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EDITORIAL

FEDERATION OF PUBLIC HEALTH ASSOCIATION OF INDIA

The twenty-fourth annual session of the Indian Public Association held in Ahmedabad in February, 1980 is be remembered for its success in holding a joint conference with the Indian Association of Communicable Diseases for the first time in its history. The idea behind this was primarily to amalgamate three separate units of Communicable Diseases operating independently and to support the proposal for establishing a Federation of Public Health Associations in India. This conference has undoubtedly enhanced the prospect of such a creation. The credit for this success goes largely to Dr. Sushila Nayar, our popular Ex-Union Health Minister and President of Indian Association of Communicable Diseases for the year.

For the last three years the Indian Public Health Association through the good offices of its Ex-President the Late Dr. S. S. Verma followed by the successive Presidents Dr. W. Mathur, S. C. Seal (offg) and S. M. Marwah and the General Secretary, Dr. Khanna, has been endeavouring to bring together the allied public health associations to form into a Federation of Public Health Associations of India.

Prior to this the 22nd Annual Session was held in February, 1979 at the College of Veterinary Sciences under the Agricultural University, Hissar (Haryana) as a joint venture between The Indian Public Health Association and the College of Veterinary Sciences participating in a symposium on "Veterinary Public Health and Zoonoses" with conspicuous success. These joint conferences are therefore the stepping stones to give a shape to the proposal for the Federation with the active support of persons like Dr. Nayar and of Dr. O. P. Gautam, the Dean of the College of Veterinary Science, Haryana and others.

The Associations that are allied to public health and operating in India are : Indian Association of Public Health, Indian Association of Communicable Diseases, Indian

Association of Preventive and Social Medicine, Association of Communicable Diseases, Bombay—Communicable Diseases Unit at the National Institute of Communicable Diseases, Indian Association of Occupational and Industrial Health, Indian Dietitio Association and Indian Association of Veterinary Sciences.

The pivotal aim of all these associations is human health with common membership between two or more Associations. It would certainly be of advantage for these members to meet at a particular place every year for their annual and scientific sessions at least on three counts, namely, (i) it will offer opportunities to participate and exchange technical and scientific knowledge about the associated problems of different sub-disciplines of health services, (ii) it will permit both joint and separate sessions and (iii) it will be highly economic to meet at one place annually rather than join the individual annual sessions at different timcs and places.

The modus operandi of the federation briefly is that each association will maintain its individual identity and carry out its constitutional functions with election of office-bearers and its executive council annually and its members being also the members of the Federation will join the scientific session held under the auspices of the Federation. The annual subscription for membership of the Federation will either be met by individual members or by the association as a lump sum as fixed by the Federation Council in consultation with its legally constituted members. The Federation will be duly registered and the annual session will be held in places selected by its Excutive Council followed by publication of a Transaction of the deliberations in the session.

The General Secretary of the Indian Public Health Association will be glad to provide further details about the Federation's plans and activities. All persons interested to join the Federation are requested to take necessary steps to bring the Federation into existence at the earliest opportunity.

S. C. Seal

INDIAN JOURNAL OF PUBLIC HEALTH
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WELCOME ADDRESS

Dr. H N. Patel, Director of Health Services,
Gujarat State

The Honourable Mayor, Municipal Corporation, Ahmedabad. Dr. Sushila Nayar, Shri Rathod, Secretary to Government, Dept of Health and Family Welfare Shri Krishnamurthy, Municipal Commissioner, Prof. Marwah, the President of Indian Public Health Association, Participants of the Conference, Ladies and Gentlemen.

I consider it an honour to welcome you all to this Joint Annual Conference of Indian Public Health Association and Indian Association for Communicable Diseases. On behalf of the Organising Committee I am grateful to the office bearers of both these Associations to give an opportunity to the State Branch of IPHA to hold this conference in this ancient city of Ahmedabad which is known as Manchester of India.

Health is a fundamental human right. So we have to ensure minimum basic health services to our people in fulfilment of the obligation to honour this human right-the right to an adequate health standard. The strategic plan of WHO. 'Health for all by A.D. 2000', the analysis of human existence and the quality of life incorporates in its structure and contents an inescapable call for decision and action on the part of all the Governments and the people.

Providing basic health services to every man, woman and child in the State is the ultimate objective of health services. During past three decades efforts have been made in our country to make available the basic health services as close to the people as possible.

The systematic efforts have also been made to develop rural health infrastructure from district down to the village level. The scheme of establishment of Primary Health Centres and sub-centres which was started as a part of Community Development Pro-

gramme in early fifties, have been gradually strengthened to meet the health needs of the rural population. The health services have also been steadily improved at sub-district and district levels. With the help of the International Agencies like WHO and UNICEF we have been able to eradicate smallpox and also bring the incidence of other communicable diseases under control. The morbidity and mortality rates due to various diseases have also been brought down with the development of modern technology and advent of newer drugs. But despite all this majority of our population predominatly living in rural areas, urban and semi-urban slum areas have no access or limited access to health services at present. It is, therefore, essential that the minimum basic health need of this population is met with by changing the existing infra-structure of health. Alma-Ata Declaration has given the concept of Primary Health Care. One of the fundamental concepts of Primary Health Care is that "Health is not a separate entity but an integral part of National Development" and the health care has to be distributed equitably. In Gujarat we have accepted the philosophy of integration of health services and implemented the Multi-purpose Health Workers' scheme throughout the State. We have also undertaken the implementation of Community Health Volunteers scheme with a view to ensure community involvement in the delivery of health care at village level.

Tuberculosis and Leprosy Control Programmes in the State have also been implemented as per the guidelines prescribed by the Govt. of India. As a part of National Tub. Programme, District Tub. Centres have been established in all the districts and services for case detection and treatment etc. are being developed at all the peripheval health institutions viz : Primary Health Centres, Rural dispensaries, Sub-divisional hospitals etc.

The modified plan of operation for malaria is also well under way in the State. During the year 1978-79 most of the population was covered with insecticidal spray of BHC and more than 30.00 lakhs population with the spray of Malathion. I think it will be just legitimate for me to say that Family Welfare Programme in Gujarat has shown good progress in successive years. The relative success of our programme is attributable to the various innovative approaches adopted and the full support and encouragement given by the State Government. The State has the honour to claim 5 National Awards for its best performance during the year 1978-79.

I extend my hearty welcome to you all once again. We have endeavoured to make your stay in Ahmedabad as comfortable as possible but I request you to kindly forgive us for any short-coings in the arrangement of this conference.

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ADDRESS BY DR. SUSHILA NAYAR, PRESIDENT, INDIAN ASSOCIATION FOR COMMUNICABLE DISEASES

Dear Friends and Colleagues,

I am glad to welcome you all to this Conference which we have called jointly with the Indian Public Health Association. This Conference is memorable in another way also. As discussed in our Conference last year, we have made efforts and succeeded in bringing the two associations in the area of communicable diseases together. I am very glad that I shall hand over the Presidentship to the New President who will preside over the organisation formed by the amalgamation of our association of Communicable Diseases and the one run by the National Institute of of Communicable Diseases. It has been agreed that the annual conference will be held in different places and the office bearers will be elected by all the members. The journals will also be amalgamated and I am sure the change will be for the better in every respect.

In our country communicable diseases still continue to be the major concern of our health services and the most important threat to the average citizen. Many such diseases which have been conquered in many countries, still take a heavy toll of life in our country.

We have conquered smallpox and Indians no longer need a vaccination certificate to go abroad. But we still need cholera Vaccination certificate. Cholera not only continues to be endemic in certain areas, but it has spread to many more areas and the El Tor Vibrio which has come into prominence, has made it more difficult to deal with. Progress in the treatment of cholera and oral rehydration therapy have considerably lowered the mortality from this disease. As a result. I am afraid, there is some complacency and reduced keenness to fight and overcome this enemy. Researches of various kinds are continuing, but I am convinced that the knowledge which enabled so many countries to become free from cholera can enable this country also to do so, provided there is political will and administrative determination to do so.

Environmental sanitation, safe water supply and proper disposal of human excreta is the basic necessity to overcome cholera and other gastro intestinal diseases such as, enteric fevers, dysenteries and the like. This joint session with the Indian Public Health Asso-

ciation gives us greater hope and confidence that we may expect more vigorous efforts to solve the problems of environmental sanitation in the coming years.

We had launched malaria cradication programme with high hopes and in the mid-sixties, we seemed to be approaching the goal. Almost three fourth of India had reached the maintenance phase and we were hopeful that within a decade malaria would be a thing of the past. Except for certain areas along international borders with some of neighbouring countries, where malaria units would have to be continued, there would be no need to worry about malaria. This hope was however short-lived. As malaria units were wound up and maintenance phase responsibilities were handed over to the regular health services, there was a set-back. Malaria workers became basic health workers with wider responsibilities, with disastrous results. The basic health service was just not strong enough to take over the vertical programme of malaria eradication. Malaria is back and we now talk of malaria control rather than malaria eradication. Many reasons are given for this failure including D.D.T. resistance of the vector and drug resistance of the parasites. Researches for the discovery of new insecticides and drugs and a vaccine are in progress. But I am sorry to note that there is no earnest effort to overcome the human failure which was primarily responsible for the failure of our malaria eradication programme. We need men like A. P. Ray who walked miles to supervise the D.D.T. spraying and providing necessary guidance, supervision, encouragement and administration, where necessary, to the field workers.

I am afraid we have done hardly any education of our colleagues in other departments with regard to their roles. They leave burrow pits along the roads and railway lines etc. and thus keep adding to mosquito breeding places. This problem has become much worse in recent years with the 'food for work' programmes, which has resulted in earth work being done for many new village roads. If our colleagues in P. W. D. would only connect the pits so that water spreads, instead of stagnating in each pit, it can help a great deal. I hope the ministers of the state governments will please take up this matter with their colleagues in other departments.

Problem of tuberculosis is a major challenge all over the country as is leprosy in many states. We had used B. C. G. as a major tool to fight tuberculosis, Recent knowledge has thrown serious doubts about its efficacy and there are some who consider it even harmful.

Domiciliary treatment of tuberculosis and multi-drug therapy are effective and the scheme of district tuberculosis clinics, which can guide, supervise and help the peripheral units like the Primary Health Centres and

private practitioners with their problems, was well conceived. Along with Demonstration training centres at the State level for training and retraining medical and para-medical personnel dealing with drug resistant cases, and the surgical departments of medical colleges which can take care of surgical problems, the scheme is capable of making a frontal attack on the problem of tuberculosis. But here again, we need enthusiasm and a will to get the job done. Many District Tuberculosis Clinics are badly run. I hope each state would set up a study team to visit and see how many of these centres are working properly, how many doctors and nurses working in them have received refresher courses and how well is the coverage of sputum positive cases in the area ? We have the knowledge and we have the tools. I hope and pray that we can have the will to deal with the problem in an effective manner in the coming decade or two, so that all the tuberculosis hospitals and sanatoria will become unnecessary.

We know how chemotherapy can make a sputum positive case negative within three to four months and we have drugs to take care of cases that are resistant to commonly used drugs such as I.N.H., PAS and Streptomycine etc., though they are costly and beyond the reach of an average patient. I feel it should be the duty of the state to supply free drugs for all tuberculosis cases including the new ones or drug resistant cases in the interest of the rest of the population. It should be our endeavour to cover all sputum positive cases in every district within a year of two. In order to discover them, sputum examination of all those with symptoms such as cough and fever lasting for more than two weeks, loss of weight and pain in the chest should be done and in every household with a case of tuberculosis, old people known to have chronic bronchitis should have their sputum examined. This will need strengthening of our laboratory services and refresher courses for our laboratory services and refresher courses for our laboratory technicians and a proper checking of all microscopes used at the periphery. I am sure the Public Health Association can and I hope it will, take up the challenge of tuberculosis in all earnestness.

As for leprosy there are newer drugs which are reported to be very effective. They are expensive, but the duration of treatment can be reduced to a few months instead of years. Government of India had set up a committee a couple of years ago, and I had the honour of chairing it. A scheme was worked out to try these drugs in five or six districts in endemic areas and work out a regimen which will be satisfactory in our country. I think Sweden was to give a free supply of drugs for the purpose. I do not know why that scheme has still not been implemented. I see no reason for slackness on the part of officers due to political changes

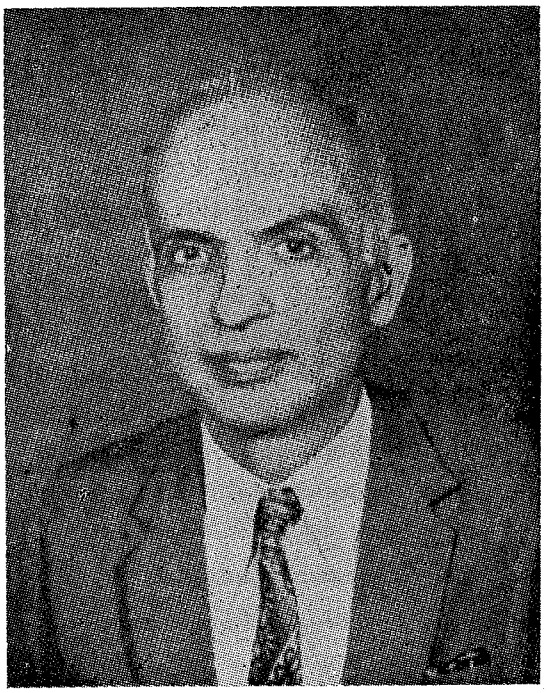
at ministerial level. Research workers are also busy searching for a vaccine for leprosy and I hope they will succeed in doing so and do it soon.

Filariasis is a big problem with us, but we still lack the technology to enable us to deal with the problem in an effective manner. Research in immunology seems promising, but so far as I know, we do not have any thing more than treatment with Hetrazan and dealing with the vector through drainage system etc. for filaria control programme. If we can have a vaccine, it will prove a real boon.

There are problems of sexually transmitted diseases for which adequate treatment is available. The same applies to trachoma and scabies etc There is no reason why with adequate health education and proper organisation for treatment, we should not be able to get over most of these communicable diseases.

New enemies such as Japanese encephalitis and certain other virus infections are threats which may become serious in future. But for the present we have the knowledge to deal with most of the communicable diseases that are prevalent including those of children, for which effective immunisation programmes, can help us in achieving success. Let us go from this conference with a determination that while the W. H. O. has set the goal of primary health care for all people by the year 2000, we shall do our best to shorten this period and overcome the threat of communicable diseases by harnessing all the armaments at our disposal in the eightees. Let this be taken up by the medical profession as the challenge for the decade that we are entering.

I thank you all for your kind cooperation during my term as President of Communicable Diseases' Association. I also thank the organisers of the joint conference for all the trouble they have taken to make excellent arrangements for the conference and our personal comforts.



ADDRESS BY PROF. S. M. MARWAH, PRESIDENT INDIAN PUBLIC HEALTH ASSOCIATION

Chief Guest, Esteemed Guests, Learned Delegates,
Ladies and Gentlemen

Simultaneous hosting of the Twenty-fourth Annual IPHA Conference and the Ninth Annual Meeting of the Indian Association of Communicable Diseases by the Gujarat Branch will hopefully snowball into joint meeting of all allied Public Health Associations during 1981 Silver Jubilee IPHA Meeting in Calcutta. IPHA is also simultaneously hosting next year the Third International Congress of the World Federation of Public Health Associations. In its first quarter century of existence 1956-1981, in my interpretation, the Association has justified its Monograph of multidimensional SERVICE TO HUMANITY in the background of the global interactions, Since the Alma Ata 1978 Declaration, Primary Health Care for all by the year 2,000 is the most important aim of SERVICE TO HUMANITY for all countries in the world. Being quite conscious of the fact that I was preceded and am being followed by a Galaxy of public health personalities as Presidents and other colleagues, I may, within my limitations, share a few life time stray thoughts for Public Health and Allied Associations' Roles for Primary Health Care in our country by the year 2000 or perhaps in the global settings CHALLANGE FOR IPHA FOR THE YEAR 2000.

Within the 20th century, the country recorded from 1901 to 1971[2] (last census) (a) increase in (i) population from 239 M to 548 M (projected. 672 M in 1981 & 799 M in 1991), (ii) population density from 77 to 177/KM^2, (iii) percentage urban population from 10.84 to 19.91 and (iv) expectation of life from 22.6. to 46.4 males and 23.3 to 44.7 for females (projected ; 52.6 for males & 51.6 for females in 1981, 57.62 for males and 57.07 for females in 1991), and (b) decline in (i) crude death rate from 42.6 to 18.9 (15 in

1976, projected : 11.6 in 1986 and 10.4 in 1991), (ii) infant mortality rate from 204 to 139, and (iii) crude birth rate marginally from 49.2 to 41.1 (34.4 in 1976, projected : 29.5 in 1986 and 27.0 in 1991).

In the last 25-35 years, the country recorded in terms of communicable diseases (a) eradication of smallpox as part of global eradication, (b) most insignificant prevalence of plague, (c) reduction of notified cases of cholera from one to two lakhs of early fifties to within ten thousand cases of late seventies, (d) reduction in incidence of malaria to ∠50 thousand in early sixties but subsequent increase to nearly 50 lakhs in the late seventies and (e) increase in estimated population at risk for filariasis from 26 M in early fifties to 237 M in late seventies etc. with still very high prevalence of plentiful communicable diseases like enteric infections, leprosy, tuberculosis etc.

During the same period with 2 to 3% or so plan expenditure on health we have purchased and set up with Rs. 10/- or so per capita expenditure by late seventies (a) 45 medical research institutes, (b) 106 medical colleges (roughly one per 6 M population) with 11160 admissions (compared with 25 medical colleges and 1983 admissions in 1947) resulting in 2.33 lakh registered doctors (one doctor per 3135 population), (c. 108 indigenous colleges with 4199 admissions resulting in 2.71 lakhs registered practitioners (nearly 50 thousand more than allopathic physicians), (d) 1.45 lakhs registered and listed homoeopaths, (e) 5096 hospitals, 12,511 dispensaries and about 5 lakhs beds (1977), nearly 5.400 primary health centres with 38,115 subcentres (1978) and (f) various national programmes.

In the period 1956-1976, per capita availability of cereals increased from 360.5 gm. to 406.6 gm. but pulses declined from 70.4 gm. to 51.2 gm. (in combined marginal increase from 430.9 gm. to 457.8 gm).

In the thirty year period 1951 to 1980[2] the expenditure on family planning increased nearly nine times while percentage of couples protected by all methods increased from 0.2% in second plan to 24.4% during fifth plan (1974-75 to 1977-78) with about 30 million estimated births averted till 1977-78,

At 1960-61 prices, the per capita income has marginally increased from Rs. 306/- to Rs. 349/- (1973-74) and subsequently to Rs. 690/- at 1970-71 price levels in 1977-78 (Rs. 1163/- at current price levels).

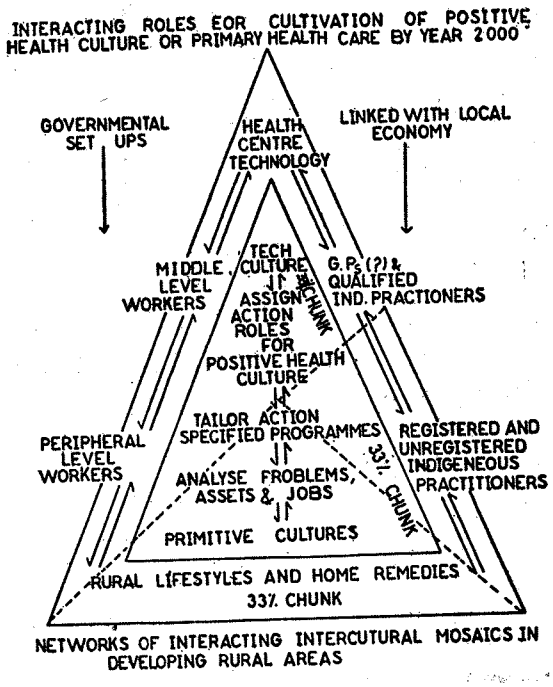
Thus the uniform pattern of the pyramidal network within the diverse socio-economic settings with regional medical colleges for about 6M including one post partum unit (106 units in medical colleges), district set ups including post partum (400 such set ups), primary health centres for 1 to 1.2 lakh rural population with multipur-

pose male and female workers for 5000 population and CHW/V along with one trained dai for 1,000 population should be well established by early eighties (multipurpose workers and CHW/V with trained dais, schemes not yet fully implemented) When fully implemented CHW/V honorarium and medicine alone will cost Rs 600 M. While evaluative studies are essential, one can perhaps project even otherwise multiple qualitative as well as quantitative dimensions of deficiencies both in Primary Health Care including services for small family norms and referral services. Qualitative as well as quantitative deficiencies can be easily depicted even from prestigious schemes like CGHS scheme provided at per capita expenditure of Rs. 40/- to Rs. 60/- or even more in some cities (1976-77) or per capita expenditure of nearly Rs. 50/- for Pondicherry, Goa, Daman and Diu or BHU per capita outpatients drug expenditure of Rs. 15/- to Rs. 30/- etc[4, 5]. Cost-effectiveness and therapeutic-effectiveness in BHU have been piercingly analysed and well documented through multiple studies[6,7,8] of drug cocktatils for minor ailments and even 25%-50% contamination of safe watersupply sources before ingestion by human mouths owing to lifestyles and personal habits in the socio-cultural settings (WHO indicators modification[8]). Limited coverages though primary health centres and subcentres especially in twilight areas as well as limitations in CHW/Vs are also documented[10,11]. As such in my humble opinion whatever commendable benefits may be available through health delivery networks evolved by number of high level expert committees[12,13,14,15] breakthrough cost-effective appropriate technology is still to be realistically evolved for cultivation of Health Culture in the Indian settings for Primary Health Care for all by the year 2000[16]. Some 60 voluntary experimentations are going on in various parts of the country for cost-effective appropriate technology for alternative strategies[17]. A number of other studies have also brought out the varied roles of traditional healers[18, 19,20] as per their definitions by varied authors. In the Varanasi studies of varied community settings like BHU, the Varanasi Corporation and the Chiraigaon Rural Block, the varied roles of modern, allopathic, indigenous practitioners as those of healers (available 4 per 100 population in rural areas and 1 per 100 in Municipal areas) have been indicated[21]. While these studies compiled voluminous data on public sector i.e. health care net work and private sector allopathic, and indigenous healers network, very little explorations have been undertaken on home remedies and/or lifestyles which perhaps contribute maximally to positive health culture in any setting. Roughly it may be very crudely indicated that based on limited parameters of morbidities and some preventive facilities[22], in some rural areas of Varanasi, contributions in terms of home remedies, folk practitioners' remedies and public

sector care remedies were approximately 33% each Based on some of these a Model for experimentations has been suggested for cultivation of Primary Health Care by the year 2030 (refer diagram). According to this model the foundations of Primary Health Centre's appropriate technology pyramid should be based on home remedies, lifestyles, and folk practitioner' remedies. We must imbibe that ours is pluralistic culture i.e. mixtures of cultures from prehistoric times i. e. 6,000 B. C. to modern ti nes and as such our Primary Health Care is bound to be pluralistic in nature i. e. imbibing diversities of magicoreligious, herbal, ayurvedic, unani, sidhha, homoeopathic and modern medicine approaches[23]. Further each and every human out of 4 billion population in this world is identified and given a lable i. e. name. This is possible owing to infinite permutations and combinations of individual diversities. When that is the situation in individuals any further permutations and combinations in terms of social units like communities in defined areas are bound to have identifiable unit or group characteristics. As such to my humble self uniform patterns of health centre or subcentre or community health worker set-ups without flexibilities for diversities throughout India are bound to be glaringly deficient in meeting requirements in realities of diverse human situations. The present uniform pyramidal health planning for the public sector network definitely needs to be supplemented with the grassroot planning in their diversities with the private sector set up whatever may be its varied dimensions in terms of home remedies, lifestyles, folk / traditional or qualified practitioners (refer diagram). To my mind this challenge is worth accepting for cultivation of Primary Health Care by Year 2000.

Experimentation in Varanasi[24,25] based on Ph. D, M. D.[26,27,28,29,30,31] and other departmental action research studies in Varanasi, Multiagencies, Multidisciplinary and Multidimensional experimentations have been undertaken through Family Planning Association of India, Community Based Distribution Project (FPAI-Varanasi CBD project with financial input of about 50 lakhs) for 2.8 million rural population. The project is multidimensional i. e. as depicted in the diagram multiple cost-effective appropriate technology models incorporating folk practitioners and home remedies are being evolved to supplement and increase the outreach of the uniform three tier governmental health care network. Some of the improvizations evolved especially in medical care are quite controversial e. g. (a) no isolation of toddlers in good health in case of chickenpox[33], measles, mumps, etc. i. e. diseases without preventive immunisation—this approach of natural immunization supplements scheduled EPI immunisations, (b) in the midst of limitations of specifics—management through natural history e. g. typhoid cases without toxaemic signs, symp-

(7)



toms etc., being managed through nursing care in extreme poverty situations etc., (c) boiled cooled rehydration management with improvised electrolytes even in situations of non-availability of drugs[33], (d) with or without simple home made sulphur preparation, management of scabies as per situations but with rigid enforcement of realistic personal hygiene supplemented with whole day exposure of fomites to bright sunlight etc. etc. Any supplies of drugs or home remedies are being supplemented with education for hygienic family practies through specially developed handouts for literates and illiterates.

The project aims to cultivate small family norms through primary health care and overall rural development. In seventies annual ranges of (a) birth control methods acceptors 3.5 M to 6.8 M (12.5 M in 1976-77), (b) equivalent sterilisations 1.2 M to 3.1 M (8.7 M in 1976-77), (c) equivalent conventional contraceptives users 1.5 M to 3 2 M (nearly 50% commercial especially condoms towards eighties) and (d) IUD insertions 0.3 M to 0.5 M, along with (e) a cumulative total of 28.1 M sterilisations (29.1% tubectomies), (f) equivalent oral pill users of over 76000 in 1977-78, and (g) 0.25 M medical terminations in three years etc. definitely indicate that the immediate needs are for provision of quality services, for cafeteria approaches in terms of home remedies and not merely in terms of remedies available only through health sector three tier approach (present achievement of which perhps cannot be more than 33%). With this emphasis strategies are being developed

in the Varanasi project for making as many contraceptives outreach in terms of home remedies as possible under existing situations of supply lines, drug act requirements and diversities of consumer requirements. In making the supply of orals as part of home remedies through education and training of varied health care suppliers in the private sectors number of professional and medico-legal issues have been raised but they will be resolved scientifically through MD, Ph. D. and other action research aspects of the CBD project (briefly outlined hereunder),

Chivaigaon Rural Block Model

PUBLIC SECTOR

1. Block with PHC
2. University RHTC
3. Ayurvedic Dispensaries-3

PRIVATE SECTOR

4. Allopathic (FRCS)-1
5. Ayurvedic (BHU Qualified) 3
6. Homoeopathic-1 (Recognised)
7. CHVS 114 (Govt. Supported)
8. RMPs with Training-45
9. RMPs without Training-28
10. Unregistered but with Clinics-12
11. Unregistered without Clinics-710×10= 7100 (640 out of 710 studied as part of Ph. D. thesis (Most Important Agents of social change for positive health culture).
12. Home Remedies to be studied.

1. Skills of 8-11 being defined in their respective diversities and through health education are being evolved to catalyse positive health culture in grassroot diversities.
2. Village to village and house to house distribution, sale of orals/condoms aimed through all 1-11 channels under two MD Theses for comparative evaluations and compliance of Drug Act (schedule 1 & k).

   (Integration of research, training and service).
3. Women development through Home Science deptt provided (other BHU Deptts getting involved).
4. Chiraigaon Block : one model ; 22 blocks : varied models in Varanasi District.

The project is Multidisciplinary as large number of disciplines other than those in the Medical Faculty are getting involved in the project through-No Profit No Loss basis of discipline wise evolving funds for integrated rural development, and primary health care. The Vice-Chancellor has kindly involved himself in the overall guidance for the integrated rural development through large number of academic departments (hopefully 40-50 departments are likely to get involved in due course).

The project is through Multiagencies as besides International Planned Parenthood Federation, Family Planning Association of India, BHU and Kashi Vidyapith Universities, efforts are being made for functional and attitudinal integration of the government and the non-governmental district, block and panchayat level agencies. The approach for integration is through existing procedures with functional modifications of all these agencies as has been achieved in BHU without any extra committees or procedures.

The final success lies in evolving the same university pattern integration at district, block, village panchayats, and 500,000 family (social) units of 2.8 M rural population for small family norm through primary health care and integrated development in their diversities. It is yet too early to make valid comments on multiway interactions generated among ivory tower expertises of two universities, procedural frankesteins of government and non-government set ups, and problems of other social set ups including families. However number of project's action and functional innovations have brought to surface hard core resistance in legal social regulators, university and government procedures which are comparable to rigidities and/or ritualistic dimensions of practices and norms in the basic social units i.e. families (refer first quarter report).

It is hoped that these multidimensional action—orientated functional experiences might indicate guidelines for appropriate technologies at grassroot levels in the diversities of the realities of human situations. These aspects to my mind also constitute a CHALLENGE for IPHA and allied associations and/or bodies (illustrated by BHU, FPAI etc) for extensive and intensive actiod research experimentations leaning to effective implementation of **Primary Health Care** outreach by the year 2000.

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EXPANDING HORIZONS OF PUBLIC HEALTH

Dr. B. C. Dasgupta Memorial Oration—1979

DR. SUSHILA NAYAR

The usual commonly accepted concept of public health has been care of the environment which includes supply of safe water, disposal of human and animal excreta and household refuse and drainage or disposal of waste water. To these have been added in recent years concern for prevention of air pollution by fumes of factories and smoke from vehicles and other sources, dust and other harmful suspended matter in the air such as silica, coal dust, maganese, cotton fibres, cane sugar fibrers etc. in various situations, Noise pollution and radiation hazards are also covered by environmental hygiene and are engaging the attention of experts in various countries to a greater or lesser extent depending on their circumstances.

The concept of environmental hygiene was expanded and public health came to include nutrition, maternal and child health, school health, family planning and welfare, prevention of adulteration of drugs and food stuffs of various kinds and necessary legislation for these purposes.

The heavy toll taken by communicable diseases led to further expansion of public health activities to include prevention, control and eradication of smallpox, malaria, cholera and other gastrointestinal infections, tuberculosis, leprosy, trachoma, goitre and the like. Epidemiology, bacteriology and biostatistics were recognised as most important tools for these purposes. Similarly importance of immunisation and early treatment of simple diseases were accepted as most important preventive measures.

Alcoholism and drug addiction are other areas which are posing a challenge before the public health physicians. Epidemiological studies have been undertaken in certain areas and have brought out very useful information with regard to causes and effects of these addictions both from

the point of view of physical health as well as the socio-economic health of the individual and his family and the society in which he lives. The epidemiology of road accidents and accidents resulting from the use of farm machinery in the Punjab will demonstrate how important a factor is alcohol consumption in this area.

A visit to the Noor Manzil Psychiatric Clinic a few months ago brought before me vividly the havoc wrought by drugs and alcoholic beverages so far as the mental health of our youth is concerned. A number of brilliant young students were lying there as physical or mental wrecks as a result of experimenting with these dangerous habit-forming intoxicating drugs and drinks. I am sure an epidemiological study of mental illness will bring out the relationship of intoxicants and loss of mental health in a much larger population covering the family and society of the addict. Thus addiction and its management has also become an important area of public health activity.

It is well understood that health and diseases have both causes as well as effects in the Society. Health practice depends on behavioural sciences, political and management science and on economics as well. The importance of human behaviour is being increasingly realised as an important factor at all levels in health and diseases as well as delivery of health care. Sociology, psychology and anthropology have already established their importance in public health.

The importance of the social and economic conditions in promotion of health and prevention and treatment of diseases was realised fairly soon, but the importance of health for the improvement of socio-economic scene is till not widely understood or accepted. It was the presentation of the economic consequences of malaria in the Terai area of Uttar Pradesh which led the planners, economists and administrators to accept the malaria control and eradication programme in the fiftees, but the set back in the eradication of malaria has by and large hardened the attitude that looks upon health and education as spending departments and welfare activities rather than as an integral part of the overall developmental programme.

National Society for the Prevention of Blindness has been carrying on an intensive educational campaign to demonstrate the economics as well as effectiveness of preventive measures including treatment of eye conditions which can restore eye sight, as against the economics and effectiveness of programmes of rehabilitation of the blind. This has led to the acceptance of the 20 years perspective plan for provision of ophthalmic services in the country in which all sectors, voluntary, governmental and semi-governmental can be fully harnessed to face the challenge of taking eye care to the existing

as well as new cases with eye disease which must lead to blindness if left unattended. But implementation of this programme also is not as satisfactory as it should be and the fear is that those who control the economy may consider other priorities more important.

The demarcation between clinical and preventive medicine has become hazy and indistinct. What is emerging today is an interesting picture of physicians who are expected to and are capable of taking care of the health needs of the vast majority of the population by adopting individual or collective measures for the promotion of health and prevention of disease, treatment of minor ailments which constitute the major share of morbidity in any community, referral for specialised care in a small number of cases to the specialist and undertaking rehabilitation of the individual after illness and disability by making effective use of his residual abilities. These are public health physicians, community physicians or general practitioners with wide horizons and perspective. On the other hand, there are clinical specialists and super specialists who take care of the small number of those who are referred to them for specialised care It is interesting to note that the glamour and rich returns which come to the clinical specialist, attract most of our brilliant young medical graduates to specialisation in clinical medicine. Public health and community medicine, with few exceptions, is left to those who cannot get into clinical specialities. Of course there are a few enlightened clinicians who, having seen the futility of treating a few cases of tuberculosis, leprosy, typhoid or cholera or other communicable diseases or of anaemia and malnutrition, neglected infections of eye and ears or mismanaged obstetric or paediatric problems, while there are ever increasing numbers to follow them unless some one can get behind the line and take preventive action, take to preventive medicine. It is a sad state of affairs that while we all recognise John Ryle as one of the founding fathers of community medicine though he spent 30 years in teaching and practising clinical medicine and having seen how futile it was, turned to community madicine, in our country we have those who would like to prevent clinicians from going into community medicine. I was taken to task by some of them recommending a Paediatrician as the Head of Community Medicine Department at the Postgraduate Institute of Medical Education and Research, Chandigarh. I wonder if this attitude is beneficial for the development of Community Medicine and expansion of the horizons of public health.

Health departments are now becoming increasingly responsible for the organisation of personal health care coverage for whole populations. A large army of medical and paramedical personnel is now engaged in

this "large-scale enterprise". This necessitates the application of modern management techniques in public health services. Management problems in health differ from other sectors in various ways. The orientation is basically to "service" rather than "production". Health is an emotional subject and irrational forms and prejudices about it can produce powerful reactions against the introduction of "rational" or "objective" methods. It is also difficult to place a "value" on health. All the same health practice now includes delivery or highly complex services to millions of people through thousands of doctors and other health workers, needing planning and management by best available means and controlled objective measures of performance. Adoption of modern management techniques is essential not only for efficiency but also because competing claims on available resources and priorities have to be examined by economists and others responsible for advising governments on the Whole range of public services, regarded as sectors of national economy. It is essential to have realistic planning, assessments and evaluations and flexibility for making necessary corrections.

As I see it, public health today comprises the total health care of the community in which medical care of the sick forms a small fraction and specialised care of the sick a still smaller fraction of the total medical care programme. It thus involves managerial skills and ability to organise the health delivery system in such a way that neglect in seeking health care on the part of an individual or his family, does not lead to the community having to pay a heavy toll in form of morbidity and mortality as well as resulting decline in productivity and deterioration of the socio-economic situation. This has led to the concept of primary health care and its delivery at the doorsteps rather than waiting for the sick to seek relief at the OPD.

It is interesting to note the definition of primary health care as given by the Alma Ata Conference. It says the scope of primary health care must include, promotion of proper nutrition, an adequate supply of safe water, basic sanitation, proper housing, maternal and child care including family planning, immunisation against major infectious diseases, prevention and control of locally endemic diseases, health education regarding prevailing health problems and the methods of preventing and controlling them, and appropriate treatment of common ailments and injuries.

How is this comprehensive primary health to reach every individual in our country by the end of this century ? It is a big question and needs very careful consideration by the medical profession as well as the planners, administrators and economists. It will require mobilisation of very considerable resources and it is a matter of deep concern to all of

us as to how to raise the resources for the health needs of the country and how to get adequate allocation for the primary health care sector.

We have to educate our administrators, economists aud planners to consider expenditure on health as developmental expenture by recognising the integral relationship of health, education and development. This alone will induce them to release the finance required for the purpose, Political will is essential if the targets laid down by the Alma Ata Conference are to be reached. Report of the Director General of WHO and the Executive Director of UNICEF on primary health care states : "Political commitment to primary health care implies more than formal support from the government and community leaders. It requires the reorlentation of national health development strategies. For developing countries in particular, it implies the transfer of a greater share of health resources to the underserved majority of the population. At the same time, there is a need to increasc the national health budget until the total population has access to essential health care. Much of this increase will have to be devoted to those institutions providing direct support to primary health care".

We have also to educate ourselves, our own profession and those engaged in medical industries. I quote from the report of the WHO that I have mentioned already : "It can be seen that the proper application of primary health care will have far-reaching consequences, not only throughout the health sector but also for other social and economic sectors at the community level. Moreover, it will greatly influence community organisation in general. Resistance to such change is only to be expected ; for instance, attempts to ensure a more equitable distribution of health resources could well meet with resistance from political and professional pressure groups, and the use of appropriate technology may arouse the opposition of medical industries.

Obstecles such as these can be overcome if they are prepared for in advance. The most important single factor in promoting primary health care and overcoming obstacles is a strong political will and support at both national and community level, reinforced by a firm national strategy. But specific antidotes can also be employed. For example, it may be possible to influence those health professionals not already convinced of the importance of primary health care by involving them in its development. They will need to be persuaded that they are not relinquishing medical functions but gaining health responsibilities. In the same way, resistance among the general public can be defused by discussions in communities and in the mass media. These discussions should aim to make people appreciate that primary health

care is realistic, since it provides, at a cost that can be afforded, essential health care for all in a spirit of social justice rather than sophisticated medical care for the few in a counter spirit of social inequality".

Understaning of public health problems and assessment of resources and technical knowledge will determine the type of health services. It is casier to start with no established pattern of health services, than to train and retrain existing staff and change the functions according to the new perceived goals. We are placed in circumstances where vertical health programmes are as strong as the general health services. The need of the day is health care delivery in an integrated manner.

With broader spectrum of health services to cover, training needs and programmes cannot be dissociated from the actual health services. Training programmes for both medical and paramedical personnel need to be geared up. When a big number of peripheral workers are to be trained, education or educators also assumes significance of a programme in itself. There is urgent need to coordinate and fit into a rational pattern all training programmes from the University level down to the field training of CHWs in such a way that all health services serve as training field for different levels of health workers and the trainees provide services in the course of their training. This approach will enable us to provide the requisite health care to all our people in the shortest possible time.

I am convinced that unless the community itself realises the importance of health and is willing to take responsibility for its health needs, the resources released by the Government will not suffice nor be utilised in the best manner possible to give the maximum benefit. This means that development of community leadership is most essential. Health education as well as enlightenment as to the role of the individual and his family and the community in promoting health, preventing illness and providing the necessary facilities for the purpose should enable these leaders to get funds from the government or semigovernmental sources such as panchayats and other local self-government institutions on the one hand and supplement the same by their own efforts on the other. Moreover they can ensure that the funds are wisely used for the greatest good of all members of the community.

Health education, in order to be effective must reach every family and every member in the family. It is the individual and the family who must take the responsibility for translating into action the health education imparted to them, be it by adopting healthful ways of living such as personal and environmental hygiene, balanced meals worked out from the locally available foods,

seeking antenatal or postnatal care, planning the size of the family, adopting modern methods of child care, supplementing mothers milk, weaning, seeking immunisation and paediatric care for the child in time add implementing the advice given.

In our country household remedies were used a great deal by our grandmothers. The educated women of today know next to nothing about them. They will have to be reintroduced to simple household remedies which are considered harmless. In the west also an increasing emphasis is being laid an the individual taking the responsibility for his or her own health. This means that the basic principles of health education must from a part of our general education so that they reach each and every citizen. This requires that the teachers training courses must give an important place to principles and methods of health, nutrition and family welfare education.

The role of the family in promoting health, preventing disease and improving nutrition by limiting the size of the family on one side and making judicious use of available foods including production in the fields and in the kitchen gardens on the other, cannot be over emphasised. It is the family which has to seek timely help for the sick child, get immunisation at the right time and attend to minor ailments.

In communicable disease control and eradication, the role of the family is most important. For instance trachoma can be overcome within 5 to 6 months by applying aureomycin ointment morning and evening to the eyes of all the members of the affected family, 5 or 6 days a week, one week in the month so that each person gets 60 applications. The family can do it far more easily and effectively than any one else. Similarly it is the family that can ensure that a case of leprosy or tuberculosis takes regular and full treatment and adequate action is taken to prevent the spread of infection to other members of the family.

The role of the community leaders in ensuring safe water supply and environmental sanitation by using appropriate methods of disposal of excreta including installsation of gobar gas plants, in promoting social forestry for providing fuel and fodder, in ensuring adequate nutrition of the vulnerable groups and provision of school meals through community participation by growing protective foods and providing them to those who need help and lastly in providing necessary health care facilities by selecting suitable persons from the village to function as community health workers, getting them trained and supplementing their tools including drug supply if need be, cannot be over emphasised. Adequate communication between community health workers and the PHC staff is necessary so that the community health workers get their support. The community leaders can help in this as

also in making sure that leprosy and tuberculosis cases in the community do take regular and complete treatment and antenatal cases and infants are immunised and advised by the ANM when she visits the village. Active and enlightened community leadership can make all the difference between brilliant success and dismal failure of the community health service.

How can the community and every family in the community he involved in their own health care is the big question mark before public health workers. It is obvious that our efforts in this direction so far have been far from adequate and we have bardly made any headway in this direction. Innovation of a community health worker for every 1000 population has been recently introduced in order to carry the message of health aud nutrition education and early treatment of minor ailments to every family through a person who belongs to the community and is therefore culturally acceptable. But these community health workers will also need the help and support of the community leaders if they are to succeed.

Development of community leadership eannot be left to the CHWs. Initiative in this direction will have to be taken by the PHC doctor and other PHC staff along with the local MLA and other political leaders. A suitable training programme for the community leaders will have to be evolved.

In several parts of the country introduction of the community health workers is being objected to by the medical associations and many of our professional colleagues. They are afraid that the CHWs will add to the number of quacks who will compete with medical men and women besides exposing the community to the risk of treatment by fnadequately trained lay persons Punjab has not accepted the community health workers scheme under the plea that within the next decade or so they will have an MBBS doctor for every subcentre under their PHCs. In theory the should be enough doctors trained before the year 2000 to take care of our needs all over the country. But let us see whether this can be reasonably expected to come about and whether additional doctors will serve the needs of the nation even if they are posted in rural eress. Moreover we must also give thought to this matter from the point of view of the needs of the community and the satisfaction to be derived by the doctor as well as the community from such services.

We are all aware of the reluctance of the doctors to serve in the villages and we also know that there are many cases wherein a bond is taken from the medical students to serve in the villages for a certain number of years after graduation, but no job is offered to the young doctort within the stipulated period. At the MGIMS every

student signs a bond to serve in the rural areas or any other difficult area where the State or the Central Government might post them within six months of their completing their internship. We have graduated doctors 339 in the decade since the Mahatma Gandhi Institute of Medical Sciences was started in 1969 as a Gandhi Centenary Project and 324 have already completed their internship. I am sorry to say only 6 have been employed by the Government inspite of my writing letters to the Central and State Governments that their services were available. I know there are Vacant posts in many parts of the country, but for reason best known to the powers that be. they are not making use of the services of the doctors who are available. Same is the case with nurses who are in still shorter supply than the doctors. This state of affairs is not likely to undergo a revolutionary change in the next decade or two so far as I can see, and the additional doctors who will graduate in the meantime are not likely to be posted in rural areas, nor are they likely to set up private practice in the villages

Secondly we must ask ourselves whether it is necessary to have an MBBS doctor for imparting primary health care ? We have long ago accepted the ANM, the vaccinator, the sanitary inspector and the malaria worker or leprosy worker as helpers of the doctor in our public health activity. The only additional work given to the CHWs is disbursing a few medicines for the treatment of minor ailments. I am unable to appreciate the strong reaction of the profession to this additional activity. The leprosy and tuberculosis workers have been allowed to give drugs and so is the ANM expected to give iron and folic acid to the antenatal cases and immunisations to the pregnant woman and her child. Why is treatment of minor ailments by the CHWs more objectionable ? It is true that the training period of the CHW is shorter, but so is the range of her work and responsibility.

We have found from experience that the ANM and the other PHC staff including the PHC doctors are able to cater for only a very small fraction of the population under their jurisdiction, say within 5 km redius of the PHC We have also seen that the village people often consider the PHC staff as aliens or outsiders They consult their own village wisemen or indigenous practitioners before going to the PHC and take the PHC medicine only if their "Wiseman" of the village so advises All this shows that the cultural gap between the doctors and nurses trained in modern medicine, and the village people cannot be easily bridged without the help of some one from the village. The community health worker who belongs to the village community, lives with them. speaks their language, is likely to be much more acceptable and experiments carried out by a number of voluntary organisations have

proved this assumption to be correct. The CHW can become the bridge between the PHC staff and the village community. I have seen almost illiterate women who get their data written up by a school going daughter or son or even a grand child, do an excellent job as a community health worker with some voluntary organisations. I am therefore of the opinion that the medical profession should not oppose the CHW Scheme. The CHWs are not our competitors. They are our helpers and they can reach where we are unable to reach and can act as a bridge between the medical profession and the para medical workers on the one side and the community on the other. A community health worker can take the message of health education, personal hygiene, environmental sanitation, protection of village wells and pot chlorination or any other method of making the water safe, installation of latrines and gobar gas plants to the villagers, and introduce kitchen gardens to absorb waste water and other similar measures much more effectively than can the doctor or the ANM and the multipurpose health workers, who have a much larger area to cover besides having to overcome the resistance of the villagers.

The CHW can help the ANM and other PHC staff by keeping a record of all pregnant cases and having them ready for examination at the time of the ANM's visit. Similarly she can keep the children ready for immunisations and can bring to the notice of the ANM any case of illness among the children or adults that she thinks needs attention. The ANM or the MPW (multi—purpose worker) can seek the help of the doctor and the case can be taken to the PHC or the district hospital if it is considered necessary. In this fashion the PHC staff can reach the entire population under their jurisdiction and the ANM and the MPW can effectively cover the subcentres and all the villages under their care, provided they fix up a schedule of their visits in advance and work in coordination with the CHWs who is posted in every village in the area

The training and supervision of CHWs may need careful review and refresher courses for them as well as for the PHC staff will have to be instituted. The time has come for all levels of the health system to review critically their methods, techniques, equipment and drugs, with the aim of using only those technologies that have really proved their worth and can be afforded. For primary health care this is vital, because there has been a tendency to concentrate on medical technologies that are more appropriate for hospital use than for front-line care. The scope and purpose of primary health care and the technical capacity of those who provide it, make it more important than ever to have appropriate technology available.

If the political leadership helps in developing community leadership in the villages and the community leaders can be trained for the role which they are expected to play, we can do a effective job of providing primary care to our people much before the year 2000.

Primary health care is a practical approach in making essential health care universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation. This approach has evolved over the years, partly in the light of experience, positive and negative, gained in basic health services in a number of countries. But it means much more than the mere extension of basic health services. It has social and developmental dimensions and if properly applied will influence the way in which the rest of health system functions.

Its shape is determined by social goals, such as the improvement of the quality of life and maximum health benefits to the greatest number ; and these goals are attained by social means, such as the acceptance of greater responsibility for health by communities and individuals and their active participation in attaining it. The healthier people are, the more likely they are to be able to contribute to special and economic development, and such development in turn provides the additional resourcss and social energy that can facilitate health development. So primary health care and community efforts towards social and economic development in general are most likely to succeed when they are mutually supportive. Also, just as the health sector functions best in harmony with the other social and economic sectors, so there is a need for harmony within the health sector through support to primary health care by all the other levels,

The expanding horizons of public health have laid a heavy responsibility on the public health physicians. They have to develop qualities of leadership along with scientific knowledge and a sense of deep social commitment. They have to carry with them the community on the one hand and other development departments on the other. For instance there has to be very close collaboration between public health people and education department to impart health and nutrition education to every one. The agriculture department has to be convinced as to the need for producing protective foods which can supply proteins, calories and essential vitamins etc. for the vulnerable groups, namely the preschool child, the pregnant woman and the nursing mothers as top priority. The need of school children comes next and then that of the rest of the population. It is not enough to produce these foods. The community leaders have to be convinced that what they produce must not all be sold in the market. They must keep enough for meeting the needs of their own

children. In some of the villages participating in dairy development, a system has been evolved by community leaders so that milk collection is done only once a day. Milk of the evening is kept for the calves and the children.

The public health physicians will have to carry with the PWD to ensure that they do not leave borrow pits along the roads and railway lines under construction, which can later become stagnant pools of water and breed mosquitoes. They have to keep in touch with legistators to have it adequately implemented, be it the Drugs Act or the Prevention of Food Adulteration Act or Prevention of River Pollution Act and so on.

They have to be in touch with those engaged in medical industry. Opposition from the medical industries can be directed into positive ehannels by interesting them in the production of equipment for appropriate technology to be used in primary health care. Any losses from reduced sales of limited amounts of expensive equipment could well be more than counter-balanced by the sale to large untapped markets of greater amounts of less expensive equipment and supplies for primary health care.

Reservations may be voiced by certain schools of economic planning, based on the common belief that economic growth alone will bring in the wake the solution of health problems. In answer to this it should be explained that, whereas real social and economic development can undoubtedly bring about improvements in health, there is also a need to apply direct health measures to improve health situations and that, as mentioned earlier, efforts from all the sectors concerned are mutually supportive.

There may even be misguided support for primary health care based on the wrong assumption that it implies the cheapest from of medical care for the poor, with the bare minimum of financial and technical support. Only political intervention, coupled with forceful explanations of the real purpose and scope of primary health care, can overcome such an attitude.

Political commitment to primary health care implies more than formal support from the government and community leaders. It requires the reorientation of national health development strategics. For developing countries in particular, it implies the transfer of a greater share of health resources to the underserved majority of the population. At the same time, there is need to increase the national health budget until the total population has access to essential health care. Much of this increase will have to be devoted to those institutions providing direct support to primary health care.

The public health doctor has to be abreast of scientific developments and

develop the managerial skills so that treatment facilities of various kinds can be made available to the people when sickness cannot be prevented and centres for rehabilitation services can be developed for the disabled. This will require establishing contacts with socical welfare departments on the one side and voluntary agencies active in these areas on the other. It may require initiative to promote voluntary agencies for the purpose if there are none in existence in any area.

Public health today requires men and women with dedication, drive and deep compassion. I am convinced a time will come before long when specialities of public health will attract the most brilliant medical students and the challenge of providing comprehensive health care for the total community within two decades will enable us to forget all differences and put our shoulders to the task by mobilising all possible resources of money and man power to meet the health needs of all our people. In this great quest the indigenous practitioners too can become our partners and coordinated approach and services can be evolved as has happened in some of the socialist countries. Let us hope what they have achieved through conscious voluntary cooperation in the spirit of Gandhiji and Jayaprakash Narayan. The total revolution that these great leaders talked about in order to evolve a new social order, can be begun with ourselves and within our own profession by each one of us taking up the challenge that expanded horizons of public health have posed before us.

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ABSTRACTS OF PAPERS

Scientific Session I

Topic : Socio-Cultural Aspects in Child Care

Authors : Dr. S. Samson, Dept. of Community Health, Christian Medical College, Vellore-2. S. India.

The theme in the International Year of the Child proclaimed by WHO is 'IMMUNISE AND PROTECT YOUR CHILD' which has a world wide significance particularly for the developing nations.

There should be no doubt whatsoever that the child is a national asset and resources spent on the care, upkeep and health of the infant and the young children are an investment for future.

The new concept is the delivery of Health care services in the form of "Health care package" (comprising of MCH, Family Planning. Immunisation and Nutrition) which has been initiated during the Fifth Five Year Plan. The sub-centres are the nucleus for the delivery of the health care package.

Topic : Child health care through subcentres.

Authors : Dr. C. R. Trivedi, Deptt. of Preventive & Social Medicine, Municipal Medical College, Ahmedabad-6.

Operation of any programme is the most difficult task. For successful operation, the units at grass root level, closest to the receipients, have got to be strong and sound. We have about 39012 subcentres in India, as peripheral units of health care delivery system to rural areas. A lot is needed to be done *strengthen* them for proper delivery of health.

Immediately following the "International children's year" if we initiate proper health care to children (0 to 14 years), through subcentres and maintain it, then we can hope to achieve the target of "health for all" by year 2000, as set by WHO.

Various ways in which this operation can be made effective are discussed. Keeping subcentres as the only outlet of all health care, would go a long way to strengthen them and avoid duplication and waste of resources.

Topic : Child health care tfirough sub centres.

Authors ; K. K. Datta, R. S. Sharma, V. K. Kaushic and R. R. Arora.

Healthy children are the proudest possession of any nation. Yet millions of our children are struggling hard to live adequa-

tely. Scarce and inadequate basic services like health, nutrition, safe water and shelter deprive them of their right to live and to live adequately. Children under 14 years of age constitute 20-25% of population in the developed countries, whereas in the developing countries like India, Mexico, Uganda etc. they constitute 40-50% of the population. Majority of our 1500 million children all over the world are living in areas where basic services are inadequate or rudimentary posing a great treat to our goal to achieve the health for all by 2000 A.D. High infant mortality rate (140-200) coupled with high preschool mortality rate (20-40) in the less prosperous world make many of our children unable to cross adolescence. Total wastage of life due to death of children is enormous. Though the problem is gigantic one yet it is ironical that we have no reliable care in our country. Concept of primary health care through the institutions of Primary Health Centres and subcentres was visualised in the early part of this century and was put in practice in India following recommedations of Bhore committee in 1946. Establishment of P. H. Cs with three subcentres in community development block comprising a population of 60-80 thousands was launched as an integral party of community development programme in 1952.

By the end of 1976, India had 399 districts, 5247 blocks, functioning P.H C.'s 5373 and 49278 subcentres. The main function of subcentres are maternity and child health, collection of vital statistics, treatment of minor ailments, health education in respect of common communicable Diseases.

Recent prospective cohort studies at Alwar involving 331, rural newborn and 349 pregnant women showed IMR to be 148 Neonatal mortality constituted 34.69 percent of IMR, MMR, abortion rate per thousand pregnancies, stilbirth rate were 5.92, 28.65, and 2 96 respectively. It signifies gross inadequacies of our health services. Major child health problems in India are material malnutrition, anaemia and intrauterine growth retardation, PEM, vitamin A deficiency and blindness, parasitic infestations, diarrhoeal disorders, respiratory diseases, diseases like measles. whooping cough, tetanus diphtheria etc.

In a review of existing health care delivery service through subcentres of Alwar district the authors found that the health team as a whole failed to meet the people's expectation. Communication gap, cultural idiosyncracies irrational targets, improver supervision, lack of orientation training to changing needs, nonavailability of drugs or immunising agents, absence of proper in-built evaluation mechanism etc. have made our health care delivery system questionable and less acceptable to the people. Under the circumstances the institution of Primary Health Centres and subcentres need to be revamped and strengthened on a rational

basis with the existance of flexibility in its administration depending on the local and changing needs, if we are to provide the core of scientific medicine to the rural vast millions particularly to our children and the mothers, through unsophisticated barefoot technology.

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Topic : A study of some aspects of maternal and child health services at sub-centres of health unit, Paithan, district : Aurangabad (Maharashtra State).

Authors : Kulkarmi, A. P. and Sathe, P. V.

A comparative study of Infant Mortality Rate (IMR) was carried out for the year 1978 for two groups of villages under Health Unit, Paithan, (A). Three villages forming head-quarters (HQ) of the three of the six sub-centres and (B) Remaining five villages under these sub-centres. The IRMs for these two groups of villages for 1978 were 26.2 and 97.3 per 1000 live births respectively. A trained nurse-midwife (NM) was posted at each of these sub-centres during this period and her easy availability for antenatal and internatal services to mothers of villages of group A rather than to the mothers of the villages of group B has probably caused this difference in the IRMs. This fact ir supported by following observations :

(i) Only 10% of the total mothers availing antenatal services belonged to the villages of group B.

(ii) The NMs conducted 77.3% of the total deliveries in the HQ villages while she could conduct only 11.9% of the total deliveries in the remaining villages.

In another sub-centre NM was not posted for complete year of 1977 due to administrative difficulties. The IMR for the HQ of this sub-centre was 125 per 1000 live births in 1977 and it dropped to 30.30 per 1000 live births when NM was posted during August 1978 to July 1979. The IMR for other villages under this sub-centre during August 1978 to July 1979 however, remained high (83.73 per 1000 live births).

IMR therefore appears to be closely related to the availability of NM for antenatal and intranatal services in the rural areas. A more provision of simple antenatal and intranatal services through trained NM to maximum possible villages can thus reduce infant mortality in rural areas.

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Scientific Session—II

Problem of Leprosy and its Control

Topic : Some features of Urban Leprosy Control.

Authors : K. K. Koticha
Superintendent. Acworth Leprosy Hospital, Wadala, Bombay.

In absence of a specific preventive measure and in absence of segregation of infective leprosy patients, the only way to control further spread of leprosy is by early detection and vigorous treatment. Early detection is achieved by examination of special groups of people like family members of known cases, school children, industrial workers, slum dwellers etc. In cities, health education to people about various aspects of leprosy is extremely important to encourage more people come forward voluntary self-detection and self-referral. The drop out rate in treatment has to be minimised on a priority basis and the treatment be made vigorous. Then only the quantum of infection as well as proportion of deformed cases in the society, will be considerably reduced. Dapsone prophylaxis to contacts of infective cases in crowded households is recommended. Only rigorous concerted efforts in an area will check the spread of the disease.

Scientific Session—III

General Public Health Problems

Topic : A Study of Antirabic Vaccines.

Authors : M. B. FULARE Reader in Preventive and Social Medicine, Medical College, Nagpur.
S. W. KULKARNI Professor of Preventive and Social Medicine. V. M. Medical College Solapur.

Rabies, a viral disease spread by the infected animal is perhaps the most perplexing problem to the modern medicine, not much because of number of cases but that it is incurable and uniformly fatal and prevention against it is also not fool proof.

2100 individuals who attended the Antirabic Centre in the District Hospital, Nagpur were studied, that includes mainly the time, circumstances, and site of injury, the species, age, sex and fate of the biting animal, delay, regularity and complications in the treatment-both local and systemic.

After analysis it is seen that the highest incidence is in Age group 5-15 years followed by 0-5 years constituting high risk group of children and adolescents. The preschool age population plays with pets, hides, stray dogs and are not able to run away.

It was seen that they were either from slum with many stray dogs, thickly populated old out-skirts of the city.

It was seen that 57 per cent of bites occurred during evening and during afternoon. The significant number of cases that occurred during road-side walk and most accessible part was lower limb.

Topic : Changing Pattern of Human Rabies and Human to Human Transmission of Rabies.

Authors : Dr. Roy Varghese, G. George, and T. P. Antony, Department of Medicine, Medical College, Kottayam, Kerala.

Human rabies is very common in India. It carries cent per cent mortality. When patients present with classical hydrophobic symptoms the diagnosis is easy. But there are more and more reports of cases presenting with a typical features where a diagnosis is not suspected till death. Successful prophylaxis of the contacts becomes a problem in such cases.

We are reporting three cases of human rabies which presented atypical features and a case of human to human transmission through corneal transplantation. Their clinical features, laboratory findings and autopsy analysis are described in detail.

Topic : Diagnosis of filarial infection by DEC provocative test and night blood examination.

Authors : P. D. Deshmukh, Y. A. Ketkar, S. G. Asoni, S. G. Asoni. S. B. Bhaskarwar, J. R. Biranjan.

A survey was carried out at village Chichad for detection of filarial infection. Two methods viz-night blood smear examination and DEC provocative test were used for detection of mf in blood. Observations of the study are presented in the paper. Out of the total population of 3116 of village, 2744 were available for night blood smear. 522 were positive for mf and of these in 437 people it was possible to carry out DEC provocative test. The test was positive in 220 persons while it was negative in remaining 217, DEC provocative test. The test was positive in 220 persons while it was negative in remaining 217. DEC provocative test was also performed in 389 age & sex matched control population where it was positive in 3 persons were positive for mf in day time before the DEC provocative test. Reports in the literature mention the reliability of DEC provocative test to be up to 90% but in the present study it is not sensitive though it is specific.

Full test of the paper deals with various observations made in respect of the reliability of the provocative test.

Topic : An appraisal of the organizational requirements for the implementation of a national programme on Rabies Control

Authors : C. Natarajan & N. P. Bhatta, Division of Veterinary Public Health Indian Veterinary Research Institute Izatnagar-243 122 (UP)

The necessity for organising a National Canine Rabies Control Programme in India has been fully realised. Several action programmes have been formulated at different levels. There is however a need for streamlining the whole system in order to implement the action programmes effectively. It has been, therefore, endeavoured in this presentation to identify/arrange :-

(i) The various committees at different, levels namely National, State, District, Municipal, Town and Block for suggesting the ways and means and for identifying opperational problems.

(ii) Provision of Rabies Control personnel and delineation o theirJ functions including the necessary training programme.

(iii) Socio-economic aspects of control programme keeping in view the latest trends in utilisation of animal carcasses and to evaluate its feasibility and economics.

Topic : Infective hepatitis and ascitis.

Authors : S A. Kamat.

Hon. Physician, Kasturba Hospital for Infectious Dieases, Bombay.

Ascitis is not mentioned as a common complication of Infective Hepatitis. In the present epidemic which prevailed during the last 2 years, ascitis was found to be a common complication of Infective Hepatitis occuring in 1% of hospital admissions for Infective Hepatitis Prognosis in these people is not so bad as expressed in the text book. Five of the twelve patients of ascitis died. Prognosis was adversely affected by high serum bilirubin and high H. G. P. T. and B. U. N. levels Serum proteins did not show much difference in 2 groups. Those who servive became free of ascitis with treatment and have continued to remain normal during the follow up period upto 2 years.

Scientific Session—IV

Assorted Papers

Topic : Aeruginocine typing of Pseudomonas aeruginosa originating from dairy cows, their environment and other sources.

Authors : M. P. Kapur, P. C. Chhabra and O. P. Gautam, Haryana Agricultural University, Department of Veterinary Medicine, Hissar-125004

Forty-eight strains of P. aeruginosa were isolated from different body sites of dairy cows, their environment and other sources. These isolates were typed by aeruginocine typing method described by Shriniwas (1974) and were also subjected to in-vitro sensitivity test to different antimicrobial agents using the disc diffusion method.

Of these 48 strains, 39 (81.20%) were found typeable and nine (13.20%) were untypeable. Amongst the typeable strains, 32 (82 0%) were classifiable and seven (18 0%) were unclassifiable. These seven strains produced five inhibition patterns not belonging to any of the know aeruginocine types. The classifiable strains belonged to Wahba's type A (12). B (7) and C (2) and Shriniwas's type 1 (1), 12 (7) and 17 (3).

These strains exhibited multiple resistance of most of the antimicrobial agents tested, viz , nitrofurantin, penicillin, streptomycin, oxytetracycline. chloramphenicol, ampicilin, kanamycin, gentamycin, polymyxin B, neomycin, oophaloridine, septran, colistin and carbenicillin.

Most of these aeruginocine types have been reported from different disease conditions in man. Thus there seems to be the possibility of definite association of specific aeruginocine types of P. aeruginosa with man and/or animals and their environment.

Topic : A Study on Leptospirosis outbreak in sheep.

Authors : Jagjit Singh, R. C. Kulshreshtha, N K. Chandiramani & B. Vasudevan.

Leptospirosis is one of the important zoonotic diseases of different species of animals. This disease is mainly characterized by jaundice and haemoglobinuria leading to death and at times with abortions, Sero-prevalence of this malady in various species of livestock has been reported, by a number of workers from India but there seems to be no report about the occurrence of this diseases as noticed in the present outbreak ; though there are reports from abroad (Hartley, 1952 ; Salisbury 1954 and Webster and Reynald, 1955).

In the present communication, leptospirosis showing the clinical symtoms of high fever, jaundice and haemoglobinuria has been recorded and discussed in sheep. The disease was diagnosed on the basis of gross (white spotted kidney and jaundice) and histopathological changes (interstitial nephritis and hepatitis) and demonstration of leptospiras in liver and kidney sections by Levaditi's staining technique. These findings were further substantiated by the presence of agglutinins against Leptospira pomona in the serum of affected sheep using the technique of agglutination lysis test. The treatment with Strepto-Pencillin gave a good response in the affected sheep, However, no sick case of human beings, who were in direct contact with the affected sheep flock, could be noticed.

Topic : Socio-Economic Factors in Intestinal Parasitic Infestation in Kashmir.

Authors : S. N. Ahmad Shah * Muzzafar Ahmad ** Abdul Rauf *** and Mohd Ramzan. ****

The study conducted in 272 families comprising 1750 persons in the Rural area of Bandipur Block of north-west part of valley 35 miles from Srinagar having population of 28209 Survey in Random sample of 7% was conducted.

Parasitic infestation rate was found 72.7% 73.9% in males and 71.3% in females. Ascaris lumbricolds was 61.8%, Gardia 9.4%, Taenia saginata 1.5%.

Age and parasitic infestations were found to be associated statistically giving significant results at p. < 05 In illiterates parasitic infestation was higher than the literates.

Least incidence of parasitic infestation was seen in cases consuming tap and spring water. Type of drinking water found to be associated with parasitic infestation. Highest parasitic infestation rate was among students and pre-school age and school age disabled persons. Least infestation rate was found in shopkeepers, Government servants and petty businessmen, No case of E. histolytica infestation was found.

Reason for absence of hookworm and E. histolytica in the valley is because of the climatic conditions.

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** Officer Incharge, Chittaranjan Mobile Teaching Cum Service Hospital, Govt. Medical College, Srinagar.

*** Assistant Professor, Government Medical College, Sgr.

**** Block Medical Office.

Topic : Prevalence of Trachoma in school going children of a rural community

Authors : R. Chandra, S. L. Bagga, V. K. Srivastava, S. C. Saxena, D. Nandan, R. P. Gupta and B. C. Srivastava

(Upgraded Department of Social and Preventive Medicine K. G.'s Medical College, Lucknow)

The present study on the prevalence of Trachoma was carried out in the area of Community Development Block, Sarojini Nagar, Lucknow. Of one thousand two hundred and thirty six children aged 5-14 years examined, 914 (73.9%) were males and 322 (26 0%) females. The overall prevalence was 34 0% and 22.5%, 9.6%. 1.7% and 0.2 of grade I, II, III and V respectively. The prevalence was significantly higher (48.5%) in children below 8 years of age than those above it ($P > 0.05$). Though the rates were apparently higher in females and in those with poor personal hygiene, the differences were not statistically significant.

Topic : Mortality Trends and prospects in developing countries.

Authors : M. Akram Bhatty, Associate Professor Community Medicine College of Medicine & Medical Sciences King Faisal University Dammam—Saudi Arabia.

This paper attempts to give an overview of current levels of child mortality prevailing in the world and examines its trends in some developing countries with reference to the socioeconomic differentials in these countries. It also reviews data on causes of child death and related environmental factors.

The paper concludes that despite the fact that child deaths are frequently avoidable, mortality differentials between the developed and developing regions of the world are more pronounced in childhood (ages one to under five years) than any other time of life, While some developing countries have substantially reduced the level of mortality in childhood, in others it remains very high. In contrast in most developed countries child death rates are now so low, that they no longer serve as useful measures of public health. In brief, barring major medical breakthroughs (or catastrophies), by the end of the century the expectation of life at birth in developed countries should be within the range of 75-80 years, with females exceeding the value for males by some 3-5 years.

This assumes that recent trends in adult and old-age mortality (less extent, females) will not seriously affect the long-term prospects, However, additional analysis such as generation studies are needed for a better understanding of the future.

Topic : A study of resource implication to health education.

Author : S.P. Mukhopadhyaya,
Assistant Professor of Health Education, All India Institute of Hygiene & Public Health, Calcutta-700 073.

In view of the present economic climate and far greater demand for medical and nursing treatment, perhaps it is now desirable to devote more time and money to educate people in the principles of healthy living and legitimate utilisation of health services. But to some people the value of Health Education is still controversial. Health Education seems to them a compounding variable with other variables like income, social class and education.

It is for this reason of doubts and conflicting attitudes towards the value of Health Education that the present study was undertaken to envisage the justification of of adequate resource allocation to encourage and extend its activities.

Comparative studies of the patterns of health and utilization of services were made between the areas which differed in spending resources to Health Education, but had other variables which may affect health patterns similar. Health patterns were measured against different mortality and birth rates. Results showed that areas having considerable higher resources in Health Education in the form of manpower and money exhibited a better standard of health and utilization of health services than the areas with minimal resource allocation to such educational activities. In some aspects, the differences were found to be statistically significant (P 7 0.05). Thus this study clearly establishes the value of Health Education in the health care of the community, provided adequate resource allocation is made towards it.

Topic : Corticosteroids in the treatment of enteric fever.

Authors : S. A. Kamat.
Hon. Physician, Kasturba Hospital for Infectious Diseases, Bombay.

Effect of corticosteroids alone on fever and bacteræmia was studied in 19 cases of enteric fever proved by blood culture at Kasturba Hospital for infectious diseases. Temperature returned to normal on the same day in 7 patients and within 3 days in another 5 patients In the remaining 7 temperature returned to normal after addition of chloramphenicol to the therapy. Average period of response in these seven patients was 7.3 days Average defervescense period for all the 19 patients was 3.4 days. While the average defervescence period in 8 patients treated with chloramphenicol alone was 3.9 days. In five patiants fever reappeared after withdrawal of corticosteroids needing a prolonged hospital stay. Corticosteroids have not affected bacteræmia. It is concluded that corticosteroids act as antipyretic only.

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ANNUAL REPORT OF THE GENERAL SECRETARY FOR—1979

Mr. President and the members of the Association.

I have the honour to present before you the annual report on the activities of the Indian Public Health Association and its branches for the period from January, 1979 to December, 1979.

1. The 23rd Annual Conference :

The 23rd annual conference of the Indian Public health Association was held from 27 to 29 January, 1979 at the Medical College, Aurangabad, Maharastra State, being hosted and organised by the Maharastra State Branch of the Association. The subject of the Scientific Session was—"Para Medicals in Health Care". A large number of members and delegates from all parts of India attended the conference.

Dr. G. A. Panse, the President of the IPHA Maharastra, Bombay, delivered the Welcome Address. In his address Dr. Panse stated that we are going through a peculiar phase of development of the health programme which has unique importance in the individual life. This challenges of the past are more or less met but new challenges are appearing on the horizon. We have to consider how best we can withstand these pressures and meet the challenges with vigour and success. He emphasised the need to bring about the behavioural change in the community. The change has to be brought about by visualising programmes that are not too expensive and those that suggest a coordinated nation wide attack on the poor hygienic conditions, superstition, ignorance etc...

After the Welcome Address, the conference was inaugurated by Dr. (Smt) Pramilabai Tople, Hon'ble Minister for Public Health and Family Welfare, Govt. of Maharastra. Inaugurating the conference, Dr. Tople said that the concept of delivery of health care were undergoing a revolutionary change, the activities of the Association might have to be suitably modified. She further stated that the moto of any welfare state was to provide health care from womb to tomb, which can not be done by handful of doctors. She laid special emphasis on the important role of paramedicals in the delivery of Primary Health Care.

Dr. P. V. Sathe, the Organising Secretary of the Conference offered vote of thanks.

2. President's Address :

Dr. W. Mathur, President of the Association delivered the Presidential Address. In his address Dr. Mathur stated that our aim was to introduce and help extending the concept of total and positive health in the country. This would mean a programme not only for the control of epidemics and treating the sick, but also to introduce measures which will bestow on every individual a state of fullest enjoyment of his or her physical and mental capacities in a harmonious social and ecological environment. He highlighted the role of communicable diseases in causation of morbidity and advocated suitable measurse to control them.

3. Dr. B. C. Dasgupta Memorial Oration Address :

The nominee for the Oration of Dr. B. C. Dasgupta Memorial Oration Address' was Dr. M. C. Mittal, Dean, Faculty of Medicine, University of Jabalpur, M. P. The topic dealt was 'Environmental Change and Human Health'. In the oration Dr. Mittal discussed about the complex environment around us. He said that that it is not merely the air, water, and soil that forms our environment but also the social and economic conditions under which we live. He outlined the different sources of pollution and suggested possible remedies for improving the environment with minimum ecological imbalance.

4. Presidential Address :

The Presidential address was given by Dr. Namdeorao Gadekar, Hon'ble Minister of State, Public Health and Family Planning Welfare, Maharastra. In his address Dr. Gadekar discussed the new approach to meet the preventive, promotive and curative needs of the rural community, through a basic health team consisting of Medical Officer and Paramedical Workers and Nursing personnel.

5. Scientific Session :

The subject for the Scientific Session was "Para Medicals in Health Care". The Session comprised of 7 (seven) Sub scientific sessions and a total of 38 papers were presented and discussed. The Keynote Address of the theme was delivered by Dr. S. C. Ghoshal, Director. Central Health Education Bureau, New Delhi. In his Keynote address Dr. B. C. Ghoshal discussed about our aim to introduce and help in extending the concept of integrated health care in the country with preference to the rural masses, which form 80 percent of India's population. He outlined the different approaches in fulfilling this job and remarked that the basic Health need must begin with the community itself and then link of these basic services with the infrastructure of dispensaries and hospitals through a sound and well organized referral system.

The abstracts of the papers presented at the above conferenee, has been published in the Association's Quarterly Journal—'Indian Journal of Public Health', Volume 23, No. 4, (October-December) Conference Number, 1979 issue of the Journal.

6. Recommendations of the 23rd annual conference :

A Sub-committee was formed consisting of Dr. G. A. Panse, Dy. Director of Health Services Govt. of Maharastra, Bombay and Dr. P. V. Sathe, Prof. of Prev. & Social Medicine, Medical College, Aurangabad for preparation of draft recommendations of the 23rd annual conference. The draft resolutions were prepared and were sent to the Director General of (i) Health Services, Armed Forces Medical Services, (iii) Health Railway Board, all the Directors of Health Services, State and Union Territories, Principals/Deans, Medical Colleges in India and many other Governmental/Semi-governmental Institutions for their implementation.

7. Award of Followship :

Nominations were invited from the existing Fellows, life members and the Presidents of all the State/local branches of the Association for the Award of Fellowship of the Indian Public Health Association for the year 1979. A total of 17 (seventeen) nominations were received. The Credential Committee under the chairmanship of Lt. General D.N. Chakraborty the Past-president of the Association, held its meeting on January 14, 1980 and recommended 9 (nine) names for the Award of Fellowship. As per Rule 7—D, of the Rules & Regulations and Memorandum of the Association, the ballots were issued for the approved nine nominees recommended by the Credential Committee, along with their brief bio-data to all the existing Fellows of the Association for obtaining their opinion (votes) for the final selection. The votes will be counted at the ensuing 24th annual central Council meeting scheduled to be held on 22nd February, 1980 at Ahmedabad. Those scoring more than fifty percent of the votes polled would be approved and ratified by the General Body at its 24th annual meeting scheduled to be held at the time of the 24th annual conference at Ahmedabad on 24th February, 1980. The names of 9 (nine) recommended members, according to the alphabetical order, are as follows :—

1. Dr. P. K. Mukherjee, Prof. of Public Health Administration. All India Institute of Hyg. & Public Health, Calcutta.
2. Dr. V. L. Pandit, Lecturer in Health to the Job oriented diploma course for M. P. H. W., Bangalore.
3. Dr G.A. Panse, Dy. Director of Health Services (Tuberculosis) Govt. of Maharastra, Bombay.
4. Dr. E. S. Raghavendra, Asstt. Director of Public Health and Prev, Medicine Govt. of Tamilnadu, Madras.
5. Dr. C. Koteswara Rao, Dy. Director of National Insti. of Com. Diseases 22 Shamnath Marg. Delhi.
6. Dr. G. C. Roy, Senior Epidemic Control Officer, Govt. of West Bengal Calcutta.
7. Lt. Col. N. L. Sachdeva, Reader, Dept. of Prev. & Social Medicine Armed Forces Medical College, Poona,

8. Dr. P. V. Sathe, Prof. of Preventive & Social Medicine Medical College, Aurangabad, Maharastra state.
9. Dr. P. C. Sen, Adviser in Nutrition, Govt. of India, Ministry of Health a Family Welfare, New Delhi.

8. Association Award :

The Central Council at its 21st annual meeting held during February, 1978 at Hissar (Harayana) constituated a Sub-committee consisting of the following judges for the best Scientific paper published in the IPHA Journal for Volume 20, 1976 and Volume 21, 1977. The Judges of the panel were as follows :—

1. Dr. S. S. Verma, Director General (Health) Railway Board Ministry of Railways, New Delhi.
2. Dr. W. Mathur, President of the Association, New Delhi.
3. Prof. S. C. Seal, Editor of the IPHA Journal.

The Panel of the Judges reviewed the papers and adjudged the paper entitled—"An Operational Model of the District Tuberculosis Programme"—which was published in the January-March, 1976, Volume 20 issue of the Journal by the/joint authors viz : (a) Sri Srikantaramu, (b) Sri G. V. J. Baily and (c) Sri S. S. Nair of National Tuberculosis Institute, Bangalore. A draft of Rs. 200/- (Rs. Two hundred only). was sent to the first author as the Association Award for the best paper published in Volume 20, 1976 issues.

The members of the Panel also reviewed the paper published in the 1977 issues of the Journal, Volume 21 and concluded that none of the papers was worth the Award of Association.

The Central Council at its 23rd annual meeting held during January, 1979 at Aurangabad constituated a Sub committee consisting of the following judges for the scrutiny of the best scientific paper for the Association Award for the papers publised in Volume, 22, 1978 issues of the Journal. The judges were as follow :

1. Dr. N. S. Deodhar, Director, All India Insti. of Hyg. & Public Health, Calcutta.
2. Dr. S. M. Marwah, Prof. & Head, Dept. of Prev. & Social Medicine, Insti. of Medical Sciences, Banaras Hindu University, Varanasi.
3. Prof. S. C. Seal, Editor of the IPHA Journal, Calcutta.

The sealed recommendations for the best scientific paper have been received from Prof. S. C. Seal and Dr. N S. Deodhar, Dr. Marwah is expected to give his assessment for the best paper during his visit to Ahmedabad. These will be opened and finalised at the 24th annual meeting of the Central Council to be held during February, 1980 at Ahmadabad.

9. World Federation of Public Health Associations, Geneva.

The Indian Public Health Association has been selected to host the Third Inter-

national Congress of the World Federation of Public Health Associations. The Selection has come through a secret ballot election where India got the highest number of votes. This International Congress of the World Federation will be held in Calcutta from 23 to 26 February, 1981 in conjunction with the 25th annual conference of the Indian Public Health Association. The year 1981 also happens to be the Silver Jubilee Year of the Indian Public Health Association.

(a) Registration Fee :

The registration fee for foreign delegates paying before 31st Dec. '80 would be US Dollors 65 (sixty five only) while those paying after this date, shall be US Dollers 75/- (seventy five only). Regarding Indian nationals on deputation by the State/Central Governments, Semi-governments etc, to attend the 3rd International Congress, the registration fee would be Rs. 500/- (Rs. five hundred only) provided it is paid before 31st Dec. 1980. Those paying after that date, the registration fee will be Rs. 550/- (Rs. five hundred fifty only). Members of the Indian Public Health Association attending the congress at their own expenses will be permitted to pay a sum of Rs. 200/- towards registration fee provided the Association agrees to subsidize the fee. Those seeking for such subsidy will have to make request.

(b) Venue :

The World Federation in their invitation letter had mentioned Delhi as the venue of the 3rd International Congress but after discussion with Dr. Susi Kessler of the American Public Health Association, it was found that the World Federation was not particular about hosting the Congress in Delhi. Since the Delhi Branch of the Association was not in a position to host the Congress in Delhi as discussed in the 22nd annual General Body meeting of the Indian Public Health Association, it was desired to hold the 3rd International Congress in Calcutta.

Dr. Deodhar and Dr. Khanna and other members of the Association had visited different Hotels, Cultural Institutions and other places to examine the facilities for conducting the Congress. At this stage, it is felt that the facilities offered by the Park Hotel in Calcutta appeared to be the best Further discussion with the management is under progress. There is also a possibility of holding the International Congress at Singur (Hooghly Dist. WB) in rural setting camps provided the Director General, Armed Forces Medical Services agrees to help us in providing tented accomodation, sanitary and food arrangements. Dr. Deodhar had discussion with the Director General of Health Services and Director General of Armed Forces Medical Services and further developments are awaited.

(c) Time :

Due to tropical climate of our country it was thought that the best time to hold the International Congress in Calcutta would be during

February, 1981 In the light of discussion, with Dr. Susi Kessler, Interim Executive Secretary of the World Federation of Public Health Associations, the dates of the International Congress were finalised as February 23 to 26, 1981.

(d) Language :

The only language of the Congress would be English as there would be practical problems in arranging other languages simultaneously. If required, attempts would be made to provide interpreters for specific persons.

(e) Scientific Theme :

Dr. Deodhar and Dr. Khanna had detailed discussions with Dr. Susi Kessler Interim Executive Secretary of the World Federation of Public Health Associations and Dr. Karl Tavlor, Professor of International Health, Johns Hopkins School of Public Health. Baltimore regarding the arrangements of Scientific Session and other matters for holding the 3rd International Congress. The Theme finalised after the discussion and approved by the Central Council is "Primary Health Care—World Strategy", with the following Sub-themes :—

(1) Developing National Plan of Action,
(2) Special Demonstration and Research Projects in Primary Health Care.
(3) Implementation of Field Programme : (a) Supervision, (b) Information, (c) Evaluation.
(4) Manpower Planning and Training.
(5) Community Participation.

(f) Official Carrier and Travel Agent.

M/s. Air India has been appointed as official carrier and through courtsey, the 1st letter of information is being printed which is likely to be available by the end of February, 1980. M/s. Sita World Travel has been made as our Official Travel Agent and the 2nd letter giving more informations is expected to be printed by them. They have also made a block booking of 200 rooms with different hotels in Calcutta during the 3rd International Congress.

(g) Support from International Organisations.

The World Health Organisation is being approached for holding the spin off conference before or and after the Congress is being worked out.

Mr. James Grant, son of the Late Dr. John B. Grant (Rtd. Director of All India Institute of Hygiene & Public Health, Calcutta) who has recently taken over the office of the Director General of UNICEF has been informed about the Indian Public Health Association's hosting the 3rd International Congress of the World Federation in Calcutta during the month of February, 1981. He has been invited to give a Keynote address on the main theme and also to consider whether the UNICEF could co-sponsor the 3rd International Congress of the World Federation of Public Health Associations. There was also a proposal from Dr. S. M. Marwah, Varanasi to organise a satellite seminar at Varanasi This seminar can be organised jointly with the University Grants Commission and Family Planning Association of India. Prof. Marwah also mentioned that

he would discuss the topic for seminar in the Calcutta Conference.

The Committee entitled "National Council" for the 3rd International Congress of the World Federation has been formed, The members of the National Council are all the Directors of Health Services of States / Union Territories, selected experts in the field of Primary Health Care/Health Services, Presidents and Secretaries of State/local branches of the Indian Public Health Association. Letters have been sent to them soliciting their assistance and guidance in organising the seminar

A list of National Associations affiliated to the World Federation has also been received. Letters have been written to all the six Regional Directors of World Health Organization requesting them to send a list of persons responsible for Primary Health Care of the different countries in their regions. The lists are being collected so that the copies of circular letter are sent to them for circulation.

The important national and foreign journals have been requested to publish the announcement of the 3rd International Congress of the World Federation.

The Organising Committee and Sub-committees have been formed in such a way that they are available at a short notice. All the members of the Committee are Calcutta based. The experts in the field of Primary Health Care are designated as consultant to the Scientific Committee.

10. Federation of Public Health Associations in India.

Inspite of the best intention of many office bearers of the like minded Associations to form a Federation, no concrete result appears to have come upto bring into a reality. Attempts to organise the holding of annual conference of different associations at one place did not materialise. However, the Indian Public Health Association and Indian Association of Communicable Diseases (Bombay), agreed to hold their joint annual conference at Ahmedabad. The other associations also reacted favourably and agreed to discuss this issue further by sending their representatives who happen to be a member of both the organisations. The Indian Association of Preventive & Social Medicine, during their annual conference held at Rewa from January 28 to 30, 1980 agreed to host their a next annual conference at Calcutta. at the time when the Indian Public Health Association would be holding its 25th annual conference. We expect a similar action from other like-minded associations. We had discussion on this point with the other two associations i.e. Indian Association of Occupational Health and Indian Society for Malaria and other Communicable Diseases. Though these associations had reacted favourably but their reply is awaited.

11. Editorial Board of the IPHA journal & Publication.

During the year, three meetings of the Editorial Board were held on 31st March,

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11. Editorial Board of the IPHA journal & Publication.

During the year, three meetings of the Editorial Board were held on 31st March,

1st August and 1st September, 1979 respectively to discuss about the administration and procedures for finalisation of the manuscripts for publication, During the year only three issues namely January to March, April to June and July to September, could be brought out. The July-September 1979 issue was a special issue on 'International Year of the Child'. These issues were sent to all the members and subscribers in India and oversens countries. The 4th issue of the journal i. e. October to December, 1979 (Conference Number issue) could not be brought out till the end of December, 1979 due to frequent load shedding and other problems with the printing press. At the time of the preparation of this report, it was learnt that the press would be releasing the 4th issue by the 3rd week of February, 1980.

Prof. S. C. Seal, Editor of the IPHA Journal prepared the Index of the Journal from the year 1975 to 1978 (four volumes) which was overdue, with the help of the Office Assistant Sri R. N. Thakur. These indices have been published and would be mailed along with the 4th issue of the Journal.

12. Central Council :

During the year one annual meeting i.e. 23rd annual meeting and five ordinary meetings were held on 27th January, 2nd June, 23rd July (emergent meeting), 21st August, 1979 and 14th January and 15th February, 1980 respectively. The 23rd annual meeting was held at Aurangabad at the time of the 23rd annual conference of the Association. At this meeting election of office bearers and other important items of agenda were discussed. The rest five meetings of the Council were held at the Headquarters Office of the Association at Calcutta.

The Council at its meeting held on 2nd June, 1979 accepted the invitation offered by the Gujrat State Branch of the Association to be held at Ahmedabad during January / February, 1980. At the annual meeting held at Aurangabad, the Central Council also nominated Dr. (Mrs) Sushila Nayar, M. P., President, Kasturba Health Society, Wardha. to deliver the Dr. B. C. Dasgupta Memorial Oration Address at the time of the 24th annual conference.

13. Financial position and Accounts.

The audited statement of Accounts of the Association for the year ending 31st December, 1979 is being placed along with the Statements of (i) Liabilities and Assets for the year ending 31st December, 1979 and (ii) Budget estimate for the period from January to December, 1980. The anticipated surplus of Rs. 21,925.78 in the budget estimate takes into account the realisation of outstanding advertisement bills for a sum of Rs 2185/- .

The Association made with the Indian Bank, Central Avenue Branch, Calcutta six Fixed deposit Accounts for a total of Rs. 13,000/- namely Rs. 2,000/- for two FDR for three years, Rs. 3,000/- and Rs. 2,000/- each for one year and Rs 2,000/- (2 FDR each for Rs. 2,000/-) for one year. The Fixed Deposit Receipts of Rs. 11,000/- made in

the year 1978 matured in the year 1979 which fetched to the Association Rs. 399.89 The Association also received a sum of Rs. 188.26 as interest on Savings Account with the above bank.

14. Membership Position and new branches :

There are 820 members on roll, which includes 107 Fellows, 297 life members and 319 ordinary members including Association's half year members (July to December, 1979). Members who have not paid their membership fee for 1979 were requested to send their membership fee. After the 2nd reminder sent the name of members not paying subscription for 1979 have been dropped from the membership list. A total of 187 new members (including life and ordinary) were enrolled during the year.

During the year a new branch of the Association has been established at Bareilly with the efforts of Dt. H. N. Misra, Bacteriologist, Division of Veterinary Public Health, Indian Veterinary Research Institute, Izatnagar. The list of members, office bearers along with the necessary membership fee has been received.

A state branch of the Association is also being established in Andhra Pradesh having its office at Hyderabad. The detaild informations are yet to be received.

15. Activities of State/local branches of the Association.

There are 10 State and 6 local branches of the Association mentioned below :—

State Branches—(1) Delhi, (2) Maharastra, (3) Tamllnadu, (4) Gujarat, (5) West Bengal, (6) Bihar, (7) Goa, Daman & Diu, (8) Karnataka, (9) Madhya Pradesh and (10) General Branch—(members not residing within the jurisdiction of existing branches).

Local Branches :—(1) Allahabad, (2) Varanasi, (3) Hissar, (4) Jamshedpur, (5) Poona and (6) Bareilly.

Out of 16 state / local branches, only 4 branches, nemely (1) Tamilnadu, (2) Bareilly. (3) Jamshedpur and (4) West Bengal State Branch have sent the informations about their main activities along with the list of office bearers. Four branches viz Bihar, Madhya Pradesh, Goa, Daman & Diu and Karnataka appear to have ceased to function.

Activities of the Branches of the Association.

1. Tamilnadu State Branch :

The Tamilnadu branch held its annual general body meeting on 11th January, 1979. At the meeting the branch mourned the loss of Dr. R. Narayan Ex-Director of Public Health. Dr. K. R. Jaganathan has stated that there are too many associations and a doctor is the railway is a remember of service Association viz. Indian Medical Association. He suggested that there should be a unified association say a Public Health Association. About the increase of membership the President. Dr. V. Kapali, has remarked that at least 10 to 12 members should be enrolled in each district and at least two to three members from the district should be present for the annual general body meeting. In his presidential Address, Dr. Kapali pointed out that he would have to chalk out ways and means to enlist more members in the Association. Dr. R. Visalakshi, Vice-president proposed vote of thanks.

2. Bareilly Branch :

This branch had held two meetings in which following topics were discussed :—

1. Proposed strategy of Malaria Eradication. The modified plan by Dr S. P. Mittal and S. Natarajan. There are proposals from some of its members to partici-

pate in Vaccination programmes for benifit of rural and urban children with available vaccine which is being contemplated to be executed in year 1980.

3. West Bengal State Branch :

The members of the Executive Committee in collaboration with the All India Institute of Hyg. & Public Health. Calcutta and the Child In Need Institute organised a seminar entitled Child Health in Subsistence Sector. This branch also organised seminar on 'Environmental pollution and its Impact on Health

The State branch of the West Bengal observed the 23rd Foundation Day of the Association and also held a seminar entitled—"Multipurpose Health Workers" scheme and its implementation. The seminar was inaugurated by Dr. P. B. Chakraborty, Director of Health Services, Govt. of West Bengal.

4. Jamshedpur Local Branch :

This branch held its 15th annual general body meeting on February 2, 1980. At the meeting the election of the office bearers and other important items of agenda were carried out. During the year 1979 this branch held four meetings including one scientific meeting. A condolence was held for sad demise of Dr. S. N. Sarkar who was a life member of the Association. During the year under review, the members of the Jamshedpur branch rendered very valuable services at the various camps including medical relief and First Aid during the communal disturbances.

16. Miscellaneous :

Dr. A. Kiran Kumar resigned from the post of the Asstt. Prof. of Epidemiology. All India Institute of Hygiene & Public Health, Calcutta and was to leave the country. As such he would not be in a position to continue to hold the office of the Treasurer. After discussion with the President, elect, Dr. N. S. Deodhar, and other senior members of the Association the name of Dr. J. S Chauhan, Asstt. Prof of Health Education, All India Institute of Hygiene & Public Health, Calcutta was proposed for the office of the Treasurer. With the kind approval of the President, Dr. S. M. Marwah the office of the Treasurer was offered to Dr. J. S. Chauhan, who very kindly agreed to function as the Treasurer of the Association for the interim period till the regular election is held, at the time of the 24th annual conference of the Association to be held at Ahmedabad during February. 1980. The Central Council at its meeting held on 14th January, 1980 appreciated the services rendered by Dr.A. Kiran Kumar as the Treasurer of the Association for the last three years.

17. Administration :

The administration of the Headquarters Office met all the needs of the members of the Association satisfactorily. The office of the Association continues to function at the Premises of the All India Institute of Hygiene & Public Health. Calcutta.

18. Concluding remarks.

I shall be failing in my dution if I do not acknowledge my sincere and deep sense of gratitude to the President, Dr. S. M. Marwah and President-elect, Dr. N. S. Deodhar, all my collegues of the Central Council for their constant cooperation, guidance and encouragement throughout the year in various matters concerning the welfare of the Association. My thanks are also due to the Vice-presidents, Joint Secretaries, Treasurer and members of the Editorial Board for their advice and valuable help in the management of the affairs of the Association.

Thanks are also due to all the Presidents Secretaries of the State/Local branches of Association for their active cooperation. I also thank Dr. A. N. Patel, Director of Health Services and Dr. J. S. Agarwal, Asstt. Director of Health Services. Ahmedabad and Dr. J. C. Gandhi, Secretary of the IPHA Gujarat State branch for playing host for the 24th annual conference.

(P. N. Khanna)
General Secretary,
Indian Public Health Association.

Copy of the Auditor's Report for 1979

We have audited the attached statement of Receipts and payments Account of Indian Public Health Association for the year ended 31st December, 1979 and report that :—

1. Account :

An Income and Expenditure Account and a Balance sheet should have been drawn up by the Association as provided under its Rules & Regulations.

2. In the following cases actual expenses have exceeded Budget Limits which should have been ratified.

3 (a) Salaries to Staff :

Budgeted—	Rs 10,000 00 p.
Spent—	Rs. 10,166 90 p.

(b) Printing & Stationery—(Publication of Journal)

Budgeted—	Rs. 12,000 00 p.
Spent—	Rs. 13,202 44 p.

(c) Annual Return to Assistant Registrar of Co-operative Societies :

Budgeted	Rs. Nil
Spent—	Rs. 25 00 p.

(d) Printing & Stationery (Office)

Budgeted—	Rs. 1,000 00 p.
Spent—	Rs. 1,895 84 p.

Subject to the foregoing observations, We report that we have found that the attached statement of Receipts & Payments to be correct and in accordance with the books of accounts maintained by the Indian Public Health Association.

Sd/- G. Basu & Co.
Chartered Accounts
3, Chowranghee Approach, Cal-72.

Dated : 20th February 1980

INDIAN PUBLIC HEALTH ASSOCIATION

Receipts & Payments Accounts

			Rs.	P.
	RECEIPTS			
To Opening Balances :				
1.	Cash in hand (including postage stamps Rs. 6·42)	2344·65		
2.	Bank Balance with			
	(i) Indian Bank on savings accounts	3139·60		
	(ii) State Bank of India, N. S. Road Branch on current account	505·97		
	(iii) Outstanding Cheque with State Bank of India, Park Street Branch (account closed) pending clearance from February 1977)	23 50		
3.	Fixed Deposit Receipts with Indian Bank, Central Avenue Branch, Calcutta.			
	(i) on account of Dr. B. C. Dasgupta Memorial Oration Fund.	10000 00		
	(ii) on account of Association's Fund	10000 00	26,013	72
4.	Membership & Journal Subscription (including previous year and subsequent year)		32,342	29
5.	Advertisements		277	50
6.	Recoveries against Puja advance for office staff.		200	00
7.	Fellowship Award Subscription (1978)		516	00
8.	Interest on Savings Account with Indian Bank.		188	26
9.	Interest on Fixed Deposit Receipts with Indian Bank on account of Association's Fund.		399	89
10.	Donation received from IPHA Maharastra State Br.		1,000	00
11.	Sale of old issue of journal & receipts		47	00
12.	Miscellaneous		000	90
			60,985	56

Sd/- P. N. Khanna
General Secretary

Dt. February 19, 1980.

HEAD QUARTERS OFFICE, CALCUTTA-73.

for the year ended 31st December, 1979.

PAYMENTS

			Rs.	P.
By Salaries			10,166	90
1.	Printing of the IPHA Journal (including paper, Press Printing Charges,, Block Charges etc. for three issues and cost of paper for 4th issues. October—December, 1979 issue).		13,202	44
2.	Office Printing Stationery.		1,895	84
3.	Postage (Office and Mailing Journal).		3,628	35
4.	Puja advance to Office Staff.		200	00
5.	Organising the 23rd Annual Conference of the Association contribution to IPHA Maharastra State Branch, Poona.		1,000	00
6.	Bank commission and charges.		342	75
7.	Award of Dr. B. C. Dasgupta Memorial Oration for the year 1978.		900	00
8.	Association Award for the best article published in the Journal, volume 20, 1978.		200	00
10.	Audit Fee for 1978.		200	00
11.	Contribution to IPHA West Bengal State Branch for celebration of Foundation Day of the Assocn.		250	00
12.	Annual return to the Asstt, Registrar for Co-operative Seciety non-profit organization, Government of West Bengal (for 1974 to 1978)		25	00
13.	Miscellaneous		645	15
14.	Advertisement Commission		22	50
15.	Closing Balances Cash in hand (including Rs. 2/- in form of postage stamps) ...	565·96		
	Bank balance with Indian Bank S/B a/c. Central Avenue Branch, Calcutta	3996·45		
	Bank balance with State Bank of India (i) N. S. Road Branch Current a/c.	720·72		
	(ii) Park St., branch (accounts closed cheque pending clearance Feb. '77	23·50		
	Fixed Deposit with Indian Bank, Central Ave., Branch (i) On account of Dr. B. C. Dasgupta Memorial Oration Fund	10000·00		
	(iii) On account of Association's Fund	13000·00	28,306	63
			60,985	56

Sd/- J. S. Chauhan
Treasurer

Sd/- G. Basu & Co., Chartered Accountant
Basu House, Chowranghee Approach
Calcutta-700 072.

INDIAN PUBLIC HEALTH ASSOCIATION

Receipts & Payments Accounts

RECEIPTS

	Rs.	P.	Rs.	P.
To, Opening Balances :				
(1) Cash in hand (including postage stamps Rs. 4·85)	95	60		
Bank balance with State Bank of India on current A/c				
(a) Park Street Branch	1297	03		
(b) Netaji Subhas Road Branch	691	77		
With Indian Bank on Savings A/c at Central Ave. Branch	1497	36	3,581	76
Membership & Journal Subscription (including previous year & subsequent year) ...			54,382	18
Fellowship Award Subscription (1977) ...			400	00
Advertisements in the IPHA Journal ...			587	50
Recoveries against Puja advance from staff			200	00
Interest on Savings Account with Indian Bank, Central Avenue Branch ...			134	25
Interest on Fixed Deposit Receipts on account of Association's Fund ...			67	50
Reprints of articles in the IPHA Journal and sale of old issue of the Journal ...			164	75
			59,517	94

P. N. Khanna
General Secretary

Dt. February 22, 1980.

HEAD QUARTERS OFFICE, CALCUTTA-73.

for the year ended 31st December, 1979.

PAYMENTS

	Rs.	P.	Rs.	P.
By Salaries—			9,799	25
Printing of the IPHA Journal (including paper, printing, block making charges etc. for all the last 3 issues of 1978 and printing charges for October, 1977 only : and payment made in full settlement for 1st issue, 1978 printing) ...			14,045	74
Advance to office staff (puja advance) ...			200	00
Office printing & Stationery ...			1,220	10
Audit Fee (1977) ...			200	00
Bank Charges			373	95
Postage (Office & Journal)			5,270	05
Conveyance & Travelling (including paid in advance for 1979.)			308	65
Contribution towards organizing 22nd annual conference of the Association at Hissar ...			1,000	00
Service charges (monthly) for Typewriter Machine (including subsequent year) ...			72	00
Miscellaneous			814	48
Cheque deposited in 1972 but not yet realised, written off			300	00
Closing Balance :—				
(i) Cash in hand (including postage stamp Rs. 6·42)	2344	65		
(ii) Bank balance with— (a) State Bank of India, Netaji Subhas Rd. Br. on Current A/c	505	97		
(b) Indian Bank, Central Avenue Br. on Saving Account	3139	60		
(iii) Fixed Deposit with Indian Bk. (a) On account of late Dr. B. C Dasgupta Memorial Oration Fund	10000	00		
(b) On account of Association's Fund— ...	10000	00	25,990	22
Outstanding cheque with State Bk. of India, Park St. branch pending clearance from February, 1977			23	50
			59,517	94

A. Kiran Kumar
Treasurer.

Sd/- G. Basu & Co., Chartered Accountant
Basu House, Chowranghee Approach
Calcutta, 700 072

INDIAN PUBLIC HEALTH ASSOCIATION

Balance Sheet as at

			Rs.	P.
LIABILITIES				
1. Membership fee due to World Federation of Public Health Associations, Geneva and being prescribed for payment—				
(i) 1975 and 1976	Rs. 1,030·00			
(ii) 1976 to 1979	Rs. 1,400·00		2,430	00
2. State share in respect of Membership			2,080	00
3. Publication of the Journal –				
(i) M/s. Eka Press, Calcutta (for April, 1973 issue)		Rs. 1,115·10		
(ii) M/s Asian Printers, Calcutta (for reprinting in January '76)		Rs. 64·00		
(iii) M/s Tower Process, Calcutta (Block making charges for Oct. '79 issue)		Rs. 163·25	1,342	35
4 Fixed deposit with Indian Bank on Account of Dr. B. C. Dasgupta Memorial Oration Fund			10,000	00
			15,852	35
5. Excess of Assets over Liabilities			17,881	78
			33,734	13

HEAD QUARTERS OFFICE, CALCUTTA-73.

31st December, 1979.

ASSETS

			Rs.	P.
1.	Advertisements in the Journal (Including Rs. 1,142·50 for 1978 and 1979)		3,327	50
2.	Advance to staff (Puja Advance)		120	00
3.	Subscription to Journal (India & Abroad)		380	00
4.	Membership Fee (Life Members paying in instalment due for 1979)		550	00
5.	Holding of Annual Meeting of the IPHA West Bengal (State Branch during 1978)		150	00
6.	Interest on Fixed Deposit Receipts on Account of Dr. B. C. Dasgupta Memorial Oration address with Indian Bank		900	00
7.	Fixed Deposit Receipt with Indian Bank on Account of Dr B. C Das Gupta Memorial Oration Fund		10,000	00
8.	**Closing Balance :**			
	(i) Cash in Hand (including Postage, Stamps of Rs. 3/-)	565·96		
	(ii) Bank Balance with			
	(a) Indian Bank, Central Avenue Branch on Saving Account	3996·45		
	(b) State Bank of India, N. S. Road, Branch on Current A/c	720·72		
	(iii) Fixed Deposit with Indian Bank on Account of Association's Fund	3000 00		
	(iv) State Bank of India, Park St. Branch pending cheque for clearance (being Accounts closed and transferred to N. S Road Branch)	23·50	18,306	63
			33,734	13

P. N. Khanna
General Secretary

J. S. Chauhan
Treasurer (Interium)

INDIAN PUBLIC HEALTH ASSOCIATION

Budget Estimate for the period from

		Rs.	P.
	INCOME		
1.	Membership fee (in form of Central Share)		
	A. Existing Member		
	(i) Oridinary 430 × Rs. 14/-	Rs. 6020·00	
	(ii) Life in instalment 20 × Rs. 50/-	1000·00	
	*(iii) Ordinary Members 73 × Rs. 20/-	1460·00	
	New Members		
	(i) Ordinary Members 100 × 14/-	1400·00	
	(ii) Life in full 20 × 200/-	4000·00	
	(iii) Life (in full Central share 30 × 140/-	4200 00	
	*(iv) Ordinary Members in full 30 × 20/-	600 00	
	(v) Life (in Instalment) 30 × 50/-	1500·00	20,180 00
2.	**Subscription to Journal**		
	(i) Govt. of West Bengal (Directorate of Health Services)	7750·00	
	(ii) Subscribers in India	4500·00	
	(iii) Subscribers in Overseas Countries	3000·00	15,250 00
3.	**Interest on Fixed Deposits.**		
	(i) On A/c. of Dr. B. C. Dasgupta Memorial Oration Fund.	900·00	
	(ii) Association's Fund (Rs 1050 00)	1050·00	1,950 00
4.	Interest on Saving Account		200 00
5.	Advertisement in the IPHA Journal		2,000 00
6.	Fellowship Award Subscription (1979)		1,000 00
7.	Sale of old issues and reprints in the Journal		300 00
8.	Recovering against Puja Advance from Staff		200 00
9.	Excess of Assets over liabilities		17,881 78
			58,961 78

* Members not residing into jurisdictions of any State/ Local Branch

Note : As the October—December, 1979 issue of the Journal could not be brought out by and of December, 1979 the account of revenue and expenses has not been taken for the same.

HEAD QUARTERS OFFICE, CALCUTTA-73.

January to December, 1980.

EXPENDITURE

		Rs.	P.
1.	Salary to Office Staff	11,000	00
2.	Puja Advance ,,	200	00
3.	Printing of the Journal (including Paper, Printing, Charges. Block Charges etc. for all the 4 issues of 1980 and printing charges only for October-December 1979 issue)	15,000	00
4.	Honorarium for Auditors (1979)	200	00
5.	Postage (Office despatch and Journal)	5,000	00
6.	Office printing and stationery	2,000	00
7.	Advertisement Commission	500	00
8.	Association Award (for 1978)	200	00
9.	Dr. B. C. Dasgupta Memorial Oration Address Award	900	00
10.	Membership Fee to World Federation of Public Health Associations (Approx.)	800	00
11.	Bank Charges	400	00
12.	State share in respect of Membership fee	500	00
13.	Conveyance and Travelling	300	00
14.	Services Charges for Type Machine	36	00
15.	Miscellaneous	1,000	00
16.	Excess of Income over expenditure (Surplus)	21,925	78
		58,961	78

P. N. Khanna
General Secretary

J. S. Chauhan
Treasurer (Interium)

INDIAN JOURNAL OF PUBLIC HEALTH
Vol. XXIV, No. 4,
October—December, 1980

PROCEEDINGS OF THE 24TH ANNUAL GENERAL MEETING

Minutes of the 24th Annual General Body Meeting of the Indian Public Health Association, held on Sunday the 24th Feb, 80, at 10.00 a m. in the Lecture Hall of Dental College, New Civil Hospital Campus, Ahmedabad.

In all 54 members attended the meeting.

Dr. S. M. Marwah, the President of the Association, thanked all the members present and took the chair to conduct the business agenda of the meeting.

Agenda No. 1 & 2.

Confirmation of the proceedings of the 23rd annual General Body meeting of the Association held on Sunday, the 26th January 1979 at Aurangabad (Maharashtra) and to discuss matters arising from item No. 1 of the above.

The proceedings of the 23rd Annual General Body meeting were read by the General Secretary, a copy of which was put in the folder of all the members of the Association, The proceedings were confirmed after discussing a few points.

The proceedings have been printed in the Conference Number (October, December, 1979), Volume 23, No. 4 issue of the Journal-Indian Journal of Public Health, which had already been circulated to the members of the Association.

Agenda No. 3.

To approve and adopt the Annual Report of the General Secretary for 1979.

Prof. P. N. Khanna, General Secretary of the Association read out the annual report on the antivities of the Association and its branches during the year 1979. Secretaries of all state and local branches were requested to send their annual reports on the activities of their branches during 1979. Reports were received only from five branches. These were included in the report. He further informed the house about the formation of two new branches of the Association viz, Lucknow local branch and Andhra Pradesh State branch respectively. The General Body recorded the appreciation of the services of the General Secretary and approved the annual report.

Agenda No. 4.

To approve and adopt the audited Statement of accounts for the year ending 31st December, 1979.

The audited Statement of Accounts for the period ending 31st December, 1979 was considered. The General Body approved and ratified the Statement of Accounts.

Agenda No. 5.

To approve and adopt the (i) Assets & Liabilities for the year ending 31st December, 1979 and (ii) Budget estimate for the period January-December, 1980.

The Assets & Liabilities for the period ending 31st December, 1979 and budget estimate for the period January to December. 1980 were considered.

The General Secretary informed the members that the Indian Public Healh Association has been invited to host the 3rd International Congress of World Federation of Public Health Association, Geneva. To host this Conference, some amount of money will be required to be transferred to the 3rd International Congress of WFPHA account to meet the immediate expense.

The General Body considered and approved the rocommendation of the Central Council for a loan of Rs. 5000/- in the first instant to be drawn from the Association's fund to meet the expenses of the office of the 3rd International Congress. If, However, some additional amount is required, the same might be drawn from the Association's fund to the International Congress account. The entire loan has to be returned to the Indian Public Health Association as and when the fund of the 3rd International Congress of WFPHA is available.

The General Body also noted a surplus of Rs. 21,925/- in the Budget estimate which takes into account the realisation of outstanding advertisement bills of Rs. 2185/-. The Assets and Liabilities and Budget estimate were approved and ratified by the General Body.

Agenda No. 6.

To approve and ratify the results of election of (i) President-elect and (ii) Two Vice-Presidents and other office bearers of the H/Q office viz. (a) General Secretary, (b) Two Joint Secretaries and (c) Treasurer for 1980-81.

As per Rule 19C of the Rules and Regulations and Memorandum of the Association, the nominations were invited from the members of the Association for election of the President elect and two Vice-Presidents for the year 1980-81. A total of five nominations each for the election of President elect and two vice-presidents were received. The nomination for Dr. C. Gopalraj Chetty of Mysore was not valid since he had not completed five years of standing in the Association. Dr. S. M. Marwah and Dr. B. C. Ghosal withdrew their names from the contest in favour of Dr. Ranjit Sen. Dy. Director General of Health Services, New Delhi, while no reply was received from Dr. J. Nath inspite of a reminder. Regarding the nomination of vice-presidents, the consent of Dr. M. S. Jayadevaiah of Bangalore was not received inspite of reminders sent to him. The nomination of Dr. Ranjit Dutta, Princi-

pal, Rural Family Planning Training Centre, Calcutta was not considered valid since he had completed only two years in the Association and membership dues were not cleared from 1976. The other two members viz Dr. (Mrs) L. Philip, Calcutta and Dr. P. N. Khanna, Calcutta withdrew their nominations, hence, there was no contest.

The General Body on the recommendation of the Central Council approved and ratified the election of the President-elect and two Vice-Presidents for the following members :

1. Dr. Ranjit Sen, Dy. Director General of Health Services, Ministry of Health & Family Welfare, Govt. of India, New Delhi. for the office of the President—elect and 2. Dr. M. M. Ganguly, Principal, Burdwan Medical College Burdwan. 3. Dr. P. K. Mukherjee, Prof. of Public Health Administration. All India Instt. of Hygiene aud Public Health, Calcutta for the offices of the Vice-Presidents.

The General Body also approved and ratified the nomination recommended by the central council for the following office bearers of the Headquarters office of the Association.

1. General Secretary : Dr. P. N. Khanna Prof. of Veterinary Public Health, All India Instt. of Hygiene and Public Health, Calcutta. (re-elected)
2. Two Joint Secretaries :
   (a) Dr. G C. Roy
   Senior Epidemic Control officer, Govt. of West Bengal, Calcutta.
   (re-elected)
   (b) Dr. A. K. Dasgupta
   Dy. Director of Health Services, Govt. of West Bengal, Writers' Buildings, Calcutta.
3. Treasurer :
   Dr. J. S. Chauhan, Asstt. Prof. of Health Education, All India Instt. of Hygiene and Public Health, Calcutta.

Agenda No. 7.

To approve and ratify the election of ten members to represent in the Central Council of the Association for 1980-81.

On the recommendation of the Central Council the General Body approved and ratified the election of the following members to represent in the Central Council :—

1. Prof. G. Anjaneyulu, Hyderabad.
2. Dr. P. V. Sathe, Aurangabad.
3. Air Vice-Marshall, J. K. Sehgal, New Delhi.
4. Prof. Rameswhar Sharma, Jaipur.
5. Dr. B. Sankaran, New Delhi.
6. Brig. R. N Taneja, Calcutta.
7. Dr. B. C. Ghosal, New Delhi
8. Dr. M. L. Chugh, Ludhiana.
9. Dr. N. K. Sinha, New Delhi.
10. Dr. I. C. Tiwari, Varanasi.

Agenda No. 8.

To approve and ratify the Award of Fellowship of the Indian Public Health Association for the year 1979.

Nominations were invited from the presidents of all State and Local branches, existing fellows and life members of the Association for the award of Fellowship. A total of 17 (Seventeen) nominations were received. The Credential Committee under the chairmanship of Lt. General D. N. Chakravorty considered the nominations and recommended 9 (nine) candidates for election to the Award of Fellowship. The ballot for the nine candidates along with their brief bio-date were sent to all the existing Fellows for obtaining their opinion on selection. The Council, during the meeting, appointed Dr. J. S Agarwal of Ahmedabad and Dr. N. K. Chandiramani of Hissar as Returning Officers in connection with the scrutiny of the ballot papers. Out of 47 (forty Seven) ballots received duly casted by the existing Follows : one ballot was declared unvalid and hence rejected. In the order of votes polled the following 7 (seven) members were declared for the award of Fellowship of the Association for the Year 1979 :

1. Dr. P. K. Mukherjee, Calcutta.
   Prof. of Public Health Administration, All India Instt, of Hygiene & Public Health, Calcutta.
2. Dr. C. K. Rao, New Delhi.
   Dy. Director, National Institute of Communicable Disease, New Delhi.
3. Dr. P. V. Sathe, Aurangabad.
   Prof. of Preventive & Social Medicine, Medical College, Aurangabad.
4. Dr. P. C. Sen, Advisor in Nutrition, Directorate General of Health Services, New Delhi.
5. Dr. G. C. Roy, Dy. Director of Health Services, Govt. of West Bengal, Calcutta.
6. Dr G. A. Panse, Dy. Director of Health Services, Govt of Maharashtra, Bombay.
7. Lt. Col. S. L Sachdeva, Reader, Dept. PSM, Armed Forces Medical College Poona.

Agenda No. 9.

Consideration and approved of the resolution(s) put forward by the member.

A total of three resolutions were received Copies of it were made and distributed to the members.

Resolution No. 1.

The resolution was moved by Dr. G. A. Panse, President IPHA Maharashtra State Branch. He proposed that the President elect of the Association should be invited to give the Presidential Address and not the outgoing President, at the time of the Annual Conference. The resolution was discussed at length and the members approved the same, In the fitness of things, it was suggested that during the 1981 annual conference both the President and the President-elect should be invited to give the Presidential address. From the year 1982 onwards, only the President elect will give the Presidential address.

Resolution No. 2.

The Resolution was moved by Dr. S. C. Seal, Editor of the IPHA Journal, in respect of the publication of the Journal. After a lengthy discussion, the house empowered

the Editor to make the necessary changes and create positions to run the office of the Journal effectively.

The request of M/s. Saroopa Trading. Calcutta, Printer of the IPHA Journal, to increase their rates towards printing charges was also put up. The house, after discussion, empowered the Editor to take necessary action, during the Editorial Boards Meeting of the IPHA Journal.

Resolution No. 3.

This resolution was moved by Dr. S. M. Marwah, out-going President of the Association and dealt with the amendment in Schedule K for item 22 of the Drugs Act. After discussions, the matter was withdrawn by Dr. Marwah.

Agenda No. 10.

To consider the progress about the formation of 'Federation of Public Health Associations in India.

Prof. Khanna explained to the General Body the efforts made be the Indian Public Health Association in the formation of a Federation of Public Health Associations in India and said that the present conference which is a joint venture between the Indian Public Health Association and Association of Communicative Diseases (Bombay), in a good step in the right direction. It was desired that more efforts are required in this direction.

Agenda No. 11.

To consider the progress made in hosting the 3rd International Congress of the World Federation of Public Health Associations, Geneva, in conjunction with the 25th annual conference of the Indian Public Health Association (Silver Jubilee year) to be held from February 23 to 26. at Calcutta

The General Secretary gave the details of the progress already made particularly in respect of the venue, theme of the Scientific Session, delegation fee, language, official carrier and Travel agent etc He also informed that the 1st letter of information is being printed through the courtesy of M/s. Air India, Bombay. He further added that the UNICEF has already agreed to co-sponsor the International Congress and the other organisations are now being approached.

Professor Marwah discussed about his plans of organising a satellite post-conference seminar at Varanasi. The house was of the view that the delegation fee for the members of the Indian Public Health Association and other co-sponsoring organisations may be reduced to Rs. 200/- (Rupees two hundred only) and the remaining amount of Rs. 300/- (Rupees three hundred only), may be met by the Indian Public Health Association. It was also decided to include the names of the Professors of Veterinary Public Health in the list of National Council.

The General Body approved the proposal of the Central Council for the chairman and the General Secretary of the Organising Committee of the 3rd International Congress of the WFPHA and 25th Annual Conference of the IPHA to take suitable steps for hosting the conference.

Dr. N. S. Deodhar, President-elect of the Association, informed the house that the world Health Organisation has kindly agreed to held a regional conference in Calcutta for three days prior to the 3rd International Congress.

Agenda No. 12.

To announce the office bearers and 2 members representing in the Central Council from various State/local branches of the Association.

Out of 16 States and local branches of the Association. only 4 (four) sent the list of the office bearers along with their annual report and the names of two members representing in the Central Council for the year 1980-81. These are as follows :—

1. Jamshedpur local branch.

a) President—Dr. R. C. Pandey
b) Vice-President—Dr. A. S. Dutta
c) Hony. Secretary - Dr. S. A. Palit
d) Treasurer—Sri A. K. K. Sinha

2 members in the Council

a) Dr. R. C Pandey
b) Dr. H. K. Samanta

2. West Bengal State Branch.

a) President—Dr. J. Nath
b) Vice-President—Dr. P. C. Sen
c) -do- Dr. A. K. Dasgupta
d) Hony. Secretary Dr. S. P. Mukhopadhyay
e) Treasurer—Dr. A. K. Halder

a) Dr. S. P. Mukhopadhayay
b) Dr. A K. Halder

3. Tamil Nadu Branch.

a) President—Dr. V. Kapali
b) Vice-President—Dr. (Smt.) R. Visalakshi
c) -do- Dr. K. R. Jagannathan
d) Secretary—Dr. S. Padmanabhan
e) Joint Secretary—Dr. K. Veeraraghavan
f) Treasurer—Dr. W. D. Chellandurai

a) Dr. K. R. Jagannathan
b) Dr. B. R. Desikachari

4. Bareeilly Branch.

a) President—Dr. C. M. Singh
b) Vice-President—Dr. Satya Prakash
c) Secretary—Dr. H. N. Misra
d) Joint Secretary—Dr. S. N. Shukla
e) Treasurer—Sri D. Rama Rao

a) Dr. C. Natrrajan
b) Dr. H. N. Misra

Agenda No. 13.

To approve and ratify the nomination for the Orator of Dr. B. C. Dasgupta Memorial Oration Address for the year 1980.

The General Body approved and ratified the recommendation of the Central Council for the following 2 names for the Dr. B. C. Dasgupta Memorial Address to be delivered at the time of the 25th annual conference of the Association. In case, the first nominee express his inability to give the oration Address, the second candidate may be offered. The preposed two names are as follows :—

1. Dr. A. P. Ray
   Retired Director, National Malaria Eradication Programme, Delhi.
2. Dr. T. R. Rao,
   Retired Director, Virus Research Centre, Poona.

The House recommended that out of the Dr. B.C. Dasgupta Memorial Oration Award, about one third of the amount should be spent for the preparation of a medal and a scroll. The remaining amount may be presented in cash or cheque to the receipient.

Agenda No. 14.

To approve and ratify the formation of Panel of judges for scrutiny of the best Scientific paper published in the IPHA Journal, Vol. 23, 1979 for Association.

Award.

The General Body approved and ratified the recommendation of the Central Council for the panel consisting of the following judges for scrutiny of the best scientific paper published in the IPHA quarterly journal Indian Journal of Public Health. Vol 23, 1979 for the Association Award of Rs. 200/- to be given at the time of the 25th Annual Conference of the Association.

1. Dr. N. S. Deodhar, Director,
   All India Inst. of Hygiene & Public Health, Calcutta.
2. Dr. S. M. Marwah, Prof. & Head of Deptt. of P. S. M, Instt. of Medical Sciences, Banaras Hindu University, Varanasi
3. Dr. S. C. Seal, Editor, Indian Journal of Public Health, 2, Fern Plance, Calcutta.

Agenda No. 15.

To approve and ratify the recommendations of the 24th annual conference of the Indian Public Health Association.

The General Body approved and ratified the recommendation of the Central Council for the formation of the sub-committee consisting of the following two members, for preparation of draft recommendations of the 24th annual conference These recommendations after finalisation, has to be circulated to all the Directors of Health Services/Secretaries, Health department of all the States and Union Territories, Director General of Health Services, Armed Forces Medical Services, Health member Railway Board etc. for implementation. The General Secretary has been requested to send the recommendations

after its finalisation. The members of the Sub-committee are as follows :—

1. Dr. J. S. Agrawal, Asstt. Director of Health Services Govt. of Gujarat, Ahmedabad.

2. Dr. J. C. Gandhi, Asstt. Professor and Medical Officer Incharge Training Centre, Bavla Dist. Ahmedabad, Guj.

Agenda No. 16.

To approve and ratify the appointment of Auditors for the year 1980.

The General Body approved and ratified the recommendation of the Central Council for the appointment of Auditors. M/s. G. Basu & Co., Chartered Accountants, Calcutta, to audit the accounts of the Association for the year ending 31st December, 1980

Agenda No. 17.

To approve and ratify the date, venue and the subject for the Scientific session for the next (25th) annual conference.

Keeping in view of the recommendation forwarded by the Central Council for hosting the 3rd International Congress of the World Federation of Public Health Associations, (Geneva), in conjunction with the 25th annual conference of the Indian Public Health Association, during February/March, 1981 at Calcutta, the General Body approved and ratified the recommendation. The date decided was February 23 to 26, 1981 and the subject decided for the Scientific Session was "Primary Health Care—World Strategy".

Agenda No. 18.

Any other matter brought forth by the member with the permission of the Chairman.

No matter was brought forth by the member for discussion.

The meeting, then ended with a vote of thanks to the chair.

Sd/- Prof. S. M. Marwah Chairman
(President)

Sd/- Prof. P. N. Khanna
General Secretary

Indian Public Health Association
H/Q. Office, Calcutta.

D. Sc. for Dr. Seal

Dr. S. C. Seal, MB, DPH, PhD., FNA, FAMS, FAS, FNIE, FIPHA FAPHA (Hon), Foundation Secretary and Ex-President of the Indian Public Health Association and currently Editor of the Association Journal has been awarded the Degree of D. Sc. (Bact-Medicine) by the Bombay University in October, 1980 for his comprehensive research on Plague leading to the possibility of complete eradication of the once most dreadful scourge of the world.