necessities for diet and anthropometric surveys are made available along with audio-visual tools for teaching.

The three major spheres of activities in which the participants engage themselves at the field camp are : Community diagnosis, assessment of the nature and extent of the community health and nutrition problems and management strategies for prevention and control of the identified problems.

Student-Centred Learning Process

In this entire exercise, the didactic approach is totally dispensed with. Since a student-centred learning is envisaged, only introductory briefings to problems and programmes are provided by the faculty who operate as facilitators. Opportunities for interaction between concerned expert faculty and the participants are provided during short presentations in the evening and discussion sessions on the day's work, gaps and shortcomings are held.

As for development of skills and allied aspects comprising psychomotor domain of learning, the method of choice, viz., task approach is followed. After demonstration of a technique such as diet or nutrition survey, participants are given the assignment involving that task, under faculty supervision. The observed defects and deficiencies are rectified and discussed. The task is repeated till the participant gets familiar with it and performs satisfactorily. Apart from the experience at the field base, participants have the opportunity to visit the teaching hospitals in Hyderabad where NIN has Out-Patient and In-Patient facilities for cases of malnutrition. In the course of these visits, supported by bedside clinics, participants get first hand experience at tertiary level in different aspects relating to health and nutrition.

Integrated Approach

The fact that solution of nutrition and health problems lies not in the health sector alone, but several allied areas in non-health sector as well, is widely recognised. Towards this end, participants are encouraged to collect data on various aspects, influencing the health and nutrition status of the community. They visit in groups sets of villages in the study area. Using standardised proformae developed by the Institute, information is collected on demography, agriculture, food availability, distribution, educational, credit and communication facilities, health statistics, health programmes, developmental, economic and social welfare projects, for community diagnosis. These data enable them to better comprehend the existing situation and diagnose the reasons for the same, as well as to interpret results of the surveys that they would be conducting, and to suggest ameliorative measures in respect of that community.

Participants undertake the surveys in selected village households and develop necessary skills for conducting diet and nutrition surveys independently, standardising the techniques. They also gain experience in conducting institutional surveys in addition to assessing nutritional status of individuals in households. Later in the day, they process the survey data and compute diet and nutrient intake.

Management Strategies

Choosing an appropriate management strategy requires the collation of basic data pertaining to the community and the results of the diet and nutrition surveys. Together, they would serve as a backdrop against which one has to devise suitable solutions keeping in view the available infrastructure and ongoing programmes. It calls for crucial decision making which equips the participants for future work in their own home settings.

In this phase, participants form into two or three groups. Pooling the data gathered on different aspects, they work on various components. Under the guidance of the faculty, they draw up a comprehensive plan, the merits and

demerits of which are discussed. After a critical review by the faculty and fellow participants, a report on the entire field experience is drawn up at the end of the placement period. The utility of such problem-based learning has been established at centres like McMaster University and Michigan State University.

Feedback on utility of field placement

A fullfledged mechanism of participant feedback is built into the NIN training programmes. Opinions of the participants on all important aspects such as course structure, content, organisation, utility and suggestions for improvement are obtained. Relevant information on specific chunks of the course syllabus, particularly, their opinion on field placement arrangement and its utility, is obtained in the feedback. Special instruments are developed for this purpose and administered during different stages of the course and thereafter, *i.e.*, entry, exit and as follow-up after the participants rejoin their positions subsequent to the training. Care is taken to ensure that the responses of the participants are objective and reflect their own considered opinion on various aspects, without operation of extraneous factors like influence of faculty etc. Assessment of the quality and applicability of the learning experience including field placement in their work situation was made. For this purpose, 0-4 point rating scale was employed to measure the level of confidence to perform specific activities covered in the training courses.

Responses regarding field placement experiences received from 64 participants in the Institute's training courses were analysed. It was seen that 65-90% of respondents were confident of undertaking specified activities. Capability with regard to management of ongoing community nutrition programmes raked highest with 91% of them giving rank-4 (highest). Coming next were the aspects 'identification of nutritional problems' (84%) and 'conducting diet and nutrition surveys' (76%). The community based orientation sessions have been endorsed as useful by the participants in respect of cognitive domain of learning and in the development of psychomotor skills regarding nutritional assessment.

This experience of NIN proves the applicability and utility of community based education approach in the basic and inservice training of health professionals in the Indian situation. During his subsequent observation study as part of a comprehensive impact assessment of the training courses, one of the authors (MMR) noted that many of the erstwhile participants were undertaking community surveys utilising skills obtained during the training. This confirms the effectiveness of the training methodology adopted.

It should however, be mentioned that there are some constraints and problems in the implementation of community-based education. Firstly, it needs multisectoral coordination for planning the field based study. The conventional system of education does not lend itself to such innovations and suitable modifications have to be made. There are also bound to be logistic difficulties such as travel, transport and infrastructure facilities for stay etc. Community based study is faculty-intensive and calls for appropriate faculty resources representing various disciplines. Nevertheless, the rich dividends it is expected to yield justify the additional effort and inputs demanded by community based learning. Δ

(Contd. from page 41)

There are four basic areas of concern in rehabilitation :

1. Medical Rehabilitation *i.e.*, restoration of biophysical functions,
2. Vocational Rehabilitation *i.e.*, restoration of the capacity of an individual to earn a livelihood,
3. Social Rehabilitation *i.e.*, restoration of family and social relationships and the capacity to react to social roles,
4. Psychological Rehabilitation *i.e.*, restoration of personal dignity and confidence.

Some examples of rehabilitation are : establishing schools for the blind, provision of aids for the crippled, reconstruction surgery in leprosy and graded exercise in neurological disorders like polio, change of occupation for a more suitable living and modification of lifestyle in general in the cases of tuberculosis, cardiac patients and others.

The following points may be made as grounds for implementing comprehensive health care :

1. Medical education and training should be reoriented rather socially reoriented to implement comprehensive health care.
2. The services should be planned and organized through multidisciplinary team approach in order to meet psycho-social as well as biophysical needs of the patients.
3. A shift from individual patient to mass based, hospital based to community based strategy is a must to provide comprehensive health care in India.

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IDEAS FOR ACTION

Learning about your Community

WOMEN'S groups, scouts, health volunteers, local organizations and health teams, should know their community if they are to be effective in improving its health. You may already know many things about your community, especially if it is a small one. But do you know *enough* about it? You will learn more by talking in a systematic way with its leaders and other people. Do not ask too many questions though; it is better to *observe, listen* and *learn!* Here are some of the things you should find out.

☐ How many people are there in the community, and how many of them are young, middle-aged, and old?

☐ How do people get food? How do they earn money? Are they farm workers, fishermen, cattle-farmers, estate workers, factory workers? How do they spend their free time? Do they work at night?

☐ Do children work? How many of the children attend school?

☐ Is the community poor? Is it becoming poorer or less poor? Is its standard of living higher or lower than the average for the country? Are there good markets, good roads? Is there a clean water supply? Is there electricity, a telephone service, a bus service?

☐ How do families live? What are the houses like? Do they have a system of sanitation? Are the houses clean and free of pests?

☐ Who makes decisions within the family? How many children are there in the average family? How are the children fed and how are they taught? What are the most common beliefs, values and traditions?

☐ What are the main health problems and what are their causes? Some causes of bad health are:
- — too many people living close together;
- — not enough water or the water is not safe;
- — not enough food of the right kind;
- — unclean houses in dirty surroundings;
- — no way to keep cool in the heat or to keep warm in the cold;
- — no latrines or the latrines are dirty;
- — no protection against insects that carry diseases;
- — the health centre is difficult to reach;
- — people cannot read and thus do not learn about health and healthy habits.

Talk to various groups and people: families or households (both rich and poor), those who make decisions for the community about the community and members of special groups. Try to find out:
- — what part of their income do they spend on health?
- — what community problems are they especially concerned about?
- — what have they been doing about these problems?
- — what do they think can be done?
- — who are the leaders, or those who make the decisions for the community? They may be tribal leaders, religious leaders or political leaders. They are the ones who are most likely to help in improving health. Other people whose opinions and support are valued may include the elders, landowners, money-lenders or businessmen.

Find out how the community is organized and who runs its affairs.

For example:
- — Which group makes decisions for all the people? Is it a development committee, a political body, or some other group?
- — Does this group deal with all the affairs of the community? Or does it have sub-committees that look after different needs of the community, such as health, water supply and education?
- — Is there a health committee? Who are its members and how are they chosen? What are their tasks? How often do they meet? Are all sections or groups in the community represented?
- — What other groups are there? For example, a women's group or a farmer's cooperative.

If you are a schoolteacher, why not ask your students to do a community survey based on questions like these? Then you could call a meeting of parents and ask the students to present their findings. May be a movement to improve health could be started?

DRAWING A MAP OF YOUR AREA

A map is a useful tool to study the health and sanitary situation in a community. If there is not already a good map of your area, ask other people (for example, the schoolteacher and schoolchildren) to help you to draw one. This map will show the rivers, schools, health centres, temples, roads, shops and other important places. Take the map to the community committee and place it where the people can see it.

As new information comes in, mark it on the map. For example, show the wells or houses that are not in good condition. Keep the map up-to-date. It will make it easier to detect some of the health problems, and also to show by how much community health improves from year to year. ☐

—The above is adapted from: On being in charge—A guide to management in primary health care. WHO, Geneva, 1992, price Sw. fr. 30 (developing countries Sw.fr. 21); and The community health worker, WHO, Geneva, 1987, price Sw.fr. 22 (developing countries Sw. fr. 15.40).

EDUCATIONAL INTERVENTION IN MANAGEMENT OF ALCOHOL DEPENDENCE

M. AMEER HAMZA
DR R. PARTHASARATHY

Whatever may be the helping processes adopted for the treatment of alcohol dependence by the mental health professionals, medical personnel, counsellors, paraprofessionals and non-professionals; one of the common core elements seems to be alcohol education at individual, group, family and community levels. Alcohol education influences an individual/group emotionally, intellectually, psychologically and socially and may result in the modification of attitudes that influences behaviour.

IN India increasing importance is being given now to problems related to drinking of alcohol. Academicians and researches focus on the antecedents and consequences of alcohol drinking among different groups of population—students, industrial workers, transport workers, daily-wage labourers, professionals, businessmen and others in urban and rural areas. Considering the increasing magnitude of these problems, the voluntary agencies and the government have been planning and organizing a wide variety of programmes in the hospital and community settings. Efforts have been made to introduce alcohol treatment programmes in general hospitals and mental health centres. De-addiction centres to cater to the needs of the people affected with drinking related problems are being established in different parts of our country. In different training programmes, information related to alcohol and health are appropriately incorporated. In addition, various legislations are enacted to control the alcohol and allied problems. To create awareness, mass media brings out different types of programmes in different languages. Inspite of all these efforts, the public do not seem to have gained scientific information and positive attitudes towards alcohol related problems.

Alcohol education

Whatever may be the helping processes adopted by mental health professionals, medical personnel, counsellors, para-professionals and non-professionals, one of the common core elements seems to be alcohol education at individual, group, family and community levels.

Alcohol education, a learning process that influences an individual/group emotionally, intellectually, psychologically and socially, may result in the modification of attitudes that influence behaviour. It involves the formal mechanism of presenting information, and includes a series of experiences and influences that help to shape the learning environment, the atmosphere of the school, the lifestyle present, the attitude of parents, the pressures within a peer group, the popular culture, the personal experience with or without alcohol and availability mechanisms employed to carry out certain kinds of behaviour.

The available knowledge related to alcohol problems presents many facets, some of which are:

1. Alcohol abuse and dependence are serious problems that affect a significant size of our population. Adverse social and medical consequences of abusive drinking arises from a single bout of drinking as well as from longer term effects of alcohol consumption. Adverse consequences may affect not only the drinker but also others with whom the drinker comes in contact.
2. The prevalence of alcohol related problems among hospitalized patients has been increasing in recent years. Co-morbidity of alcohol related diagnosis with other

(*Contd. on page 48)*

MESSAGES
ON
ANTI-LEPROSY DAY—30TH JANUARY

PRESIDENT
REPUBLIC OF INDIA

ON Martyr's Day it is important for all of us to recall the struggle waged by the Father of the Nation, Mahatma Gandhi, for the alleviation of the suffering of patients of leprosy. Bapu's words to us were: "Leprosy work is not merely medical relief. It is transforming the frustration in life into the joy of dedication......It is not enough merely to wipe out the tears from the eyes of the disabled, it is necessary also to see that the disability is prevented."

Drawing upon modern science and technology, and with a spirit of service and devotion we can give to patients of leprosy a life of dignity as participants in national reconstruction, and strive to protect humankind from this disease.

In this task, the contribution by social and voluntary organisations and by specialised institutions, is of great value and strengthens the efforts by the official agencies to combat leprosy.

On the occasion of the Anti-Leprosy Day, I extend my greetings and good wishes to the Hind Kusht Nivaran Sangh and all other organizations fighting Leprosy, for every success in their mission in the months and years ahead.

SHANKER DAYAL SHARMA

13th January, 1993

PRIME MINISTER

OBSERVING January 30 as Anti-Leprosy Day is a fitting tribute to the Father of the Nation, Mahatma Gandhi, who dedicated his life to the welfare of the downtrodden and drew the attention of the country to the plight of lepers through his own dedicated service to the hapless victims of this disease. It is gratifying to note that the Hind Kusht Nivaran Sangh is continuing the noble work of Gandhiji with the same spirit of love and sympathy.

I send my best wishes to the Hind Kusht Nivaran Sangh on the occasion of the Anti-Leprosy Day.

New Delhi, P. V. NARASIMHA RAO

January 16, 1993

MINISTER OF HEALTH AND FAMILY WELFARE

THE menace of leprosy in India has since been substantially reduced as a result of concentrated efforts of the Government and Non-Governmental Organisations. However, leprosy still continues to be a major public health problem in our country. With the expansion of Multi Drug Therapy (MDT) coverage to all leprosy cases by 1994, it should be possible to eliminate the incidence of new leprosy cases by the turn of the century. Rehabilitation of cured leprosy patients and prevention of deformities by active involvement of the community would require continuous attention of all the voluntary organisations, philanthropic bodies and other welfare institutions.

On the occasion of Anti-Leprosy Day on the 30th January, 1993, I extend my best wishes to all those engaged in Leprosy eradication programme for success in this noble mission.

New Delhi, M. L. FOTEDAR

13 January, 1993

(Contd. from page 46)

disorders has been found to include disorders of the liver, pancreas, digestive system, respiratory system, nervous system and cardiovascular system as well as drug abuse, mental illness, injuries, and accidents, infections, anemias, and malnutrition.

3. In alcoholism, the interaction of genetic and environmental factors is emerging as fundamentally important research issues. Although the mechanisms of genetic transmission are not yet known, evidence for genetic transmission of vulnerability of alcoholism has been provided by different studies. Likewise such psychological and social factors as cultural and group norms, peer influences, expectancies about alcohol's effects, and subjective experiences have been found to influence drinking behaviour. Problems in the childhood, home and childhood behaviour difficulties have been observed as antecedents of alcohol dependence, but causal role has not been established.

4. Various biological researches have found that certain neurohormones such as vasopressin may play a critical role in maintaining tolerance and that other neuro-transmitters, receptors, and ions such as calcium may play a role in mediating tolerance to alcohol. Studies have shown that the sons of the alcoholics display some unique electrophysiological behaviours. Further researches are being conducted to know about other brain mechanisms.

5. Alcohol has been found to have profound metabolic effects on carbohydrates 'Lipid', and protein metabolism; chronic alcohol abusers can develop clinical signs of cardiac dysfunction and upto 50% of excess mortality in alcoholics and heavy drinkers can be attributed to cardiovascular disorders. Chronic alcohol consumption is associated with a significant increase in hypertension. Alcohol affects immune, endocrine and reproductive functions. Heavy alcohol consumption is also a well documented cause of neurological problems including dementia, blackouts, seizures, hallucinations and peripheral neuropathy.

6. The deleterious consequences of maternal drinking during pregnancy are long-lasting. Problems related to foetal exposure to alcohol is one of the leading known causes of mental retardation.

7. Research findings suggest that alcohol increases the risk for falls, fires and burns. A significant percentage of suicide victims have a history of alcohol abuse or were drinking shortly before their suicides, and that alcohol tends to be associated with suicides, that are impulsive rather than pre-mediated; untreated alcoholics and other families have higher general health care cost than non-alcoholics and their families. General health care cost tends to decrease following the treatment of alcoholism.

8. Several screening instruments have been found particularly useful in identifying alcoholics. Usually self-reports, clinical examinations, and laboratory tests have been used in assessment of the problems.

9. Recent researches have studied prevention efforts focused on school-aged children that employ a cognitive behavioural approach and often involve interventions intended to improve the general coping skills. Although results have been mixed, there is some evidence of short-term effects and of reductions in the amount of drinking among young people. Other prevention approaches such as those emphasizing alcohol education have been found to increase young people's knowledge about alcohol and its effects.

10. Elements of early and minimal interventions include combinations of brief advice and assessment interventions, feedback and admonition sessions and self-help behavioural training manuals. These simple approaches can effect drinking patterns and alcohol related problems.

11. The components of treatment include management of alcohol withdrawal, long-term management of alcohol dependence and prevention of relapse. A range of treatment options is available including pharmacologic interventions, psychotherapy and counselling, alcoholics anonymous and a variety of behavioural training programmes. Research on the effectiveness of various treatment approaches has improved knowledge about the effectiveness of group therapy, spousal involvement in alcoholism treatment, marital therapies, social skills training and Alcohol Anonymous. The researches show the effectiveness of a combined approach involving biological, psychological and interpersonal approaches.

Alcohol Education Approaches

(a) *Frightening approach:* One of the methods adopted in the past was to righten people away from alcohol use by recounting or fabricating horror stories about alcohol or its use. This approach has not been very effective, specially when the concerned individuals have been able to identify discrepancies or untruths in the stories. Scare tactics might work in short run but can only hope to be effective when the stories are real and are appropriate to the audience and the situations.

(b) *Appeals:* The traditional appeals usually involve the use of credentialed authorities such as psychiatrists, psychiatric social workers, psychologists, psychiatric nurses, clergy and variety of law enforcement personnel who describe alcohol abuse from their perspectives. Similarly ex-addicts provide a different type of appeal. From personal experience, they are generally able to tell a variety of horror stories about their own addictions. These methods if appropriately used would be effective.

(c) *Self-esteem:* Building self-esteem in the individuals affected with alcohol problems and helping them to be assertive in their day to day activities are essential components of alcohol education.

(d) *Factual information:* Factual presentation of information on alcohol have been the hallmark of many educational efforts. The major emphasis should be on the transmission of information that would be useful for individual decision-making about alcohol and its use. This is effective for mature audience, who have all the skills and the information for responsible decision-making.

(e) *Selection of models:* The use of carefully selected peers who could serve as responsible models is another approach tried in many settings. The idea is to take a cadre of youngsters who are already respected by the target population. Through intensive training, these youngsters would become an important component of the alcohol education programmes. In practice, this approach depends for its success on adequate selection and training of the core group.

(f) Self-examination and attitude confrontation involve changing of attitudes or clarifying values, or improving the level of understanding. This approach is enormously successful in affecting the character of education in general but it probably does not have widespread impact on alcohol abuse as yet.

(g) *Informal education philosophy:* The use of informal education philosophy on current or future members of religious, social or political groups has been identified as a successful approach in drug education. This approach is simple to comprehend but some times difficult to achieve. What is required is the identification of an individual's real needs. A group must be found that is dedicated to satisfying those needs while at the same time, the individual becomes thoroughly committed to that group's goals. Then the group tries to achieve its goals.

Group education

In hospital settings or de-addiction counselling centres, the group education provides a suitable medium for incorporating many of the positive elements of education—motivation, support, guidance, provision of role models, and other coping mechanisms for the members of the group. The groups could be for the patients only in the initial stages and subsequently including their family members/spouses and others. Such group education would serve as effective therapeutic force and helpful for treatment adherence. The group could be guided by the mental health professionals like Psychiatric social workers, Psychologists, Psychiatrists and psychiatric nurses. Whoever conducts such groups, he/she should be well versed with the scientific information about alcohol-diagnosis, treatment and rehabilitation, and also knows about the health education methodologies and group dynamics. These educational elements are seen in all the methods of management of alcohol dependence. If such efforts are well documented indifferent centres, it is possible to arrive at culturally and socially suitable educational package programmes for individuals, groups, families and communities. The colloborative efforts of professionals, para-professionals and non-professionals working in the government and voluntary sectors are essential to consolidate and propagate the educational inputs in the effective management of alcohol dependence in Indian setting. Δ

DR HIROSHI NAKAJIMA NOMINATED FOR A SECOND TERM OF OFFICE BY WHO'S EXECUTIVE BOARD

Dr Hiroshi Nakajima was nominated on 20 January 1993 for a second 5 year term of office as Director-General of the World Health Organization (WHO) by the 91st session of the Executive Board, meeting in Geneva.

Dr Nakajima's present term of office ends in July 1993, when he will have completed 5 years as Director-General. Today's nomination will be submitted for the approval of the 46th World Health Assembly meeting in Geneva next May.

Dr Nakajima was born in Ciba City, Japan, on 16 May 1928. He obtained his medical degree at the Tokyo Medical College in 1955 and he holds a postgraduate degree in medical science.

Dr Nakajima joined the World Health Organization in 1974 in the position of Scientist, Drug Evaluation and Monitoring. He became Chief, Drug Policies and Management unit in 1976. In 1978 the WHO Regional Committee for the Western Pacific nominated Dr Nakajima as Regional Director. In May 1988, while still in office as Regional Director, he was appointed Director-General of the World Health Organization by the 41st World Health Assembly.

Dr Nakajima is the author of scientific articles and reviews relating to the medical and pharmaceutical sciences, published in the English, French and Japanese languages. Δ

TRADITIONAL HEALTH PRACTICES FOR THE CARE OF CHILDREN

DR MEHARBAN SINGH

Traditional health practices for the care of children can be categorised into four main sub-groups namely useful, harmful, innocuous and of uncertain utility. The health workers must be conversant with common customs and beliefs pertaining to health care of children in the area or community in which they work, says the author.

THE traditional practices are time honoured rituals and beliefs which are prevalent in a community and they may pertain to a wide range of activities. Every community has its own way of rearing children which is ingrained in the society through traditions established over the centuries. The customs and cultural practices pertaining to mothercraft and child care are passed from one generation to another, from grandmother to mother and to their grand children. The ancestral or conventional child care practices are by and large based on core knowledge and wisdom although some of them may have emerged purely from intuition and superstition. The traditional practices are influenced by the education level, socio-economic status and value system of the family and the community.

It is neither possible nor feasible to provide modern medical care to all the people of a huge country like India which is bogged by numbers, illiteracy and economic poverty. There is no doubt that a combination of modern and traditional healing is appropriate to serve our health needs. However, the rapidly changing lifestyle and introduction of modern medicine has caused confusion in the minds of tradition-bound people and their promoters in the Indian system of medicine. There is evidence to suggest that traditional health care practices have a definite link with the science of Ayurveda.

Utility of Traditional Health Practices

Most of our health care practices have their origin in our traditions based on core knowledge and wisdom of our ancestors. The conventional or traditional practices have become part and parcel of our lifestyle. They are readily available at the door-steps of the people and they are readily acceptable to the society. Above all, they are cheap and affordable and can be utilised by a large segment of our community. The traditional practices and home remedies are promoted by village healers, midwives, physicians practising Indian systems of medicine (ayurveda, siddha, unani), charltans, quacks and of course wise old people of the community. The traditional practices are so ingrained in the minds of people that it is difficult to change them even when they are identified to be useless or harmful.

Types of Traditional Health Practices

Traditional health practices can be categorised into four main sub-groups : useful, harmful, innocuous and of uncertain utility. The health workers must be conversant with common customs and beliefs pertaining to health care of children in the area or community in which they work.

(i) Useful traditional practices

A number of traditional health practices for the care of newborn babies are useful and based on sound scientific basis and logic (Table 1). They must be promoted and actively encouraged in the society. Their promotion shall facilitate the participation of the community and their acceptability by the health care providers of modern systems of medicine. These practices are more appropriate to serve our health needs as they are based on simple technology. A large number of diseases are minor and self-limiting and it is appropriate to treat them with safe and cheap home remedies.

Table 1 : List of useful traditional practices

1. Confinement at mother's place
2. Isolation of the mother-child dyad for 40 days
3. Oil massage
4. Universal breastfeeding and wet nursing

5. Instillation of colostrum in the eyes
6. Use of cup and spoon or "paladey" for top feeding
7. Baby sleeping on mother's bed and latter avoiding to turn her back towards the baby.

(ii) Harmful traditional practices

A large number of customs and cultural practices prevalent in our country for mothercraft and child rearing are positively harmful (Table 2). Many traditional practices have undergone lot of change and developed aberrations over the years and they have become unacceptable in the context of current scientific understanding. It is essential that community must be educated so that harmful rituals pertaining to child care can be stopped. There is an urgent need to inform and educate the promotors of traditional practices and remedies such as village healers, midwives, physicians practising Indian systems of medicine and quacks, etc., regarding the dangers of some of the traditional practices which are rampant in our country.

Table 2 : List of harmful traditional practices

1. Eating less and restricting certain foods during pregnancy
2. Conducting delivery in a dark and ill-ventilated room
3. Use of rags/dirty clothes during delivery
4. Using ineffective and harmful resuscitation procedures : splashing water on face, squeezing onion in front of nose, vigorous and prolonged slapping, making loud noises, roasting placenta, etc.
5. Use of unsterile knife for cutting the cord
6. Application of ash, cow dung, catechu, etc., on the umbilical cord
7. Discarding colostrum and delaying breastfeeding
8. Avoiding certain foods during lactation such as pulses, legumes, vegetables, some fruits, etc.
9. Discrimination against girl child
10. Opium for diarrhoea/crying child
11. Kajal
12. Pacifiers
13. Dilution of milk
14. Castor oil for constipation and diarrhoea
15. Delayed weaning and giving inappropriate weaning foods
16. Branding
17. Instillation of oil and urine for ear ache
18. Exanthematous diseases as personification and wrath of goddesses

(iii) Innocuous or inconsequential traditional practices

A large number of traditional practices are apparently harmless or innocuous but are widely practised (Table 3). Unless their hazards are recognised, it is best to ignore them because a concerted drive against these practices may actually be counter productive. Though most of these practices are harmless but their utility is doubtful and they may lead to delay in seeking medical aid with resultant deterioration of the child health.

Table 3 : List of innocuous or inconsequential traditional practices

1. Prelacteal feeds : glucose water, honey, jaggery water, cow's urine, donkey's milk etc.
2. Nose and ear piercing, talisman, amulets, removing "nazar" by burning lahi, chillies and alum
3. Tying neen leaves on the door of the house
4. Massage of anterior fontanel
5. Keeping knife under pillow to protect the infant against harmful spirits

(iv) Traditional practices of doubtful or uncertain utility

A number of popular child rearing practices are of uncertain or doubtful utility (Table 4). There is certainly a need to systematically study the utility, futility and possible dangers of these traditional practices. The blind faith in the traditional health practices of doubtful utility may lead to nonacceptance of modern system of medicine.

Table 4 : Traditional practices of uncertain/doubtful utility

1. Janam ghutti
2. Gripe water
3. Boiled water containing anisi, cummin seeds, ilachi for the mother after delivery
4. Use of a variety of traditional galactogogues : garlic, ginger, coconut, jaggery, bajra, ghee fenugreek, pepper, margosa etc.
5. Brandy for URI/pneumonia
6. "Hot" and "Cold" feeds
7. Avoiding exposure of pregnant woman to eclipse
8. Use of copper, steel and magnetic bracelets

Under the garb of tradition, many unstandard and unwanted commercial preparations like gripe water and *ghuttis* are being promoted and sold across the counter. However, we must try to preserve the good old traditions for the care of children by integrating them in the primary MCH care programmes and weed out the harmful cultural beliefs and practices by health education. A campaign should be launched through media against balatant advertisements by manufacturers of various formulations of doubtful utility and safety. Δ

COUNSELLING FOR PSYCHOSOCIAL PROBLEMS

Dr V. N. Rao
Dr R. Parthasarathy

Counselling is a planned and systematic application of psychological facts and social understanding to the alleviation of a large variety of human ailments and disturbances, particularly those of the psychogenic and interpersonal origin. It also strengthens the problem solving capacities and coping abilities of the individuals and families in the society.

Of late, we have been hearing much about the word "COUNSELLING" specially in the context of deaddiction, students' academic and vocational problems, marriage and sexual problems, legal problems, family interaction related problems, interpersonal problems of industrial workers, planned parenthood, health education, and other activities related to personality and competence development. The Government and voluntary agencies are actively involved with training and utilizing the skills and expertise of counsellors in health, welfare, education and developmental programmes in institutional and community settings.

Though the counselling is used widely and becoming popular among the general public, the exact meaning of counselling is rarely understood. Because of lack of understanding of the essential nature of counselling, it is not uncommon to see exploitation of the concept of counselling by quacks, unqualified people, pseudo-therapists and others in big cities, towns and remote villages. More often than not, the gullible people are carried away by the false promises and high claims made by such unscrupulous and anti-social elements, in the pretext of managing any problem under the sun with the label of counselling.

According to the Dictionary, the word, "counsel" has different meanings like—"consultation", "deliberation", "advice", "plan" and "purpose". The counsellor is one who counsels.

Scientifically speaking, there are several definitions given by mental health professionals and counselling experts. For example—Gustard gives the comprehensive definition as: "counselling is a learning oriented process, carried on in a simple, one-to-one social environment, in which a counsellor, professionally competent in relevant psychological skills and knowledge, seeks to assist the client by methods appropriate to the latters' needs and within the context of the total personnel programme, to learn more about himself to learn how to put such understanding into effect in relation to more clearly perceived, realistically defined goals to the end that the client may become a happier and more productive member of his/her society."

In other words, counselling is planned and systematic application of psychological facts and social understanding to the alleviation of a large variety of human ailments and disturbances, particularly those of psychogenic and inter-personal origin.

Usually, counselling services are offered by persons trained in mental health. In addition to the

professionals, people who undergo special training programme in counselling run by recognised centres impart short term training programme in counselling for volunteers, teachers, medical personnel, welfare agency personnel and others involved in developmental programmes. Depending on the training and knowledge, the counsellors offer their services to the clients affected with variety of problems related to studies, vocation, job, marriage, family, child rearing, adjustment, etc.

Stages of Counselling

There are five stages of counselling. In the first stage, the counsellor establishes working relationship or rapport with the clients. As a result, the client tends to trust the counsellor and reveals his problems to the Counsellor. In the second stage, the counsellor makes an assessment of the problem by collecting information related to presenting problem, clients current life setting, family and personnel history including his careful observations/perceptions during the interview sessions. In this stage, the counsellor makes an assessment of the psycho-social situations and problems of the client. In the third stage, depending on the problems, he with the help of the client sets certain goals for solving the problems. In the fourth stage, he adopts certain systematic techniques (like—assertive training, catharsis, clarification, environment manipulation, interpretation, reassurance, relaxation, suggestion, support, self-esteem reconstruction, insight facilitation, etc.).

In the final stage, he terminates the professional contact and advises suitable follow-up action. The client is asked to consult the counsellor in case of problems which he finds difficult to manage.

Many researches have focused on the characteristics of effective counsellors. They listed out the following characteristics which contribute towards the effectiveness of the counsellors.

(1) Sensitivity to the client's problems.

(2) Open mindedness in understanding the client's situation.

(3) Objectivity in approaching the situation.

(4) Competence by virtue of training and experience.

(5) Humane and helping qualities.

(6) Trustworthiness involving confidentiality.

(7) Self-awareness and understanding.

(8) Good psychological health.

By such qualities and systematic approach usually involving 5-15 sessions, each session being of 45-60 minutes, spread out for few days to weeks, the counsellor helps the clients in the following ways:

(1) Clients are able to accept responsibility for themselves, their problems and their lives.

(2) Clients develop greater understanding of atleast four aspects of the problems : feelings and somatic reactions, thoughts, behaviour and interpersonal dimensions.

(3) The clients develop new behavioural responses/different interactions to avoid repeating the same pattern.

(4) The clients develop effective and satisfying interpersonal interactions, social support and relationships with others.

Counselling, usually results in more than one single, all inclusive outcome for clients. Effective change is multifaceted and comprehensive from clients point of view.

In some settings like hospitals, Child Guidance Clinics, and Schools, counselling is also offered in group situations wherein clients with more or less similar problems are guided to discuss their problems and solve the problems by mutual learning, sharing and collective thinking and decision making. This is called group counselling method. In some situations, either the family of the client of groups of families of clients become the focus of counselling efforts. It is called Family Counselling. Likewise there are many types of counselling, all of which aim at helping the clients to help themselves.

By effective counselling, it is possible to find solutions to many problems to prevent several psychosocial problems and also to strengthen problem solving capacities and coping abilities of the individuals and families in the society. Δ

TRADITIONAL HEALERS AND COMMUNITY HEALTH

WILBUR HOFF

A review of projects in various countries suggests that traditional healers, if properly trained, can contribute significantly to the work of primary care teams. Recommendations are offered with a view to making the best possible use of this valuable resource.

In the Third World, traditional healers are a significant resource that should be fully employed in the struggle to provide adequate health care. Indeed, efforts are already being made to incorporate them into primary health care programmes. Considerable light has been thrown on the value of these endeavours by a review of the literature describing projects that have used traditional healers as community health workers *(1)*.

Information was obtained from developing countries on 17 projects in which traditional practitioners were trained to carry out one or more primary care activities in communities. Fifteen of the projects were sponsored by governments and two by non-governmental organizations. They involved herbalists, diviners, spiritual or faith healers, traditional midwives, traditional birth attendants, *curanderos*, shamans, traditional Chinese doctors, Ayurvedic doctors, Unani practitioners and other types of traditional healer.

Positive outcomes and changes

Training produced positive changes in healers, their clients, and modern health staff.

Traditional practitioners were available and willing to work in primary care when trained, and established good working relationships with other health staff. A great variety of healers from many different cultures were successfully trained to work in primary care projects in Afghanistan, Brazil, China, Ghana, India, Nepal, Nigeria, Philippines, Sierra Leone, Sudan, Swaziland, Thailand and

The author is Consultant on Health Education and Training, International Child Resource Institute, 1810 Hopkins Street, Berkeley, CA 94707, USA.

Zambia. Herbalists, spiritual healers, Ayurvedic and Unani practitioners, traditional midwives, bone-setters, magico-religious practitioners and other healers enthusiastically accepted new roles in primary care. The skills taught included the following :

- Promotion of education in local health problems and methods of preventing and controlling them.
- Promotion of improved food supplies and nutrition, with information on balanced diets, breast-feeding, weaning foods, and the growing of vegetables and fruit in kitchen gardens.
- Promotion of safe water supplies and basic sanitation, including the construction and use of latrines, personal hygiene, and the preparation and storage of food.
- Promotion of maternal and child health care, with regard to family planning, the monitoring of pregnancy and recognition of abnormalities, antenatal care, basic delivery techniques, referral for abnormal delivery, and the distribution of oral contraceptives and referral for other methods of birth control.
- Promotion of immunization against major infectious diseases, including referral of children under five to clinics for immunization against childhood diseases.
- Promotion of prevention and control of locally endemic diseases, including the recognition of symptoms of dangerous diseases such as diarrhoea, tuberculosis, leprosy, malaria and malnutrition, and the referral of affected individuals for treatment, the mixing and use of oral rehydration solution to treat dehydration and diarrhoea, the distribution of packets of oral rehydration salts, the referral of women in high-risk groups, and the use of readily available allopathic medicines (e.g., antimalarial prophylaxis).
- Provision of treatment for common diseases and injuries, as well as first aid and accident prevention.
- Provision of essential drugs, including aspirin and other first-aid medication; and the operation of basic dispensaries.

In a project in Ghana, healers were taught preventive and promotive measures, family planning, the use of allopathic medicines, and basic first aid *(2)*. A project in Swaziland focussed on training healers to recognize symptoms of dangerous children's diseases and their prevention and control through oral rehydration therapy, improved nutrition, safe water and sanitation, and personal hygiene *(3)*; it also developed a referral system that enabled traditional practitioners and clinic nurses to improve communication and cooperation between the traditional and modern health sectors in the treatment of mothers and children. In Nepal, traditional practitioners learned how to recognize and manage tuberculosis, leprosy, and childhood diarrhoea and malnutrition, and how to refer patients with symptoms of tuberculosis and leprosy *(4)*. In Brazil, local healers were trained to integrate the use of oral rehydration therapy with their own indigenous practices aimed at achieving child survival. In general the healers were reliable clinical observers, knowledgeable about antidiarrhoeal plant remedies, skilled in the preparation of oral rehydration solution, and pragmatic in integrating effective modern therapies into their practices *(5)*.

In seven projects, training produced specific advances in the attitudes, knowledge and behaviour of healers, the health status of population groups, and the attitudes and behaviour of health sector staff. This indicates a need for more documented results from demonstration projects representing a diversity of circumstances throughout the world. Such data could help to answer questions on the selection, training and utilization of healers in primary care and to evaluate the cost-effectiveness of these activities.

An atmosphere of understanding, trust and respect should be created between modern health workers, traditional healers and the communities they serve.

Projects in Brazil, Ghana, Nepal, Sudan and Swaziland indicated that participants had a high degree of interest in and enthusiasm for acquiring new information and skills in primary care *(2, 3, 5—7)*. They also demonstrated the following changes in the practices of healers after they had attended training workshops :

- — increased use of oral rehydration solution for children with diarrhoea;
- — use of washbasins for cleaning hands in traditional healing clinics;
- — decreased use of strong purges and enemas for treating diarrhoea;
- — construction and use of latrines in healer's homes;
- — increased referrals to clinics for patients with dangerous symptoms;
- — increase in numbers of births attended by village midwives.

Only two projects reported specific changes in the health status of target populations : in Sudan the proportion of women aged 30-34 using contraceptives increased from 25% to 38% over a two-year period and the overall use of contraceptives rose from 13% to 21%; in Nepal a project achieved an increased attendance at rural clinics after the trained healers began working in local communities. Most projects indicated a high degree of acceptance of trained healers by communities.

Healers have traditionally been private practitioners, and attempts to alter this state of affairs could create confusion or misunderstanding.

Many projects indicated that there was an increase in trust and respect between nursing staff and traditional practitioners, and that working relationships between the two groups improved. In the Swaziland project, nurses reported that there was an increase in referrals by healers to rural clinics, particularly for children with diarrhoea and vomiting. This reflected the development of a mutual referral system. In Nepal it was found that the *dhami-jhankri* or faith healers could play a culturally appropriate and cost-effective role in health education and family planning. It was estimated that the country had well over 100 such healers for every health worker, and that they were paid only modest fees by the people for their services.

In Swaziland the cost to government for training traditional practitioners was relatively low, the country's Traditional Healers' Organization having committed a large amount of time and resources to the project and the community paying for the healers' services *(8)*.

In a Philippines project the main strength of the community-based health programmes was their low cost *(9)*, achieved through the employment of traditional medical practitioners using inexpensive therapies.

Constraints

The absence of clear recognition by many governments of the potential value and role of traditional practitioners in primary care creates a poor climate for healers and health staff to work together, and tends to reinforce secretive practices. A lack of government commitment in some projects has discouraged healers from coming forward to participate in training programmes. In countries where, until recently, healers were prohibited from practising, many are reluctant to participate in government-sponsored health programmes.

A lack of dialogue between healers and government staff has led to misunderstandings. Open discussion on common health goals has been absent and the coordination of services has been impaired. One example of this is the difficulty in establishing referral systems between healers and clinic nurses. In Swaziland such referrals increased following a training workshop during which members of the two groups agreed to cooperate.

Where the role of the healer in relation to other members of the primary care team was not clearly defined, and the tasks they were to perform were not specifically described, problems arose in both the

training and work settings. For example, a weakness of many community health worker programmes was that the range of assigned duties was too broad and tasks were poorly defined. Thus in Nigeria, because the role of healers was not made clear, some feared their integration into the primary care programme might threaten their status, income and freedom of action in the community *(10)*.

The conflict between the traditional, holistic, spiritual-oriented healing and the modern, biomedical, treatment-oriented approach reflects a basic difference in philosophy on the causation of disease and the promotion of health. This difference can cause barriers between traditional and modern practitioners, not least in the planning and implementation of training projects for healers.

Some practices, such as witchcraft and sorcery, can cause dangerous psychological stress and bodily harm. Clearly in opposition to the modern biomedical approach, they are strongly rooted and often quite resistant to change, particularly where belief in the supernatural is concerned.

The activities of charlatans and fraudulent practitioners may obscure the worthwhile contributions of the large majority of bona fide healers. Isolated incidents of witchcraft, malpractice or unscrupulous behaviour are widely publicized in the media and tend to prevent understanding and cooperation between the traditional and modern health sectors.

There has been little or no evaluation or follow-up after the completion of training projects. Relatively few reported specific data indicating how effective the training had been, what the healers were accomplishing in the community, and how satisfied the community members were with the performance of primary care activities by healers.

Future involvement of traditional practitioners in primary care

The following recommendations relate to the promotion of community health by incorporating traditional practitioners into primary care teams:

Government ministries and departments of health should take the lead in formulating policies and acting to promote the training and use of healers in primary care. They should ensure that traditional practitioners are incorporated as fully and effectively as possible into health service systems that meet the needs of communities. An atmosphere of understanding, trust and respect should be created between modern health workers, traditional healers and the communities they serve. This requires a mechanism whereby activities such as informal meetings, seminars and workshops are planned and key people representing the modern and traditional sectors come together to express their views, establish common goals and develop ways of using traditional healers in primary care teams. Official policies should be formulated which knowledge the value of traditional healers in this field and indicate how government intends to utilize them. A government intention to cooperate with and include healers in coordinated primary care teams might be declared. Because relatively little experience has been gained in training and using traditional practitioners, government may wish to indicate a desire to explore the roles that healers can play, and to define, through pilot or demonstration projects, appropriate functions and tasks. It may not be possible to formulate detailed policy statements and strategies until data from trial projects have indicated more specifically how traditional practitioners should be trained, their performances monitored, and their services rewarded.

The role that traditional practitioners should play in providing primary care ought to be carefully defined. Healers have traditionally been private practitioners, and attempts to alter this state of affairs by employing them or enlisting their cooperation as community health workers could create confusion or misunderstanding. The views of people in the modern and traditional health sectors, as well as those of the community in general, should be considered when defining the roles to be filled by traditional practitioners in a particular region or country. The roles may vary in accordance with the levels of responsibility, traditional status, and cultural practices of the healers, the priorities, goals and resources of the ministries of health, and the wishes of the communities.

- The planning, implementation and evaluation of programmes for the training and use of traditional practitioners in primary care should be done jointly by representatives from health and other related sectors of government, nongovernmental organizations, traditional healers, and the communities served. A system of primary care requires cooperation between modern and traditional health practitioners. The two sectors should establish a partnership in which all members are part of a team serving the community. Some projects have established mutual referral systems, whereby healers refer patients with certain conditions to Western medical clinics and hospitals, and Western-trained nurses and doctors refer certain patients to healers, an arrangement that can lead to an overall improvement of health services. Increased communication enables both modern and traditional health workers to learn from each other.

- Training programmes should be designed which meet the special needs of traditional practitioners. Many healers lack formal education and have low levels of literacy, and this can pose difficulties in training. In some projects it was found that these circumstances required specially designed training methods and materials. Conventional methods, involving lectures and written materials, were not appropriate. Because traditional practitioners have cultural and health orientations differing from the western ones, and because many of them have a lower level of education and training than modern health staff, it is important to design training programmes that meet their special needs.

- In order to develop effective strategies and methods for the incorporation of traditional practitioners into national primary care programmes, it is desirable to conduct demonstration, evaluation and research projects. Because of the scarcity of data on training and using traditional practitioners in primary care, carefully designed pilot projects should be conducted to demonstrate and test methods before they are widely employed. Good evaluation components should be incorporated so that progress can be measured. It is important to collect information about the impact that training programmes have on the attitudes, knowledge and practices of healers and on the health status of communities.

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The present review suggests that traditional practitioners are a valuable resource for providing primary care to communities. Services can be strengthened so as to promote health and prevent illness if traditional practitioners are properly trained and utilized.

Recommendations are offered in this article with a view to making the best possible use of traditional practitioners in the provision of primary care in community settings, and to limiting problems and difficulties. They are intended as guidelines for government and nongovernmental organizations wishing to give improved primary care to communities and ultimately to improve people's quality of life.

Health workers should look carefully at the resources in the traditional health sector. Given the major status and influence of most traditional practitioners among their own people, their role in providing sound and culturally appropriate primary health care should not be underestimated. In countries where needs are great and resources scarce, traditional practitioners can play a significant role in helping people in rural communities to improve their quality of life.

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EVALUATION OF DENTAL HEALTH EDUCATION APPROACHES IN SCHOOL CHILDREN

PANNA LAL,
DHARMVIR JAIN
AND
SMT. URMILA PANT

DENTAL caries is a major health problem in both developed and developing countries[1]. In India, around 30% of school Children have been reported to be suffering from dental caries[2]. It is irreversible after development[3] but can be prevented by maintaining proper dental hygiene. It is essential to provide dental health education to the children at regular intervals through various methods available. The present study was undertaken with the objectives of: (1) Strengthening the basic essential knowledge regarding dental hygiene and to bring out effective change in attitude and practices of dental care in the school children, (2) Selecting most suitable method of health education to them based on efficacy of different methods.

Material & Methods

This study was carried out amongst students of a local school situated in Alipur Block, the rural field practicing areas of P.S.M. Deptt., Maulana Azad Medical College, New Delhi. A health education programme on dental hygiene was launched amongst all 120 students of Class IX. The contents of health education included knowledge regarding (1) basic facts about anatomy and physiology of teeth, (2) Common causes of tooth decay and gum diseases, (3) prevention of dental and gum problems by basic dental care which included practices of the rules of dental hygiene, proper diet, regular dental check up by a qualified dentist and importance of timely treatment in case of any dental problem[4].

The students were divided into four groups namely, A, B, C & D each having strength of 30 students selected randomly. A different health education method was used for each group but the contents of the programme were same for all. Group 'A' had method of self instruction through reading material in the form of colourful and attractive pamphlets covering all planned contents of health education programme. The matter was arranged serially and presented in steps consisting of self explanatory pictures and simple text. Group 'B' was shown a film entitled "ALL ABOUT TEETH" a production of Films Division of India which covered all requisite contents concerned with dental hygiene. Group 'C' had a teaching session in the form of health talk. To make it interesting and informative, a series of flash cards specially prepared for the programme from the material collected from WHO and other agencies were utilised. For Group 'D' filmshows and health talk in combination were used. The medium of health education throughout was Hindi.

All four groups were subjected to pre and post evaluation test[5,6] with the help of a questionnaire

containing multiple choice questions in three parts covering knowledge, attitude and behaviour. A student who had information on dental hygiene was defined as 'having knowledge'. Those in favour of adopting dental hygiene practices (eg. brushing) categorised of having favourable attitude. Those who were actually practicing kept under behaviour. The post test was administered seven days after the implementation of the programme. Each correct response carried score '1' while wrong answer had zero. The change in knowledge, attitude and behaviour was worked out and compared.

Results & Discussion

Table 1—Percentages of Correct Responses Before & After Health Education

Study groups & Approaches	Knowledge		Attitude		Behaviour	
	Pre test (%)	Post test (%)	Pre test (%)	Post test (%)	Pre test (%)	Post test (%)
(a) Reading material	52.3	72.9	56.8	77.5	48.3	75.8
(b) Film Show	53.3	74.0	36.5	82.7	57.5	63.4 (NS)
(c) Health talk	57.7	89.3	39.2	89.2	55.3	78.5
(d) Film show & Health talk	50.0	94.4	37.5	87.5	47.9	79.2

NS: Not significant.

The results of the study indicate that all the four methods used, brought about a positive shift in knowledge, attitude and behaviour of the students except in group 'B' for whom the film show alone was used. In this group the change in the behaviour was not significant. The combination of health talk and film show was found to be maximally effective method in bringing out statistically highly significant change ($P<0.001$) in all three components *viz* knowledge, attitude and behaviour. The second best method was the health talk alone whereas the reading material ranks third. The film show alone brought about significant change ($P<0.05$) in knowledge and attitude but not in behaviour.

The film show has better efficacy and can prove to be most useful method of health education if accompanied by a prior health talk and post film show discussions.

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US $ 1.8 BILLION BUDGET FOR 1994-95 ADOPTED

THE Ninety-first session of the World Health Organization (WHO) Executive Board concluded its work in Geneva on 29 January 1993 by approving a US $ 1.8 billion budget for 1994-95. The Director-General, Dr Hiroshi Nakajima, was requested however to strive to make reductions and economies that could decrease the level of the proposed budget and to present the results of his efforts to the 46th World Health Assembly, scheduled to meet in Geneva from 3 to 14 May 1993.

The proposed regular working budget for the biennium amounts to US $ 872 496 000, made up of assessed contributions from Member States. In addition, Member States and other contributors provide extrabudgetary funding targeted at specific programmes of their choice. According to WHO estimates, extrabudgetary contributions should amount to nearly US $ one billion for 1994-95, bringing the total budget to US $ 1.8 billion.

On Wednesday 20 January 1993, the Executive Board nominated Dr Hiroshi Nakajima for a second 5-year term of office as Director-General of WHO.

During this session, which began on 18 January, the Executive Board also adopted a series of resolutions on major health issues. All the Executive Board's resolutions and recommendations will be submitted to the 46th World Health Assembly.

Meeting under the chairmanship of Professor Jean-Francois Girard, Director-General of Health in the French Ministry of Health and Humanitarian Action, the 31 member Executive Board, discussed the principal health issues facing mankind. It reviewed the progress of the global programme to combat the spread of *AIDS*. The programme is WHO's biggest and has a planned budget for 1994-95 of US $ 180 million. WHO estimates that 2.5 million people have developed AIDS and that another 13 million, including one million children, are infected with HIV.

Among the health issues addressed in the resolutions adopted today:

Malaria—The disease threatens 2.2 billion people and kills more than a million a year. WHO plans to spend US $ 118 million on it in the 1994-95 budget. The Executive Board resolution urges WHO Member States where malaria remains a problem or is a potential threat, to reinforce their efforts for prevention and control, and requests the Director-General to reinforce WHO leadership in malaria control and to ensure that Member States get the necessary technical support for malaria control programmes.

Poliomyelitis—Having wiped out smallpox in 1977 through immunization campaigns, WHO is now seeking a comparable triumph over polio. In 1991, 13,201 cases were reported to WHO, a 60 per cent decrease since 1988. An Executive Board resolution reaffirms that the goal of eradication by the year 2000 is achievable and calls on United Nations agencies and governmental and nongovernmental organizations to support countries committed to eradication. Poliomyelitis accounts for a large share of WHO's Expanded Programme on Immunization, the total budget of which is close to US $ 40 million.

Tuberculosis—There is a resurgence of the disease in many countries, partly due to the spread of HIV infection, with which it is linked, and drug-resistance. WHO aims to spend over US $ 20 million in combatting tuberculosis. Member States are urged to take rapid action to strengthen national tuberculosis

programmes. Concern is being expressed that inadequately managed programmes appear to be exacerbating dangerous drug-resistant forms of the disease, while there is still inadequate appreciation of the seriousness of the situation, particularly in developing countries.

Dengue—Epidemic dengue, transmitted by mosquitoes, continues to pose a serious problem in tropical regions. The Board adopted a resolution confirming that dengue prevention and control should be among the priorities of WHO and urging Member States to strengthen national and local programmes aimed at this disease. The resolution also requests the Director-General to establish strategies to contain the spread of dengue and dengue haemorrhagic fever which threaten more than 85 countries throughout the developing world. Programmes covering research and control of tropical diseases, including dengue, account for nearly US $ 200 million of the 1994-95 budget.

Nutrition—WHO is playing a leading role in the global fight against hunger and malnutrition. A resolution urges Member States to strive to eliminate, by the year 2000, famine and famine-related deaths, starvation and nutritional deficiency diseases in communities affected by natural and man-made disasters. WHO's nutrition budget for 1994-95 is overUS $ 20 million.

Emergency and Humanitarian Relief Operations—WHO's role in this area is growing, as recently demonstrated in Mozambique, Somalia and the former Yugoslavia. It is also providing assistance in Ethiopia, Iraq, Liberia and Tajikistan. The health assistance needs of other former Soviet republic are currently being examined. A resolution adopted today calls on the Director-General to ensure that WHO fulfills its responsibility for co-ordinating the health aspects of disaster preparedness and response within the United Nations system, and to consider further improvements in staffing and technical capabilities related to the management of health emergencies.

Environmental health—In the developing world, environment-related infectious diseases remain the most serious health threat, particularly water-borne diseases, as dramatically demonstrated by the global cholera epidemic, now in its third year. Tropical diseases affect millions of people but in many instances can be prevented and controlled by using sound environmental management measures. In developed countries diseases related to environmental pollution and to life-styles are an increasing cause of concern. In addition, the long-range transport of air pollutants, the transboundary movement of hazardous products and wastes, and stratospheric ozone depletion have direct and indirect global health implications. The 1994-95 programme budget allocates US $79 million for the activities of WHO's Division of Environmental Health.

WHO response to global changes—Economic difficulties and the growing debt burden affecting many countries have led to a decline in the resources available, nationally and internationally, for health. Together with the sharp increase in the costs of medical care worldwide, these developments threaten the sustainability of primary health care programmes. In addition, health and disease patterns are being affected by environmental factors, demographic changes, unplanned urbanization, mass migrations, the spread of the AIDS pandemic and the resurgence of long-standing problems like tuberculosis and malaria.

Calling for a review of WHO's capacity to respond to these challenges, the Executive Board last year established a "Working Group on the WHO response to global changes" which presented a preliminary report during this session. The preliminary report, which analyses various aspects of WHO's mission and structure, received considerable attention in a course of the session which ended today. Among other observations, it warns that the Organization and its Members States have not been sufficiently able to plan and implement their programmes to achieve WHO's strategic objective of "Health for all by the year 2000". Under this programme, formulated in 1978, every human community should have access to appropriate and affordable health care by the turn of the century. The Director-General has been requested to prepare an analysis of the resources required by WHO and Member States to make this goal a reality. Δ

(Contd. from page 39)

Some Problems and Suggestions by PVOs

Some of the constraints being faced by voluntary organisations in conducting their activities are:

1. Inadequate finance
2. Unresponsive community
3. Untrained and inadequate staff
4. Inadequate Government Support
5. Inadequate transport facilities

Some of the suggestions offered by voluntary organisations for development of primary health care in rural areas are:

1. More staff in health centres
2. Continuous training to health functionaries
3. Proper supervision
4. Adequate supply of medicine to health centres
5. Adequate transport facilities
6. Emphasis on community involvement
7. Adequate supplies of appealing IEC materials in local dialect to the health centres
8. Rewards based on target achievement and excellence

Conclusion and Recommendations

Viewing the success and achievement of PVOs in promotive and preventive health care services, the Government of India has evolved the Private Voluntary Organisation for Health Scheme (PVOH) under which financial assistance is being given to projects undertaken by PVOs for expansion of Health, Family Welfare and Nutrition services in different parts of India. Now a days need for giving more financial assistance to the smaller PVOs is urged. For proper functioning of PVOs, appropriate human resource development and training should be conducted for the key trainers of the PVOs. Later on, necessary support would be provided to the PVOs to train their volunteers for carrying out their programmes. Given adequate training, the voluntary agencies have an important role to play in formulating, implementing, evaluating and monitoring the health and family welfare programme in rural sector. Δ

Authors of the month

Dr Gajanan D. Velhal
Associate Professor,
Deptt. of Preventive & Social Medicine,
Topiwala National Medical College &
B.Y.L. Nair Charitable Hospital,
Dr. A.L. Nair Road,
Bombay Central,
Bombay-400 008.

B.B.L. Sharma
Asstt. Professor (Health Economics) &
Faculty In-charge National Documentation Centre

and

Dr B.K. Pattanaik
Asstt. Research Officer,
Deptt. of Education & Training,
National Institute of Health & Family Welfare,
New Mehrauli Road, Munirka,
New Delhi-110 067.

Dr Devi Saran Sharma
Lecturer in Social Work,
Institute of Social Sciences,
Agra University,
Agra,
Uttar Pradesh.

Dr S.B. Dabral
Professor & Head
S.P.M. Department,
S.N. Medical College,
Agra-282 002,
Uttar Pradesh.

M. Mohanram & V. Ramadasmurthy
C/o National Institute of Nutrition,
Hyderabad-500 007
Andhra Pradesh

M. Ameer Hamza
Psychiatric Social Worker
Clinical Psychiatric Unit

and

Dr R. Parthasarathy
Associate Professor,
Community Mental Health Unit

and

Dr V.N. Rao
Associate Professor
Deptt. of Psychiatric Social Work,
National Institute of Mental Health & Neuro Sciences,
Bangalore-560 029.

Dr Meharban Singh
Professor & Head
Deptt. of Pediatrics and Neo-natal Division,
All India Institute of Medical Sciences,
Ansari Nagar,
New Delhi-110 029.

Panna Lal
Senior Resident

and

Dharmvir Jain
Junior Resident

and

Smt. Urmila Pant
Ex-Lecturer in Health Education,
Deptt. of Preventive and Social Medicine,
Maulana Azad Medical College,
New Delhi-110 002.

RESEARCH STUDY

DIET AND NUTRITIONAL STATUS OF GIRL CHILD

IT is, generally, believed that females are discriminated with respect to several benefits as compared to the males and consequently suffer from the ill effects on health and nutritional status. A study was therefore, carried out on a group of preschool children to see if this is true.

Three hundred and eight households in six villages around Hyderabad were surveyed. Demographic and socio-economic particulars and information on attitudes and practices of child rearing were collected from the mothers of the preschool children. Dietary intakes were assessed by 24-hour recall method on a sub-sample of 100 households.

Nutritional status of 192 boys and 204 girls of the preschool age group from these 308 families was assessed by taking anthropometric measurements like weight, height and mid-arm circumference. Clinical examination was carried out for nutritional deficiency signs.

The main findings are as follows :

1. All the families belonged to poor socioeconomic status; 58% of the fathers and 81% of the mothers were illiterate.

2. Cradle ceremony was celebrated in a significantly higher proportion of boys (73%) as against girls (56%), and higher proportion of parents of boys (12%) as compared to those of girls (1%) also arranged feast on the occasion, indicating the preferential attitude of the parents at the birth of boys.

3. Higher proportion of boys (51%) were being breast fed at the time of the survey than the girls (30%). Prolonged breast feeding (36-59 months) was more common in boys (85%), than in girls (76%).

4. The practice of giving pocket money to purchase eatables was also more in the case of boys (71%) than in girls (43%).

5. During illness, higher proportion of boys (80%) compared to girls (63%) were taken to medical practitioners and the mean number of visits to the doctors was also higher in boys (2.3%) than in girls (1.8%).

6. Twenty one per cent of older girl children looked after their siblings when the parents were at work; whereas elder brothers were not assigned this work.

7. Higher proportion of mothers of girls wanted their daughters to discontinue their schooling. The parents were willing to send boys for high school education even outside their villages, but they were not willing to send girl children.

8. There were no significant differences in the dietary intakes between boys and girls. Access to nutritionally better foods like milk and meat was similar in both the sexes. But in general, due to poverty, consumption of such foods is low in these households.

9. The distribution of children according to Gomez and Waterlow classification based on weight for age, weight for height and height for age—was similar in both the sexes.

10. There were no differences between the sexes in clinical deficiency signs.

The study indicates that though there is social preference for boys, there is no deliberate discrimination against girl children with reference to diet and nutrition. Δ

—NUTRITION NEWS
July 1992

BOOK REVIEW

WHO EXPERT COMMITTEE ON RABIES

Eighth Report

Technical Report Series, No. 824
1992, vii+84 pages (English, French and Spanish in preparation)
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This book evaluates new knowledge from basic and applied research on rabies in terms of its relevance to the prevention and control of this disease. Noting the many new tools now available for both clinical and field application, the report issues advice and recommendations intended to help national control authorities bring their policies—whether concerning first-choice vaccines or procedures for quarantine—in line with the latest scientific knowledge. The report also identifies specific research problems that need to be solved in the drive to develop more sensitive diagnostic techniques, to improve the immunogenicity and cost-effectiveness of vaccines, and to eliminte rabies in canine and wild animal populations.

Information is presented in eleven sections. The first reviews recent advances in rabies research, including progress in understanding the molecular structure and genetics of lyssaviruses, significant strides forward in methods for the production and delivery of vaccines, the development of several unique recombinant vaccines, and the potential use substances such as monoclonal antibodies, interferon, and interferon-inducers for post-exposure treatment. The second section, devoted to diagnosis, evaluates existing and evolving techniques for diagnosis in animals and humans and for the characterization of virus strains.

Recent improvements in human and veterinary rabies vaccines are reviewed in the third section, which features extensive information on the quality controls that must be followed during production and the safety and potency tests that must be performed on each vaccine batch before its release. The report also strongly recommends that encephalitogenic vaccines derived from brain tissue be replaced, as soon as possible, with vaccines prepared in cell culture. Other sections bring readers up-to-date on the status of WHO reference materials for potency testing of vaccines and immunoglobulins, and outline procedures for the licensing and testing, prior to release, of inactivated tissue culture vaccines.

In view of the extremely high fatality rate of human rabies, information on prevention is especially detailed. Practical advice includes recommended immunization schedules for the protection of individuals at high risk of exposure, guidelines for post-exposure treatment, and an explanation of the factors to consider when deciding whether or not to initiate post-exposure treatment. The treatment of confirmed rabies in humans, although almost inevitably fatal, is also briefly discussed.

Strategies for rabies prevention are further detailed in sections describing new approaches to the control of rabies in dogs and wild animal populations. Drawing upon lessons learned in several large mass immunization campaigns, the report explains how the recently developed oral vaccination technique can be used to control the disease in foxes, racoons, other wild animals, and possibly also in dogs. The report further concludes that the removal and destruction of dogs and wildlife should no longer be carried out on a large scale, as such an approach has never been shown to have a significant, long-term impact on either population densities or the spread of rabies. The final main section issues recommendations, in line with new knowledge, for the international transfer of animals, including guidelines for the possible reduction of quarantine procedures and a recommended special exemption for guide dogs for the blind.

Further practical advice is set out in a series of eight annexes, which provide guidelines for the testing of vaccines, post-exposure treatment, the format of vaccination certificates, the use of a standard reporting form to record data on exposed humans, and the design of a national programme for the control of rabies in dogs. Δ

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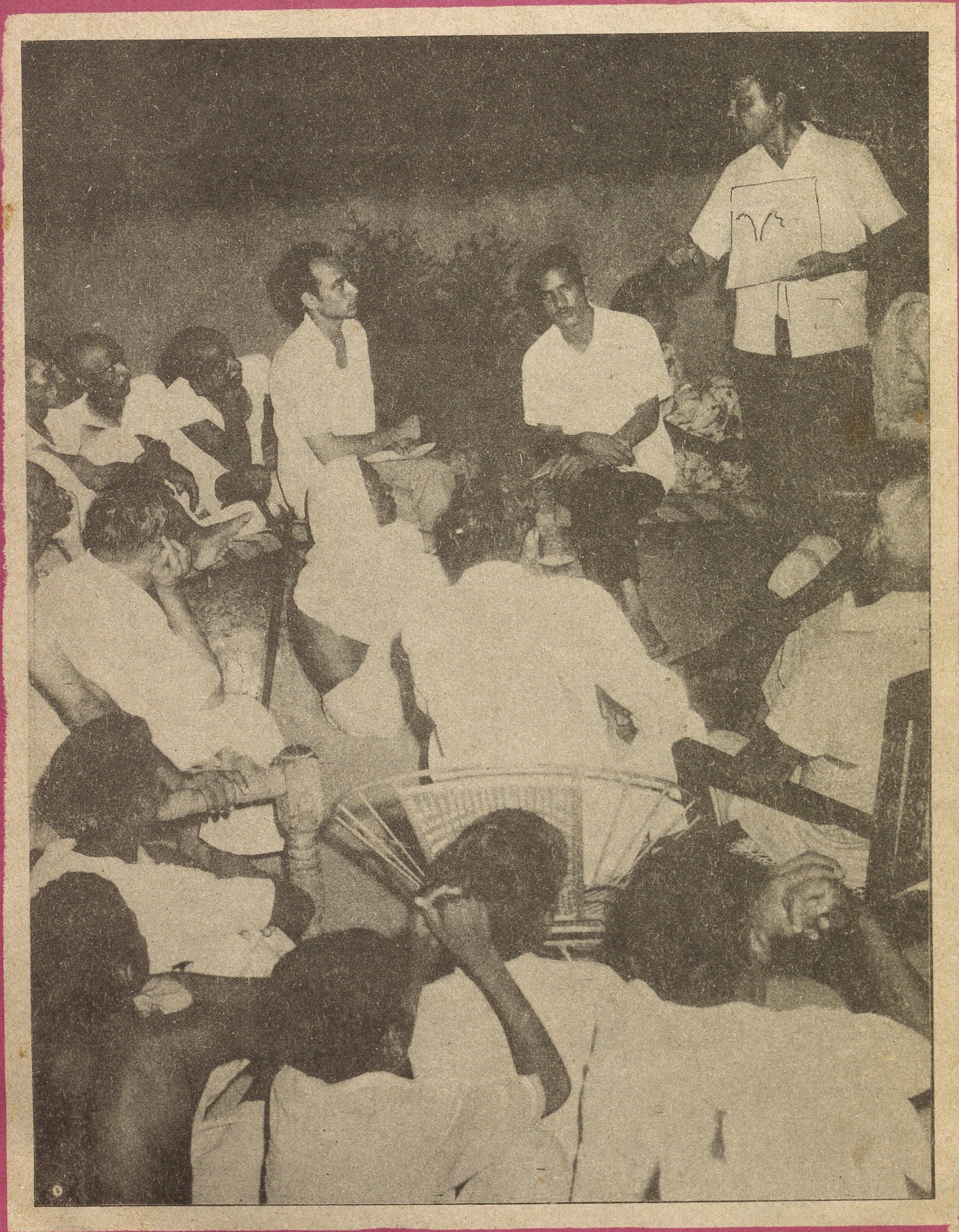

COMMUNITY PARTICIPATION FOR HEALTH